

DISCOURSE, DISEASE AND DISPLACEMENT:
INTERROGATING SELECTED SOUTH AFRICAN TEXTUAL CONSTRUCTIONS OF AIDS

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FELICITY JUNE HORNE

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SUPERVISOR:
Dr G. Graham-Smith

CO-SUPERVISOR:
Prof. B. Spencer

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DEDICATION

Dedicated to my late parents

Margaret and Billy Kirk

for giving me a love of the English language and books.

DECLARATION

I declare that this thesis, entitled 'Discourse, Disease and Displacement: Interrogating Selected South African Textual Constructions of AIDS', is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

Signed:

Discourse, Disease and Displacement: Interrogating Selected South African Textual Constructions of AIDS

SUMMARY

This thesis explores the theme of displacement in AIDS (Acquired Immune Deficiency Syndrome)-related discourse in post-apartheid South Africa in the period 1994–2010. It contends that the subject of AIDS and the AIDS-ill is seldom confronted directly in the discourse, but displaced in various ways. Using the theory of social constructionism and the discourse theory of the French poststructuralists, particularly Michel Foucault, selected texts, both literary and non-literary, are subjected to discourse analysis, in which the interrelationships between linguistic and visual representations of AIDS, practice, knowledge and power relations are examined.

Recognising that all representations are to some extent displaced constructions, the thesis investigates additional reasons for the particular kinds of displacement of AIDS seen in AIDS discourse. These include stigma, fear, defensiveness and the enduring power of pre-existing discourses onto which AIDS is grafted. In narratives by and about the AIDS-ill, personal stories are displaced when mythical structures are used to give meaning to what could otherwise be viewed as futile, random suffering. As a result of the different displacement devices employed in AIDS discourse, new meanings of AIDS are constructed, related to the social, political and cultural context out of which they have arisen.

The thesis comprises five chapters, each of which explores a different form of displacement. In Chapter 1, 'Displacing AIDS through Language', the focus is on language as a form and means of displacement; Chapter 2, 'Politicising AIDS' explores the way that AIDS discourse is projected onto the larger, well-established discourse of politics, and specifically on the discourse of 'the struggle' against apartheid; while Chapter 3, 'Satirising AIDS', considers the way that satirists displace AIDS through irony, exposing the contradictions and absurdities inherent in the discourse. Chapter 4, 'Gendering AIDS', shows the extent to which AIDS-related discourse is articulated to gender-related issues such as unequal power relations between men and women and stereotypical views of women's identities and 'proper' roles. The final chapter, Chapter 5, 'Narrating AIDS', deals with the discourse of personal illness narratives, showing how individuals displace the experience of illness through narrative, often using the structures of myth to give meaning to their experience.

Key terms:

HIV; AIDS; South Africa; discourse; discourse analysis; displacement; representations; social constructionism; texts; language; politics; satire; gender; narrative.

Discourse, Disease and Displacement: Interrogating Selected South African Textual
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Key Terms and Acronyms

ABC	Abstain; Be Faithful; Condomise (Government AIDS-Education Campaign)
ANC	African National Congress
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral: medication which inhibits the replication of the HI-virus
AZT	Zidovudine: an antiretroviral treatment
AWB	<i>Afrikaner Weerstandsbeweging</i> (Afrikaner Resistance Movement)
CD4	a cell in the immune system which is attacked by the HI-virus
CD4 count	the number of immune cells in the blood, used as a measure of immune function in the body
HIV	Human Immunodeficiency Virus
MSF	<i>Médecins Sans Frontières</i> (Doctors without borders)
MTCT	Mother-to-child transmission
Nevirapine	An ARV used to treat HIV-positive pregnant women
TAC	Treatment Action Campaign
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
WHO	World Health Organisation

HIV-positive and AIDS

To be HIV-positive indicates that a person has been infected with the HI-virus, but is not symptomatic: they will generally appear and feel healthy. AIDS is the disease syndrome that eventually results from this infection. The time delay between HIV-infection and manifestation of the symptoms of AIDS varies, but can take many years. Being HIV-positive and having AIDS are therefore two separate, but related conditions. It is now customary to use the compounds 'HIV/AIDS' or 'HIV and AIDS' to refer to the condition, but to avoid clumsiness I have chosen to use the term AIDS in this thesis in a generic way, except when referring specifically to the HI-virus, which I term 'HIV'.

Discourse

'Discourse' is understood differently according to which field or school uses the term. In the discipline of Linguistics, 'discourse' is synonymous with 'text', and refers to a stretch of language, spoken or written.

The European or 'Continental' School, represented chiefly by Michel Foucault, understands 'discourse' in a more broad and abstract way which includes knowledge systems, social practices, visual texts and other forms of semiosis, as well as linguistic texts. Discourse is seen as a human construct which brings an object into being, or produces a social reality. Discourse is inaccessible in its entirety, but traces of it are found in the texts that help to constitute it.

This school holds that discourses reflect and shape the power structures in society. Discourse constructs identities by defining groups, their interests and their status in society.

It labels, classifies and organises social structures. However, such constructs are not fixed or stable.

In this thesis, I draw on both these strands of meaning. Many of the texts on which this study is based are linguistic or literary, but some constitute cultural events and abstract phenomena such as bodies of knowledge and schools of thought and opinion.

Discourse Analysis

Following from the differences in the way the term 'discourse' is understood' (explained above), 'discourse analysis' cannot be seen as a single methodology. When used in the field of linguistics, it involves the examination of the language of texts at the micro-level of language use, as well as a consideration of the connections between different texts, and their context. This is known as 'textually-oriented discourse analysis' (TODA) (Fairclough 1992: 37).

According to the Foucauldian tradition, 'discourse analysis' involves the analysis of texts (where 'texts' are seen as more than linguistic artefacts) to demonstrate how these contribute to the creation of social realities, including institutions and cultural entities ('discursive formations'). This involves a consideration of the power relations and discursive inequalities that operate in society.

Here again, my study draws on both these traditions, and I employ a synthesis of both approaches in my analyses.

Disease

'Disease' refers to the way medical discourse views, labels and constructs health problems. 'Disease' is distinguished from 'illness', which refers to the patient's experience of ill health. This corresponds with Kleinman's (1988) distinction between 'hard' discourse, which emphasises the scientific and technical aspects of illness; and 'soft' discourse, which embraces the psychological and subjective dimensions.

Displacement

On the literal level, displacement refers to the removal of something from its usual or correct place.

The notion of displacement has its psychoanalytical origins in the work of Freud. From the German *Verschiebung*, literally meaning 'shift' or 'move', displacement is an unconscious defence mechanism whereby threatening emotions or ideas are transferred from their original cathexis to a 'safer', more acceptable substitute. This psychological trope also has significance in relation to the euphemistic linguistic displacements that typify much of the discourse surrounding AIDS.

Introduction

The terrain is as important as the germ. (Louis Pasteur)¹

The discursive field of AIDS unfolds as a landscape of displacements (Lee Edelman)²

... the metaphor of the discursive, of textuality, instantiates a necessary delay, a displacement, which is always implied ... you will always be working in an area of displacement. There's always something decentered about the medium of culture, about language, textuality, and signification, which always escapes and evades the attempt to link it, directly and immediately, with other structures.
(Stuart Hall)³

This thesis examines selected South African texts related to Human Immunodeficiency Virus (hereafter referred to as 'HIV') and Acquired Immune Deficiency Syndrome (hereafter referred to as 'AIDS') in the post-apartheid period, from the time of the first democratic election in April 1994 to April 2010. This period of South African history has been marked by dramatic political and social change. Temporally, the peak of the epidemic of AIDS coincided with the changeover to democracy,⁴ so that the disruption caused by AIDS has complicated an already turbulent period of social transformation. In this process, the discourse of AIDS has become inseparably entangled with many other discourses.

Although this study ranges over a number of subject fields, it is located in English Studies. My academic background has primarily involved the study of English literature and

¹ (Downing 2005: 72)

² (Edelman 1994: 94)

³ (Hall 1992: 284)

⁴ The new ANC-led government took power in 1994, which was also the approximate period that AIDS began to manifest as an epidemic. While massive HIV-infection took place in the 1980s, as it did in the rest of the world, the delay between infection and manifestation of illness (8-10 years) meant that the epidemic only began to be really noticeable post-1994 (Lewis 2004: 102). In the years before democracy, testing was not conducted on a national basis because South Africa was divided into 'white' areas and 'black homelands'. The latter were excluded from earlier surveys as they were not considered to be part of South Africa under the apartheid regime (Barnett and Whiteside 2002: 117).

language, which I have taught for more than thirty years. Over this period, the discipline of English Studies has broadened, venturing into other areas in the human sciences including sociolinguistics, cultural studies, sociology, anthropology, psychology, history, politics, and gender studies. This thesis reflects this increasingly multidisciplinary approach. Indeed, it would not be possible to engage with the topic of the AIDS pandemic without taking into account political, historical, economic, social, cultural and other factors. Theoretically, the thesis is informed by the work of the French poststructuralists, and especially Michel Foucault's constructionist and discourse theory. I engage in both textually-oriented discourse analysis (TODA) (Fairclough 1992: 37), as well as the kind of discourse analysis practised by the European school (see Introduction, pages 7-8), favouring the social constructionist approach. The writings of the sociologist Pierre Bourdieu and anthropologist Johan Galtung have also been highly influential in my approach to and understanding of discourse. Other cultural theorists including Susan Sontag, Paula Treichler, Deborah Lupton and David Morris have all developed my insight into the sociological dimensions of HIV and AIDS.

I have chosen this particular topic because the phenomenon of AIDS is a relatively new one, in historical terms, and has had a dramatic impact on individuals and communities in South Africa, permeating and absorbing many different discourses. My personal and professional interest in language, and many years' experience of close textual analysis, have given me a sharp awareness of how linguistic and other discursive formulations reflect perceptions and enable conceptualisation of the condition. Language operates as a form of social practice which constructs versions of AIDS and the AIDS-ill. These versions are not natural or inevitable and serve the interests of particular groups. Hegemonic, Eurocentric, patriarchal, heteronormative discourse subtly defines black people, women, prostitutes, the poor, homosexuals and the AIDS-ill as the 'Other', effecting their marginalisation in society, but the dominance of such constructions may be challenged by counter discourses. The Bambanani women's group, for example (discussed in Chapters 4 and 5), assert themselves and speak out with pride despite their disadvantaged backgrounds and HIV-positive status, while the courageous stand taken by Judge Edwin Cameron (Chapter 5) represents an

important challenge to the stigma associated with homosexuality and AIDS. Highly vocal and visible activist groups such as the Treatment Action Campaign (TAC) have done much to reverse the marginalisation of HIV-positive people, defiantly giving a favourable meaning to the word 'positive' in the phrase 'HIV-positive'. Similarly, the work of satirists like Pieter-Dirk Uys and Jonathan Shapiro ('Zapiro') radically subverts the dominant discourse, dislodging it from its position of power. I believe that this study could help to achieve a more critical awareness of the linguistic and discursive meanings constructed around AIDS and the AIDS-ill, and encourage a more balanced and accepting attitude.

The magnitude of the AIDS-epidemic in South Africa – and hence its importance as a research topic – may be gauged by the following statistics. In proportion to its population, South Africa has the biggest HIV-positive population in the world. UNAIDS statistics indicate that 5.7 million out of nearly 48 million South Africans are living with HIV. It is estimated that, since 2000, approximately 5000 people a week have died of AIDS in South Africa.⁵ From 1999, AIDS has been South Africa's leading cause of death. In the year 2000, 40 per cent of deaths among those aged 15-49, and 25 per cent of total deaths, including children, were from AIDS-related illnesses (Van der Vliet 2004: 66). Approximately two and a half million deaths will have occurred from AIDS by the end of 2010. By 2015, the projection is that about 32 per cent of all children in South Africa will have lost one or both parents to HIV/AIDS, leaving one in three children orphaned.⁶

Reasons for the rapid growth and catastrophic scale of the South African AIDS epidemic are numerous and complex, but the socio-political context has been a key factor. The epidemic has been described as a consequence of 'apartheid's chickens coming home

⁵ Statistics relating to AIDS are notoriously unreliable. Data are often skewed by the 'invisibility' of AIDS as a cause of death. Because AIDS deaths may carry social and financial consequences, and doctors are not obliged to give HIV/AIDS as an underlying cause of death from tuberculosis or pneumonia, death certificates are not necessarily a useful guide to actual AIDS deaths, and will always underestimate actual incidence (Van der Vliet 2004: 66).

⁶ *Pretoria News*, 2 December 2009. A child is regarded as an orphan if his or her mother (not necessarily both parents) has died.

to roost' (van Niekerk 1991: 16). The apartheid system⁷ which was in place for roughly half a century, from 1948⁸ to 1994, left many black⁹ people poor and deprived of essentials such as basic education¹⁰ or marketable skills, creating conditions which have favoured the spread of AIDS. Apartheid was also responsible for displacing people in order to bring about the racially segregated society the architects of apartheid envisaged. Economic forces, such as the reliance of the gold-mining industry on the long-established migrant labour system, reinforced patterns of social upheaval and movement between cities and rural areas, creating conditions which helped to promote the spread of disease. This system produced a concentration of young men in cities (many in single-sex hostels) far from their wives and families for extended periods, and then, after several months, dispersed them (many now unwittingly HIV-positive) back to their families in rural areas during holidays or at the end of their contracts (Phillips 2004: 32).

⁷ *'Apartheid'* is an Afrikaans term that means 'apartness' or 'separateness' and refers to the political system which institutionalised racial segregation in South Africa. It was coined to refer to the policy adopted by the National Party (NP) in the early 1940s, although segregation did already exist. Under National Party rule, apartheid was extended, made more comprehensive and more rigorously applied. It is viewed as primarily a political device to preserve racial identity and secure and bolster white supremacy and white privilege. Among other instances of social engineering, it entailed the forced removal of over three million people in an attempt to remove as many blacks as possible from white areas in South Africa without endangering the labour supply (Saunders 2000: 20-21).

⁸ 1948 was the year that the National Party came into power.

⁹ Under the National Party government, a strict system of racial classification operated, with the population being divided into 'Europeans' and 'non-Europeans' or 'whites' and 'non-whites'; the latter group including Indians, Coloureds and Africans (or 'Bantu'). The black consciousness movement of the late 1960s and early 1970s rejected the negative terms 'non-white' and 'non-European' as well as the term 'Bantu', and preferred the term 'black', which was more suited to the aggressive image they sought. Although the term 'black' defined all those who were discriminated against on the grounds of race, the use of the term 'black' to refer only to Africans remained widespread and was taken over by the government itself in 1977. However, 'black' can also be understood more inclusively to refer to Africans, Coloureds and Indians (Saunders 2000: 38).

¹⁰ Under the apartheid system black people were subjected to schooling which limited them to little more than manual labour. The Bantu Education Act of 1953 initiated separate and inferior state-controlled education for those classified as 'Bantu'. Education was severed from the church-run institutions that had been founded by missionary societies in the 19th century, through which the majority of blacks had received their education. Most of these schools were obliged to close. Under Bantu Education there were enormous disparities in the quality and funding of education for blacks and whites. The system was unique in having as its aim the disempowerment of the majority of the population. The 1976 Soweto uprising marked the beginning of overt black rejection of apartheid education (Saunders 2000: 94-5).

Poverty plays a significant role in HIV infection but it is something of a paradox that if South Africa were a poorer country, people would be less at risk of infection and the AIDS pandemic would not have reached the proportions it has. Whiteside and Sunter point out that 'it is South Africa's relative wealth that has caused HIV to spread so fast here [because] we are a more mobile society than other African countries' (2000: 25) as a result of a 'good transport infrastructure' (2000: 53) and the fact that men have 'disposable incomes that allow them to travel and ... purchase sex' (2000: 91). Critical to the spread of AIDS is not so much the overall level of wealth of a country, but how that wealth is distributed. In South Africa it is the steeply unequal distribution of resources that 'assisted (and continues to assist) in the spread of HIV' (2000: 64). The unequal distribution of wealth is directly linked to South Africa's political history.¹¹

Political change has also played a major role in the rampant spread of AIDS in South Africa. As the oppressive apartheid machinery began to relax, laws such as influx control fell away,¹² giving black South Africans more freedom to move around the country. Thousands flocked to the cities to seek work, accelerating urbanisation. During the transition period from apartheid to democracy, further massive social movement took place as exiles, previously alienated by apartheid, returned to their homeland. In his book *Beyond the Miracle: Inside the New South Africa* the eminent writer, journalist and political commentator Allister Sparks explains the connection between the change of government and the spread of AIDS in the following way:

¹¹ Throughout the 20th century, South Africa remained one of the most unequal societies on earth. In 1995, the poorest 40 per cent of households earned less than 6 per cent of total income, while the richest 10 per cent earned more than half the total income. This inequality was related largely to race. Africans made up 76 per cent of the population, but the African share of income amounted to only 29 per cent of the total. Per capita, whites earned 9.5 times the income of blacks and lived, on average, 11.5 years longer (Saunders 2000: 212-3).

¹² In mid-1986, President P.W. Botha abolished influx control which had restricted where black people could live and work. Under the grand plan of apartheid, different 'tribes' or ethnic groupings had had to reside in their 'homelands' or 'bantustans' and needed permits to live and work in urban areas (Lawson 2008: 47). The Group Areas Act, the manifestation of this policy which had shaped the social geography of South Africa for decades, was repealed in 1991 (Saunders 2000: 117-8).

The disease caught South Africa off guard. It made its silent inroads mainly between 1990 and 1995, as guerillas and anti-guerilla fighters, lonely men with pay, made their way home from infected areas to the north and while the apartheid regime and the liberation movements were locked in intense negotiations that absorbed all their attention These returning fighters, together with truck drivers coming down the long transport routes from the north, were probably the principal vectors of the disease (2003: 284).

Such 'vectors' arrived in circumstances ideal for the rapid spread of sexually transmitted diseases at a point in history which was unfavourable for dealing effectively with health problems. Hein Marais, author of two books on the topic of AIDS in South Africa, comments that:

in the early 1990s South Africa was the only country in the world which had to contend with an exponential rise in HIV prevalence rates in the context of a major political transition. In 1990-1994, therefore, what was unavailable was the institutional and political stability – not to mention the political legitimacy of government – necessary to implement a coherent and co-ordinated response (2000: 6).

But even post-1994, when the new government was legitimate, it did not take effective action against AIDS, turning its attention to other matters that were judged to be more important. Professor Malegapuru Makgoba, physician, public health advocate, academic and vice-chancellor of the University of KwaZulu-Natal, who headed the South African Medical Research Council between 1999 and 2002 and was involved in developing South Africa's AIDS strategy, states that:

the pandemic could have been curbed during the early period of its incursion, but it was not, because between 1990 and 1995 both the old regime and the ANC were too preoccupied with their negotiations, and with the drama and excitement of writing a new constitution and transferring power. When the ANC-led government found itself facing an array of problems across the full spectrum of governance, the HIV epidemic simply became one challenge too many (Sparks 2003: 285).

The period under review in this thesis includes the terms of office of the first three democratically-elected presidents of South Africa; Presidents Mandela, Mbeki and Zuma.

Each of these presidents has strongly influenced the discourse of AIDS in different ways, both personally and through the political structures they headed.

President Mandela came into power on a wave of euphoria, as the black population, so long denied political and other rights, looked forward to 'a better life for all'.¹³ Most white anxieties about black majority rule were allayed by Mandela's integrity and commitment to reconciliation, and there was a general sense of hope about South Africa's future. Realising the idealistic vision of 'the rainbow nation' – a multiracial, multicultural people, diverse yet united, and living together in peace and harmony – seemed a real possibility. This optimistic mood made it difficult to appreciate the looming crisis of AIDS which was still largely in its silent, asymptomatic phase. Decisive action at that point may have prevented AIDS from reaching the proportions it since has, but during his term of office President Mandela did not confront and deal with the epidemic effectively.¹⁴ Van der Vliet observes that AIDS arrived at the 'best of times' because of the transition to democracy under Nelson Mandela, 'a charismatic leader with immense moral authority'; and the 'worst', because 'the new government would prioritize positive programmes, such as housing, jobs, education and wider healthcare issues, [and] AIDS warnings ... were not congenial to those savouring the euphoria of freedom' (2004: 54). As Sparks, Marais, Makgoba and van der Vliet have suggested, the lack of effective action on the issue of AIDS can probably be accounted for by the number of pressing political issues that seemed more urgent at the time. The National AIDS Plan became lost among competing priorities, and President Mandela, 'the one person who held the nation's heart, did not lead' (Lawson 2008: 92). A further factor in the government's reluctance to confront and expose the AIDS-crisis was the policy it was pursuing at the time of trying to attract and cultivate foreign investors. This initiative required playing down domestic problems.

¹³ 'A better life for all' was the election slogan of the ANC.

¹⁴ It was more than three years into his term of office (1997) before Mandela made a major public statement against AIDS, and then it was to an international audience in Davos (Lawson 2008: 161-2; Nattrass 2007: 40; Van der Vliet 2004: 55). The action he acknowledged in his speech was necessary to combat AIDS, did not materialise on his return.

However, in his personal capacity, both during and after his presidency, Mandela has always expressed solidarity with and compassion for those ill with AIDS,¹⁵ or who died from it, which included his own son.¹⁶ Initially, he did not openly oppose his successor's policies with regard to the supply of ARV treatment, but as Mbeki's presidency went on, Mandela became more outspoken¹⁷ and proactive in his support of such initiatives as the prevention of mother-to-child-transmission (MTCT)¹⁸ and fundraising efforts for people living with AIDS. In these and other ways, including his virtual embodiment of the culture of human rights, he helped to create a more supportive and sympathetic climate for those who were suffering the ravages of the epidemic.

His successor, President Mbeki, who assumed office in 1998, is notorious for his views and policies on AIDS, discussed in Chapter 2 of this thesis. His challenge to the dominant biomedical model that HIV alone causes AIDS, and its corollary, that drug medication is an effective form of treatment, coupled with his denial of the magnitude and seriousness of the epidemic and apparent lack of sympathy for the AIDS-ill, seriously aggravated the plight and mortality rate of HIV-positive people. A study carried out in 2008 by the Harvard School of Public Health showed that 'the failure to provide antiretroviral drugs (ARVs) to Aids [sic] patients in South Africa led to the premature deaths of 365 000

¹⁵ For example, Mandela visited Zackie Achmat, leader of the TAC, at his home, and took up Achmat's case with President Mbeki. Achmat had taken a public stand refusing to take ARV treatment until it was made available, free, to everyone who needed it (Lawson 2008: 268-9). Mandela persuaded Achmat to take the medication by asserting that he was more useful to South Africa alive than dead.

¹⁶ Mandela announced that his son Makgato had died of AIDS in January 2005. His public disclosure that close members of his own family were infected with HIV was a highly significant action which helped to break the silence and stigma around AIDS (Gumede 2005: 173).

¹⁷ Gumede observes that the former president broke his own rule of non-interference with his successor's governance and increasingly began criticising both Mbeki and the official AIDS policy in public. Mandela was greatly concerned about a growing perception that 'the ANC does not care about the death of millions' (2005: 169). In September 2000 Mandela told the *Daily News* that he shared the dominant scientific opinion that HIV causes AIDS and would depart from it only if new research showed conclusively that that view is wrong (Nattrass 2007: 76). In March 2002, he announced support for ARVs at a Press conference (Nattrass 2007: 102).

¹⁸ In his closing speech at the international AIDS conference held in Durban in July 2000 Mandela called for widespread interventions to prevent MTCT (Van der Vliet 2004: 61).

people between 2000 and 2005',¹⁹ a period which fell into Mbeki's term of office. He was eventually forced to modify his stance and provide ARVs to designated groups of HIV-infected people,²⁰ but this was a belated and seemingly reluctant step. Underlying this reluctance was his aversion to helping to increase the profits of pharmaceutical companies and a fear of being 'controlled' by the West.

Mbeki's personal image has been that of an aloof, detached and highly Westernised intellectual, out of touch with his people and more concerned with international affairs and diplomacy than domestic problems. There is considerable irony in this perception: as a determined Africanist, he dedicated himself to improving the image of Africa and lifting Africans out of poverty and their disadvantaged social position, but the effect of his AIDS-related views and policies brought about the opposite effect in the black communities he was committed to helping.²¹

In sharp contrast to President Mbeki, President Zuma, the third²² and current President, has enjoyed huge popular support and presents himself as a populist figure who

¹⁹ *Pretoria News*, 2 December 2009.

²⁰ In 2001 the TAC took the Health Minister to court to make Nevirapine available to pregnant HIV-positive women. In 2002 the Constitutional Court ruled in their favour and instructed the government to make medication available in the public sector to prevent MTCT. The government was denied leave to appeal (Nattrass 2007: 190). This judgement was a highly significant index of the health of the new democracy since it demonstrated that 'constitutional rights were justiceable, and that government was accountable to the courts' (Van der Vliet 2004: 75).

²¹ The report of the South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey of 2008, based on a sample of the general population of South Africa, showed that in 2008 the HIV-prevalence by population group was 13.6% for blacks and 0.3% for whites. (<http://www.avert.org/safricastats.htm>) The factor of race as a determiner of AIDS is problematic, as indeed are the very categories of 'black' and 'white' (see footnote 9 of this chapter). Nevertheless there is validity in Hein Marais observation that: 'While it is true that all "races" are at risk of HIV infection, South Africa's demographic profile and its history also mean that the preponderance of HIV infections have been among black South Africans ..., and especially those who are poor' (Marais 2005: 57).

²² Strictly speaking, Jacob Zuma is the fourth president. Kgalema Motlanthe was chosen by Parliament to occupy a caretaker position for approximately six months in the interim period between President Mbeki's resignation in September 2008 and the general election in April 2009, when Jacob Zuma was elected President. Brief as this period of office was, it began crucial AIDS-related changes, including the appointment of Barbara Hogan as Health Minister; the explicit linking of HIV and AIDS; the pledging of further supplies of ARV

relates well to and cares about the ordinary people. Prior to his becoming president, he was Chairperson of the South African National AIDS Council. With regard to his stance on AIDS as President of the country, he officially increased support to the AIDS-ill by extending the numbers of those eligible to receive treatment,²³ a policy shift for which he has been enthusiastically praised. In comparison to President Mbeki, his attitude generally has appeared to be much more sympathetic towards those infected and affected by AIDS. However, in his personal capacity and private behaviour he is regarded as having seriously harmed AIDS-education efforts. Polygamy, infidelity, alleged rape and the fathering of illegitimate children demonstrated values that went against those advocated in government AIDS-awareness campaigns such as the 'ABC' campaign ('Abstain; Be Faithful; Condomise'). Moreover, his admission that he had unprotected sex with an HIV-positive woman and thought that a post-coital shower would prevent infection (discussed in Chapters 3 and 4), was widely condemned for its potentially damaging influence on those who were ignorant of how HIV –transmission can be prevented and looked to him for leadership.

The discourses of all three Presidents referred to above have been complex with regard to AIDS, containing ambiguities and contradictions in the disjunction between professed aims and actual performance, and between public and private behaviours. In addition to these inconsistencies, the changes in approach and policy between the different presidents have militated against continuity. The absence of an overarching, coherent, co-ordinated plan of action to curb AIDS in the post-apartheid period, and the lack of political leadership to implement such a plan, has been a major causative factor in exacerbating the scale of the epidemic. It is this socio-political 'terrain' or 'landscape' that has provided the

treatment; and the shifting of the government attitude at state and provincial level to one of 'We shall overcome'.

²³ On 1 December, 2009, World AIDS Day, President Zuma announced that HIV-positive patients with CD4 counts of 350 would be eligible for free ARV treatment if they had already contracted tuberculosis. Before the announcement, only patients with CD4 counts of 200 or lower were eligible for free treatment (*Mail and Guardian*, December 18 to 22, 2009). In addition, all children under one year of age would get ARV treatment irrespective of their CD4 counts, and all parents and pregnant HIV-positive women with CD4 counts of 350 or less, or with symptoms, regardless of their CD4 counts, would have access to ARVs (*Pretoria News*, 2 December 2009).

fertile ground on which AIDS has flourished in South Africa. Longstanding historical forces made the land and its people 'uniquely receptive to the new disease', as Lawson puts it (2008: 19), adding that 'it is easy to see how the fractured social landscape of late-1980s South Africa would have provided a welcoming environment for the new virus' (2008: 59). Kauffman reinforces this point when he observes that 'it is not surprising that South Africa became the HIV capital of the world'; and that 'it would have been difficult to create circumstances more favourable for spreading the virus' (2004: 28).

Louis Pasteur's words, 'the terrain is as important as the germ' (Downing 2005: 72), quoted as an epigraph to this Introduction, are strikingly pertinent to the AIDS epidemic in South Africa, where non-biological factors such as wider social, economic, political and cultural forces have combined to affect the course of disease in individuals and whole communities. The word 'terrain' relates to the modern phrase 'geographies of health' which is based on the view that where people live affects their risk of ill-health, while the term 'geographical epidemiology' is the study of how disease is distributed in geographical space (Gatrell and Elliot 2009: 3). The notion of 'terrain' incorporates social and class structures, and socio-economic conditions are strong determiners of the course and outcome of disease.²⁴ Pasteur's words that 'the terrain is as important as the germ' are the more remarkable because he was one of the founders of the 'germ theory' of disease, also known as the 'theory of specific etiology' which proposes that micro-organisms cause disease. At the end of his life it is claimed that Pasteur recanted the position he had previously held and acknowledged the important role played by the context in which disease occurs.²⁵ The 'terrain' Pasteur referred to was understood as the internal physical environment that allows bacteria and viruses to flourish, but for the purposes of my discussion, I interpret this meaning to include the patient's external environment as well.

²⁴ By 'determiners', I do not mean that these factors cause disease, but that they create conditions conducive to its spread.

²⁵ It is claimed that on his deathbed Pasteur uttered the words: 'Bernard is right. The pathogen is nothing. The terrain is everything'. ('Bernard' refers to Claude Bernard, one of Pasteur's critics.) There is no proof that Pasteur said these actual words, but they are often quoted by those who argue that bacteria and viruses are not the sole cause of disease. <http://www.flu-treatments.com/germ-theory-of-disease.html>. (Accessed 30/04/2010)

Pasteur lived in Europe in the nineteenth century, an era that predated AIDS, the focus of this thesis, but the observation that ‘the terrain is as important as the germ’ is eminently applicable to South African AIDS. Social issues, entailing physical circumstances and material consequences, cannot be solved or cured by medicine alone.

The word ‘terrain’ denotes landscape in a material, physical sense, but it may also be understood metaphorically, and this brings us to the words of Lee Edelman, quoted as a second epigraph to this Introduction, that ‘the discursive field of AIDS unfolds as a landscape of displacements’ (1994: 94), in which his use of the term ‘landscape’ refers to the discursive environment of AIDS. Throughout the ages, disease has been given meanings beyond, or extrinsic to, its biological nature. The discourse of disease is both cultural and linguistic. Edelman’s visualisation of AIDS discourse as a ‘landscape of displacements’ recognises – in a way that is similar to Pasteur’s revised view – that the phenomenon of disease has more than biological and biomedical dimensions. Disease is constructed as both a biological and social phenomenon. Edelman’s statement is a response to his perception of the indirectness of constructions of AIDS in the United States, but here again, the observation applies equally to AIDS-related discourse in South Africa, where a dense and contradictory array of meanings located in a variety of different domains surround the phenomenon and are displaced from it.

Stuart Hall’s words, also quoted as an epigraph, that the realm of the ‘discursive, of textuality, instantiates a necessary delay, a displacement, which is *always* implied you will always be working in an area of displacement’, and that ‘there’s always something decentered about the medium of culture, about language, textuality, and signification’ (1992: 284), draw attention to the inevitability of displacement in discourse. This relates to Saussure’s theory of signs in which a ‘sign’ is composed of a ‘signifier’ and a ‘signified’ – where the term ‘signifier’ denotes the signifying symbol (which could be semiological or linguistic), and the term ‘signified’ denotes the concept being referred to. Putting anything into language or another form of symbolic representation automatically involves displacement in that it then becomes a reconstruction of a phenomenon, different and

distinct from the phenomenon itself. Mediation occurs in any act of writing, which necessarily involves construction – the selection, omission, manipulation and even fabrication of material.

The word ‘landscape’ in Lee Edelman’s statement that ‘the discursive field of AIDS unfolds as a landscape of displacements’ deserves closer examination. Geographical metaphors in relation to the occurrence and experience of disease recur throughout literature. In *The Birth of the Clinic*, Foucault states that:

... disease has a land, a mappable territory, a subterranean, but secure place where its kinships and its consequences are formed; local values define its forms (1973: 149).

Foucault suggests that the metaphorical territory of disease has its own values, a consequence of the way ‘the science of man ... opened up a field that was divided up according to the principles of the normal and the pathological’ (Foucault 1973: 36). The ill person has ‘failed’ to conform to the norm of health which is a condition of inhabiting the world of the well, and so is obliged to occupy the territory of the diseased. Morris emphasises the displacement entailed in such discursive division and ordering of reality when he observes that ‘Western biomedicine, with its objectifying, materializing, clinical gaze, contributes to shaping a culture in which substandard bodies are relegated to institutions or to marginal social spaces ...’(1998: 159).

Susan Sontag uses similar geographical imagery in the opening lines of *Illness as Metaphor*:

Everyone who is born holds dual citizenship in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place (1978: 3).

The metaphor of illness as a journey to and sojourn in a different place is also evident in Alan Kleinman’s extended metaphor of illness which, he states:

involves rites of passage between different social worldsThe chronically ill are like those trapped at a frontier, wandering confused in a poorly known border area, waiting desperately to return to their native land. Chronicity for many is the dangerous crossing of the borders, the interminable waiting to exit and reenter normal everyday life, the perpetual uncertainty of whether one can return at all (1988: 181).

Morris expresses the experience of illness using a similar metaphor:

A serious and protracted illness constitutes an immersion in an alien reality where almost everything changes ... few experiences are so disorientating as our glimpses into the counterworld that opens up whenever we cross over from health to illness (Morris 1998: 22).

Common to all the descriptions quoted above is the notion of illness as a different world, or 'counterworld', to which the ill cross over, leaving behind the world usually regarded as 'normal'. All resonate with Edelman's geographical metaphor of AIDS discourse as an 'unfolding *landscape of displacements*' (my emphasis). Implicit in all these conceptualisations are the notions of alienation and displacement. Illness changes not only the ill person's physiological experience, manifested in particular bodily symptoms, but the perception that the person has changed and become different in an existential sense, and has entered a different space, removed from the space occupied by the 'normal'. The sense of social alienation results to a large extent from the cultural meanings given to illness. Herzlich and Pierret comment that illness – 'more perhaps than any other phenomenon – *signifies*'. In addition to being a physical condition, an organic state which can be reduced to physical determinants, it 'is always also a vision of something else' (Herzlich and Pierret 1987: 29).

In *The Birth of the Clinic*, Foucault observes that ill health has always been linked with 'conditions of existence and the way of life of individuals' (1973: 33), and traces different meanings attributed to disease from the Middle Ages to the present. Undesirable physical and moral behaviour was seen to have been shaped by social circumstances dictated by the government of the day, so it was believed that '[t]he first task of the doctor

is therefore political: the struggle against disease must begin with a war against bad government' (1973: 33). In *Mein Kampf*, Adolf Hitler wrote that syphilis was a symbol of moral degeneration and its persistence the result of a weak government (McCombie 1990: 22). This view implies that in an ideal society where healthy norms prevail, there would be no disease (Foucault 1973: 33-6). In *Illness as Metaphor* (1978), Susan Sontag also discusses the cultural construction of illness throughout history, focussing particularly on the blame attached to twentieth-century cancer-sufferers, as though they bring their illness on themselves, in contrast to the romanticisation of patients suffering from tuberculosis, which, in the nineteenth century, was seen as a 'refined disease' leading to a 'beatific death' (1978: 16).²⁶

In a continuation of this discursive tradition, and in accordance with this logic, AIDS has been 'depicted as a consequence of the "sexual revolution"' (Alcorn 1988: 71) and the 'permissive society' that emerged in the latter half of the twentieth century, characterised by 'deviant' or 'excessive' sexual practices. This illustrates Alcorn's observation that the 'meanings [of disease] are generated within specific sociohistoric contexts' and betray 'hidden anxieties about strength and weakness in the social order' (1988: 71-2). Such constructions shift the emphasis from the biological role of the germ (or in this case, the HI-virus) to social trends and the patterns of behaviour of infected persons, who are seen as 'different', having deviated from the social 'norm'. This shift in emphasis and meaning both exemplifies and even justifies the displacement of the AIDS-ill who are seen by some to have 'forfeited' their right to live in the social and discursive space occupied by the 'normal'. Deborah Lupton makes the point that 'in the "new morality" of preventive health, ... those who have fallen ill have often been judged to be morally culpable for allowing illness into their bodies by failing to conform to cultural regulations and taboos' (2000: 58). They may then be dismissed as deviant outsiders by those who wish to uphold regulation, i.e. by those in power.

²⁶ Figures such as the Polish composer Frederic Chopin and the English poet John Keats, both of whom died prematurely from TB, helped to sustain such beliefs.

The sociologist Freidson develops this thinking when he explains that the notion of 'deviance' does not lie in the individual 'deviant' so much as in the social process of creating rules that make acts or attributes deviant, and which label people as deviant or offenders (1970: 217). This view shifts the focus of analysis from the ill person to the societal response to their illness: in other words, from illness to the discourse of illness. It is the discourse that projects negative meaning onto illness. This is what prompts Lee Edelman to comment that 'there is no available discourse on AIDS that is not itself diseased' (1994: 92). In other words, it is the discourse that contaminates the disease, rather than the other way round. The anthropologist Michael Quam elaborates:

When an illness is perceived as sufficiently serious and the ill person is held blameless for their deviation, then legitimacy is ascribed and the sick role is entered unconditionally. But if the illness is perceived to be the result of some serious deviation from social rules and norms, then the ill person may be denied the sick role and instead be treated as a criminal [Since sexually transmitted diseases] are the result of non-monogamous sexual relations, which according to idealized moral standards are acts of moral deviance, they are illegitimate and cannot be used as the reason for entering the sick role (Quam 1990: 33).

Such thinking has serious implications for the treatment and care of the AIDS-ill. The stigma attached to 'deviant' sexual behaviour can be used to justify withholding medical treatment and compassion.

The key term 'discourse' as it is used in this thesis should be understood not only to refer to linguistic texts but also – in terms of the European School – to social structures and practices. Foucault explains in *The Archaeology of Knowledge* (1972) that discourses are human constructs which bring an object into being, or produce a social reality (refer to definition of Key Terms on pages 7-8 of this Introduction). Poststructuralists such as Foucault built on the social constructionist movement pioneered by sociologists such as Berger and Luckmann. Social constructionism is an approach which explores how and why the social world comes to have the meanings that it does. It is premised on assumptions

which include a critical stance towards taken-for-granted knowledge; historical and cultural specificity; and the view that knowledge is sustained by social processes (Burr 1995: 2-5). Berger and Luckmann's seminal text, *The Social Construction of Reality: A Treatise in the Sociology of Knowledge* (1967), was highly influential in demonstrating how discourse constructs perceptions of reality, and in challenging the objectivist perspective on medicine and the body, among other phenomena. Berger and Luckmann were influenced by the linguistic philosophers Wittgenstein and Winch who, in the 1960s, initiated what came to be known as 'the linguistic turn' in the social sciences (Phillips and Hardy 2002: 12-3). This movement emphasised that language is a key aspect of discursive construction, since the way we view, think and feel about aspects of the world cannot be separated from the words and symbols used to represent them. There is a strong correlation between words and the way the world is conceptualised. As Treichler observes:

we cannot ... look 'through' language as though it were a plate glass window, to see what AIDS really is. [We have to] look at the window itself, where language, like a series of special effects, constructs what we think we know about AIDS (1999: 329).

Discourses go beyond language, or 'groups of signs', and include 'practices that systematically form the objects of which they speak' (Foucault 1972: 49). Central to this is the understanding that discourses, and the texts they comprise, can in no way be seen as reflective of 'reality': instead, they constitute that reality. This is not to deny the existence of the real, but to assert that the way we perceive and interpret reality depends on the way that discourse constructs it. We cannot understand the objects of knowledge outside discursive practices, since what appears to us as knowledge is only knowable through discourse. As Potter observes: 'The world is not ready [sic] categorized by God or nature in ways that we are all forced to accept. It is *constituted* in one way or another as people talk it, write it, and argue it' (1996: 98, emphasis in original).

In *Power/Knowledge* (1980), Foucault discusses the way that discourses are linked to the power structures in society which grant legitimacy and authority to some discourses

and not to others. When a discourse is backed by institutionalised force, the meaning and order it imposes on aspects of the world profoundly influence thought and social practice. Some areas of reality, and selected individuals, are privileged and regarded as worthy of attention, while others are dismissed and excluded. With regard to HIV and AIDS, often the people most affected – those who are ill or who have died from AIDS – are absent from the debates that directly concern them, and from the texts that constitute them. This bears out the observation of the Marxist literary theorist Terry Eagleton that ‘it is in the significant silences of a text, in its gaps and absences that the presence of ideology can be most positively felt’ (1976: 34-5). Related to Foucault’s notion of discursive power is the anthropologist Johan Galtung’s concept of ‘structural violence’, defined as ‘violence that is built into social structures, and which is silent, largely invisible and seen to be as natural as the air around us’ (Galtung 1969: 173). The sociologist and anthropologist Pierre Bourdieu develops this concept using the term ‘symbolic violence’, which he defines as ‘the violence which is exercised upon a social agent with his or her complicity’. He proposes that marginalised people ‘contribute to their own domination’ (Bourdieu 2004: 341) by accepting the status quo. This is the psychological result of having internalised the dominant discourse which has determined their perceptions of themselves, so that they themselves sustain and uphold their exclusion or subjugation.

Foucault stresses that what is taken for granted as important and ‘the truth’ is actually the result of the political and economic forces that command power in society. Foucault defines ‘truth’ as ‘a system of ordered procedures for the production, regulation, distribution, circulation and operation of statements’, and this is ‘linked in a circular relation with systems of power which produce and sustain it, and to effects of power which it induces and which extend it’. He calls this system ‘a regime of truth’ (1980: 133), the word ‘regime’ encapsulating the notion of power and authority. However, the power of a discourse, and what is accepted as ‘the truth’, is unstable and changeable, and contingent on the dynamics of power operating within society. Deborah Lupton sums up the concept of discourse when she observes that discourse ‘brings together language, visual

representation, practice, knowledge and power relations, incorporating the understanding that language and visual imagery are implicated with power relations' (2000: 51).

An example of the power relations embedded in AIDS-related discourse may be seen in the competition between orthodox biomedical and 'alternative' models of treatment for HIV-infection. For a time – from roughly 1998 to 2003 – the dominant, orthodox biomedical discourse was displaced in South Africa by an alternative view espoused by ex-President Mbeki and his Health Minister, the late Manto Tshabalala-Msimang. The latter discourse was given institutionalised force and its operation was evident in the treatment policies imposed on – or withheld from – HIV-positive South Africans. Helen Schneider, of the Centre for Health Policy at the University of the Witwatersrand, observes that 'ultimately, policy contestation around AIDS in South Africa can be understood as a series of attempts by the state to legitimately define who has the right to speak about AIDS, to determine the response to AIDS, and even to define the problem itself' (2001: 21). Marais observes that at play in this episode – more fully discussed in Chapter 2 – were 'fascinating, but debilitating struggles for legitimacy, influence and power' (2000: 17). These opinions illustrate Foucault's view that:

one's point of reference should not be to the great model of language (*langue*) and signs, but to that of war and battle. The history that bears and determines us has the form of a war rather than that of a language: relations of power, not relations of meaning (1980: 114).

Here Foucault indicates that more often it is power, not intellectual difference, that underlies the conflict between discourses, and that, 'where there is power, there is resistance' (1976: 95). This was demonstrated in the powerful resistance to government policies by AIDS activists, who eventually won their battle for access to treatment.

Discourse analysis assumes and is premised on a constructionist approach, and involves the examination of individual texts as well as a consideration of the connections between these texts, their context, the discourses towards which they contribute, and the

'realities' they create. In this thesis I employ both the linguistic and Foucauldian kinds of discourse analysis (see Key Terms on page 8 of this Introduction). I do close linguistic analysis of language-based texts, but also analyse the institutional and political dimensions of discourse associated with Foucault. I have found it fruitful to synthesise linguistically-oriented discourse analysis and the discourse analysis associated with Foucauldian social theory.

Discourse analysis is both a perspective and a methodology. Epistemologically, it adopts the view that knowledge is constructed through text and that the world cannot be known separately from discourse, while methodologically, it uses close analysis of texts (linguistic and otherwise) and the relationships between them, to demonstrate this. Discourse analysis explores the relationship between discourse and 'reality' in both a philosophical and practical way, examining why and how textual representations construct social phenomena.

I see an alignment between discourse analysis and postmodernism in that postmodernism challenges the received definitions and distinctions that are generally accepted as 'common sense'. Because discourse analysis sees all texts as constructed representations which produce different versions of 'reality', it follows that reality, or what we naively call 'the truth', can never be established with any certainty. The 'meaning' of different phenomena is similarly elusive, because multiple interpretations are possible. There are no simple, coherent, consistent interpretations of anything. Concepts once believed to be stable, such as identity, are now seen as fluid and contradictory. The discourse of the State or any institutionalised form of power is regarded with distrust since it is no longer believed that neutrality or objectivity is possible. Texts have to be read with the critical and reflexive awareness that they are unreliable: displaced, mediated constructions of perceived reality, several times removed.

Disease, another key term (see Introduction, page 8) in this thesis, is necessarily represented through discourse. Biomedicine is just one of many discourses relating to

health and illness, but it is dominant in the medical world, and has privileged status, positioned at the top of what Foucault terms the 'hierarchy of knowledges and sciences' (1980: 82). The power and respect medical science enjoys derives in part from popular assumptions about its 'scientific' and 'objective' character. Modern biomedicine is located within the rationalist-empiricist theory of knowledge: it was built on science, drew from it the same epistemological status, and is supposed to possess 'benevolent neutrality' (Wright and Treacher 1982: 1-4). However, when the discourse of biomedicine is deconstructed, it is found that it is not as pure, rational and disinterested as it seems. Radical constructionism challenges biomedicine's claim to a high degree of correspondence between scientific models and reality. It holds that our knowledge of disease, in common with all other phenomena, is inevitably mediated through symbolic constructions. Scientific accounts do not simply discover and label autonomous aspects of the 'real' through a transparent process, but actively construct entities such as the HI-virus through their own discourse. Scientists are fallible human beings and their beliefs may be false or distorted. Morris describes the biomedical model or 'grand narrative' of germ theory as 'dubious' because it 'reduces every illness to a biological mechanism of cause and effect', and lacks postmodern 'awareness of the elaborate interconnections between biology and culture' (1998: 11). He states that, '[f]rom a postmodern point of view, AIDS is never simply about the science of a microbe' (1998: 40). This recalls the words: 'the terrain is as important as the germ.'

Medical knowledge is just as subject to challenge, change and revision as are other systems of knowledge. Contests for meaning can be seen in the way that names and definitions of AIDS have changed over the last three decades, from GRID ('Gay-Related Immune Deficiency'), to HTLV-III ('Human T-cell Leukemia Virus Type III'), to LAV ('Lymphadenopathy Virus'), and, currently, to HIV ('Human Immunodeficiency Virus') and AIDS ('Acquired Immune Deficiency Syndrome') (Treichler 1999: 167). A variety of realities and responses to the AIDS-ill have been created by these different names. As part of the hegemonic discourse of biomedicine, which is informed by the politics of funding for specific kinds of research, scientists and medical specialists have acquired the authority to define reality. Treichler makes the point that:

Names play a crucial role in the construction of scientific entities; they function as coherent signifiers for what is often complex, inchoate, or incompletely understood. In turn, names establish entities for the public as both socially significant and conceptually real Many questions remain about the various signifieds represented by the original array of names, but the existence of HIV and AIDS as unifying signifiers now makes it possible to proceed *in discourse* as though the questions have been resolved (1999: 167-8, emphasis in original).

The fact that 'HIV' and 'AIDS' are currently accepted, official names for the syndrome represents the outcome of a struggle. But this struggle is not over. There is continuing debate over and research on what causes AIDS and, in time, new names and models will supplant the one that is currently dominant.

It is undeniable that there are difficulties in naming and defining a condition which is intrinsically protean and slippery. The HI-virus is a unique, complex, highly-developed virus which lends itself to a plethora of meanings. AIDS does not attack a specific part of the body but breaks down the immune system, allowing multiple infections to present in a variety of ways. It designates a collection of more than fifty widely diverse clinical conditions (Treichler 1999: 169). As Couser observes, AIDS 'is not in the usual sense a disease at all, but a syndrome whose symptoms are diseases' and that 'exactly what constitutes a clinical case of AIDS is a matter of shifting definitions' (1997: 82). The HI-virus that is believed to cause AIDS has a long dormancy period, symptoms vary, and prognosis is unpredictable. Many aspects of the condition are blurred: for example, HIV-seropositivity is often conflated with AIDS so that it is unclear where the one ends and the other begins. Nettleton asserts that 'it is not possible to give an unequivocal answer to the question ["What is AIDS?"] and adds that 'some authors prefer to substitute the term "HIV disease" for AIDS because ... the clinical definitions of AIDS fail to describe the range of health problems which occur once a person has been infected' (2006: 61). Edelman comments that 'AIDS lacks a coherent medical referent, remaining a signifier in search of the determinate condition or conditions it would signify' (1994: 93). Because of its ambiguities, AIDS has been described as the 'first postmodern disease' (Edelman 1994: 95; Morris 1998: 50). Rosenberg also observes that

AIDS can be seen as postmodern in that, 'after a generation of epistemological – and political – questioning of the legitimacy of many disease categories, AIDS has exposed the inadequacy of any one-dimensional approach to disease' (1992: 291-2). He goes on: 'The more we have come to understand the disease as both a biological and social phenomenon, the more we understand that our interaction with it reflects a complex and multi-dimensional reality ... [for one thing] the history of AIDS demonstrates the arbitrariness of our habitual distinction between culture and biology' (1992: 303). In similar vein, Morris stresses that '*[p]ostmodern illness is fundamentally biocultural – always biological and always cultural – situated at the crossroads of biology and culture*' (1998: 71, emphasis in original).

There are different ways of conceptualising displacement in AIDS discourse: linguistic; psychological; and mythical; amongst others. As far as linguistic displacement is concerned, Jacques Derrida and Roland Barthes have explored the complex questions relating to the representation of reality. In *S/Z*, Roland Barthes cautions against equating texts with reality, stating that 'this famous *reality* ... is set farther away, postponed, or at least captured through the pictorial matrix in which it has been steeped before being put into words: code upon code, known as realism' (1974: 55, his emphasis), while in *Image, Music Text* he alludes to the infinite deferral of meaning intrinsic in verbalisation when he remarks that 'the writer ought ... to know that the inner "thing" he thinks to "translate" is itself only a ready-formed dictionary, its words only explainable through other words, and so on indefinitely' (1977: 146).

Along comparable lines of thought, Jacques Derrida's use of the key concept '*différance*' when he refers to meaning is not easily translatable into English, but plays on both the senses of 'difference' and 'deferral' (Derrida 1973: 129; 1978: xvi). Referring to Saussure's theory of signs, Derrida sees the sign as 'a deferred presence'; it 'is second in order after an original and lost presence, a presence from which the sign would be derived' and which it mediates (1973: 138). The signified concept is never present in itself, but is 'necessarily and essentially inscribed in a chain or a system, within which it refers to another

and to other concepts' (1973: 140). He develops this thinking when he explains that '*différance* is what makes the movement of signification possible' because 'each element that is said to be "present" ... is related to something other than itself but retains the mark of its relation to a future element. This trace relates no less to what is called the future than to what is called the past ...' (1973: 142, emphasis in original). The term 'trace' is explained as 'being not a presence, but ... rather the simulacrum of a presence that dislocates, displaces, and refers beyond itself ... it has, properly speaking, no place, for effacement belongs to the very structure of the trace' (1973: 156). This endless chain of deferred meanings implies, for Derrida, the gradual fading or loss of meaning, as words become increasingly remote from what they originally purported to represent. As they are deferred further and further away from the 'lost presence' of the phenomenon that gave rise to them, they come to occupy liminal spaces, conceptual landscapes different and displaced from their original ones.

Compounding the displacement between the original phenomenon (the signified) and the linguistic representation of that phenomenon (the signifier), is the gap between the written text and its reader. Mediation takes place in the act of reading as well, since the reading process requires interpretation. How a text is interpreted depends on what the reader brings to it: possible meanings cannot be controlled. Barthes develops this point of view when he states that the reader is not a 'consumer' but a 'producer' of the text (1974: 4), and that '[t]his "I" which approaches the text is already itself a plurality of other texts, of codes which are infinite or, more precisely, lost' (1974: 10). This is another form of displacement.

According to 'reader-response' theory (Rosenblatt 1978), the act of reading involves a transaction between the reader and the text, and each transaction is a unique experience in which the reader and the text continuously act and are acted upon by each other. In Storey's words, reading is 'an interaction between the discourses of the text and the discourses of the reader' (2001: 12). Barthes takes this line of thought to its extreme, asserting that 'the reader lends, by proxy, his or her *displaced* voice to the discourse: the

discourse is speaking to the reader's interests ... we see that writing is not the communication of a message which starts from the author and proceeds to the reader; it is specifically the voice of reading itself: *in the text, only the reader speaks*' (1974: 151, emphasis in original). If we follow this argument, this view implies 'the death of the author':

As soon as a fact is *narrated* no longer with a view to acting directly on reality but intransitively, that is to say, finally outside of any function other than that of the very practice of the symbol itself, this disconnection occurs, the voice loses its origin, the author enters into his own death, writing begins (1977: 142, emphasis in original).

Deferral is an intrinsic part of the transmission and reception of any message, creating a chain of displacements between the original phenomenon and the reception of the symbolic representation of that phenomenon. Barthes speaks of the way that:

[t]o read is to find meanings, and to find meanings is to name them; but these named meanings are swept toward other names; names call to each other, reassemble, and their grouping calls for further naming ... so the text passes: it is a nomination in the course of becoming, a tireless approximation, a metonymic labour (1974: 11).

Apart from the displacement inherent in all representations, displacement in AIDS discourse takes many other forms. The term 'displacement', as this is used in the discipline of psychology, refers to a 'defence mechanism involving redirection of emotional feelings from their original to a substitute object ... [which is] less threatening than the original one, and the displacement may therefore have the effect of avoiding or reducing anxiety' (Colman 2001: 210). If applied to AIDS, this definition assumes that AIDS is a threatening subject which induces anxiety and an avoidance impulse. When used in a branch of literary criticism known as psychoanalytic criticism, the term 'displacement' refers to a form of 'distortion' in which a socially acceptable object is made to stand for something 'forbidden' (Gray 1992: 235-6). If related to AIDS, this would suggest that the subject includes a taboo element which necessitates euphemistic expression and other forms of distortion in order to make it more socially acceptable. The above definitions suggest psychological reasons for

displacing the subject of AIDS or any other subject that causes discomfort, using different strategies. The terms 'immersive' and 'counter-immersive' have been used to describe the way the subject of AIDS is treated in different discourses (Cady 1993). 'Counter-immersive' writing – a common feature of AIDS discourse – uses a variety of distancing devices to protect its audience from 'too jarring a confrontation with the subject [of AIDS]', and exemplifies displacement as this is understood in the discourse of psychoanalytic criticism. By contrast, 'immersive' writing 'thrusts the reader into a direct imaginative confrontation with the special horrors of AIDS and requires [him or her] to deal with them with no relief or buffer provided by the writer' (Cady 1993: 244).

Different meanings assigned to AIDS – for example, that it is a homosexual disease ('the Gay Plague' or 'God's curse on Homos'); a disease of prostitutes (described as 'reservoirs of contagion'); a black disease ('the Black Plague'); a punishment for promiscuity (seen in the acronym 'WOGS' or 'Wrath of God Syndrome'); a racist plot aimed at the black population (evident in another acronym: 'Afrikaner Invention to Deprive us of Sex'); a form of suffering which develops character (seen in yet another acronym: 'Accelerated Inner Development Syndrome') – all articulate pre-existing discourses. These include deeply-entrenched homophobic discourses, anti-feminist discourses, racist and political discourses, religious and moralistic discourses, and the discourse of suffering as a means to personal growth. Morris remarks that the effect of the plurality of constructed meanings attached to AIDS and the AIDS-ill is that it takes 'real effort ... to see AIDS patients as merely people who are ill' (1998: 191). AIDS functions to strengthen ingrained patterns of blame, and reinforces positions and opinions already held. Projecting the topic of AIDS onto these familiar discursive repertoires, or what Couser terms 'available cultural templates' (1997: 161), is a clear form of displacement. AIDS-related texts then draw on, revise, develop, challenge, counter or ironise these discourses to fit the speakers' or writers' particular purposes. In this sense, AIDS discourse could be said to have a parasitic relationship with larger, pre-existing discourses on which it 'piggy-backs'; or, to use another metaphor, onto which it is grafted. Treichler cautions against acceptance of what she terms 'recycled reincarnations' of old discourses, believing it is important to challenge and disrupt these (1999: 96). The variety of

displaced meanings AIDS is given illustrates that apart from being an epidemic of disease, AIDS is also, to use Treichler's phrase, 'an epidemic of signification' (1999: 1).

Another sense of the term 'displacement' is that used by Northrop Frye in *Fables of Identity* (1963), which explores the way that established myths are displaced from their ancient origins and adapted to contemporary, real-life situations. When personal illness narratives by and about the AIDS-ill are given mythical shape to confer meaning and purpose on what might otherwise be read as pointless suffering – an action which may be linked to a didactic impulse – this constitutes a form of displacement, in Frye's terms. Analysis of illness narratives – what are sometimes termed 'pathographies', or 'autopathographies' if self-written – reveals that the quest myth, most commonly, underlies these narratives. This form of displacement can result in a reduction or loss of individuality and uniqueness, as the illness experience is presented in universalised terms.

Using both linguistic and Foucauldian approaches to discourse analysis, this thesis explores selected texts, events and bodies of thought and opinion which illustrate displacement and the various cultural significations attached to AIDS. Each text analysed is partial, in both senses of the word: it represents an incomplete and biased point of view. Collectively, these partial representations contribute to the complexity and richness of the overall discourse of HIV and AIDS.

I have been highly selective in the literary and non-literary texts used as illustrative material: it would have been impossible to survey the discursive field of AIDS in South Africa comprehensively, as it is simply too vast and diverse. The primary texts selected for analysis are disparate and deliberately chosen, according to how they illuminate displacement, either by demonstrating or challenging this. They include examples of 'naturally occurring language' such as slang and colloquial expressions; biomedical discourse; literary texts such as poems and prose fiction; media articles; films; political cartoons; personal narratives and cultural texts. This is an eclectic assemblage, but they all share the delimiting criteria of

being related to the subject of HIV and AIDS; written or spoken by South Africans; published in South Africa; or to have occurred in South Africa in the post-apartheid era.

I have defined five areas in which to trace the theme of displacement. Each of the five chapters of the thesis explores a different form of displacement in South African AIDS discourse. In Chapter 1, 'Displacing AIDS through Language', the focus is on language as a form and means of displacement in AIDS discourse; Chapter 2, 'Politicising AIDS' explores the way that AIDS discourse draws on the larger, well-established discourse of politics, and specifically on the discourse of 'the struggle' against apartheid; while Chapter 3, 'Satirising AIDS', considers the way that satirists displace AIDS discourse through irony, exposing its contradictions and absurdities, and at the same time, indulging in 'scapegoating', another form of displacement. Chapter 4, 'Gendering AIDS', shows the extent to which AIDS-related discourse is contextualised within gender-related issues such as unequal power relations between men and women and stereotypical views of women's identities and 'proper' roles. The final chapter, Chapter 5, 'Narrating AIDS', deals with the discourse of personal illness narratives, showing how individuals displace the experience of illness through narrative, often using the structures of established stories, derived from myth.

I believe that this study, 'Discourse, Disease and Displacement: Interrogating Selected South African Textual Constructions of AIDS', makes an original contribution to the study of AIDS discourse in that it examines how selected constructions of AIDS in the South African context, particularly, bring about displacement. Research²⁷ has been done on the discourse of AIDS elsewhere in the world²⁸ and much excellent research has been done in

²⁷ The databases searched for other research projects in this field are SA Theses (including NAVTECH and UCTD); NEXUS database (an NRF product); and Dissertations and Theses (international; a Proquest product).

²⁸ Examples most relevant to the field of study covered in this thesis include:

Attree, Elizabeth. 2007. *The literary responses to HIV and AIDS in South Africa and Zimbabwe 1990-2005*. Ph.D.: SOAS, London.

Comfort, Laura. 2009. *Will the "fight" ever end? A critical reading of the metaphors and discourses that construct HIV/AIDS in an African context*. M.A.: Brock University, Canada.

in South Africa²⁹ but as far as I am aware, no previous study which explores the theme of displacement based on literary and non-literary texts, as well as on social discourses, has been done on the discourse of AIDS in post-apartheid South Africa.

Dauge-Roth, Alexandre Erik Michel. 2000. *Testimonial literature and experiences of alterity: AIDS narratives and diaries in France*. Ph.D: University of Michigan.

Long, Thomas Lawrence. 1997. *AIDS and American apocalypticism: discourse, performance and cultural production of meaning in New York City, 1981-1996*. Ph.D: Indiana University of Pennsylvania.

Mechar, Kyle William. 1995. *The cultural logic of dis-ease: difference and/as displacement in popular discourses of the AIDS crisis*. M.A. McGill University, Canada.

²⁹ See, for example:

Campbell-Hall, V. E. 2006. *Five isiZulu women living with AIDS: Illness, antiretrovirals, selves and life-stories*. M.SocSc.: University of KwaZulu-Natal (Westville).

Judge, M. 2005. *The contemporary construction of the causality of HIV/AIDS: a discourse analysis and its implications for understanding national policy statements on the epidemic in South Africa*. M.A.: University of the Western Cape.

Klein, H. L. 2002. *Pastoral-therapeutic work with family members infected and affected by HIV/AIDS: a narrative approach*. Ph.D.: University of Pretoria.

Lightfoot, N. G. 1997. *The Construction of the AIDS patient in South African bio-medical discourse*. M.A.: University of South Africa.

Lynch, I. 2007. *Constructions of masculinity among black South Africa men living with HIV: a discourse analysis*. M.A.: University of Pretoria.

Makhubu, R. L. 2002. *Interpreting in the education and discourse of HIV/AIDS: a case study of isiZulu speakers*. D.Litt. et Phil.: University of South Africa.

Miles, L. M. 1996. *Masculinity, power, sexual negotiation and AIDS: a discourse analysis*. M.A.: University of Cape Town.

Olivier, J. 2005. *Hope in the view of HIV/AIDS in South Africa: public discourse, faith and the future*. M.Phil.: University of Cape Town.

Pienaar, S. 2004. *The untold stories of women in historically disadvantaged communities, infected and/or affected by HIV/AIDS about care and/or the lack of care*. Ph.D.: University of Pretoria.

Richter, A. 2008. *Addressing the psycho-spiritual needs of adolescents orphaned by HIV and AIDS: the role of faith-based organizations and churches in South Africa: a narrative approach*. Ph.D.: University of Pretoria.

Salcedo, M. O. 2004. *Discourse and disease: an analysis of Thabo Mbeki's position on AIDS 2000-2004*. M.A.: University of the Witwatersrand.

Smith, S. M. C. 2005. *Nonverbal and discourse marker conversational dynamics in cross-cultural and cross-linguistic medical interactions with HIV*. M.A.: University of the Witwatersrand.

Templeton, L. G. 2003. *Lovelife: Productions and re-productions of gender constructs and HIV/AIDS*. M.SocSc.: University of Cape Town.

Van der Wouwer, P. M. 2002. *A sociolinguistic investigation of gender stereotypes in AIDS discourse*. M.A.: University of South Africa.

Chapter 1: Displacing AIDS through Language

All accounts of the AIDS epidemic ... are at some level linguistic constructions. (Paula Treichler)¹

Paula Treichler's statement points to the fact that knowledge of AIDS is always mediated through language, and this, inevitably, constitutes a process of displacement. Language 'constructs' AIDS in different ways, producing an array of meanings attached to the condition. While this is true of linguistic representations of all phenomena, the number and variety of linguistic forms of displacement used in AIDS discourse suggest that AIDS is a particularly complex topic and more difficult than most to deal with directly.

To summarise a point explained in the Introduction, the term 'displacement' used in the context of psychology refers to a 'defence mechanism involving redirection of emotional feelings from their original to a substitute object ... [which is] less threatening' (Colman 2001: 210), while in terms of language and literature, 'displacement' refers to a form of 'distortion' in which a 'forbidden' subject is made more socially acceptable (Gray 1992: 235-6). These definitions indicate that human beings will tend to avoid a 'threatening' or 'forbidden' subject which causes uncomfortable feelings. AIDS is certainly such a subject. If people do refer to AIDS, they will tend to try to make it more psychologically and socially acceptable by means of various devices. In personal narratives by and about the AIDS-ill, for example, the experience of illness is often mythologised in ways that displace and soften the harsh reality of suffering. Linguistic devices of displacement include the use of significant silences and omissions (an absence of language which suppresses and highlights the horror), politically correct terminology, the use of intertextuality, slang, euphemisms, circumlocutions and frequently 'black'² humour, as well as metaphors, metonymic substitutes, or analogies situated in 'safer' domains. It is not only the disease itself that is avoided: the AIDS-ill and their suffering are also often

¹ (Treichler 1992: 378)

² 'Black humour' refers to the humorous treatment of unpleasant subjects.

marginalised. In biomedical discourse, the impersonality of the language dehumanises and erases the AIDS-ill from the social space. Literary texts, on the other hand, succeed in reversing the displacement of AIDS victims through their skilful use of language, increasing awareness of the depredations of the disease. When writers are able to recover the presence of the obscure multitudes who have died of AIDS or suffer from its effects, this compensates to some extent for the fact that the capacity of language to convey the experience of trauma, illness, pain and death is limited, and that such extremes of human experience are finally inexpressible in words.

David Crystal observes that ‘the stronger the taboo [surrounding an issue], the larger the number of [language] avoidance forms’ (1995: 172). De Klerk (1995: 269) remarks that ‘[g]enerally one finds an abundance of slang terms in the following semantic areas: sexual activity, scatological terms, eating, drinking and sleeping, money, cigarettes, mental and physical deficiencies, death and conflict’ while Bryson tells us that in the English language more than 1, 200 expressions for sexual intercourse alone have been counted (1990: 211). The paradoxical co-existence of silence and numerous indirect references to the forbidden subject illustrates how ‘speech and silence actually interrelate’ (Harper 1993: 119). In many AIDS-related texts discussed in this thesis, AIDS is not explicitly named and remains an ‘absent presence’ (Belsey 2005: 41) in the discourse. Concealment itself becomes a defining characteristic of the text. Silence on the subject of AIDS is observed in spheres where one would least expect it: a good example of obfuscation being a South African city hospital offering a training programme for providers of home-based care for the dying in which the word ‘Aids’ [sic] was never once mentioned (van Dyk 2005: 261-2). Such omissions testify to what can be regarded as the ‘unspeakable’ nature of AIDS. Susan DiGiacomo makes the apt comment that ‘the afflicted are twice victimized, either by a dearth or by an excess of meaning that denatures and even denies their experience’ (1992: 117). Critical reading of AIDS discourse requires what Gilman terms ‘listening with the third ear – paying attention to silences, refusals, omissions and displacements as the necessary mode of access’ (2009: 70).

Joseph Cady uses the terms ‘immersive’ and ‘counter-immersive’ to describe the way the subject of AIDS is treated in different discourses. ‘Counter-immersive’ writing protects its audience from ‘too jarring a confrontation with the subject [of AIDS] through a variety of distancing devices’, as opposed to ‘immersive’ writing which ‘thrusts the reader into a direct imaginative confrontation with the special horrors of AIDS and requires [him or her] to deal with them with no relief or buffer provided by the writer’ (Cady 1993: 244). An example of the immersive approach is seen in the following extract from a letter written by members of the Treatment Action Campaign (TAC)³, apropos the 2006 court case over the provision of antiretroviral (ARV) medication to prisoners in Durban Westville prison:

Coughing blood, wasting away from diarrhoea, uncontrolled bowel movements, a strange white fungus growing on your tongue and throat that prevents you from eating: this is what tens – if not hundreds – of thousands of people in South Africa experience daily, as they watch their once healthy bodies deteriorate. Dying from AIDS is usually painful, slow and undignified. But it is also avoidable. For the vast majority of people whose HIV infection has brought on AIDS, antiretroviral treatment can restore health and dignity (Bodibe 2009: 178).

This discourse is immersive in that it confronts the illness, the patients and the scale of the epidemic in blunt and graphic terms. It neither evades the actual physical effects of the disease; displaces the people who suffer; nor underplays the numbers involved. This approach is directly related to its persuasive purpose. The discourse marker ‘But’ signals a turning point in the text when the writer argues that such horrific suffering is unnecessary and reversible if treatment interventions are made available.

Another example of immersive AIDS discourse – which throws into relief the reticence usually noticeable in addressing sexual behaviour and AIDS – is the language that has come into use in some AIDS-education programmes, where explicit terms are employed to describe, for example, different ways of having sex,

³ The Treatment Action Campaign (TAC) is a pressure group founded in 1998 whose mission has been to demand that the government and the pharmaceutical industry make AIDS medication accessible and affordable to all.

with the purpose of explaining how infection is transmitted and can be prevented. Pieter-Dirk Uys, a satirist and actor who visits South African schools giving AIDS-education talks, believes in the effectiveness of blunt speech. In his talks he deliberately uses words that would formerly have been taboo in such situations: ‘fuck’ and the Afrikaans equivalent ‘*naai*’, for example. He feels it is necessary to use this discourse to communicate with his audience in terms they can relate to, and deliberately sets out to strip away the coyness and mystique that surround sex and AIDS. He caused a furore when he placed an advertisement in a Grahamstown newspaper at the 2003 Grahamstown Festival with the headline: ‘Think before you fuck’. A few years ago this word would have been regarded as unprintable in a generally circulated newspaper. His response to the outcry was: ‘Great. The message is finally hitting home’.⁴ However, the very fact that Uys’s approach is noteworthy and has provoked reactions of shock, disapproval and anger demonstrates that it is not the norm. The counter-immersive discursive trend of avoiding – or in some way displacing – the harsh realities of AIDS, is far more commonly found. Most of the texts discussed in this thesis display the characteristics of counter-immersive writing, where AIDS is significantly unspoken, or dealt with in an oblique or indirect way. This tendency to ‘skirt round’ the issue of AIDS is a discursive strategy of distancing and displacing the disease.

A broad form of euphemism is recognisable in narratives by and about the AIDS-ill, where the experience of being HIV-positive is frequently presented in optimistic terms. I use the adjective ‘broad’ because the euphemistic effect does not exist so much in individual words as in the overall tenor of the narratives, which are told in a way that gives them a positive significance. In Chapter 5 I examine in detail how particular narratives demonstrate this trend, but for the purposes of this chapter, it is enough to make the general point that illness narratives tend to underplay or ‘write out’ the reality of suffering and focus on its ‘benefits’ instead. Arthur Frank describes how terminally ill people are often put under pressure by their listeners to assert that ‘something good’ has come out of their illnesses (1995:

⁴ *Pretoria News*, 4 July 2003.

78; 1998: 6), because a 'healthy audience wants to dilute the harsh realities of illness' (1998: 7). Family members of the terminally ill and other listeners may project their own need for meaning onto a narrative because pointless suffering is too disturbing to bear. When this occurs, the subjectivity of the ill person is displaced by the subjectivity of others. Couser observes that:

... the master plot of autobiography ... is a comic plot; according to some evident standard, the protagonist is better off at the end than at the beginning. But a disjunction exists ... between the required or desired plot of personal narrative and the inherent or intrinsic 'plot' or 'story line' of AIDS – that is, decline and dissolution (1997: 91).

The paucity of autobiographical and biographical narratives of the multitudes who have died of AIDS could, at least in part, be attributed to the fact that there is no willing audience for such narratives. Frank reminds us that a story needs a listener, and he believes that people fear and avoid stories of terminal illness because the voices of those that suffer 'bespeak conditions of embodiment that most of us would rather forget our vulnerability to' (1995: 25). Jackie Stacey sees the reluctance to deal with issues of suffering and death as a feature of our age, remarking that:

in contemporary Western culture, we are encouraged to think of our lives as coherent stories of success, progress and movement. Loss and failure have their place but only as part of a broader picture of ascendance. The steady upward curve is the favoured contour (2007: 9).

Martha Bayles has termed the aversion to dealing with suffering in modern times the 'Oprahfication of literature', which alludes to the way Oprah Winfrey's television programmes encourage 'notions of self-improvement and moral uplift'⁵ and her book club selections favour stories about 'people who are up against hard circumstances but who manage to endure, if not prevail, in the spirit of heroic optimism' (Diedrich 2007: 62). On the 'ennobling' effect of illness, Howard Rosenberg makes the acerbic but apt comment that 'it is apparently impossible to be terminally afflicted these days without also being inspirational' (Treichler 1993: 177),

⁵ This perspective draws on Christian discourse. Oprah Winfrey's shows are part of American culture, but her popularity in many countries including South Africa has meant that her values are widely accepted.

and for this reason, AIDS has been mockingly named the 'Accelerated Inner Development Syndrome' (Frankenberg 1990: 363).

Barbara Ehrenreich, herself a sufferer of breast cancer, deplores what she describes as 'brightsiding' attitudes in relation to illness. 'Brightsiding' discourse pressurises the ill to be relentlessly cheerful and positive about their condition which they are encouraged to see 'not as a dreadful disease', but as a 'chance for creative self-transformation – a makeover opportunity, in fact'. She objects to the 'delusion and false hope' implicit in such attitudes (Ehrenreich 2002: 71), which normalise terminal illness, 'pretty it up', and present it, perversely, as a positive and almost enviable experience (Ehrenreich 2002: 77). In defiance of such discourse, she declares that any slow and painful way of dying is an 'abomination', and that far from making her more 'spiritual', her illness only made her more angry (Ehrenreich 2002: 79). The 'brightsiding' evident in so many illness narratives can have the effect of trivialising and even betraying the experience of real pain and trauma, in Ehrenreich's opinion. There is a further problem in brightsiding: if the survivors of illness are constructed as heroes, the same rhetoric requires that those who die are seen as 'failures'. Ehrenreich asserts that the 'mindless triumphalism of "survivorhood" denigrates the dead and the dying' by suggesting that they were somehow less brave than the survivors (Ehrenreich 2002: 79).

Stacey asks a number of acutely perceptive questions regarding the popularity of illness narratives which take a counter-immersive approach and insist on 'brightsiding':

But what remains untold in these heroic narratives? ... What cannot be restored with closure? Where is the continued chaos and disorder in such accounts? Where is the forgotten pain? Stories of progress and rationality are tempting, but perpetuate the illusion of life as a steady upward learning curve in which all crises have a profound meaning and show that 'God is working his purpose out'. Such mythologies encourage us to believe that suffering makes us wiser and serve to heroise those who suffer most. They leave no room for the futility of the pain and the arbitrariness of disease, the unbearable pointlessness of suffering (1997: 15).

Stacey objects to the displacement of the horror which accompanies prolonged, terminal illness. Her view that the writing of disease in positive terms is a feature of the modern age would, however, be contested by Gilman who asserts that the assumption that 'suffering must be purposeful' is an 'ancient idea' (2009: 3-4) based on theodicy, or the belief in divine justice. Scripture teaches that God used plague as a means of inscribing his judgement on the sinful (Gilman 2009: 73), which is punitive for the individual and therapeutic for society as a whole. Discussing the discourse of disease in the context of the plague in seventeenth-century England, Gilman observes that 'what cannot be thought, much less said ... is that the plague is in fact unjust and merciless, or a merely natural and causal event; ... or, worse, that it is the work of a God who has no interest in justice; or, worse yet, that the plague has no particular significance because there is no God' (2009: 67). Theodicy as an explanatory paradigm for disease long predates modern germ theory, but it endures in the accommodation of disease to theology still observable in some contemporary AIDS discourse. Since AIDS is a condition that many perceive as a consequence of immoral behaviour, it is easily grafted or displaced onto this old, moralistic discourse. From a more secular point of view, this can be seen as an attempt to find a cause-and-effect structure or orderly, purposive design in what would otherwise be a terrifyingly random universe, what Gilman describes as a way of 'suturing a traumatic rupture into the fabric of the comprehensible' (2009: 61). Such attempts epitomise the way that AIDS 'evokes and revises traditional narratives ... associated with infectious disease, drawing other cultural elements old and new into its orbit' in a process of 'discursive appropriation' (Gilman 2009: 5); what Ruthven describes as 'syncretizing the new with the old' (1976: 69). The projection of AIDS onto a modernised form of the discourse of theodicy is a clear example of displacement. This may be seen in autobiographical accounts such as that by Adam Levin (more fully discussed in Chapter 5), who accepts blame for becoming infected with HIV, regarding this as his punishment for 'immoral' sexual behaviour.

Another important reason for the counter-immersive treatment and displacement of AIDS in AIDS discourse is that it is a stigmatised condition, and so

discourages open and direct reference. The Greek word *stigma* originally referred specifically to physical marks that publicly disgraced a person, and this literal meaning could be related to the 'tokens' on the bodies of the ill: in the case of AIDS, the cancerous lesions of Kaposi's sarcoma, skin rashes, or the extreme emaciation which is the telltale sign of the final stages of AIDS. Such outward, visible marks of disease can be seen as signs of 'impurity', 'inscriptions' to be 'read' on the bodies of the afflicted (Gilman 2009: 3), which become 'texts' and are regarded as the 'site of moral revelation' (2009: 40). However, not all AIDS-sufferers get Kaposi's sarcoma or manifest infection through external symptoms such as skin rashes, and HIV-positive people can appear healthy for many years, so the notion of visible, physical stigma in relation to AIDS usually does not necessarily always apply.

Nowadays *stigma* refers more to the concept of disgrace than to actual bodily marks. This change in meaning, according to Kleinman, is 'an instance of a more general process of psychologization of experience in the West, through which metaphors of distress and other human problems that were once bodily have become mental'. Kleinman adds that 'stigma often carries a religious significance – the afflicted person is viewed as sinful or evil – or a moral connotation of weakness and dishonour. Thus, the stigmatized person is defined as alien other, upon whose persona are projected the attributes the group regards as opposite to the ones it values. In this sense, stigma helps to define the social identity of the group' (1988: 158-9). Because AIDS is (usually) sexually transmitted, it carries the taint of sexual excess or deviance and so the use of evasions to avoid the subject and euphemisms to deflect it is a common response. In one study on HIV care and counselling in South Africa, 98% of the subjects indicated that 'secrecy and confidentiality concerning AIDS are very important to them because they fear rejection by the community and even death if their HIV-status becomes general knowledge' (van Dyk 2001: 10). In an obvious strategy of displacement, families who have lost members to AIDS will cite secondary, opportunistic infections such as tuberculosis as the cause of death

instead of acknowledging the HI-virus as the responsible pathogen⁶. Suppression of the fact and impact of AIDS in medical records exemplifies the significant gaps or silences which exist in the discourse.

Among certain sectors of the black population in South Africa, it is taboo to actually speak the words 'HIV' or 'AIDS' because there is a fear that people could become infected or bewitched just by saying the name⁷. AIDS is thus referred to vaguely as 'this thing' or by means of circumlocutions such as 'the disease of nowadays'. In the Drakensberg district of KwaZulu-Natal, specifically, there is use of circumlocutions such as 'someone has died of the feet' (*izinyawo*), referring to the swelling of the legs and feet; 'of the head' (*ikhanda*), denoting the headaches associated with meningitis; 'of the chest' (*isifuba*), indicating TB or pneumonia; or 'of the stomach' (*isisu*), suggesting uncontrollable vomiting and diarrhoea (Henderson 2004: 5). The indirectness of these expressions, which describe AIDS in terms of the symptoms of the particular opportunistic infections associated with the condition, suggests the extent of the fear attached to it. In respect of their euphemistic effect — they soften and render more homely and familiar the unknown horrors of a new disease — these circumlocutions exemplify counter-immersive discourse and displacement.

The social anthropologist Isak Niehaus has conducted research in particular communities in the Lowveld and has shown that death — more than sex — is the reason for the stigmatisation of AIDS in these communities. The equation of AIDS with certain death persists despite advances in and greater access to treatment. It is true that AIDS is not curable, but with anti-retroviral (ARV) medication, AIDS is now a treatable, manageable disease in a similar way to a chronic condition such as diabetes. However, this view is not widely known or believed among lay people with little medical knowledge who perceive HIV-infection as a death sentence, which, in

⁶ Death certificates often cite opportunistic infections such as TB, influenza and pneumonia as causes of death rather than the underlying cause of AIDS itself. (Please refer to Footnote 5 of the Introduction.)

⁷ *Pretoria News*, 22 November 2001.

under-developed areas, it still is. Weston observes that in South Africa HIV/AIDS 'is perceived differently to developed countries', and 'viewed as incurable and still spreading' (2006: 27). Whereas in the United States or Britain, AIDS was associated with drug users, sex workers and homosexuals, and so stigmatised for its association with sexual and social 'deviance', in South Africa where AIDS is largely a heterosexual phenomenon, this is not necessarily so. Sexual morality is of less concern than the association of AIDS with death. Even the newly infected person is 'tainted with death' (Niehaus 2007: 856). People with AIDS are seen as 'living corpses'; in a liminal state between the living and the dead; or biologically alive but socially dead. Such perceptions are a form of displacement: the AIDS-ill are regarded as inhabiting a different world from the healthy and the resultant distancing effect reduces anxiety. According to Niehaus, the perception that people with AIDS are dead before dying carries as much symbolic weight as if they were 'lepers and zombies'⁸ (2007: 845). In an interview conducted by Niehaus one respondent stated:

If you test HIV positive, you will think all the time about death and dying. People will take you as dead. They will take you as a living corpse.... We blacks are brought up to believe that death is a terrible tragedy. If they tell me that I am HIV positive I'll think of dying.... I'll see death in my mind and I will dream of a grave. Because people fear death so much they would not want to talk to me or even come close to me (2007: 854).

Another respondent told Niehaus: 'You are speaking to a dead person' (2007: 857). The dread and fear of dying a premature and unnatural death associated with AIDS extends to the bloodline of the infected person. The journalist Jonny Steinberg, author of *Three-Letter Plague* (2008), went to live in Lusikisiki, an AIDS-riddled community in the Eastern Cape, South Africa, to explore the reasons why people would rather die than avail themselves of the services of their local clinic for testing and provision of free ARV treatment. He discovered that the death-related stigma of AIDS goes beyond the infected individual to their (potential) descendants, since premature death may prevent the AIDS-ill person from having children. A person

⁸ In certain African cultures a 'zombie' refers to a dead body that has been made alive again by witchcraft.

who does not leave progeny is regarded with deep disapproval and suspicion. The young man, Sizwe, in *Three-Letter Plague*, compares himself to ‘an ox’, a castrated bull who can produce no young, but ‘would sweat in the fields for a while and then get sick and die’ (Steinberg 2008: 231). This reality is so dreadful for him that he cannot bring himself to go for an HIV-test. If an infected person does have offspring, these will most probably be infected too, sully the purity of the bloodline and threatening its continued existence. However, whether they are infected or not, the descendants will not inherit the parent’s money or possessions because, in their culture, other family members, such as the father and brothers, are entitled to the material goods. The implications of having AIDS are thus extremely serious: the bloodline will either be stopped, polluted or robbed of its inheritance. All three of these possibilities are regarded as deeply shameful, hence the need to deny, displace or evade the possible reality of HIV-infection.

On a global (as opposed to an exclusively African) level, making sure that AIDS-related language is politically correct is a form of counter-immersive writing. The United Nations Development Programme has developed a detailed HIV-related language policy,⁹ the aim of which is to normalise the condition and resist discrimination against people living with HIV. When it comes to naming HIV-positive individuals, for example, it recommends that we should avoid terms like ‘victim’ or ‘sufferer’ because these carry connotations of helplessness and defeat. If, on the other hand, we talk about people ‘living’ rather than ‘dying’ and use the phrase ‘someone living with HIV’, we are recognising that an infected person may continue to live for many years. We should also avoid such phrases as ‘AIDS patient’ because we are then identifying someone by a medical condition alone, and should instead use ‘person living with AIDS’, where the individual’s personhood is primary. The policy states that being sensational and using metaphors such as ‘plague’ or ‘scourge’ gives the impression that the epidemic cannot be controlled and this could create hopelessness and panic and make infected persons reluctant to seek help.

⁹ ‘Defusing words of mass destruction’ in *Guardian Weekly*, November 13-19, 2003. See also: <http://www.undp.org/hiv/policies/langpole.htm>.

Underlying such recommendations is the tacit recognition that language can have a profound effect on attitudes and behaviour.

A key recommendation of the United Nations Development Programme HIV-related language policy – possibly influenced by Susan Sontag’s well-known study, *Illness as Metaphor*, discussed later in this chapter – is that the discourse of war should be avoided. Language should be drawn from the language of peace, instead. In practice, however, it seems difficult for people to avoid the discourse of war when discussing disease, a practice which predates the AIDS pandemic. As Sherry comments: ‘there was a long tradition before AIDS of militarizing disease’ (1993: 45). It has become almost habitual to discuss overcoming disease in terms of waging war, and its extension to include AIDS is a natural development. It is nonetheless ironic that Kofi Annan described HIV and AIDS as ‘the real weapon of mass destruction’¹⁰ in a news conference given at the end of 2003. In his speech he lamented the fact that the Iraqi war had taken attention away from other major problems, including AIDS, that ‘caused more daily insecurity than terrorism or unconventional weapons’. Such comparisons went directly against the policy of the organisation he headed. However, bearing in mind that 2003 was the year that the United States invaded Iraq and that that event dominated world affairs that year, it is not surprising that he drew on the highly charged ‘war against terror’ discourse when attempting to give impact to his speech.

While politically correct AIDS-related language appears to have the laudable purpose and effect of showing greater sensitivity to affected people, it can also be seen more critically as a form of euphemism and circumlocution which disguises and displaces the realities of AIDS. In her article ‘Metaphor as Illness’ (wordplay inverting the title of Susan Sontag’s book, *Illness as Metaphor*), Susan DiGiacomo argues that in the process of making AIDS discourse polite and socially acceptable, language is prioritised at the expense of the AIDS-ill, displacing and rendering their real suffering insignificant. She contends that ‘the reduction of experience to text makes the

¹⁰ *Pretoria News*, 20 December 2003.

politics of language the central concern and reduces living, ill, or dying persons to footnotes ... [so that] literary theory seems to have turned AIDS into meta-death' (1992: 125). It is ironic that, in the linguistic attempt to be more sensitive to and supportive of the AIDS-ill, they are effectively marginalised and the reality of their illness minimised and displaced. When the source of such language policies is as authoritative as the United Nations, the policies are bound to be highly influential in constituting the social order. Challenges by voices such as DiGiacomo's are a healthy and necessary way of resisting the kind of hegemonic discourse which erases AIDS sufferers from social space and relegates them to the metaphorical territory of the diseased.

As mentioned in the Introduction, scientific, medical discourse is generally assumed to be neutral and objective, and in this respect believed to be radically different from ideology, but this assumption is not valid. No language, not even scientific language, is in a simple correspondence with natural reality, since linguistic signs and their referents are inherently unstable, whatever the field. A virus, for example, is an entity constructed by human perception, which is always subject to bias, manipulation and error. Scientific language, like other kinds of language, is constructed, and as Morris observes, 'so-called objective statistics and lab reports are only meaningful so far as fallible human beings produce and interpret them, and interpreters differ'. He adds that 'the objectivity of medicine is a myth fostered as much by patients as by doctors' (1998: 42). Morris quotes the philosopher and psychologist William James's observation that 'human motives sharpen all our questions, human satisfactions lurk in all our answers, all our formulas have a human twist' (1998: 42). In biomedical discourse, accounts of phenomena come to be taken for granted as 'black-boxed', or 'reified autonomous objects' (Treichler 1999: 159), and are easily accepted as 'facts'. Once established, such 'facts' become synonymous with 'the truth' and are hard to dislodge.

Biomedical discourse is also not 'pure', or free of ideology. Medicine pursues its own research agenda and has its own economic interests. To start with, the biomedical model is based on the 'germ theory' of disease, which accepts that

particular microscopic agents cause particular illnesses. This means that it is biased towards pharmacological responses to disease and so is linked to the powerful structures of the pharmaceutical industry. This entails massive economic interests, which inevitably compromises claims to objectivity. Charles Rosenberg's comments are relevant here:

Medical knowledge is not value-free ... but is at least in part a socially constructed and determined belief system, a reflection of arbitrary social arrangements, social need, and the distribution of power.... The physician is not above social interest but is a social actor whose mission of defining and treating disease can express and legitimate professional, class, or gender interests (1988: 13).

Unequal 'distribution of power' in society and the 'professional interests' of medical experts could account for the depersonalisation and marginalisation of patients which is a feature of much biomedical discourse and which effects another form of the displacement of the AIDS-ill. This can be illustrated by examining a sample of text from an article in the *South African Medical Journal*, entitled: 'Clinical and financial burdens of secondary level care in a public sector antiretroviral roll-out setting (G. F. Jooste Hospital)' (Kevany *et al* 2009: 320). The article describes a study which set out to determine the cost of care for HIV-positive inpatients and outpatients at a particular medical institution in Cape Town. The authors state that their study 'neither undermines nor questions the affordability and viability of the ARV roll-out' (Kevany *et al* 2009: 325), but the choice of the word 'burdens' in the title of the article has negative connotations, suggesting an undue, even illegitimate drain on health resources by the AIDS-ill. In the actual text of the article, what is striking about the language is the consistent use of the passive voice in relation to patients:

while many patients are initiated and managed on ART [anti-retroviral therapy] at the primary level, the development of complications frequently requires referral to secondary hospitals. Secondary facilities therefore also face significant resource demands to investigate and treat patients on or preparing for ART and presenting with opportunistic infections ... (Kevany *et al* 2009: 320).

The syntax of such constructions as ‘patients are initiated and managed’ constitutes the patient as an acted-upon object rather than an autonomous individual. This is an example of the way the body of the patient becomes subject to and constructed by ‘the medical gaze’ (Foucault 1973: 9), or surveillance, a practice of the dominant discourse that supports and is supported by medical practitioners. Such an approach has a disciplinary function in that it renders the patient docile and disempowered, illustrating the way that, in Foucault’s words:

the registration of the pathological [is] constantly centralized. The relation of each individual to his disease and to his death passes through the representatives of power, the registration they make of it, the decisions they take on it (Foucault 1977a: 196-7).

Such discourse edits out or ignores the patient’s individual needs, supporting what DiGiacomo describes as ‘asymmetrical relations of power by appropriating and deauthorizing the experience of the ill’ (1992: 133). This example demonstrates how linguistic analysis can provide illuminating insights into the way that processes of medical construction show up practices of domination and power relations.

It is noteworthy that the disease, rather than the sick person, is made the subject of the sentence, in ‘the development of complications frequently requires referral’, which grants agency to the disease process and omits reference to the patient altogether. Agency is also located in technology in such expressions as:

Laboratory testing costs were dominated by blood tests. Imaging and radiology costs were primarily accrued by CT scanning. Medication costs were dominated by non-ARV antimicrobials and ARV drugs (Kevany *et al* 2009: 323).

In all three of the above sentences, technical processes constitute the subject of the sentence, and the patient is conspicuously absent in the syntactic constructions.¹¹

¹¹ It is appreciated that the purpose of this article was to explore the cost of treatment, an important factor which has to be taken into account. However, the erasure of the patient as a human being remains significant, in my opinion.

Underlying the language used is the assumption that the medical professionals are important and 'right', while the patient is devalued. Where patients are referred to, they are constructed as economic units, not human beings:

The high proportion of inpatient and outpatient costs as a result of infections suggests that the treatment of infections is critical in secondary level care for ART patients, especially for tuberculosis, cryptococcal meningitis and bacterial pneumonia. Treatment of infections remains one of the most costly and complex aspects of HIV care.

The mean CD4 count for outpatients was higher than for inpatients, and there were also lower total and per-patient costs of care per outpatient than per inpatient. This finding illustrates the importance of earlier diagnosis and initiation onto ART to avert these high inpatient costs. The difference in total costs between outpatients and inpatients suggests that earlier referral and easier access to referral services for ART patients should be provided, rather than allowing patients to become so ill that they require inpatient care (Kevany *et al* 2009: 325).

Early diagnosis and ART treatment are recommended not so much for the patient's sake, but to 'avert' the high inpatient costs entailed in treating advanced illness. Monetary implications take precedence over people. Within this 'hard' economic, technocratic and bureaucratic discourse, patients are dehumanised, disempowered and displaced, their experience 'disqualified as inadequate' (Foucault 1980: 82), exemplifying the way that, in the clinic, 'the patient is the accident of his disease, the transitory object that it happens to have seized upon' (Foucault 1973: 59). Or, as DiGiacomo puts it: 'the afflicted person is further burdened by a reduced and defective patient self constructed for him or her through biomedical discursive practices' (1992: 123) which are 'power-saturated' (1992: 124). The sample of discourse analysed above strongly betrays a deeply embedded ideology in which the AIDS-ill, as human beings, are discounted and displaced from general society, and demonstrates the fallacy of the belief in the 'neutrality' and 'objectivity' of biomedical language and discourse. As Morris puts it:

disease as objective and illness as subjective are categories that convey a powerfully divided sense of worth. What the patient reports is subjective (and untrustworthy), what the lab reports is objective (and true).

Numbers are objective (and serious), stories are subjective (and trivial). Doctors are the authorities in disease, while patients remain the more or less unreliable narrators of their own unruly illnesses. The distribution of power within the traditional doctor/patient couple is tellingly one-sided (1998: 38).

Another language-related point which further disempowers the patient is that the discourse of AIDS exists largely in the hegemonic linguistic medium of standard English, which, in South Africa, is generally familiar to first-language speakers and the educated elite only. This results partly from South Africa's multilingual, multicultural composition but it also reflects wider discursive structures which are the legacy of South Africa's political history. Standard English, the dominant language variety, is not used by the majority of South Africans, so automatically acts as a barrier, excluding the people most affected by AIDS. Instead of language acting as a medium enabling communication and expression, the prestigious status of standard English alienates and silences those who have not mastered this language variety.¹²

In response to the argument that the biomedical excerpts analysed above are impersonal in style because the discourse necessarily has to focus on scientific matters and sacrifice the personal dimension, I would answer that this is not so. Not all biomedical writing makes exclusive use of the passive voice when referring to patients, nor does it always erase the ill person from the discourse, as can be seen in the following example from an article entitled 'Coping strategies and social support after receiving HIV-positive results at a South African district hospital', also taken from the *South African Medical Journal*:

Patients mostly utilised active coping strategies involving emotional support, acceptance, positive reframing and planning. Avoidance coping strategies, such as disengagement, substance use and denial, were in the minority. Many patients turned to religion to cope, which might have helped them to find meaning and spiritual support.

¹² Only 8,2% of the South African population speak English as their home or primary language. 45% have a speaking knowledge of English, but it is their second or additional language.

Most patients had disclosed their status after 2 weeks and reported emotional support as their commonest coping strategy. In contrast to other studies, emotional support was largely derived from families and 'significant others' as opposed to networks of friends. Patients were reluctant to disclose to their friends, presumably because of the fear of stigmatization and loss of confidentiality (Myint and Mash 2008: 277).

In this excerpt, the patient retains agency through the use of the active voice and is not marginalised or displaced from the text. Patients are also allowed a voice, when they 'report' their experience. These factors indicate a more patient-centred approach on the part of the researchers, which does not compromise the scientific nature of the discourse it represents. This contrasting discourse, which deviates from the norm, demonstrates that a different attitude and approach are possible within biomedical discourse, and that the impersonal style is chosen (if unconsciously), not obligatory.

Intertextuality, which 'foregrounds the often hidden relations between texts, discourses or genres' (Potter 1996: 80), is another form of displacement, entailing the transfer of expressions and the ideas and connotations associated with those expressions from one discourse to another. The example where HIV and AIDS were described in terms of 'weapons of mass destruction', is an instance where intertextuality adds new meanings to AIDS. Analogising the AIDS-situation to a distant arena of action, the Iraqi war, is an obvious exercise in displacement, but one that worsens, rather than ameliorates, its emotional effect. In an example taken from South African discourse, the image of Nelson Mandela has been used intertextually in AIDS discourse – specifically in the '46664'¹³ concerts – to link the positive connotations associated with his name and personal history to the cause of AIDS. By contrast, profoundly negative meanings are transferred intertextually to the phenomenon of AIDS when a word like 'genocide' is connected with it, evoking the discourse of the Holocaust where people were killed as a result of deliberate official policy. Fox discusses how intertextuality alters and thickens meaning: in his words,

¹³ The '46664' concerts were fundraising events for the victims of AIDS. '46664' was Nelson Mandela's number when he was imprisoned on Robben Island.

through intertextuality, 'meaning comes into being, is sustained, distorted, obscured, or re-introduced' (1997: 32). Brown and Augusta-Scott observe that intertextuality shows that 'individual experience is ... always more than subjective, as it is never outside cultural discourse and social relations. In this way, there is no singular author of experience' (2007: 182).

The effectiveness of intertextual references depends on the reader's familiarity with them, since readers may not recognise the source of the reference, or, if they do, their response to it cannot easily be controlled. Readers may miss, accept or reject the intended significance of a text like Mandela which has no single or final meaning. In terms of Barthes' thinking, the ' "seme" [connotations or possible meanings attached to an image] is linked to an ideology of a person' so Mandela could be seen as the 'sum, the point of convergence' (1974: 191) of a plurality of meanings ranging from resistance, rebellion, subversion, terrorism and anarchy to courage, integrity, reconciliation, democracy, stability and peace (and many others). Barthes points out that 'all images are polysemous; they imply, underlying their signifiers, a "floating chain" of signifieds, the reader able to choose some and ignore others' (1977: 38-9). For Barthes, each text is, at least in part, a pastiche of past texts. He states that 'the intertextual [is that space] in which every text is held, it itself being the text-between of another text', but cautions that it is futile to try to find all the sources and influences in a work, because these are 'anonymous, untraceable, and yet *already read*: they are quotations without inverted commas' (1977: 160, his emphasis). The result is that the '[t]ext ... practises the infinite deferment of the signified', or meaning; it is 'dilatatory' (1977: 159), implying delayed interpretation owing to the displacement of meaning onto other discursive landscapes. Hillis Miller observes that a literary text 'is inhabited ... by a long chain of parasitical presences, echoes, allusions, guests, ghosts of previous texts' (Gilbert and Gubar 1979: 290).

The use of metaphor to conceptualise the reality of AIDS is an important form of displacement, although it needs to be said at the outset that language, in general, is intrinsically metaphorical. As Hawkes observes, '[a]// language, by the nature of its

transferring relation to reality ... is fundamentally metaphorical', and that 'all languages contain deeply embedded metaphorical structures which covertly influence overt "meaning" ' (1972: 60, his emphasis). However, AIDS is a condition which lends itself particularly to metaphorical construction. Couser comments that 'AIDS is an illness whose symbolic dimensions are especially prominent and significant; it offers an obvious and extreme instance of the "cultural construction" of illness' (1997: 81).

The word 'metaphor' derives from the Greek root *metaphora*, derived from *meta* meaning 'over', and *pherein*, 'to carry' and works on the assumption that 'terms literally connected with one object can be transferred to another object ... with the aim of achieving a new, wider, 'special' or more precise meaning' (Hawkes 1972: 1-2). Gray defines metaphor as 'one thing ... described as being another thing, thus "carrying over" all its associations' (1992: 174). The *Oxford English Dictionary* (*OED*) defines metaphor as 'the figure of speech in which a name or descriptive term is transferred to some object different from, but analogous to, that which is properly applicable' (*Oxford English Dictionary*, Vol. VI. 1933: 384). I. A. Richards has appropriated the terms 'tenor' and 'vehicle' to describe metaphor; 'tenor' being the subject of the metaphoric combination, and 'vehicle' being the metaphoric word which carries over its meaning (Gray 1992: 174). In all these definitions, the notion of movement is strongly indicated. The verb 'transferred', used in Hawkes's and the *OED*'s definition, is roughly synonymous with 'displaced', suggesting the movement of an object – together with all its connotations – from its previously occupied space to a different one; the phrasal verb 'carrying over' similarly captures the process of displacement of meaning; while Richards's use of the noun 'vehicle' (itself a metaphor) implies the means by which movement, and the 'carrying over' of meaning, is made possible.

Referring back to Aristotle's discussion of metaphor in the wider context of rhetoric and poetics, Ricoeur draws attention to the fact that 'metaphor is defined in terms of movement [and is] ... a sort of displacement, a movement "from ... to ..." ' (1977: 17); that it implies 'change with respect to location' (1977: 18); and that 'the metaphorical term is borrowed from an alien domain' (1977: 20), while Steen asserts

that ‘the notion of “distance” between domains is seminal for metaphorical comparisons’ (1994: 13). Derrida states that ‘[m]etaphor in general, [is] the passage from one existent to another, or from one signified meaning to another ... the analogical displacement of Being ...’ (1978: 27). All these explanations are premised on the notions of movement and the displacement of meaning.

When AIDS, specifically, is constructed in metaphorical terms, the condition is displaced or attached to other realms of discourse, removed from illness, and a transfer of associations takes place. For example, in a slang metaphorical expression drawn from soccer, an AIDS-ill person is described as having been given a ‘red card’, implying that he has been sent off the field (of life). In another example, the discourse of travel is used when someone is said to have a ‘boarding pass’, or to be ‘in the departure lounge’. These colloquial expressions¹⁴ employ metonymy, a trope related to metaphor, in which an item that is an attribute of – or is closely associated with – something, is used as a substitute for it (Gray 1992: 176-7). ‘A red card’ and ‘boarding pass’ are objects which are parts of greater wholes. While these comparisons imply the inevitability and imminence of death for the AIDS-ill person, they also have a euphemistic effect in that they substitute illness and dying for activities like sport and travel which have positive associations, and transfer or displace the deathbed to other, more neutral arenas such as a football field or an airport. These examples exemplify ‘displacement’ as this is understood in psychoanalytic criticism, where a ‘socially acceptable object’ is made to stand for something ‘forbidden’ (Gray 1992: 235-6) or frightening.

In another definition of the term ‘metaphor’, the cultural anthropologist Naomi Quinn uses the words ‘mapping’ and ‘domain’ when she observes that ‘metaphor is mapping from some source domain to some target domain’ (Quinn 1991: 57). She goes on to say:

particular metaphors are selected by speakers because they provide satisfying mappings onto already existing cultural understandings – that

¹⁴ The source of all the colloquial and slang expressions discussed in this chapter is *Irin/Plus News*: 18 June 2008. ‘Africa: mind your language – a short guide to HIV/AIDS slang.’

is because elements and relations between elements in the source domain make a good match with elements and relations among them in the cultural model (1991: 65).

The notion of projecting aspects of one subject in the 'source domain' (in this instance, AIDS) on to pre-existing metaphorical constructions (the 'target domain') clearly articulates the displacement of meaning.

Lakoff and Johnson (1980) demonstrate that the use of metaphor to describe various phenomena is not a question of merely adding verbal embellishment but is fundamental to the way we conceive of and define reality. Representing what is known as 'the cognitive turn' in metaphorology (Steen 1994: 3), Lakoff and Johnson reject the notion that metaphor is 'deviance' from 'normal' language, or a 'figure of speech', and see it instead as a 'figure of thought'. Choice of metaphor reveals how things are conceptualised and generates what Lakoff and Johnson term a 'network of entailments' (1980: 156) or implications, which shape responses to whatever it is that is being defined. Such responses can have major consequences since they can lead to action or inaction on the part of individuals and governments, involving policy design and funding which could profoundly affect lives. And indeed, different 'figures of thought' or changing conceptual paradigms subscribed to by successive post-apartheid administrations did determine the difference between life and death for thousands of the AIDS-ill.

AIDS's particular susceptibility to metaphorical construction is explained in the following way by Christopher Taylor:

While certain sicknesses do not engender illness metaphors because of their innocuousness, sicknesses that are contagious, life-threatening, characterized by bizarre or debilitating symptoms, or associated with abnormal behaviour are likely to give rise to imagery embodying positive or negative sociomoral judgments. Moreover, these judgments are further reinforced when the sickness manifests a propensity to afflict members of society who are already marginalized for reasons of ethnicity, life-style, or socioeconomic status (1990: 56-7).

Clatts and Mutchler suggest what some of these 'sociomoral judgments' might be for the person with AIDS:

to say someone has AIDS is to say much more than that person is experiencing the progressive exposure of fragile organs to the ravages of common infections. It is to say that he or she is a certain type of person, socially and morally defined ... the metaphoric predication of AIDS opens a door to the dark musty cellar of cultural associations of the profane, the defiled, the denied, the unshown, the forbidden, the feared (1989: 108).

Here Clatts and Mutchler refer to metaphorical displacements which intensify rather than reduce the 'forbidden' dimensions of AIDS, and so are not euphemistic: they do not 'redirect emotional feelings to a substitute object which is less threatening, thereby reducing anxiety' (Colman 2001: 210). However, the 'othering' process which operates when a 'certain type of person' is identified and stigmatised as 'morally defiled', brings about displacement in a different way; through stereotyping. Epstein discusses the way that certain so-called 'high-risk groups' are categorised as 'not us' (1995: 180), endorsing Kleinman's statement, quoted earlier in this chapter, that 'stigma helps to define the social identity of the group' (1988: 158-9). Epstein observes that 'the threatening *presence* [her emphasis] of the HIV-infected on the public terrain of social prejudice has far outweighed the actual threat, ... making it possible to continue to figure AIDS as a disease of Otherness Social fears can be kept in check only by their displacement onto the "ever available" bodies of gays and lesbians and bisexuals, the Others who are all of us' (1995: 182-3). Epstein's frame of reference is the United States, where the AIDS epidemic has obvious demographic differences from the South African one, but the psychological principle she refers to is applicable here too: 'undesirable elements' in society are blamed for generating and 'leaking' AIDS to the rest of 'us'. 'Us' is an amorphous grouping, but Epstein sees it as a 'clearly white, middle-class, suburban, "decent", and, above all, heterosexual "general population", a population that is clearly delimited *against* the transgressive otherness of same-sex desire, racial difference, injection drug use, and illness' (Epstein 1995: 159, her emphasis). The stigmatised

types of AIDS-ill that Epstein names are minority groups in the United States, and therefore easy to ‘other’, but in South Africa, the sector most affected by AIDS is black and heterosexual, and black heterosexuals constitute the majority of the South African population. However, this does not automatically mean that they are seen as the ‘standard’, since the ‘standard’ does not necessarily depend on numbers, or the notion of ‘majority’. This paradoxical point is discussed in Antjie Krog’s book *Begging to be Black* (2009), where, in answer to the question whether – despite the fact that majority rule is black, and that Africa is a majority black continent – blacks are still seen as a minority, the following viewpoint is voiced:

Minority in this sense has nothing to do with quantity ... the majority is represented by the ‘standard’, and that is always the adult-white-heterosexual-European-male-speaking-a-standard-European-language (Krog 2009: 100).

In terms of this perception, black heterosexuals who are HIV-positive or ill with AIDS will still be seen as the alien ‘other’, even in South Africa where blacks form the majority of the population, and the majority of the AIDS-ill are black and heterosexual. This perception could suggest that, even though we are living in a post-colonial, post-apartheid period of history, South African society has not transformed for the majority of black people. The gap between a new black elite and the poor has widened, with class, rather than race, determining status (Saunders 2000: 213).

Epstein elaborates on the connection between ‘othering’, denialism and displacement of the AIDS-ill:

The cultural production of categories of visibility and invisibility, speakability and unspeakability, points toward a global strategy of containment that is also a strategy of denial. To put it another way, if the epidemic can be contained by denying those who suffer and die from AIDS, AIDS as an epidemic – an invasion of and by those who are perverse and foreign – will cease to exist (1995: 159).

‘Othering’ is akin to psychological banishment, or sending those who are stereotyped as ‘undesirable’ into a liminal space. ‘Containing’ them in a different place is a symbolic form of exile. This displacement strategy creates the illusion that the problem has gone away and is no longer a part of the space occupied by the rest of ‘us’.¹⁵

In the same way as was observed in relation to intertextual references, the connotations of metaphors are multiple (Barthes uses the adjective ‘plural’) and cannot be limited or controlled. In Barthes’ words in *S/Z*, ‘[c]onnotation is the way into the polysemy of the ... text ... a feature which has the power to relate itself to anterior, ulterior, or exterior mentions to other sites of the text (or of another text)’. Implicit in this expression is the notion of displacement. When correlated and combined with other meanings outside the material text, connotations form what Barthes terms ‘nebulae’ of signifieds (1974: 8). The ‘seme’ (the connotations linked to the signified) is ‘uncertain, approximative, unstable’ (1974: 190), and semes ‘migrate from one figure in the text to another’ (1974: 191). Comparing the text to a ‘pregnant female’ (1974: 201), Barthes asserts that ‘the text is replete with multiple, discontinuous, accumulated meanings’ (1974: 200). In *Image Music Text* Barthes states that the ‘logic regulating the text is ... metonymic; the activity of associations, contiguities, carryings-over coincides with a liberation of symbolic energy’ (1977: 159). Gräbe makes the point that the different meanings and implications of metaphors can be *productively* ambiguous (1985: 9, her emphasis), but from the ill person’s point of view, some of the ‘signifieds’, or ‘irreducibly plural’ (Barthes 1974: 159) meanings ‘liberated’ through imagery, may be highly undesirable. Frank observes that ‘[w]hen illness happens, the disease carries a metonymic overload that compounds suffering’ (1995: 176).

¹⁵ Attempts have been made to counteract the predominantly ‘othering’ effects of AIDS discourse: the *Sunday Times*, for example, ran a feature called ‘Everyone knows someone’ from April 2006 to June 2009 in which readers were encouraged to send in personal stories about people they knew who were living with AIDS. These narratives were intended to encourage people to know their HIV-status and to destigmatise the condition. In a deliberate effort to break the silence around the reality of AIDS, certain prominent figures in public life disclosed that they were HIV-positive before they died; among them, entertainment celebrities Gibson Kente and Fana Khabzela. Political figures Nelson Mandela and Mangusothu Buthelezi openly declared that the cause of their adult children’s deaths was AIDS.

In *Illness as Metaphor* Susan Sontag objects to the use of metaphor when referring to illness, stating emphatically that ‘illness is *not* a metaphor’ (1978: 3). She believes that the way illness is conceptualised through metaphor can aggravate the experience of illness for the sufferer and discourage support for the ill person by others. Sontag takes exception to the use of metaphor in relation to illness because of the possibly ‘punitive’ associations that may be given to certain illnesses and those who are ill when negative metaphorical meanings are imposed (1978: 3). She is especially critical of the use of military metaphors in relation to illness (one of the points addressed in the United Nations Language Policy, mentioned earlier in this chapter). She believes that we need to purify the language we use to speak and write about illness, stripping it of both metaphor and the affective content expressed through metaphor, in order to transform perceptions of illness. Lisa Diedrich compares Sontag’s desire to render illness devoid of metaphoric meanings to the ‘anatomy-clinical approach’, which regards illness as a mere ‘pathological fact’ (2007: 28).

Various researchers have argued – validly, in my opinion – that it is impossible to remove metaphor from language. Hawkes asserts that ‘there is, finally, no way in which language can be “cleared” of metaphor’ (1972: 55), pointing out that even this apparently straightforward expression (‘cleared of metaphor’) employs the metaphorical verb ‘to clear’, and shows that language makes use of metaphor even while making the claim to be free of it (1972: 60). Ricoeur asserts that ‘it is impossible to talk about metaphor non-metaphorically’ (1977: 18), while Potter observes that even supposedly literal descriptions are not innocent of figurative roots of which the user may not be aware (1996: 180). It is easy to demonstrate this point: an academic textbook on the subject of AIDS, which we might expect to be scientific and literal in style, readily yields examples of metaphorical language use: the immune system is compared to a ‘defence force’ (a common metaphorical construct), with words like ‘attack’, ‘invader’ and ‘battle’ featuring prominently (Van Dyk 2001: 8); another example makes use of the metaphor of a train journey when describing the course of HIV-infection, referring to speed, ‘distance markers’ and ‘destination’ (Van Dyk 2001: 4); while another

appropriates a musical image in which the T-cell is identified with the 'conductor' of the 'orchestra' that is the immune system (Treichler 1988: 203). To illustrate just how figurative and emotive academic language on the subject of AIDS can be, the following serves as an example:

This diabolical virus, malignant in every sense, first disrupts the organism's immune defences, disorganizes its internal regulation. It then ricochets outward to disturb sexual relations and finally, dangerously, to poison social habits in a new way, more subtle and more insidious than medieval leprosy, Renaissance syphilis, or machine-age tuberculosis (Grmek 1990: xi-xii).

In this one short paragraph AIDS is identified with the devil, a bullet, poison and various dread diseases which are given additional gravity by their historical references. It is also given what could be seen as the human attribute of malicious intent, in being described as 'malignant', 'subtle' and 'insidious'. These various images cumulatively construct AIDS as a terrifying and deadly entity, and exacerbate, rather than displace, the negative meanings of the condition.

Of all metaphors applied to illness, the military metaphor is the one Susan Sontag 'is most eager to see retired' (1989: 94). Ross agrees, discussing how entrenched the metaphor of medicine as war is in general language usage to the extent that 'we can scarcely imagine any other way of talking about how health care providers deal with diseases and patients' (1988: 85). She states that since the occurrence of AIDS, 'the phrase "the war against AIDS" is perhaps the most common metaphor used in the popular press' (1988: 86). She concurs with Sontag that seeing the virus as 'the enemy' is undesirable because it makes the carriers of the virus (the infected person) into spies and traitors, since – like the Trojan horse – they harbour the unseen enemy within themselves, and indeed it is easy to see how such an equivalence could promote discrimination against HIV-positive people.

Media discourse used in relation to AIDS in South Africa is permeated with war metaphors. Some examples are: 'SANDF declares war on HIV: opening salvo

fired in battle against deadly disease'¹⁶; 'Aids battle hots up'¹⁷; 'Climate of fear cripples Aids fight'¹⁸; 'President must lead the war on AIDS'¹⁹; and 'Barbara is a trooper in her field', about a woman called Barbara Michel who heads an HIV/AIDS education programme. The opening sentence of the latter report reads: 'The war's not lost while there are passionate troops willing to give their all for the fight'²⁰. Communities in KwaZulu-Natal gave the name *mashayabhufe*, meaning 'hit squads', to AIDS, after the hit squads of the apartheid state. They christened the virus with this name because 'it hits everything': AIDS destroys everything in its path (Lawson 2008: 57). This is an example of the entanglement of the discourses of AIDS and the struggle²¹, the focus of Chapter 2. The lexical chains relating to war in these examples are obvious but semantically unsatisfactory because, in Sherry's words, it is unclear 'who, or what, is fighting whom, or what, where and how' (1993: 41). The military metaphor could operate on the biological micro-level, referring to 'the war within the bodies of the disease's victims' or on the macro-level, 'in the arena of social and political action'. It could refer equally to 'action against the disease, war by the disease on its victims, or by those who tolerated it on those victims, or by those who transmitted to others' (Sherry 1993: 41).

Allan Brandt takes issue with Sontag's anti-metaphorical standpoint when he argues that 'disease cannot be freed of metaphors' because '[it] is simply too significant, too basic an aspect of human existence to presume that we could respond in fully rational or neutral ways' (1988: 416). He holds that '[d]isease is not merely a biological phenomenon; it is shaped by powerful behavioral, social and political forces. Social values affect both the way we come to see and understand a particular disease and the interventions we undertake. In his view, 'disease is

¹⁶ *Pretoria News*, 21 January 2004.

¹⁷ *Sowetan*, 2 April 2004.

¹⁸ *Pretoria News*, 26 November 2003.

¹⁹ *Sunday Times*, 30 November 2003.

²⁰ *Pretoria News*, 21 February 2004.

²¹ 'The struggle', as this phrase is used in South Africa, refers to the conflict entailed in the fight against apartheid.

“socially constructed”’, and is ‘literally “loaded” with affect’ (1988: 415-6). Paula Treichler also believes that it is impossible ‘to strip AIDS of its politics, its metaphors, its terrifying murkiness, in short its entire connotative life, and at last reveal it as it is, an infectious disease and nothing more’. She adds: ‘To believe that information and communication about AIDS will separate fact from fiction and reality from metaphor is to suppress the linguistic complexity of everyday life’ (1992: 401). DiGiacomo adds her voice to opposing what she describes as Sontag’s ‘extraordinary argument against interpretation’ when she asserts that ‘we can experience anything at all only through and by means of culturally constructed and socially reproduced structures of metaphor and meaning’ (1992: 117). The consensus, with which I agree, is that it does not seem possible to detach or separate metaphor from language, and, in particular, metaphor from the language of AIDS.

In Sontag’s later work, *AIDS and its Metaphors*, she modifies her earlier position, conceding that while we ‘cannot think without metaphors’, we ‘might well abstain from or try to retire’ some metaphors which connote AIDS in ways that encourage dread and stigmatisation (1989: 5). Other scholars support her contention and have also warned against the negative effects of constructing AIDS in particular ways (Lupton 1994; Ross 1988; Simpson 1988; Watney 1987). Paula Treichler makes the point that ‘reality is inevitably mediated’ (1989: 48) through language, and that it is up to us to sort out, understand, and where necessary, challenge existing discursive productions.

In his book, *Witness to AIDS*, more fully discussed in Chapter 5, Edwin Cameron shows an acute awareness of the way AIDS is displaced in the multiple metaphorical constructions it is given, and does exactly what Treichler urges when he challenges these ‘existing discursive productions’:

AIDS is a disease. It is an infection, a syndrome, an illness, a disorder, a condition threatening to human life. It is an epidemic – a social crisis, an economic catastrophe, a political challenge, a human disaster. AIDS is known. It has been analysed assessed assayed tested measured surveyed considered reflected documented depicted exhaustively described. Its virus is primal particular sub-cellular mutant enveloped nitrogenous. Our

knowledge of it is clear and precise. But the disease is also unknown. It is guessed estimated projected approximated sketched debated disputed controverted hidden obscured. Still, it is mere fact: an event, a circumstance, a happening, a reality as present as the ocean or the moon.

AIDS is mouth and tongue and scar and nerve and eye and brain and skin and tum and gut. AIDS is smell and feel – of sweat and grime and snot and breath and bowel and secretion, discharge, pus, putrescence, disintegration, excrement, waste. Human waste. AIDS is feeling – painful sharp tingling burning heavy dull weakening wasting enervating diminishing destroying bereaving. AIDS is fear. It is breathless and nameless.

AIDS is stigma disgrace discrimination hatred hardship abandonment isolation exclusion prohibition persecution poverty privation. AIDS is metaphor. It is a threat a tragedy a blight a blot a scar a stain a plague a scourge a pestilence a demon killer rampant rampaging murderer. It is made moral. It is condemnation deterrence retribution punishment, a sin a lesson a curse rebuke judgment. It is a disease (Cameron 2005: 42).

There is a paradox at work here: even as Cameron reels off the multiple ways in which AIDS is perceived, experienced and metaphorised, he begins and ends the above passage by making the point that AIDS also exists literally as just ‘a disease’. AIDS is all of the things ascribed to it, and none of them. Cameron does not try to explain away the inconsistencies and contradictions in the multiplicity of significations given to AIDS. As he lists the array of meanings attached to it, including its social implications, its physical symptoms, the moral opprobrium associated with it and its representation in catastrophising discourse, he reminds us that it is, in the end, a disease and nothing more. While he emphasises the range and number of its effects and significations, the breathless, unpunctuated volley of epithets possibly satirising how emotive and exaggerated many of these are, his final statement that ‘[AIDS] is a disease’ is clearly bathetic and refutes the displaced meanings heaped upon it as he restates its essential nature in the simplest possible way.

When he describes AIDS as ‘sweat and grime and snot and breath and bowel and secretion, discharge, pus, putrescence, disintegration, excrement, waste. Human

waste', Cameron adopts an immersive approach, confronting the disease directly, and in its most repulsive and frightening aspects. However, he gives AIDS an alternative metaphorical significance of his own, constructing it as 'a reality as present as the ocean or the moon'. This comparison of AIDS to natural phenomena – and notably those which carry culturally positive connotations – indicates that he is intent on deconstructing its negative constructions, eliminating fear, and encouraging an attitude of acceptance. Cameron challenges the frightening metaphorical displacements that cluster so thickly round AIDS in common discourse, displacing AIDS on to a natural landscape that includes the ocean and the moon. Rather than trying to purge AIDS discourse of its metaphors, as recommended by Susan Sontag in respect of cancer (1978), Cameron seeks to do what Couser describes as 'commandeer metaphor and enlist it on the side of embattled patients' (1997: 168).

Cameron's attempt to dispel the terror that surrounds AIDS is necessary and understandable because fear can be counterproductive, but his displacement of AIDS through alternative metaphorisation could be seen as not altogether appropriate or convincing. AIDS does not fit into the same category as the 'ocean or the moon', which – unlike AIDS – are not intrinsically harmful. From another point of view, however, it could be said that Cameron is suggesting that illness and death are part of the natural order of life. Just as the ocean and the moon combine to mark (through the tides) the passing of time, so do physical decline and death remind us of the temporal and temporary nature of all forms of life. If we cannot accept this, it is because we do not want to confront an inescapable condition of human existence. This relates to fear and the cultural taboo which surrounds death. Cameron's construction of AIDS is complex: he frames it both immersively in a way that 'thrusts the reader into a direct imaginative confrontation with the special horrors of AIDS' (Cady 1993: 244), and counter-immersively, in a 'protective way' that 'distances its fearfulness' (1993: 254).

An unusual form of metaphorisation in AIDS discourse occurs in the novel *The Book of the Dead* (2009) by Kgebetli Moele. AIDS is personified in this narrative

which traces the life of Khutso, a young man who makes the shocking discovery after his wife's death by suicide that she was HIV positive. Filled with rage at the realisation that she had kept this fact secret and that he himself must certainly be infected, he sets out to seduce as many girls and women as possible in order to spread the virus, in a displaced form of revenge. In effect, he becomes a serial killer. The title of the text, *'The Book of the Dead'*, refers to the journal he has custom made for himself in which he records, one by one, the names and other salient facts relating to his victims.

About halfway through the novel, the voice of a new protagonist – the personified virus – makes itself heard:

I live amongst you, waiting like a predator. I am faceless. I am mindless and thoughtless. But I am feared and despised. You hate me You define me and give me all types of names. You try to understand me. But I like the game you are all playing, talking about me as if you can identify me – thinking that I am a virus when I am out walking in the street. You have never seen my face. You think that the bony remains that are breathing their last look like me, but they are bones that I have long deserted. They are no longer of any use to me. I have long moved on.

I am coming for you. This is a promise. I promise you that I am coming for you (Moele 2009: 77-8).

The virus is no longer an invisible biological entity but is constructed as personal, a character in its own right. In this passage the virus's voice is in the first person singular, but at other times it becomes the first person plural, when its identity is linked with Khutso's, the result of their common purpose:

We were sitting in Khutso's study, both of us pondering the mission ahead, the mission that we were going to undertake together. We are going to fuck 'em dead, I told him, and he smiled (Moele 2009: 89).

The virus has an ambiguous identity: singular, plural and multiple, because it lives in many people; Khutso's ally and his enemy, because it will eventually kill him; independent of, yet dependent on, him and others who carry it for its continued

existence. Personification is a form of metaphor and, as previously discussed, metaphor is a technique of displacement, yet the metaphorisation of the AIDS virus in *The Book of the Dead* does not have a displacing or counter-immersive effect. On the contrary, the directness of its voice creates shock. A characteristic of immersive writing is that it ‘thrusts the reader into a direct imaginative confrontation with ... AIDS’ (Cady 1993: 244), and this is certainly the effect that personifying the virus has in *The Book of the Dead*. The construction of the virus as a personality gives it a vivid imaginative form and enables it to speak directly to the reader in statements such as ‘I am coming for you. This is a promise. I promise you that I am coming for you’. The effect is a chilling sense of its determined agency. Deadly infection for sexual predators like Khutso – both villain and victim in this drama – and his prey is constructed as certain and inescapable. Moele also reverses the common military metaphorisation of resistance to AIDS when he militarises the AIDS virus instead. The virus ‘character’ refers to ‘recruiting legions of soldiers’ in his campaign to infect as many people as possible. The writer could have an underlying moral purpose in his employment of this literary device: by giving AIDS a ‘live’ voice, ruthless intention and military character, he constructs AIDS as a powerful, efficient killing machine, implicitly warning his audience of the inevitable, fatal consequences of irresponsible sex.

Turning to a different form of discourse which does have the effect of displacement, I consider the way that the HIV/AIDS epidemic has given rise to several new slang²² and colloquial expressions²³, some of which (‘red card’, ‘boarding pass’) have already been discussed. Many more colloquial expressions related to HIV and AIDS, other than those discussed in this chapter, are probably also in existence but are not yet documented, since slang originates in spoken language and circulates for some time before getting into print, if it ever does. Asher describes slang as ‘vocabulary in limbo ... applicant language that is awaiting

²² For a fuller discussion of AIDS-related slang, see Horne, Felicity: ‘Slanguage and AIDS in Africa’, in *Language Matters* 41(1), July 2010: 25-40.

²³ The terms ‘slang’ and ‘colloquialism’ are used virtually interchangeably in this discussion, but ‘colloquialism’ has a broader meaning and subsumes slang. According to Crystal, ‘slang is the most colloquial variety of language’ (1995: 82).

acceptance or rejection by standard usage, or endlessly awaiting neither' (1994: 3961). This description in itself suggests displacement: the expression 'vocabulary in limbo' conveys the liminal space occupied by slang, which is constructed as ephemeral, 'free floating' language with uncertain status and unstable meanings, not fixed or tied down in dictionaries or other printed texts. When these slang terms refer to AIDS, this means that their sociocultural significance is marginal, uncontrolled and uncontrollable.

Pierre Bourdieu relates slang usage to power relations in society, when he examines the ways in which those who are most deprived in terms of economic and cultural capital express themselves. He sees forms of speech like slang and 'cant' as a rejection of dominant modes of speech, and 'the product of the pursuit of distinction in a dominated market' (1991: 22). He contends that:

[slang] is one of the ways in which those individuals – especially men – who are poorly endowed with economic and cultural capital are able to distinguish themselves from what they regard as weak and effeminate. Their pursuit of distinction therefore goes hand-in-hand with a deep-seated conformity with regard to established hierarchies, such as the hierarchy between the sexes. It also leads them to take for granted, and indeed positively to assert, the very characteristics (e.g. physical strength, lack of education) by virtue of which they occupy a subordinate position in the social space (1991: 22).

The attempt by individuals from lower-class backgrounds to assert a degree of power through non-standard speech, ironically, betrays the fact that they share, to some extent, values that work against them. This is an example of what Bourdieu terms 'symbolic power', or 'symbolic violence' (1991: 23): active complicity with the social structures by which they are disadvantaged.

In his classic study, *Slang: Today and Yesterday*, Eric Partridge identifies several reasons why slang is used. These include the impulse 'to lessen the sting of ... something'; 'to reduce the solemnity, the pomposity, the excessive seriousness of a subject'; 'for ease of social intercourse'; 'to show that one belongs to a certain school, trade, or profession, artistic social or intellectual set'; and 'to be secret — not

understood by those around one' (1933: 6-7). All these points are applicable to AIDS-related slang. In particular, the purpose of 'reducing the solemnity, the pomposity, the excessive seriousness of a subject' relates to the use of humour as a distancing device, and relates to displacement. The dreaded connotations of AIDS are displaced by the adoption of a jocular idiom and tone, 'to lessen the sting'. Many examples of AIDS-related slang which refer to AIDS-sufferers by their appearance, and particularly the emaciation which accompanies advanced AIDS, have a somewhat comic effect, albeit of a very dark kind. This humour encourages detachment. In the early days of the epidemic in Uganda, AIDS was known as 'Slim' because of the wasted bodies of its victims (Sidiropoulos 2006: 83), while in South Africa a person with AIDS was said – with heavy irony – to be *o ya dayete* – Sotho for 'on diet' (Niehaus 2007: 849). In similar vein, the South African expression 'OmoMicro' (a commonly-used washing powder) to refer to AIDS²⁴ evokes the image of a person who has become deathly pale, as though washed in a highly concentrated detergent. Again, the definition of displacement used in psychoanalytic criticism: 'distortion, in which a socially acceptable object is made to stand for something forbidden' (Gray 1992: 235-6), is clearly applicable. There is also a degree of grotesque humour in the expression, used in South African prisons, that someone who is HIV-positive has 'a slow puncture', referring to the gradual leakage of vitality, until the person is 'flat'. The element of humour embedded in these expressions facilitates distancing, and is used as a psychological strategy of displacement to cope with the horrors associated with the final stages of the disease. Muponde's remark, quoted in *Irin/Plus News* (2008), that slang enables people 'to speak about something more comfortably'; that it 'gives the unspeakable street value by making it look accessible and banal', is relevant here, and exemplifies the counter-immersive approach to the topic of AIDS, and its displacement.

Partridge's point that slang fulfils the purpose of 'secrecy', links well with the fact that AIDS, as a stigmatised condition, is often articulated in oblique, cryptic

²⁴ *Pretoria News*: 22 November 2001.

terms. Examples are those which play with the acronym 'HIV', such as 'house in Vereeniging' and 'Helen Ivy Vilikazi'. Other coinings play on the number three, based on the fact that 'HIV' consists of three letters: HIV is actually termed *maina a mararo* (Sotho for 'the three letters'), and may also be referred to as 'driving a Z3' (a luxury sports car) or 'having 3 kids'. The expression 'Tracker'²⁵ to denote a person who is infected with HIV refers to the popular southern African service that tracks and recovers stolen vehicles, implying that the person is being tracked by God or Death and that it is only a matter of time before he or she is 'found'. The reference to 'Tracker' is easily recognisable to South Africans – a comment on the high rate of vehicle theft and hijacking that occurs in the country – but its connection to AIDS is obscure and would not be understood by someone not initiated into AIDS discourse.

Cryptic techniques such as these serve either to mark belonging to the in-group, or to 'other' the condition, to indicate that it affects other people, and so 'enable[s] people to distance themselves from AIDS' (Adendorff and De Klerk 2006: 71). Asher observes that 'the semantics of slang, especially its names for kinds of people (ethnic, class and other social types), display a pervasive structure of ... binary opposition, frequently expressed in invidious distinctions between "Us" and "Them"'. Slang is greatly about the new and the different and, in the social realm, often expresses stressful social relations and a dislike for the unlike' (1994: 3963). Because slang is an indirect form of reference, understood only by the initiated, it can be a useful way of *excluding* outsiders and keeping information secret. Cryptic slang references to people with AIDS could thus imply that speaker and audience are associated with such people, part of the group 'in the know', or the other extreme: that they are completely separate from them. In the latter case, slang serves the purposes of stereotyping and othering, of disassociation and displacement, helping 'to define the social identity of the group' (Kleinman 1988: 158-9).

²⁵ The vehicle tracking system utilises a transmitter in the vehicle which, when activated, emits signals which are received by radio beacons strategically placed around the country. The signals enable the headquarters to locate the position of the vehicle.

One highly revealing metaphor on which some AIDS slang is based is that of gambling. In some South African communities AIDS is referred to as *iAce* or *iLotto*²⁶, where the Nguni prefix *i* is attached to the English words ‘ace’ and ‘lotto’; lotto being the national lottery. These comparisons suggest the risky nature of sexual activity: ‘winning’ (remaining healthy) or ‘losing’ (becoming infected) are displaced into the arena of chance or fate, implying a lack of control on the part of the individual engaging in sex. Similar denial of personal responsibility is seen in the expression that someone with AIDS is one who ‘stepped on a landmine’ or ‘slipped on a banana’. Although the context and effects of the latter two expressions – one deadly, the other comical and harmless – are very different, the mindset behind both is the same: they construct infection as accidental and skim over the reality of volition and personal choice. The fact that consequences stem from conscious decisions; mainly, having unprotected sex, is ignored.

It is possible that the attitude of non-responsibility and fatalism evident in these examples articulates with and is encouraged by deeply-rooted beliefs which often attribute adversity to supernatural forces. Van Dyk tells us that ‘[w]itchcraft is believed to be the causal agent in HIV-transmission and AIDS in many African countries, especially among the rural poor or least-educated people’, and that ‘death is only accepted as natural when old people die, but most other cases where “the queue of dying is jumped”, death is seen as punishment or the work of evil spirits and witches’ (2001: 4). Ashforth relates how the belief in witchcraft as the cause of AIDS is captured in the isiZulu word *isidliso*, or its Sesotho equivalent *sejeso*, meaning ‘Black poison’. It is believed that this ‘poison’ is sent by a witch through *muthi* and this causes a great many symptoms, ‘most commonly anything that affects the lungs, stomach or digestive tract, or that leads to a slow, wasting illness’ (2002: 129). Ashforth cites a study carried out in KwaZulu-Natal in 1998 where twenty-four traditional healers were asked for their diagnosis if a patient reports chronic cough, chest pains, and blood in sputum. Eighteen of the healers responded ‘*isidliso*’; six diagnosed tuberculosis (2002: 130). This mixed response indicates the liminal space

²⁶ *Pretoria News*: 22 November 2001.

occupied by healers caught between Western and traditional modes of thought, and suggests the greater strength of traditional beliefs.

The discursive landscape of witchcraft pre-dates AIDS by centuries, but it is easy to understand why AIDS can be projected onto it so easily. The indeterminacy and apparent randomness of HIV infection are puzzling and witchcraft provides a useful explanatory framework, helping to make sense of events that are seemingly unconnected. A person infected by HIV can remain without symptoms for up to ten years, so that a person can seem healthy while invisibly incubating the virus. This makes it virtually impossible to pinpoint the time and source of the infection. Once illness manifests, a range of different diseases occurs, making it difficult to recognise a predictable pattern, and, unlike other sexually transmitted diseases, the different physiological sites of the disease are displaced from the probable site of the original infection – the genitalia. Moreover, the fact that totally ‘innocent’ individuals like babies can be infected, makes the view that malicious persons are pursuing secret evil work very plausible. As Ashforth puts it, ‘a disease or complex of symptoms better suited to interpretation within the witchcraft paradigm than AIDS would be hard to imagine’ (2002: 128).

Attributing infection and death to the malice of others who use supernatural forces to take revenge is an obvious strategy of displacement, since the causal agent is constructed as external and beyond the control of the victim. Such beliefs are connected to powerful psychological motivations, although these could be unconscious. The belief in witchcraft as a cause of AIDS holds even if someone is well-informed about HIV-transmission and understands that there is an immediate physical cause of infection (the virus). Even when people explicitly recognise the role of the pathogen in the infection process they will still question why, when two men are exposed to the same woman, one would become infected while the other would not. The answer to this would be that someone, by means of magical manipulation, ‘sent’ the virus to a chosen individual. Van Dyk explains that ‘to blame external factors such as witches and sorcerers for AIDS has a [psychologically] protective function, because it prevents feelings of guilt and it alleviates anxiety’ (2001: 4). Her

explanation accords completely with the definition of displacement in the discipline of psychology: a ‘defence mechanism involving redirection of emotional feelings from their original to a substitute object’ (Colman 2001: 210). However, the implications of constructing AIDS as the result of *isidliso* are potentially serious since, as long as people believe that HIV-infection is beyond their control, they are less likely to adopt safer-sex habits. Dianna Games concludes her study of AIDS in *Africa’s Tsunami: Turning the Tide on Aids* with the statement that ‘cultural barriers to Aids [sic] information, prevention and care remain formidable ... these include traditional beliefs that encourage fatalism’ (Sidiropoulos 2006: 107). Following linguistic clues helps us to recognise the possible beliefs that underlie attitudes such as fatalism and to achieve insight into how discourse constructs different worlds. Behaviours that might seem inexplicable are rendered intelligible when set within their cultural frames.

A final difficulty in confronting the subject of AIDS directly is related to the difficulty of verbalising trauma. As Gilman observes in relation to the plagues of seventeenth-century London:

By their sheer magnitude, urban pandemics – claiming thousands of victims in days, if not hours, and bringing social disorder and psychic trauma in their wake – are said to exceed the limits of language. Like the Holocaust, or visions of the sublime, or, latterly, the ‘events of September 11’, they can be described only in the rhetoric of indescribability – or in terms of other narratives to which they can be accommodated (‘It was just like in the movies’)(2009: 51).

Accommodating trauma in terms of ‘other narratives’ is a clear form of displacement. What is unbearable or inexpressible is retrofitted or grafted onto pre-existing discourses in other domains. Morris asserts that illness ‘remains at its deepest level inaccessible to language ...’ (1998: 5), arguing that the suffering that accompanies advanced illness eludes ‘every linguistic and conceptual tool that humans employ to understand it’ because such experience is ‘resistant to description’ (1998: 196).

Like trauma and illness, pain too is an inherently inchoate phenomenon. In *The Body in Pain*, Elaine Scarry contends that pain is unsharable because of its resistance to language. She takes this a step further when she states that ‘physical pain does not simply resist language but actively destroys it, bringing about an immediate reversion to a state anterior to language, to the sounds and cries a human being makes before language is learned’ (1985: 4). She points out that ‘pain – unlike any other state of consciousness – has no referential content. It is not *of* or *for* anything. It is precisely because it takes no object that it, more than any other phenomenon, resists objectification in language’ (1985: 5). Chambers observes that ‘the attempted representation of pain entails acknowledgement of its impossibility: trauma interrupts all continuity and coherence; it challenges discursive treatment’ (1998: 6).

Death too, remains difficult to represent. Belsey comments that the experience, ‘the way it *feels* [her emphasis], retains its mystery, since those who have known it are by definition no longer here to tell us about it’ and ‘our own death is difficult to imagine’. She concludes: ‘death thus constitutes a paradoxically absent presence in the symbolic order’ (Belsey 2005: 41). The gap that always exists between the signifier and the signified is especially wide in the relationship between the word ‘death’ and the actual phenomenon of dying. As Diedrich observes, ‘death is about the absolute aloneness of the person who dies’ (2007: 132). Ultimately, the existential isolation of all human beings renders such experience unknowable, and this is one of the central problems of writing AIDS. Hence Diedrich’s observation that ‘[t]he crisis of AIDS is ... an epistemological crisis’ (2007: 123), a statement I would modify by positing the view that the difficulty of writing AIDS is partly an epistemological problem, and partly one of representation. Words are not sufficient to convey the force and complexity of the experience of suffering and dying. Frank comments that ‘[u]ltimately, chaos is told in the silences that speech cannot penetrate or illuminate’ (1995: 101). Such views are reminiscent of Kant’s belief that ‘we can know things only as they appear to us, within a framework of knowledge that we ourselves create. Beyond this, there lies a realm of things-in-themselves, which is forever inaccessible to our knowledge’ (Belsey 2005: 22). Yet, paradoxically, as Gilman points out, ‘meaning can arise from the empty spaces, silences and

omissions within them' (2009: 63). Language communicates meaning and fails dismally to do so. It both constructs and constrains the construction of AIDS.

Literary texts can fill the 'empty spaces, silences and omissions' in non-literary discourse. Poets and other creative writers are able to utilise language in a highly effective way to represent and bring awareness of AIDS-related realities that are ignored by official sources and generally go unnoticed, particularly by the affluent upper classes who are little affected by the epidemic of AIDS. In the poem 'From the Air', included in the collection entitled *Nobody ever said AIDS: Stories and Poems from Southern Africa* (2004: 178), Michael Cope draws attention to the story told by a silent cemetery:

He said that he could see it from the air,
 Clipped in beneath his glider, almost free
 Below cloud-base. He said, from there
 You spy things that the road-bound never see.
 It's marked out like a picture book, he said.
 Tucked in away behind some folded hill
 The graveyards lie. Here the assembled dead
 Are ranked by time. The older graves are still
 There in their place. Some tended once a year,
 Some with stones or flowers, dates and names.
 The old time regular deceased lie there.
 And all around them, file on file, the graves
 of the new dead, packed with red earth
 and marked with a cross or stick or nothing
 and the grass still not grown about them
 and the new ones, rows of pits,
 and the diggers digging more,
 fresh earth in raw heaps,
 dark rectangular holes . . .
 And round these, fields of clear land, he said,
 Waiting to be cultivated with the dead.

In an understated way, and without mentioning AIDS at all, the poet succeeds in conveying the devastation caused by mass deaths from the epidemic and suggests that it will not be long before the whole countryside is one huge graveyard. The ironic choice of the word 'cultivated' in the last line, evoking the discourse of

agricultural production, highlights its opposite: destruction. The cyclical process of sowing, growing, and reaping is replaced with the unproductive work of 'sowing' (or burying) the dead. The impossibility of a harvest suggests that there can be no future for this land as it is turned into a sterile graveyard, a modern wasteland.

'Compassionate Leave' by Ingrid de Kok (2006: 134) also succeeds in communicating the tragedy of catastrophically changed communities, exhausted by the emotional and financial costs of constant deaths and ceaseless funerals:

Almost everyone's on leave
gone away

to the countryside
in threadbare trucks

to pay respects
in rooms and huts,

to watch and pray for dying ones
shrunken under sheets,

to vigils through the night
in closed-off streets

where grandmothers prepare
small and smaller funeral feasts

after truncated prayers
chanted by tired priests

over cardboard caskets
in the deathwatch heat.

Gone to taxi ranks and stations
to wait for information

from billboards, radios
word of mouth and trumpets in the sky

where ubiquitous hadedas,
unlike Auden's mute impervious birds

blast their high shofars

over each infected space.

As in 'From the Air', the poem bespeaks a death rate – from an unnamed cause – too rapid to be properly managed. The worsening poverty of individuals and communities is signified by telling details such as 'threadbare trucks', meagre 'feasts' and cardboard coffins. The necessity for shrinking funeral rituals takes on greater poignancy when it is considered that in the African culture it is enormously important that the dead are given lavish burials: traditionally no expense is spared. Forced economy would be an additional source of grief, pain and shame. That 'grandmothers' have to cater for the mourners, indicates an inversion of the natural order of things, with the elderly surviving their adult children and being left to bury them. Those who remain behind search their surroundings in a quest for meaning, not only from human sources of information but also possibly supernatural ones, suggested in 'trumpets in the sky'. The raucous cries of the hadeda bird, metaphorically identified with the shofar, the ancient Hebrew ram's horn sounded for warning and which brought down the walls of Jericho,²⁷ creates a mood of apocalyptic pessimism, since the shofar is sounded during Rosh Hashanah and at the end of Yom Kippur when judgment of life and death is made. The question asked on these religious occasions is: 'Who will live and who will die in the coming year?' This intertextual reference to biblical history displaces the situation from contemporary South Africa and frees it from the limitations of space and time. This displacement has the effect of elevating the significance of the situation described in the poem and adding *gravitas*.

This chapter has focussed on the paradoxical ways in which language is used to construct and facilitate the displacement of AIDS: the disease itself; the people who are ill with it; and their experience of the illness. Fear and stigmatisation surrounding AIDS account to a large extent for its displacement. For a different reason altogether – an imbalance of power in doctor-patient relations – the language of biomedicine prioritises science and generally erases the AIDS-ill from its

²⁷ Joshua 2:6: New International Version.

discourse. On the other hand, through their sensitive use of language, skilful creative writers succeed in rescuing the dead and worst-affected communities from oblivion, recovering their presence in the discourse. By speaking for the voiceless and disempowered, they create awareness of the scale of the devastation and the extent of the suffering caused by the epidemic, in a way that statistics or 'hard' discourse fails to do.

In the epigraph to this chapter, Paula Treichler was quoted as saying that 'all accounts of AIDS are at some level linguistic constructions', and this is certainly a valid observation. Ultimately, however, language fails to capture the experience of living with and dying of AIDS, thus effecting displacement of an unintentional kind. The difficulty of articulating the experience of pain, illness and death results in the displacement of these phenomena to the metaphorical landscape of the psyche, a mindscape which remains unknown to all except those who have been there themselves, and which is, finally, incommunicable.

Chapter 2: Politicising AIDS

In Africa, the collision of epidemiology with race and politics has led to bizarre deviations from rational debate on the causes of — and the possible treatments for — AIDS. The cost to the continent — in lives and in public truth — has been very high. (Edwin Cameron)¹

The outbreak of AIDS has been, and still is, a hugely politicised issue all over the world. However, the displacement of AIDS onto the landscape of political discourse has been especially marked in South Africa, where it seems virtually impossible to discuss the epidemic without referring to the political background which has affected its course so dramatically. It is beyond dispute, for example, that the policies of the post-apartheid government exacerbated the mortality rate from AIDS in South Africa. This thesis argues that this was largely the result of the fact that AIDS itself was displaced as a central concern, and projected onto a political landscape where it was dwarfed by the discursive power of politics. This is not altogether surprising: the emergence of AIDS roughly coincided with the emergence of the new democracy, complicating a period of radical political and social transformation and resulting in the entanglement of the discourses of AIDS and politics, and particularly ‘the struggle’.² In this chapter I consider a selection of texts, including public statements made by political figures; cultural events; and selected creative writing texts, to demonstrate the interpenetration of the discourses of AIDS and politics, and the way that AIDS has been displaced by and subordinated to politics in both public and creative discourse.

Political discourse has been extensively used in the long-standing and bitter debate in South Africa about what causes AIDS; its prevalence; how it should be treated; who should be treated; whether or not the treatment is effective; and many other related issues. How these questions are answered depends a great deal on the medical

¹ (Cameron 2005: 92.)

² Refer to Footnote 21 of Chapter 1.

discourse adopted: whether this is the scientific, Western, biomedical model, based on the 'germ theory' of disease; or 'alternative' approaches (adopted by Mbeki) which are less concerned with identifying specific pathogens and instead place greater stress on environmental factors in the causation of disease. The kind of treatment given the AIDS-ill follows from whatever discursive medical model prevails. Mainstream biomedical practitioners hold that the HI-virus is the etiological agent and that treatment entails treating the infections that result from lowered immunity and prescribing antiretroviral medication to inhibit the growth of the virus itself (Downing 2005: 24). This view thus emphasises the role of drug therapy. A more holistic approach to treatment, which stresses nutrition, is favoured by AIDS dissidents, who, at their most extreme, claim that the HI-virus does not exist; and that AIDS is caused by poverty and the very drugs used to treat it, which they believe are toxic. However, there are degrees of dissidence. Some dissidents completely reject the notion that HIV causes AIDS, while others accept it but reject the belief that it is the sole cause, and emphasise the role of cofactors in contexts where AIDS thrives. Dissidents believe that 'since the problem [of the disease] is multifactorial, solutions need to be as well' (Downing 2005: 119).

It may seem inappropriate that differences between medical approaches should take on political meaning, but when we take into account the implications of the two paradigms outlined above, it becomes clear that politicisation is inevitable. For one thing, the biomedical model's endorsement of drug treatment has strong economic entailments, since the drugs are unaffordable to the poor, and so must be provided by the State, necessitating policies which reassign budgetary resources. The alternative model's stress on socioeconomic factors in the causation of disease is also intrinsically political, since the distribution of wealth in the country is largely a consequence of its political history (as discussed in the Introduction), and in order to change socioeconomic conditions, government has to initiate different policies. In addition, the fact that the biomedical model is the 'standard', hegemonic one – the biomedical paradigm is privileged over other kinds of medical knowledge and points of view; it holds power –

means that challenges to its authority automatically take on political overtones and are regarded as anti-establishment, or 'dissident'. The expression 'dissident' is significant in itself since the word is associated with politics rather than the discourse of health and medicine.

Former President Thabo Mbeki has been associated with the so-called 'AIDS dissidents' in the dispute between the dominant and alternative medical models, and he supported the alternative medical model, at least for a time. At the International AIDS Conference in Durban in July 2000, he said in his keynote speech that it seemed to him that 'we could not blame everything on a single virus', and that 'every living African,... is prey to many enemies of health that would interact one upon the other in many ways, within one human body' (Downing 2005: 71). It needs to be pointed out that Mbeki did not deny the existence or importance of the HI-virus: throughout the speech he referred to 'HIV' and 'AIDS' (Downing 2005: 71). But he emphasised the role of other factors, especially poverty, as causative cofactors. In so doing, he distanced himself from a unifactorial theory of disease and aligned himself with a moderate – not extreme – degree of AIDS dissidence, showing awareness of what Morris describes as a 'postmodern' perspective (1998: 40) which sees disease as more than the science of a microbe. This stance, on its own, did not warrant the severe attack he came in for for being an 'AIDS denialist'. When Mbeki and his Health Minister appeared to contest the fundamental tenet of biomedical science – germ theory, or 'the doctrine of specific etiology'³ – and emphasised the role of poverty and nutrition in the causation and treatment of AIDS, they engaged with a discourse that ran counter to the hegemonic one, and it is not surprising that this provoked resistance. But it was the policy of withholding antiretroviral medication from those who could not afford to buy it for themselves, and certain other actions and statements by Mbeki (to be analysed later in this chapter), that provoked the strong reaction against him and his Health Minister. For

³ In April 2001, Mbeki refused to take a public HIV test because it would send a message that he supported a particular scientific viewpoint. He said: 'I go and do a test – I am confirming a particular paradigm' (Van der Vliet 2004: 63).

a time the alternative paradigm that they supported – and its attendant implications for treatment – prevailed, but eventually succumbed to the pressure of opposition from the orthodox medical profession and AIDS activists. The provision of ARV treatment began in 2004.

The conflict over HIV and AIDS in South Africa illustrates a number of Foucauldian principles. The fact that conflicting models of AIDS exist in the first place demonstrates Foucault's view, set out in *The Archaeology of Knowledge* (1972), that discourses are human constructs which bring an object into being, or produce a social reality. There is no such thing as objective reality, or 'the Truth'. Medical models are constructed by human perception, and this is fallible. All discursive constructions are open to challenge, and indeed the hegemonic paradigm that the HI-virus exists and is the cause of AIDS is still being disputed, although, as Treichler comments, the 'unifying signifiers' of HIV and AIDS appear to settle the question and 'make it possible to proceed *in discourse* as though the questions have been resolved' (1999: 168, emphasis in original). Also, the power of discourse is contingent on the dynamics of power operating within society, and the dynamism of power structures implies the instability of discourse. Whether or not a particular discourse enjoys power depends on whether it is favoured by those who have power and will be able to give it institutional force. But power provokes resistance: the one implies the other. Mbeki's powerful position as President enabled him to implement his beliefs and transform them into policy, and sustain them for some years until activist groups forced change.⁴ Of great importance is the Foucauldian point that discourse goes beyond language, and includes 'practices', including treatment of the ill, so that material consequences follow from the particular discursive model in operation. In this instance the AIDS-ill were either denied, or given, access to free antiretroviral medication, and this entailed continued life or death.

⁴ In 2001 the TAC brought a high court action against the government to compel the Health Minister to provide Nevirapine to pregnant HIV-positive women. In 2003 the TAC embarked on a civil disobedience campaign against the government to force it to supply free ARV medication to all who needed it.

It is not my intention to give a full account of the long and complicated course of this dispute over the policies of AIDS treatment which has been comprehensively documented elsewhere,⁵ nor to judge whether Mbeki was 'right' or 'wrong' in the controversy. Indeed, it would not be relevant to do so. The point of the discussion which follows is to show how the language used by all the parties involved was rooted in the conflict between different political discourses. Apart from the fact that medical discourse is inherently politicised, owing to the hegemonic status of the biomedical model, in South Africa a further political dimension to AIDS – specifically the struggle against colonialism, apartheid and racism – has been articulated to the discourse around the epidemic. Various people have given different explanations for Mbeki's stance on AIDS (Nattrass 2007: 80-90) – his challenging of the view that HIV is the sole cause of AIDS, his denialism that AIDS was a major problem in South Africa, and his reluctance to provide antiretroviral (ARV) treatment – but it is my contention that his stance needs to be seen in relation to the prior sociopolitical constructions onto which he displaced the phenomenon of AIDS. The appeal that alternative medicine had for him does not adequately explain the intensity of some of his reactions towards AIDS, or his angry outbursts. It is necessary to explore the discursive matrix which, I believe, coloured and shaped his AIDS-related political decisions. When he used this discursive landscape of politics as his frame of reference, he catapulted AIDS into a different domain.

Anyone even slightly acquainted with South African history knows that, as a result of the policy of apartheid, politics in South Africa has been, and still is, inseparable from the notion of race. Similarly, disease and race have been connected through discourse in South Africa for centuries, as I will demonstrate below. Acute sensitivity and defensiveness towards perceptions that AIDS is a 'black' disease is thought to be a large part of the reason for Mbeki's reluctance to confront and deal with the realities of the

⁵ See, for example, Fourie, Pieter. 2006: *The Political Management of HIV and AIDS in South Africa: One Burden too Many?* Basingstoke: Palgrave Macmillan; Nattrass, Nicoli. 2007: *Mortal Combat: AIDS Denialism and the Struggle for Antiretrovirals in South Africa*. Scottsville: University of KwaZulu-Natal Press; and Van der Vliet, Virginia. 2004: 'South Africa Divided against AIDS: A Crisis of Leadership'.

AIDS-epidemic during his presidency. When delivering the inaugural Z. K. Matthews Memorial Lecture at the University of Fort Hare in October 2001, Mbeki railed against representations of Africans as ‘germ carriers, and human beings of a lower order that cannot subject its passions to reason’ by people who ‘proclaim that our continent is doomed to an inevitable mortal end because of our devotion to the sin of lust’.⁶

The anger behind President Mbeki’s emotive words is evidence of a strong reaction to what he saw as the conflation of disease in general – and AIDS in particular – with black identity. His outbursts against racism in the context of AIDS may have seemed shockingly out of place when they occurred, but, when seen in relation to the discursive background outlined below, they become more understandable. His stance on AIDS has been motivated by a complex mixture of political, ideological and psychological strands so powerful that AIDS itself has been completely sidelined.

The displacement of illness into the discourse of politics and race predates apartheid.⁷ In *Black Skin, White Masks*, first published in 1952, Frantz Fanon describes the longstanding colonial objectification of the black as a ‘sexualized “Other”’.⁸ The racist myth of black sexuality was one of excessive sexuality: it held that ‘[i]n relation to the Negro, everything takes place at the genital level’ (Fanon 1986: 157). Jean Comaroff traces the conflation of biological and ideological discourses during the colonial period, when, ‘as an object of European speculation, “Africans” personified suffering and degeneracy’, and ‘the black body became ever more specifically associated with degradation, disease and contagion’ (1993: 305-6). She shows how medicine and imperialism ‘were cut from the same cultural cloth’, and how ‘[e]ach came to verify the other through the categories and metaphors of an underlying vision’ (1993: 307). This

⁶ *Mail and Guardian*: ‘Mbeki in bizarre Aids outburst’, October 26, 2001.

⁷ For the purposes of this discussion ‘the apartheid period’ is regarded as having coincided with the rule of the Nationalist government, 1948-1994.

⁸ This thinking may be linked to that of Edward Said whose work (1978; 1993) was foundational in the field of Post-Colonial Studies. He championed the rights of colonised people, uncovering the power structures hidden within imperial and colonial administrations.

'vision' comprised a hierarchy in which '[n]on-Europeans filled out the nether reaches of the scale of being, providing the contrast against which cultivated man might emerge with clarity' (1993: 308). Such perceptions typify racist discourse, which relies on what Wetherell and Potter term 'positive/negative' contrasts, and which constructs the 'bestial other', which is different from 'self'. While the 'other' is presented as driven by 'id-type' forces of irrational emotion, the 'self' becomes 'all ego – a rational, thoughtful and reflective subject who speaks with the authority of facts' (1992: 214). As medical science advanced, such a vision took on more authority, and 'the vocabulary of natural science ... formalize[d] an existing European association of dark continents with black bodies and dim minds' (Comaroff 1993: 308). Over time, this rigidified further into what Comaroff terms 'scientific racism' (1993: 309), of which the following statement by the Director of Medical Services of Southern Rhodesia (present-day Zimbabwe) in 1930 is an example:

The native is the reservoir of infective tropical disease, from which the European and his family is subject to invasion. Unfortunately, the native carrier is commonly a perfectly healthy looking individual, so that the European may not have the opportunity of realising until too late the danger to which he is being subjected (Vaughan 1991: 150).

The prejudiced assumptions underlying this pronouncement are appallingly crude: the white person is constructed as pure and vulnerable, and the black person as diseased and threatening. Making the latter more dangerous is the fact that his physically corrupted state is not visible, so that, on top of being diseased, he is also regarded as deceptive and treacherous. It would be difficult to imagine a discourse more likely to create racial fear and distrust.

Ironically, the discourse of Christianity unintentionally reinforced racist perceptions by representing Africa as an ailing, backward continent awaiting the restorative attentions of the white man. The missionary Robert Moffat (David

Livingstone's father-in-law) stated in an address to a large and philanthropic audience in London in 1870 that:

Africa ... wants all the machinery we possess for ameliorating her wretched condition. Shall we, with a remedy that may safely be applied, neglect to heal her wounds? Shall we, on whom the lamp of life shines, refuse to disperse her darkness? (Comaroff 1993: 313).

Metaphors of healing portray imperialism as humane, 'making of it an heroic response rather than an enterprise of political and economic self-interest' (Comaroff 1993: 313). Such thinking, constructed by the combination of political, medical and evangelical discourses, was used to justify intervention and control by the colonial state over the indigenous population. During an outbreak of bubonic plague in 1900-1901, the Medical Officer of Health in Cape Town blamed it on 'uncontrolled Kafir [sic] hordes', and sanitary inspectors were dispatched to rout out 'scattered nests of filth' throughout the city (Comaroff 1993: 322; Van der Vliet 2004: 33). The 'persistent association of the African body with noxious organisms that threatened to invade the inviolable world of white order' (Comaroff 1993: 316), underpinned racial segregation and the establishment of the black peri-urban 'locations' outside South African towns and cities. Perceptions such as this endure: Comaroff observes that 'we are still all too ready, in the West, to seek the origins of virulent disease in the uncontained nature of "others" – in the undisciplined sexuality of Africa, for example' (Comaroff 1993: 324).

Simon Watney discusses the way in which 'Western AIDS commentary ... redraws the epidemic in the likeness of older colonial beliefs and values, targeted at the assumed (white) reader'. He cites Joseph Conrad's *Heart of Darkness* as part of the 'long discursive tradition' which constructed Africa as a 'treacherous' domain of 'lurking death' and 'hidden evil' (Watney 1994: 104-5), depicting it as an 'undifferentiated domain of rot, slime, filth, decay, disease, and naked "animal" blackness. This infernal

and unhygienic territory⁹ is the perfect imaginary swamp in which a new virus might percolate ... – a virus which eventually kills by transforming all its “victims” into “Africans” and which threatens to “Africanise” the entire world’ (Watney 1994: 112). The displacement of AIDS on to this well-established, discursively constructed, racist landscape has provided convenient and what seem like ‘common-sense’ explanations for an alarming new epidemic. Seen against this discursive background, Mbeki’s knee-jerk anti-racist reaction is legitimate.

In a similar vein, Packard and Epstein discuss the way medical researchers’ theories of disease in Africa from the nineteenth century onwards have been influenced by assumptions about Africa, Africans and African life which were ‘infused with racial and cultural stereotypes’ (1992: 347), and the way in which disease was linked to supposedly ‘higher levels of sexual promiscuity among Africans’. Packard and Epstein report that, in recent times, ‘more than one Western AIDS researcher ... [has] suggested that African heterosexuals had a pattern of promiscuity similar to that of promiscuous gay men in the United States and Europe (a conclusion that incorporated two discriminatory stereotypes)’ (1992: 352). They point out that by focusing attention on sexual promiscuity and other culturally attributed behaviours, these explanations have deflected attention from cofactors which are crucially important in understanding AIDS transmission (1992: 357).

All of these views highlight how extreme racist assumptions dating back to the colonial period about disease in Africa have displaced the focus from AIDS itself to issues of racism, and the way that unwarranted conclusions about sexual behaviour among Africans have discouraged more rigorous African AIDS research. Paula Treichler comments that ‘one consequence of this inadvertent cultural imperialism is that very simple generalizations about the epidemic may be accepted as “the truth about AIDS,”

⁹ This view of Africa recalls nineteenth-century miasma theory which held that certain places harboured diseases, caused by their filthy atmosphere (Downing 2005: 96).

with few efforts made to unravel their diverse and often contradictory claims' (1992: 377).

When we take into account the colonial discourse outlined above, and Mbeki's position as an African Nationalist in the postcolonial world, as well as the pride he expressed in his famous 'I am an African' speech ¹⁰ (Mbeki 1998: 31-6), his emotional outbursts become more understandable. His powerful sense of his own African cultural identity also throws light on his reaction against the Western, biomedical model of AIDS, seen as an extension of colonial discourse, and his attraction to an alternative approach. Delivering the keynote address at the African Renaissance Conference in 1998, Mbeki stated that:

An enormous challenge faces all of us to do everything we can to contribute to the recovery of African pride, the confidence in ourselves that we can succeed as well as any other in building a humane and prosperous society.

None of us can estimate or measure with any certainty the impact that centuries of the denial of our humanity and contempt for the colour black by many around the world have had on ourselves as Africans. But clearly it cannot be that successive periods of slavery, colonialism, and the continuing marginalisation of our continent could not have had an effect on our psyche and therefore our ability to take our destiny into our own hands.

Among other things, what this means is that we must recall everything that is good and inspiring in our past (Makgoba 1999: xx-xi).

Such intentions explain Mbeki's vision of the 'African renaissance', a powerful discourse he was anxious to establish during his presidency. He was at his most poetic and eloquent when expounding on this topic, as the following extract from a speech he delivered to an international audience ¹¹ shows:

¹⁰ The 'I am an African' speech was delivered in Cape Town on 8 May 1996, on the occasion of the adoption by the Constitutional Assembly of The Republic of South Africa Constitution Bill 1996.

¹¹ Address delivered at the United Nations University, Tokyo, Japan, on 9 April 1998.

And as we speak of an African renaissance, we project into both the past and the future.

I speak here of a glorious past of the emergence of *Homo sapiens* on the African continent.

I speak of African works of art in South Africa that are a thousand years old. I speak of the continuum in the fine arts that encompasses the varied artistic creations of the Nubians and the Egyptians, the Benin bronzes of Nigeria and the intricate sculptures of the Makonde of Tanzania and Mozambique.

I speak of the centuries-old contributions to the evolution of religious thought made possible by the Christians of Ethiopia and the Muslims of Nigeria.

I refer also to the architectural monuments represented by the giant sculptured stones of Aksum in Ethiopia, the Egyptian sphinxes and pyramids, the Tunisian city of Carthage and the Zimbabwe Ruins, as well as the legacy of the ancient universities of Alexandria of Egypt, Fez of Morocco and Timbuktu of Mali.

When I survey all this and much more besides, I find nothing to sustain the long-held dogma of African exceptionalism, according to which the colour black becomes a symbol of fear, evil and death (Mbeki 1998: 241-2).

Mbeki's vision here is a highly idealised one, of a glorious, pristine Africa. His strong reactionary stance against racist discourse blinds him to the reality that this Africa cannot be reconstructed because it has been 'permanently altered by Western culture' and a host of other factors over time (Mbali 2002: 14). However, Mbeki invoked the notion of an 'African renaissance' to overlay and substitute the negative, stereotypical discourse of Africa as what he described as 'home to an unending spiral of anarchy and chaos, at whose unknown end is a dark pith of an utter, a complete and unfathomable human disaster' (Mbeki 1998: 200), with a positive discourse in which Africa was constructed as the locus of intellectual and artistic achievement, and Africans as creative and accomplished people rooted in a civilisation older than that of Europe. AIDS, with its attendant attributes of suffering, mass death and stigma, did not fit into this vision, so it is consistent – from a psychological point of view – for Mbeki to have adopted a position of denial towards the epidemic. Van der Vliet asks the question:

Why should an intelligent, sophisticated man who believes passionately in an 'African Renaissance' ... refuse to deal with the epidemic in a rational way...? One answer might lie precisely in this passionate belief itself. It is surely impossible to hold this vision for the continent and at the same time concede that tens of millions of young adults are infected and dying... Faced with such a painful reality, denial, or grasping at the prospect of some alternative explanation, is understandable. Both can lead to 'genocide by omission' (2004: 86).

It is pertinent that in 2001, Professor Malegapuru Makgoba wrote a news article, the title of which – 'HIV greatest threat to the "African Renaissance"' ¹² – speaks for itself.

In 2002 a dissident document known as the 'Castro Hlongwane Manifesto' was produced and distributed at the 51st National Executive Conference of the African National Congress. Its full – and peculiar – title is: *Castro Hlongwane, Caravans, Cats, Geese, Foot & Mouth and Statistics: HIV/AIDS and the Struggle for the Humanisation of the African*. Castro Hlongwane, whose name forms part of this title, was a 17-year-old schoolboy who was ordered to leave a caravan park in Port Edward where he and a group of friends were having a party in December 2001. He was the only black youngster in the group. The caravan park owner, one Teresa Smit, told one of the white boys in the party that the reason Hlongwane must leave was that he had AIDS and would rape the other campers, thus spreading the disease (*Castro Hlongwane Manifesto* 2002). This appalling racial incident epitomised the discursive link between blackness, sexual licentiousness and disease, proving that – for such racists – this kind of thinking had not died out with colonialism or the end of apartheid.¹³

¹² *Mail and Guardian*, May 25, 2001.

¹³ Apartheid can be seen as a later form of colonialism. Although the white ruling class of the apartheid regime had lived in South Africa for several generations, they were still seen as 'Europeans' and 'settlers' rather than indigenous South Africans.

Mbeki did not directly claim authorship of the *Castro Hlongwane* document (although this has been disputed),¹⁴ but said it reflected his views. It is believed to have been written by a 'collective' of South African AIDS-dissidents who are not named but who are thought to include President Mbeki himself, Peter Mokaba (former ANC youth leader) and Anthony Brink, a Pietermaritzburg lawyer and author of a book condemning antiretroviral medicine (Brink 2000). The manifesto argues that the Western science of HIV/AIDS is simply an expression of 'deeply entrenched and centuries-old white racist beliefs and concepts about Africans and black people' (*Castro Hlongwane Manifesto* 2002: 3). The 114 page-long document remains the only official record of the views of South African AIDS dissidents (Cullinan 2009: 95). It is prefaced by a number of declarations which include the following:

- [This monograph] accepts that the HIV/AIDS thesis as it has affected and affects Africans and black people in general, is also informed by deeply entrenched and centuries-old white racist beliefs and concepts about Africans and black people. At the same time as this thesis is based on these racist beliefs and concepts, it makes a powerful contribution to the further entrenchment of popularisation of racism.
- In this context, it recognises the reality that in our own country, the unstated assumption about everything to do with HIV/AIDS is that, as a so-called 'pandemic', HIV/AIDS is exclusively a problem manifested among the African people.
- It rejects as baseless and self-serving the assertion that millions of our people are HIV positive.
- It rejects the assertion that, among the nations, we have the highest incidence of HIV infection and AIDS deaths, caused by sexual immorality among our people.
- It rejects the assertion that, as Africans, we are prone to rape and abuse of women and that we uphold a value system that belongs to the world of wild animals, and that this accounts for the alleged 'high incidence' of HIV infection in our country.

¹⁴ The *Mail and Guardian* newspaper traced the embedded signature of the electronic version of the document to Mbeki's computer (Cullinan 2009: 94-5).

- This monograph seeks to advance the cause of both better health for all our people and the recovery of our dignity as black people and human beings. These are fundamental to our very being as a movement and a people and therefore do not permit of any compromise (*Castro Hlongwane Manifesto* 2002: 1-6).

The outstanding characteristic of this text is the centrality of the concern about the image of the African people in the context of HIV/AIDS. The destruction of old but enduring racist stereotypes is a major objective, to the extent that the issue of AIDS itself, and the people suffering from AIDS, are displaced and all but excluded from the discourse. There is bitter irony in this: Mbeki's determination to transform the discourse of Africa and Africans resulted in their further marginalisation. Cullinan comments that:

[t]he President [Mbeki] and the Health Minister [Tshabalala-Msimang] and the key officials that supported them embraced these strange bedfellows [such as Brink and other dissidents] at great cost to the country and to people living with HIV. In doing so, they showed themselves to be more interested in gathering support for their dissident stance on AIDS and undermining those who opposed them than in helping South Africans with HIV, who were mostly poor and thus had very little political 'currency' other than as occasional voting 'fodder'. This was a tragic betrayal for South Africans who had waited so long for a democratic government to represent them and treat them with the respect and dignity lacking in our country ever since a white minority took power so long ago (Cullinan 2009: 111).

Part of the title of the *Castro Hlongwane Manifesto*, 'the struggle for the humanisation of the African', is significant because it indicates a determination to reverse the *dehumanisation* of the African brought about by the previous political discourse. Mbeki and his fellow dissidents continued to operate from within the pre-established discursive landscape that couples AIDS with blackness, even as they rejected it. While the desire to challenge old racist stereotypes was a legitimate and necessary endeavour from their perspective, it is unfortunate that the position they took also incorporated denial of the reality and seriousness of the AIDS-epidemic, seen in such

assertions (from the above document) as: 'It rejects as baseless and self-serving¹⁵ the assertion that millions of our people are HIV positive'. Mandisa Mbali remarked at the time that 'Mbeki appears to be attempting to throw out altogether the Western biomedical/scientific paradigm relating to AIDS, as racist and neo-colonial' (2002: 4), asserting that 'Mbeki is fundamentally constrained in his thinking by the ghosts of apartheid and colonial discourse around Africans, medicine and disease' (2002: 8). Elaborating on this point, Mbali states that:

[t]o attempt to construct arguments that AIDS is a Western biomedical plot to discredit Africans and their sexuality, and on that basis make complicated and unjustifiable denials of its causative roots in HIV, and the existence of effective treatment for HIV, is a tragic and inappropriate response by Mbeki to ... remnants of racist colonial-style discourse on AIDS, rarely made anymore by the mid 1990s or 2000s, by doctors and media in the West (2002: 10).

Myburgh contends that, over and above his opposition to the racist discourse which linked blackness and AIDS, Mbeki adopted his denialist and anti-ARV position because he had interests in the production of Virodene, an alternative AIDS 'cure'. Mystery still surrounds the precise extent and manner in which Mbeki was involved in the complex process of researching, testing and subsidising the development of this drug, but what is relevant for the purposes of this discussion is that, once again, political – rather than medical – considerations appear to have been Mbeki's motivating factor. Virodene's attraction lay in the fact that it was a 'medicine developed in Africa for Africa'. If successful, it would racially affirm the new government, and disprove once and for all Western stereotypes of black African incapacity. Salim Abdool Karim, director of HIV prevention and vaccine research for the Medical Research Council (MRC), told the *Washington Post* in 2000 that 'the Cabinet ... believed the discovery would validate South Africa's black majority in much the same way that Christiaan Barnard's first

¹⁵ The adjective 'self-serving' reveals deep suspicion on the part of the dissidents who accused the pharmaceutical companies of conspiring to inflate numbers to create a 'bogus epidemic' in order to boost profits on ARV medication, which the dissidents condemned as 'toxic' (Cullinan 2009: 110).

successful heart transplant in 1967 affirmed apartheid South Africa to the world'¹⁶ (Myburgh 2009: 4). The drug was seen to hold the 'possibility of a kind of racial vindication for the black African majority' (Myburgh 2009: 8). However, the Virodene project collapsed in failure. A German company conducted tests on the substance in 1998, and found it had 'no antiviral effect'. The latter finding then further encouraged the dissident viewpoint that AIDS was not caused by a single virus, but by a whole host of factors including poverty (Myburgh 2009: 15). This view was regarded as serious enough to warrant a firmly-worded statement reinforcing the orthodox view by the South African Medical Association (SAMA):

Whilst SAMA welcomes any debate on health it is obliged to point out that the view that HIV may not cause AIDS has been thoroughly discredited by several recent scientific studies. This view is dangerous and its propagation may lead to cases of AIDS that may have otherwise been prevented (*South African Medical Journal*, 2000: 461).

Reacting to media and opposition parties' criticism of the Virodene debacle, Mbeki's response was significant: he warned that the ANC would not be cowed by 'racists hankering for an apartheid past' or 'those who wanted to see a black government fail to prove their own beliefs that blacks cannot govern efficiently' (Gumede 2005: 155). Again, the emphasis was on politics, history and race rather than on controlling and treating disease in the present. Gumede marks this event as the point in time from which 'the AIDS issue became racially charged in South Africa' (I would argue that the racialisation of AIDS had started well before this point), stating that '[a]ll future responses to the crisis would be coloured by race' (Gumede 2005: 155), thereby displacing the primacy of AIDS and the AIDS-ill from the discourse. At times, this thinking assumed mean and petty proportions, for example, when Manto Tshabalala-Msimang blamed 'the white man' (an obvious reference to Mark Heywood, head of the AIDS Law

¹⁶ This does not imply that Barnard himself had this political intention, but his achievement and the acclaim it brought to South Africa was certainly welcomed by the apartheid government at a time when its political standing in the international community was very low.

Project) for masterminding the civil disobedience campaign initiated by TAC (see Footnote 4 of this chapter), saying that Africans waited to be deployed by ‘the white man’ before doing anything themselves (Van der Vliet 2004: 79). This acrimonious attack was a completely racialised distortion of the actual reasons for the campaign.

The compilers of *Nobody ever said AIDS: Stories and Poems from Southern Africa* observe in the Introduction that creative writers ‘have returned to the language of struggle to confront both the pandemic and the inadequate response of local governments’ (Thomas and Samuelson 2004: 13). The first part of the title of the anthology, ‘*Nobody ever said AIDS*’, is taken from one of the poems, but it highlights the general culture of silence around the epidemic and the avoidance of confronting it directly. Just as, in the public debate about AIDS, the discourse of politics dominates and displaces the actual epidemic and those suffering from AIDS, in creative writing on the subject of AIDS at this particular time, political discourse is also an overriding feature. Specifically, it reflects the mood of disappointment caused by government policy on AIDS. The birth of democracy in South Africa in 1994 was a momentous historical event which heightened political awareness and created huge expectations, but these were largely dashed by the AIDS-related policies of the post-apartheid government.

The poem ‘Fanon’s Land’ by Roshila Nair, featured in the anthology *Nobody ever said AIDS: Stories and Poems from Southern Africa* (2004: 179), takes its title from Frantz Fanon, the author of the key postcolonial texts, *Black Skin, White Masks* (1952), and *The Wretched of the Earth* (1967). *The Wretched of the Earth*, prefaced by Jean-Paul Sartre, explores the injustices and suffering of the poor and oppressed in African countries and, more specifically, Algeria, which was colonised by the French in 1848 and achieved independence in 1962 after a particularly bloody struggle lasting seven years. Through this intertextual link, colonialism and its violent overthrow constitute the discursive matrix of this poem which is dedicated to the well-known AIDS personalities Gugu

Dlamini,¹⁷ Zackie Achmat,¹⁸ ‘all AIDS activists in Africa and elsewhere’ and ‘the brave people who dare to remind us that freedom is a never-ending journey’. In the poem itself AIDS is not mentioned and the emphasis once again is political. The poem is premised on the belief that AIDS activism is not different from — or less important than — the quest for political liberation. A clear parallel is drawn between the struggle for freedom from colonial oppression and the fight for the rights of those struck down by AIDS. Both colonial oppression and that inflicted on the AIDS-ill by the prejudices of civil society and the policies of the State create ‘the wretched of the earth’.

In the complex opening lines of the poem:

Threadbare in the blood
 bloody in the tongue
 tongue-tied by the birth-push,
 we have washed up on a word
 like an old bed sheet
 wrung dry of the fight
 on laundry day

a number of images are conflated. ‘Threadbare in the blood’ immediately evokes the connection between poverty and AIDS, as well as suggesting that our efforts in the struggle for human rights have become feeble. Like the threadbare fabric of a sheet washed too often as a result of soiling, we have been ‘wrung dry of the fight’. Weakened by the fight for democracy in South Africa, we have ceased to speak out with the clarity and energy needed to drive the struggle for the rights of the AIDS-ill. We are ‘tongue-tied’ – rendered inarticulate – in the aftermath of the ‘birth-push’. The idiom ‘tongue-tied’ conveys the inability to discuss AIDS openly: in fact, the whole discourse could be described as ‘tongue-tied’ for multiple reasons including stigma, but largely because of political denialism. In the

¹⁷ Gugu Dlamini was a young woman who was stoned to death in KwaZulu-Natal in 1998 after declaring her HIV-positive status (Fourie 2006: 132).

¹⁸ Zackie Achmat co-founded the Treatment Action Campaign (TAC) in 1998. Refer to Footnote 15 of the Introduction.

line 'we have washed up on a word', the 'word' indirectly refers to AIDS, but even this is an uncertain inference. The issue of AIDS in the poem is obscure.

In the final stanza:

here in Fanon's no-man's land
we are beginning to learn
how to make everything
out of nothing again

the poet suggests that the victory in the fight against political oppression was short-lived. 'Fanon's Land' has become a 'no-man's land', in which the 'wretched' (those suffering from AIDS) do not belong and have no legitimate citizenship. They have been displaced into a liminal space and a new liberation struggle — this time for the AIDS-oppressed — has to start again, from scratch. 'Fanon's Land' is steeped in a tone of regret and disillusionment. The victory of the struggle has given way to despair.

In the poem 'Douse the Flames' by Kaiser Mabhilidi Nyatsumba, also part of *Nobody ever said AIDS: Stories and Poems from Southern Africa* (2004: 149-50), disillusionment with the post-apartheid government is again the overriding theme. The poem begins by recalling the struggle:

Once,
When menacing clouds
Hovered oppressively
Over the horizon
children braved guns
and casspirs
in demand for free air
and sunshine
while leaders
ululated
and urged them to their death
pronouncing them
brave young lions.

The reference to ‘children’ and ‘casspirs’ evoke the discourse of the Soweto uprising of 1976, where black learners revolted against apartheid education policies, encouraged and supported by their political leaders. In the second stanza of the poem, the poet contrasts this exhilarating past with the present:

Today,
 the fearful clouds have departed
 and sunshine reigns supreme
 with salubrious air truly free
 yet stubbornly
 does a nauseating stench
 hang in the air
 as those to whom
 the future belongs
 perish
 — as if of the black death of old —
 and are weekly interred ...

In the aftermath of the struggle, which was successful, since the ‘fearful clouds have departed’ and ‘the sunshine reigns supreme’, the conjunction ‘yet’ signals the unexpected reality that freedom cannot be enjoyed because it is tainted with the ‘nauseating stench of death’ — the result of mass mortality of young people, ‘those to whom the future belongs’, from AIDS, ‘the black death of old’. Those who ‘are weekly interred’ refers to the victims of AIDS, who are also victims of political ineffectuality. In what is a clear reference to Thabo Mbeki, the poet describes how

... those who style themselves leaders
 trawl the internet
 deep into the night
 and with schadenfreude combined with hubris,
 chant nonchalantly:
*a virus
 cannot cause a syndrome.*

AIDS-denialism results from 'schadenfreude'¹⁹ and 'hubris': an attitude of callousness and arrogance towards the masses. The poem ends on a note of regret and nostalgia as the poet longs for the passionate spirit and commitment of former anti-apartheid leaders to fight the new enemy, AIDS, which is compared to a fire destroying the land, a metaphor further effecting the displacement of AIDS.

Oh,
 how we yearn for true leaders
 to douse the flames
 consuming the nation
 to end the wailing
 afflicting our ears.

The vision of a bright, free South Africa is lost, replaced by suffering caused by the new leaders' political ineptitude before 'the flames' of AIDS.

In the creative writing texts discussed above, the feature that stands out most strongly is the way that AIDS is constructed in terms of the discourse of political struggle. The texts pivot on the comparison between the old colonial/apartheid regime on the one hand, and the new post-colonial/post-apartheid government on the other. The new political dispensation is attacked for its unsupportive attitude and ineffectuality in relation to the AIDS-epidemic, which threaten to undo all the gains achieved in the struggle. In this discourse, the AIDS-ill themselves are displaced by the power of the political discourse.

Antjie Krog's prose piece: 'Visit to the Eastern Cape', included in *Nobody ever said AIDS: Stories and Poems from Southern Africa* (2004: 145-8), echoes these feelings of betrayal by the post-apartheid regime. After witnessing ward after ward of people dying of AIDS in a rural hospital, the narrator reacts thus:

¹⁹ 'Schadenfreude' is a German word referring to a feeling of pleasure when bad things happen to other people.

Doctor Kabir keeps on opening doors. I turn around and walk, and then I am running down the long passage out of these Novilon-clad vaults of misery and death. I gasp out into a night transient with dew.

Around me the flowers have grown fangs, but I breathe.

Coldness comes paring down, but I breathe

And I breathe, in order not to suffocate with shame. I want to blame. I want to pluck someone from somewhere and shake him for answers. What happened to us? Where are all the dreams we once had for ourselves? What happened to our desire to change ourselves, to release ourselves into un suffering lives, living this land more lovingly? What happened to our dreams to change the heart of rage of this country into one of care? Where are we? Have we forgotten so soon what we wanted to be?

How could we ever become what we would be, if so many parts of what we are die daily into silently stacked-away brooms of bone?

Overwhelmed with horror at the suffering caused by AIDS, the narrator has to escape the suffocating interior of the hospital to the fresh air outside, but for her, reality has been horribly changed. Flowers have metamorphosed into snakes, appearing to have 'grown fangs', and have become symbols of death, not life. She gasps for breath, but even this reminds her that this basic life-giving physiological function sets her apart from those struggling to breathe and those whose breath has already left them because of AIDS.

Her initial reaction of shock is followed by critical reflection as she realises how completely the hope of a better life for all in the new democracy have been destroyed. The heady ideal of a more loving and caring society, so powerfully embraced by the first post-apartheid president, Nelson Mandela, has been replaced by the evidence of the opposite reality: vast numbers of the dead and dying. Their 'broom'-like remains convey their stick-like thinness; the way they have been dehumanised and reduced to common, expendable objects; as well as suggesting the idiom of being 'swept under the carpet'. This description evokes visual images of the Holocaust and other genocides in Africa; ironically, the discourse Mbeki was intent on obliterating by means of the African renaissance. The corpses are 'stacked away', the use of the passive voice reinforcing the

sense of the impersonal power of the State which treats its citizens as objects, while 'silently' suggests secretiveness and denialism. Hidden from public eyes and ears, the AIDS-dead are displaced physically and symbolically.

The narrator in Krog's text adopts an immersive, anti-displacement position. She refuses to 'other' the AIDS-ill, as we see in her implicit identification with them: they are seen as 'parts of what we are'. Her use of the first-person plural pronoun 'we' in '[h]ow could we ever become what we would be, if so many parts of what we are die daily ...?' suggests her sense of collective identity. 'We', which presumably denotes the whole South African nation, are diminished by the deaths of the AIDS-ill, and this morbid erosion of the population is preventing us from achieving the vision, 'what we would be', promised by the post-apartheid era. The dreadful scenario she has just witnessed attests to massive culpability. She wants to blame someone in authority, but her use of the word 'shame' in 'I breathe, in order not to suffocate with shame' reveals that she herself feels implicated in the guilt, and is appalled by her own previous lack of awareness, a feeling that could be related to her whiteness. Even as she identifies with the suffering of poor, black people, she remains outside their experience.²⁰ She nevertheless immerses herself in the horror and resists the displacement of responsibility. Her attitude throws into sharp relief the policies of the government at the time, under Mbeki's leadership, which distanced itself from and covered up the realities of the AIDS epidemic.

It is ironic in the extreme that Mbeki's well-intentioned desire to reconstruct the discourse of Africa and Africans by representing them in a positive way actually brought about the opposite effect. Photographs of emaciated Africans in the last stages of AIDS²¹ and catastrophic statistics of mortality from AIDS have reinforced old stereotypes of

²⁰ In her most recent work, *Begging to be Black* (2009), Antjie Krog struggles to define her identity as a white African with European roots. The difficulty of doing this is the major theme of the book.

²¹ See, for example, Mendel, Gideon. 2002: *The Broken Landscape*. Johannesburg: M&G Books.

Africa as the locus of disease, suffering and death. It is equally ironic that South Africa, under the new democratic regime and with one of the most liberal constitutions in the world, has stood accused of grossly violating human rights, and even of genocide, because of its failure to subsidise medication for those living with HIV and AIDS.²² Mbeki's political agenda so completely overshadowed the plight of AIDS sufferers, that they were altogether neglected. The very people whose disadvantaged status he was so anxious to reverse – the poor, black sector – were the ones worst affected by his policies. The position he adopted appeared to depart radically from the promises of the National Health Plan for South Africa (part of the Reconstruction and Development Programme of 1994) which stated that:

Every person has the right to achieve optimal health, and it is the responsibility of the state to provide the conditions to achieve this. Health and health care like other social services, and particularly where they serve women and children, must not be allowed to suffer as a result of foreign debt or Structural Adjustment Programmes (African National Congress 1994: 19).

Mbeki was also criticised for his silence on AIDS when opportunities for him to address the issue in words or action presented themselves.²³ Discourse is structured as much by what is absent as by what is present. Often what is not said is as important as what is. The Mbeki government's 'reign of silence' on the issue of HIV and AIDS contributed to the displacement of the AIDS-ill from public awareness. Mbeki's eventual

²² After an interval of several years, and after Mbeki's presidency had ended, these issues were revived in November 2009 when Cosatu general secretary Zwelinzima Vavi said that Mbeki should apologise for the suffering of those who died during the era of AIDS denialism, and the leader of the Young Communist Party called for Mbeki to be charged with 'genocide' over the denial of the existence of the virus (*Pretoria News*, 2 December 2009).

²³ See, for example, *The Citizen* 17 February 2003: 'Mbeki accused of HIV silence'; *Pretoria News* 1 April 2003: 'Medical Journal flays Government on AIDS'; *Pretoria News* 27 September, 2003: 'Outcry at Mbeki's Aids claim: President says he knows no one who has died of HIV'; *Financial Times* 13 April 2004: 'Mr Mbeki and his health minister have underplayed the disease's importance, quibbled over mortality figures and delayed the dispensation of life-prolonging anti-retroviral drugs. A comprehensive HIV/Aids treatment plan is now under way, but the government's leadership and commitment on the issue remains in doubt'; Morgan, Jonathan. 2003. *Long Life: Positive HIV Stories*. Cape Town: ABC Press: 44-45, 158, 169.

acquiescence to the provision of ARV treatment was widely regarded as a step that came too late,²⁴ and the fact that 2004 – the year such treatment was made available – was also an election year, and that provision of ARV drugs was a hot election issue, did not escape notice. Once again, it seemed, political considerations took priority and determined the fate of those suffering from AIDS, although in this instance it was to the advantage of the AIDS-ill, who at last gained access to government-subsidised ARV treatment.

Government policies, utterances and non-utterances on AIDS inevitably provoked responses of resistance. Illustrating Foucault's view that 'where there is power, there is resistance' (1976: 95), this era of South African history has seen the emergence of oppositional discourses: the voices of the marginalised AIDS-affected. One such voice was that of the writer Phaswane Mpe, who died in 2004.²⁵ In his ironically titled poem 'elegy for the trio', which also appears in *Nobody ever said AIDS: Stories and Poems from Southern Africa* (2004: 151), the 'trio' are named as 'thabo manto mokaba' (Thabo Mbeki, Manto Tshabalala-Msimang and Peter Mokaba),²⁶ all of whom were AIDS-denialists in various ways. The poet points out the absurd lack of logic in the government's stance on AIDS:

hiv does not cause AIDS
but let thy condom come
anyway ...

where he suggests that if there is doubt about the causal link between HIV and AIDS – an aspect of extreme dissidence – it makes no sense to advocate the use of condoms. In

²⁴ In November 2003 the government announced they would fund a programme to provide free ARV drugs to those who qualified for treatment: patients with a CD4-count below 200. This programme began in April 2004, but due to 'capacity constraints', the AIDS-ill had to wait months for the first drugs to reach them (Gumede 2005: 150). Even when the drugs did become available, the Mbeki government failed to roll them out to the numbers promised. (See Footnote 23 of the Introduction.)

²⁵ In his Obituary, written by Liz McGregor (*The Guardian*, 20 December 2004), the cause of his death was said to be 'unclear', but it was almost certainly AIDS-related.

²⁶ Peter Mokaba was a supporter of President Mbeki's AIDS-denialist position. He died of an AIDS-related condition in 2002 (Gumede 2005:164).

a mocking intertextual reference to the Lord's Prayer; 'thy kingdom come', the poet bitterly satirises the inconsistency of what is seen as a religious insistence on the use of condoms in the context of a culture of denial.

Pressure groups, the best known of which is the Treatment Action Campaign (TAC), asserted the right of the AIDS-ill to be heard and to have their needs recognised and addressed, specifically in regard to receiving antiretroviral treatment. Its co-founder, Zackie Achmat, was a former anti-apartheid activist who adapted apartheid activism into AIDS activism, using his anti-establishment experience for a new cause. In 2001, the TAC took the matter of providing the drug AZT (later Nevirapine) to HIV-positive pregnant women to prevent mother-to-child-transmission (MTCT) to the Constitutional Court which ruled in its favour. In terms of the judgement, the government was forced to supply treatment to pregnant HIV-positive women in 2002. Mark Heywood, TAC National Chairman and head of the AIDS Law Project, told a news conference in Johannesburg that he found it 'regrettable' that a government for which the people had struggled, had to be taken to court in pursuit of people's constitutional right to life, and to compel government to fulfil its constitutional obligations (Van der Vliet 2004: 69). In 2003, the TAC laid charges of culpable homicide against the Health Minister Manto Tshabalala-Msimang and her Trade and Industry counterpart Alec Irwin, holding them responsible for the deaths of 600 people a day who could have been saved by antiretrovirals (Lawson 2008: 270). These events attest to the highly politicised nature of the AIDS debate in South Africa which, increasingly, became located in the discourse of human rights.

The predominantly political nature of AIDS discourse at this time stands out in a letter Mbeki wrote to foreign leaders in April 2000, including Bill Clinton and Tony Blair, justifying his position as a dissident. In this letter he attacked the orthodox biomedical view, stating that:

Not long ago in our country people were killed, tortured and imprisoned because the authorities believed that their views were dangerous. We are now being asked to do the same thing that the racist apartheid tyranny did, because there is a scientific view against which dissent is prohibited (Sparks 2003: 264).

Notable here is the violence of the language used ('killed'; 'tortured'; 'tyranny') and the fact that it is taken from the discourse of apartheid politics. The argument is not entirely clear, however; the vagueness resulting largely from the use of unspecified personal pronouns and the use of the passive voice. When Mbeki says: 'We are now being asked to do the same thing...', it is not clear to whom the pronoun 'we' refers, nor does he say by whom 'we' are being 'asked'. He uses the vague passive form again in 'dissent is prohibited', making the agent seem shadowy and sinister. It appears that Mbeki is equating biomedical practitioners with apartheid tyrants, and the AIDS dissidents with anti-apartheid activists. (This conceptualisation, as explained at the beginning of this chapter, is more easily understood in the light of the association of biomedicine with political power, by virtue of its hegemonic status in the Western world. From this association, it follows that the critics of the biomedical paradigm are identified with political dissidents.) By putting the AIDS dissidents in the same camp as those individuals who struggled against apartheid, Mbeki evokes sympathy and admiration for them, at the same time arousing hostility against those they were opposing – the body of mainstream biomedical practitioners.

A statement from Mbeki's office by spokesman Smuts Ngonyama soon afterwards accused the AIDS activists who were demanding that the government provide antiretroviral drugs in the public hospitals of trying to poison black people. The actual words were: 'Our people are being used as guinea pigs and conned into using dangerous and toxic drugs reminiscent of the biological warfare of the apartheid era' (Sparks 2003: 265). It is certainly true that ARV drugs are toxic and can have negative side-effects. It is also true that these drugs were still being developed, so there is a sense in which human recipients could be called 'guinea pigs'. While it is a distortion to

see this in terms of a white-driven policy against blacks for a hidden political agenda, such perceptions are understandable: they stem from longstanding distrust between black and white groups and echo conspiracy theories that whites wished to reduce the black population because they feared being outnumbered and losing political power. These beliefs have some justification. During the apartheid regime, agents such as Wouter Basson²⁷ perpetrated the 'dirty tricks' of apartheid, *inter alia*, by means of chemical or biological warfare. When purporting to discuss AIDS, it seemed to be impossible for participants in the debate to move beyond the politics of the past.

Such paranoid perceptions were articulated more fully when, in March 2002, Peter Mokaba wrote:

The story that HIV causes AIDS is being promoted through lies, pseudo-science, violence, terrorism and deception. We are urged to abandon science and adopt the religion and superstition that HIV exists and that it causes AIDS. We refuse to be agents for using our people as guinea pigs and have a responsibility to defeat the intended genocide and dehumanisation of the African child, mother, family and society (Sparks 2003: 266).

Prominent again is the political tenor of the language. The fact that Mokaba specifies that the victims of this 'conspiracy' are 'African' is significant. He counts on his audience's familiarity with, and emotional response to, past racial oppression, recalled by his use of highly-charged struggle discourse.²⁸ His words exemplify the view that AIDS treatment is a 'racist conspiracy to demean Africans by impugning their sexual dignity, and to exploit them by selling useless and toxic medications to them. Ultimately, the white racist conspirators' design is to poison and kill Africans' (Cameron 2005: 135).

²⁷ Wouter Basson, nicknamed 'Dr Death', was the head of the country's secret chemical and biological warfare programme. He allegedly supplied lethal cocktails to anti-apartheid activists and others who posed a threat to South African covert operations.

²⁸ The high emotional register of Mokaba's speech could be due, in part, to denial of his own personal condition. (See Footnote 26 of this Chapter.)

On the other side of the debate – the pro-biomedical faction, supportive of drug treatment – the TAC also adopted emotive political terminology such as ‘genocide’ and ‘holocaust’ to describe AIDS deaths caused by government policy. But the ‘genocide’ that the TAC attributed to the government for failing to provide ARV treatment, Peter Mokaba believed was being perpetrated by the promoters and suppliers of ARV medicines. Paradoxically, the same word – ‘genocide’ – was used to describe two completely opposite activities: providing the drugs and withholding them. Equally contradictory was the fact that the apartheid metaphor used by Mbeki, based on the conflict between opposing medical camps, identified the biomedical profession with the former apartheid state, while critics of Mbeki, such as the TAC, likened his dissident policies to those of the old apartheid government. The fact that each accused the other of the same ‘crimes’, couched in the same language, is illogical to the point of absurdity. This demonstrates how the same discourse can be invoked to legitimate opposite courses of action, and how far removed it can become from the original subject. AIDS, an urgent health matter, is treated instead as a political issue and displaced onto a terrain of political conflict. As Fourie observes, ‘the AIDS policy environment degenerates into an arena for blame and auto-exculpation’ (2006: 178), becoming a ‘context which recreates the patterns of the past: counter-attack, blame, the invocation of racist politics and a total breakdown in any possible constructive engagement ...’ (2006: 179). Dr Ashraf Grimwood, chairman of the National AIDS Convention of South Africa at the time, commented: ‘South Africa’s history of addressing AIDS is the most appalling debacle. We have shot our allies, knifed our neighbors [sic], and instead of attacking the enemy, attacked each other’ (Van der Vliet 2004: 80). This recalls the words of Foucault that ‘the point of reference’ in discourse ‘should not be to the great model of language (*langue*) and signs, but to that of war and battle’ (1980: 114).

While the oppositional parties engaged in a new version of the apartheid struggle, adopting ‘ready-made’ resistance discourse to attack each other, the people

about whom they were arguing, those ill and dying of AIDS, were rendered curiously irrelevant, displaced out of sight and out of mind. As it is, not much is known about the AIDS-dead because many were unemployed, and so made little measurable impact on the formal economy; because their death certificates did not record that AIDS was the real cause of their deaths; and because their families remained silent because of stigma. Above all, they themselves did not speak out. As Paul Farmer remarks, the poor are 'anonymous victims who have little voice, let alone rights, in history' (2004b: 286) and are 'not only more likely to suffer, [but] ... are also more likely to have their suffering silenced' (2004b: 288). Their silence collaborated with the structural violence around them, condemning them to oblivion.

'Structural violence' is a concept derived from the anthropologist Johan Galtung who distinguishes between the narrow concept of *physical* or *personal violence* as visible acts committed by concrete actors in a clear 'subject-object relation' and *structural violence* which is largely invisible and built into social structures (1969: 173). Racism, sexism and discrimination against the poor are all forms of structural violence. Building on Galtung's definition, the anthropologist Paul Farmer defines structural violence as 'violence exerted systematically – that is indirectly – by everyone who belongs to a certain social order' (2004a: 307). Pierre Bourdieu adds a further dimension to this concept in his phrase 'symbolic violence', which he defines as 'the violence which is exercised upon a social agent with his or her complicity'. The word 'complicity' does not mean that people enjoy being victims, but that they 'unwittingly, sometimes unwillingly, contribute to their own domination by tacitly accepting the limits imposed' (Bourdieu 2004: 341). Bourdieu warns against the supposition that symbolic violence is a purely 'spiritual' violence that ultimately has no real agents or effects (2004: 339): although the forces exerted by the structures of domination may be invisible, they are 'the consequence, direct or indirect, of human agency' (Farmer 2004b: 286) and their effects are physical. Human decisions are behind the absence of treatment for the poor: lack of treatment brings about their deaths.

Former president Nelson Mandela pointed out, in a diplomatic way, how victims of AIDS in South Africa have been rendered silent and invisible, displaced by a political power struggle that overshadowed them. In the closing speech he gave at the 13th International AIDS Conference in Durban in July 2000 he stated that:

So much unnecessary attention around this conference has been directed towards a dispute that is unintentionally distracting from the real life and death issues we are confronted with, as a country Now, ... the ordinary people of the continent and the world, and particularly the poor, who on our continent will again carry a disproportionate burden of this scourge, would, *if anybody cared to ask their opinion*, wish that the dispute about the primacy of politics or science be put on the back burner, and we proceed to address the needs and concerns of those suffering and dying... (Gumede 2005: 149, my emphasis).

The tragic irony of the whole biomedical/dissident conflict – based as it was on ideology and politics rather than health – was that it displaced the most crucial party in the AIDS situation, the AIDS-ill.

As we have seen, creative responses to the AIDS epidemic in South Africa, like public discourse, are also steeped in political and racial discourse. This is evident again in the poetic text below, written by Sandile Dikeni and published in his collection *Telegraph to the Sky* (2000: 50):

Culture

White theatres
overflow with the drama:
TO BE OR NOT TO BE.

Black townships
are drained by the drama:
TB OR NOT TB.

It requires effort on the part of the reader to recover the presence of AIDS in this poem, so completely has it been erased from the text, 'TB' being its euphemistic substitute. This, in addition to the foregrounding in the poem of the 'racialisation of space' (Dixon 1997: 9), or what Fassin describes as 'settings which are the result of history [having] become physical reality' (2003: 54), effectively displaces AIDS, as a central concern, from the text. The poet assumes that the reader has the necessary background knowledge to fill in the gaps and understand what the poem is about. The polarity between the 'white' and 'black' worlds sketched in the two stanzas of the poem links its discourse unmistakably to South Africa's sociopolitical history, and apartheid in particular. It is interesting that the poet still perceives South Africa in this racially divided way in 2000, some six years after the official demise of apartheid, indicating how deep and lasting the divisions within South African society are, and how scarred are its human products.

Within the discourse of the poem 'Culture', AIDS is constructed as a purely 'black' phenomenon. This binary opposition between blackness and disease on the one hand, and whiteness and health on the other, reinforces outdated colonial discourse and the more recent discourse of AIDS as the 'black plague' in South Africa. While it is undeniable that in South Africa the majority of the AIDS-ill are black,²⁹ the racial dichotomy on which the poem is based is an over-simplification: many whites are HIV-positive or have succumbed to AIDS. Moreover, the South African population is highly diversified and complex: 'white' and 'black' are not homogenous, unified groups as the poem suggests. The most important point, for the purposes of my argument, however, is that in this text AIDS is completely racially politicised. The phenomenon of apartheid – arguably the most salient feature of South Africa's political history – is the overriding concern.

²⁹ While people of all ethnic groupings are equally susceptible to infection, in reality AIDS is a racially differentiated epidemic owing to the greater levels of poverty among the black population. (Refer to Footnote 21 of the Introduction.)

Dikeni sustains the polarised relationship between the white and black worlds through the stereotyping of their lifestyles, which caricatures and even dehumanises South Africans. The 'white theatres' in the first stanza are representative of the discourse of privilege: they imply wealth, leisure and educational levels necessary to appreciate Shakespeare, while all black South Africans are 'ghetto-ised' in the 'townships'. The link with AIDS is not made until the final line, 'TB OR NOT TB', a parodic echo of Hamlet's famous line 'TO BE OR NOT TO BE'. While the two lines are phonetically similar, they signify profound social difference. It is implied that the whites have the luxury of experiencing questions of death at a remove and in an artificial, dramatised form, but that black people experience death directly and are 'drained', weakened and undermined, by its realities. The white audience vicariously ponders Hamlet's existential dilemma, while the black inhabitants of the townships grapple at first hand with the real life-and-death question of whether they or their friends or family members have TB, and – if so – if this masks underlying HIV-infection, the 'real' cause of disease.

It is ironic that in the poem 'Culture', Dikeni uses pre-existing racial discourse, which equates blacks with disease, in a post-colonial, post-apartheid context. But whereas the colonial discourse blamed blacks for causing and being the source of disease, in his poem 'Culture', Dikeni sees blacks as victims. Underlying the poem is anger that black communities experience higher rates of infection because of political forces which have brought about social injustice. Such systematised ideology exemplifies Galtung's concept of 'structural violence'.

Dikeni's bifurcated construction of South African society echoes the structure of Mbeki's 'Two Nations' speech,³⁰ of which the following is an extract:

³⁰ Speech given at the opening of the debate on reconciliation and nation-building in the National Assembly, 29 May 1998.

... South Africa is a country of two nations.

One of these nations is white, relatively prosperous It has ready access to a developed economic, physical, educational, communication and other infrastructure.... [A]ll members of this nation have the possibility to exercise their right to equal opportunity, the development opportunities to which the Constitution of 1993 committed our country.

The second and larger nation of South Africa is black and poor This nation lives under conditions of a grossly undeveloped economic, physical, educational, communication and other infrastructure. It has virtually no possibility to exercise what in reality amounts to a theoretical right to equal opportunity....

This reality of two nations, underwritten by the perpetuation of the racial, gender and spatial disparities born of a very long period of colonial and apartheid white minority domination, constitutes the material base which reinforces the notion that, indeed, we are not one nation, but two nations ³¹ (Mbeki 1998: 71-2).

This speech of Mbeki's, in turn, recalls the words of Benjamin Disraeli, Prime Minister of Britain during the reign of Queen Victoria, who wrote in 1845 that 'the Queen's nation' was in reality

two nations; between whom there is no intercourse and no sympathy; who are as ignorant of each other's habits, thoughts, and feelings, as if they were dwellers in different zones, or inhabitants of different planets; who are formed by a different breeding, are fed by a different food, are ordered by different manners, and are not governed by the same laws ... THE RICH AND THE POOR (Altick 1973: 11).

Nor does the intertextuality end here: Disraeli borrowed the 'two nations' concept from the American preacher William Ellery Channing, whose two-word phrase echoes through Victorian literature of social criticism (Altick 1973: 11). This chain of intertextual references bears out the validity of Barthes' contention, discussed in Chapter 1, that each text is, at least in part, a 'pastiche' of past texts, and that the '[t]ext ... practises infinite deferment of meaning' (Barthes 1977: 159), as interpretation is displaced onto other discursive landscapes.

³¹ This perception of Mbeki's was diametrically opposed to Nelson Mandela's vision of the 'rainbow nation', an image which encapsulated unity in diversity.

As was discussed in Chapter 1, war metaphors are considered undesirable when used in relation to AIDS, a view laid down in the United Nations Language Policy and strongly associated with Susan Sontag, who argues that military metaphors 'contribute to the stigmatizing of certain illnesses and, by extension, of those who are ill' (1988: 11). Apartheid discourse could be regarded as a particular, local variety of the overused, more generic war discourse commonly used in AIDS discourse here and worldwide,³² and so might also be criticised for damaging the cause of AIDS and the AIDS-ill. However, Susan Sontag's stand against the war metaphors that dominate illness has been challenged. Miller (1993) believes that it is possible, and even necessary, to employ war metaphors as resistance for positive effects, and indeed, in the South African context, where the language of warfare refers specifically to the liberation struggle, it could be argued that this offers some hope. One entailment of the 'AIDS is War' paradigm could be that AIDS will eventually be overcome, just as apartheid was, despite its apparent insurmountability at the time. This could spur on efforts to end the pandemic and reinvigorate it as a topic for discussion and action. War metaphors need not have destructive psychological effects, as Sontag believes: on the contrary, they could be inspirational and empowering. This possible interpretation illustrates Brandt's view that

... so complex a phenomenon as disease cannot be understood outside the culture in which it occurs. The biological world is fundamentally transformed by culture and politics Rather than decrying the metaphorization of disease, it seems more appropriate to analyze the process by which disease is given meaning By drawing careful analogies, recognizing that specific diseases elicit particular responses at historically defined moments, we may come to understand the meaning of disease in our culture at a deeper level (1988: 417-8).

³² Although the anti-apartheid struggle does not conform to the traditional notion of conventional warfare, it was a protracted conflict and involved bloodshed, so can be regarded as a kind of war.

AIDS-related discourse in South Africa has to be seen in its cultural and historical context, as Brandt suggests: it cannot be dislocated from the socio-political background out of which it has grown.

The use of struggle discourse for the purpose of offering encouragement and hope is observable in a number of AIDS texts, with varying results. In the poem 'Arise Afrika, Arise!' by Nape 'a Motana, in *Nobody ever said AIDS: Stories and Poems from Southern Africa* (2004: 103-4), struggle discourse is evoked in a very direct and crude, but finally uplifting, way. Once again, the current fight against AIDS is located firmly within the discourse of past resistance against colonialism:

Yesterday Afrika ran red
with freedom fighters' sacrifice.
Today, under the jaws of man-eater AIDS, red
As vicious viruses colonise black blood.

Black people, once the victims of colonialism in Africa, are still seen as victims, but now the oppressor is not a European power or a minority group of white supremacists, but AIDS, represented as a vicious monster. As the awkward, ungrammatical syntax of the opening lines – quoted above – shows, the poem is not finely crafted (or perhaps it was poorly translated from Sepedi),³³ but it has a raw energy, and with its repeated exhortations, resembles a rousing battle cry:

Afrika, stop AIDS!
He who pussyfoots towards
the lion of sexual temptation
must be armed with a burning spear!

The poet indicates that AIDS has the upper hand at present, replete with those it has devoured:

Today AIDS laughs

³³ 'Arise Afrika, Arise!' was written for performance with musical accompaniment. The Sepedi-language version of this poem was performed during a World AIDS day event in Mamelodi, Pretoria.

With reddened teeth, . . .

but proclaims with confidence that this situation will change:

But tomorrow on the monster's grave
with triumph-inflamed faces —
teeth egret-white, songs pregnant with victory
we shall belch
when the shattered dream of
Patrice Lumumba and Mwalimu Nyerere
Rises from ashes of AIDS!

So completely are the fight against AIDS and the anti-colonial struggle conflated that when AIDS is conquered, the poet envisages that, phoenix-like, the spirit of *Uhuru* — as this was experienced in the Congo (Lumumba) and Tanzania (Nyerere) — will also triumph. This vision could also be seen as a different form of the African renaissance, but instead of the cultured, intellectual one envisaged by Mbeki, this one urges military action. The tone is highly charged and hopeful, showing that military discourse need not be negative in effect.

An example – in another genre and with a different outcome – of the way that AIDS discourse has been carried over to the political struggle against apartheid with the intention of offering hope, can be seen in the title of the musical *'Sarafina II'*. This stage production had as its aim the education of the youth in AIDS-prevention³⁴ but what is significant is that it took its name from the earlier film *Sarafina*, which had nothing whatever to do with AIDS. Instead, the theme of the film was the 1976 Soweto student uprising, a major event in the history of the struggle, and which predated AIDS. Presumably the director, Mbongeni Ngema, was exploiting the popular political message of the earlier film — successful resistance to oppression — by linking it to the AIDS-situation. The show *Sarafina II* was characterised by energetic singing and dancing of actors playing school-children, reminiscent of the film *Sarafina*, but its educational

³⁴ The whole *Sarafina* venture erupted in controversy and scandal in 1996 when it became known that R14.2-million donated by the European Union for AIDS research was being used to fund it, and, because of public outcry, the contract was eventually cancelled (Nattrass 2004: 45).

message relating to AIDS – which was supposed to be its purpose – came over weakly. In this case, displacing the theme of AIDS onto a pre-existing political discursive landscape in the expectation of popularising the message, was self-defeating. The whole project was a dismal failure.

The displacement of AIDS by projecting it into the arena of politics with the aim of elevating its image and offering hope was also a striking feature of the '46664' rock concerts. The first '46664' concert,³⁵ held in Cape Town on 30 November 2003, was timed to coincide with World AIDS Day; AIDS was the prevailing concern, and the whole point of the occasion was to raise awareness of the plight of the AIDS-ill, as well as to raise money for their cause. However, the discourse that dominated the event was political; more specifically the discourse of Nelson Mandela. He was present both in person and symbolically, in a huge image of his face which towered above the stage, and in the number '46664' of the concert's title (his personal prison number on Robben Island). The discourse associated with Mandela was intended to confer legitimacy, dignity, importance, and a sense of drama to the issue of AIDS in which many people have lost interest³⁶ or prefer to ignore. Signs in the modes of language, pictures, sounds and music all operated to produce meaning at the '46664' concert. The organisers maximised to the full the semiotic power of Nelson Mandela's image which conveys a complex range of meanings. As Barthes explains, 'the seme [the connotations linked to the signified] is linked to the ideology of the person ... and the person is no more than a collection of semes' (1974: 191). Some positive semes which make up the ideology of Mandela are liberation, humanitarianism and moral authority. More than any other individual, he is associated with the end of the apartheid state and the transformation of South Africa into a democracy. Mandela's elevation from convict to President of

³⁵ Other '46664' concerts have been held since this date, but for the purposes of this discussion I focus on the first one only. For a fuller discussion of this event, see Horne, F. J. 2004: 'Some Aspects of AIDS-related Discourse in Post-Apartheid South Africa', in *Alternation*, 11: (2), 401-19.

³⁶ 'AIDS Information Overload Syndrome' (AIOS) has been identified as a widespread reaction to the plethora of material about AIDS in the media.

South Africa has often been described as a ‘miracle’: the words ‘miracle’ and ‘miraculous’ often occur in discourse about him or South Africa’s transformation.³⁷ The discourse of Mandela was used to make the supremely important point that – miraculously – he was eventually freed, and the fight against apartheid was eventually successful. Mandela is living proof that the struggle ended in victory. By analogy, the audience was being persuaded to believe that efforts to contain AIDS can also succeed. However, the success alluded to was displaced from the current AIDS epidemic: it occurred in a previous time and in a different domain. Whether the message of inspiration was successfully transferred to the domain of AIDS is a moot point.

The towering image of Mandela on the concert stage is what Tilley would describe as a ‘solid’ metaphor. According to his definition, ‘solid’ metaphors are spatial and seen ‘all at once’, as opposed to ‘verbal’ ones which unfold in time and sequence. Tilley believes that solid metaphors act most subtly and powerfully when they are not linguistically translated, because they are ‘a primary element of the unconscious in culture’, and ‘words domesticate and partially destroy the metaphorical powers of things’. He holds that to analyse such metaphors may be to ‘detract from their cultural efficacy’ because of their ‘power of suggestiveness’ (Tilley 1999: 263). The polysemic significance evoked by the solid metaphor of Mandela’s image at the ‘46664’ concert was intended to transfer and add value to the cause of AIDS, but what happened, in my opinion, was that the power and rich suggestiveness of Mandela’s discourse overshadowed and displaced AIDS from the event.

The study of how meanings are associated is known in the marketing world as ‘branding’ (Myers 1999: 7; 18). Brand-names are usually the labels given to consumer goods being sold as commodities. In the instance of the ‘46664’ concert, nothing was being sold, but the audience was being asked to ‘buy’ the cause of AIDS because of their

³⁷ See, for example, Cameron-Dow, John. 1994. *South Africa 1990-1994: The Miracle of a Freed Nation*. Cape Town: Don Nelson.

faith in the Mandela brand-name which adds value to it. The marketing strategy of branding still operated through the meanings linked with Mandela.³⁸ Branding, by means of his name, his prison number, and his physical image is a simplification of his complex mythology. The way marketers ‘try to project a ready-made heritage...; [to] carry the associations of a brand across to a new sector’ (Myers 1999: 21) exemplifies displacement: in this case, displacement entailed transferring the meanings attached to Mandela to the cause of AIDS, compounding the displacement that already existed between the event and the people it purported to honour.

The spoken words around the ‘46664’ event all drew on struggle discourse. When receiving the artists who had gathered in Cape Town beforehand to perform at the concert, Mandela himself told them that ‘it would take greater unity and effort to conquer HIV than it took to tear down apartheid’. He went on to say: ‘We are called to join the war against HIV/AIDS with even greater resolve than was shown in the fight against apartheid.’³⁹ Developing the struggle metaphor at the ‘46664’ concert, the artist Bono stated: ‘Madiba’s greatest gift to the world is to say: “I was in prison for all those years. Those people with AIDS, they’re in prison. Let them out. Let them go”’. These words echo the title of the book *Let My People Go*, written by another South African Nobel Peace Prize Winner, Chief Albert Luthuli.⁴⁰ The words: ‘Let my people go’ recall, in turn, God’s words to Pharaoh⁴¹ in another, much earlier liberation struggle. This use of intertextuality is another illustration of the infinite deferral of meaning that takes place in a text. The conflation of apartheid and AIDS discourse was used at the ‘46664’

³⁸ A US survey placed Mandela second only to Coca-Cola as a brandname. The use of Mandela’s image is carefully controlled by a team of advisors. Requests are considered only if the proposal ‘embodies the values Mr Mandela stands for’ (*Pretoria News*, 26 April 2004).

³⁹ *Pretoria News*, 29 November 2003.

⁴⁰ Albert Luthuli (1898-1967): Zulu teacher, religious leader and President of the ANC from 1952-60. He was the first African to be awarded the Nobel Prize for Peace (1960) in recognition of his non-violent struggle against racial discrimination.

⁴¹ ‘Thus saith the Lord God of Israel: “Let my people go”.’ Exodus 5:1: King James Version.

concert to construct inspirational meanings, intended to uplift. Far more than simply an entertaining event, the '46664' concert was a text loaded with cultural assumptions and a multiplicity of meanings. It illustrates that 'a text is made up of a contradictory mix of different cultural forces' (Storey 2001: 12) and that popular cultural happenings are 'sites where the politics of signification are played out in attempts to win readers to particular ways of seeing the world' (Hall 1985: 36).

The '46664' concert set out to bring to public notice the presence and predicament of the AIDS-ill, to bring them out of obscurity and into the limelight, metaphorically speaking. The popular music added colour, vitality and a mood of celebration to the occasion, counteracting the associations of AIDS and death. The blaze of light and loud noise that are defining features of rock concerts, and the presence of local and international celebrities at the occasion, were intended to make a statement, in the boldest possible way, that people with AIDS must be recognised and affirmed, not marginalised, forgotten or ignored. Yet nothing could have seemed more remote from the event than those who were ill with, or who have died from, AIDS. The utilisation of a combination of powerful signifiers, most notably the icon of Nelson Mandela, succeeded in eclipsing awareness of those suffering from AIDS to the point of obliteration. The people who were intended to have been brought to the fore in the public imagination, the AIDS-ill, were all too obviously absent, displaced by the wealth of symbolic meanings constructed to highlight and enhance their cause.⁴² Ironically, the overall effect was to distance the AIDS-ill further from the world of the well. Although 'every available signifying practice join[ed] forces here against the annihilating power of death' (Belsey 2005: 67), in the end the concert all but annihilated a sense of the reality of the epidemic of AIDS, and the reality of the people who have succumbed to it.

⁴² In sharp contrast, the physical presence of the frail Nkosi Johnson on the stage when he spoke at the 13th International AIDS Conference in Durban in 2000 brought home, in a highly dramatic way, the reality of the suffering of the AIDS-ill and the urgency of their need for support and treatment.

The liberation struggle and the establishment of the new democratic dispensation in South Africa have been supremely powerful and dramatic phenomena. It is not surprising, therefore, that they have impinged so forcefully on AIDS discourse, particularly when it is considered that the birth of democracy and the emergence of the AIDS epidemic occurred more or less simultaneously. Reciprocal displacement of the two discourses has taken place: apartheid discourse has been manipulated in different, even contradictory, ways to fit different AIDS-related purposes; while AIDS discourse has been manipulated to suit political purposes. Perhaps the most striking instance of the latter endeavour is seen in former president Thabo Mbeki's stance on AIDS, which was inextricably linked to his ambition to transform the racist discourse of colonialism and apartheid in an effort to elevate the status of Africa and Africans in the eyes of the world.

Political discourse has been pervasive in the discourse of AIDS: it has been used ambiguously, illogically and destructively, yet it has also been invoked to energise and inspire. In the final analysis, however, it is my view that the overall effect of the displacement of AIDS into the discourse of the anti-apartheid struggle has been counterproductive to the cause of AIDS. AIDS discourse in South Africa has been characterised by 'conflict, ideological strife and value shifts' (Fourie 2006: 175), against a background of immense socio-political change. The discourse of the struggle, its rhetoric and iconography, carry so much power, and have been so passionately evoked, that, in most of the texts considered, they have had the effect of relegating to a subordinate zone the reality of AIDS, displacing it both as an epidemic, and also as a factor in the lives of those affected.

Chapter 3: Satirising AIDS

Humor in times of insanity is what keeps us sane. It is also what keeps us free. There is nothing that tyrants and rascals fear more than satire and ridicule.
(Jerry Robinson)¹

In this chapter I analyse a selection of AIDS-related satirical texts, considering the extent to which the use of satire contributes to the displacement of AIDS. Like all satire, AIDS-related satire is a discourse of power and attack, criticising and mocking aspects of the discursive context in which it is rooted. Most AIDS-related satire in South Africa works at undermining those in positions of power and exposing the negative consequences of their decisions. The main targets are politicians, the authors and agents of government health policies. But because satire is recognisably a site of resistance to dominant cultural and political discourse, it also is implicated in hegemonic discourse (Connery and Combe 1995: 11) and forms part of it. Many of the AIDS-related issues discussed in Chapter 2, 'Politicising AIDS', recur in the satirical texts under consideration in this chapter.

The use of satire contributes to the displacement of AIDS in different ways. For a start, the element of humour often present in satire functions as a distancing device, a form of displacement. Second, satire is a means of dislodging hegemonic discourse. At its iconoclastic best, satire knocks hegemony off its pedestal, displacing it from the dominant position it holds in society. In the context of AIDS in South Africa, a great deal of satire comprises scapegoatism, whereby politicians and influential others are blamed for the huge proportions the epidemic has assumed. This constitutes another form of displacement. Finally, displacement occurs in the transformation and transposition of the genre of the original texts (the ones being satirised) into the genre of the particular satirical form, as, for example, when a serious political statement is transmuted into a dramatised parody or a graphic cartoon. Satire finds expression in – and is displaced into – a wide range of modalities: as Pollard remarks, 'the variety of satire is almost infinite' (1970: 2). Thus satire

¹ (Robinson 1981: 6.)

can be seen as a 'transgressive literary form; a genre constituted – paradoxically – by its transgression against genre' (Connery and Combe 1995: 11).

However, satire can also be seen to work against displacement. It often adopts an immersive approach, confronting the reader with uncomfortable or shocking truths about AIDS that are usually avoided or kept hidden. Pollard asserts that 'one function of satire is to confront us with a thing and to say 'It is not what it seems. Look!' (1970: 19). Seidel comments that 'satire ... compromises gestures of polite civilizing that cover over dirty notions' and brings 'violations to the surface' (1979: 17). He quotes Girard's view that 'if history is the encoding of violence, satire is the decoding of violence' (Seidel 1979: 21). The word 'encoding' suggests calculated secrecy on the part of those in power, whereas satire's 'decoding' suggests revelation of the truth. In this way satire can effectively reverse the displacement of AIDS and its victims in AIDS-related discourse.

While the satirical texts discussed in this chapter are very context-specific, being localised in contemporary South Africa, they share qualities and participate in satirical conventions that have been in existence for centuries, satire being a literary tradition which goes back to classical antiquity. Defining satire is not a simple matter, however, and there has been disagreement over its key characteristics. According to Dryden, 'satire is a kind of poetry ... invented for the purging of our minds; in which humane vices, ignorance, and errors, and all things besides ... are severely reprehended' (1974: 77). In the *Dictionary*, Dr Johnson defined satire as 'a poem in which wickedness or folly is censured' (Pollard 1970: 1). Abrams (1981) defines satire as the 'literary art of diminishing a subject and making it ridiculous by evoking attitudes of amusement, contempt, indignation or scorn', and its purpose, according to Abrams, is to be a 'corrective of human vice and folly'. The target of ridicule may be 'an individual, a type of person, an institution, a nation, or even the whole race of man' (1981: 167-70). A more recent source defines satire as 'literature which examines vice and folly and makes them appear ridiculous or contemptible', and which 'differs from the comic in having a purpose: it is directed against a person or a type, and it is usually morally censorious' (Gray 1992: 255). While there is a great deal of agreement in these definitions, not all critics concur that the targets of satire are 'human *vice* as well as folly', or that it has a moral purpose. W.H. Auden believes that it is inappropriate to satirise serious vice or evil because this trivialises it. He states that 'any person who causes serious

suffering to the innocent ... [should be] the object, not of satire, but of prophetic denunciation'. Auden gives the example – uncannily pertinent to the AIDS-situation in South Africa – of 'a black marketeer in penicillin [who] is not satirizable because those who need it are innocent and, if they cannot pay his prices, die' (1952: 202). This kind of evil, he believes, is too serious for satire.

Northrop Frye regards satire as 'militant irony' and believes that two things are essential to satire: 'one is wit or humor founded on fantasy or a sense of the grotesque or absurd, the other is an object of attack' (Frye 1957: 224). The dual ingredients of humour and attack stipulated by Frye as essential to satire, vary in relative strength: some satires are more humorous than angry; and vice versa. In some satires, the kind of humour which 'evokes amusement' is absent, and is seen only in the element of the grotesque, which may evoke revulsion or disgust rather than laughter. Or, the humour is so dark or bitter that it produces only a grunt of recognition, or a thoughtful nod of the head to indicate that the message has been understood. Feelings of discomfort often accompany this understanding, as an unsettling truth is brought home. Connery and Combe comment that 'the one thing we know about satire is that it promises to tell us what we do not want to know – what we may, in fact, resist knowing' (1995: 1). Satire can thus counter displacement, because it does not allow us to escape from an uncomfortable subject to one that is more socially acceptable. Patricia Spacks observes that 'a work that evokes no real uneasiness in the reader is in effect not a satire at all' (1968: 375), a view which Bogel supports when he remarks that satire 'will plunge us into a state of considerable unease, but ... that is where we must be if we are to read satire in meaningful ways' (1995: 52).

The 'attack' dimension of satire is directed at something that is wrong in society, since 'satire is born of the instinct to protest; it is protest become art' (Pollard 1970: 7); but Abrams's and Gray's view that there is deliberate didactic intent on the part of the satirist who has a moral purpose and aims to 'correct' human vice and folly, is contested. Wyndham Lewis declared that 'the greatest satire is nonmoral', arguing that 'there is no prejudice so inveterate, in even the educated mind, as that which sees in satire a work of edification' (1934: 69). Although he conceded that 'satire can only exist in contrast to something else', he maintained that satire is possible '*for its own sake*' (1934: 71, as an art form without a moral purpose. In support of this view, Petro quotes Philip Pinkus who states that 'satire is

not in the reform business. Its purpose, ultimately is ... to bring awareness' (1982: 19). When satire succeeds in creating awareness, it counters displacement by forcing us to acknowledge unpleasant, suppressed or 'forbidden' subjects. By fostering reflection, satire could, conceivably, encourage social change.

However, even if we assent to views against the intentional didacticism of the satirist, this does not have to mean that moral norms are completely absent in satire. Northrop Frye argues convincingly that 'satire's moral norms are relatively clear: ... it assumes standards against which the grotesque and absurd are measured' (1957: 223). In other words, because the ridiculous or the grotesque are by definition deviations from a norm, implicit in satire are ideal counterparts or models which have normative value, and individuals or events in the satire are judged in relation to these. Pollard observes that 'satire is always acutely conscious of the difference between what things are and what they ought to be' (1970: 3), and that it grows 'out of an idealism at odds with ... society' (1970: 34). Implicit models or norms are inferred by the reader, who intuitively supplies or realises what is not directly preached or stated by the satirist. Yet the subtle presence of the moral norm does not necessarily provide comfort and assurance: Patricia Spacks makes the point that, with satire, 'the reader is left insecure, unanchored; if positive standards have been by implication reasserted, they have been shown as seriously threatened by reality' (1968: 364).

These are some of the theoretical questions which arise when considering the nature, purpose and effects of satire, but they can be more fruitfully explored when applied to actual satirical texts, rather than discussed in the abstract. Each text demonstrates individual characteristics, so it is not helpful to generalise. In the discussion which follows, I consider the AIDS-related satire of Pieter-Dirk Uys; a sample of the writing of columnist David Bullard; a particular work of prose fiction entitled 'Thabo's Tongue'; and the work of the political cartoonist Jonathan Shapiro.

The satirist, actor and writer Pieter-Dirk Uys has used satire to attack follies and injustices in South Africa long before the advent of AIDS. Remarking that 'fighting fear and political madness with humour has been my way of life since the 1970s' (2002: 6), he explains how humour facilitates his purpose: while acknowledging that 'apartheid wasn't

funny', laughing at fear has become his 'secret cure' (2002: 1). When he parodied P.W. Botha on stage, people laughed, and '... when we realised that we were laughing at absolute power and were getting away with it, it made us feel stronger' (2002: 4). For Uys, humour has the effect of reducing the power differential between government and people: when the President was made the subject of ridicule, his power appeared to diminish, and the audience's sense of empowerment grew. This illustrates a point already made, that texts – in this case, a satirical performance – can function as a site of resistance to hegemonic discourse, while at the same time becoming part of that discourse.

Uys's position in South African society is interestingly complex: he stands both within and outside the establishment, as a gay white male with an Afrikaans background. Politically, he would have been expected to support the conservative Nationalist government when it was in power, but he adopted an anti-apartheid stance instead, which was all the more striking and effective because he is white and Afrikaans-speaking. This earned him credibility and respect from the new democratic government. After 1994 and the demise of the old government, Uys turned his attention to the AIDS epidemic, commenting that 'the minefield has moved: from politics to sex' (2002: 3). This statement needs qualification: Uys's AIDS-related satirical targets do not exclude politics. Again he has adopted an anti-establishment stance. His objectives have been two-fold: to educate the youth in AIDS-prevention strategies, and to criticise the government for its AIDS policies. With regard to his first objective, sex-education, he remarked: 'The whole scenario begs for laughter. Firstly, leave the virus out of it. Just look at sex. If politics is funny, sex can be a scream!' (2002: 3). When he embarked on his campaign to teach young people to practise safe sex, he took full advantage of the comic potential of sexual behaviour to deflect the fear and embarrassment usually attached to sex, especially for children and teenagers. For example, he talked to one school audience about a teacher he had as a schoolboy, who told them that she was going to give them a lesson about the 'birds and the bees':

' "The birds and the bees" '? I shrugged. 'I've never worked that out. How does a bird fuck a bee?'

Fuck! The word was out! I'd passed the test to join the gang! Not a new word by any means, but certainly the last one they'd expected today! It suddenly made us the same age and we spoke the same taal² (2002: 145).

Uys's deliberate use of words generally regarded as taboo in school settings creates a shock effect which produces laughter, dispelling the awkwardness surrounding sex, demystifying it and facilitating ease of communication. At the same time, his satirical treatment of the teacher's coy use of old-fashioned sexual discourse – 'the birds and the bees' – makes it clear that he rejects indirect, euphemistic language to discuss sex and believes that such vague, sentimental terms are unhelpful, stupid and misleading. In a similar way, his blatant use of props such as dildoes of various colours and sizes provokes shock and laughter while they provide the very necessary practical means of demonstrating how condoms should be put on.

On the one hand, Uys's approach is immersive, in that he confronts the subjects of sex and AIDS directly, but to the extent that he uses humour and ridicule – distancing devices – in his presentation, he adopts counter-immersive tactics. The humour creates a zone of relaxation in which the tensions and guilt attendant on sexual matters are dissipated. Also, his assumption of various personas (such as 'Evita Bezuidenhout')³ while he does his presentations is a clear example of displacement: his self-transformation into different identities enables him to speak from perspectives other than his own, giving him the freedom to express conflicting opinions. Clark's general observation about this satirical technique is very pertinent to Uys: 'The satirist loves this ploy: he dons his masks ... with the deliberate dash and excess of the parodist, taunter, ventriloquist and clown ... [in order] to wreak havoc, to electrify the enlightened citizenry, and to short circuit the system'. He adds that 'satire over the ages has regularly tended to turn fictional and to create "voices" that are, among other things, self-exposing' (1995: 22). This describes Uys's method exactly: through 'Evita Bezuidenhout' and other personas, he expresses views that he is intent on

² 'Taal' is Afrikaans for 'language'.

³ 'Evita Bezuidenhout' is one of the characters Pieter-Dirk Uys – dressed in drag – assumes. 'She' is a middle-aged, yet fairly glamorous figure, who holds the position of 'First Lady' of 'Bapetikosweti', a fictional 'homeland' in South Africa, and is outspoken in her views on the sociopolitical situation in South Africa.

discrediting and demolishing. He displaces his own views and replaces these with 'hers', which then stand out and are revealed as crudely racist and self-serving.

As an example of Uys's second objective – criticising the government for its AIDS policies – he wrote an open letter to President Thabo Mbeki in February 2002, which was also published in the *Sunday Independent* and the *Cape Times*. He signed the letter 'Evita Bezuidenhout'.

Thabo, skat⁴, not everyone regards you as a pretentious, arrogant, paranoid, heartless, ruthless Stalinist! My son Izan, who is in jail with AWB⁵ leader Eugene Terreblanche, says you are his hero. In fact, the whole Afrikaner Resistance Movement is inspired by your brilliant leadership. Izan says that thanks to you, Afrikaners will soon rule South Africa again.

I did point out that we have a very large black majority in government, but Izan just laughed.

'Mama, not for long!' he said, and explained. Because there is so much official confusion about what causes AIDS, black men refuse to wear condoms to protect themselves against HIV. So they infect the black women, who then infect their black children. And because they are refused anti-retroviral drugs on a national level, they will all die!

AIDS will succeed where apartheid failed.

Izan says soon there will be so few healthy blacks left in South Africa, that he looks forward to a democratically elected white majority government, with Terreblanche as president!

So don't feel too bad. I know many citizens of our rainbow nation are wondering how long they can support a party whose leadership persists in condemning their children to death. But not all South Africans feel like that.

The AWB loves you!

Evita Bezuidenhout (Uys 2002: 220-1).

Adopting an ironically cheerful, amiable tone, Uys uses the 'Evita' persona to 'praise' the stance of the former President for effectively wiping out the black population and so enabling the white supremacists to regain power. He cleverly targets Mbeki's well-known

⁴ 'Skat' is Afrikaans for 'treasure', a term of endearment.

⁵ 'AWB' stands for 'Afrikaner Weerstandbeweging' (Afrikaans for 'Afrikaner Resistance Movement'), an all-white, right-wing political group led by the late Eugene Terreblanche at the time.

racial sensitivities to suggest – with piercing irony – that he (Mbeki) is an ally of the AWB and is helping them to realise their racist political ideals of eliminating black people from the South African population. The naive attitude he falsely assumes – an ironical pretence of agreement – is diametrically opposed to his true feelings and values.

Uys's use of comic irony in this instance prompts us to question its appropriacy in a matter so serious: we recall W.H. Auden's criticism of satire that 'trivialises' serious vice or evil. Yet the light tone of mock admiration assumed by Uys in the letter quoted above does not weaken his point; it makes it more powerful than if he had solemnly made Mbeki the object of what Auden calls 'prophetic denunciation' (1952: 202). Regarding the balance between attack and humour in satire, Uys says that his 'sacred recipe' is '49 per cent anger vs 51 percent entertainment' (2002: 186). The 'entertainment' component is a means to an end: his underlying purpose is deadly serious. Uys himself acknowledges the danger of making too light of AIDS-related problems:

I become more aware of the horrors of experience. The countless incidents of daily rape that never see the light of knowledge and yet fester inside like a cancer. I realise how dangerous this is, how easily one can trivialise pain with flippancy, or forget that victims are good at disguising their fears. Never underestimate the fact that everything you talk about can happen to anyone. And that those who have been raped need to embrace life after rape. Like those with HIV and AIDS have to be encouraged to believe in life, and not just early death (2002: 162).

The seriousness of his purpose is very clear:

Good demands everything, and every time a child sees something good in what's being done, the challenge to extend that good is inevitable. This is the ultimate fix. The final addiction. If we can keep these thousands of young people alive, the children of our democracy, we will have the greatest generation the world has ever seen! Keep them alive tonight! For tomorrow! (2002: 163).

The comic approach of Uys belies his earnestness and passion: any doubt about this is quelled by the fact that he visited hundreds of schools to give his AIDS-awareness presentation without charging anything for his services. He may adopt what seems to be a detached, flippant attitude, but there is nothing frivolous or trivial about the dedication and deep commitment evident in his AIDS-education initiatives, designed to influence his audience and so bring about change.

David Bullard, an ex-*Sunday Times* journalist, has also satirised Thabo Mbeki's stance on AIDS, and particularly the acute racial sensitivity Mbeki has shown when he attributes comments and questions about the seriousness of the AIDS epidemic to racism (a point discussed in Chapter 2). The particular incident referred to in Bullard's column, which is worth quoting at length (below), is Mbeki's angry response to a question he was asked in Parliament about AIDS:

Everyone knows that the President doesn't like talking about Aids [sic] and so it's insensitive to even mention the topic in his company Anyway, instead of giving a simple answer to the question, the President made a very moving speech in which he accused white people of thinking that all black people are lazy, liars, diseased, foul-smelling, corrupt, violent, sexually depraved and savage. Thankfully he stopped short of suggesting that we also thought their driving skills fell a bit short of acceptable standards....

Predictably, many of my fellow columnists fell upon the President, wilfully misinterpreting his oration as a sign that he might be a sandwich or two short of a picnic. Nothing could be further from the truth.

Racism, like mineral wealth, is one of South Africa's greatest natural resources and without it the ANC [African National Congress] would not be where it is today.

After ten years of ANC government the nation's racism reserves are running perilously low and there is a very real danger that we may become just another thriving, tolerant democracy with a booming economy. The terms 'struggle' and 'previously disadvantaged' could become redundant and we might easily be mistaken for boring places like Canada and Australia.

Considering our turbulent history, that would be a tragedy. President Mbeki knows this and sees it as his duty to keep racism alive and well in South Africa. In fact, the ANC almost certainly has a secret policy unit tasked with monitoring inter-racial relations. When it seems as though we are getting along famously with one another it is this unit's job to present divisive strategies to the President in order to whip up a bit of instant racial hatred. The problem is that it's getting more and more difficult to think of something with wide-spread appeal (*Sunday Times*, 14 November 2004).

Using highly polished, ironic wit, Bullard suggests that Mbeki seizes on the topic of AIDS because it has sufficiently broad 'appeal' to serve the purpose of inciting racism, claiming (tongue-in-cheek) that racism is good for the country and that this is a strategy deliberately used by Mbeki and the ruling party to maintain unity in its own ranks. Whether

or not one agrees with Bullard's view, the incident referred to in the above text clearly exemplifies the way AIDS is displaced into the discourse of politics and racism. Bullard criticises Mbeki for deflecting attention away from the issue of AIDS by accusing his questioner of racism, but then Bullard's ironisation of Mbeki's reaction politicises the original issue still further, adding yet another stage of displacement to the issue of AIDS. Pretending to admire and find Mbeki's response 'moving', when he clearly regards it as ridiculous and agrees with other journalists that it shows Mbeki to be lacking in reason ('a sandwich or two short of a picnic'), Bullard's real purpose is not to comment on AIDS but to attack the government for what he sees as its policy of raking up old racial divisions for its own political advantage. However, unlike Pieter-Dirk Uys, whose previous reputation as an anti-apartheid activist had earned him the respect of the post-apartheid government, David Bullard operates from an anti-establishment position and is clearly aligned with an 'old, white' point of view. This compromises the validity of his criticism of Mbeki's evasive tactics, since his viewpoint could be seen to be just as racist and politically opportunistic as he claims Mbeki to be. It is not surprising, therefore, that he was subsequently fired from the *Sunday Times* for expressing views – in a later column – that were seen as racist to a degree that was deemed unacceptable.

In completely different mood and mode, the short story 'Thabo's Tongue', by J. J. Eli in the collection *Nobody ever said AIDS: Stories and Poems from Southern Africa* (2004: 180-2), is an AIDS-related allegory which uses the genre of prose fiction for its satire. It also satirises the way the AIDS epidemic in South Africa has been handled politically, but without the element of comedy so characteristic of Uys. However, this bleak story still qualifies as satire because it draws attention to what is wrong in a particular society, attacks folly and wilful blindness, and includes a strong element of the grotesque. Although the writer's satirical diagnosis of the South African AIDS-situation points to a serious pathology in the society he describes, this pathology is not represented as residing in AIDS but in the ruler, whose poor judgement, callousness and stubbornness are shown to be the real source of sickness in society. The emphasis of the story is thus displaced from AIDS as a real disease affecting the general population to a symbolic disease of the king which brings the whole country to ruin. The 'Thabo' in the title 'Thabo's Tongue' connects the main protagonist to

Thabo Mbeki, although his name is mentioned only once, in the story's title. In the story itself, this protagonist is nameless, referred to only as 'the King'.

Once, a short while ago, time gave birth to a mighty King. It is reported that the heavens split and the sun turned amber at the moment of his birth.

The people had waited almost three generations for this sign — the indication of the beginning of a new time. Those who witnessed the birth passed the bleeding infant from one to another and marvelled at the swollen Emperor's mark, so clearly visible on the body of the child (2004: 180).

The story is told in the style of a folktale which gives the narrative a legendary quality, displacing it and making it seem remote from contemporary South Africa. The story tells of the birth of the new leader, marked with the sign of the 'Emperor', but in spite of this, and the cosmic events which accompany his birth and create heroic expectations, he fails to rise to the first great challenge of his reign: a destructive Beast, threatening the safety, happiness and prosperity of the nation.

Then time delivered tales of terrible magnitude, spreading north, east, west, south. Like hardy desert weeds the tales blossomed, tentacles of uncertainty and discomfort stretching, on and on just below the soil surface. The King noticed his people stalling, weakened by fear. The entire land was infected. Life and happiness were stolen from the once-busy streets. The people spoke amongst themselves, telling tales of a Beast so violent, an animal so vigorous, that no one was safe (2004: 180).

On the secondary level of signification this supernatural 'Beast', of course, represents the epidemic of AIDS. The King responds with fear to this threat, and the course of action he takes arises out of his fear. At first, his action sounds sensible and constructive: 'the King and his advisors worked day and night to educate the people. He travelled, performed, trained and argued ... he taught them not to fear'. The words 'educate' and 'trained' carry positive connotations which accord with the impression already given that the king is an intelligent and enlightened ruler. However, this impression is subverted by the reason the King gives for his educational campaign: 'He taught them not to fear, *as there could be no*

animal, no beast, who had more power than the king himself (2004: 180, my emphasis).

This statement provides an ominous hint that the King is arrogant and egotistical, qualities which will stop him from dealing effectively with the 'Beast' that threatens the nation. His self-reflexive frame of reference betrays narcissism. His advice to his people: 'Be quiet, there is no such thing: we have other important matters. No more talk of this', is an obviously inappropriate response, rendering ironic the earlier reference to his 'wisdom' as a ruler. Instead of confronting and discussing the problem, he resorts to denial. The people take their cue from the King:

Sufferers and mourners were shamed into silence. Stories about deaths at the hands of the Beast were repressed. Many cried silently for their land, their dead children, and their lost parents. Each prayed to their god to end the suffering. Pain became private. The people closed their ears to all tales of the Beast. And the streets lit up, lived again, as people loved, fornicated and invested in the future (2004: 181).

Like their leader, the people become silent, 'repress' their stories about the depredations of 'the Beast' and resume normal life. The words 'the streets lit up' at first create a sense of vitality and suggest a dynamic, vibrant society, but they also carry connotations of the garish, artificial brightness of neon lights, sleazy night life, prostitution and promiscuity. These suggestions are made explicit in the choice of the verb 'fornicated' from biblical discourse, suggesting immoderate sexual practices, but with morally pejorative connotations. That this potentially lethal behaviour is described as 'investing in the future' takes on heavily ironic meaning since the consequences of such behaviour will be illness and death, effectively stunting the future of the nation as a whole. Paradoxically, suppressing the 'Beast' promotes its growth and power.

In the second phase of the story, the King begins to experience physical symptoms which seem to presage illness, but instead of the onset of a normal disease, the King begins to manifest bizarre symptoms which are clearly symbolic rather than real: his tongue begins to grow abnormally and rot in his mouth. The King's earlier failure to use his tongue wisely to speak out about the reality of the Beast and to communicate with his people, made it useless and redundant, and this, presumably, is why it has begun to putrefy. His denialism increased the Beast's power to destroy. Hence the specificity of his symptoms.

The King dies alone in the 'dense thicket around his fortress' and the narrator confirms that his death has indeed been a form of revenge inflicted by the Beast who has 'taken particular pride in proving to the King that he was real, punishing the King for denying his superior strength'. The link between the King's denialism and the horrible death he suffers is thus made explicit. Hideous and grotesque in death, the King's body shows that his tongue was so enlarged that it blocked his sight, 'making it impossible for him to even see' and so defend himself against the enemy that finally killed him. The swollen tongue also 'obstructed' his voice, making his prolonged screaming inaudible to the soldiers who would have defended him had they been able to hear the sounds of his agony. The implication is that the King's self-involvement both blinded him and made him mute. Had he been less selfishly concerned with his own power and more concerned with the welfare of his people, he would have recognised the danger and spoken out against it. This representation recalls Foucault's observation that 'undesirable physical and moral behaviour was seen to have been shaped by ... the government of the day, so ... the struggle against disease must begin with a war against bad government' (1973: 33). The epidemic is firmly blamed on the King for its origin and spread: AIDS is displaced through scapegoating, when the ruler is made completely responsible for the epidemic.

The soldiers' reaction when they discover his body is to run away, burning surrounding land as they flee, thus effecting a 'scorched earth' policy. Both the King and his land are destroyed as a logical consequence of his policy of denial. However, any comforting hope that a lesson has been learned and a better, more open cycle of governance could grow out of the ashes of the old regime is quashed as we are told that the soldiers 'agree that it would be better to tell no one what they had seen'. Denial and silence will continue, perpetuating the ignorance and stigma in which the epidemic thrives.

The strong element of the grotesque which links 'Thabo's Tongue' unmistakably to the satiric tradition, points to the moral norm. By representing what is under attack (the king's tongue, and by extension, the power of speech which he neglected to use and which he stifled in his people) in an exaggerated, repulsive way, the writer suggests to the reader what the unspoken norm should be: the proper use of the tongue, representing good governance and freedom of speech. If the king had spoken out about the Beast, as would have befitted an enlightened ruler, neither he nor his country would have suffered. Instead,

the king's abuse or neglect of his organ of speech, signified by its abnormal growth and putrefaction, leads to catastrophic results. This illustrates Frye's principle, mentioned above, that the moral norm – although not spelt out – is embedded in satire. 'Thabo's Tongue' also exemplifies Frye's view that satire is 'a combination of fantasy and morality' (1957: 310).

The techniques of displacement evident in 'Thabo's Tongue' include the absence of the term 'AIDS', which is evoked only metaphorically through the vehicle of the 'Beast', making it necessary for the reader to infer what the Beast signifies. Also, the fable or folktale quality of the story makes the narrative seem remote, displacing it from what we would immediately recognise as 'real life' South Africa. Distance, defamiliarisation and the choice of an obviously artificial literary convention contribute to the effect of displacement.

The use of the allegorical genre as a vehicle for the satire is also a form of displacement since an allegory tells a story which, like metaphor, says one thing and means another. Ricoeur quotes Fontanier's view of allegory as an 'extended metaphor' which 'presents one thought in the image of another that is better suited to making it more tangible or more striking than if it were presented directly and without any sort of disguise'; and as 'a proposition with a double meaning, having a literal and spiritual meaning together' (Ricoeur 1977: 68). Press observes that an allegory 'is always false on the surface', an 'exaggeration' or 'misrepresentation' to 'get at an underlying truth – one more true than the facts themselves' (1981: 19). The protagonists in 'Thabo's Tongue' are all 'false' or 'disguised' to a lesser or greater extent: their real meaning exists on the secondary level of signification (symbolic, or what Fontanier calls 'spiritual' meaning), displaced and at a remove from their literal status in the text.

It is possible that there are intertextual links between this short story and many African tales and legends about strange beasts, half-ape, half-human, that are sexual predators and represent the darker side of humanity. These mythical creatures live in shadows and are nocturnal. One such version of this legend is the Afrikaans verse epic 'Raka' (1941) by the South African poet N. P. van Wyk Louw which tells the story of an African tribe that is initially contented with its way of life before a creature called 'Raka' emerges from the bush and disrupts its equilibrium. The chief, Koki, recognises the threat it poses to the life of the tribe and sets out to kill the beast, but Raka kills him instead. Raka is

then free to take over the leadership of the tribe and the suggestion at the end of the poem is that this will eventually destroy them. There are many possible interpretations of the poem's significance, but it dramatises what seems to be the conflict between mankind's most basic, primal urges and its higher, more intellectual faculties, and suggests the triumph of brutality. It could also symbolise the perceived dangers of colonialism or Afrikaner nationalism. Another legend, prevalent among Sesotho-speaking people, is that of Kholumolumo, a huge, dragon-like monster that devours people and livestock. It has a gigantic tongue, and this eventually strangles and kills the creature. In discussion of the metaphorical significance of the monster, it is suggested that it could represent Western civilisation, or AIDS (Krog 2009: 174-7). There are parallels between these stories and 'Thabo's Tongue', and although I have no evidence that the writer of 'Thabo's Tongue' was consciously using the narrative framework or content of such legends, it seems probable that intertextual links exist.⁶ If this is indeed so, it would constitute another form of displacement in 'Thabo's Tongue', since the writer would be using a pre-existing discourse on which to project his understanding and representation of the current AIDS epidemic.

The element of fantasy in 'Thabo's Tongue', seen in the aberrant growth of the protagonist's tongue, is another technique of displacement, an example of what Frye terms a 'violent dislocation in the customary logic of narrative' (1957: 310). The writer's creation of an impossible, unnatural scenario distances us from the situation and issues he is addressing. It is difficult to relate to what is grotesque: our response to the grossness of the protagonist's tongue which transforms him into a monster, is one of horror and alienation. We cannot identify, or feel sympathy with him. These alienating and displacement devices succeed in highlighting the issues, enabling the reader to see the king's folly or vice more clearly and to recognise the causal link between his style of rule and the destruction of his kingdom. The decay of the king's tongue becomes a symbol of government corruption which is directly responsible for turning the country into a wasteland. However, the unpleasantness of the story could alienate readers in a way that makes them unreceptive and unresponsive to its moral message, so that the text's purpose could be defeated. As

⁶ In *HIV/AIDS Care and Counselling: A Multidisciplinary Approach* (2001) Alta van Dyk uses extracts from 'Raka' as epigraphs at the beginning of each chapter, explaining in her Introduction that she sees 'Raka' as an 'appropriate metaphor' for AIDS because it 'warns that beasts of unknown origin may at any time attack and destroy our culture, our integrity, our hopes, our community and our very lives' (2001: iv).

already mentioned, Bogel regards a reaction of 'considerable unease' to satire as a necessary one, but it is possible that reactions to 'Thabo's Tongue' could go beyond a level that is desirable, causing readers to turn away from it in disgust, and reject its message.

It is significant that the victims of the 'Beast', who correspond to the AIDS-ill, are not constructed as recognisably 'ill', but rather as injured:

People from far and wide were brought before [the king] to bear tortured testimony to their encounters with the Beast. Some poor persons were ordered before the royal entourage, the deep scars inflicted by the beast evident in the display of their naked bodies (2004: 180).

These 'scars' evoke the idea of wounds inflicted externally rather than the symptoms of disease. This suggests that the people are suffering from injury by an external agent (indirectly, the ruler or king) rather than illness or an internal pathogen. There are only two other references to the victims in the story, and these are oblique: 'Many cried silently for their land, their dead children, and their lost parents'; and: 'more and more bodies were carried to the holy places to be buried' (2004: 181). The focus of the narrative is more sharply on the king than the people who are the victims of his denialism and inaction, and more on his graphically described symptoms than their illness, which is not even described in terms of disease. The discourse of pathology is thus displaced from AIDS and its victims to the king (or Thabo Mbeki): he is pathologised as the real source of the plague that afflicts and destroys the country.

A form of satire which falls into a completely different genre from the texts considered thus far – dramatic performance and satirical prose – is the political cartoon, which has distinctive characteristics of its own. When transposing abstract political issues into graphic form – a technique of displacement – a skilled cartoonist distils complicated concepts into visual images which can be appreciated almost immediately. Structural brevity is the defining feature of this genre. A single cartoon can make a point with more impact than extended writing because of its simplified visual form, and is memorable in a way that written texts are not. Theoretically, pictorial representations such as cartoons, being largely non-linguistic, should reach a wider audience than written texts because they do not rely on skills of literacy, but many of the cartoons examined in this chapter are sophisticated and assume the reader's familiarity with images and scenarios that may not be recognised by

everyone. The remark by Stanley Fish, that ‘the validity of any reading ... will always depend on the assumptions ... that he or she happens to share with other members of a particular interpretive community’ (1980: 58) is pertinent here. It takes a certain kind of reader – one with the relevant schemata – to ‘release’ the message the cartoonist intended to communicate. As discussed in Chapter 1, in Reader-Response Theory, the reader is not passive but plays an active role in constructing meaning. How a text is interpreted depends on what the reader brings to it. In his case study of AIDS and political cartoons, David Wigston (2002) cautions against assuming that cartoons are easily understood, commenting that ‘aberrant decoding’ can take place between those who create the message and the recipients owing to differences in educational level, insight, and cultural background. In a small experiment he conducted among postgraduate students studying Communication Science, he found a wide range of interpretations of a particular cartoon’s message, and some serious misinterpretations (2002: 92).

Definitions of the political cartoon vary: the British cartoonist Nicholas Garland describes it as ‘a small space in which the news can be simplified, compacted and encapsulated, in a form which is comic or melodramatic or frivolous’ (Harvey 1997: 39). The ‘perfect cartoon’, according to Trostle, is ‘humorous, the drawing well-executed, the message valid, the symbolism clear but not yet a cliché’ (Trostle 2004: 5). As with the definitions of satire, not everyone agrees that humour is an essential quality of the cartoon. Bryant, another British cartoonist, believes firmly in the seriousness of the political cartoonist’s purpose and questions whether the term ‘cartoon’ should even be used, since it implies something ‘inconsequential and lightweight’. Arguing against the latter description, he believes that to see cartoons in this way would be ‘grossly unfair to cartoonists in general, but doubly so to the political cartoonist’ (1997: 60). From his own personal experience as a political cartoonist, he observes that:

... to survive ... in this immensely stressful profession, the political cartoonist has to sit down each day with a blank sheet of paper, absorb every aspect of the day’s news, produce anything up to six roughs by mid-morning and then create a cartoon which is topical, well drawn, features recognisable caricatures of leading celebrities, is in some indefinable but powerful sense ‘telling’, and also, if possible, is spiced (but not necessarily so) with some large grains of wry humour. But the most important thing is always the message – without that it fails completely The political cartoonist is not by definition making a joke out of

everything he draws. What he is doing is making a comment; sometimes it is ironical, satirical, witty, mocking. But at other times it is simply ghastly, and the message cannot be communicated in any other way (Bryant 1997: 61-2).

Bryant believes that 'the role of the political cartoon is of immense importance in a democracy and in order to fulfil this function humour may often have to be discarded in the interests of Truth' (1997: 63). Whatever 'Truth' may be is contestable, but it remains a valid point that political cartoons often confront unpleasant subjects, sometimes sacrificing the comic element to do so, and in this way counter displacement.

Jerry Robinson describes cartoons in this way:

Editorial cartoons at their best ... are an oasis of emotion in a newsprint desert of dispassionate verbiage and objective reporting. They are unabashed personal opinions, a free indulgence of exaggerations and prejudice, an irreverent questioning of motives, and often fiercely partisan. Cartoonists are functioning subversives, waging war on the powerful, the exploiters, and the privileged. In the tradition of Tom Paine, cartoons of political satire are the revolutionary essays of our time (1981: 7).

Charles Press believes that political cartoonists save readers 'time and effort', by 'making some kind of sense for citizens out of what those who run the government are up to'. Arguing that it is not just information that people want, because 'all of us get more information that we can absorb: [and] what we yearn for is interpreters', he sees political cartoonists as 'intermediaries' between public officials and the public. People trust cartoonists to offer comment, judgments and interpretation of governmental action, helping them to decide if 'the system is legitimate and deserving of loyalty or not' (1981: 50-1). Press asserts that the cartoonist 'tries to influence the viewer to a particular viewpoint and predispose him to a particular action' (1981: 13). If we accept this opinion, cartoonists could perform a serious function in public discourse, fulfilling an important role as 'opinion formers' and the shapers of action. In Press's view, the political cartoon is '*critical comment aimed at the fairly bright*, that group of society which ... manages most of society's affairs' (1981: 49, his emphasis). Although such readership is limited, Press suggests that it is an empowered minority, raising the likelihood that they could bring about change. However, it would impossible to determine reliably whether this form of satire leads to action, and by

whom. Wigston makes the valid point that ‘to establish the role played by political cartoons in changing or influencing opinions regarding AIDS one would need to combine a content analysis of cartoons together with evidence of opinion change over a period of time in a sample drawn from the public identified as regular readers of the newspapers concerned. Even so, such research would be hampered by the vast number of variables that could influence attitude change within respondents’ (2002: 93).

In South Africa, Jonathan Shapiro (aka ‘Zapiro’) is a highly successful cartoonist who has been well recognised for his work as an important political commentator.⁷ It would be a mistake to be misled by the term ‘cartoon’ into thinking that Shapiro’s art is ‘inconsequential and lightweight’: his substantial *oeuvre* amply demonstrates how skilfully he captures and presents complex issues of the day through powerful images that clearly communicate serious concerns, of which AIDS is one. His work acts as a vivid diachronic record of the way AIDS has been perceived and managed – or mismanaged – in South Africa. The examples I have selected of his cartoons on the subject of AIDS are in chronological order.

⁷ Zapiro won an honorary award in August 2005 (*Sunday Times*, 28 August 2005) and in 2006 was named ‘Journalist of the Year’. In 2009 he won the Media Institute of South Africa’s Press Freedom Award. He also received his second Vodacom Cartoonist of the Year Award, and his sixth Mondi Shanduka Newspaper Award for Graphic Journalism.



(Shapiro 1999: 158)

This cartoon⁸ depicts the fact that, at the end of the twentieth century, AIDS has become the biggest cause of death in Africa. There is nothing remotely humorous about this message which is presented in a way that provokes repulsion and fear and which Bryant would describe as 'simply ghastly' (1997: 62). Shapiro makes use of the ancient iconography of the Grim Reaper and its scythe to personify death and its different causes in Africa, illustrating cartoonists' practice of using existing imagery which is so well known that it can 'provide a framework on which to hang other meanings ... in an attempt to establish some visual common ground' (Bell 1997: 34). The symbol of the Grim Reaper would be 'well known' to educated readers because it has a long history and is frequently seen in medieval representations of the plague, but it may not have such resonance for the less educated or those with different cultural backgrounds. However, the skeletal figures are powerful visual indicators and would probably still be recognised as symbols of death even without awareness of their historical and cultural associations.

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The metaphorisation of AIDS as the Grim Reaper, symbol of death, is a form of displacement in itself, but it also constitutes displacement in that it links AIDS to the past, and to major outbreaks of disease that occurred in Europe throughout the centuries, projecting it onto a much larger, older landscape. The displacement that results from this intertextual reference could have the effect of making AIDS seem remote, but it could also make it seem more serious and important as it gathers to itself these powerful historical associations.

The irony in the text is very clear: AIDS is represented in positive terms as a 'winner', shown holding up the symbolic scythe in celebration of its victory over War (pictured as gripping a gun), and Malaria (with a mosquito on its shoulder). To represent a profoundly negative situation as though it is a positive one, and to substitute grotesque Grim Reaper figures for the fit, healthy athletes we would expect to see in this scenario, creates a powerful sense of incongruity and heightens the shock effect of the information that AIDS kills more people in Africa than war and malaria. When the message that AIDS is the 'Number One' killer in Africa is acclaimed as though it is a wonderful triumph, it has far more impact than if it were presented as a neutral statistic. The depiction of Africa in this cartoon – as a hopeless case overrun by disease and mass killings – could be challenged, and Shapiro could be accused of resorting to a biased, worn-out discursive representation in which Africa is regarded as 'a continent of perpetual catastrophe and unnatural disasters' (Watney 1994: 118), a point discussed in Chapter 2, and an image that President Mbeki was intent on overturning. This representation stands in stark contrast to his vision of Africa, the 'African Renaissance', and his pan-Africanist dream of prosperity and progress.

In this cartoon Shapiro effectively foregrounds the power and prevalence of AIDS, of which most people are either unaware, or push to the back of their minds. He places the fact of its mortality rate 'centre-stage', as it were, recovering it from the oblivion usually assigned to such unpleasant facts, and making us uncomfortably aware of the magnitude of the threat to the continent. Importantly, here and in his other cartoons, Shapiro insists on naming AIDS, unlike other texts where the reader has to infer what the subject is. He refuses to compromise in confronting the disease as a reality. Seen in this way, the cartoon exemplifies the immersive approach where we are faced directly with shocking facts about AIDS. On the other hand, the metaphorisation of AIDS as a competitor in a major sports

event held in a stadium – a scenario familiar and accessible to most South Africans because of extensive television coverage of events like the Olympic Games and the 2010 Soccer World Cup⁹ – is a marked form of displacement which could distract and distance the reader from the reality of AIDS. This cartoon can thus be seen as exercising and countering the displacement of AIDS.

Satire usually rests on what Bogel terms the ‘satiric triangle’ (1995: 52), formed by the satirist, reader and satiric object. Reflecting on this concept, it seems that, in the case of this cartoon, the third point of the triangle, the satiric object, is missing, or certainly obscure. As a natural, non-human phenomenon, AIDS cannot in itself be an object of satire, and this raises the question what kind of cartoon this is, and what constitutes its purpose. It seems that it could fall into the category, identified by Press, of the ‘descriptive’ (as opposed to the ‘satiric’) political cartoon, in which, as Press puts it, ‘the cartoonist is saying little more than “this is the way it is”’. Descriptive cartoons serve as ‘the expression of status quo viewpoints’ (1981: 75). The purpose of this type of cartoon is described by Wigston as ‘neatly summing up a complex situation’ rather than being ‘humorous or propagandist’. Cartoons in this category, Wigston contends, do not debunk but ‘simply offer an allegory on a given political or social situation’ (2002: 78). According to this view, in this cartoon Shapiro is simply presenting us with his depiction of the status quo of AIDS in Africa, which is that it is gaining ground and has outstripped other causes of death. However, this sounds too neutral for what Shapiro is doing in this text. His representation is far too striking and forceful to be merely a visual statement of the status quo. It aims to shock readers into an awareness of the power, gravity and scale of the disease. The target of the satire, then, could possibly be the apathy or complacency of all those not affected by AIDS, or who do not take it seriously enough, and therefore need a shocking reminder. Alternatively, the cartoonist could be suggesting that AIDS is a victor only because human behaviour has allowed it to become this. Carelessness, recklessness and denialism are examples of some of the attitudes which have encouraged the rapid spread of the disease. In this instance, the target of the satire could be the attitudes and habits of all the inhabitants of Africa. This makes the message of the cartoon an even more uncomfortable one, as the satiric object is

⁹ The expectations and patriotism engendered by the 2010 Soccer World Cup, reminiscent of the euphoria of the Nelson Mandela era, stand in stark contrast to the representation of South Africa under Thabo Mbeki in this cartoon.

not what Bogel terms the ‘securely “other” ’ (1995: 52), but lies within ourselves. In Bogel’s view, the ‘profound discomfort’ of such realisations has the power to produce ‘the most important difference satire can make: a difference between readers and themselves’ (1995: 52). The complexity of this cartoon results from its challenge to the reader’s intellect, emotions and conscience.



(Shapiro 2000: 27)

In contrast to the previous cartoon, the ‘third point of the triangle’ (Bogel’s ‘satiric object’), is very clear in this cartoon: it is President Mbeki and his Health Minister, the late Manto Tshabalala-Msimang. However, full understanding of the satire in this cartoon depends on the reader’s schemata and the ability to recognise the intertextual allusion to the Roman Emperor Nero, who is said to have played his fiddle while Rome burned. The legendary episode depicted in this cartoon is supposed to have typified Nero’s style of rule, which is reputed to have been one of selfish indifference to the welfare of his Empire and people, and neglect of his responsibilities as a ruler. By means of the ‘fiddling while Rome burns’ metaphor, these qualities are transferred to the ‘fiddlers’, Thabo Mbeki and Manto Tshabalala-Msimang, who are implicitly accused of being like Nero in their indifference to the ‘fire’ of AIDS, symbolising destruction, evil, hell, and divine wrath. It is significant that

the eyes of both figures are closed, suggesting an attitude of wilful blindness to the problem. The cartoon conveys 'bureaucracy's "deaf ear", its interminable off-putting delays and postponements, [and] its failure to note the dire consequences of its indecisiveness', the state's 'implacable opacity, its refusal to comprehend, and its consequent inability to act responsively to the human suffering that presents itself ...' (Scheper-Hughes 2004: 280). Their particular fault is shown, in this cartoon, to be their negligence in failing to provide AZT medication to prevent mother-to-child-transmission of the HI-virus, an effective treatment that was available at the time.

By metaphorising Mbeki as the figure of the Emperor Nero, South Africa as Rome, and AIDS as a fire, the artist displaces the South African situation into another time and place, in what could be seen as a counter-immersive technique. Shapiro's choice of a scenario such as this is revealing of his own frame of reference and shows that he is targeting an educated audience who share his cultural heritage. Many South Africans may not be familiar with the analogy and would miss its message and meaning. Even those readers who do recognise the analogy may not relate to it as a South African problem, because it is depicted in a way that makes it seem distant. On the other hand, it could be said that by means of this ironic dislocation, the South African AIDS problem is represented more clearly, as the reader is defamiliarised to what is happening under the Mbeki regime.

This cartoon attacks the President and his Health Minister, and by extension the political order that both represent, for their criminal inaction on a matter shown to be a serious threat to the country, and a national emergency. Their deviant attitude of irresponsibility suggests the implicit moral norm that rulers should observe: awareness, responsibility and concern for the welfare of their people. The cartoon delivers a stinging comment on how the government is failing the people, but this comment may be too obscure to have the intended impact. A further point about this cartoon could be that the association of Mbeki with a non-African cultural context could suggest his alienation from the constituency he rules: that he is remote from Africa's problems and the realities that his people are experiencing.



(Shapiro 2000: 127)

Manto Tshabalala-Msimang is satirised in this cartoon, published at the time of the International AIDS conference held in Durban in July 2000. At the Durban conference, the mainstream medical fraternity signed what has come to be known as the 'Durban Declaration', which clearly set out and reinforced the established, scientific point of view about the cause of AIDS and its treatment. Manto Tshabalala-Msimang dismissed this document as 'elitist'. Her response is compared in this cartoon to the legendary actions of King Canute, a medieval English King who thought he was so powerful that even the ocean would obey his commands. In this intertextual analogy, the Health Minister is seen trying to keep back the waves which represent 'AIDS Science', or mainstream biomedical discourse; a comment on the way she and President Mbeki supported alternative medicine. She is represented as blind and arrogant in believing she can hold back the tide of medical advancement. An alternative interpretation of the cartoon could be that it is a biblical allusion to the parting of the waters by Moses, as he led his people out of Egypt to the Promised Land. This interpretation would make the cartoon deeply ironic, as the outcome of the Minister's leadership is not the salvation of a people but their mass destruction.

In ridiculing the Health Minister, Shapiro belittles and undermines her, dislodging the hegemony of the government's health policies, while simultaneously endorsing hegemonic biomedical discourse. Shapiro frequently represents the alternative medical faction as odd and peculiar, and in many of his cartoons stereotypes them as deluded crackpots. This creates a degree of ambiguity as to the satirist's position and purpose. He both undermines and upholds hegemony. The fact that Shapiro is anti-government and white makes him vulnerable to charges of racism, but to the extent that his sympathies are clearly on the side of the poor and disempowered in South Africa, he can be seen as a *de facto* representative of 'the people', and specifically the AIDS-ill, intent on provoking awareness of their plight.

When the cartoonist displaces the South African situation into another historical space, this could make the full meaning of the cartoon obscure to those unfamiliar with the intertextual reference to King Canute, and thus less effective. Shapiro assumes a readership which will understand the allusion, and this restricts his audience to those with a Western frame of reference and the necessary historical background, although it could be argued that it would be obvious to anyone that trying to hold back the sea is foolish and futile. To those readers who are familiar with the historical allusion, the effect could be to make the message more meaningful. The defamiliarisation brought about by the displacement could have the effect of sharpening the reader's awareness of the absurdity and danger of the Ministry's stance in relation to AIDS. Alternatively, its displacement could make it seem inapplicable to the South African situation.



(Shapiro 2001: 88)

This cartoon's satiric object, Health Minister Manto Tshabalala-Msimang, is very clear and the message can be rapidly grasped. The miniscule size of the Health Minister in relation to the huge beast, representing AIDS, on whose head she is perched, certainly 'cuts her down to size', both literally and figuratively, and makes the point that the magnitude of the problem of AIDS is far beyond her and her Department's capabilities. The object of the satire is her conviction that she is 'on top of it' which is deeply ironic and true only in a narrowly literal sense. The metaphorical meaning of the idiom 'on top of it' – that she is in control of the AIDS epidemic – is patently a delusion on her part, indicating both blindness and arrogance. She appears oblivious or indifferent to the group of people – still alive – clutched in the beast's hand, which are, presumably, its next batch of victims. That the Minister's efforts have thus far proved ineffectual is demonstrated by the piles of skulls on which the monster's head is resting. The cartoon effectively contrasts the power of AIDS and the powerlessness of the Minister, and ridicules her unawareness of this differential.

AIDS is powerfully present in this cartoon. Again, significantly, it is named and depicted as a massive monster or beast, recalling the allegorical portrayal of AIDS as a beast in 'Thabo's Tongue'. However, this metaphorisation is a form of displacement, which is

increased by the fact that the creature belongs to the realm of fantasy. The skulls around the chin and neck of the monster are a more realistic reminder of the mass deaths that have already occurred, however, and restore, to some extent, the presence of the victims of AIDS which are so often absent in AIDS discourse, thus conveying the deadly reality of the AIDS epidemic.



(Shapiro 2002: 69)

This cartoon refers to the President's purchase of an expensive aircraft for his own private use while his government maintained its refusal to fund medication which prevents mother-to-child transmission of HIV, on the grounds that such treatment was too costly. The picture shows the obscene contrast between the President's extravagance (spending a large amount of money unnecessarily on a luxurious private jet) and his grotesque parsimony (saving government money at the cost of the AIDS-ill). Shapiro neatly – but brutally – suggests that the two extremes are connected: the reason Mbeki was able to buy the jet was because he economised on medication which could have saved lives.

The object of the satire in this cartoon is not mere 'folly' (Mbeki's blindness and arrogant indifference, frequently satirised by Shapiro), but the more serious 'vice' of indulging his own expensive desires at the expense of the lives of thousands of mothers and babies. Morally, this implies an additional dimension: the conscious and deliberate choice

of putting his own selfish desires before the lives of his people. The fact that the victims are innocent babies makes his action seem even more callous and reprehensible. The President's behaviour as this is represented in this cartoon is tantamount to genocide, and again raises the question as to whether some faults are 'too serious' for satire, the opinion expressed by W. H. Auden (1952: 202). When considering whether Shapiro's satiric treatment 'trivialises' Mbeki's action in this cartoon, it does not seem to me that it does. The graphic, hard-hitting way he reveals Mbeki's distorted values evokes not the slightest degree of humour. If anything, the extent of the President's culpability strikes the reader with greater force. The grim message of this cartoon illustrates Bryant's view that 'humour may often have to be discarded in the interests of Truth' (1997: 63).

Techniques of displacement in this cartoon are minimal: humour and intertextuality are absent, and metaphor is employed only in the identification of the babies' skeletons with the aircraft's steps. The physical reality of the AIDS dead shown in the cartoon illustrates Connery and Combe's point that satire can function as a way of 'exposing the violence that civilisation conceals' (1995: 7). If the latter point is developed, it could be said that a cartoon such as this has the effect of negating the displacement of AIDS victims. It makes visible what has been ignored or deliberately covered up, bringing 'violations to the surface' (Seidel 1979:17). In this way it effectively reverses the displacement of AIDS in AIDS-related discourse.



(Shapiro 2003: 62)

Like the cartoon about Nero, this cartoon presupposes an educated, Western frame of reference in the reader when it draws on the history of ancient Rome. The message of the cartoon pivots on the intertextual reference to the soothsayer's prophetic warning to Julius Caesar: 'Beware the Ides of March' (15 March, the day Caesar was assassinated), but here the cartoonist manipulates the words to become 'Beware the March of AIDS!' President Thabo Mbeki is transformed into Julius Caesar, and the soothsayer is portrayed as Zackie Achmat. Mbeki is portrayed as above and separated from the ordinary people, the expression on his face being one of distaste and disdain. He is characterised as distant and alienated from the electorate. The identity Shapiro gives Mbeki here is ironic when it is remembered that Caesar was the arch imperialist, coloniser and oppressor, all the practices the post-apartheid government opposed most bitterly in the struggle, and this raises the question as to whether the cartoonist is suggesting that Mbeki has become what used to be regarded as 'the enemy'. Those familiar with history will know that Caesar ignored the soothsayer's prophesy, because – in his arrogance – he believed that he was unassailable, and he was indeed stabbed to death on the Ides of March. The implication is that Mbeki will also disregard the warning, and will be destroyed for his foolish arrogance.¹⁰ The effectiveness of this cartoon results not only from the cartoonist's graphic skill in evoking an historical event so economically, but in the verbal wit in the wordplay of the 'Ides of March'/'March of AIDS'.

Here again, former President Mbeki, and specifically his qualities of arrogance and stubbornness in ignoring clear warning signs, are the objects of the satire. The metaphorical displacement of the South African situation to that of Ancient Rome may not be understood by everyone, and so the significance of the intertextual connection may be lost. AIDS itself, and the suffering it causes, are not shown. This could limit the effectiveness of the cartoon's message, despite – or perhaps because of – the cleverness of its message, which depends on sophisticated powers of inference to unravel. However, as with the 'Nero' cartoon, Shapiro could be hinting at Mbeki's cultural inaccessibility: it is significant that again he is

¹⁰ This could be regarded as prophetic in real life as well as in the historical allusion. At Polokwane in December 2007 President Mbeki was supplanted as the President of the ANC by Jacob Zuma, and in September 2008 he was forced to resign as President of the country.

contextualised in a foreign, non-African setting. His geographical displacement shows that he does not share the locus of his people and their problems.

Jonathan Shapiro leaves us in no doubt as to the real outcome of the consequences of government policies in his depiction of a cemetery in the cartoon below.



(Shapiro 2004: 38)

The cartoon shows Manto Tshabalala-Msimang making the announcement which came too late to save thousands too poor to buy private healthcare.¹¹ By making medication inaccessible to the poor by refusing to subsidise it, the State is shown to be responsible for numberless deaths, exemplifying structural violence.¹² The lectern at which the Health Minister stands represents her hegemonic power over the masses who have become her victims. The cartoon succeeds in making visible the landscape onto which the

¹¹ In South Africa, only about 7 million of the country's 44 million citizens can afford private health insurance (Gumede 2005: 151).

¹² In the wake of Manto Tshabalala-Msimang's death in December 2009, her obituaries included the obligatory tributes to her efforts and contribution to the struggle, but there were also many outspoken comments on her mishandling of the AIDS crisis. Under the headline 'Dire legacy haunts SA', the *Sunday Times* began its report on her life and career with the words: 'The only tears shed as we bury Manto Tshabalala-Msimang, who has died at 69, should be for the hundreds of thousands of people who died because she refused them, and pregnant mothers, the drugs which probably would have saved them'. The report goes on to state unequivocally that 'she failed to do her job, one of the most criminal derelictions of duty in South African history' (*Sunday Times*, 20 December 2009).

AIDS-dead have been displaced and discarded, and boldly presents the stark reality of mass deaths, a reality that is easy to ignore or hide. Here again, Shapiro's depiction of the crowded graveyard 'exposes the violence that civilisation conceals' (Connery and Combe 1995: 7), effectively reversing the displacement of AIDS victims by making their graves, and their sheer numbers, shockingly visible. The countless gravestones are the only 'texts' the majority of the AIDS-dead leave behind. Mortality on this scale is another example of an outcome that W.H. Auden would believe is too serious to satirise. He would regard a more appropriate reaction to be 'prophetic denunciation' (1952: 202).



(Shapiro 2004: 54)

Here Shapiro targets President Mbeki's denialism of AIDS, which the President persists in ignoring although the evidence of mass mortality – a cascade of human skulls – is forcing its way, metaphorically, into the very space he occupies. The way that Shapiro portrays Mbeki, as he shuts the evidence of AIDS out of his residence or office, suggests symbolically that he shuts AIDS out of his mind, displacing it elsewhere so that he does not have to deal with the problem. In the picture he is shown assuming a comfortable, cross-legged posture and holding a pipe, which the artist regularly uses as Mbeki's trademark, or 'tab of identity'. We associate a pipe with the nonchalant demeanour of a leisured British gentleman rather than a committed leader of a country in crisis and, again, this suggests

Mbeki's elite, Westernised image. His relaxed posture and pipe suggest how unconcerned the President is about what is going on in his country, and how little it affects or moves him. This portrayal is ironic in the same way that his identification with Nero or Caesar was: Mbeki is represented as being a leader who enjoys a position of supreme privilege; the type of leader who is effectively an enemy of the people because he fails to use his power in a way that benefits them.

An avalanche of human skulls threatens to engulf him from a window behind him. His desire to displace AIDS from his personal space is shown to be unsuccessful, because the skulls are coming closer, and this suggests that he will not be able to continue indefinitely pretending that the problem of AIDS does not exist. Again, Shapiro does not displace the physical reality of AIDS in this cartoon: he adopts an immersive approach to the subject when he shows the relentless advance of countless skulls, which serve as a forcible reminder of the victims of government policy. Mbeki's portrayal as a leader who refuses to acknowledge and discuss the AIDS crisis makes him appear guilty of the silence of neglect. It is suggested that this silence, in the circumstances, is criminal.

Displacement of AIDS is seen in the cartoon below in the exploitation of the discourse of the 1976 Soweto uprising for the cause of AIDS. It replicates the most iconic image of that historical episode, and possibly of the whole struggle: the dead child, Hector Peterson, victim of a police bullet, being carried off by a comrade and friend on June 16th 1976.



Pretoria News: 15 June 2006

As was discussed in relation to the cartoon which depicted AIDS as the Grim Reaper on the winner's podium at the Africa Games, the satiric object of this cartoon is not obvious, nor does it appear to be at all satirical. The tone is one of deep solemnity, and it is completely devoid of the elements of humour or the grotesque. Like the Africa Games cartoon, it could be seen as merely 'descriptive' and 'the expression of a status quo viewpoint' (Press 1981: 75). However, its emotional impact is far too powerful to be only this. More careful thought reveals its hidden satiric object. Shapiro has adapted the original photograph of the death of Hector Peterson in a subtle, but highly significant way: 'HIV/AIDS' is written on the chest of the dead child, so that he personifies all those who have died of AIDS. In 1976 Hector Peterson was regarded as a victim of police brutality, and thus indirectly of the violent machinery of the State. In this parallel representation, his identification with AIDS sufferers, past, present and future, suggest that they too, are victims of the State. Although absent in the picture, the government is the villain of the piece. As the invisible perpetrator of violence, it fulfils the definition of structural violence. In regard to the AIDS epidemic, its culpability goes beyond mere folly: it is presented as guilty of murder.

This picture would be instantly recognisable to most South Africans, and the cartoonist relies on its familiarity for its intertextual significance. The *gravitas* associated with human rights and the liberation struggle, and associated with the idealism of Mandela, is evoked in an effort to dignify those infected and affected by AIDS, and to enhance appreciation for the critical importance of the cause. It is clear that the heroic discourse associated with Hector Peterson is intended to be carried over to the cause of AIDS. The grafting of AIDS discourse onto struggle discourse is a clear strategy of displacement. However, its effect is uncertain. The message of State culpability may not be inferred by all readers. The conflation of the two discourses – AIDS and apartheid – could shock readers into a greater awareness of the seriousness of the AIDS epidemic in the immediate present, thus countering displacement, or, on the other hand, as was discussed in relation to the 46664 concert in Chapter 2, the power of struggle discourse could overshadow and render insignificant the subject of AIDS. This text is particularly interesting because it suggests that resistance to AIDS has become the ‘new struggle’, supplanting the fight against apartheid.



(Shapiro 2006: 144)

This cartoon is far less complex than the last one discussed: the satiric object is clearly Manto Tshabalala-Msimang. AIDS itself does not feature strongly in this cartoon: it is displaced from the scene which is depicted, and is referred to only indirectly, in the sign on the wall. The focus is on Manto Tshabalala-Msimang. The cartoon records what happened at

the World AIDS conference held in Canada in 2006, when the Health Minister made a laughing stock of herself and South Africa's AIDS policies by advocating vegetables such as the African potato, garlic and beetroot to treat AIDS, rather than modern drugs like anti-retrovirals. The picture shows the vegetables being thrown out of the conference venue as so much garbage, and Tshabalala-Msimang herself is identified with one of the vegetables – the African potato. This highly unflattering lampooning of the Minister suggests stupidity (in common parlance, a 'vegetable' refers to someone who is alive but brain-dead), and as a general practice Shapiro makes vegetables Tshabalala Msimang's 'tab of identity' (Bryant: 1997: 59), a device which functions as a 'visual shorthand' (Bryant: 1997: 61). Vegetables have come to symbolise her obtuseness and unorthodox approach to the treatment of AIDS, and this is also seen in her nickname, 'Dr Beetroot'.

In this cartoon Shapiro shows in graphic terms how the international community reacted to her views, condemning and dismissing her. The cartoon's portrayal of her as a vegetable and piece of rubbish succeeds in destroying her professional and political credentials, displacing her from the hegemonic political position she holds. It also demolishes the alternative medical regime she supported. When we remember Mbeki's earnest desire to improve the image of Africa and Africans in the eyes of the world, this portrayal takes on bitter irony. The way Shapiro ridicules her illustrates that satire is often 'openly vulgar and abusive' (Connery and Combe 1995: 77). Shapiro's own position here, as a white male who has adopted an oppositional stance to the black majority government, could, like David Bullard's, weaken his satirical point, and lay him open to accusations of prejudice and racism.



(Shapiro 2006: 154)

Here Shapiro's target is Jacob Zuma – at the time Deputy President of South Africa – and, in particular, Zuma's opinion, expressed during his rape trial in 2006, that a shower could wash away HIV-infection after unprotected intercourse with an HIV-positive person. So ludicrous was this statement that Shapiro used the showerhead thereafter as Zuma's 'tab of identity' symbolising his ignorance about AIDS, in the same way that Mbeki's pipe functions as a symbol of his indifference to AIDS and vegetables symbolise Tshabalala Msimang's unorthodox approach to AIDS treatment. The showerhead perched on the top of Zuma's head has a comical effect, but it makes a serious comment about his character and behaviour. In the cartoon Zuma is shown holding the 'ABC' ('Abstain; Be Faithful; Condomise') AIDS-prevention code which he should have been actively promoting, but which he flagrantly disregarded when he had an adulterous sexual encounter, demonstrating that he did not 'abstain', was not 'faithful' to his wives, and did not 'condomise' although the woman he had sex with was known to be HIV-positive. The water from the shower fixed to his head is shown to be washing away the writing of the code, suggesting that his behaviour has weakened and discredited the government's AIDS-prevention strategy. This is all the more incongruous because he was for a time Chairperson of the South African National AIDS Council and should have been setting an example, in his official capacity, for others to follow. The upturned faces of the people suggest that they look to him for leadership and are closely attentive to his behaviour, in contrast to the distance that existed between President Mbeki and his electorate. Mbeki and Tshabalala-

Msimang are often portrayed as addressing the dead, who cannot hear them, and to whose fate they are oblivious, whereas Zuma is shown to be more in touch with the population he leads. The fact that Zuma has the ear of the people, in a way that Mbeki did not, makes it more tragic that he has not served as a positive role model in AIDS prevention.

This cartoon and numerous others by Shapiro demonstrate how cartoonists, in Robinson's words:

bring into fusion their abilities as journalists, political analysts, artists and caricaturists to make significant graphic statements on public issues with wit and humor, turning an abstraction into a concrete image. They do this in the time and space of hours and inches – an exercise unique in the art of communication (1981: 9).

Shapiro's talent and skill as a cartoon satirist are beyond question, but his effectiveness as a voice of resistance could be compromised by the fact that, like David Bullard, he operates from a 'white', anti-establishment position and is aligned with a 'white' point of view, which weakens his credibility. Shapiro has had to contend with accusations of racism from young black readers many of whom did not know of his roots in the anti-apartheid movement. He has defended himself by saying that 'he is tackling people in power who happen to be black, rather than because they are black', and points out that his cartoons of previous white rulers were at least as brutal as any he has drawn more recently.¹³ Also, his satire shows that his sympathies lie with the ordinary people: the masses who are led – and misled – by political leaders.

Another factor limiting the effectiveness of Shapiro's satirical voice, as I have shown, is that his cartoons often assume background knowledge and cognitive scaffolding which his potential audience may not have. However, as previously mentioned, the more educated readership – who can interpret his message fully – is empowered, and so has the potential to exert pressure on government policy.

Shapiro's form of satire can – but does not always – make use of the comic mode as a distancing device: many of his cartoons are completely lacking in humour. His use of metaphor to construct AIDS in condensed symbols such as the Grim Reaper, a Beast, or

¹³ *Mail and Guardian*, 12 -18 September 2008: 'A licence to cheek'.

Hector Peterson is ambiguous in effect, both displacing AIDS and making it seem more immediate, dramatic and real. When he uses scenarios in remote spatial and temporal settings as dislocated analogies for the AIDS situation in South Africa, he jeopardises recognition of his message. However, many of his cartoons reverse the displacement of AIDS seen in other kinds of AIDS discourse because they name AIDS and retrieve the voices and presence of those who have suffered and died from the disease. He does not allow us to forget that government policies have had real physical effects: countless people have died as a result of arbitrary decisions. When he includes symbolic representations of victims in the form of skulls, skeletons or graveyards, he recovers their presence, reminding us of their reality and sheer numbers. The effect of his form of satire is thus ambiguous: it both displaces and replaces the reality of AIDS in AIDS discourse.

Of all the satiric texts considered in this chapter, 'Thabo's Tongue' is probably the text furthest displaced from the reality of AIDS, owing to the fable-like quality and element of fantasy in the allegorical tale. Its comment on the actual AIDS-situation in South Africa is indirect and could well be missed by readers. The transference of disease from the people to the king in the story – another form of displacement – makes an interesting point about the reason for the epidemic's spread, but is counter-immersive in that it avoids confronting the 'mysterious illness' that sweeps through the populace itself. In contrast, Pieter-Dirk Uys's satirical approach is direct and immersive, although he does use the distancing devices of humour and impersonation to make his message lively and entertaining. Shapiro's work can be seen as both immersive and counter-immersive in effect: he displaces AIDS from his texts in various ways, but often replaces it vividly in discourses from which it is usually removed.

The fact that – with the exception of Eli, author of 'Thabo's Tongue' – all the satirists whose work is discussed in this chapter are white, needs comment. There is a dearth of black satirists and cartoonists in South Africa, and even newspapers with chiefly black readerships use the work of white cartoonists like Shapiro. In his report on the International Workshop of Cartoon Journalism and Democratisation in Southern Africa which took place in Botswana in 2007, Andy Mason, a cartoonist, comics publisher, director of Artworks Publishing in Durban and co-ordinator of the African Ink Cartoonists Working Group, commented on the absence of black South African cartoonists at the Workshop, observing

that 'few, if any black cartoonists have achieved prominence in South Africa', and that 'cartoons and comic strips in the country's black papers and magazines have, with few exceptions, been created by white cartoonists'. One of the resolutions taken at the Workshop was the need to develop an indigenous culture of cartooning, and the *Sowetan's* initiative of launching a competition with a cash prize to identify new cartooning talent was described as 'a step in the right direction' (Mason 2007).

The lack of skilled black cartoonists in South Africa can probably be related to the larger discourse of South African history and politics. Under the repressive apartheid regime, criticism of the government was treated punitively and the political climate would have been hostile to the growth of a culture of satire, particularly from black South Africans. Talented black cartoonists had to go abroad to practise their art.¹⁴ Later, in the early years of the new democratic regime, a sense of pride that black people were now in power and deserved unswerving loyalty, as well as a cultural reluctance among black people to criticise those who are senior and occupy positions of authority, could account for a lack of satiric expression from black satirists. Aversion to ridiculing authority figures is seen in the reactions to some of Shapiro's cartoons from quarters such as the National Union of Metal Workers of South Africa (NUMSA) who were incensed by Zapiro's portrayal of President Zuma as a rapist. They publicly condemned Zapiro's work as 'a sign of disrespect to [the President's] office and the position he occupies in society as the fourth democratically elected Head of State'.¹⁵ The ANC Youth League also denounced negative portrayals of Zuma as 'disrespectful of the leadership of the ANC and the alliance'.¹⁶ Shapiro has had two law suits brought against him for depicting Jacob Zuma negatively in his cartoons.¹⁷

At the risk of making a generalisation which is difficult to prove, I would venture the opinion that there is misunderstanding in black culture that, while satire and cartoon art do

¹⁴The Durban-based cartoonist Nanda Soobben, for example, struggled through the years of apartheid under the watchful eyes of the censors, eventually leaving South Africa in 1987 for Brazil, and later New York. After Nelson Mandela's release he returned to South Africa and produces cartoons for local newspapers. <http://www.cartoonist.co.za/nanda.htm> (Accessed 15/09/2010.)

¹⁵ *City Press*, 15 January 2010: 'Another Zapiro cartoon offends'.

¹⁶ *Mail and Guardian*, 12 -18 September 2008: 'A licence to cheek'.

¹⁷ 'Cartoonist defends right to satirize South Africa president' (<http://www.cbe.ca/arts/media/story/2009/06/22/zapiro-cartoonist.html>). (Accessed 15/09/2010.)

set out to shock, this purpose is not destructive, but a means to an end, which is the improvement of society. There also appears to be a lack of awareness that satirical expression is a sign of a healthy democracy. As Jerry Robinson, quoted in the epigraph to this chapter, observes: 'Humor in times of insanity is what keeps us sane. It is also what keeps us free.' (1981: 6.)

A common feature of all the satire discussed in this chapter is displacement through scapegoatism. All the satirists whose work has been reviewed in this chapter target and blame government officials for the catastrophic proportions AIDS has reached in South Africa. While this is legitimate satirical practice, since satire is always about people, being 'essentially a social mode; [and] having nothing in it of the transcendental' (Pollard 1970: 7), it does mean that AIDS *per se* is generally bypassed and relegated to a subsidiary position. Political figures, rather than AIDS, are the main focus of AIDS-related satirical discourse. In AIDS-related satire, AIDS is displaced and finally subordinated to the real subject: 'human vice and folly'.

Chapter 4: Gendering AIDS

AIDS takes us to the heart of feminist inquiry ... including the question of how sex and sexuality are constructed. (Paula Treichler)¹

Chapter 2 highlighted the way that the dominance of racial and political concerns has displaced AIDS and HIV-positive people in AIDS-related discourse, and in a comparable way, gender-related discourse has displaced AIDS and women, particularly, from the epidemic. The prevalence of patriarchal values in society, which accords women a lower status than men, has meant that the woman's experience has been under-represented and under-valued, in spite of the fact that more women than men are infected and affected by AIDS.² This reflects the discursive assumption that 'what happens to men is more important and/or more "real" than what happens to women' (Felman 1975: 12). Where women are represented in AIDS discourse, it is most often in a negative way. Women are thus under-represented and misrepresented. This chapter explores the patriarchal discourse which frames AIDS in a gendered way, perpetuates stereotypes prejudicial to women, and displaces AIDS as a central concern. In the latter part of this chapter I consider discourse that runs counter to this trend, and analyse texts by women asserting their right to be replaced in the discourse and to have their experience of AIDS heard and validated.

Biomedical discourse – as mentioned in Chapter 1 – is commonly thought to be 'objective' and 'scientific', but closer examination reveals that it is often discriminatory towards women. This is not surprising when it is borne in mind that biomedical discourse is part of hegemonic discourse linked to the patriarchal structures of society.

¹ (Treichler 1988: 192.)

² A combination of biological factors and issues of gender makes women and girls more vulnerable to HIV-infection than men. The report of the South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey of 2008, based on a sample of the general population of South Africa, showed that in the age group 20-24, HIV-prevalence among males was 5.1% as against 21.1% for females, and in the age group 25-29 male prevalence was 15.7% as against 32.7 for females. (<http://www.avert.org/safricastats.htm>)

Paula Treichler comments that medical authorities are 'heirs of an ancient medical legacy of semantic and gendered imperialism ... [which serves to] define and categorize, codify and regulate, and contain and silence the diseased others whom they diagnose, treat, and study' (1999: 45).

Biomedical discourse includes and is supported by 'an extensive economic and social structure in the form of an academic and pharmaceutical research complex with literally billions of dollars at stake in the development of vaccines, antibiotics and antiviral agents' (Rodrigues 1997: 30). The combination of personal and economic interests in largely male-dominated professions means that the discourse is inevitably androcentric. Medical knowledge and power are closely linked. Kathryn Anastos and Carola Marte, physicians who work in women's health and with HIV-infected people, observe that research on heterosexual HIV transmission is 'permeated with sexist assumptions', and that women are 'studied by the medical profession as vectors of transmission to their children and male sexual partners rather than as people with AIDS who are themselves frequently victims of transmission from the men in their lives'. They state that 'until recently, one could gain epidemiologic information concerning women and AIDS mainly from perinatal studies,³ and to a lesser extent, from studies of prostitutes. Women have been defined primarily in terms of childbearing activities ... not as individuals with a life-threatening illness' (Anastos and Marte 1989: 10). In South Africa, the TAC and other activists won the battle in 2001 to have anti-retroviral medication supplied free of charge to pregnant HIV-positive women to prevent transmission to their babies, and this was hailed as a great victory for women. However, it is significant that this medication does not help the women themselves, but decreases

³ Many statistical studies on HIV-prevalence in South Africa are based on data from antenatal clinics, since pregnant women regularly attend these clinics, thus constituting an easily identifiable, accessible and stable population. However, there are flaws in this sampling practice, because pregnant women are, by definition, engaging in unprotected sex (factors which do not necessarily apply to other population groupings), which obviously puts them at higher risk of HIV infection. Overestimation of HIV prevalence is a known bias in antenatal studies. (<http://www.avert.org/safricastats.htm>)

vertical transmission to their babies. Implicit in this policy is the view that women are not valuable in and for themselves but only in terms of their reproductive role, as incubators for the next generation. Ida Susser discusses the need to develop programmes that aim at saving the mother as well as the child (2009: 17-28), commenting that, in the United States, women were 'chiefly conceived as vectors of [AIDS] for men and infants more than victims themselves and sometimes this emphasis remains the focus of research' (2009: 20). In her article titled 'Gender Bias in AIDS Research', Diana Hartel – also using the United States as her reference point – asserts that 'the central struggle for advocates of female AIDS patients revolves around changing research focus from the infectious female body to the body in need of care' (1994: 47).

Studies that focus on prostitutes are undertaken because this affects heterosexual transmission to men. Anastos and Marte point out that 'prostitutes are frequently seen as the guilty parties in the infection of women whose husbands or steady partners are the clients, ... shift[ing] the responsibility away from the man who engages in risk-taking sexual encounters' (1989: 11). Murrain comments that the 'framing of women as "vectors" of HIV has been the dominant paradigm for research on women with AIDS' (1997: 64), while Paula Treichler describes as an 'historical axiom' the enduring way that prostitutes have been represented as 'so contaminated that their bodies are virtual laboratory cultures for viral replication' (1999: 20); and as 'reservoirs', 'harbours' and 'vectors' for venereal disease. They are constructed as 'infectors', not 'infectees' (1999: 53).

With regard to the perception of women as 'vectors', there is a long discursive history connecting women and disease, and specifically sexually transmitted ones. This has been studied by the historian Allan Brandt who gives examples – drawn from the United States from 1880 onwards – of the way that venereal disease (VD) has traditionally been assigned a female identity. He gives one example where a World War

II poster warning US servicemen about the risks of syphilis shows a woman walking arm-in-arm between Hitler and Hirohito above the caption: 'VD: the worst of these' (Brandt 1985: 165). The identification of women, and particularly prostitutes, with sexually transmitted diseases is deeply entrenched in discourse. Women have long been blamed for being 'the primary locus of venereal infection' (Brandt 1985: 72) and active agents in the spread of disease, with 'few stopp[ing] to consider from whom the prostitute acquired her infection' (Brandt 1985: 92). Brandt critiques the dichotomous discourse on which venereal epidemiology was based and which constructed 'two types of women – good and bad, pure and impure, innocent and sensual', and in terms of which 'an "innocent" woman could only get venereal disease from a "sinful" man, but the man could only get venereal disease from a "fallen woman"'. This uni-directional mode of transmission reflected prevailing attitudes rather than any bacteriologic reality' (1985: 31-2). Hartel shows that, 'in syphilis and HIV, two class-dependent stereotypes dominate: the lower-class whore and the middle-class innocent' (1994: 36). Women from the lower social classes were seen as 'naturally susceptible to immorality', while the middle-class woman was the 'appropriate child-bearing vessel and could not be identified as infective to men' (1994: 35). Paula Treichler describes as 'dizzying' the 'ease and simultaneity with which women can be both invisible and culpable, transparent instrumental carriers and reservoirs of contagion, dangerous and willful infectors and naïve, irresponsible infectees' (1999: 274). These points relate to representations in the West, but South African examples demonstrate similar patterns of stereotyping and blame.

An example of South African anti-feminist AIDS-related discourse where the woman is constructed as the source of the epidemic occurs in the novel *Dog Eat Dog* (2004), by Niq Mhlongo, set in contemporary Johannesburg. There is an episode where a group of university students are socialising in a bar, and begin to discuss, in an informal and bantering way, the origins of AIDS. Various questionable theories circulating in popular culture are put forward, such as the view that 'circumcised straight men never catch the gay plague' (2004: 119); that it is an American plot and

that AIDS stands for 'American Invention for Discouraging Sex'; that Americans are making money out of the drugs used by the AIDS-ill; and that the rich are protected by better-quality condoms that the poor cannot afford. Then, more seriously, a character called Themba declares that AIDS originated in Soweto in the 1980s from a succubus called 'Vera the Ghost'. This creature, whom he describes as a 'maneater', lures men to her bed through her powerful sexual attractiveness. She creates the illusion that they are sleeping 'in a queen-sized bed in a five-star hotel', but when they awake the next day they find themselves covered with ash on top of a grave — her grave — in Avalon cemetery. The men then take ill with a 'deadly syphilis that develops into HIV' (2004: 126-8). This story has links with ancient African myths such as Mami Wata, which originated in Western and Central Africa, and which slaves spread to other parts of the world. The tales based on this deity take different forms, but in essence Mami Wata is a beautiful, seductive, half-woman, half-fish, a mermaid goddess who can assume the appearance of a mortal woman, flirt, and go to bed with men who find out soon after that they have venereal disease or have become impotent. 'Mami Wata' is sometimes used as a slang term for a prostitute.⁴

Mythological discourse which represents women as beautiful but evil: fatal temptresses, is found in Western as well as African culture. Quina *et al* observe that 'everywhere we look in our culture there are images of women's sexuality as powerful Their power is often portrayed as dangerous to men, as in Homer's sirens or Eve's original sin ... usually because of the way they look' (1997: 188). One well-known example from the literary canon is the *femme fatale* in Keats's poem 'La Belle Sans Merci' who seduces a young knight who then languishes and dies. In the South African context Motsei asserts that 'blaming the woman is embedded in a specific patriarchal discourse that views women not only as inferior, but as evil and dangerous and a menace to society' (2007: 147). These are dominant cultural narratives, which may be defined as 'stories that are so pervasive as to be unquestioned, yet so powerful as to

⁴ <http://www.beautiful-mermaid-art-com/african-folk-tales.html>. (Accessed 17/09/2010.)

carry with them assumptions about character, attributions of motivation, and expectations about behaviour' (Thomas and Rappaport 1996: 319). These stories, or discourses, are not natural: they have been 'created and maintained to serve particular purposes' (Thomas and Rappaport 1996: 326). Yet it is not only men who subscribe to such narratives: Thomas and Rappaport make the point that these stories are 'usually believed by those who benefit from and are hurt by them' (1996: 319). Women too support stories that represent them in a negative way, thereby enacting symbolic violence, a concept that will be more fully discussed later in this chapter.

Representations which blame the female for infecting innocent men are clearly recognisable in the novel *Welcome to our Hillbrow*, by Phaswane Mpe (2001). The text is ironically-titled because Hillbrow is portrayed as a far from welcoming or desirable place to live. The narrator tells of a young man who died of a 'strange illness in 1990 ... [which] could only have been AIDS. After all, was he not often seen roaming the whorehouses ...of Hillbrow? ... [H]e was often seen with *Makwerekwere*⁵ women, hanging on to his arms and dazzling him with sugar-coated kisses that were sure to destroy any man, let alone an impressionable youngster like him' (2001: 3). The 'fatal temptress' discourse is clearly recognisable in the prostitutes' actions of 'dazzling' him 'with sugar-coated kisses'. It is implied that the 'sugar' hides their underlying disease from the young man, who is blinded by their beauty. His vulnerability to such ostentatious female charm is stressed, constructing him as the 'innocent' victim. These Hillbrow sex workers are not only 'othered' because they are prostitutes, falling outside respectable mainstream society, but also because they are '*Makwerekwere*' (foreigners). Local people blame these aliens for bringing AIDS into South Africa from the north. Such discursive representations both reflect and encourage anti-feminist and xenophobic attitudes. They also oversimplify the difference between the innocent and the guilty, a distinction which is neither just, nor reflective of reality.

⁵ The word *Makwerekwere* is onomatopoeic and derives from *kwere kwere*, 'a sound that their unintelligible foreign languages were supposed to make' (Mpe 2001:20).

Similarly, in the poem 'Nobody ever said AIDS' by Eddie Vulani Maluleke, which gives its name to the collection *Nobody ever said AIDS; Stories and Poems from Southern Africa* (2004: 17-20), women are constructed as contaminated whores:

There were the girls
 In rouge red glossy lips
 Tight red dresses
 Waiting for Jimmy
 Petros
 Jabu ...

In the powerful iconography of the colour red, simultaneously signifying sexual passion and danger as well as signalling HIV-infection, 'the girls' are represented as predatory temptresses – literally 'scarlet women' – luring young men to their deaths, and illustrating what Simpson describes as the 'persistent relationship between women, sex and danger ... ascribed to [the woman's] insatiable, irresistible, but deadly sexuality...' (1988: 202). The scene begins to change after two years:

Jimmy
 Petros
 And Jabu
 All got sick
 And skinny like broomsticks
 They started coughing
 And couldn't dance any more
 They held up their pants
 With belts
 And just drank and drank
 Then they died of TB
 In 1996.
 TB?
 Strong healthy men
 Who worked in Jozi
 And danced every Friday night

Then the girls in their rouge red glossy lips
 Died too

Painfully so,
 With hollow eyes
 And black spots on their faces ...

We all died
 Coughed and died
 We died of TB
 That was us
 Whispering it at funerals
 Because nobody ever said AIDS.

From the one extreme of demonising women as ‘sources of contamination and pollution’ (Lupton 1994: 128) is the opposite construction of the ‘sacrificial good woman’ (Hogan 2001: 6). ‘She became the mother again’ by Angifi Proctor Dladla, included in the collection *Nobody ever said AIDS; Stories and Poems from Southern Africa* (2004: 123), focuses on those women who nurse the AIDS-ill:

She became the mother again
 to her daughter of 47 –
 Changing nappies;
 washing her,
 force-feeding her ...
 And, Lord, she sighed a lot
 on that sleeping mat!...

She became the mother again
 To her grandson of 23 –
 Changing nappies;
 Washing him,
 Force-feeding him ...
 And, Lord, she cried a lot
 On that sleeping mat!...

She loved them all;
 yet they left her alone
 with the cause
 of their deaths – and,
 without a mother ...

This woman of 1920.

These representations demonstrate how creative literary texts succeed in replacing the 'missing persons in the AIDS epidemic', but are not unproblematic. Representations seem either to scapegoat or valorise women. Marais comments that:

[r]ather than trigger[ing] a 're-imagining' of 'womanhood' and 'manhood', AIDS is cementing the schizoid typology of women as angels of mercy and/or sullied whores. It is women who are accused of 'bringing the disease' into homes, girls who are subjected to 'virginity testing', and women who tend the sick and the frail and survivors. Men seem to hover along the fringes of this drama, leaving women ubiquitous yet trapped between blame and praise ... (2005: 110).

Marais' reference to virginity testing refers to an invasive and humiliating ritual that young Zulu girls are involuntarily subjected to, for which there is no male equivalent. This in itself suggests the double standards and biased perceptions that exist towards girls who are treated with suspicion, while the premarital sexual activity of boys is implicitly condoned. In general discourse, it is considered 'natural' and 'right' for women to take over the role of caring for the ill: it is accepted as something dictated by Nature, rather than something socially constructed. Such views can legitimate injustice, just as constructing women as 'whores' and seeing them as the source of infection justifies ignoring their humanity and needs. In her ambiguously-titled book *Women Take Care*, Katie Hogan highlights the dangers for women of the traditional discourse that 'good women are self-denying women who willingly care', pointing out the toll this takes on 'those with the least amount of power'. She adds: 'Western culture, history, myth, family, and economic structures continue to link caretaking activities with certain groups of people, mainly women, instead of viewing care as the responsibility of the entire society'. As a result, 'women and minorities, who labor under the burden of being defined as the inevitable, biologically-destined caretakers of the world, are often the last to receive care in the AIDS epidemic' (2001: 4). In addition to nursing the terminally ill, female relatives are usually the ones who take over the care of AIDS-orphans, making their burden heavier. Van Dyk makes the point that at the family level, the primary

caregivers in South Africa are predominantly women (2005: 323). Often ill and in need of care themselves, they observe at first hand how they too will die. Isolated, without training or support and fearful of the future, such caregivers are severely stressed (2005: 325-6).

The following poem by Ingrid de Kok, 'Women and children first' (2002: 61), reflects what Marais terms 'the schizoid typology' of women:

It's always been so.
This makes it worse.
Women and children first.

First to be hurt
last to be nursed.
It's always been so.

When rumour stalks
first to be cursed.
And worse.

Turned out, inside out.
Only safe in the hearse.
Women and children first.

This poem – in which, significantly, both the signifier 'AIDS' and the signified condition of AIDS are absent – is structured on the tension between opposing ideologies of the status and role of women. Its title, 'Women and children first', evokes the chivalrous convention of saving women and children before men – for example, when a ship is sinking – but this discourse is undercut by the discourse of woman abuse in which women are exploited, marginalised and blamed. The theme of AIDS is displaced and alluded to only indirectly, in the pronoun 'This', in the second line. The first line of the poem asserts that there is nothing new about the disempowerment of women and children, but in line 2 the poet states that '[t]his' (the AIDS epidemic) has made it 'worse', aggravating existing patterns of gendered inequality and discrimination. AIDS is a secondary – even background – issue here, supplanted by the primary issue of the

hypocrisy of attitudes towards women, who are ostensibly valued because of their ability to bear and nurture children and so to ensure the continuation of life, but who are in reality exploited and abused.

The short story 'Leave-taking' in *Nobody ever said AIDS; Stories and Poems from Southern Africa* (2004: 124-41), by Sindiwe Magona, dramatises the way that women shoulder the responsibilities of care in the midst of male hostility. The main protagonist, Nontando, is a woman whose three adult children become ill with AIDS, and when in desperation she appeals to the Church for help, she is castigated by her husband for 'opening her big mouth and talking to the whole wide world about what was a private family matter', and for being 'selfish'.

"Selfish?" she asked, astounded at the accusation, so unwarranted.

Here she was, minding Luthando, who wore nappies like a baby, feeding him because he was so weak he could hardly hold a spoon and, on top of that, cooking and cleaning and keeping house for all of them. And her own husband calls her selfish.

"Don't you see how you're going around begging for sympathy?" asked Thando. "What is that if it is not drawing attention to yourself? Taking it away from those who really deserve it, our children, both the sick as well as the others. They all need us" (2004: 135).

Nontando is the victim of abuse in this situation. Not only does her hard work go unrecognised, but she is also unfairly attacked. Aggravating her distress is the knowledge that she encouraged her daughter, who died of AIDS, to stay married to her husband in spite of his extramarital affairs:

Nontando choked as she remembered her words to her daughter.

"Nyamezela, ntombi yam. Ukwenda kukunyamezela. Patience, my daughter. To be the wife of a husband is to endure untold hardship." Had she contributed to her daughter's death? Even inadvertently, was she an accessory to Thami's murder? (2004: 135).

By endorsing the patriarchal discourse which requires women to put up with marital strife, no matter how unacceptable, she blames herself for contributing to her

daughter's death. Unwittingly, she colluded with structural violence (referred to in Chapter 2), helping to perpetuate a system which works against women, including herself and her daughter. In doing so, she acted out Bourdieu's concept of symbolic violence in terms of which people 'contribute to their own domination by tacitly accepting the limits imposed' (Bourdieu 2004: 341). However, towards the end of the story, Nontando makes a stand, rebelling against the individuals and discourse that would silence her.

Male attitudes towards women have a strong bearing on the AIDS epidemic. South African women are often victims of abuse and sexual violence: ⁶ alarmingly, South Africa has 'the highest level of rape in any country not at war' (Lawson 2008: 61). Kauffman comments that 'extremely high rates of rape in South Africa are an indication of the way South African men view their relations with women' (2004: 23). There is a proven correlation between violence against women and AIDS: women in abusive relationships are far more likely to contract HIV/AIDS than women who are not abused by their partners. In a study led by Rachel Jewkes of the SA Medical Research Council and published in *The Lancet*, it was found that women in 'low power' relationships who had suffered physical abuse had a much higher incidence of HIV infection compared to women with 'medium or high relationship power'. The researchers noted that 'reducing men's violence and increasing women's power were key to preventing HIV infection in women' (Jewkes *et al* 2010). Van der Vliet observes that 'it is one of the ironies of South Africa that a country with one of the most gender-sensitive constitutions, including a commission on Gender Equality, should also experience very high levels of violence against women'. She goes to say that 'the inability to negotiate safer sex because of gender inequality is a major driving force in the HIV/AIDS epidemic' (2004: 68).

⁶ According to Interpol statistics, South Africa reported 12.5 rapes per 10 000 people in 2001 compared to 3.2 rapes per 10 000 people in the United States (Kauffman 2004: 23). The medical journal *The Lancet* reported that over a quarter of South African men (27.6 per cent) admitted to having committed rape. In 2003, in Gauteng, almost four in ten girls reported experiencing sexual violence before the age of 18 (*Pretoria News*, 26 August 2009).

These issues are effectively dramatised in the short story 'Baba's Gifts', by Jenny Robson and Nomthandazo Zondo, in *Nobody ever said AIDS; Stories and Poems from Southern Africa* (2004: 98-102). The central character is MaNdlovu, a married woman who awaits the return of her long-absent miner-husband, Baba, with trepidation. The reason she is nervous is her awareness that she has to make him wear a condom when he sleeps with her. She has been part of a group of women educated at the local clinic by Nurse Margaret who has informed them graphically about the dangers of AIDS and demonstrated what to do to prevent infection. While the rest of the family anticipates the head of the household's return with eager excitement, knowing that he will bring them gifts from the city, MaNdlovu dreads having to speak to him as Nurse Margaret has instructed her to. She puts off the moment of truth until they are alone at bedtime, when she produces a condom and begins her oft-rehearsed speech. His response is:

'Nurse Margaret! Why do you listen to Nurse Margaret? She is an ugly woman who will never be married. So now she tries to destroy the marriages of other women. You throw that nonsense away, MaNdlovu. And then you join me here in bed.'

And even though he is laughing, MaNdlovu knows she must do what he instructs, no matter what Nurse Margaret has explained. Dlamini has turned the lamp off now. In the darkness, without her small square package of protection, MaNdlovu gets into bed beside her husband. He still smells of the city, despite his bath.

This conclusion of the story illustrates that information and knowledge are useless in a such a situation: women such as MaNdlovu have been conditioned not to oppose male authority, illustrating that 'a heterosexual woman is usually not an equal partner in the bedroom' and revealing the 'underlying inequity between women and men, at the level of individual relationships as well as in the culture at large' (Anastos and Marte 1989: 11). The final sentence: 'He still smells of the city, despite his bath' suggests that Baba is irreversibly infected, and that the most notable 'gift' he is bringing home is the HI-virus. Her fear of talking to him about condom usage and submission to his will suggests that he may have used physical violence against her in the past, and her choice of silence

rather than resistance bears out the validity of Monti-Catania's observation that '[g]iven the choice of immediate serious injury or the gamble of contracting HIV, many women have been forced to choose the latter' (1997: 245).

Alternatively, it is equally possible that Baba has never used actual force against MaNdlovu. Galtung's (1969) theory of structural violence and Bourdieu's (1991) concept of symbolic violence both stress that oppression can be exercised silently and invisibly without overt physical force. Galtung makes an important distinction between 'violence that works on the body, and violence that works on the soul; where the latter would include lies, brainwashing, indoctrination of various kinds, threats, etc. that serve to decrease mental potentialities' (1969: 169). Subtle but prolonged indoctrination results in what Bourdieu terms a particular *habitus* (the meaning of which corresponds roughly with the phrases 'cast of mind' or 'mindset'), which refers to a set of *dispositions* which 'incline agents to act and react in certain ways'. *Habitus* is usually unconscious and pre-reflexive, and becomes embodied in the individual. '*Dispositions* are acquired through a gradual process of *inculcation* in which early childhood experiences are particularly important, and are *structured* in the sense that they unavoidably reflect the social and cultural conditions within which they were acquired' (Bourdieu 1991: 12, emphases in original). In other words, external social structures, or discourses – in which forces like racism, sexism and classism are embedded – are absorbed into the subjective, mental experience of agents. Exposure to these insidious mechanisms over time means that women like MaNdlovu unconsciously come to acquire the dispositions and habitus which perceive male power as legitimate. They then reproduce these patriarchal structures in their own behaviour, sustaining the unjust social order, and so participate in their own subjugation. By accepting the hierarchical relations in which they are embedded, they fail to see that the hierarchy is an 'arbitrary social construction which serves the interests of some groups more than others' (Bourdieu 1991: 23). The central issue of 'Baba's Gifts' is gender inequality. AIDS itself is displaced in the story, remaining a shadowy background presence; a vague

future threat, much less direct and immediate than the husband's exercise of symbolic power over his wife.

'Baba's gifts' illustrates the weakness inherent in the South African government's 'ABC' campaign ('Abstain; Be Faithful; Condomise'), which fails to take account of the unequal power relations that exist between males and females.⁷ Some of the problems ignored are that women are highly vulnerable to coercive sex, so, however strongly they resolve to 'abstain' from sex, this will not help them when they find themselves in a situation with a physically stronger male to whom they are also psychologically subordinate. As far as the second injunction, 'Be Faithful', is concerned, it will not help a married woman (for example) to remain faithful to her husband if he engages in extramarital affairs. She cannot control his behaviour when he has sex outside the marriage. Similarly, the 'Condomise' instruction is only effective if the man is prepared to use a condom, and this is clearly under his control. Women who have been socialised to respect male authority lack the power to insist that he use one if he is not willing to do so. As Maria de Bruyn notes, 'it is continually emphasized that the practice of preventive methods is an individual decision, ignoring the fact that decision-making also depends on social factors [including gender relations] facilitating a particular course of action' (De Bruyn 1992: 251). Farmer *et al* reinforce this point when they state that 'the call to change "lifestyle and behavior" is directed toward precisely those persons whose agency is most harshly constrained'; and assumes, fallaciously, that 'women may choose, freely and equally, to avoid or engage in risk' (1996: 173). Only women who are 'free and equal' can exercise choice.

⁷ The 'ABC' anti-AIDS-campaign originated in the United States and was promoted by the Bush administration. It was criticised there for, amongst other things, failing to promote sex education at the same time, and for ignoring the long-accumulated data demonstrating that marriage is a major risk factor for women in terms of HIV-infection (Susser 2009: 47-8).

Another facet of male violence and female victimisation in the AIDS epidemic is the rape of babies, thought to be a cure for HIV-infection (Jewkes 2002).⁸ Van der Vliet (2004: 68) notes the absence in South Africa of strong information campaigns needed to counteract this barbaric myth, and the lack of public statements from political figures, community leaders, traditional healers, pop stars and sports heroes on the subject. She attributes this failure to speak out to the sensitivity of the issue. Again – as in the case of ‘From the Air’ and ‘Compassionate Leave’, discussed in Chapter 1 – it is a literary text which counteracts this silence and provides a voice for the voiceless and powerless. In the poem ‘Just a Child’, by Mthuthuzeli Isaac Skosana in *Nobody ever said AIDS; Stories and Poems from Southern Africa* (2004: 97),⁹ the poet assumes the persona of a baby girl who is a victim of this myth.

I’m just a child
 I’m just a little girl
 I’m just a baby girl waiting
 waiting to be picked up
 by the hands of a father
 or uncle
 or neighbour

I’m just a little daughter
 The one you cherished with a name
 I’m your little daughter

I’m just a neighbour’s child
 The one you bought gifts for
 The child you said you would look after

I’m just a child
 not prescribed as a cure
 I’m not your HIV medication

⁸ Jewkes casts doubt on the view that child rape has increased markedly as a result of the ‘virgin cure’ myth. She attributes the violence against women and children to more general problems of a society extremely brutalised by the political violence in the country’s past, disruption of families, poverty, gender inequalities, a culture of male entitlement and the lack of severe enough punishment and societal condemnation of rape. However, it remains true that the ‘virgin cure’ myth has been behind some cases of baby rape.

⁹ The poem is dedicated to Baby Tshepang, who was raped in 2001 when she was less than a year old.

even my scream could not stop you
 your ears are my witness
 I'm just a child.

This creative construction of the baby's experience creates awareness of her cruel violation and dehumanisation when she is commodified as 'HIV medication', illustrating how the language of literature can counter the discursive displacement, silence and invisibility of female victims in the AIDS-epidemic.

I have chosen to regard the rape trial of Jacob Zuma as a cultural text and analyse its discourse to demonstrate the destructive effects of gendered perceptions in matters of HIV/AIDS. The trial is relevant not only because the woman who brought the charges against Jacob Zuma was HIV-positive, but also because the discourse of the trial and of Zuma himself highlight the extent to which the epidemic is driven by gender inequality.

The behaviour of Jacob Zuma, who became president of South Africa in 2009, reflects, to a large extent, the patriarchal attitudes still prevalent in South Africa despite the new Constitution which guarantees gender equality. Zuma is a polygamist and, in addition, has had extramarital relationships resulting in illegitimate offspring.¹⁰ In 2006, when he was Deputy President, Zuma stood trial on a charge of raping a thirty-one-year-old woman who was HIV-positive, and some of the statements made during the trial, and certain words and actions of his supporters outside the court, which I examine below, displayed sexist values highly damaging to women and to the AIDS-epidemic. In the discussion which follows, I have used Mmatshilo Motsei's *The Kanga and the Kangaroo Court* (2007) as a key text because it showcases the discourse of the trial, which, as the title of the book suggests, was as brutal and illegitimate as the mob justice which put 'traitors' to death in the 1970s and 1980s during the struggle. The title of

¹⁰ For example, in February 2010, it emerged that he had had an affair with Sonono Khoza, daughter of his friend Ivin Khoza, and that she had had his baby in 2009. This despite the fact that he had taken a third wife in 2009 and was engaged to a woman who will be his fourth.

Motsei's text also plays cleverly on the words 'kanga' and 'kangaroo', drawing attention to the way the complainant's dress (a kanga)¹¹ was exploited by the defence.

During the trial, Zuma's defence team, led by Advocate Kemp J. Kemp, used a number of different tactics to discredit the complainant, whose identity was kept secret and who was given the pseudonym 'Khwezi'. Kemp constructed the young woman as culpable by construing her attire (a kanga) on the evening of the incident as an invitation for sex. In so doing, Kemp was drawing on the well-established discourse which holds the woman responsible for the sexual violence perpetrated by men. In his testimony Zuma blamed the complainant for wearing a knee-length skirt and later a kanga which he said were 'signals' that she wanted to have sex with him.¹² This illustrates Justice Malala's view that 'if the man alleges the woman was dressed provocatively, such as in a miniskirt, the alleged rapist always gets acquitted. In folklore and in law, the woman in the miniskirt was begging for it [rape]'.¹³ Allan Brandt describes how, in the United States at the time of World War I, women were held responsible for soldiers' sexual behaviour through the way they dressed. A pamphlet aimed at young women asked, in a tone of patriarchal didacticism:

Did you ever stop to ask yourself what might be the effect upon young men of the kind of clothes you wear? The too transparent waists, showing plainly all the underwear beneath, the dresses cut too low in the neck, the gowns that cling too closely to the figure – what are these but suggestions to young men to think only of the physical charms of these young feminine creatures, and of nothing else (1985: 82)?

The women were blamed for the sexual misconduct of the soldiers who were constructed as innocent and decent defenders of the nation.

¹¹ A kanga is an item of traditional dress which originated in East Africa. It is a piece of cotton cloth as long as an adult's outstretched arms and wide enough to cover an adult woman's body from above her breasts to below the knee.

¹² 'Skirting the real issues in the war against Aids': *Pretoria News*, 8 April, 2006.

¹³ 'Media buy into miniskirt myth', *Sunday Times*, 19 March 2009.

Kemp also used Khwezi's past sexual history to suggest that she had loose morals and was in the habit of making false claims of rape. The defence team made much of the fact that the complainant had been raped three times by the time she was fifteen, when she was in exile in Lusaka with her family. The ANC committee which at the time investigated allegations that the complainant was raped twice when she was thirteen, found the two men concerned (both significantly older than the complainant) guilty of having sex with a child. However, eighteen years later, Kemp put it to the complainant that she had consented to having sex with both men, that she regarded them as her 'boyfriends', and so these events did not constitute rape. By constructing her as sexually precocious as a teenager and promiscuous as an adult – evidenced by her 'provocative' dress on the night of the alleged rape – Kemp was drawing on the familiar discourse of the 'woman as whore', and resorting to the old practice of blaming the victim. Underlying such constructions are what Baym describes as 'profound misogyny' (1984: 160).

Moreover, from a strictly legal point of view, Liesl Gertholtz, executive director of Tshwaranang Legal Advocacy Centre pointed out that, in constructing past events in this way, Kemp chose to ignore the fundamental legal precept that sex with a minor, whether consensual or not, is statutory rape. In his efforts to construe her past rape allegations as 'false', Kemp intended her rape allegation against Zuma to be seen as false as well. In so doing, both he and the court (Judge Van der Merwe allowed the complainant's sexual history to be taken into consideration) were violating the Criminal Procedure Act which specifically prohibits the leading of evidence on past sexual history and experience, a provision intended to protect survivors of rape and sexual assault from being subjected to embarrassing and humiliating cross-examination, a tactic that defence lawyers have often resorted to, to intimidate and silence complainants.¹⁴

¹⁴ 'Trial sends grim message to other survivors': *Sunday Times*, 19 March 2006.

While the defence was allowed to explore and expose Khwezi's sexual history, Zuma's record of multiple marital and extramarital relationships was never interrogated.

To cast doubt further on Khwezi's integrity and reliability as a witness, psychological evidence was led to impute mental instability to the complainant. Dr Louise Olivier, the forensic psychologist who testified for the defence, represented the woman's report of sexual violation as a personal pathology. Motsei describes the practice of shifting the focus from the "badness" of the male offender to the "madness" of the female victim' (Motsei 2007: 183) as a 'key tactic of patriarchy'. Institutions of power suppress voices of dissent by labelling people who challenge the status quo as mad, unstable, irrational or unbalanced (Motsei 2007: 149-50). In *Madness and Civilization* and *The Birth of the Clinic*, Foucault describes the social machinery of oppression and the methods of control and constraint which evolved in the eighteenth century and which 'objectified' certain individuals, including mental patients, and subjected them to 'dividing practices'. Foucault describes such practices as 'modes of manipulation that combine the mediation of a science (or pseudo-science) and the practice of exclusion' (Rabinow 1984: 8). In the case of Khwezi, the intended strategy was to 'use science' (psychology) to exclude and displace her from the world of 'rational' people and so dismiss the validity of her testimony. Khwezi was pathologised, while Zuma's actions were normalised and redeemed. This construction accords with old discursive assumptions which link masculinity with reason, and femininity with its opposite; unreason or madness (Felman 1975: 12-3), a dualism based on entrenched oppositions between men and women, in which male qualities are valorised and female qualities inferiorised. Domna Stanton, referring to French literature, notes the 'recurring identification of the female ... with madness, antireason, primitive darkness, [and] mystery', which Baym sees as 'congruent with the idea of the hopelessly irrational, disorganized, "weaker sex", desired by the masculine Other' (1984: 158).

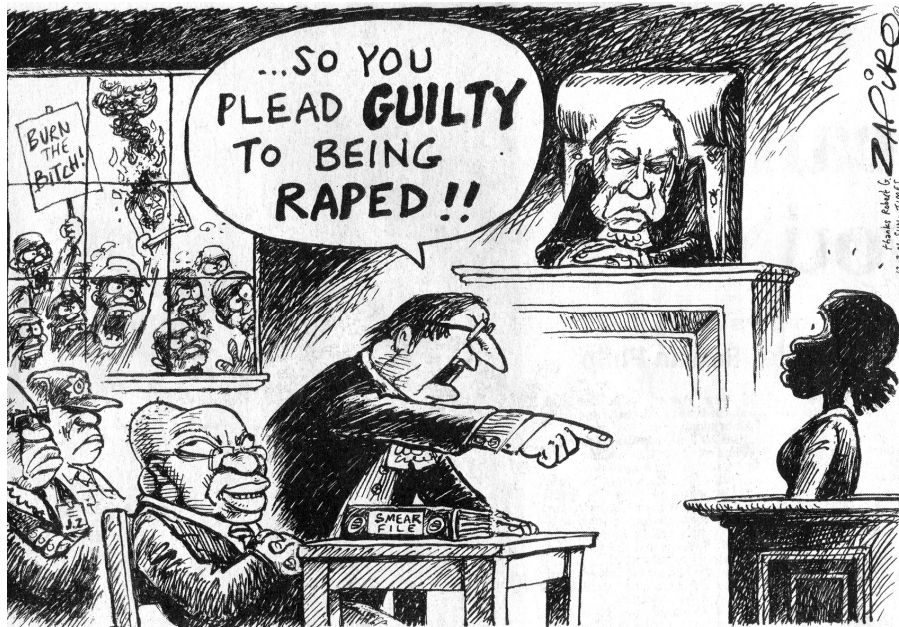
As if being constructed as immoral and mad were not enough, the complainant was also caught in the crossfire of the succession debate. There were accusations that she was pursuing a political agenda by trying to sabotage her alleged rapist's chances of becoming the next president of the country. Jacob Zuma was constructed as the victim of a conspiracy, in which she was complicit, to ruin his political career. As a senior member of the ruling political party, and a possible candidate for the next president of the country (which was in fact realised three years later), Zuma was strongly identified with government institutions, so Khwezi's charges against him could be construed as an attack on the State. According to this narrative, her action was tantamount to treason. Fine *et al* (1996) discuss public perceptions of cases of sexual abuse involving men in positions of institutionalised power in the United States, showing that, in the main, both men and women rally toward 'defending the institution from the harm brought by the wound of public exposure of alleged wrongdoing', so that the accuser's voice has to be 'buried beneath institutionalised interests' (1996: 152-3). 'She is [seen as] the victimizer. He is the victim. She threatens the institution; he must be protected if the institution is to survive. Her charge (and not the abuse) is the crime' (1996: 141). The original issue of rape against Zuma was turned into a case of something completely different. Fine *et al* demonstrate that Khwezi's treatment was typical in this respect:

We watch the girl/woman wither as she sees her story be denied, denigrated, reconstituted or ... discarded. After the telling, the institution reasserts its coherence, seals its borders, and struggles to insure its sense of integrity. ... Official discourses normalize what has happened (1996: 134).

Fine *et al* describe such outcomes as 'feats of institutionalized coherence, [accomplished] despite a recognized transgression' (1996: 137).

All these tactics, which displaced attention and suspicion from the accused to the complainant, meant that Khwezi was actually the one put on trial, forced to defend herself, and unofficially judged 'guilty'. The trial ended in her humiliation and defeat. The perpetrator, Jacob Zuma, on the other hand, was exonerated on the grounds of her

discreditation and his Zulu culture. He was acquitted. The cartoonist Jonathan Shapiro highlights the reversal of the roles of victim and offender in the cartoon reproduced below:¹⁵ a confused and frightened-looking Khwezi is standing, as though the accused, in the dock, while Zuma adopts a relaxed posture and self-satisfied expression as he sits in the court. The outstretched arm and accusing finger of Kemp J. Kemp, who personifies patriarchal authority and power, directs the reader's attention towards her, suggesting that she is the one in the firing-line, while Zuma escapes scrutiny. The white space between her and Kemp suggests her distance from the hegemonic power she is attempting to challenge, but which is controlling her.



(Shapiro 2006: 76)

Khwezi was virtually silenced by Kemp's aggressive cross-examination, in a dramatic illustration of what Bourdieu means when he says that 'relations of communication' or 'linguistic exchanges' are also 'relations of symbolic power in which the power relations between speakers or their respective groups are actualized' (1991: 37). Such interactions cannot be divorced from the specific social contexts (what

¹⁵ © YYYY-2010 Zapiro. This, like all other Zapiro cartoons in this thesis, is printed with permission from www.zapiro.com.

Bourdieu calls 'fields') in which they take place. A 'field' may be seen as a 'structured space of positions' which determines the interrelations between the participants (1991: 14). In the field of the courtroom and as a legal specialist himself, Kemp was supported by the intimidating machinery of the law and imbued with power, while Khwezi, an outsider in this field, was completely disempowered and rendered all but speechless. It was only in an interview after the trial was over that the young woman could make her voice heard:

'I haven't spoken out before because I did not want to be part of the game I saw happening through the media. I see myself being described and defined by others, the media, the defence, the judge. I have heard the things said by members of various structures and parties. I see analysis and judgement from all sides

Now I am angry and ready to speak. It is an anger with direction. I am ready to use it to take on the huge battle we have in our society when it comes to how women are viewed and treated and the kind of roles men play to keep women in these positions. I am not mad. I am not incapable of understanding the difference between consensual and non-consensual sex. The fact that I have been raped multiple times does not make me mad. It means there is something very wrong with our world and our society' (Motsei 2007: 150-1).

In saying that 'there is something very wrong with our world and our society', the complainant was pointing to structural and symbolic violence; in this case, sexist structural violence that is particularly injurious to women, even though – ironically – many women themselves uphold and perpetuate it. Some of the most vicious statements and slogans against Khwezi came from the women among Zuma's supporters at the time of the trial, who served as the 'moral guardians of a civic order built on gendered violence and inequity' (Fine *et al* 1996: 145). This illustrates Farmer's definition of structural violence as 'violence exerted systematically – that is indirectly – by everyone who belongs to a certain social order' (2004a: 307) and Bourdieu's concept of symbolic power, 'that invisible power which can be exercised only with the complicity of those who do not want to know that they are subject to it or even that they themselves exercise it' (1991: 164). In an extreme example of the phenomenon of

symbolic violence, a group of teenage girls outside the court at the end of the second day of evidence, said: 'we are waiting for Zuma to rape us too; we want to be Zuma's women'.¹⁶ Bourdieu and Wacquant illuminate such responses:

The immediate agreement of a gendered habitus with a social world suffused with sexual asymmetries explains how women can come to collude with and even actively defend or justify forms of aggression which victimize them, such as rape (2004: 274).

As Motsei observes, 'what Zuma did cannot be condemned in isolation. It is a reflection of the prevailing thoughts, attitudes and perceptions in broader society' (2007: 15-6).

In his defence, Zuma testified that, far from abusing the complainant, he was doing her a favour, because, according to his culture, 'you cannot leave a woman who is already at that stage [of sexual arousal]'.¹⁷ By raising a cultural defence within criminal law, Zuma 'took advantage of the cultural pluralism that exists in South Africa' (Motsei 2007: 185) to silence his critics, but at the same time failed to mention other cultural principles he was clearly violating. The press and others were quick to point out the weakness in this argument. For example, as the child of his friend, the complainant should never have been regarded as a sexual partner. Simphiwe Sesanti, a lecturer at Stellenbosch University's Department of Journalism, asserts that 'in African culture a child of your contemporary is your child. It is taboo to have sex with your charge – consensual (as Zuma claimed was the case with Khwezi) or not'.¹⁸ Because of the age difference between them and past family connections, the complainant regarded him as an elder to be respected, and as a father-figure who had a moral obligation to protect her. Instead, he exploited her subordinate position and abused his position of seniority and power.

¹⁶ 'Trial sends grim message to other survivors': *Sunday Times*, 19 March 2006.

¹⁷ 'Quotes of the week': *Pretoria News*, 8 April 2006.

¹⁸ 'Badly behaved leaders set back our African aspirations': *Pretoria News*, 6 February 2010.

The official judicial proceedings of the Zuma rape case showed that the law both ‘translates’ power as non-power (coercive sex was reconstituted as consensual sex between equal partners), and also ‘constitutes’ power (Fine *et al* 1996: 146), in that it legitimates and reinforces structural violence, in this case, discrimination against women. The law is not the neutral, autonomous body it is thought to be, but, like the medical profession, is part of hegemonic discourse connected to other patriarchal structures in society. This resonates with the view of Fine *et al* that ‘institutions of presumed justice’, which fail to hold men accountable for mistreatment of women and subscribe to gendered interests, are actually ‘institutions of *injustice*’ (1996: 155).

Events outside the courtroom were also intensely hostile to the complainant. One remark made by a supporter was: ‘How do you walk around barely clothed in the house of a man imbued with feelings? Any man with a functional penis would have reacted the way Zuma did’ (Motsei 2007: 57), thereby invoking the discourse of ‘Nature’, where the man is constructed as simply following his ‘natural’ instincts and hormones in an entirely normal and healthy way. Fine *et al* observe that ‘[s]ubmerging male accountability into “nature” ’ conveniently shifts the initiative and blame to the bad woman (1996: 147-8). Another poster, more crudely, stated: ‘To Hell with Kanga Monkey’.¹⁹ Many Zuma supporters held banners reading ‘BURN THE BITCH!’, a slogan which was also chanted by the crowd, and picked up in Zapiro’s cartoon, reproduced above. ANC Youth League spokesman Zizi Kodwa said he would respect the court’s ruling not to identify the complainant. He would, instead, refer to her as ‘Lucifer’ (the devil). By contrast, Zuma was implicitly identified with Christ, when a large, hand-held crucifix was waved aloft. The text on the cross read: ‘Why are you crucifying Zuma?’.²⁰ Motsei sums up the situation perceptively:

¹⁹ ‘Vuvuzelas sound on judgement day’: *Sunday Times*, 14 May 2006.

²⁰ *Ibid*: *Sunday Times*, 14 May 2006.

It is clear from Jacob Zuma's rape trial that in the 21st century a woman who decides to lay a charge of rape still has to face insurmountable challenges It is also clear from the reportage on the trial that a female rape victim who doesn't fight back is perceived as a willing participant. If she fights back, however, she runs the risk of injury or death. If she chooses not to speak out, she will die inside. If she speaks out, she is a devil and deserves to burn in hell (Motsei 2007: 34).

Zuma's 'trademark song', *umshini wam* ('bring me my machine gun'), which he frequently sings at political gatherings, accompanied by dancing, was also sung at his rape trial, raising questions about the association of sex with violence. Njabulo Ndebele drew attention to the link between the AK-47 and what he termed 'the invasive penis', and the relevance of this connection to the high incidence of rape in South Africa.²¹ Motsei reports that when Ndebele challenged phallogocentric notions of masculinity, he was attacked by David Masondo, chairman of the Young Communist League, 'for being a traitor to the male species', while Masondo saw Zuma purely as a 'victim of a political conspiracy plot'. There was no attempt to see the song 'within the context of a rape trial taking place in a sexist culture in a society where extramarital sex for husbands is tolerated despite the epidemic prevalence of HIV/Aids' (Motsei 2007: 61-2).

In the wake of the Zuma rape trial, the journalist Maureen Isaacson wrote:

Until we confront the deep shadows cast by gender terrorism on men as well as women, we will be unable to move forward into the promised land of true equity.... Pitifully, it is still necessary to endorse the fact that women do not invite rape and violation. Khwezi's admission that she was raped three times before the age of 15 is an indictment of the trials of women and children This admission does not set her apart. Her story, with its tragic details, is the story of everywoman.²²

In addition to the destructive effects of the anti-feminist discourse that came out of the Jacob Zuma rape trial, Zuma's ludicrous explanation that he had unprotected sex with

²¹ Ndebele, N. 'Why Zuma's bravado is brutalizing the public': *Sunday Times*, 5 March 2006.

²² Isaacson, M. 'How to be raped in the dark ages of male entitlement': *Sunday Independent*, 12 March 2006.

an HIV-positive woman and believed that a shower afterwards would minimise the risk of infection, did serious damage to AIDS-education efforts. Zuma knew that the young woman was HIV-positive: she testified in court that she had confided this information to him in 2001 ‘because as a father he should know’.²³ Outraged organisations working in the field of HIV/AIDS prevention said that the statements by Zuma – who, ironically, also chaired the South African National AIDS Council – had reversed their work in the AIDS awareness field by at least 15 years.²⁴ Dr Francois Venter, president of the Clinicians Society, stated that ‘there has been significant confusion sown in the minds of the public. We call on public figures to show responsibility when making statements on HIV prevention, especially when these are in conflict with current scientific and government messages’.²⁵ Stephen Lewis, special United Nations envoy for AIDS in Africa said that ‘Zuma had done irreparable damage to efforts to curb the spread of Aids with actions that came to light in his rape trial’.²⁶ Similar concerns were expressed in 2010 at the time when Zuma’s fathering of a baby by Sonono Khoza was revealed. Helen Zille, leader of the official opposition, the Democratic Alliance (DA), stated that ‘Zuma has set us back at least a decade in the fight against HIV/Aids’.²⁷ Generally speaking, the effects of the rape trial – in particular, the condemnation of Khwezi and the exculpation of Jacob Zuma – reinforced patriarchy in South Africa, to the serious detriment of women and AIDS-prevention.

Patriarchal power and its role in the AIDS-epidemic is an important theme in a cinematic text, the Oscar award-winning film *Tsotsi* (2006). At the beginning of the film there is a wide-angle view of the interior of Johannesburg’s Park Station, and

²³ ‘HIV poser hangs over Zuma’: *Pretoria News*, 17 March 2006.

²⁴ ‘Aids: Zuma’s shower talk causes furore’: *Pretoria News*, 7 April 2006.

²⁵ ‘Aids helpline flooded over Zuma’s shower remarks: Damage control under way after controversial utterings’: *Pretoria News*, 10 April 2006.

²⁶ ‘UN envoy slams Zuma’: *Pretoria News*, 11 May 2006.

²⁷ ‘Zuma takes break after “hectic” trips: DA, ID slam sexual conduct’: *Pretoria News*, 5 February 2010.

dominating the vast scene is a huge advertisement with the slogan: 'AIDS affects everybody'. The sign silently makes a powerful point: that AIDS is a pervasive factor in this society and a major determiner of individual human lives. However, amidst the hustle and bustle, no one takes any notice of it. The immediate urgency of getting to and from work and home displaces the reality of AIDS in the commuters' consciousnesses. However, the sign is a major clue to the underlying significance of events that make up the narrative.

The central character in the film, 'Tsotsi' himself, is a ruthless thug who does not hesitate to kill to gain his ends. He masterminds his gang's killing of an old man whom they rob; he beats a gang member to a pulp for challenging him; and pointlessly shoots a woman whose car he hijacks. These events happen in quick succession in the film's opening sequences, leaving us in no doubt that violence is second nature to him. Yet a more tender side of his nature comes to the fore when he discovers a baby in a car he has hijacked, and instead of abandoning him, he takes the baby home and tries to care for him. This other dimension to his character makes him complex and puzzling, and we only come to an understanding of the genesis of his character through flashbacks to his early childhood when it becomes apparent that he is an AIDS orphan.

There is a poignant scene in which we are shown Tsotsi, as a small boy, standing beside his mother's sickbed. She reaches out weakly to touch him, but as their hands connect, the father appears and angrily shouts at the mother for touching her son with her 'sickness'. We realise that she is dying of AIDS and that the father believes that she could contaminate the child through physical contact. The young David (alias 'Tsotsi') runs outside in terror – he is clearly used to his father's violence – and hides behind the chicken coop. He watches as the family dog reacts aggressively to the father's rage, and the father kicks the dog viciously, breaking its back in the process. The trauma of this experience is so intense that the child runs away from home, never to return. He joins the homeless children who live in unused concrete sewerage pipes. Symbolic

significance is attached to their makeshift 'home': the children are implicitly identified with the unwanted waste of society, the discarded effluent of the AIDS epidemic. Without education or parental care, such displaced children resort to crime as their only means of survival. We realise that many of the children occupying the sewerage pipes will drift into crime, as Tsotsi has done.²⁸

AIDS, its stigma, and the violent reaction of the father – who is apparently used to abuse as a means of controlling his household – have combined to cause the main character's delinquency: the fact that David metamorphoses into 'Tsotsi'. The 'sickness' the wife is suffering from is not named: we are left to draw our conclusions from the husband's belief that her touching their child could infect him. His reaction to AIDS is a crucial catalyst in the tragic events we witness in the film, but it remains a displaced factor: silent and invisible. The billboard at Park Station – 'AIDS affects everybody' – is shown several times and grows in significance as the film proceeds, but the connection of AIDS to the turn Tsotsi's life takes is indirect and has to be inferred.

Many of the gender-related themes in the texts discussed above are more fully explored in the film text *Yesterday* (2003), which narrates the story of a young black woman, called 'Yesterday', who has AIDS.²⁹ Feminist ideology underlies this text³⁰ and

²⁸ The homeless who have become street children as a result of being orphaned by AIDS represent a potential threat to South African society and undermine Mandela's vision of the 'new' South Africa. Martin Schönreich, Senior Researcher at the Institute for Security Studies, refers to the rapidly growing orphan population as 'South Africa's crime time bomb'. He observes that 'governmental policy makers would be well advised to brace themselves for an increase in juvenile-related crime as the number of orphaned juveniles increases over the next two decades' (1999: 4).

²⁹ For a fuller discussion of the film *Yesterday*, see: Horne, Felicity. 2005. *Yesterday, AIDS and Structural Violence in South Africa*. In *Communicatio*, Vol. 31, (2), 172-197.

³⁰ I am aware that there is more than one 'feminism', but a full exposition of these would fall outside the scope of this thesis. For the purposes of the discussion of *Yesterday*, I use the term 'feminist ideology' to explain certain features of the film: the choice of a female protagonist from whose perspective the audience experiences events; her growth as a character when she is tested by adversity; and her strength and complexity as a human being.

many of the problems Yesterday has to contend with are shown to stem from the gender-related power structures that operate in society.

In the opening scenes of *Yesterday*, the heroine is shown trying to get medical attention at a rural clinic far from her home. Because it takes her so long to walk there, she always arrives too late to be seen by the only doctor on duty, and is turned away repeatedly. The film demonstrates the power of the visual (as opposed to the linguistic) medium to convey setting and its significance. Slow, wide-angle views show that the landscape is vast, empty, harsh and undeveloped, unsoftened by trees or shade, and lacking in essential support such as transport and medical care. This inhospitable environment is effective on a literal and metaphorical level, suggesting that the nature of the terrain Yesterday inhabits is a key factor in her illness. Her persistent cough indicates the probability of tuberculosis. She is in urgent need of medical attention, but the health services are hopelessly inadequate. Frustrated in her efforts to see the doctor, Yesterday consults a *sangoma*,³¹ representing an alternative discourse to Western biomedicine. The *sangoma's* 'diagnosis' is that Yesterday's condition is the result of internal anger, anger that she must 'let out' of her body, but Yesterday denies this, saying: 'What have I got to be angry about?' Her puzzled expression, combined with our observation of her generally good-natured and compliant demeanour, inclines us to accept Yesterday's response and disagree with the *sangoma's* pronouncements. However, the *sangoma's* words are prophetic, carrying a psycho-spiritual truth which is later to emerge.

When Yesterday eventually succeeds in getting to the clinic early enough to see the doctor, she is subjected to a blood test. Highlighted in this scene is her lack of education. When she is given the medical consent form to read and sign, we see it from over her shoulder. The print is deliberately out of focus so we share her experience of illiteracy. She has no awareness of the possible cause of her infection, and it is evident that she finds it difficult and uncomfortable to answer the doctor's questions about her

³¹ A *sangoma* is the isiZulu word for a traditional healer.

and her husband's sexual habits. This points to the taboo nature of sex as a subject for discussion in her culture in which, as Zungu-Dirwayi *et al* observe, 'women are often viewed as "good" and "virtuous" and therefore socially acceptable if they display no knowledge of sex These gendered conventions ultimately limit women's access to, and knowledge of, safer sex practices A culture of silence that surrounds sex dictates that "good" women are expected to be ignorant about sex and passive in sexual interactions ...' (2004: 63-4).

On learning that the husband is a migrant labourer on the mines in Johannesburg, the doctor – a white woman fluent in Zulu – asks her if she and her husband use condoms. Yesterday's bewildered expression and naive question: 'But why? I am a married woman', show that she thinks of condoms only for the purposes of contraception and has never doubted her husband's fidelity. Yesterday's response to the doctor's question as to whether they had a normal sex life: 'You know what men are like after they have been away for a long time ...', carries the unspoken implicature that men expect sex frequently when the wife is available. Her words and resigned tone of voice suggest that she uncritically accepts that it is the man's prerogative to demand sex how and whenever he likes, regardless of the woman's feelings. Also apparent is Yesterday's assumption that the doctor, as another woman, understands this state of affairs and also accepts male power. Anastos and Marte's observation that 'women are unable to protect themselves adequately from infection because they are frequently unaware that they are at risk; and even when they are aware, they are unable to assert their need for protection' (1989: 12) is absolutely pertinent to Yesterday.

In the follow-up appointment, the doctor's silence, when Yesterday asks if the HIV-positive result of the test means she is 'going to stop living', is wordless confirmation that this is indeed so. The deliberate omission of dialogue at this juncture makes a powerful point, far more potent than any attempt at explanation by the doctor. The heavily-loaded silence is held for a long time, an aural signifier of the treatment

vacuum that exists for people like Yesterday. Visually, the figures of the two women appear to shrink as the camera cranes upwards in stages, so that the audience looks further and further downwards at them in the small consulting room. The final high camera angle makes them seem trapped at the bottom of what almost resembles a pit. This technique creates a dramatic awareness of the helplessness of professional and patient: we are made to feel that they are both victims of larger forces. The doctor is a representative of the institutionalised health system, the power of which robs her of her power to prolong life. Yesterday's illness is treatable and her premature death is preventable, but, because of government policy, medication is not available to her.

Following the doctor's instructions to inform her husband of her condition so that he can be tested for HIV himself, Yesterday makes the difficult journey to *Egoli* (Johannesburg). Upon her arrival at the actual goldmine, we are given brief views of the mine headgear, emblematic of the goldmining industry. Its height and dominance over the general scene function as a material signifier of the power of the historically-engineered socio-economic machinery that – to a large extent – determines the circumstances and fate of those linked to the mining industry.³² Yesterday is, of course, one such person, albeit indirectly. We feel her vulnerability in the all-male environment of the mine as her presence there is met with catcalls from the men and rudeness from the mine official she approaches for help in locating her husband. When he emerges from underground he recognises her, but he stands aloof, his attitude verging on hostility. There is some stilted dialogue between them before the scene cuts to the interior of a room where we see but cannot clearly hear them speak. Their figures are vague as the encounter is shot from the window of the adjacent office where the same mine official sits reading the newspaper, his back to the window. When the tall silhouette in the room behind him lunges forward and strikes the smaller one and we hear Yesterday's faint screams, the mine official turns around and observes what is happening, but dismisses the sight with a fatalistic shake of the head. He does not

³² Refer to discussion of the migrant labour system in the Introduction, p. 12

intervene. The focus remains on him in the foreground while the husband's actions of repeatedly punching Yesterday's cowering body are kept in the background, which goes more and more out of focus, and her screams become inaudible, suggesting how successfully the official shuts the assault out of his consciousness. His silent passivity, ironically, is a form of violence, because it colludes with the actual violence of the husband.

When Yesterday's husband returns to the village some months later, his skeletal frame and blemished skin serve as fatal signifiers of full-blown AIDS. The abusive husband is transformed into a weak and pathetic child as he gives a shivering, low-voiced, weeping account to his wife of what he suffered in the workplace. Gone is his swaggering arrogance: victimiser has become victim. He confides intimate personal experiences relating to the uncontrollable diarrhoea from which he suffered on the mine. The film director adopts an immersive approach here: the audience is not spared the graphic reality of the husband's incontinence. His stooped, huddled body position conveys his profound shame and self-disgust. His use of the image that 'he stank like an animal' indicates his sense that he lost all human dignity, and became sub-human, an inferior form of life.³³ It is significant that the husband's AIDS-symptoms manifest as diarrhoea, while Yesterday's symptoms are those of tuberculosis. The reason for the director's choice in this respect could be that he does not want to risk jeopardising the emotional identification of the audience with the heroine, and so chooses the more 'romantic' form of illness for Yesterday, and the more repulsive one for the secondary character, the husband. Susan Sontag has explored the way TB – in contrast to cancer – has been aestheticised in popular mythology, to the extent that it has been 'the preferred way of giving death a meaning – an edifying, refined disease' leading to a

³³ Rozin states that such disgust 'is ... an index of the extent to which our sense of our humanity is vested in the idea of a well-bordered body ... no-one is disgusted by their faeces, for example, while they are within the intestines'. Nussbaum supports this view, commenting that 'waste and some bodily fluids are universally the object of human disgust, but only once they seep out of the borders of the body' (Posel 2004:7).

'beatific death' (1978: 16). The husband's AIDS is treated immersively, while Yesterday's is given counter-immersive treatment. Yet the explicitness with which the husband's symptoms of AIDS are described is unusual and significant, and does evoke compassion. However, displacement occurs in the erasure of how he became infected. In terms of the dualistic construction of womanhood identified by Brandt (1985: 31-2), Yesterday's husband was contaminated in the city by the 'bad', 'impure' and 'sensual' type of woman, while Yesterday conforms to the opposite type: the 'good', 'pure' and 'innocent' woman infected by her husband. The city women are not shown in the film, and are an 'absent presence'. Similarly, the possibility that the husband may have been infected by homosexual contact at the mine, is also elided.

On a subsequent visit to the clinic, Yesterday indicates that it is her mental rather than her physical state that is keeping death at bay. By telling the doctor that only when her child goes to school can 'this thing'³⁴ take her away', she shows that she feels she has a degree of control over the disease and over her life. The positioning of Yesterday relative to the doctor in this scene – they are both standing, as opposed to the way the doctor previously stood over her during the examination – signifies another change in power relations: it is Yesterday who tells the doctor why her condition is as it is, and not the other way round. This reflects her growing empowerment, as does her strange plan of building her own 'hospital' for the husband some distance from the village. She is driven to this step because of the lack of beds at the local hospital and the villagers' increasingly hostile attitude towards them. The isolation of the unsightly 'hospital' structure Yesterday builds on the otherwise bare plain is a visual index of the way she and her husband are forced to the edges of the little community, exemplifying the way that 'social death ... precedes the physical one' (Sontag 1989: 34; Niehaus 2007: 845). Here again, the visual representation has great impact, showing their liminal existential state between the living and the dead. Displaying independence, resourcefulness and courage, Yesterday's efforts show that she is trying to assume

³⁴ As mentioned in Chapter 1, among the black population, AIDS is referred to vaguely as 'this thing' or by means of different circumlocutions to avoid naming it.

power over her situation. Her actions show her refusal to live fearfully and be at the mercy of the villagers' intolerance, and so she voluntarily displaces herself and her husband from the community, finding her own solution, imperfect though this is. In a dramatic reversal of their original roles, her husband ends his days totally dependent on her. She has become the strong one.

In a pivotal scene Yesterday gives vent to her feelings. This occurs after her husband's death, when she physically attacks the 'hospital' shack with an axe, angrily trying to smash it down. In this endeavour she is unconsciously following the *sangoma's* instructions to 'let the anger out'. The causes of her anger are clear: her infection; her stigmatisation by the community; her fatal ignorance resulting from lack of education; the inadequacy of healthcare services and treatment for the poor; and gendered violence. Cumulatively, these constitute overwhelming justification for her pent-up feelings of rage. Her gender, race and class have structured her experience of AIDS, and constitute the 'terrain' of her life. This is a defining moment in her growth as a character, as she fully realises the injustice of what has happened to her and gives full expression to this realisation. At the start of the film, she accepted the structural violence which determined her disadvantaged existence, demonstrating active, but unconscious, complicity with the oppressive structures that limited her opportunities in life. Sadly, her new awareness and rebellion come too late to be of help. The soundtrack does not record the blows of the axe, or her anguished cries, the silence suggesting metaphorically that her agony goes unnoticed by the outside world.

Yesterday and her husband both display anger at different points in the film, and it is instructive to compare their expression of this emotion. As we have seen, the husband's anger takes the form of aggression towards her when she travels to the mine and he projects his anger on to her, externalising his problem by transforming her into the guilty party. Yesterday, on the other hand, vents her anger on the shack. She chooses this as a target because it is tangible and present, whereas the real objects of

her anger are abstract or absent. The shack is the site of complex aspects of her experience. It was necessitated by poverty, stigmatisation and ostracism and is associated with the horror of disease, dying and death. Its solid presence makes it an icon of structural violence, all that is wrong in society, and all that has gone wrong in her life. Her reaction against it shows her transformation from a state of passivity to active protest against the violence done to her, and can be read both as an expression of powerlessness and an attempt to exercise power in this situation. Instead of being a victim, one who is acted upon, Yesterday claims a measure of agency for herself, although her anger is completely futile. Crawford *et al* see the difference in the quality of the emotion of anger between females and males as a 'function of power'. They comment that '[a]nger ... is not necessarily empowering, particularly when it is female anger', and suggest that 'the anger of a powerless person has a strong element of victimization: it is a response to a perceived circumstance of injustice. Anger functions ... to convey the conviction of the protester's sense of unfairness. Male anger, on the other hand, is equated in a male-dominated society, with aggression' (Ariss 1997: 195).

Although, as already mentioned, this filmic representation of AIDS is informed to a large extent by feminist ideology, it contains some contradictions. In acting the part of the devoted wife and mother who puts up with conjugal abuse, denies her own needs as she nurses her husband and wills herself to live only for the sake of her child, Yesterday conforms to traditional patriarchal discourse about the 'rightful' roles of women. It could be argued that the film reinscribes the discourse of the 'sacrificial good woman' (Hogan 2001: 6), perpetuating perceptions that women should ideally be 'forgiving, selfless martyrs' (Hogan 2001: 53). The co-existence in this film text of a progressive feminist ideology and a conservative domestic one could be regarded as an 'uneasy fusion' (Hogan 2001: 27). It could also be argued that the choice of an attractive heroine is sexist in origin, and raises the question as to whether the audience would have been able to relate as sympathetically to Yesterday and the AIDS-related issues her experience raises had she been unattractive in looks and personality. Another question

that arises is whether she would have retained the audience's sympathy if she had not been an 'innocent' recipient of the HI-virus within the marriage relationship. The director would have risked losing the viewer's sympathy for Yesterday if she had become infected by having engaged in an extra-marital affair. Moral discourse would have judged that she had brought her 'punishment' on herself: that AIDS was 'self-earned'. Representations of 'innocent' AIDS-sufferers like Yesterday are problematic in that they imply that other kinds of people living with AIDS are 'guilty', and thus undeserving of sympathy or treatment.

Feminist ideology also underlies the choice of gender of the doctor, which departs from the perceived 'norm'. The anomaly of a 'woman doctor' (the very use of this marked term being significant), is remarked upon by Yesterday to her teacher friend, who reacts with amused surprise, suggesting their patriarchal, hegemonic social conditioning. However, the fact that the female doctor is young, blonde and pretty, could be seen as 'reflective of dominant patriarchal and heterosexual cultural assumptions' (Paget 1990: 96); again suggesting the co-existence of contradictory discourses within the text. Also, Yesterday receives crucial support from her friend, who offers to care for Beauty after Yesterday's death, suggesting the value of female solidarity, but the women in her village are heartless in their rejection of her. These contradictions show the mixed and complex nature of female responses to AIDS and the AIDS-ill. And even as we witness the tragic way that lack of education and power have doomed Yesterday to a stunted life and early death, traces of hope are offered by other female characters in the film who demonstrate that education can transform women into doctors and teachers. Beauty, who starts school towards the end of the film, has the chance of greater empowerment and a better quality life than her mother.

The film's closing sequence shows Yesterday's figure making its way slowly along the deserted dirt road winding into the distance, symbolic of death. The details of Yesterday's death are elided. This technique of displacement is partly a way of ensuring

that our sympathies are not alienated because ‘human kind /Cannot bear very much reality’, to use T. S. Eliot’s phrase (Eliot 1963: 190), and partly an effective way of suggesting that what happens to her is of no interest to society at large. Her death, like her brief life, is ‘invisible and of little or no account’ (Scheper-Hughes 2004: 278). Yesterday’s expendability is a function of the combined factors of being female, black and poor. Had she been empowered by education, status and money she would have been able to afford the medication that could have staved off her death from AIDS. In avoiding showing the reality of Yesterday’s death, it could be said that the director of *Yesterday* displaces AIDS from a central position in this narrative, but it is significant that he does not spare us the graphic details of the husband’s illness. Moreover, the film succeeds in bringing to the fore the role of the terrain and structural forces – including sexism and the remnants of institutionalised racism – in the etiology of AIDS and Yesterday’s fate, dramatising how ‘the ideologies of gender and everyday practices of subordination interact with political and economic forces to reproduce inequality’ (Susser 2009: 18).

While *Yesterday* draws on conflicting patriarchal and feminist discourses, most of the texts discussed thus far have demonstrated the dominance of patriarchal values in AIDS discourse: women are often silenced or represented in negative ways which reinforce old stereotypes. However, some texts are beginning to contribute to a counter discourse in which women are asserting their right to be heard. *Long Life: Positive HIV Stories* (Morgan 2003), is one text which exemplifies this trend. This text is discussed more thoroughly in Chapter 5 (‘Narrating AIDS’), but it is also relevant in this chapter because it illustrates how women may be replaced in the discourse in a positive way. *Long Life: Positive HIV Stories* (Morgan 2003) is not centred on a single life but on thirteen HIV-positive women from poor backgrounds, the ‘Bambanani’ group (the word ‘Bambanani’ means ‘to support each other, to lend hands’). None of the women finished school, and most of them have a history of male abuse, some at the hands of their fathers; all from sexual partners. They are Xhosa-speaking, with English as a second or even third language. At one time, the combination of these factors would have ruled out

their becoming writers of their life histories, but exceptional circumstances (they were part of a group selected by *Médecins Sans Frontières* (MSF) to be recipients of ARV treatment)³⁵ granted them the privilege of treatment and expression and the means of publication denied to the vast majority of South African AIDS sufferers. Unusually for people of their gender, race and educational level, they were enabled to articulate their experience of illness in spite of being infected with a stigmatised condition. Indeed, it was – ironically – their HIV-positive status that brought the Bambanani women out of obscurity and gave them status of another kind. Had they not become ill with AIDS, their lives would have remained undocumented. Significantly, in all the accounts there is a refusal to be seen as victims or as blameworthy for their HIV-infection in the first place: their narratives of their past sexual histories are matter-of-fact and do not subscribe to the myth of the ‘loose woman’ or ‘whore’.

The Bambanani group came together in Khayelitsha, Cape Town over a period of some months, and over time the group became a tightly-knit, mutually supportive unit. Facilitating their treatment and activities was a small number of professional people including a psychologist, three doctors and an art teacher. Apart from meeting to receive treatment, the group engaged in shared activities such as discussion; the making of ‘Memory Boxes’;³⁶ the drawing of ‘body maps’; the narration of their life stories; and in some cases, teaching and training in HIV-related support work. The informal declaration of intent at the beginning of the book states:

We Bambanani women are making this book because we want to teach people living with HIV how to live with HIV. And to also teach those who are not living with it how to survive. And to let people know that we positive people are getting a [sic] treatment to help us live longer. We want to tell the whole world that we are many and we are working. We are healthy. Also we want our stories to be published to [sic] the other

³³ The South African government’s provision of free treatment for approved cases of the AIDS-ill in 2004 had not yet begun when this group was formed, and these women could not afford to pay for the treatment themselves.

³⁶ Memory Box work, as it is understood in the context of HIV and AIDS, is about preparing for death, and about preparing legacies for children who are soon to become orphans (Morgan 2003: 9)

countries. For those who are positive not to lose hope, maybe some day we will get a cure. We want people outside to know that it is not the end of the world. You can live as many years as you want (Morgan 2003: 5).

In this opening statement it is apparent that the women have found a voice, a sense of the importance of the positive message they are conveying, and a feeling of confidence in being able to convey it. What they say is more important than its grammatical correctness, yet their use of English needs comment. Their narratives show that they do not have a command of standard English, the dominant language variety. The hegemony of standard English puts them at a disadvantage which has obliged them to depend on the educated social workers. This problem reflects broader historical and socio-political structures in South Africa, but it is significant that the obstacles which at one time would have disqualified them from publication and kept them silent have been overcome. Each woman tells her story in her own way – language usage has not been corrected – so that their voices come through authentically and their class origins are not concealed. This is reflective of the way the group has been organised and is ideologically significant. The divisions of ethnicity and education which separate the professionals from the Bambanani women are deliberately minimised and the professionals have clearly chosen not to intervene to ‘improve’ the women’s expression in an attempt to efface the power relations that might have been expected to operate. However, the crucial part that the group facilitators played in eliciting the accounts, and transcribing, presenting and publishing these, cannot be ignored or underestimated. The Bambanani women verbalise this relationship in this way:

We told our very private stories to Kylie and Jonathan and trusted them to help us tell them to the world (Morgan 2003: 10).

There is thus a tension between the Bambanani women’s autonomy (in being the authors of their own life histories) on the one hand, and their dependence on the group leaders for the power to express and publish these, on the other.

In one of the women's narratives, she discusses her reaction to the kind of work she does in the Bambanani group:

... I like this job very much. Nomondo, Nondumiso and I are members of the first Khayelitsha A-team. 'A' does not stand for AIDS but for the best team. We are trained by the Memory Box Project to do things that help win the fight against HIV and AIDS, mostly teaching other people the Memory Box work and doing field work for researchers Next week we are hoping to get a big contract to teach 75 lay counsellors from the homeless organization about Memory Box and HIV. We got some letters and references saying they like us a lot (Morgan 2003: 56).

What emerges here is the sense of pride and empowerment she has gained from belonging to this group and engaging in useful and valuable activities. The positive feedback they receive (from letters) has reinforced this sense. Her allusion to 'the A-team' refers to a popular 1980s American television series in which a diverse group of men acted together to fight crime, which they did with spectacular success. This use of intertextuality signifies her sense of highly effective agency; of no longer being socially isolated but belonging to a group; of being in control; and even of being a kind of celebrity. This remaking of the self has resulted in a strong, healthy self-image in contrast to previous feelings of being a pariah. Her use of the military metaphor in the phrase 'the fight against HIV and AIDS' is also wholly positive in effect, since the fight is externalised and she sees herself and the other women on the winning side.

The overwhelming importance of *Long Life: Positive HIV Stories* is that it allowed the women to speak for themselves. They were enabled to overcome the 'cultural conditioning which has deprived [women] of the very means of protest or self-affirmation' (Felman 1975: 7). The text is an example of the 'discourses of rights and empowerment', in contrast to the 'discourses of control or exclusion' (Seidel 1993: 186) which it subverts. However, the Bambanani women's achievement in successfully publishing their experiences of AIDS is haunted by countless untold narratives of others who became ill, suffered and were allowed to die. The lives of these voiceless dead, to whom ARV treatment was unavailable and who were not enabled to tell their stories,

descended into an unchecked spiral of chaos and suffering, and terminated on literal landscapes covered with numberless graves. These are the displaced persons of the AIDS epidemic. Vast, silent cemeteries are the 'narratives' of their lives. On this point, Stuart Hall observes that:

[t]he question of AIDS is an extremely important terrain of struggle and contestation. In addition to the people we know who are dying, or have died, or will die, there are the many people dying who are never spoken of. How could we say that the question of AIDS is not a question of who gets represented and who does not? (1992: 285)

Of all the texts discussed in this chapter, the one that goes the furthest in challenging old stereotypes and breaking the mould of female marginalisation in relation to AIDS, is 'I Hate to Disappoint You', by Puseletso Mompei in *Nobody ever said AIDS; Stories and Poems from Southern Africa* (2004: 105-8). The persona who narrates the short story is an assertive, liberated young HIV-positive woman who vigorously rejects 'the schizoid typology of women'. The title, 'I Hate to Disappoint You' assumes expectations on the part of the reader; attitudes that the writer sets out to overturn. The expectations are the preconceived ideas that people have about people living with AIDS: stereotypes that are unthinkingly applied to anyone in the narrator's position. The story highlights how dependent prevailing AIDS-related discourse is on stereotypes, particularly in representations of women with AIDS. The speaker's purpose is to disrupt and break down this dependence.

One stereotype the writer expects to be in the reader's mind is the image of suffering, skeletal patients hanging on to life *in extremis*, abject and pitiable.³⁷ She totally rejects this discourse, presenting herself as still active and vital, living a productive life, and physically still attractive:

³⁷ The visual images the writer has in mind are probably photographs such as those that appear in *The Broken Landscape* by Gideon Mendel (2002), showing emaciated AIDS patients suffering and dying in different parts of Africa.

I hate to disappoint you by looking as good as I do. This is not how an HIV-positive person is supposed to look. How are we supposed to look? Are we supposed to suddenly have sunken eyes, dry lips, hollow cheeks and bent, stooping shoulders? That change in appearance doesn't happen overnight, nor is it my destiny. ... Despite the reality that there are millions of HIV carriers running corporations, commanding flourishing businesses, teaching children in schools and flying planes, we are still fixated by the image of a solitary dying man who was filmed lying on a hard hospital bed. His body is ravaged by the disease, and you can count every rib beneath his leathery skin. While this is a compelling image, it is annoyingly one-dimensional (2004: 106).

The stereotype of the innocent victim is also rejected: the writer despises the image of the virtuous woman who is the product of 'immaculate infection'. She presents herself instead as someone who knowingly exposed herself to the danger of AIDS: implying that she was sexually active while aware of the existence of the sexually transmitted virus. With refreshing frankness she rejects the notion that she was naive and thus blameless, and refuses to blame the man or men who infected her. A tough, streetwise tone accompanies the words:

I was a '90s teenager, I knew HIV was out there. I knew that it could happen to me. ... I'm really surprised by stories of women who claim they never, ever thought they could be HIV positive. Who feel the ground being sucked from beneath them, who seem to think their naivety would be an immunising factor. To anyone carrying this idea in their head, I say look at the statistics, they spell out everyone's chances pretty clearly (2004: 106).

The writer also rejects the opposite stereotype of the 'scarlet woman', irresponsibly promiscuous and sensual. She has obviously become infected as a result of past behaviour for which she takes full responsibility. She talks frankly about her current attraction to a particular man, but shows responsible awareness of potential problems when considering the implications of an intimate relationship with him.

I worry about having to face this reality with another person. What if he decides he can deal with my status and wants to be with me despite everything? See, I've been handling this thing single-handedly, quietly taking care of my health, going to gym, eating right, reading up on HIV, vaccines, T-cells, viral loads and all sorts of things. It has been *my* problem,

and I have had the freedom to handle it the way I want to. On some days I just don't want to think about it at all, so I don't. If I let another person in on my status that would force me to deal with his reactions, his concerns and whatever emotions he is grappling with. If I let him know I am HIV positive I'll have to face his questions ... (2004: 107).

The speaker avoids issues of morality: she refuses to feel shame, or be the stigmatised, guilty party. On the contrary, she accepts herself and her behaviour — behaviour that has led to her condition — and has a healthy sense of self-esteem. Unlike MaNdllovu or Yesterday, she is not the casualty of unequal gender power relations, but recognises her responsibility for what has happened to her. She neither was, nor is, disempowered. Nor is she the sacrificial patient, suffering and dying alone like a martyr.

My fighting instinct is as sharp as ever, but I'm still realistic about my status. Just because I refuse to have it define me doesn't mean I forget I'm living with HIV. I'm still determined to be filthy rich, to travel the world. Just as I'm determined to live as positively with HIV as I can. I hope I didn't disappoint you with my lack of remorse, or tears. I hope you start to realise that beautiful women carry HIV as well, that we still swing our hips as we walk into parties, that we are socialites and trendsetters. That we grapple with issues in our relationships, but can maintain our strength at the same time. I hope you expand your definition of HIV positive and stop thinking of us as skinny prostitutes who live in shacks, using candles for light. We are more than that. I hate to think this truth might have disappointed you in any way (2004: 107-8).

Her assertiveness, bordering on defiance, has the incremental effect of making her repeated 'I hate to disappoint you' anything except an expression of concern for the reader whom she is apparently intent on saving from disappointment. Far from being an apology, 'I'm sorry to disappoint you' is a gesture of contemptuous dismissal. She clearly despises the judgemental and sentimental social discourse surrounding HIV-positive individuals. At the risk of losing the reader's sympathy for the speaker in the story by making it clear that she is not an 'innocent victim', the short story represents an important attempt to dislodge dominant stereotypes of HIV-infected women. The speaker in the story succeeds in demystifying AIDS, and destigmatising and devictimising herself.

By contradicting what is familiar in the dominant narrative, a text such as 'I Hate to Disappoint You' breaks down the sense that 'reality is petrified or that the way things are is the way things will always be' (Thomas and Rappaport 1997: 330). Such narratives illustrate the potential of texts to create an alternative model of social relations between men and women, which could help to bring about historical change in society. Felman welcomes such a possibility:

The challenge facing the woman ... is nothing less than to 're-invent' language, to re-learn how to speak: to speak not only against, but outside of the ... phallogocentric structure, to establish a discourse the status of which would no longer be defined by the phallacy of masculine meaning (1975: 18-9).

In conclusion, it is evident that discursive representations of women infected and affected by HIV and AIDS vary widely, from those which espouse conservative values to those that embody the discourse of liberation and transformation. In certain texts, notably *Yesterday*, competing, even contradictory, discourses relating to women underlie the narrative. The overriding point about all the texts considered, however, is that gender relations and the unequal balance of power between the sexes, are the most powerful themes: AIDS itself usually features obliquely and indirectly. Various techniques are employed to keep the disease at a distance, and the significance of the illness is constructed in terms of long-established, gendered discourses. Scripts about the role and nature of women are replayed in most of these texts, reinscribing well-worn distinctions between the 'innocent' and the 'guilty', and displacing the phenomenon of AIDS as a concern in its own right. However, the final texts discussed in this chapter, where HIV-positive women affirm themselves, refuse to be displaced and instead assert their right to be replaced in the discourse, hold the promise of improving the status of women in their own eyes and changing the perceptions of society at large. Such women have moved beyond victimisation and assert their own right to survival. They both critique the existing social order and suggest an alternative vision, demonstrating the potential of texts to displace, disrupt and rewrite culturally dominant

narratives. In time, the emergence of such discourse could help to raise awareness of and resistance to the gendered distortions associated with AIDS.

Chapter 5: Narrating AIDS

The ill body is certainly not mute – it speaks eloquently in pains and symptoms – but it is inarticulate. We must speak for the body, and such speech is quickly frustrated: speech presents itself as being about the body rather than of it.
(Arthur Frank)¹

Arthur Frank's words point to a crucial problem in the verbalising of illness. Putting the experience of illness into words necessarily produces a gap: the symbolic representation is and will always be at a remove from the phenomenon that gave birth to it. Displacement is an automatic entailment of the process of relating, describing or narrating illness, as already noted. It is ironic that in the writer's attempt to give voice to the body, to understand and express the changes it is undergoing, the textualised body becomes a thing apart, an entity that appears distant and even estranged.

Frank's statement that 'we must speak for the body' recalls the old Cartesian duality of mind and body: Descartes' famous statement: 'I think, therefore I am' identifies the self with the mind, the thinking self or the consciousness, and relegates the body to a separate category with a secondary status. The long-standing tradition – sustained by theology – which conceives of mind and body as separate entities, is now contested, but its influence has been pervasive and endures. The sense that the body is distinct from the mind-self arises and increases when the body is sick, heightening the feeling of displacement between the mental and physical dimensions. Zygmunt Bauman makes the arresting point that 'the body ... is the enemy of survival' (1992: 36) in the sense that we die when the body fails us. As long as the body is healthy and mortality is beyond the horizon of consciousness, associating the self with the body comes easily, but the recognition of mortality complicates this association. Linda Garro comments that 'because of illness, the body becomes a problem, no longer the subject of unconscious assumption, but the object of conscious thought. Illness transforms the "lived body", in which self and body are unified and act as one in the world, to the "object body", where the body is a source of constraint and is in opposition to the self' (Garro 1992: 104). The sense of disconnection between body and self

¹ (Frank 1995: 2)

is reflected in colloquial discourse such as 'I don't feel like myself', used when people feel ill, suggesting a sense of alienation between the self and the sick body. Such statements illustrate that 'in a symbolic way, *we are not ourselves* when ill and dysfunctional ... ' because 'we find this self unfamiliar, and prefer not to claim it' (Estroff 1993: 256, her emphasis). When the affliction is severe and long-lasting, a more profound and exaggerated sense of distancing occurs. Illness results in alteration, where 'alteration' may be understood not only in the sense of change, but also in the less obvious sense that a feeling of alterity is introduced into the individual's consciousness: the body appears to have become 'other', estranged from the self. David Morris eloquently gives expression to this sense:

Illness threatens to undo our sense of who we are. Its darkest power lies in showing us a picture of ourselves – false, damaged, unreliable, and inescapably mortal – that we do not want to see. A serious and protracted illness constitutes an immersion into an alien reality where almost everything changes (Morris 1998: 22).

The experience of illness seeks expression in self-told narratives which attempt to render in linguistic form experience which is difficult – if not impossible – to convey: as Frank remarks, 'such speech is quickly frustrated'. Yet the need to try to express the response to illness remains strong. On becoming ill, humans search for meaning which is quite independent of their biological state. Illness, as Freidson observes, 'may be a biological disease, but the idea of illness is not, and neither is the way human beings respond to it Only among human animals is there language and meaning' (1970: 208). Abraham Verghese explains some patients' quest for meaning, following a positive HIV diagnosis, in the following way:

People with HIV infection, shortly after they learn about their condition, knowing that they have anywhere from two to twelve years more to live, feel an urgency to come to terms with their lives, to understand the meaning of why they are on earth, to try and put a value on the friends, relatives and even the material goods in their lives. Life becomes compressed, as if forced into a crucible ... and the pressure of the encircling wall of the crucible has the effect of exaggerating every human emotion (1995: xii).

In general terms, constructing narrative can be argued to be a profound human need – 'a basic, perhaps *the* basic mode of human understanding' (Edwards 1997: 268, his emphasis).

When the experience is a premature confrontation with one's own mortality, the sense of its importance could not be greater. Part of the purpose of illness narratives is to preserve a sense of identity in the face of a profound life disruption, which has been termed 'nothing less than an ontological assault' (Garro 1992: 104). Couser observes that 'AIDS presents a particularly difficult challenge, a threat not just to life but to identity, a crisis of self-understanding and self-acceptance that may not be resolvable in the short time available' (1997: 151). Hence the sense of urgency that arises to write one's own identity and experience in terms of a larger cultural script which confers meaning on the condition of being ill.

In *The Illness Narratives: Suffering, Healing and the Human Condition* (1988), Arthur Kleinman distinguishes broadly between two kinds of discourse used in the discussion and treatment of disease: so-called 'hard' discourse, which emphasises scientific and technical aspects; and its opposite, so-called 'soft' discourse, which embraces the psychosocial, experiential, subjective dimensions of illness. 'Hard' discourse would correspond to doctors' charts and graphs, what Foucault terms biomedicine's 'network of writing' and 'mass of documents' that 'capture and fix' individuals under surveillance (Foucault 1977a: 189), while 'soft' discourse corresponds to what Foucault terms 'subjugated knowledges' in the discursive hierarchy, described by him as:

a whole set of knowledges that have been disqualified as inadequate ... naive knowledges located low down on the hierarchy, beneath the required level of cognition or scientificity ... low-ranking knowledges ... (such as that of the psychiatric patient, of the ill person...) (Foucault 1980: 82).

Kleinman's binary opposition between 'hard' and 'soft' discourse overlooks the fact that in recent times laypersons are better informed than they used to be about the more technical aspects of biomedicine and have assimilated much of this 'hard' discourse into their own personal accounts of their illness.² However, it is still a valid perception that 'hard' discourse, described by Kleinman as a 'radically materialist pursuit of the biological

² Hardey observes that lay knowledge, facilitated by the wide use of the Internet, works to challenge medical dominance 'by exposing medical knowledge to the public gaze' (1999: 822), in a reversal of the usual relationship between patient and health professional. This displacement helps to dislodge the authority of the doctor and exemplifies the power of information technology 'to change economic and social relationships in an egalitarian direction' (1999: 830).

mechanism of disease' (1988: 9), is overvalued in the medical profession at the expense of 'soft' discourse. The value, for the ill person, of trying to express the experience of illness in language, however imperfectly, is endorsed by narratologists and narrative psychologists.

The need to narrate the experience of illness is not new, but the practice of doing so in writing is a feature of postmodernism. Diedrich marks 1980 as the year in which the 'politicized patient' emerged,³ and since then, a new genre – illness narratives – has proliferated (2007: 26). Frank observes that 'stories are premodern'; that 'in the modern period the medical story has pride of place'; but that the postmodern divide is crossed when people's own stories, told in their own voices, 'are no longer told as secondary but have their own primary importance' (Frank 1995: 7). The postmodern ill person claims the right to have his or her suffering heard and recognised. Sociolinguist Norman Fairclough observes that: '[d]emocratization of discourse, like democratization more generally, has been a major parameter of change in recent decades'. He defines the 'democratization of discourse' as 'the removal of inequalities and asymmetries in the discursive and linguistic rights, obligations and prestige of groups of people' (1992: 201). This democratising trend is a global one and should be particularly marked in South Africa since the political watershed of 1994, enabling ordinary, previously marginalised individuals to find a voice, but this is unfortunately not true for the majority of South Africans who are still disempowered. Most of their stories remain untold, and, in the case of those who have died, the tellers have been permanently displaced from the discourse.

This chapter focuses on the discourse of the few personal narratives that have been published, by and about ordinary South Africans with AIDS. The texts discussed are *Long Life: Positive HIV Stories*, by a group of women living with AIDS; and two self-told illness narratives by AIDS survivors, *Witness to AIDS* by Edwin Cameron and *Aidsafari* by Adam Levin. Biographical narratives about two people who did not survive AIDS – Nkosi Johnson and Fana Khaba ('Khabzela') – are more briefly discussed. Although the selected texts represent different sectors of the South African population: female and male; working-class

³ This date is based on the publication of Audre Lorde's *Cancer Journals* in 1980. Around this date 'a more general politicization around the experience of patienthood, as well as the widespread sense that the experience of patienthood can be transformed in and through writing', became apparent (Diedrich 2007: 173).

and middle-class; poorly-educated and well-educated; black and white; child and adult; homosexual and heterosexual,⁴ I cannot claim that they are representative of the experience of the countless numbers of those who have become ill – or died – from AIDS in South Africa.

Arthur Kleinman, who made the distinction between ‘hard’ and ‘soft’ discourse, mentioned above, believes that ‘legitimizing the patient’s illness experience – authorizing that experience, auditing it empathetically – is a key task in the care of the chronically ill’ (1988: 17). He believes that having the experience of illness witnessed and ordered can be of enormous therapeutic value to the ill individual (1988: xii), and the failure to take account of the existential experience of suffering is a serious shortcoming in modern medical practice. He argues persuasively for a greater sensitivity to the need of the patient to make personal meaning out of his or her illness, asserting that ‘the meanings communicated by illness can amplify or dampen symptoms, exaggerate or lessen disability, impede or facilitate treatment [because] powerful emotions attach to these meanings’ (1988: 9). The active role that the patient can play in his or her healing is stressed by Bryan Turner who observes that ‘there is a sense that sickness is something we *do* rather than something we *have*. Being sick involves interpretation, choice and action. Being sick has, for human beings as social actors, a meaning’ (1987: 213, my emphasis). Significant here are the words ‘action’ and ‘actors’, which contradict the sense of passivity inherent in the word ‘patient’, and reinforce the idea that the experience of being ill is constructed, not just suffered, a view that is echoed by Kleinman:

personal myths ... give shape to an illness so as to distance an otherwise fearsome reality The illness narrative is a story the patient tells ... to give coherence to the distinctive events and long-term course of suffering Over the long course of chronic disorder, these model texts shape and even create experience (1988: 49).

Kleinman’s concept of ‘distance’ in the first line of the above quotation emphasises the process of displacement inherent in the telling of illness stories – the gap between direct and represented experience – and suggests that this distance makes the actual experience

⁴ These examples are not cited as binary pairs in which one term is privileged against its opposite: rather, the intention is to be inclusive, to adopt a logic of ‘both/and’.

easier to bear, while the word ‘create’ in the final sentence of the quotation resonates with the pervasive Foucauldian view of the constitutive nature of discourses, which are ‘practices that systematically form the objects of which they speak’ (Foucault 1972: 49). Narratives, like other discursive forms, do not simply reflect reality, but actively construct it. Garro remarks that ‘as people tell their narratives, not only is the past reconstructed to account for illness, but the view of the present and future is also evaluated and constructed anew’ (Garro 1992: 104). Although referring to autobiography rather than illness narratives specifically, Philippe Lejeune stresses the primacy of the text over the life that it is about, exclaiming: ‘How can we think that in autobiography it is the lived life that produces the text, when it is the text that produces the life!’ (1989: 131). Edwards reinforces this point when he comments that: ‘we have no business, as analysts, reading *through* [personal narratives] to the life beyond, any more than we can read through discourse of any kind, to recover the world it purports to represent’ (Edwards 1997: 271, his emphasis). Texts are unreliable: displaced, mediated constructions of perceived reality, several times removed.

Frank believes in the importance of personal illness narratives, seeing them as a ‘necessary counternarrative’ to the hegemonic discourse of the medical profession (1998: 7), but apart from their political significance, Frank, like Kleinman, is convinced of the therapeutic value of narrating illness, a practice which originated in the nineteenth-century in the fledgling discipline of psychoanalysis,⁵ when patients were encouraged to take responsibility for and enact change in their lives. Frank believes that illness narratives ‘can help move a person through a particularly difficult situation by providing some critical distance’ (1998: 9), or displacement. Frank continues:

[w]hen experience becomes an object [through the process of narration] ... the teller gains some distance between what is being lived and what is being told. Only at this distance can actions – including interpretations – be perceived as possibly having alternatives, thus making change imaginable. This critical distance is the key to any ‘movement’ that may occur (1998: 9).

Significant here is the idea of illness being transformed into an ‘object’ which is different from the lived experience. In similar vein, Hyden puts forward the idea that

⁵ It was ‘Anna O.’, a patient of Sigmund Freud and his co-author Joseph Breuer, who invented the phrase ‘the talking cure’ to describe her treatment (Belsey 2005: 34).

the illness narrative creates something *new* – it does not merely reflect a self-perpetuating pathological process. What is new is that suffering is given a form. That is to say, the illness is articulated and positioned in time and space, and within the framework of a personal biography. The narrative transforms symptoms and events into a meaningful whole, thereby creating the world of illness (1997: 56, his emphasis).

The notion of illness being constructed into a different ‘object’ or ‘world’ through narrative – that the experience of disease is transformed into *something else* – corresponds with Edelman’s image of disease being projected through discourse onto a ‘landscape of displacements’ (1994: 94). Narrative therapists refer to this process as ‘externalizing’ a condition, and regard it as an invaluable aspect of therapy because of its beneficial psychological effects. White and Epston (1990), well-known pioneers in the field of narrative therapy, explain ‘externalizing’ as:

an approach to therapy that encourages persons to objectify and, at times, to personify the problems they experience In this process, the problem becomes a separate entity and thus external to the person ... (1990: 38).

The practice of narrative therapy grows logically out of the constructivist view of discourse. The rationale is that if personal life-narratives are self-constructed – albeit influenced by dominant cultural norms – and are negative in content and outcome, then there is no reason why new, alternative ones may not be reconstructed, with more favourable content and outcomes. Narrative therapists believe that ‘therapeutic conversations’ can ‘bring forth new sites of narrative possibility and resistance and modify prior ... interpretations of persons and problems’ (Brown and Augusta-Scott 2007: 139). The work of narrative therapists aims to help patients deconstruct unhelpful, ‘problem-saturated stories’ (White and Epston 1990: 4), to reconstruct ‘alternative stories’ (1990: 15) and to ‘re-author their lives’ (1990: 13). For Frank, the purpose of writing about the experience of AIDS is to repair ‘the damage that illness has done to the ill person’s sense of where she is in life and where she might be going’ (Frank 1995: 53). As mentioned in Chapter 1, there is a body of opinion which is critical of this belief, dismissing such constructions as ‘brightsiding’ discourse.

Another potential benefit of narrating illness is the sense of control it provides for the teller. Frank draws attention to the problem of loss of control when illness strikes; and the distressing effect unpredictability has on the ill person, since 'society demands a considerable level of body control from its members; [and] loss of this control is stigmatizing'. Frank believes that 'turning illness into story is a kind of meta-control' (1995: 31-2), an attempt to restore an order that illness interrupted. Displacement takes place when the lived experience of being ill is transformed into 'text': a form which the ill person can control, in contrast to their inability to control their embodied experience. Turning chaos into a story is to have some reflective grasp of it, and necessitates a process of distancing. Ill persons often describe becoming seriously ill in terms of losing their 'map' and 'destination', and needing to 'redraw' maps and 'find' new destinations (Frank 1995: 53, 165). Telling stories helps them to find a way out of the 'wreckage' of their lives, and enables them to redirect their metaphorical journeys. Again the notion of distancing and displacement is implicit in this extended metaphor, evident in the sense the ill person gains of venturing into new experiential spaces.

Displacement in many AIDS narratives occurs through the process whereby the lived experience of being ill is frequently expressed in terms of pre-existing discourses. Individuals often use the structures of established stories to articulate their illness experience, exemplifying Brown and Augusta-Scott's observation that the stories told about our experiences 'are not separate from the larger social stories that circulate as universal representations of truth' (2007: xviii), or, as Kleinman comments, 'the plot lines, core metaphors, and rhetorical devices that structure the illness narrative are drawn from cultural and personal models for arranging experiences in meaningful ways' (1988: 49). While individual stories possess their own particularities, generic elements underlying the narrative structure may be traced. These recurrent elements may be linked to myth,⁶ revealing, in Ruthven's view, the human 'yearning for order in the midst of upheavals and fragmentariness' (1976: 82), an impulse which may not be conscious. Reference to myth foregrounds another, more particular sense of the term 'displacement' as it is used by Northrop Frye in his study of the mythological basis of narratives, *Fables of Identity* (1963).

⁶ 'Myth' in this context may be understood as 'an intellectual attempt to order chaos and contradiction in the perceived relation of men to nature' (Comaroff 1982: 50).

'Displacement', in this context, refers to recognisable links with established myths displaced from their ancient origins into contemporary, 'real-life' situations. Frye saw literature as displaced mythology, whereby mythologically-based stories are made 'credible, logically motivated or morally acceptable – lifelike, in short' (1963: 36). Drawing on the work of Jung and Frazer, Frye believed that the impulse to mythologise arises from the deep human need to ascribe meaning to experience and to believe in a coherent universe, and originates in the subconscious mind. Literature – which would include illness narratives – derives its central structural principles from myth, and this is what gives literature its power to communicate across centuries and cultures. This thinking has clear links with that of Carl Jung, the analytical psychologist, who held that myth, together with religion, dreams and fantasies, originate in what he termed 'the collective unconscious', the 'psychic residue' inherited from our primordial ancestors (Abrams 1981: 10). The 'collective unconscious' differs from the 'personal unconscious' unique to each individual, in that the collective unconscious is impersonal in nature and identical in all individuals. Ruthven explains it as 'constituting a common psychic substrate of a suprapersonal nature which is present in every one of us' (1976: 20).

Frye identified the quest-myth as the 'central myth of literature' (1963: 18), and this accords with the work of Joseph Campbell in *The Hero with a Thousand Faces* (1973). After analysing hundreds of myths worldwide, Campbell found that myths share fundamental structures, and use similar themes, archetypes, symbols and motifs that connect us to our deeper selves. He developed the notion of the 'monomyth' which, in essence, describes the actions of a hero who suffers, achieves self-knowledge, and then makes that knowledge known. The central metaphor of the monomyth is that of a journey, or quest, and involves the three stages of *separation or departure; road of trials and victories of initiation; and return and reintegration with society* (Campbell 1973: 36, his emphases). If we apply Campbell's model of the monomyth to the experience of illness, the 'departure' stage would be the manifestation of illness; the 'road of trials and victories' would correspond to the suffering of the ill patient, during which s/he undergoes transformation; and the 'return and reintegration with society' would correlate with the survival of the hero, who is marked by illness, and whose responsibility it is to witness to others what s/he has learned from the experience. The mythic heroism of the ill person is evidenced by perseverance.

The work of Jung, Frazer, Campbell and Frye has not been above criticism and is now dated, but the connection between myth and literary narratives remains alive as a research topic. Hawkins (1993) specifically identifies the 'myth of rebirth' as a common theme in what she terms 'pathographies', which she defines as 'a form of autobiography or biography that describes personal experience of illness, treatment and sometimes death' (1993: 1). She compares certain illness narratives to old narratives of religious conversion because the experience of illness affords 'a process of transformation so profound as to constitute a kind of death of the "old self" and rebirth to a new and very different self' (1993: 33). This view is supported by the research of sociologist Steven Robins (2004), who discusses how the extremity of 'near-death' experiences of full-blown AIDS, and the profound stigma and 'social death' associated with the later stages of the disease, produce the conditions for AIDS survivors' commitment to 'new life' and social activism. Re-telling their traumatic experiences 'animates', in his view, the construction of a new, positive HIV-positive identity. He stresses the power of their treatment narratives to effect 'death-to-life' transitions – also known as 'the Lazarus effect' (Wooten 2004: 187) – which can be seen in their boosted self-esteem and social reintegration. In Robins's view, such narratives have a 'quasi-religious quality' (2004: 7) and this accords with Hawkins's comparison of the 'myths of rebirth' in illness narratives to narratives of religious conversion (1993: 33).

Frank (1995; 1998) identifies three major types of illness myth: 'restitution', 'chaos' and 'quest' narratives (1998: 3). In summary, 'restitution' narratives tell of 'getting sick, suffering, being treated, and through treatment being restored to health' and represent the 'triumphant optimism of medical science' (1998: 4), while 'chaos' stories are its antithesis, comprising accounts of pain and suffering that continue and worsen, exacerbated by social problems arising from loss of employment and income, and bureaucratic bungling. In chaos stories, 'the modernist bulwark of remedy, progress, and professionalism cracks to reveal vulnerability, futility, and impotence' (Frank 1995: 97). Frank believes that true chaos narratives cannot be articulated, because 'people live chaos, but chaos cannot in its purest form be told' adding that while 'our culture loves the restitution narrative that any illness can be cured, it fears the chaos narrative that with illness, troubles multiply' (1998: 5). The third type of narrative, the 'quest' story, tells of how illness may be lived as a condition from which something positive can be learned and passed on to others (1998: 6); how illness

leads to greater self-knowledge, insight and personal development. An important purpose of the quest narrative is witnessing or testimony: giving a voice to illness, and 'showing the healthy how they too could be living' (1998: 8). Frank elaborates on how the status of the teller depends on the kind of myth used to describe the illness experience:

The quest narrative affords the ill person a voice as teller of her own story, because only in quest stories does the *teller* have a story to tell. In the restitution narrative the active player is the remedy: either the drug itself ... or the physician. Restitution stories are about the triumph of medicine; they are self-stories only by default. Chaos stories remain the sufferer's own story, but the suffering is too great for a self to be told. The voice of the teller has been lost as a result of the chaos, and this loss then perpetuates that chaos The quest narrative speaks from the ill person's perspective and holds chaos at bay (1995: 115).

Shaping their stories in terms of the quest myth allows the tellers to reclaim agency in the experience of their illness; to assert their right to be heard; and to challenge the power and hegemony of the medical profession in which the ill person, as a *person*, is absent. As discussed in Chapter 1, medical discourse usually objectifies the body, and the patient, as a whole individual, is effectively displaced. 'Soft' discourse, or what Foucault terms 'subjugated knowledge' (1980: 82) is frequently missing. Couser observes that 'personal narrative is an increasingly popular way of resisting or reversing the process of depersonalization that often accompanies illness – the expropriation of experience by an alien and alienating discourse' (1997: 29), serving to counter displacement and exclusion.

Jackie Stacey (1997), a cancer sufferer herself, discusses the popularity of the quest myth, or what she describes as the 'crisis-rescue-recovery formulation' in cancer narratives which 'pit the hero against the disease in a life-and-death struggle'. In these stories, 'the hero usually has truth, goodness and the pursuit of knowledge on his/her side', and the narrative moves from 'problem to resolution', fitting the 'pattern of a journey from chaos to control' (Stacey 1997: 8-11). Stacey believes that the conflict between good and evil is at the heart of such narratives which are peopled by heroes, victims and villains (1997: 13) – the archetypal stuff of mythology. Her criticism of the mythologisation of illness in which suffering is transformed into triumphant quests, is related to what Ehrenreich describes as 'brightsiding' discourse (discussed in Chapter 1).

Hawkins, Frank and Stacey identify specific types of myth-based illness narratives, but, as I intend to show in the analyses which follow, an illness narrative may not neatly fit any one of these models. A single story may include elements of all types; there may be overlap; or a story which most closely resembles one kind of narrative may be given the significance of another. For example, a story such as that told in the film *Yesterday* (referred to in Chapter 4) is essentially a chaos narrative because the eponymous protagonist's life descends into deteriorating health, social ostracism and inevitable death, but the narrative is softened and sweetened by erasures and other devices. A strong sense of order is provided by the causal and temporal linking of events, giving her story a pleasing aesthetic form, and masking the chaos that has overtaken her life. For example, there are parallels between the opening and closing scenes where *Yesterday* is shown walking along a deserted dirt road winding into the distance. By means of this framing device the film provides satisfying symmetry and visual closure but – significantly – spares the audience the messy, indecent spectacle of her death. The filmic representation displaces *Yesterday*'s death both spatially, by making this happen in a place that is out of sight; and temporally, by projecting it into a future beyond the film's time-frame. Riessman makes the valid point that 'where one chooses to begin and end a narrative can profoundly alter its shape and meaning' (1993: 18), and the premature ending of *Yesterday*'s life story does indeed change its effect completely. The chaos and anguish of the heroine's death are transformed into something which appears calm and orderly, providing the illusion at the end of the film that harmony has been restored, and creating a false sense that the story has moved from 'problem to resolution', and 'chaos to control' (Stacey 1997).

In contrast, the biography by Liz McGregor about the late Fana Khaba, *Khabzela* (2005), a disc jockey (DJ) on Radio YFM, seeks to convey the full extent of the chaos that accompanies terminal illness from AIDS. This can be seen in the book's opening:

Fana Khaba died a horrible death. The HI-virus had destroyed his brain, leaving him demented and hallucinatory. He could no longer move his arms or legs. He could neither defecate nor urinate. The colostomy bag attached to his bowel to drain his waste was leaking blood. Pus seeped from the wound left by the operation to remove his intestines. A vast bedsore had eaten away his right buttock. More bedsores festered on his back, hips, ankles and elbows.

It must have been a relief to him when, at 12.10 on January 14, 2004, he finally stopped breathing.

He was thirty-five years old (McGregor 2005: 7).

Evident in this shocking opening is the narrative of unmitigated chaos. Khaba's loss of control over his bodily functions – a dreaded feature of severe illness – is compounded by the medical profession's loss of control over his disease, seen in the patent futility of their surgical interventions. Disintegration has become the encompassing reality. McGregor's description is deliberately direct and graphic: in an approach that could be described as 'a-literary', or 'anti-literary', she uses no metaphors or other devices to displace the horror. This is a striking example of 'immersive writing', which 'thrusts the reader into a direct imaginative confrontation with the special horrors of AIDS' (Cady 1993: 244). McGregor neither avoids nor aestheticises the repellent details of Fana Khaba's illness and death. Cady points out that such an immersive approach carries risk: the blunt description of the 'raw embodiment of the wreckage of AIDS' could 'so unnerve the denying reader that he or she will bolt its texts'. However, Cady adds that the merits of immersive writing are 'its willingness to defy the dominant culture directly and fully, and its faithfulness to the emotional and social anguish of people affected by AIDS' (1993: 261).

Yet McGregor's immersive approach still cannot capture Khaba's experiential reality. She can list in the bluntest possible terms the way AIDS has ravaged his body, but cannot know what he felt. Duvall and Beres, referring to the experience of victims of the Holocaust, comment that 'there are limits to empathy. We cannot know what it is like to live in a ghetto or a camp, if we have not experienced it' (2007: 223), and George Steiner refers to the way that, during the Eichmann trial, witnesses repeatedly told the prosecutor: 'You cannot understand. Who was not there cannot imagine' (Steiner 1969: 201). If lived experience is often beyond imagination, how much more difficult is it, then, to know or imagine the experience of another's death. McGregor's use of the subjunctive mood and the modal auxiliary verbs 'must have been' in 'it *must have been* a relief to him when, at 12.10 on January 14, 2004, [Khaba] finally stopped breathing' tacitly acknowledges that she is operating in the realm of speculation. She can know all the facts about his death: its causes, time, place and so on, but cannot know for certain whether or not the moment of death was welcome for Khaba.

Khaba's life was characterised by blatant promiscuity and, on air, he regularly boasted of his conquests. He referred to his penis as his 'anaconda' and made frequent reference to its activities, as in 'my anaconda ate last night' or 'my anaconda is hungry' (McGregor 2005: 148). The author does not shy away from the facts of his sexually reckless behaviour, nor does she buy into the various positive meanings imposed on his illness and death. On the occasion of his funeral, McGregor listens to the different orations and, with some scepticism, comments:

When a person dies young and tragically just as he is beginning to enjoy the success he has struggled long and hard for, and particularly when the hopes and dreams that person embodies resonate through hundreds of thousands of others, one option is to collapse into despair. The other is to try to salvage something positive out of it (McGregor 2005: 27).

She understands the human need to displace a story of chaos into a quest myth, which 'tells of how illness may be lived as a condition from which something positive can be learned and passed on to others' (Frank 1998: 6), but does not give such attempts much credence. Yet, at the end of *Khabzela*, she herself tries 'to salvage something positive' out of his suffering and death so that these are not seen only in terms of chaos and loss:

I'm hoping that this book ... will serve some purpose. That it will help to open up the debate. That it will show the many thousands of people who loved and admired him the consequences of his choices and help them to make better ones (McGregor 2005: 246).

Here his death is given value in the form of a warning to others to try to avoid a similar fate by making 'better' choices, which implies a subtle moral judgment on McGregor's part. Despite her best efforts to avoid turning Khaba into a hero, a villain or a failure, she does add a slight mythological element to his narrative when she asserts:

The fact that Fana's life ended in tragedy should not obscure the fact that he lived an extraordinary life in extraordinary times, and that he made a difference. Not many people can claim that (McGregor 2005: 247).

Although exactly what 'difference' he made is left unspecified, these statements are faint echoes of the quest myth, and suggest a desire to counter the absurd, nihilistic view of human experience which sees suffering and premature death as random and futile.

McGregor's rejection of so negative a view impels her, in the end, to resort to a degree of displacement, suggesting the human need to 'find some redeeming significance, even in terminal illness' (Couser 1997: 16).

The blatant promiscuity of Fana Khaba's life contrasts strongly with the purity of Nkosi Johnson's, the boy who died of AIDS in 2001 aged 12. As a paediatric AIDS case infected *in utero*, Nkosi Johnson is seen as 'innocent' and so – through a simplistic process of binary opposition – placed in a completely different discursive category from those infected through sexual transmission, who are commonly seen as 'guilty' and so 'deservant' of their illness. Nkosi Johnson's narrative portraiture could not be other than sympathetic: the pathos of childhood illness and death is undeniable. As Robinson observes, the death of a child is perceived differently from that of an adult:

The death of a child challenges the order of the world, for it is always premature. We cannot invoke a tale of a long, well-lived life when a child dies, and so we create new stories about innocent suffering, the injustice of the world, the need for heroic rescue, or the pain of tragedy. These stories are the narratives we use to guide our way through the events of life and death: they set the stage for our actions and provide the framework for our beliefs and intentions (Robinson 2002: 97).

This comment, recalling Stacey's view of the 'heroes, victims and villains' which populate illness narratives (1997: 13), demonstrates the human need to displace the awful, unacceptable reality of childhood death onto surrounding issues instead, using familiar narrative structures. Nkosi's story is told in ways that are more about struggle and courage than sickness and death, so that his illness is given a meaning that most resembles the displaced quest myth. Two versions of Nkosi Johnson's life have been written: *Nkosi's Story* by the South African Jane Fox (2002), and *We are all the Same* by the American Jim Wooten (2004). The subtitle of Wooten's book in itself indicates the emphasis of the narrative: 'A Story of a Boy's Courage and a Mother's Love'. Nkosi's discourse, being interestingly complex, offers plenty of attendant issues on which to displace his AIDS-illness: a black child adopted by a white family, he represents novel features of post-apartheid South Africa, straddling the racial divide that characterised South Africa under the previous regime. The relationship and interaction between Nkosi's biological and adoptive families were complicated during his life and worsened after his death: conflict over traditional African

and conventional Western religious ceremonies dominated his funeral arrangements, highlighting cultural dissonances within the South African population. He had already made headlines a few years earlier when his foster mother, Gail Johnson, fought to have him admitted to school as an HIV-positive child, testing the human rights discourse embedded in South Africa's new constitution, and his speech when he stood up and addressed a huge audience at the International AIDS Conference in Durban in 2000 trained world attention on the South African health ministry and its policies. In one part of his speech he said: 'I hate having AIDS because I get very sick and I get very sad when I think of all the other children and babies that are sick with AIDS. I just wish that the government can start giving AZT to pregnant HIV mothers to help stop the virus being passed on to their babies' (Fox 2002: 184).

Nkosi Johnson attained iconic status at the end of his life, personifying as he did AIDS victimhood. He was seen as a casualty of poverty (his biological mother and family were seriously disadvantaged); of government health policy which had failed to protect him from infection by his mother and then effectively denied him the medical treatment for it; and of racial and cultural conflict, apparent in the unseemly wrangling over him towards the end of his life and over his body when he died. His death brought home the tragic waste of life brought about by AIDS, and while this applies to all AIDS victims, Nkosi's youth and innocence intensified perceptions and won him sympathy and support denied to most people with AIDS. His frail, shrunken figure, when he stood up on the stage in Durban and challenged President Thabo Mbeki, emphasised the unequal power relations between government and the individual, highlighting the government's unsupportive policies regarding people living with AIDS, a stance which has been described as 'genocide', discussed in Chapter 2. The undersized Nkosi – ironically – became a powerful political activist. In the tributes reproduced at the end of Fox's narrative, *Nkosi's Story*, Nkosi is hailed as a 'giant of humanity' (2002: 293), a 'symbol of courage' (2002: 298) and a 'brave little soldier' (2002: 300). The last-mentioned phrase came from a letter to Gail Johnson from Jacob Zuma (then Chairperson of the South African National AIDS Council), who also said that Nkosi 'made the nation recognize the magnitude of the HIV/AIDS problem, ... [and] successfully gave a face to HIV/AIDS as it affects the most vulnerable in our society – our

children' (2002: 300). This observation threw into relief the failure of President Mbeki to respond compassionately to the event of Nkosi's death.

Nkosi Johnson's illness narrative illustrates that AIDS stories, while intensely personal, are unavoidably political. No story is neutral or can exist outside the web of power inherent in society. Issues of race, class and gender are inseparable from the stories of individual human beings. More specifically, whether or not people have access to medical treatment is the direct result of political decisions (discussed in Chapter 2), and is also linked to their socio-economic status and educational levels, which have historical and political roots. But Nkosi Johnson was not only a victim of power: he also exerted it. Foucault discusses how, 'where there is power, there is resistance' (Foucault 1976: 95), and, as we have seen, Nkosi became a potent symbol of resistance.⁷ The discourse of his life and death challenged and opposed political bureaucracy,⁸ epitomising displacement by illustrating how 'the story of a sickness may ... function as a political commentary, pointing a finger of condemnation at perceived injustice and the personal experience of oppression' (Kleinman 1988: 50).

Displacement is seen in Nkosi's discourse in the emphasis on political issues relating to AIDS rather than on Nkosi's illness itself. In addition, the adaptation of the displaced quest myth in his narrative – suggesting that his illness was 'a condition from which something positive could be learned and passed on to others' – is strongly present. Former President Nelson Mandela's tribute to him, printed on the book's back cover is: 'He was an example for the whole world to follow He was exemplary in showing how one should handle a disaster of this nature ...'. In the Foreword to the book Danny Glover writes: '[T]his is not a tragic story; ... it is above all, hopeful. It shows us what determined individuals can do' (Fox 2002: 11). Nkosi was heroicised in life, and in death was given the status of a virtual martyr. These are the hallmarks of myth. Cady sees such constructions as typical of the counter-immersive approach which glosses over tragedy and chaos (1993: 258).

⁷ It could be argued that it was only through the intervention of his white adoptive family who had power and access to resources that Nkosi acquired this status. Had he not been adopted by a very proactive woman, he, like thousands of others, would have been condemned to oblivion.

⁸ There were suspicions that Nkosi was exploited as a political instrument during his lifetime; deliberately used as a symbol of resistance against the government's AIDS policies (Fox 2002: 166).

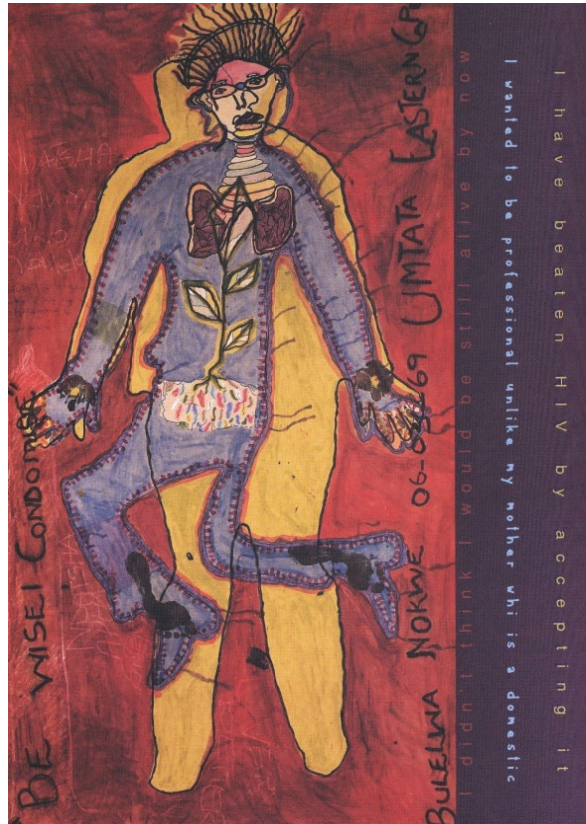
The narratives of Fana Khaba and Nkosi Johnson are third-person narratives and the narrators obviously could not know the lived reality of their subjects' illness 'from the inside', as already suggested. McGregor can only surmise or intuit Khaba's thoughts and feelings, and neither Fox nor Wooten can capture the experience of Nkosi Johnson's life and death in their narratives. These third-person biographical narratives are necessarily displaced representations, and the first condition of representation, according to Chambers, is that 'the act of witness can never be immediate or direct but must always be oblique and deferred with respect to its object' (1998: viii). Mediation and displacement are automatically entailed. These secondhand accounts are written from 'outside infected bodies', and told from a 'safe' remove (Couser 1997: 169).

In contrast to the narratives discussed so far, illness narratives that are written in the first person are autobiographical in nature: what Couser terms 'autopathographies' (1997: 5). Yet self-reported experiences of illness do not tell the whole story either, nor can they be accepted as necessarily valid and authoritative. Edwards expresses the view that: '[w]hen talking about their lives, people lie sometimes, forget a lot, exaggerate, become confused, and get things wrong. Yet they *are* revealing truths. These truths do not reveal the past "as it actually was", aspiring to a standard of objectivity. They give us instead the truths of our experiences' (Edwards 1997: 280, his emphasis). Personal illness narratives may not possess accuracy or verisimilitude, but they possess psychological truth for the teller, and are thus 'real' and valuable for him or her. As Kleinman comments: 'retrospective narratization can readily be shown to distort the actual happenings of the illness experience, since the *raison d'être* is not fidelity to historical circumstances but rather significance and validity in the creation of a life story' (1988: 51).

The first of the autobiographical texts to be analysed, *Long Life: Positive HIV Stories* (Morgan 2003), comprises a multi-vocal, collage-like collection of drawings, photographs and narratives. This text has already been referred to in Chapter 4, where the emphasis lay in the significance of marginalised women voicing their experience of AIDS in a patriarchal discourse from which they are normally displaced. *Long Life: Positive HIV Stories* is important in the context of this chapter because of the prominence of the displaced 'quest' myth, which, as mentioned earlier in this chapter, tells of 'how illness may be lived as a

condition from which something positive can be learned and passed on to others' (Frank 1998: 6). The women engaged in the activities of 'body mapping' (art therapy) and storytelling (narrative therapy), constructing visual and verbal representations of their experience of AIDS. The striking body maps resulted from an activity in which the women outlined their entire bodies onto large sheets of card which were then filled in and coloured according to the way each woman envisaged her body and what was going on inside it, as well as key events in her history. The body maps and other drawings are simple and childlike, and could easily be dismissed as crude, but in this context they were taken so seriously that the originals are on permanent display in the Constitutional Court in Johannesburg, indicating their alignment with the democratic discourse of post-1994 South Africa. They have become part of the discourse of liberation. To illustrate distinctive discursive features I have had to be selective in my choice of specific body maps and narratives.

The dominant image in Bulelwa's body map is a tree, which she shows growing up from her lower abdomen to high on her chest and over her lungs. The tree she pictures in her body is a profoundly significant symbol for her because, as she relates in her narrative, trees provide shade, beauty and fruit. The leaves are drawn as large and the growth is vigorously upward, suggesting a belief in the vitality of the life forces operating in her body.



The therapeutic effect of drawing her body map can be seen in this response of hers:

When I look at this picture I just love the picture. I didn't know when I draw myself down [sic] I can be like this. I feel very better [sic] now. Before I just saw myself as I am, not like this, like a tree (Morgan 2003: 86).

Bulelwa's words show her awareness of the sharp distinction between her real self and her drawn representation of herself. Displacement has taken place both through the transferring of her self-image to another place, a cardboard surface, and through simile ('like a tree') which represents her in another way, as a different form of life. The effect of seeing herself as a healthy, growing tree is emotionally uplifting: she feels liberated from her diseased body. Making a visual representation of her body has intensified her appreciation of the reality of her body and what is going on inside it.

In the light of her non-Western, affective, 'soft' discourse, it is perhaps surprising that Bulelwa also uses a substantial amount of biomedical discourse in her narrative although, like the other women in the group, she is not well educated:

At MSF Themba took some bloods [sic] from me to see if I qualify for the ARVs. My CD4 count was 275 then and he said I'm not qualifying for the treatment yet. It must be less than 200 Every time I got sick I didn't get better and I was treated for TB and I finished the TB treatment and after that Themba told me that I have peripheral neuropathy that makes my feet be sore. (Morgan 2003: 84).

There is a duality in Bulelwa's discourse: she switches comfortably between dominant Western and alternative non-Western discourses which appear to work for her in a complementary – rather than contradictory – way. Bulelwa's account (and those of some of the other women) shows a keen understanding of the technical indices of her illness as these are determined by the dominant discourse of medical science. She has absorbed and is able to use medical terminology meaningfully, blurring the boundaries between medical and lay discourse, and collapsing Kleinman's (1988) binary opposition between 'hard' and 'soft' discourse. There is a sense in which women such as Bulelwa could be perceived as more 'expert' than the professionals because they have direct, lived experience of what it is like to live with the virus, unlike those who have book knowledge only. Ironically, Bulelwa's appropriation of biomedical terminology could be seen as helping to sustain and uphold the dominant discourse, and this, in the long run, could be disadvantageous to herself and others of her race, class and gender, but her acquisition of medical knowledge could also be construed as having given her power. The latter construction would correspond with the Foucauldian insistence on the inseparability of knowledge and power, and the fact that power need not only be understood as 'negative, repressive and constraining', but also as 'positive and productive' (Foucault 1980: 119). We see the positive effect of empowerment through knowledge in the competent way the Bambanani women manage their illness and treatment regimens:

Many people in the government say that poor people are too stupid to understand how to take the ARVs. We love these drugs. If we are out we hunt for a tap to take them. We put them in a smaller box if we know we are going out the time we need to take them. We never forget. This is the most important thing to us. Like air (Morgan 2003: 85).

Bulelwa's words expose the fallacy of the view that most of the AIDS-ill are generally too ignorant or too irresponsible to understand and comply with treatment regimens, often cited as a justification for withholding treatment from people living with AIDS.⁹

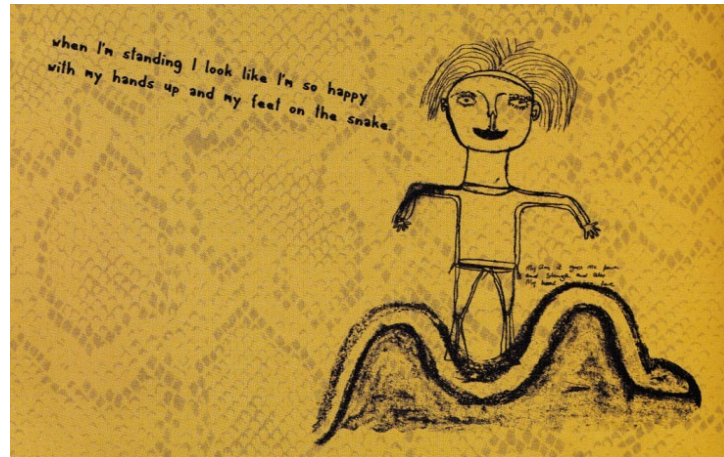
Another Bامbanani woman, Babalwa, expresses the value of body mapping as an aid to understanding what is happening in the body in this way:

When I look at this body map I feel like my life is not finished. I feel good actually, explaining how I feel inside, certain feelings and memories that I don't normally talk about So this body map explains the fears, sadness, happiness and troubles through a life of HIV and how this changes life. In the end you see the map lying down, you see your inside and you yourself are someone looking from outside at your inside. Your problems become something like a tale (Morgan 2003: 167-70).

The words 'you yourself are someone looking from outside at your inside' exemplify displacement and illustrate that autobiographical writing (in the form of body-mapping and explanatory narrative here) is a concrete way of distancing the self from the body and experiencing the self as a separate entity from its embodiment. However, Babalwa's comparison of her AIDS-related problems to a 'tale' may suggest a subliminal awareness that she has displaced her problems into the realm of fiction. While her creative act provides a strongly beneficial psychological effect, this effect could be groundless.

The power of visual representation in conceptualising disease comes out strongly in the body map and narrative of Nomawethu who imagines the HI-virus as a snake. She draws herself standing on top of this snake with a smile on her face.

⁹ The late Health Minister Manto Tshabalala-Msimang has stated that 'many [people needing AIDS drugs] do not understand the importance of completing a course of drug therapy. People don't have watches'. One important study at an antiretroviral programme in Somerset Hospital, Cape Town, found that poor people from the townships maintained excellent adherence to their medication programmes. The researchers proved that socio-economic position could not predict adherence (Cameron 2005: 198-9). Cameron comments that: 'It is true that many Africans ... live in desperately poor and often squalid living conditions. But it is patronizing to presume that living in adversity disqualifies people from taking responsibility for their own lives by taking medicines properly' (2005: 200).



Her verbal narrative is embedded in the same metaphor:

In my opinion the virus look [sic] like a snake. You can't see it and it's moving in the secret ways and the dark ways. I make the virus look like that because with AIDS many people are dying and you can't point to the people who have the virus. It's a destroyer like a hurricane that destroys everything on earth. With the snake, if there is a strong wind or storms people wake up to see houses fall down. Inkanyamba, a big snake that lives in the water, is moving them, so our mothers told us It destroys me but you see I am standing on the snake. This virus is a destroyer but I destroy this virus too (Morgan 2003: 22-3).

The interdependence of visualisation, language, metaphor and conceptualisation is evident here. Nomawethu's comparison of the virus to a snake demonstrates the way she has externalised the virus, conceptualising it as outside of her body. AIDS is displaced; seen as an entity apart from herself. At first it seems that she is mixing the snake metaphor with that of a hurricane, but it becomes apparent that the snake/storm image is in fact a unified one in terms of her Xhosa cultural background. We need to take account of non-Western discursive knowledge systems, which Kleinman illuminates:

For members of Western societies the body is a discrete entity, a thing, an 'it', machinelike and objective, separate from thought and emotion. For members of many non-Western societies, the body is an open system linking social relations to the self, a vital balance between interrelated elements in a holistic cosmos. Emotion and cognition are integrated into bodily processes. The body-self is not a secularized private domain of the individual person but an organic part of a sacred, sociocentric world, a communication system involving exchanges with others (including the divine) (1988: 11).

By using her own mythological framework to understand the virus, Nomawethu is displacing AIDS onto a cultural landscape that long pre-existed her and her illness. The overriding

significance of her representation, however, is that she sees herself standing on the snake, a clear sign that she feels she is conquering it: that she feels its powerlessness in relation to herself. The snake metaphor illustrates how the notion of a physically real entity (the snake) concretises and makes visible an abstract, invisible state (the HI-virus) and the subject's attitude towards that state (standing on, and thus controlling it). Nomawethu's representation illustrates Kleinman's view that 'patients' explanatory models of chronic illness ... enable sick persons to order, communicate, and thereby symbolically control symptoms' (1988: 48-9).

In the body map of another Bamabanani woman, Nondumiso, the only internal organs she shows are her lungs (Morgan 2003: 36), probably because her HIV-infection first manifested as TB (Morgan 2003: 38). The next stage of her illness was a serious skin problem:

My brother told me about MSF when I got very sick, sick, sick. I had things like ringworms in my skin – it looked like a brown map. My skin was very light before but it slowly started to get a grey colour, then it went darker and darker. The doctors never told me why it happened. I thought maybe it's the HIV, but I don't know how it works. It's all over my body. It started to itch when I was eating the TB tablets and I told the nurses, these tablets are making my body itch. They said it was nothing. I finished the pills and my skin started to go dry and itch; then it started to peel and peel like a snake. As I scratched, it turned dark. It was terrible and I felt like going underground. When I looked at myself in the mirror I felt it's not me. I couldn't go outside. People were going to ask me, 'What is wrong with you? Why are you so dark?' So I just stayed inside the house. If I went to the clinic I just took an early taxi and came back again and went inside the house and stayed in bed and watched TV. I thought to myself, there's no future, I'm going to die. I have done nothing, no children, my family is still poor. I thought like that (Morgan 2003: 41).

Nondumiso's use of the snake image when she says her skin started 'to peel and peel like a snake' is very different from Nomawethu's usage. Nomawethu successfully externalised AIDS as a snake and drew herself standing on top of it, but Nondumiso internalises the image and sees herself as a snake which is in the process of sloughing its skin. The visible marks on her body, 'ringworm' and dark patches, could be seen as physical stigmata, inscriptions written on her body that signify 'impurity' and which she internalises in a sense of self-disgust. Her feeling that her body has become an alien and repulsive thing

exemplifies the paradox, highlighted at the start of this chapter, that giving voice to the body through narrative makes the body into a thing that is strange and apart from the self. The displacement of experience through her use of metaphor does not make her illness easier to accept, but it may be helpful psychologically because it enables her to confront and express her horror and despair at her deteriorating condition. At this point her narrative is starting to sound like a 'chaos' myth – an 'account of pain and suffering that continues and worsens, exacerbated by social problems' (Frank 1998: 4) – but her fear and shame at what is happening so visibly to her body, and her despair at what seems to be her imminent death and the futility of her life, later give way to hope as the medication begins to work. On her body map she marks her body with large, striking, tricoloured blotches: blue dots inside, encircled by red and then white. This is how she explicates her drawing:

On my picture I drew the virus – it's the small blue dot. The white is my blood. The red circles are the ARVs eating the virus, and the virus is going down. The ARVs are strong. I have been on ARVs for five months now. It's changed a lot since the first month when I took them. By the second month I was well. It's amazing. First I was always getting sick, sick, sick. I went twice a week to the doctor. Now that I've got the ARVs, the whole month I'm fine (Morgan 2003: 41).

The significance of this visualisation is the choice of colour and relative size of the physical contenders within her body. The virus is represented as blue and small, while the surrounding ARVs are shown as large and red in colour. The more obvious choice would be red for the blood, but she chooses this strong colour for the medication. The dominance in hue, intensity and size of the ARVs reveals her sense of their efficacy and power over the physically insignificant HI-virus. Like Nomawethu's, her drawing and narrative are an indication of her psychological confidence that AIDS is being checked and controlled within her body. Nondumiso's narrative changes from the chaos myth to the restitution myth, which tells of 'getting sick, suffering, being treated, and through treatment being restored to health' and which represents the 'triumphant optimism of medical science' (Frank 1998: 4), but her sense of being 'fine' is not accurate because in real terms AIDS is not curable. ARV treatment may alleviate symptoms to the extent that health may seem to have returned, but the infection has not been overcome. The binary opposition between being 'sick, sick, sick' on the one hand or 'fine' on the other, does not correspond to reality. She and others like her are 'neither fully cured of nor dead from their illnesses, but, rather, are

in and out of remission ... remain[ing] haunted by illness and its threat', and 'occupy[ing] a liminal position between health and illness' (Diedrich 2007: 3). However, to the extent that mortality is a condition of being human, and that – for everyone – life is a terminal condition, there is a sense in which all human beings are 'in remission'.

The psychologically therapeutic value of the body-mapping exercise is seen in Victoria's reaction to the drawing she has done:

When I look at this picture I can see what I am, and what I'm not, and what I believe in, and what I don't. I can see that my finger is missing and that I have HIV, but also that I'm strong, very strong ... I have power over this virus (Morgan 2003: 56).

This response echoes those previously quoted, of confidence that the virus is being conquered. Displacement is twofold: it occurs in the symbolic representation of Victoria's body, and in the displaced form of the restitution myth. On the one hand this optimistic perception is a welcome indication that the dominant discourse which equates AIDS with death and doom has been disrupted and that an alternative discourse has been created, but their confidence could be seen as misplaced, raising the question as to whether displacement through narrative brings about false hope. As previously noted, Stacey is critical of the effects of such narratives, believing that storying illness 'offer[s] fantasies of power and control through the narrative rationalisations of progress and improvement' (1997: 15).

Telling their stories has enabled the Bambanani women to put their experience of AIDS in the past, as though it is not part of their present reality. This technique of temporal displacement is seen in Nondumiso's statement: 'I love this HIV. Before I was sitting at home, no job, no nothing, now everything is *lekker*'¹⁰ (Morgan 2003: 121); Nomawethu feels she can 'fly and climb a mountain', adding: '... I can now do the things I used to be afraid of' (Morgan 2003: 121); and Nondumiso declares: 'I am a new person' (Morgan 2003: 154). These triumphant responses echo the myths of restitution and rebirth. To narrative therapists, such affirmations vindicate narrative therapy, the aim of which is to deconstruct

¹⁰ '*Lekker*' is an Afrikaans word meaning 'nice', or 'good'.

unhelpful, 'problem-saturated stories', to 'reconstruct alternative stories' and to 're-author preferred identities' (White and Epston 1990), proving that 'changing people's stories about their lives can help to change their actual lives' (Brown and Augusta-Scott 2007: xvii).

However, one needs to remain cognisant of the fact that while narrative therapy has certainly been useful in helping the Bambanani women feel more comfortable with their condition through the process of distancing and displacement, a key factor in their energetic reappropriation of life and transformation from passive victimhood to euphoric empowerment has been ARV treatment. The Bambanani women's new sense of well-being has occurred both as a result of narrative therapy and biomedical intervention, and it is the synergistic effect of these different modes of treatment which has helped to improve their lives with AIDS.

I now turn to the discussion of two other self-told illness narratives by AIDS survivors, *Witness to AIDS* by Edwin Cameron and *Aidsafari* by Adam Levin, both published in 2005. In contrast to the disadvantaged status of the Bambanani women, Cameron and Levin are educated and empowered, and could voice their own narratives without having to rely on mediators.

The discourse of Edwin Cameron as an individual is interestingly complex since, like Pieter-Dirk Uys, he stands both within and outside the dominant discourses of the establishment. As a well-respected lawyer and judge, he is solidly part of mainstream society; but as a homosexual man infected with HIV, he is 'alternative' and 'other'. Socioeconomically, he belongs to the affluent, professional class, but has not always done so: he knows poverty, having come from a poor, broken home. He freely acknowledges that it was his 'white skin' that enabled him to access money and power, and so overcome his disadvantaged background. The somewhat polemical quality of his discourse is the result of his earnestness and passion which has its origins in his childhood, in particular being placed in a children's home with his two older sisters, and his eldest sister's death in an accident at the age of twelve. These events were deeply traumatic: 'For years Jeanie [his sister] and I kept our time in the home a secret. We felt ashamed, soiled, disadvantaged' (2005: 207). He buried the 'pain, grief, the stigma of poverty and destitution [and] an amputating bereavement' (2005: 209) deep in his psyche but they have given him 'an intense, central,

motivating awareness' (2005: 22) of the injustice of discrimination, based on factors such as race, financial status, sexual orientation and HIV-positive status, and the determination to fight such injustices. His early experiences of feeling 'soiled' and stigmatised throw light on his ability to relate to the underdog and are directly relevant to his later efforts relating to the cause of the AIDS-ill. He has applied the profound sense of justice which comes from his own experience and principles, and his professional training as a human rights lawyer, to the AIDS situation in South Africa. An explicit political critique of South African health policies strongly underpins his narrative.

Cameron chooses to open *Witness to AIDS* at a moment of deep personal crisis:

I knew that I had AIDS when I could no longer climb the stairs from the judges' common room in the High Court to my chambers two floors above. For nearly three years, every morning after tea, I made a point of walking. Two flights, four landings, forty stairs. But on that day in late October 1997 I couldn't. Each step seemed an insuperable effort. My energy seemed to have drained from my legs. I was perspiring grey exhaustion. My lungs felt waterlogged. My mouth rough and dry. No pain. Just overwhelming weariness.

And fear.

After twenty steps I paused on the midway landing to lean my forehead against the wall. The stairwell was quiet. I could hear myself panting. I grimaced. The thought – that thought – could no longer be postponed. I would have to see my doctor. This afternoon.

But already I knew what he would say. It was what somehow I had been waiting for – fearing, dreading, denying, as it encircled me, closing in, for twelve years.

My mouth and lungs told me what I didn't want to know, didn't need to be told. I had AIDS (2005: 9).

Cameron's approach is immersive. He starts his narrative *in media res* by plunging the reader into a direct, personal account of what it feels like to discover that one has AIDS, choosing not to follow the linear, chronological structure of his life and the events leading up to this moment. We are reminded of Riessman's point, made earlier, that 'where one chooses to begin and end a narrative can profoundly alter its shape and meaning' (1993: 18). Cameron's choice of this specific experience – his realisation that he did indeed have AIDS – to begin his narrative, establishes its overwhelming importance in his life and indicates the emphasis of the narrative to follow. His technique of immediacy, of temporal and experiential immersion, has a shock value that captures the reader's attention and works counter to displacement. It is immediately evident that Cameron has adopted

directness as his preferred mode of narration. However, there is much about Cameron's personal life that he omits in *Witness to AIDS*. For example, he does not discuss his marriage or other significant relationships, perhaps because he wished to preserve privacy in some areas of his life, or because he felt that they were not relevant to the overriding theme of his book – AIDS. This illustrates Brown and Augusta-Scott's statement that '[s]tories of the self are creations involving selective information about what is included and what is excluded. They are, therefore, only ever partial' (Brown and Augusta-Scott 2007: xxvi). Certain major sections of the text are not personal but deal with AIDS-related issues in the public domain. Two chapters of the book were not written by Cameron alone, but were co-written with Nathan Geffen. Some parts of *Witness to AIDS* are impossible to categorise as either 'personal' or 'public'.

Initially Cameron kept his HIV-status secret, displacing this reality to a hidden part of his life, while functioning in his professional life as normally as possible. But he felt uneasy at the false dichotomy between his internal and external identities:

... there was a tension, and a paradox. I was dealing with AIDS as a judge, chairing a committee, making public statements and important public recommendations. But I was also dealing with AIDS within myself. As the disease's symptoms raged through my body, the split between the two roles unsettled me more than ever before. I began to think that at some time, sooner rather than later, I would have to unite the public and the personal. I couldn't continue being a highly visible and respected AIDS policy advocate in public life while dealing secretly with the debilitating effects of the sickness in my own life (2005: 33).

Cameron cannot sustain this displacement and finds this double persona increasingly uncomfortable to live with:

A dualism began. Publicly, I was a human rights lawyer involved with trade unions, community organizations, ANC fighters, military resisters – and HIV issues. Privately, AIDS was hideously, almost unthinkably, close (2005: 52).

His efforts then become directed at creating congruence between his public and private selves; his interior, secret world, and his outward, public image. Writing *Witness to AIDS* can be seen as an important part of Cameron's endeavour to achieve personal integration, at closing the gap between the person living with AIDS and the professional persona. This is an

attempt to counter displacement: to reconfigure his identity by incorporating AIDS as an integral part of his being.

The word 'witness' in the title *'Witness to AIDS'* is closely tied to Cameron's professional field: that of law. 'Witness' has more than one meaning, the most obvious one being the sense of an eyewitness account based on first-hand knowledge. In the context of Cameron's life, witnessing implies a direct encounter between him and the phenomenon of AIDS: no distancing is suggested as he describes how it affects his body and his life. Yet, as already mentioned, witnessing is automatically a mediated process: as Chambers reminds us, there is no such thing as the 'unmediated perception of the reality of things' (1998: 2), and 'acts of witness are necessarily acts of deferred (not "immediate" or "direct") communication' (1998: 117). 'Witness' also means 'bearing witness' to something that cannot be seen, and providing evidence of its truth. Cameron feels he has been 'called to bear witness' to the truth of AIDS in South Africa, as we see in the following passage:

I am still the only person holding public office in South Africa who has chosen to make public my HIV status. When the agony of denialism beset our country, I felt I was called to witness. I felt called to account for my survival in a country in which hundreds of thousands were dying unnecessary deaths. I felt called to state the truth about my survival on the very treatment that was being denied to others because of the denialist debate that was taking place. I felt called to speak, and to speak out, and to challenge untruth and obfuscation in the debate about AIDS and its causes and to speak the truth about the proper treatment of AIDS. I did not feel I could or should remain silent (2005: 135).

There is no doubt that Cameron is sincere in his desire to bear witness to the 'truth', but it has to be borne in mind that 'truth is only ever partial, located and invested' (Brown and Augusta-Scott 2007: xv). Swearing 'to tell the truth, the whole truth and nothing but the truth' may be a taken-for-granted notion in a court of law – the discourse with which Cameron is familiar – but is not a simple matter from a postmodernist point of view, in which 'there is no absolute truth to be discovered, but rather multiple interpretations and multiple truths' (Duvall and Beres 2007: 234). Cameron's use of the verb 'called', repeated in 'I was called to witness', 'I felt called to account', 'I felt called to state the truth' and 'I felt called to speak' suggests the noun 'calling', in the sense of a strong urge or feeling of duty to perform a certain task or function. The word 'calling' has clear moral, even spiritual or

religious connotations. This serious sense of purpose, or quest, informs Cameron's writing throughout *Witness to AIDS*:

I speak – I must speak; my life forces me to speak – with sombre passion about this. I nearly became one of the dead. After a poverty-ridden childhood, my white skin earned me passage into a relatively affluent South African adulthood. I led the generally cautious life of a hard-working lawyer. Yet I fell ill from AIDS. I fell ill from a single virus. It was transmitted to me in a single incautious episode of unprotected receptive sexual intercourse during Easter 1985. Poverty, the environment and decadent behaviour cannot explain my illness. The virus in my body, the reality of whose presence and activity the most sophisticated medical tests monitor, overcame my affluent living circumstances and my cautious conduct. A single virus brought me to the point of near-fatal illness from AIDS (2005: 121-2).

It is apparent that Cameron does not try to circumvent or attempt to avoid the facts of his infection; his discourse is marked by honesty and directness. He does not seek to distance himself from his condition, or displace it by considering issues like poverty, the environment or decadent behaviour. However, we can recognise elements of displaced myths commonly found in illness narratives:

It is only because of medical microbiology and its antiretroviral interventions that I am living today. To live is to know. It is to feel the joy of life's forces coursing through one's veins. To survive AIDS is to feel the joy of escape, and the elation of continued life. It is also to bear the duty to speak, and the responsibility to bear witness (2005: 121-2).

Cameron's sense of the 'joy of life's forces coursing through his veins' and his feeling of 'elation of continued life', which he earlier describes as 'a renewed and joyful wellbeing' (2005: 38) recall the restitution and rebirth myths, but, as observed in the discussion of the Bambanani women, restoration to complete health is not possible once HIV-infection has taken place. What is indisputable in Cameron's narrative, is the power of the quest myth, and the role of witnessing and testimony it entails, seen in his acceptance of 'the duty to speak, and the responsibility to bear witness', for the sake of other people less fortunate than himself. At the International AIDS conference in Durban in July 2000 (the same one at which Thabo Mbeki and Nkosi Johnson spoke), he delivered the keynote address, from which the following is an extract:

I exist as a living embodiment of the iniquity of drug availability and access in Africa ... because, on a continent in which 290 million Africans survive on less than one US dollar a day, I can afford monthly medication costs of about US \$400 per month I stand before you because I am able to purchase health and vigour. I am here because I can afford to pay for life itself. To me this seems an iniquity of very considerable proportions – that, simply because of relative affluence, I should be living when others have died; that I should remain fit and healthy when illness and death beset millions of others¹¹ (2005: 110).

This is clearly the language of testimony, the use of the first person and present tense – ‘I exist ...’; ‘I can afford ...’; ‘I stand before you ...’; ‘I am here ...’; ‘I should be living ...’; ‘I should remain fit and healthy...’ – creating a powerful sense of his presence as an AIDS-survivor and crusader for the rights of those who are not. The use of antithesis in: ‘I should be living when others have died; that I should remain fit and healthy when illness and death beset millions of others’ heighten the contrast between his own life and the lives of the anonymous, disadvantaged millions, bringing home the immorality of the fact that health is income-dependent. The inequality of wealth distribution is also highlighted in the contrast between ‘one US dollar a day’ and ‘US \$400 per month’.

Cameron does not avoid issues he admits are embarrassing. In sections of *Witness to AIDS* he engages in introspection for the answers to troubling questions about the experience of having AIDS, one of which concerns the self-stigma felt by HIV-positive people:

But there remains something even harder to grapple with. The most inaccessible, the most intractable element of stigma is the disfiguring sense of shame that emanates from the internal world of someone with HIV or AIDS What causes this shame? ... Without special expertise in behaviourism, psychology or the human soul, I can only cast within myself for some inkling of the truth. And my conjecture, neither novel nor dramatically revealing, is that it is to do with HIV and sex. HIV is a sexually transmitted infection. ... Why does sex leave shame? Perhaps it lies in the embarrassment that arises from exposure of what one thought was utterly private and intimate. Perhaps to admit to having a sexually transmitted infection is to be caught out in an act of sexual intimacy, with all its attendant embarrassment – and shame ... (2005: 70).

During the discussion of the narrative about Fana Khaba above, I pointed out that the writer indicated uncertainty about her subject’s thought processes and I suggested that this is

¹¹ On the inequality of South African society, refer to Footnote 11 of the Introduction.

because she was telling his story 'from the outside'. However, we see that Cameron also leaves space for doubt in his first-person narration, in his choice of the interrogative form: 'What causes this shame?' 'Why does sex leave shame?'; the subjective modality markers: '[w]ithout special expertise in behaviourism, psychology or the human soul I can only cast within myself', and 'my conjecture'; the modal adverb 'perhaps', used several times; and the hedging technique; 'some inkling of'. These modality features convey a degree of speculation about what he is proposing, even though he is narrating his own story. It is significant that certainty and accuracy are elusive even when the narrative is self-told.

He digresses briefly at this point to speculate whether, in his case, the shame stems from the fact that the virus was homosexually transmitted, but after reflecting that heterosexual people also suffer intense shame about having HIV, he continues:

Perhaps in our deepest selves we feel that a sexually transmitted infection shows others that we have been 'caught out'. The infection leaves a mark, a stain, a print, linking us to an act so private, so intimate, so sacrosanct, so emotionally and spiritually unguarded – the moment of sexual coupling – that its external manifestation in an illness, its exposure to the world, is deeply embarrassing and therefore shameful (2005: 71).

In this aside he shows a keen awareness of how stigma is experienced by the AIDS-ill, both in its external and internalised forms.

The conclusion of *Witness to AIDS* is characterised by a move away from the first-person singular to the first-person plural; from the individual to the universal, as Cameron exhorts all to become involved in united action to support the cause of the AIDS-ill, but what is most significant, again, is the way he constructs AIDS:

AIDS is above all a remediable adversity. Our living and our life forces are stronger, our capacity for wholeness as human beings is larger, than the individual effects of the virus. Africa seeks healing. That healing lies within the power of our own actions. In inviting us to deal with the losses it has already inflicted, and more importantly, in enjoining us to avoid future losses that our own capacity to action make unnecessary, AIDS beckons us to the fullness and power of our own humanity. It is not an invitation we should avoid or refuse (2005: 215).

Cameron's overriding point here is that AIDS is something that can be overcome. At no point in *Witness to AIDS* does Cameron minimise the seriousness of the epidemic, but he represents it here as less powerful than unified human effort. This representation diminishes AIDS, and therefore the fear associated with it, and offers hope instead. But Cameron goes further than deconstructing AIDS as something that need not be dreaded: he reconstructs it as benign. In the penultimate sentence of the extract quoted above, he uses personification when stating that AIDS 'invites', 'enjoins' and 'beckons' us, these verbs suggesting a relationship of co-operation between it and us. This is markedly different from the military metaphors so commonly used when people are urged to 'join the fight' or 'wage war' against AIDS, discussed in Chapter 1. Cameron seems deliberately to avoid the discourse of conflict when he refers to AIDS as an 'adversity', not an 'adversary', and says that this 'adversity' is 'remediable', not 'conquerable'. There seems to be a conscious effort here to use what Fairclough describes as 'alternative lexicalizations ... generated from [a] divergent ideological position' (1995: 34).¹² What AIDS is 'inviting' us to, moreover, is a wholly positive experience: the opportunity to fulfil our human potential. In helping to heal Africa, it is implied, we will also be healing ourselves and realising our full humanity. By accepting this invitation, we stand to gain as much as those we help. If we are prepared to take up actively the challenges it presents, AIDS can offer us a chance to become whole. Cameron is inviting us to make his quest ours as well: to join him in 'bearing witness to AIDS'. Here Cameron is endeavouring to bridge the distance between text and reader: to 'penetrate the barrier of [the readers'] disengagement ... getting them involved in spite of themselves' (Chambers 1998: 111). This attempt to immerse the reader in the issues of AIDS; to overcome the displacement and deferral intrinsic to the process of writing and reading involves a request to his reading audience to assume responsibility and commit to the cause of the AIDS-ill. Cameron's narrative constitutes the strongest form of the quest myth: the 'manifesto' (Frank 1995: 120), which carries with it a demand for social action: the desire to move others forward with the teller. Cameron turns illness into a moral quest for himself and his readers. This impulse resonates with Jung's concept of the collective unconscious, by means of which 'we are no longer individuals but the race; the voice of all mankind resounds in us' (Ruthven 1976: 21-2).

¹² This accords with Cameron's choice of benign, natural metaphors to describe AIDS, discussed in Chapter 1, pp. 66-69.

Whereas Edwin Cameron's discourse falls partly within the establishment, and partly outside of it, the discourse of Adam Levin, author of *Aidsafari*, falls clearly outside dominant discourse: in addition to being gay, he is also self-reportedly promiscuous and a user of recreational drugs, all of which mark him as 'alternative' and 'other' in terms of the dominant, conservative discourse. It is surprising and ironic, therefore, that he should draw on dominant religious and heteronormative discourse to interpret his experience of AIDS. Levin comes to accept commonly-held beliefs about the connections between sexual behaviour and AIDS that have the effect of making his HIV-infection into 'a problem of morals rather than medicine' (Brandt 1985: 158).

As mentioned in Chapter 1, AIDS is a predominantly black, heterosexual phenomenon in South Africa, but Levin's discourse could be said to have the effect of 're-homosexualising' the condition, to use Watney's term (1987: 18), in the sense that Levin focuses on the connection between his practice of homosexual sex and the fact that he has AIDS, in a way that Cameron does not. Earlier in this chapter we saw how Cameron rejects the idea that the sense of shame he felt at being HIV-positive is related to the fact that he is gay. 'Re-homosexualising' AIDS implies, in Watney's view, evoking all the old, negative associations of homosexuality and projecting these onto the AIDS-ill.¹³

By profession Levin is a journalist and an author, having published two other books, *The Wonder Safaris* and *The Art of African Shopping*. As the title of his book, *Aidsafari*, indicates, Levin uses the metaphor of a journey to describe experience of AIDS, and this title provides, as Northrop Frye observes about such titles, an 'explicit clue' to the 'mythical shape' (1963: 37) of the narrative to follow. Levin explains why he chose the discourse of the journey:

I reflected on all the miraculous but exhausting African journeys of wonder I had chronicled in my first book, *The Wonder Safaris*. I thought of that beautifully

¹³ For Watney, the term 'homosexual' is pejorative, loaded with 'connotations of effeminacy, contagion and degeneracy' (1987: 18). Watney distinguishes between the words 'homosexual' and 'gay' on the basis that 'homosexual identity involves a primary and self-abasing awareness of *not* being heterosexual' and therefore is intrinsically negative, unlike the category 'gay', 'which remains a positive term of immediate collective and self-identification' (1987: 27).

lyrical Swahili word for journey: 'safari'. And I realized that the hardest, most frightening safari of all had been the one that had not required a single step. It had been the journey in my head and through every aching nerve in my body (2005: xii).

Levin's adaptation of the literal journey to a symbolic one of overcoming trials and reaching goals through the experience of having AIDS powerfully retells the quest myth in displaced form.

Whereas Cameron's tone throughout his narrative is passionately earnest, Levin adopts a relaxed tone, interspersed with black humour, as can be seen in the style of the following excerpt:

They [the doctors] tell you the worst. The very worst. And you find yourself face to face with your greatest fears – not only are you HIV-positive; you have – capital letters – AIDS. A couple of months later, you find out you've got fucking cancer. A month after that, they toss in tuberculosis – *correction*, three different kinds of tuberculosis. You've lost a third of your body weight and your damaged nerves keep you in excruciating pain 24/7. You can hardly stand, let alone walk. Your cancerous eye is bloodshot, and your lesions sting ... on your arm, your dick. And you get other pains in weird places. Your hair starts falling out like autumn leaves and you look like some hobbling corpse. So what you gonna do? (2005: 102).

This is clearly immersive writing, thrusting the reader into a 'direct confrontation with the special horrors of AIDS' (Cady 1993: 244). However, the humorous, sardonic treatment of the subject matter has a distancing effect which saves it from being self-pitying in tone and detracts from the fear and underlying anger discernible in statements like '... you find out you've got fucking cancer. A month after that, they toss in tuberculosis – *correction*, three different kinds of tuberculosis ...'. The effect is amusing in spite of its grim content, and this makes the reality easier to deal with. Levin's treatment of his condition thus simultaneously resists and brings about displacement.

Levin approaches the task of writing in a self-conscious way, drawing attention to the writing process at intervals throughout the book. In the early stages of his illness he has no outside audience in mind, but later begins to think about publishing his writing.

However, he expresses his ambivalence about such a venture, taking his reader into his confidence about the reasons for his reluctance:

I played with the idea of publishing this memoir someday, but I knew that would entail a frightening degree of public exposure. As the weeks passed, I grew more comfortable with friends and family knowing about my illness Family was one thing, but coming out about this to the nation? I'd never get a date again – that was certain. What was I to become – the pitiful public face of Aids? I thought deeply about this. Rationally, there was no one I was beyond telling. Given the stigmas associated with Aids, I felt compelled to deal with my status with candour and honesty. But, emotionally, I wasn't ready to become some contaminated celebrity. Later, perhaps. Right then, the prospect overwhelmed me (2005: 47-8).

While it is understood that everyone is entitled to privacy and no-one should feel obliged or pressurised to declare their HIV-status, it is nonetheless significant that Levin is held back by a sense of stigma which he has internalised. He acknowledges the split between his reason and emotions: while rationally he wishes to be honest and open about his condition, he shrinks from the prospect. His use of the word 'contaminated' in connection with himself betrays a sensitivity that his illness signifies, and will be perceived as, a form of moral corruption probably linked to his gay identity, seen in his choice of the phrase 'coming out', which echoes that of declaring gay orientation. There are important parallels. Both processes involve disclosure of something sensitive and personal; both conditions (being gay and AIDS-ill) carry social stigma; and the person 'coming out' risks rejection and discrimination by doing so.

At various stages of his narrative Levin expresses doubt about having it published, but when he agrees to pose for a photographer friend of his, he suddenly has a change of mind and heart:

I did so for a few shots, and then I did something very brave. Spontaneously, I took off my shirt. I knew this was completely unflattering, frightening even. My skeletal ribs, my tiny waist, my pale skin ... and yet I felt that if the portrait could embody both dignity and honesty, my nakedness would make it all the more powerful. I also hoped that by coming out, I might help others to do the same and may chip away at the conspiracy of silence. I was pleased I had done this.

Later, I got to see a photo of some skeleton, laughing cheerily. It was me, and it worked. I felt liberated. 'D'you know what?' I said to Carl. 'I think I *am* going to publish the memoir I've been scribbling, after all. I don't care who

knows any more. I think there's room for some kind of journal. Simply written. Just detailing what can happen and how it makes you feel. I'll speak to my publishers about it. Who knows? Maybe it could be useful' (2005: 78).

This incident indicates the complexity of the relationships between embodiment and identity; body and self; self and representation of self. In a way that is comparable to how the Bamnanani women viewed their body-maps, Levin relates to, yet feels distanced from, the photographic image of his body. The picture – a displaced image of himself – enables him to see himself with increased clarity, but it also has an alienating effect, seen in his choice of the detached phrase 'some skeleton' to describe himself. Levin sees his sick body as if it were someone – or something – else. His response recalls the view of Roland Barthes, that 'photography transform[s] subject into object, and even, one might say, into a museum object' (2000: 13); and when applied personally to Barthes himself, that 'the Photograph is the advent of myself as other: a cunning dissociation of consciousness from identity' (2000: 12), which makes him 'invariably suffer from a sensation of inauthenticity, sometimes of imposture' (2000: 13).

Levin's repetition of the phrase 'coming out' is significant. His removal of his shirt – which could be described as 'flashing' his AIDS – is a symbolic act of disclosure and exposure, one that translates into the practical step of continuing to write and eventually making public his experience of AIDS. Chambers would see this as a 'kind of victory over one's own complicity in social cover-up ... forcing the viewer ... to see ... what one would rather not see' (1998: 69; his emphasis), and Cady would describe it as an immersive strategy, which 'thrusts the audience into an uncomfortably direct encounter with the effects of AIDS'.

Levin declares himself to be 'outrageously proud' (2005: 194) of the fact that he is gay and could be seen to represent the 'sex-affirmative gay culture' (Watney 1987: 13) which emerged in the latter part of the twentieth century. He intersperses his narrative of his steadily worsening illness with descriptions of past events he enjoyed with his friends, when they dressed up in bizarre, colourful drag outfits and did impromptu dramatisations in public places such as restaurants. It seems that he needs to recall these episodes of being flagrantly camp not only to remind himself of the good times, but also to construct his

identity fully for the reader. He is intent on demonstrating that the frail, pale, dependent person he has become (at the lowest point of his illness) because of AIDS, is not really who he is. Yet there is a disarticulation between Levin's almost defiantly gay identity and his reaction to testing HIV-positive. Becoming ill with AIDS forces him to reflect on and re-examine past actions, and in the process he reveals a significant element of self-judgement:

I am still not certain whether, on the rare occasions of unsafe sex, I simply exposed myself to an immense risk, or whether perhaps, on some subconscious level, I actually sought it out as some kind of twisted, excruciating lesson that I needed to learn (2005: 165).

Significant here is the suggestion that Levin may have actually 'courted' death. At the time this could have been unconscious, but even now, on careful reflection, he cannot be sure of his motives. As in Cameron's narrative, the speculative quality of Levin's first-person narration is apparent in the posing of alternative possible explanations: 'whether ... or whether'; the subjective modality marker 'I am still not certain'; the modal adverb 'perhaps'; and the hedging technique; 'some kind of', reinforcing the point, made earlier, that certainty about human motivation and thought processes, even when these are one's own, is impossible. The fact that Levin thinks he needed to 'learn a lesson' suggests self-pathologisation; a sense of wrongdoing and a feeling that retribution is appropriate. He sees AIDS as the 'lesson' he was subconsciously 'seeking', and which he eventually found. This discourse – that AIDS is a self-deserved form of punishment for 'immoral' behaviour – is what Cameron describes as 'retribution punishment a sin a lesson a curse rebuke judgment' (2005: 42) and derives from the ancient discourse of theodicy (referred to in Chapter 1), in terms of which God was believed to use plague as a form of judgement on the sinful. At a deep, sub-rational level, Levin appears to have imbibed the dominant discourse's longstanding assumptions and stereotypes linking certain kinds of sexual behaviour to disease, described by Brandt:

[f]irst, venereal infection is considered a disease of behavior, a punishment (be it just or unjust) for those who take risks. Second, the danger of venereal disease is raised to argue (at least implicitly, but often explicitly) for a more restricted sexuality. And finally, venereal infection is viewed as not just a disease but as a symptom of a more profound socio-sexual maladjustment, a failure of control. [This construction] transform[s] venereal disease, the biomedical entity, into a symptom of social decay (Brandt 1985: 180).

In its crudest form, such moral discourse expresses itself in slogans like ‘ “AIDS – God’s curse on Homos” ’ (Watney 1987: 54). That Levin is morally uncomfortable with much of his sexual behaviour suggests that he has internalised homophobia. This emerges strongly in the following account, which has a confessional quality:

There is something mysterious and unexplainable about promiscuity Since I broke my virginity a century ago, I have wrestled with this monster. Increasingly, as I grew older, I got into a pattern of seeking out men for one-night stands, having some quick fun and then berating myself with guilt for days afterwards. I’ve had a few serious, very loving relationships but this was something completely different. It crept up on me at times like an insatiable hunger – less of an expression of love or even lust, and more a desire to conquer beauty or power, own it briefly and then distance myself totally from it. There was always something thrilling about meeting a stranger, dicing a daring short cut through the standard protracted courtship rituals, and leaping instantly into intimate territories. It seemed so haphazard – as if it confirmed some weird belief in a delightfully random universe – as if my true love was waiting around the next corner. Only he very rarely was.

The monster tormented me. I had spent thousands in psychologist’s bills discussing it over the years. I had acknowledged its dangers - both physical and emotional - and I had resolved to change my ways, but it was no good. While I was involved in relationships I behaved like a good little girl, but no sooner was I on my own I’d be struck by a deep loneliness that sent me hunting in all the wrong places and landing up with all the wrong men (2005: 29-30).

His metaphorisation of his promiscuity to a ‘monster’ constructs it as a destructive, malignant force he cannot control. It also displaces what he perceives as the source of his problem, representing it as an outside entity that arises unbidden and takes over his volition, rather than something that exists within himself. This recalls White and Epston’s therapeutic technique of externalising problems (1990: 38), a technique of displacement. His comparison of himself to ‘a good little girl’, when he was sexually controlled and faithful to one partner, is also significant, suggesting a naïve belief in simplistic, clear-cut categories of ‘good’ and ‘bad’ behaviour. Levin’s moral self-condemnation is tempered, however, by the more sympathetic psychological explanation that it was ‘deep loneliness’ that drove him to promiscuous behaviour. Elsewhere also, the moral nature of his self-judgement alternates with an attempt at a softer, psychological explanation:

For a long time, I’d suspected the punishment for these crimes was death. That Aids was the final reckoning for this kind of behaviour Many of us have vices

or obsessions that we cannot control, and we must treat these not as crimes, but as illnesses that we are capable of managing. My psychological illness had now revealed itself in a tormenting physical one, and the healing of both of these was equally important (2005: 35).

The word 'crimes' is powerfully pejorative, conjuring up juridical discourse and revealing a perception that his promiscuity is an offence deservant of punishment. But then he argues himself out of this position and switches to medical discourse which views his behaviour as the result of 'psychological illness' and thus not his fault. The shifting of interpretation between seeing his promiscuity sometimes as a 'crime' and sometimes as an 'illness' entrenches what Watney describes as the 'discursive pathologising and criminalisation of homosexual desire in all its forms and manifestations' (1987: 89), so that 'the hospital ward joins the prison cell as the "proper" site of homosexuality' (1987: 86). Yet later in the book Levin concludes that 'this sentence [AIDS] is only a consequence and not a punishment ...' (2005: 220), although the choice of the word 'sentence', in the sense of a punishment given by a court of law, betrays an underlying acceptance of the discourse of criminalisation. Levin's 'immersive' discourse, which initially confronted the horrors of AIDS in a direct and graphic way, has given way to counter-immersive discourse which Cady would regard as 'complicity with the dominant culture' (1993: 259) because it upholds conservative morality. The focus is no longer on the disease *per se*, but has been displaced onto the moral issues surrounding it. The complex (and sometimes confused) relationship in *Aidsafari* between the discourses of sexuality (and particularly gay promiscuity), crime, morality, illness and recovery is seen in the following extract:

I remember asking myself a few months before I got ill, 'If you could no longer have sex, would life be worth living?' The answer was a definite 'No'. I couldn't picture myself without the regular ecstasy of an orgasm. But right now, I've shifted completely. If I don't get an erection for the rest of my life, I'll be quite fine with that. Perhaps it's because I'm so sick right now. Or perhaps I'm healing (2005: 35).

The word 'healing' is significant. He indicates that his loss of sexual desire could be a physical symptom of his illness, but, paradoxically, it could also be seen as a positive sign of a healthier moral and spiritual state, in that it has brought about a cessation of promiscuity, his 'real' sickness in his own opinion. This contradictory view of AIDS as both the cause of

(physical) sickness and the cause of (spiritual) healing recurs throughout the text. He composes a mantra for himself:

H.I.V. / Pozitivity / Makes you a fighter / Sets you free (2005: 85).

AIDS is represented here as character-building, strengthening and liberating. The word 'pozitivity' links and equates the state of being HIV-positive to being positive in mind and spirit. In a way that is clearly linked to the myth of rebirth, akin to narratives of religious conversion according to Hawkins (1993), it is construed in wholly positive terms as a spiritual cure for his soul. He expresses this belief more directly in another passage:

In that process ... I had learnt to change some of the lifestyle patterns that were leading me to a quick spiritual and emotional death. I was no longer ruled by hungers and desires. My demons had retreated to a safe distance. God, I'll probably kick the bucket for saying this, but fuck it, in some twisted way, it was as though Aids had saved my life (2005: 103).

Levin's construction of his experience of AIDS here epitomises displacement as he fits his own experience into the pattern of the mythical quest narrative, described by Stacey as 'the journey from chaos to control', and which combines the 'masculine heroics of adventure with the emotional intensity of feminine suffering' (1997: 10). His pride in having achieved control over his 'hungers and desires' suggests that he has transformed himself into what Foucault calls a 'docile body', a process whereby 'individuals participate in normalizing and disciplinary practices of the self' (Rabinow 1984: 179) and which has larger social implications because, when multiplied through a general desire for conformity, it brings about the regulation of society. Levin has implicitly acquiesced in the constraints of the socially dominant discourse. It is also noteworthy that when he says that his behaviour was 'leading [him] to a quick spiritual and emotional death' he does not mention physical death. He construes promiscuity here as more of a threat to his spiritual being than his physical one. His phrase 'lifestyle patterns' reveals the common fallacy that AIDS is caused by a 'lifestyle' rather than a virus. This exemplifies what Watney describes as the 'implicit ideological slippage from "homosexuality" to "promiscuity" to Aids' (1987: 54) and the view that homosexual sex *per se* 'causes' AIDS. It is apparent that Levin is drawing on the morality of the dominant culture and theological discourse in spite of the fact that he regards himself as an atheist who had not attended synagogue since his bar mitzvah (2005: 66-7). During his

acute suffering from AIDS-illnesses he finds himself beginning to turn towards a divine power:

There were indeed a couple of moments on this *Aidsafari* when I found myself praying and pleading for mercy, and, hard as it was to admit, I was *praying* to someone or something greater than myself – to God, if you like. Thus far, my prayers had been answered, and the blessing of my resurrection had demanded a certain transformation I had reluctantly, in sheer desperation, turned to believing, and in that act I had committed myself as a believer.

In the humbling course of my journeys – both inside and out – I had come to develop a healthy respect for miracles: I was after all, their living proof (2005: 192).

Unmistakable here is the discourse of Judaism seen in words such as ‘praying’, ‘mercy’, ‘resurrection’ and ‘miracles’. The Jewish religion and its associated moral norms, probably absorbed in childhood, become the context of Levin’s consciousness and his experience of AIDS is projected onto this discursive landscape. The archetypal conflict between good and evil is clearly recognisable in the narrative: the main protagonist is Levin who has achieved heroism through facing death and suffering with ‘fortitude and will-power and triumphing over evil’ (Stacey 1997: 13). The immersive approach towards AIDS Levin initially adopted has changed over the course of the narrative to a counter-immersive one in which he constructs AIDS as the catalyst in his moral regeneration and rebirth, ‘muffling’ its jarring character (Cady 1993: 257).

Levin’s construction of AIDS in terms of theodicy, as a ‘lesson’, a ‘punishment’, a ‘gift’, and a spiritual ‘cure’, converges with the discourse of the symbolic journey/quest inherent in the title ‘*Aidsafari*’, and alluded to at several points of the narrative. He believes that AIDS has introduced a new purpose in his life and represents it as the goal of his quest: the precious something he was seeking as he travelled all around the world, misguidedly imagining he would find it in some foreign clime. At a small social gathering he sings a song, based on an existing U2 song that he loves, adapting its words – based on a journey motif – to fit his present situation:

*I have climbed / Highest mountains
I have swum / Deepest seas
On my Wonder Safari / I liked to wander
But I still / hadn’t found / What I’s looking for*

Looking for / Looking for

So I climbed / In my bed-sheets

Nearly laid / Down and died

On my Aids-sa-fa-ri! / And I came to wonder

If I just hadn't found / What I's looking for

Looking for / Looking fo-o-or

If I just / Hadn't found / What I's looking for (2005: 178-9).

His literal journeyings, described in the first stanza, brought him nothing. It was only when he undertook the symbolic journey through suffering the trials of AIDS, the 'Aidsafari' described in the second stanza – a crucially important, existential quest which involved no travel – that he found what he was 'looking for': the cure for his diseased soul. In his view, loss (of physical health) has become gain. In the book's conclusion, he reinforces this point when he states:

I must welcome the extraordinary growth and the profound, eternal lessons of existence that this journey has offered me, and continue to treasure each single, blessed thing the weather happens to blow into my life (2005: 229).

A dramatic change in the style and tone of the language he uses in the final stages of the book is noticeable. Words like 'treasure' and 'blessed' border on the sentimental, and, in contrast to his earlier ironisation of AIDS, he now valorises it. The jaunty tone he adopted in early parts of the book gives way to one that is philosophical:

There are also times when it helps me to think of my discomfort as something with a greater purpose: to perceive it as a constant physical reminder of the suffering of so many others – as a metaphor for all that is not right on the planet. For indeed, if there is any possible reason for this terrifying pandemic at this stage of human evolution, I figure, it might be this: to engender within us all a greater sense of compassion for the pain of others (2005: 202-3).

This is a clear articulation of the displaced quest myth. Levin looks back and interprets his experience of AIDS as a necessary intervention from a higher power with the purpose of forcing him to change his life for the better, but perceives the benefits and 'blessings' of AIDS as further-reaching than his own spiritual cure. The autobiographical focus expands to embrace all of humankind to whom, he believes, AIDS offers the opportunity for spiritual growth, thus improving the general state of the world. As was observed in the final part of Cameron's narrative, this could be linked to Jung's collective unconscious, whereby we are

released from our individual identities, move beyond the personal and achieve a state in which 'the voice of all mankind resounds in us' (Ruthven 1976: 21-2).

In Levin's paradoxical representation of AIDS in *Aidsafari*, he constructs AIDS as a moral and spiritual cure for himself and the whole world. But in this process, his discourse could have the effect, certainly unintended, of reinforcing old, negative prejudices about gay behaviour since it appears to 'concede to the dominant culture by repeating its most negative conceptions and terms for homosexuality' (Cady 1993: 259). His representation of AIDS as a lesson or punishment implies judgement of his previous behaviour, both re-pathologising and re-criminalising gay sexuality. In addition, the view of AIDS as a self-inflicted condition lessens sympathy for the AIDS-ill, encourages their marginalisation, and could militate against their being granted the social support they need.

Common to the autobiographical writings considered in this chapter, different though they are in other respects, is the positive construction of AIDS, despite the acute suffering it entailed. The Bambanani women construct their experience of AIDS as having given purpose and meaning to their lives, while Edwin Cameron and Adam Levin both derive moral value from the experience; Cameron by speaking out on behalf of those he feels are ethically entitled to life-extending drugs, and Levin by transforming himself so that he can pass on to others what he has found to be true for himself. Framing the experience (albeit unconsciously) in terms of the quest myth, tempers the horror of the core subject – being ill with AIDS.

Narrative therapists believe writing narratives can transform the experience of patienthood because they 'allow construction of meaning and are themselves intrinsically therapeutic or palliative' (Gwyn 2002: 158), so would ascribe a large part of the psychological benefits experienced by the AIDS-survivors discussed above to narrativisation. However, such transformation would be rhetorical rather than real. The role of medical intervention in the healing and extended life spans the writers enjoy cannot be underestimated or discounted. Without this, the narratives considered in this chapter would have been ones of chaos and suffering, if they had been written at all.

In comparison to the countless numbers of AIDS infections and deaths in South Africa, the number of published autobiographical AIDS narratives is insignificant. The voices of the poor, the disempowered, those with dementia or *in extremis*, have not been – and will not be – heard. The voices and autobiographical stories of most of those who have died of AIDS are lost to us forever. The handful of texts which have been published point to the loss of the many: a presence which testifies to an absence. Nevertheless, they are important. Optimistic in tone, and written by patients in remission rather than ‘survivors’, it has to be remembered that these stories are not yet over. Autobiographical illness narratives are necessarily open-ended. No-one is able to write his or her own death. The absence of true chaos narratives, in contrast to the number of narratives based on displaced rebirth, restitution and quest myths, results from the obvious reality that moribund patients cannot write and complete their narratives. Those narratives which have been written contain limitations, omissions and distortions, and are necessarily incomplete. As David Morris observes:

The writers who give voice to an otherwise often inarticulate discourse about pain also create a body of error and misrepresentation along with their knowledge. Pain passes much of its time in utter inhuman silence, and writers who describe something so inherently resistant to language must inevitably shape and possibly falsify the experience they describe (Morris 1991: 3).

As representations, illness narratives are displaced from the reality they purport to describe and, in addition, mythical shape is frequently imposed on them, further displacing the reality. These factors suggest that the experience of being terminally ill with and dying of AIDS cannot finally be articulated in any reliable or comprehensive form. Brown observes:

[t]hrough a postmodern lens, experience cannot be conflated with truth or treated as though it were authoritative, self-legitimizing, and thus uncontestable. Rather, stories of experience are interpretative, political, and contestable. Like all stories, they are multiple, fluid, changing, contradictory, and full of gaps. They are, like all stories, imperfect (Brown 2007: 192).

The difficulty of bringing the experience of illness and death into language highlights the limits of signification. Suffering cannot be reduced to story form and displaced through symbolisation in any wholly satisfactory way. It exists in a realm beyond articulation, or, as George Steiner poetically puts it, ‘[l]anguage can only deal meaningfully with a special,

restricted segment of reality. The rest, and it is presumably the much larger part, is silence' (1969: 41).

Conclusion

In this thesis I have examined selected AIDS-related texts written in South Africa in the post-apartheid period up to the present time (2010), discussing various forms of displacement found in the discourse, over and above the displacement which is intrinsic to all representations. These additional forms of displacement, which constructed different realities of AIDS and the AIDS-ill, were shown to have effects that were usually negative. Distorted meanings of the disease and the people who suffer from it resulted when AIDS was laden with metaphorical significance and articulated to entrenched, powerful discourses in other domains. In this process, AIDS and the AIDS-ill were often sidelined and displaced.

Five different forms of displacement were identified and explored, with varying results. In Chapter 1, 'Displacing AIDS through Language', the focus was on language as a form and means of displacement. The counter-immersive approach to the subject of AIDS, which employs a variety of distancing devices, was discussed and illustrated. These devices include euphemism, circumlocution and political correctness. Although the intention behind these counter-immersive techniques is to show delicacy and sensitivity towards the AIDS-ill, the result was that they and their suffering were often marginalised.

AIDS was shown to be strongly associated with sex and death, both of which are taboo subjects in some communities. The stigma attached to 'excessive' or 'deviant' sex and sexually transmitted infections have made AIDS a taboo subject, although, in South Africa, fear of death is thought by some researchers (Niehaus 2007; Steinberg 2008) to be a stronger reason for the stigmatisation of AIDS than its connections with sexual activity. Whatever the reason, the subject is avoided and those who are ill are ostracised. 'Othering' in texts occurred when the AIDS-ill were negatively categorised or stereotyped and symbolically banished from the social space, effecting their displacement from mainstream society.

Metaphors in relation to AIDS, which compared or identified the condition with other phenomena, carried over meanings and associations which displaced AIDS into domains removed from the disease. The effect was either to aggravate or ameliorate the

connotations of the condition. Some theorists, notably Susan Sontag (1978; 1989), have appealed for the de-metaphorisation of the language of illness, and particularly metaphors pertaining to war, but I have argued that this is an impossibility, given that language is intrinsically metaphorical. Some writers, such as Cameron (2005) have deliberately endeavoured to give AIDS alternative, positive significance by using metaphors which compared it to natural, healthy phenomena. Like metaphor, intertextuality entails the transfer of meanings from one discourse to another, a form of displacement by analogy, but whether the intended meanings are understood or not depends on the reader's or listener's background knowledge.

In AIDS-related biomedical discourse, HIV-positive people were often shown to be erased and displaced. The impersonal constructions used in the language, and the fact that the voices of the patients themselves were not heard, reflected power-saturated relationships and hierarchical structures within the medical profession. In addition, the fact that most of the AIDS-ill have not mastered standard English because they are second- or additional-language speakers of English excludes them from the discourse, which means that they and their suffering could be ignored. By contrast, literary texts were able to recover the presence of those marginalised by the discourse of AIDS. Creative writers who use language and their writing skills to raise awareness of the suffering caused by AIDS, were – to some extent – able to reverse the process of displacement evident in other forms of AIDS discourse.

Humour is a distancing device which helps to reduce the anxiety around a subject such as AIDS. This form of counter-immersiveness was apparent in most forms of slang, which is characterised by conciseness and wit. Some slang terms employed to refer to AIDS are cryptic, which I linked to the stigmatisation and secrecy surrounding AIDS. Other slang expressions reflected cultural beliefs premised on fatalism.

All constructions of AIDS are to some extent language-dependent, but I showed that language ultimately fails to capture the experience of living with and dying of AIDS. The difficulty of verbalising the experience of pain, illness and death constitutes a barrier to the understanding of these experiences.

Chapter 2, 'Politicising AIDS', explored the way that AIDS discourse has been projected onto the larger, well-established discourse of politics, and specifically onto the discourse of the struggle against apartheid. The dispute over the legitimacy of the biomedical paradigm assumed political dimensions, with alternative thinkers – of which former President Mbeki was one – being labelled 'dissidents'. Bitter conflict over competing discourses and ideologies, steeped in the racist and politicised discourse of the colonial and apartheid past, characterised public debate. Government policies which effectively withheld free ARV medication from the AIDS-ill, provoked intense resistance. Many of the creative writing texts written in this period reflect disillusionment and anger towards Mbeki's government and could be termed 'resistance' or 'protest' literature. Although, in some texts, the discourse of the struggle was invoked to energise the fight against AIDS, the thesis contended that, on the whole, the politicisation of AIDS has been counterproductive. The discourse of the struggle is so powerful, and has such bitter historical roots, that within it, AIDS and the AIDS-ill have been rendered almost insignificant, displacing their importance.

Chapter 3, 'Satirising AIDS', considered the way that particular satirists displaced AIDS through irony and humour and exposed the contradictions and absurdities inherent in the discourse. Analysis of different satirical texts revealed that they can be both immersive and counter-immersive in effect. AIDS was displaced from the texts in various ways, but it was also often replaced in the discourse from which it is usually removed, via graphic representations of its victims, the silent dead. Their absent presence was strongly recovered. Displacement was also effected in satire through scapegoatism. All the satirists discussed blamed individuals in government for the scale of the AIDS epidemic in South Africa, which meant that AIDS *per se* was not the central focus. This fell on political figures. In AIDS-related satire, AIDS was displaced in favour of the real subject: human vice and folly.

Chapter 4, 'Gendering AIDS', showed how embedded patriarchy is in AIDS-related discourse which is articulated to gender issues such as unequal power relations between men and women and stereotypical views of women's identities and 'proper' roles. Biomedical discourse, generally assumed to be scientific and objective, was shown to be imbued with bias against women and in favour of men. Many AIDS-related literary texts, too, constructed women in simplistic, distorted terms, either as whores or angels. Gender

inequity and male sexual violence were shown to be major factors in the AIDS epidemic. In all the texts discussed in this chapter, AIDS itself featured only obliquely and indirectly so that the phenomenon of AIDS as a concern in its own right was displaced. However, textual constructions of women infected and affected by HIV and AIDS appeared to show development in the sense that they moved from conservative representations to those that embodied the discourse of liberation and transformation. A rejection of traditional gendering was discernible, indicating a determination by women to be replaced in the discourse from which they have frequently been displaced and marginalised, and to reconstruct more positive identities for themselves.

Chapter 5, 'Narrating AIDS', dealt with the discourse of personal illness narratives, showing how individuals displaced the experience of illness through narrative, often using the structures of myth to give meaning to their experience. Most commonly, the quest myth was appropriated, which lent a positive purpose to the suffering involved in illness. Displacing the experience of illness using universal mythical structures involved some loss of the uniqueness of individual stories, but the process of narration, or creating other forms of representation to externalise illness which construct alternative interpretations of their illness, was psychologically beneficial and therapeutic for the patient. However, the relatively small number of AIDS-narratives that exist have been written by the fortunate, empowered few who had access to the medical treatment which enabled them to survive to tell their stories, and access to the resources necessary for publication, so could not be regarded as representative. Most stories of AIDS, if they had been told, would be ones of pain, anguish and chaos, and a downward spiral towards death. The experience of being terminally ill and dying of AIDS cannot finally be articulated in any reliable or comprehensive form. Suffering cannot be reduced to story form and displaced through symbolisation in any wholly satisfactory way. It exists in a realm beyond articulation.

Most texts within AIDS-discourse and interrogated in this thesis, showed that AIDS and the experience of being ill were constructed in ways that distorted them, or further entrenched negative perceptions. However, some texts illustrated the potential of texts to create alternative models which could help to bring about discursive change. Such texts critiqued the existing social order and demonstrated the potential of discourse to displace, disrupt and rewrite culturally dominant narratives. In time, the emergence and

development of such discourse could help to reduce the cultural distortions attached to the subject of AIDS, but it is doubtful that the discourse will ever be free of these.

Problems in the area of AIDS research include the fact that it is a rapidly changing field, and so hard to keep up with. Information is quickly outdated, and it is not possible to have the final word on anything. Society in general is in a perpetual state of flux and it is difficult to gather stable data or to establish with any certainty how the epidemic is evolving. All infectious diseases constitute complex bio-ecological problems in which host, pathogen, and a number of social and environmental forces interact: as I have demonstrated, 'the terrain is as important as the germ'. The multiple variables and forces which shape the discourse of AIDS are impossible to isolate and study separately.

In the field of medical science, in a relatively short period of time, developments have changed AIDS from being certainly fatal to a chronic, treatable condition. Medicine continues to advance, altering the course and nature of the disease in ways that cannot be foreseen. Different definitions and paradigms have come into existence that have radically shifted perceptions and understandings of AIDS. Also, from a political point of view, successive government administrations have changed AIDS-related policies and this has resulted in discursive transformation. Nowhere is the dynamism of discourse more apparent than in the discourse of AIDS, making it an exciting but challenging area of research.

Another research-related difficulty is that a great deal of cultural theory on the subject of AIDS applies to American and European societies and is not generalisable to the African context where AIDS has a very different epidemiological pattern. Important, insightful and well-informed theory grounded in overseas contexts had to be discounted because it was largely irrelevant to the particular problems and circumstances of Africa.

One example which illustrates the context-specific nature of AIDS discourse was seen in attitudes towards the usage of war imagery in AIDS discourse. Metaphorical language that draws on the notions of conflict and battle is regarded as politically incorrect and discouraged in the West, as seen in the UNAIDS language policy document, but in South Africa, where AIDS is often conflated with the struggle against apartheid, war imagery abounds, and in some instances, it was seen to have demonstrably constructive and

uplifting effects. This shows that discourse can never be detached from its social, historical and political background or assessed in isolation from its context.

Future research monitoring how the discourse of AIDS varies over time would be extremely valuable. The inevitable changes to the existing dominant biomedical discourse would provide interesting material for investigation in various branches of the human sciences. As was illustrated in this thesis, the three main post-apartheid administrations reviewed in this survey have each pursued their own distinctive policies with sharply different results, and political dispensations are transient. Following the effects of future political change on AIDS discourse would be an important and fruitful line of study. It would also be interesting to see whether, in time, the maturation of our young democracy produces more black satirists, presently in short supply. Analysis of texts by and about women affected by AIDS in Chapter 4 suggested slow but significant changes, with women refusing to be silenced and asserting their legitimate place in the discourse. It would also be valuable to follow and trace whether this trend continues and strengthens. Further research into the complex metaphors and linguistic strategies used to displace AIDS in different African languages would provide valuable information about how the disease is perceived from within, and in this way, some of the lost or silent voices of the AIDS-ill could be reclaimed.

The deconstruction of the chosen texts in this thesis has attempted to lay bare the biases, value systems and power relations embedded in them, encouraging a more critical response to textual representations relating to AIDS. The social construction of this disease and its close association with negative discourses and prejudices have contributed to the stigmatisation of AIDS and the AIDS-ill. I believe that the value of this study lies in its potential to raise awareness of the arbitrary, unstable nature of the discursive meanings that have been constructed around AIDS and the AIDS-ill, and to conscientise readers to how questionable many of the assumptions that underlie these constructions are. Over time, this could help to make attitudes towards AIDS and people living with AIDS more balanced and accepting.

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