

# (Re)Mediatizing HIV/AIDS in South Africa

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Written from a partly autoethnographic perspective, this article investigates current and past South African government stances on HIV/AIDS, grounding them in their larger political and ideological contexts, and examining the broader repercussions. A comparative analysis of South Africa's loveLife and STEPS interventions problematizes the self-branding used by loveLife in favor of the uplifting and humanizing message of STEPS. The author highlights the dangers of favoring AIDS solutions seeped in racial and cultural discourse over scientific ones and calls for the country's current HIV/AIDS strategy to be (re)mediatized in terms of its local and global representations. The idea of sham reasoning is discussed in relation to the generation of pseudoscientific discourses.

*Keywords:* HIV/AIDS; loveLife; STEPS; South Africa; sham reasoning

In 1995, I found myself elected to serve on the Minister of Health's Advisory Committee on HIV/AIDS and sexually transmitted diseases. My selection had been engineered by a number of my previous graduates who were working in public health communication (cf. Dalrymple, 1997; Parker, 1994). They were concerned about the difficulties government and other stakeholders, all working predominantly within a biomedical paradigm, had in comprehending how media could be used in prevention and education with regard to HIV/AIDS. Although I then knew next to nothing about AIDS, I did know how to develop communication campaigns. What I learned from these meetings was that the biomedically oriented experts were panic stricken. They could not understand why

- a. so many millions of South Africans would proactively commit suicide by engaging in risky sexual practices,
- b. their educative pamphlets and public appeals for safe sex were not working, and
- c. why government could not appreciate the extent of the crisis.

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War metaphors were used: If 333,000 people a year (as in 2005/2006) were being killed in a military attack on South Africa, all the resources of the state would have been directed at the invader. Yet, little if any HIV prevention activity was occurring in the mid-1990s when upwards of 600 people a day were dying from AIDS-related illnesses.

Twelve years later while much is happening in prevention and education, a slower path is being trodden in providing treatment to those ill with AIDS. So much so that the civic-led Treatment Action Campaign (TAC)<sup>1</sup> has since the turn of the millennium become an irritating thorn in the side of the government, most recently jockeying for entry into international meetings, taking the headlines and demanding the resignation of the Minister of Health (Breytenbach, 2006), and also exerting a “significant influence upon government policy” (Jones, 2005). The TAC, deploying a human rights-based strategy (Jones, 2005), has instituted court actions against the state’s proxy, the Rath Foundation, which proposes a vitamin cocktail over antiretroviral (ARV) treatment (Nattrass, 2006). Delay in rolling out ARV treatment has been historically connected to President Thabo Mbeki’s support for unorthodox views of AIDS dissidents, such as Peter Duesburg and David Rassnick (Mbali, 2004). Inspired by these and a handful of other dissidents, Mbeki and some influential but otherwise sensible cabinet ministers have on several occasions questioned the scientific evidence linking HIV to AIDS, the accuracy of HIV/AIDS statistics, and the reliability of HIV tests (Deane, 2005; Heywood, 2005; Mbali, 2004). Similarly, in 2000, Mbeki speculated on the “potential toxicity of anti-retroviral AZT” (Butler, 2005, p. 594; Leclerc-Madladla, 2005). The government has constantly appeared to be in a state of denial despite the wealth of scientific literature demonstrating the causal relationship between HIV and AIDS, the accuracy of HIV tests in diagnosing infection, and the effectiveness of ARV drugs in preventing mother-to-child transmission and in the treatment of HIV positive patients (see, e.g., NIH, 2003; Pallela et al., 1998; UNAIDS, 2003).

As shown by Figure 1, South Africa has one of the highest HIV prevalences in Southern Africa, with about 5 million people being HIV positive in 2006 (Butler, 2005). As South Africa is the regional economic power, trends occurring in this country symbolically impact Southern Africa as a whole, much like the way U.S. trends influences the Western world. In this way, any controversy or debate surrounding the virus initiated in South Africa will spread throughout Southern Africa as well. To date, several incidents have occurred that have contributed to the heavy criticism of South Africa’s response to HIV. Some examples are as follows:

1. In August 2006, the Minister of Health was dubbed “Dr. Beetroot” by the media (Samodien, 2006, p. 1). Beetroot was the most recent ingredient to her prescription for treating AIDS, which had previously included olive oil, garlic, spinach, and a solution of extracts from the African potato (Deane, 2005).
2. The president has been persuaded to silence<sup>2</sup> in his HIV/AIDS denialism, but he always rises to the bait when questioned by impertinent journalists. His remark, captured on television in April 2002, that he would not take a HIV test because he would be “confirming a particular paradigm” (Van der Vliet, 2004, p. 63) was seen

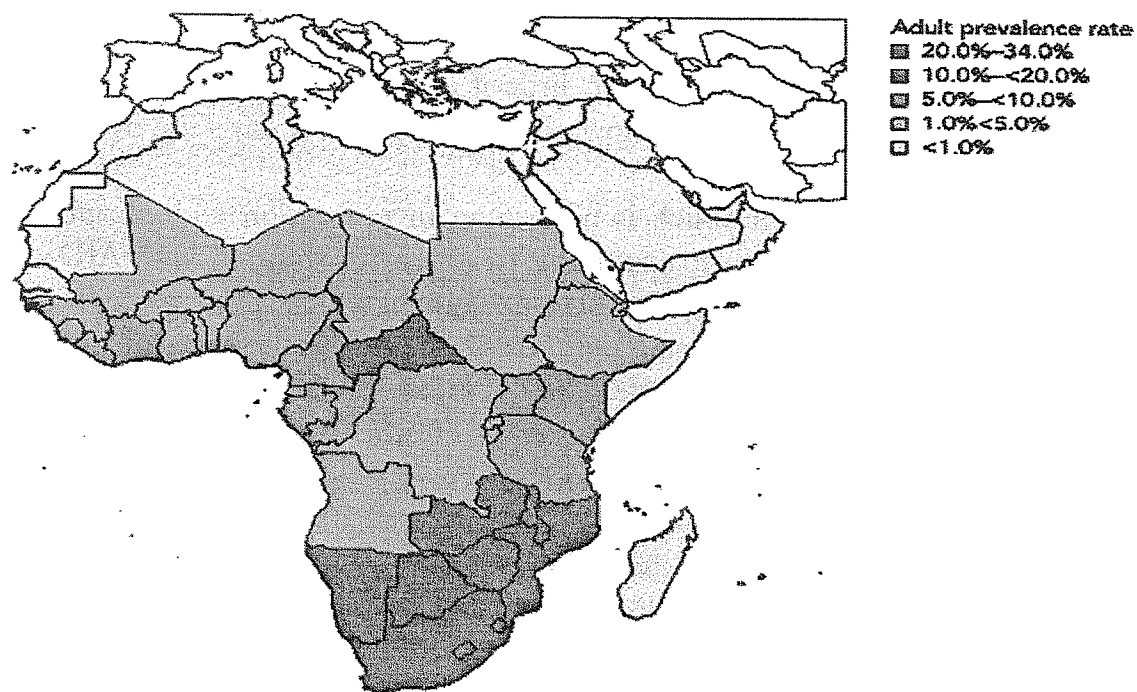


Figure 1: HIV Prevalence (%) in Adults in Africa, 2005  
SOURCE: UNAIDS, 2006.

by scholars and the media as a confirmation of his continued denialism (Natrass, 2006).

3. In August 2006, 140 Africans, mostly including HIV positive South Africans, failed to return to the continent after an international AIDS conference in Toronto, having applied for refugee status and asylum (*Sunday Independent*, 2006).

Despite its immense social, political, economic, and human rights impacts, the impact of AIDS on governance is an area in which surprisingly little research has been done (Barnett & Whiteside, 2002; cf. De-Waal, 2003), and academic research has been unable to completely uncover why Mbeki and his ministers of health are in denial (cf. Cullinan, 2003; Mbali, 2004). Anthony Butler, however, attributes South Africa's AIDS policy to apartheid's social and political structures: The country's "history of apartheid division, exile, and racist science predisposed numerous powerful and rational decision-makers to doubt the benevolence and coherence of the biomedical/mobilization paradigm" (Butler, 2005, p. 612). Two policy models are identified by Butler, ameliorative and biomedical (Butler, 2005), which differed in their responses to HIV/AIDS. The biomedical paradigm aims to mobilize all social resources, including the use of ARVs and postexposure prophylaxis, to combat the epidemic, whereas the ameliorative paradigm focuses instead on mass communication campaigns, condom marketing, sexually transmitted infection treatment and life-skills education (Butler, 2005). Despite the benefits of both, South African responses, and solutions, to HIV seem to have become polarized between the two, with a third more recent model hinging on an emerging African cure.<sup>3</sup>

Critical scholars attribute the government's position to the socioeconomics of providing ART treatment. They perceive denialism as "a convenient clause to avoid drastic increases in public spending that would be required to roll out combination HIV treatment" (Mbali, 2004, p. 110). This claim is supported by comments attributed to the late presidential spokesperson, Parks Mankahlana, that the South African government was worried that preventing mother-to-child transmission of HIV would lead to an increase in the number of orphans that would burden the state (Deane, 2005; Mbali, 2004). Although government is also said to have refused to make Nevirapine available to pregnant women due to the cost, Butler (2005) also argued that human resources in the public health sector rather than affordability is the major shortfall as although government plans to create 12,000 new posts, 30,000 are already unfilled.

Government's denialism is also framed as a form of resistance to the colonial and postapartheid discourses on race, sexuality, and disease. Mbeki and some senior Africa National Congress (ANC) officials have unequivocally objected to the linking of the origin and spread of AIDS to Africans and the perception that Blacks are naturally promiscuous. He therefore prefers an African response to HIV/AIDS (Mbali, 2004). Similarly, the paper *Castro Hlongwane, Caravans, Cats, Geese, Foot & Mouth Statistics: HIV/AIDS and the Struggle for Humanisation of the African*, said to be authored by Peter Mokaba (2002), a leading ANC figure and denialist, argues against the apparent stigmatization of African sexuality by Western biomedicine paradigms (Jones, 2005). Although his own body was allegedly suffering the effects of HIV/AIDS, Mokaba (2002) still maintained that Western biomedicine campaigns further entrenched the "dehumanization" of African people (p. 5), "pre-prescribing" their behavior and cultivating sexual stereotypes (p. 103), and that the pharmaceutical industry purposefully propagated false information about HIV/AIDS to sell its drugs (Jones, 2005).

Although AIDS was represented by Mbeki as a syndrome rather than a disease, emphasizing the viewpoint that people die of consequent opportunistic infections rather than of the disease itself (Jones, 2005), there is no connection, however, between these discourses and current Health Minister Manto Tshabalala-Msimang's emphasis of nutrition over ART treatment. The minister seems to have been convinced by the claims of a self-proclaimed nutritionist, Tine Van Der Maas, who argues that taking a concoction of lemon, olive oil, crushed garlic, spinach, ginger, beetroot, and a solution of African potato would help in strengthening the immune system of AIDS patients (Deane, 2005).

This concoction has since been examined by many researchers. They warn that there is no scientific evidence to support the claim that this mixture would enhance one's immune system. Instead, they argue that certain forms of garlic can cause severe damage to stomach membranes, whereas onions cause gastro-intestinal discomfort. In fact, a safety and efficacy study on the African potato had to be abandoned after patients who had been administered the solution showed signs of severe suppression of the bone marrow (Deane, 2005). However, the health minister chose to ignore all this evidence in her crusade for nutrition, a very necessary

consideration for anyone taking AIDS drugs, as this discourse is linked to Mbeki's claim that poverty is the cause of HIV, which itself is indicative of a blame-colonialism stance (cf. Niyonzima, 2007, for a discussion of this issue).

Perhaps, the most cogent of explanations comes from a newspaper columnist:

What troubles me most about the whole foolish business is the underlying suggestion that, somehow, because we are in Africa, cradle of mankind, the fruits and roots of the African soil must inevitably produce a universal cure. That's on a par with the idea that rhino horn gives men an erection. It's just another meaningless factoid that has brought these animals to the brink of extinction.

I hear people saying that only within the culture of Africans lies the cure and, in a radio debate, someone claimed that it is a form of patriotism to reject drugs that contain "a form of chemical poison that indiscriminately destroys human cells" . . . the rhetoric about natural healing and African culture . . . [confuses] agriculture with national culture . . . [which] served up as a traditional feast with beetroot, garlic and potatoes in an olive-oil dressing, could prove to be a last supper for way too many people. (Ronge, 2006, p. 1)

### Sham Reasoning and Pseudo Science

Apart from the expense, the problem of ART treatment in South Africa lies not with the pharmaceutical companies, the medicines themselves, or how they work; rather, it lies in ideology, an ideology which encourages sham reasoning based on a confusion of discourses serving particular interests. When pseudoinquiry becomes commonplace,

[people] come to look upon reasoning as mainly decorative. . . . The result of this state of things is, of course, a rapid deterioration of intellectual vigor. . . . [M]an loses his conceptions of truth and of reason. If he sees one man assert what another denies, he will, if he is concerned, choose his side and set to work . . . to silence his adversaries. The truth for him is that for which he fights. (Haack, 1997)

The kind of discursive exclusions, elisions, and decontextualizations evidenced in AIDS discourses found in South Africa and in President Mbeki's ill-feted courting of a few notorious AIDS dissident scientists<sup>4</sup> delivers, at taxpayers' expense, a pseudoscience aimed at making a case for a predetermined conclusion immovably believed in advance of the inquiry itself (Peirce, 1905). Having first embedded a cure as an ethnic sociobiological character, the discourse identified by Ronge actually works toward what Father Cosmos Desmond asserted: to deny Azido-Thymidine to babies in utero is tantamount to genocide (Brink, 2000). Jerry Coovadia of the University of KwaZulu-Natal Medical School closed the 2000 Durban AIDS Conference with the statement that "there are too many mavericks, hypocrites, charlatans and downright criminals trading on the AIDS misery" ("Who are the AIDS criminals," 2005, para. 5).

The point here is simple: There is a fundamental difference between racism and discourses about race (Arendt, 1958) and between sexual preference and discourses about who qualifies as being human. Peris Jones (2005) wrote that the disease has

become associated with preexisting cultural notions of what causes vulnerability, thereby exacerbating stigmatization and exclusion directed at less powerful groups and individuals. Neither race nor racism, nor homosexuality, in fact, have anything to do with treating HIV/AIDS, though a connection can be drawn in terms of how Africans living with AIDS are imaged in the media (van Kesteren, 2000; von Stauss, 2004) and with regard to prevention strategies (regarding safe-sex practices). This battle over how Africans are imaged in the global media seems to be what is being put at stake, backgrounding the real problem—that of health, not image. The fact that the minister of health's exhortations actually feed into these racist myths about Africa seems to be eluding her as she attempts to terminate media and activist criticism of her lethal cocktail, silence the TAC and its ultraleftist stance (see Jones, 2005), and bypass medical ethics in permitting the Rath Foundation to conduct illegal experiments amongst high-risk populations<sup>5</sup> (see TAC, 2005; van Noort, 2005).

Sham reasoning as a form of argument is found in popular discourses. This reasoning is (a) legitimized by senior politicians, (b) propagated by an ally in the vitamin industry (Rath), (c) and the so-called dissident scientists. This approach is also peddled by opportunists looking for political patronage. Of a different order is one of the four major media/educational interventions,<sup>6</sup> loveLife. The case of loveLife is instructive because this project is driven by the opposite ideology to one that denies science, and it is an example of Butler's (2005) ameliorative model as it uses mass communication and behavior change rather than biomedical treatment to reduce HIV infection. loveLife espouses a global vision, complete openness and acceptance of science, but its messages are framed in a consumerist capitalist culture (Parker, 2003). This discourse is very different from a culture embedded in belief in ancestors and dark spiritual forces (Lynn Dalrymple, personal communication, 11 October, 2006).<sup>7</sup>

In 1995, it was my job to design a media education campaign to assist the minister's Advisory Committee in its work. Sham reasoning, however, systematically undermined the work of the committee, a discourse which continues to this day. The brief life of the committee found itself successively and overwhelmingly embroiled in damage control:

- a. First was the *Sarafina 2* scandal; in 1995, President Nelson Mandela's cabinet, without consulting its own Advisory Committee, approved R14.27 million of EU-donated funds for the production of a single play scripted and directed by Bongani Ngema, a Zulu playwright. Critics questioned the exorbitant cost of a single play and bemoaned the lack of a transparent tendering procedure (Health Systems Trust & the Henry J. Kaizer Family Foundation, 1996).<sup>8</sup> Some members of the committee observed the play and recommended its immediate closure as it totally misunderstood HIV transmission and propagated dangerous myths about AIDS (Health Systems Trust & the Henry J. Kaizer Family Foundation, 1996). The producer was later put into sequestration as he was accused of misappropriation of funds. "Don't worry," the critics were told, "It's only EU money." The EU was not impressed as one committee member reported having been in Brussels when this statement hit the media.

- b. The Virodene debacle of 1997 came next (Epstein, 2000)<sup>9</sup> when Cabinet, without referring to its own Advisory Committee or the Medical Research Council (MCC), approved what it was told by its inventors was a cure for AIDS. None of the three scientists behind Virodene—Olga Visser, Dirk du Plessis, and Kallie Landaure—were an expert in HIV, microbiology, or virology (Deane, 2005). Notwithstanding screaming newspaper headlines, reports, and graphics offering pseudoscientific information as medical fact, Virodene was exposed as a toxic industrial solvent (Folb, van Gelder, & Swan, 1997; Kalk et al., 1997; Mohamed, 1997; Sidley, 1997; Spencer, Hugo, & Mahomed, 1997). Two senior officials of the MCC lost their jobs for pointing this out; however, they were reinstated in 1999 after being vindicated (Mason, 2000). The promise of balancing the national budget faded as fast as Virodene had appeared on the scene. However, this opportunism, faddishness, and sham science ominously set the context for things to come.
- c. The new discourse propagated by Thabo Mbeki cast serious doubt on the link between HIV and AIDS. The problem, we were told, was caused by underdevelopment and lack of nutrition. There was a call from the ANC leadership to generate an African response to AIDS, which, ironically, involved bringing in foreign experts—the dissidents (Crewe, 2000).
- d. Virodene and *Sarafina* were just two of the defining incidents that very fortunately distracted the then minister from the real grassroots interventions and research work that needed to be done. Her Advisory Committee in the meantime set about devising a media and education strategy, known as Beyond Awareness Campaigns (BAC) I and II (1996-2000). BAC aimed at creating conditions for participatory approaches drawing on local knowledge developed by scores of nongovernmental organizations (NGOs) already working on HIV/AIDS issues<sup>10</sup> (see also Tomaselli, Shepperson, & Parker, 2002).

Just as Africa became the killing fields between the Soviets and the West during the Cold War, thus did South Africa allow itself to become a battleground between conventional science and dissident scientists who think that HIV is some kind of imperialist plot led by global pharmaceutical companies (cf. Fears, 2005). The dissidents' arguments can be beguiling; for a while, even I was doubtful of real science:

- a. President Mbeki and the minister of health's arguments about nutrition are crucial in societies where the vast majority live in poverty and squalor, hotbeds for opportunistic infections of all kinds.
- b. Apartheid did seriously disrupt Black family life, and it brutalized people. An often violent patriarchy has replaced previously normal social and gender relations, where rape, sexual assault, and unprotected multiple sexual encounters, some of them of an extreme nature, have become considered as normal behavior (Epstein, 1998).
- c. Africa is seen as the global basket case as far as HIV/AIDS goes, an image that both Mbeki and the minister are at pains to counter. To admit HIV/AIDS, in their eyes, is to perhaps also admit the often bizarre sexualized Western myths about Africa and Africans, as the place where HIV was germinated, jumping—as one theory has it—from apes to humans. Certainly, earlier discourses on the disease were often characterized by racist stereotypes of the African continent (Jones, 2005).

How does anyone come up with successful campaigns to counter these structurally induced forms of real and symbolic violence, and theories balanced between

Western voodoo and African alternatives (Jones, 2005)? Butler argued that often religious and traditional values hinder HIV education and the removal of stigma, and that although leaders may aim to create an environment for behavior change, this cannot occur given the “informal institutions” through which young people acquire their HIV/AIDS knowledge (2005, p. 597). How then does one bring about change when fact is undermined by fallacy and doubt from top political figures down?

We had an answer in the mid-to-late 1990s when a consortium of NGOs was awarded the Beyond Awareness I and II campaigns, which were based on the notion of participatory communication, action research, intersecting both small bottom-up and big top-down media, supported by on-the-ground work in communities, educational institutions, faith-based organizations, trade unions, taxis, and other places used on a daily basis by communities at risk (Tomaselli et al., 2002). This was a classic Freire (1973) critical pedagogy that intersected big (broadcast) media with small (community) media, creating a comprehensive public sphere involving all kinds of media and educational institutions. The campaigns were funded by the Department of Health.

A video entitled *See You at Seven*, made for one of the main partners of the BAC campaigns, DramAidE, shows high levels of participation, and evaluative research indicates that attitudinal change has occurred among the school children with whom DramAidE has worked for more than a decade.<sup>11</sup> One outcome is that gender relations are now openly debated at these schools. Proving behavior change, however, is not so easy. The point of the approach is that ordinary people at risk make their own messages on the basis of their own frames of reference, their own experiences, and their own suggested solutions. They are encouraged to take responsibility for local message dissemination and for themselves via life-skills training (Dalrymple, 1997; DramAidE, 1995; Ndhura, 2004; Tomaselli et al., 2002).

Enter loveLife<sup>12</sup> in 1999, with the support of Knowns<sup>13</sup>—political celebrities and authoritative sources like Archbishop Desmond Tutu, Mrs. Zanele Mbeki, provincial premiers, and others. The loveLife intervention followed the cancellation of BAC in 2000. One of the criticisms against the BAC was that it was not visible—in the media—That is, the self-serving politicians weren't getting enough publicity. The state, they argued, was “seen” to be doing nothing. “Being seen to be doing something” was considered more important than actually doing the necessary work with those outside of the national media and economic grids without fanfare—Political return was/is all (Kerr, 1997; Tomaselli, 1997).

loveLife changed all that. In essence, a hugely expensive public relations-oriented self-branding exercise, it promised what it could not deliver in terms of prevention—a halving of HIV prevalence amongst youth in 5 years (something that did not change at all). However, it did deliver on encouraging an ideology of consumption—All its campaigns are associated with promoting consumption, embourgeoisification, and the freeing up of restrictive discourses about sex. Its catchphrase, “Talk about it,” is specifically directed toward encouraging youngsters to talk about sex,

to learn how to negotiate and do it safely, and to fracture African taboos on discussing sex. The problem is that loveLife's media are often incomprehensible and often misleading for more literal interpreters (Delate, 2001; Diko, 2005; Jordaan, 2006; Parker, 2003, 2005a). loveLife does not take criticism kindly though, and through a series of complex partnership agreements, it is provided space in the media that allows its intervention to obtain the highest, often exclusive, profile. This is an uncritical profile, given that the media conglomerates who celebrate partnership with loveLife as a sign that they are doing something about AIDS are hardly likely to, at the same time, subject this same partner to critical scrutiny. Media publicity on other inventions is rare, and loveLife has made numerous attempts to claim a monocausal relation to any changes evidenced among youth irrespective of the likely and demonstrable impacts of other major interventions, which do provide supportable evidence, rigorously evaluate their own projects, and share this research with each other.

loveLife has been repeatedly exposed for its sham reasoning, its idiosyncratic claims to be reducing infection, and its normalization and naturalization (during the late 1990s and early 2000s) of soft porn images among its target audience of 14 to 24 year olds, supposedly as a means of promoting safe sex (Delate, 2001; Parker, 2003). The safe-sex message, however, is often drowned out by catch-phrases propagating great sex, presented as the goal, "everyone's doing it." Where this intersects with the media is through partnerships that both legitimate loveLife's vision for HIV communication, at the same time fitting with the broader commercial logic of media institutions that is linked to profiting through the promotion of consumption.

### **(Re)mediatizing AIDS**

(De)mediatizing AIDS was given to me as the topic of an address from which this article derives. The task was to offer an analysis that examined the epidemic in terms not managed, framed or reported by, the media. However, in undertaking the research, we found that media images, in fact, offer the symbolic frames via which ordinary people not only encounter HIV/AIDS but also how they make sense of it in terms of labeling particular kinds of behavior, health, illness, and identity. As is now evident from just one case study reported on below, the condition is being remediatized through popular discourses, often in defiance of the sham reasoning offered by some members of government. Myths of all kinds are being produced, articulated, disarticulated, and rearticulated all the time. In a study conducted by the Centre for AIDS, Development, Research and Evaluation (Parker, Makhubele, Ntlabati, & Connolly, 2007), it was found that the 15% high-risk cohort who engaged in multiple concurrent sexual encounters defined *faithfulness* as not using a condom with the main girlfriend. Trust was earned with this partner by the male partner admitting to using condoms with his other multiple partners. Faithfulness is not linked to monogamy. Is this the new postmodern polygamy? Multiple partners in the absence of an economically constituted

family unit, in which roles, obligations, and responsibilities are clear, seems to also be partly a coping mechanism by the women who are mostly unemployed and poor (Parker, Ntlabati, & Makhubele, 2007).

Although I have talked about the mediatization and mythmaking at macro- and meso levels, what is happening at the microlevel is equally, if not more, chilling and has enormous implications for campaigns based on social learning theories (e.g., Bandura, 1962), which assume popular industrial-type rationality. A study conducted by some of my students revealed that stigma and discrimination still commonplace in some rural parts of KwaZulu-Natal is hindering the uptake of voluntary counseling and testing (VCT; Kunda, 2006). Through linguistic discourses that describe them as social misfits, individuals known to be HIV positive are ostracized and separated from their communal bonds.

The Kunda (2006) study identified a number of discourses that have emerged in reference to HIV/AIDS, four of which shall be discussed here. First, *cleansing discourses* are used by people in the rural Valley of a Thousands Hills, outside Durban, to describe the separation of the infected from the uninfected. Metaphors invoking OMO<sup>14</sup> [washing away] are used to show the removal of unwanted stains or dirt (infection) from clothes. Sieving or winnowing is used to describe removal of chaff from grain or any other separables from essentials. This discourse opposes individuals into binary oppositions of the essential and the nonessential, the clean and the dirty. The sick are the chaff that is being disposed of from the community or the dirt/infected that/who is being washed away by OMO. In other words, HIV/AIDS is metaphorically likened to OMO, which cleans the "dirt/the infected" from the community, killing them, thus performing a positive social function.

*Ipot* is formed by adding the Nguni prefix, "i," to pot, which is a three legged traditional Zulu cooking vessel used over an outdoor fire. The pot is used in collective cooking activities and metaphorically connotes the *discourse of commonness* of the disease. It additionally indicates that something is boiling or cooking in someone's body, which will soon be eaten away. This discourse announces the inevitable dawn of death for the person living with AIDS. When the metaphorical food/sickness is brought to the boil, then the individual is ready for death. This metaphor reminds the infected that they should prepare for death rather than prepare for positive living.

Channel O, a risqué pop music station broadcast by the South African satellite television platform DStv, is invoked as a visual metaphor to attach *connotations of promiscuity* to those known to be infected. Individuals who are living with HIV/AIDS are categorized as promiscuous, akin to the loose living depicted on pop music TV. People going for voluntary testing and counseling are named as *Channel Os*. Semiotically, this naming "hails," identifies, and Others infected individuals in terms of the *discourse of stigma*.

*Blame by association* is the fourth discourse and intersects with the loveLife campaign's association of talking about sex in the context of the highlife, signified by excessive and conspicuous consumption, acquisition of material consumer goods, and embourgeoisification. The sign that connotes this fast-living culture is

the BMW Z3 sports car model. This aspirational capitalist symbol mobilizes the sign of promiscuity and links it to urban cosmopolitanism with its inevitable consequence of infection. HIV infection is seen by ruralites as a modern disease of the town. Those infected then return to the rural areas to die. The Z3 thus connotes both positive upward class mobility and its negative opposite of the highlife aspired to being unsustainable and resulting in death.

What these four discourses reveal is that death is not seen as the problem: Being *Seen To Be Sick* or being observed going for voluntary testing and counseling is identified as the real problems. How does one cut through the discursive garble—so to speak—in making sense of the minister's claims and these popular responses? The link may be found between the use of herbs by traditional healers and nutrition. The minister is very supportive of traditional healers—an African solution/alternative—and, of course, opportunists have taken the opportunity to peddle their snake oil (e.g., Virodene and the Rath vitamin concoctions). More recently, an herbal concoction called *ubejane* has been marketed in KwaZulu-Natal. Healers are good psychologists in societies where people believe that disease is a spiritual condition or “God’s will” (Ashforth, 2005, pp. 44-45). It is obvious that in the context of a severe epidemic, many people hedge their bets in much the same way as Christians who pray to saints while also consulting their doctor.

Recovery from any disease requires good nutrition, thus making poverty a very real issue. Tshabalala-Msimang (2003) noted how “hunger still discourages people from completing their six months’ treatment for Tuberculosis.” However, science has also found the drugs that give the body a fighting chance under the right conditions. Although Msimang knows that it is not an either/or situation, it is a puzzle to know what the minister was trying to communicate with her vegetable display stand at the 2006 International AIDS Conference in Toronto. There may be something to be said for the rhino-horn theory, but then how conscious is she of what she is espousing? By lampooning and ridiculing her, the media have made her more stubbornly African—a kind of David and Goliath stand against Western power, including science. Science is, of course, not African or Western, but how to reconstruct knowledge so that it doesn’t appear to be oppressive or as a tool of the oppressor that seems to be at the root of the state’s discourse.<sup>15</sup>

### **New Directions: *STEPS for the Future***

A fifth intervention, working in Southern Africa as a whole, is the STEPS documentary film series, which subcontracted a number of producers in Southern Africa. The STEPS Web site states the following:

From six different countries of the Southern African region comes a unique collection of films. Positive, provocative, humourous, brave—unusual stories about how individuals are confronting their lives and how societies are having to change under the impact of HIV/AIDS.<sup>16</sup>

The *Steps for the Future* video collection has emerged out of a collaboration of Southern African and international filmmakers, broadcasters, AIDS organizations, and people living with HIV/AIDS who have united to produce high-quality, professional films. These compelling stories reveal the effect of the HIV/AIDS pandemic on the lives of individuals, families, communities, and nations. The films form part of a media-advocacy campaign, which is intended to promote debate and discussion around HIV/AIDS-related topics, such as disclosure, discrimination, treatment, and living positively. Diverse perspectives are presented through the eyes of a range of people and communities. This campaign cautions the popular responses documented by John Kunda, by engaging these myths and media associations, nullifying the stigma at the level of the community, where screenings and discussions are held.

The unconventional STEPS stories celebrate the strength of the people who share and reflect on their experiences of HIV/AIDS. *Steps for the Future* not only challenges fear and stigmatization with stories of hope but also dismantles discrimination and ignorance by cultivating tolerance and promoting the belief that, actually, life is a beautiful thing and that the infection can be managed. This message is opposite to that found by Kunda (2006), where infection leads to ostracism.

Let us compare the in-your-face, overcharged sexual imagery communicated by loveLife (which constructs Africans as licentious, unrestrained, wedded to sexual acts rather than relationships, and youth in particular as hypersexual), with the STEPS series, which is much more personalized, humanized, and local. One film from the series, *The Ball* (Mozambique), provides a useful and entertaining example.<sup>17</sup> The film shows a group of boys playing a game of soccer somewhere on a dusty soccer field in Mozambique. Suddenly, a man runs onto the field shouting. He stops the game and accuses the boys of stealing his condoms. There are different ways to use condoms, and in Mozambique young boys are great consumers of them, turning them into soccer balls. *The Ball's* central metaphor is that life is cyclical: The film starts with wool from a child's jersey hanging on a washing-line being pulled, looped over an inflated condom, and made into a soccer ball. The boys have fun collectively playing soccer, return the wool to the line, and the knitter starts again. Thus, the film echoes birth and rebirth, as well as the STEPS catchphrase "Life is a beautiful thing," with no undefined imperative, such as loveLife's talk about "it."

Similarly, the video could also be seen as an implicit critique of donor imperatives, which impose solutions, rather than developing them out of local contexts, connecting with indigenous ways of making sense, and shaping behavior change via these. Here are images of a positive Africa, of inventive individuals who engage the problem not just via the stark, individualized technician and stark sexual imagery of loveLife but via community, relationships, and the circulation of meaning. This is a self-resourced communal agency, not a donor funded and imposed one. Sexual health does not require conspicuous consumption, having fun does not automatically mean having sex, and using condoms becomes a more naturalized set of activities that eliminate stigma.

## Identity Politics and Science

To return to an earlier point, the discourse of sham reasoning is deeply embedded in so-called African responses to the AIDS crisis. The issues need to be separated: health prevention strategies from identity politics, for example. When this does not occur,

- Gays are denigrated as less than human; they become a means of political legitimation for repressive regimes (Namibia, Zimbabwe).
- People living with AIDS are accused of being anti-African, antihuman, and traitors to their identity, carrying the stigma of the diseased subhuman.
- NGOs are warned off dabbling in politics, considered by politicians as the sole realm of government.
- Scientific engagement is demonized as racist, irrelevant, and injurious. African solutions are called for, thus dismissing science as alien ideological imposition.
- Popular discourses link to media images, such as OMO, Channel O, and Z3s, in ways that legitimize unsafe practices and which metaphorically visualize stigma.

As Susan Haack (1997) concluded,

When sham and fake reasoning are ubiquitous, people become uncomfortably aware, or half-aware, that reputations are made as often by clever championship of the indefensible or the incomprehensible as by serious intellectual work, as often by mutual promotion as by merit.

This is what seems to be happening in South Africa today as government political agendas obstruct treatment rollouts. Quite where or how loveLife fits into the scenario has never been clear, but as Warren Parker (2004) has argued, the answer may lie in the dimension of international donor politics: who gets to make meaning, who gets to benefit from the meaning made, and how that meaning serves the global function of capital may offer something of an explanation.

Although I have not spoken much about poverty, it should suffice to say that in states faced with huge death rates; overburdened, inefficient, and misdirected health systems; and denial on the scales that are occurring in some southern African countries, economic growth cannot occur as entire workforces succumb. Blaming colonialism for poverty is no longer a valid accusation—The answer, as Barry Ronge (2006) insisted, cannot be found in mixing medical and agricultural discourses/metaphors but in something called “[African] culture” that holds the solution. As much as the media trash this discourse, it always resurfaces in the minister’s utterances, and vulnerable groups generate all kinds of myths and media interpretations to not only label what they do but also in how they make sense of where they fit into the pandemic.

I end on a pessimistic note, as it seems that ideology is the determining discourse. People are not ignorant of HIV/AIDS; their use of the ubiquitous red ribbon<sup>18</sup> at funerals attests to this. The real disease is that of denial, aimed at preventing stigma (individual, communal, national, continental), a social condition that hampers state policy and clear thinking. A lack of leadership at every level—including

ordinary citizens—is at its core. Unwilling to attack the stigmatization that AIDS brings, the president himself, as well as other senior politicians, transmit opaque messages about how HIV is transmitted and the safety of ARVs (Butler, 2005). We have skirted the true meanings of living in a severe and deadly epidemic. Discourses are skewed and power lies at the centre of what becomes dominant. Like Sethunya Mphinane's (2002) conclusion of Botswana, "people do not live their sexuality in response to AIDS messages, they live their lives in spite of them."

## Notes

1. TAC Web site: [www.tac.org.za](http://www.tac.org.za).

2. The president announced his withdrawal from public debate on AIDS science in October 2000 as it was causing misunderstanding within the ruling alliance, the Africa National Congress (ANC), the Congress of South African Trade Unions (COSATU), and the South Africa Community Party (SACP; cf. Beresford, 2006a, 2006b). COSATU and the SACP disagreed with Mbeki and the health minister's denialism.

3. See, for example, Dispatch Online (2001) and le Roux (2006).

4. Mbeki invited all the major AIDS dissidents to a panel meeting with codiscoverers of the HIV virus and a few senior local and international scientists in May 2000 and again in July that year to "debate both the accuracy of HIV tests and the causal link between HIV and AIDS" (Mbali, 2004, p. 105; Natrass, 2006). The panel ended in a disagreement between the two camps.

5. The Rath Foundation conducted an unofficial trial outside of South Africa's regulatory structures in Khayelitsha in 2004/2005 under the leadership of Sam Mhlongo, seemingly with the approval of health minister (Natrass, 2006).

6. Soul City, Khomanani, loveLife, and the Health Communication Partnership led by Johns Hopkins University.

7. Lynn Dalrymple is a member of DramAidE. Web site: <http://www.dramaide.co.za/contentpage.aspx?pageid=2194>

8. See statement by minister's Advisory Committee: <http://www.ukzn.ac.za/ccms/mediacommunication/pubhealthcommunication.asp?ID=9>

9. Virodene "poison" resurfaces, [http://www.news24.com/News24/South\\_Africa/Aids\\_Focus/0,,2-7-659\\_1766122,00.html](http://www.news24.com/News24/South_Africa/Aids_Focus/0,,2-7-659_1766122,00.html)

10. Beyond Awareness, <http://www.cadre.org.za/awareness.htm>

11. The video is of an audience-participation play, performed at a rural school by peer educators. Learners chosen from the audience acted as characters in the play. They were offered a selection of choices regarding premarital sex and condom use, and the various consequences were then acted out, that is, teen pregnancy or HIV infection.

12. loveLife, <http://www.lovelife.org.za/>

13. *Knowns* is a term developed by Herbert Gans (1979), which accounts for people well-known in the news (pp. 29-30).

14. This is a brand name for washing powder that is common in the area.

15. The interrogation of power is what DramAidE has been trying to do with its participatory approach. I am indebted to Lynn Dalrymple for the ideas expressed in this paragraph.

16. *STEPS for the Future*, [www.dayzero.co.za/steps/guide/guide.htm](http://www.dayzero.co.za/steps/guide/guide.htm)

17. Volume 24 of *Steps for the Future*, a 25 cassette series on AIDS in Southern Africa. *The Ball* by Orlando Mesquita, 5 minutes, Mozambique, <http://www.newsreel.org/nav/title.asp?tc=CN0151-24>

18. A red ribbon is used to symbolize AIDS awareness. It is often placed on coffins by surviving family members who might often deny that the person being buried had died of AIDS-related diseases.

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