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Narratives and Silences in Discussions of AIDS/HIV Amongst Young People in Mpumalanga, South Africa

Fiona Larkan

I entered Siphos' hospital room to find him curled up in a foetal position on the bed with his back to the door and facing the windows. I walked around the bed to greet him and saw an attractive young man with a fashionable haircut who looked as though he had once been physically powerful, but was now too weak to sit up or even move easily. He was wearing blue hospital pyjamas. His face seemed drawn and tired and his lips were chapped and bleeding badly so that it seemed to me that any attempt on his part to speak would be difficult. I greeted him in Zulu and asked his permission to talk to him. I felt, given his obviously poor health, that I should check again that he was comfortable with my presence. He said I should stay and talk to him and I sat down beside the bed, which had been raised quite high so that our heads were now at the same level. I did not take out a tape-recorder.

Siphos was 29 years old when we met. He was born and lived locally, with his wife and two young children. His oldest son was seven and the other one, he smiled – he can't remember – but "still a baby". We spoke about his wife and two sons, and about his job in a local Joshua Doore furniture shop where he had worked as a salesman for the past six years. "Your uncle in the furniture business"² he says. His wife stayed at home to look after the children.

He told me he had come to the hospital three or four times because he was experiencing dizziness. He doesn't like it here but won't say why. On the latest occasion, two weeks ago, the doctors did tests but, he said, did not give him the results. No-one had come to talk to him about why he is sick. At this stage I asked if I should leave but he smiled and says "No, I will talk to you". But I could see that it was physically difficult for him to talk. His mouth seemed dry and he spoke in a whisper. The sores on his lips were now bleeding onto his sheets and pillow. I held a glass of water with a straw to his mouth and he took a drink.

I did not know how to broach the subject of AIDS because he was apparently not going to volunteer the information that he was HIV positive and I was no longer sure if I was supposed to know about his status. I commented about the AIDS situation in the area and Siphos shifted his position slightly and looked away. He said nothing and for a full five minutes we sat in silence. It was almost as though there was a silent struggle going on. I wanted to say, "Its OK, I know", but I couldn't. It was obvious that he was not prepared to discuss anything about AIDS. In the end I did what so many friends and family members do when confronted with a loved one diagnosed with AIDS – I

¹ Not his real name.

² "You've got an uncle in the furniture business – Joshua Doore!" has been the marketing slogan for this national retail furniture store for the past twenty years.

pretended not to know. That was the way he wanted it. Finally he broke the silence by repeating that he did not like the hospital and was going home today. I asked again, if he wanted me to go away and again he said no.

We changed the subject and talked instead about traditional healers he had visited because of the bad dreams he has but he wouldn't talk about the bad dreams either. His eyes filled with fear. He was tiring rapidly and still struggled to talk until eventually I decided it was time for me to go. This time he agreed and we said goodbye.

Outside the nurse reconfirmed that Siphso had undergone counselling. He was not going home that day but they were confident that he would be well enough to go home at some stage "for a short while". I came away feeling incalculably sad.

This paper centres on discussions surrounding people living with HIV and AIDS in Mpumalanga province of South Africa and challenges an accepted hypothesis that a Euro-American understanding of stigma is the main reason for the silence surrounding HIV and AIDS. Through the example of Siphso's silence above, and narratives of various participants, I examine the choices available to this community in the face of the calamity that is a provincial HIV infection rate of 27.3%³ and the silences that often accompany a diagnosis of HIV/AIDS. I begin by identifying alternative, although not necessarily mutually exclusive, cultural mechanisms, which are in place in Mpumalanga. I look at the role of stigma, whether "felt" or "enacted" (Scambler & Hopkins, 1986) and the internalisation and reproduction of external public criticisms (Goffman 1986). While some stigma does exist, it is important to emphasise that in each model identified, silence plays a major role in the strategy of a people working to protect, restructure, and re-affirm their community. This paper, then, is my attempt to understand each of these mechanisms and reconcile some of those divergent views and discordant voices.

Throughout South Africa the story of HIV/AIDS is prominent. Regular magazine and newspaper features keep the issue front and centre. Television programmes and radio talk shows have ongoing awareness campaigns and human-interest stories. Drama and musical societies do awareness concerts. Local community clinics are littered with posters and literature and hand out free condoms. Schools throughout the country have "Life Skills" teachers whose job it is to inform young teenagers about safe sex practices and the dangers of HIV/AIDS. Billboards along motorways and posters on lampposts scream out about the dangers of HIV/AIDS, although in Mpumalanga in 2001 there were fewer posters than I had seen elsewhere.

As with all public health campaigns, the message is clear, direct, and unambiguous. Using a medical model, the causes of transmission of HIV/AIDS are laid out, and people are informed about how best to protect themselves. While the politics of the latter may lead to contradictions in the message (*e.g.*, abstinence, condoms, faithfulness) there is a consistency about

³ South African Dept. of Health, *HIV/AIDS & STD Strategic Plan for South Africa 2000-2005*: 2000.

the former – the virus is transmitted through the exchange of bodily fluids, most often during sexual intercourse but also in a variety of different forms (dirty needles, intravenous drug use, mother-to-child transmission, etc.). Despite the furor surrounding President Mbeki's comments about the link between HIV and AIDS at the 13th International AIDS Conference,⁴ during recent years the message from the Department of Health has been entirely consistent with the international public health models, and the President himself has withdrawn from any further public comment on the matter.⁵ It would not be true to say, therefore, that the South African public is uninformed about the existence, prevalence and causes of HIV/AIDS although the extent to which they engage with such information, and the manner in which they choose to do so, varies considerably.

Alongside the vast amounts of public information, there is a reluctance to discuss sex privately or in family circles. Although it is not a cultural taboo, it is certainly considered improper for parents to discuss sex with their children. None of those people I spoke to had received any sexual education or information from their parents, and all considered it quite proper that they learn about such matters from friends or peers, although they admitted that in many cases the information they had gained from such sources had been incorrect.

Witchcraft

As with many other African countries (and indeed further afield), there exists in South Africa a witchcraft complex, which cannot and should not be ignored. To do so would be to disregard a cultural mechanism which is “chillingly concrete, its micropolitics all too real” (Comaroff 1993:xxvii). Witchcraft has for many years provided a moral framework, a vehicle for interpretation, a means of both social healing and of searching for causal links for the frustrations of those questions that cannot ordinarily be answered – the “why me? why now?” questions.

Witch beliefs do not merely express social relations, but are a set of beliefs and practices in their own right which structure chaotic experiences so that the world can be made meaningful. [Witchcraft] enables people to explain, diagnose and compensate for unmerited misfortune. [Hammond-Tooke cited in Niehaus 1993:500]

Just as the witchcraft paradigm itself merits attention, so too do the shared characteristics of AIDS and witchcraft. Whereas HIV/AIDS relies on an exchange of bodily fluids for transmission, witchcraft often requires the hair/nails/blood of a victim to be successful; they share symptoms of lung and stomach problems and are generally slow “wasting” sicknesses; witches are always intimately known to their victims – neighbours, family members, loved

⁴ Held in Durban, South Africa in July 2000.

⁵ Minister for Health, Dr. Mantombazana Tshabalala-Msimang, publicly advocates a diet of raw garlic, lemon peel, olive oil and beetroot to fight HIV, arguing that South Africans should be given treatment choices and that ARVs cannot, and should not, be promoted as the sole remedy for the disease.

ones - whereas AIDS singles out particular victims within intimate social networks (Ashforth, 2002); both relate to inexorable human problems of death and undeserved misfortune and both require silence, discretion and constant vigilance, since it would appear that neither can ever really be obliterated.

Most notably, during times of extreme crisis or trauma, populist campaigns for witch-hunts emerge. Until 50 years ago, structures did exist for dealing with witches either through a ritual process of identifying and reintegrating witches into a healed and reunified community (Delius 1996), or through banishment (Niehaus 1993; Stadler 1996). However a combination of the breakdown of chiefly rule, "betterment" plans, Apartheid resettlement policies, The Suppression of Witchcraft Act (1959) and government protection of accused witches, have served not to rid the community of witches, but to upset the precarious balance of forces that did exist and to change the landscape and social responses to witches within the community. A dissatisfaction with government responses to, and protection of, witches in the community has led to the perception that witches are even more firmly established than ever and evidence of their work is more prevalent. Not only have witchcraft accusations increased but, more often now, dealing with witches requires that their punishment be equal to or more violent than the crime itself and the past thirty years have seen an increase in stoning, beating and burning to death of those accused. In addition, accusations themselves have moved from socio-centric to egocentric. Whereas accusations in the past generally related to malice caused to an entire community, say by preventing rain to fall on crops, now they are almost entirely concerned with malice directed at individuals.

In fundamental ways, then, both HIV/AIDS and witchcraft are concerned with the politics of public morality. There is a desire to rid the community of any undeserved misfortune and evil that exists, an important part of which is currently manifest in the epidemic of HIV/AIDS. That is not to suggest that there is necessarily any blame attributed to the AIDS patient him/herself. Ashforth (2002), for example, argues that it is entirely plausible for people suffering with AIDS to interpret their afflictions as a form of witchcraft or *isidiso*, and that such an interpretation is by no means based on irrationality or superstition.

...[W]hile the virus might be contracted from a man's illegitimate love affairs, the witchcraft responsible for his infection could have been sent to him by his wife, his mother-in-law, or a jealous neighbour or a person in any one of a number of different relationships who might have been motivated by jealousy and hatred to malicious action. [Ashforth 2002:132]

Most significantly, however, is the knowledge that witches have the power not only to kill their victims, but to turn them into zombies – living dead, who work at night as slaves to increase the wealth of the witch. Little has been written about these individual victims who occupy the space between life and death, but given the already existing parallels between HIV/AIDS and

witchcraft, it is entirely possible that people identified as HIV positive could be seen to be occupying that same ambiguous space as the “living dead.”

By virtue of their diagnosis, individuals who are HIV positive are unable to conform to standards that society calls “normal”, represent a difference from socially ascribed expectations and as such are disqualified from full social acceptance, so they become stigmatised individuals (Goffman 1986). Furthermore, insofar as the diagnosis “predicts” an imminent death, it conforms to some of the expectations of how witchcraft is seen to operate. This similarity can have drastic consequences, as was the case in December 1998 when one young woman, Gugu Dlamini, was stoned and stabbed to death three weeks after making a public statement that she was living with AIDS. This act of violence is suggestive of the treatment of witches and indeed AIDS, like a witch, is anomalous and disruptive of the social order.

Similar acts of violence have been visited upon others who have disclosed their status, although, thankfully these seem to be reducing in number. Everyone is agreed then, that HIV/AIDS is stigmatised and disclosure can be dangerous. In a social-medical context of the scarcity of triple anti-retroviral therapy, HIV positive people who reveal their status to the community are declaring a social death. As I argue below, in a society whose members understand themselves as profoundly mutually constituted this social rupture can often be harder to experience than the disease.

Ubuntu

Ubuntu is the Zulu word meaning variously “humanness” or “humanity.” It refers to a world-view, the central tenets of which are *umuntu ngumuntu ngabantu* (*a person is a person through other people*) and *Simunye* (*we are one!*). It invokes a sense of the mutual construction of personhood and is widely held throughout South Africa as a philosophy, a factual description and as a code of ethics. It is sometimes glossed by Western philosophers as being a variation on the theme *do unto others as you would have others do unto you*, but, as I argue below, this translation misses some key aspects of this worldview. Above all, *Ubuntu* cannot be reduced to a simplistic individualistic versus socio-centric analysis. It is my contention that a fuller understanding of the practice and philosophy of *Ubuntu* goes some way towards explaining the relationship between HIV positive people and the wider community, including the issue of health care.

Much has been written about the view that the *other people* through whom one becomes a person has in fact a religious connotation in terms of ancestor worship, and this is indeed part of the picture (Prinsloo 1995:4, 1998:46, Van Niekerk 1994:2, Ndaba 1994:13-14). However, equally important is the affirmation of “others” and a respect for the beliefs and practices of others. There is a lesser-known but fuller translation of *umuntu ngumuntu ngabantu*, as “A human being is a human being through (*the otherness of*) other human beings” (Van der Merwe 1996:1). Thus understood, *umuntu ngumuntu ngabantu* is interpreted as: “To be human is to affirm one’s humanity by recognising the humanity of others in its infinite variety of content and form”

(Van der Merwe 1996:1). Effectively, *Ubuntu* tells us “only when I affirm your humanity do I fully confirm mine.”

Such a strong emphasis on community can pose some difficulties. It can insist on conformity, totalitarianism and continuity, whilst shunning difference, and fearing change (Louw 1995). More than anything else, *Ubuntu* makes mutual constitution categorically part of human personhood. Clearly, if human beings are mutually constitutive, then the removal of one constituent poses a threat to the whole. The central issue in the declaration of “having AIDS,” then, is that it equals “death” but “not right now.” Thus, both the person living with AIDS, and her community, are left in an extremely anomalous position, structurally similar to the challenge to sociality posed by witchcraft. A sort of hole is predicted in the social fabric, one that refuses the immediate ritual reconstitution that a “real” death would offer, that is a funeral. Thus, the person with AIDS finds herself between categories not just for herself, but for every other person with whom she interacts. I have struggled to find any perspective that resonated with the public discourse and explained people’s behaviour, including the narratives and more specifically the silences. This aspect of *Ubuntu*, it seems to me, explains important aspects of the symbolic economy around AIDS in Mpumalanga.

Narrative and Silence

Narratives can also be seen as a cultural mechanism, albeit one which at least initially is enacted on an individualistic basis. Narrative in the first place exists as a presentation of the self to the self. If we accept the principle that narrative is itself a process through which the life-world is reconstituted (Good 1994:133), then informants regain control and rebuild self-image with every telling of their narratives. Further, it provides a means of dealing with events and incidents that need to be accessed, tested, and processed in order to make sense of situations, both for the self and for the listener. “To explain more is to understand better” (Ricoeur 1984). It can express both internal struggles against a moral authorizing society, as well as external struggles against a structural position within society. On an inter-subjective level narratives are part of what Arendt (1958) identifies as the “subjective in-between” which is not tangible and mediated, but, she says, “for all its intangibility, this in-between is no less real than the world of things we visibly have in common.” Stories and storytelling exist to fill the surplus/void that escapes signification in symbolic systems. They are the means people use to constantly hold back this surplus, or reconstruct the void, and the means by which they create their identity (Zizek 1995). This a self-identity constructed through an understanding of the projection of the self to other persons.

Self-help groups do exist where HIV positive patients will meet and discuss their situation, exchanging stories in a comforting and supportive environment. Those attending refer to the positive benefits of having such a facility and say they will live longer because they are living without the extreme stress of those who have no forum within which to experience their disease. These centres do not deal with biological or technological solutions, but with social ones – preparing people who wish to disclose to their families; providing practical day-to-day assistance – a meal to those attending;

information on safe practices and care. Such centres are attended by fewer than 20% of the HIV positive population although it has to be said that non-attendance cannot be construed as rejection of this option, as there are multiple reasons for not attending – including ease of access. I was told by doctors and nurses in Mpumalanga that because nurses live in close proximity to the patients and have to interact with them when they return to the community, they do not want to become involved with counselling outside the hospital and are reluctant to provide the mandatory pre- and post-test counselling required even within the hospital setting. It seems that they require of themselves that they go through a process of “un-knowing” the knowledge that could interfere with the community dynamic. It would seem then, that narrative, while it plays a part in the lives of people living with HIV, is contingent.

Alongside narrative, the act of silence, and a knowledge of when not to speak, cannot be overlooked. The primary hypothesis in HIV/AIDS literature is often that the silence surrounding HIV/AIDS is based in “stigma;” that that stigma is in turn based on ignorance; and, finally, that fear of violent repercussion prevents people from disclosing and that with enough education, awareness and openness around the disease silence will be consigned to the past and we can all move forward.

I do not deny that stigma exists. But there are a number of questions which arise, which I feel should be examined, particularly in the light of the range of cultural mechanisms which do exist in this community. Firstly, the extent to which such stigma is “enacted” as opposed to “felt” is unclear. Secondly, must silence always be seen as obstructing the disclosure and acceptance of an HIV status? Third, should the same meaning always be inferred from silence? And finally, to what extent are silence behaviours cross-cultural? In the remainder of this paper I will attempt to examine these questions through narratives and silences collected during my own fieldwork in Mpumalanga.

Whereas “enacted” stigma refers to penalties or sanctions against people living with HIV/AIDS, “felt” stigma refers to the feelings of oppression and fear of “enacted” stigma. I asked informants how they felt about disclosing their HIV status to family and friends. While they all had had concerns about disclosing their condition, because, they said, of stigma [1, 2], those that had told their families had found at least some support, albeit after a period of education and/or counselling [3 –6]

[1] If I did my life would change because they would reject me. They wouldn't want to be near me or share with me. AIDS kills but its not as though you go looking for it. You go out looking for a stable life and that's what people want – not AIDS.

[2] I just say I am healthy so how can I have that kind of a disease. Sometimes you think you tell your friends but you tell a snake. That friend is a snake. You can't trust a friend when you have that kind of a problem.

[3] The family were not angry because they saw me so sick... different sicknesses in my body....so they were alright now because now they at least knew what was the problem. Also the six months treatment killed the other diseases [TB and pneumonia] and at least now I am left with just HIV.

[4] I couldn't tell my family so I moved to Capetown to live with my sister. But the doctor I was going to in Capetown told my sister about my status. When my sister confronted me I told her but I decided also to come back to Jo'burg. But she is still keeping in touch with me.

[5] I did not disclose to the family immediately. I educated them and prepared them about AIDS first and I asked them once what would they do if I was HIV positive. Then they saw me on TV.

[6] They were angry and upset and can't understand what happened to me – was it because of how they raised me or because I went away when I was still young? So many questions. They received counselling because they thought I was very sick and I was going to die tomorrow. They did not understand AIDS. Now they accept me.

When I questioned the reason for the stigma I was repeatedly told that it was because of the promiscuity that people aligned with it. A strong emphasis was placed on deserved punishment or retribution for past sins.

[7] They don't like talking to you because it's like you've sinned or you've done something wrong or you went out asking for this disease or did not behave well sexually.

[8] The terrible thing is that in some churches I have been in the elders say this subject should not be discussed because this disease only affects people who mis-conducted themselves.

[9] Hey, we are having it because of immorality.

[10] They say its because I have lived a bad life and I did this, and this, and this."

[11] They get it because they are so promiscuous. They'll sleep with anyone. They don't think like us.

[12] There is this notion that if you are HIV positive you are an outcast. You are not taking good care of yourself.

As a reaction to that, many people are at pains to emphasise that HIV/AIDS can be contracted by other means, and play down the sexual transmission of the disease, even to the point that they exaggerate the risk in other areas.

[13] The thing is, we have to move away from this notion that HIV/AIDS is caused by our people behaving badly and getting it through intercourse. If I go to the barber to have my hair cut and the barber has cut somebody before me and if there is even a speck of blood on the blade and he doesn't clean some of that blood, then I can get AIDS. We have to put more emphasis on other ways of contracting AIDS.

But (except in the case of children born with AIDS) categorization of modes of transmission is not really accepted as a mitigating factor within the black community when dealing with a person with AIDS. Some white people I spoke to made clear distinctions and seemed to attach a moral hierarchy to each means of contraction of the disease. Once again, such observations simply contribute to an already established pattern of castigating the "other". They see "grades of AIDS" and in such circumstances intravenous drug use is "less bad."

[14] A few of my friends have children who have died of AIDS but at least in their case it was because of drugs.

Nor is this stigma attached to promiscuity seen as contradicting the high social esteem enjoyed particularly by younger men who have multiple partners.

[15] It's not a cool thing if you don't sleep with your boyfriend. We encourage a certain behaviour but when something happens as a result of that behaviour they will complain that you sleep around.

[16] If you are a young boy and you don't have a girlfriend then you are stupid. If you are a young boy and you have a girlfriend but you don't sleep with her, then you are very stupid. If you have many girlfriends then you are the man.

Upon closer questioning, all informants I spoke to said that there was little stigma associated with other sexually transmitted diseases (STDs) such as syphilis and gonorrhoea, which would, on the face of it, give lie to the stigma-based-on-promiscuity theory. Sufferers of STDs can reveal the circumstances of their infection or disease and go quite openly to clinics to receive treatment without fear of negative response from family, friends or community.

It seems that the stigma attached to HIV/AIDS, despite being expressed in terms of promiscuous behaviour, has more to do with the fact that it is incurable and is bringing death into the community. Unlike other STDs, AIDS, like a witch, brings death to the community. Any element of blame focussed on an individual's behaviour has less to do with a moral judgement against the individual for contracting the disease, and more to do with a response to the danger that the individual has caused to the wider community by visiting this disease upon the collective.

[17] People view AIDS as the most deadly disease.... I guess it [stigma] is because there is no cure for this disease, from the beginning. It is sexually transmitted like any other STD, but they don't mind about those, but HIV, no. They even hide themselves.

[18] Those very peers need to come out if they know they have HIV, but then it will be known that they have spread HIV all around – that's why they are very afraid. Because it kills.

[19] There is no stigma attached to other STDs. They don't have a problem with that. When you've got STDs you have a sickness that can be cured but when you've got HIV they say you are going to die now, now, now. They don't care as long as it's out there. They only care when it's in their home.

Among those people I spoke to where stigma does exist, it is clearly more “felt” than “enacted.” HIV positive patients internalise and reproduce negative external messages, specifically about morality, even when such messages are completely without foundation. Families and community do not always react negatively to a HIV positive disclosure. Central to this, however, is the manner in which such a disclosure is made. Not surprisingly, a blanket statement to a family or community, which is not prepared in advance, seems to result in a knee-jerk reaction rather than a considered response. Further, where stigma does attach, it is not because of perceived immorality, but because of the threat to the community that such a death causes.

Despite claims to the contrary, primarily in public health literature and awareness messages, I would argue that silence does not always obstruct disclosure and acceptance of a HIV positive status. Rather, there is evidence to suggest that a substantial amount of work is carried out in the space afforded by silence. Skhosana, in her work among AIDS patients in hospice care (2002 unpublished), provides ample evidence to show that complicit silence about HIV infection is common, with intimate family all knowing and all pretending not to know. This happens within families and among friends and neighbours as well as within the wider community-run institutions.

One home-based Community Care Centre I visited was a prefabricated building with a small patch of ground, surrounded by a pre-cast concrete wall, fairly typical of the many such community self-help centres throughout South Africa. The large painted sign above the door tells visitors that the centre deals with TB and cancer. Oddly, from a public health perspective, it made no mention of the fact that it exists to support people living with HIV or AIDS – even the centre will not publicly disclose its full function. TB or Cancer diagnoses and treatment are acceptable and accepted and allow care to be given to a patient.

Similarly, I was invited to a small Pentecostal church with a congregation of about 200, which meets in a large marquee at the side of a main road in the area. I was specifically asked to speak to young members of the congregation because they have established what they identify as a safe platform from which people can publicly disclose their HIV status and receive counselling.

The church feels that as members of the community they need to tackle the issue of HIV/AIDS in the community. We spent many hours together and the final question I asked the group was whether any one of them knew (or knew of) a person living with AIDS? If the regional statistics were applied here there should have been 10 or 11 of the 40 people present who were themselves HIV positive. As I asked the question I looked towards the elder who had invited me, intending to say “I know Michael⁶ deals with HIV patients, but is there anyone else?” As I began to speak I was stopped by the look of horror that spread across his face and his eyes widened. I realised that despite their expressed intention to offer a platform for disclosure and counselling, this group of people – his friends, family and church community – had no idea that one of their own elders was HIV positive. Although he had disclosed to me privately, he had never disclosed his own status to them. In fact, despite Michael’s presence, at the time of my visit nobody had ever disclosed their status to the group and all the members present insisted that they knew of nobody who was HIV positive.

According to Goffman (1959), while the necessity of each individual to maintain his or her front in order to promote the group reduces the possibility of dissent, those identified as having “contravened normal expectations” are ostracized and must constantly strive to adjust to their precarious social identities. Their images of themselves must daily confront, and be affronted by, the images that others reflect back to them (Goffman 1986). The difference in this situation is that “normal expectations” require that the community be protected against danger from within. The narratives above [17 – 19] clearly show that it is death, more than disease (even sexually transmitted disease), that is the threat, and this threat is not mainly the destruction of one individual, but of his or her role in the constitution of all other persons in his or her society. Whereas in the Western world the availability of medicine has led to AIDS being seen in the same light as many other chronic diseases (say, diabetes), this community has very little hope of accessing any medication, thus a positive diagnosis remains a death sentence. If a group identity is being expressed, then the community must surely also suffer psychologically as a result of the alienation of some of its members. In the same way as the individual is experiencing disease because of a virus, the community is also experiencing a dis-ease because of the imminent loss of one of its members. It is a communal problem, which is collectively shared and requires a collective response. While very real and immediate threats to this community have existed for many generations, particularly during the apartheid years these were largely external threats, more easily identifiable, and the community could reshape itself to deal with or counter such threat - even strengthening itself as a result of its response to adversity. How then do they deal with such a devastating threat from within?

I should perhaps re-emphasise at this point that I do not wish to suggest that communal or group identity be placed in opposition to individual identity. The practice of *Ubuntu* specifically works against such a polarization. Faced with a loved one, or a member of the community who is HIV positive, how does one practice *Ubuntu*? The accepted wisdom has been that a community

⁶ Not his real name.

transforms the status of the sufferer by first identifying the sickness as belonging to one cluster of symbolic domains, then ritually moving the sufferer across the mysterious margins to a new identity grounded in opposing symbolic domains. However, *Ubuntu* and *Simunye* require that the person not make that move to the new identity, he or she should be kept as part of the whole.

Such a stance requires that a diagnosis of HIV be met with an active silence. In a society where individuality is highly valued, intimacy is often created through disclosure. However, somewhat counter-intuitively, where individuals are mutually constructed, this kind of knowing silence can be far more intimate. It was easier then, for people at the church group or at the clinic to disclose their HIV status to me, because I had an insider/outsider status. I was close, but not too close. They could speak freely, knowing that my knowledge would not change their community.

By the same token my encounter with Siphon (above) was entirely counter-intuitive. Of all the people in South Africa I met who were actively “living with AIDS,” Siphon was the only one I met who was socially acknowledged to be “dying of AIDS.” The texture of Siphon’s story, therefore, is different from my other interviews because it is shaped by the fact that, because I felt it inappropriate to use a tape-recorder, I simply listened and took notes immediately after leaving his room, but I was silent throughout. As ethnographer, I moved, during this interview, into the more participant side of my participant-observation role. I became a participant in the socialisation of Siphon’s death. Without realising it at the time, I played the role that so many family members and community members play when they come into contact with a loved one diagnosed HIV positive, communicating, somewhat accidentally, a knowing silence. Clearly, I had not expected this, and was not prepared for it and my own discomfort is reflected in the fact that, despite him insisting I should stay, I constantly asked if I should (could?) leave.

One of the central efforts in healing is to symbolize the source of suffering, to find an image around which a narrative can take shape (Good 1994). Narrating is a process of locating suffering in history, of placing events in a meaningful order in time, and was used as such for the vast majority of the respondents I spoke to. The two of us in that hospital room represented a meeting of genders, race, class, and ideologies present in South Africa. However for Siphon, the “what,” “why,” and “wherefore” of his disease was no longer relevant. He maintained a polite but stubborn silence whenever the subject of HIV or AIDS arose, despite crude attempts on my part to bring him back to the subject. While at the time I was certainly aware of being profoundly affected by the encounter, it was only much later when I felt strong enough to re-visit my notes that I understood that the silence had provided us both with an intimate space within which to share an experience. Siphon had shown me *Ubuntu*. On a deeper ontological level he had moved me from my position as an observer and forced me to be a participant and to feel what that was like. In so doing he affirmed my humanity, and I, his. Such mutual constitution, though, could only occur in silence.

Silence is of central importance to all of the cultural mechanisms examined above. Within the witchcraft paradigm to engage in talk is to enter the struggle. Siphoh told me he had visited a healer, which is not unusual in itself since more than 70% of South Africans visit traditional healers; many do so in addition to attending a medical doctor. However, Siphoh could not speak of the visit – having initially mentioned it, he retreated to his silence whenever I tried to enquire any further.

This silence was not an absence, an inability to verbalise a traumatic event. Siphoh had invited me to visit and to talk to him; he spoke freely and without any hesitation (within his physical limitations) about other subjects; he also insisted that I stay and talk to him. I did not, therefore, get the impression that Siphoh's silence was in any way trauma-related, or even that he was necessarily uncomfortable about the silence. Any discomfort was my own.

It is equally unlikely that Siphoh's reluctance to talk was because of any stigma ("felt" or "enacted"). As I said, he had been told prior to my visit that I wished to speak to people who were HIV positive. He knew, therefore, that I was already aware of his status, so that the silence was neither obstructing disclosure, nor acceptance of a diagnosis

Too often, silence in the face of HIV/AIDS in South Africa is interpreted as fear, denial, or even ignorance of the situation. Public health messages and self-help groups adopt an American-European psychologizing model of disclosure, clarity, discussion, counselling. While of enormous benefit to some, the existence of this model should not close off further exploration. It is my contention that a far more nuanced investigation is required to interpret both the silences, and their context and to incorporate this into a new, culturally appropriate model. Siphoh's silence has its roots in the *Ubuntu* worldview – a silence that accommodates and even facilitates a disclosure of HIV positive status, and provides a mechanism for dealing with the patient with respect, dignity and humanness.

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