AIDS Myths and Myths about AIDS Myths: A Study about AIDS-related Perceptions in South Africa

Jonas Sivelä

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Jonas Sivelä

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Abstract

This doctoral thesis, consisting of four separate articles and a summarizing report, discusses so-called South African AIDS myths – also called AIDS beliefs, rumours, misconceptions and legends. AIDS myths have been put forth as an outcome of – and a major reason behind – the severe HIV/AIDS situation in South Africa. They are proposed to flourish among black South Africans living in impoverished townships and villages. In previous studies, the reasons and mechanisms behind AIDS myths have been understood to be rather straightforward, and it has been suggested that they have a considerable effect on people’s behaviour. This thesis argues that the processes and expressions related to them are, in fact, much more complex and multifaceted.

The theoretical backbone of this thesis is influenced by folklore studies, which emphasizes the importance of taking into account the nuances of textual and verbal expressions conveying both historical and contemporary meanings of a specific cultural setting. Most of the empiric observations that are discussed in this thesis are based on ethnographic fieldwork conducted among Xhosa people living in two different townships in Cape Town. This part of the thesis examines the meanings and processes related to the manifestations and possible impact of AIDS myths. The thesis also includes a discourse analytic section that examines how South African AIDS myths are presented in current academic studies.

Fieldwork shows that AIDS myths do exist among informants in these two township settings in Cape Town. AIDS-related communication, including expressions of AIDS myths, stems from a specific cultural and social setting, and it is influenced by specific manners of communication and a complex past characterized by apartheid-era legacies. Against this background, AIDS myths can be understood as expressing a kind of cultural and narrative resistance to the disease and its manifestations, as well as to cultural models which impose a certain kind of behaviour and communication. Fieldwork also shows that the impact of AIDS myths on people’s behaviour is not as direct as proposed, and that there is a difference between knowing the myths and acting in accordance with them. Furthermore, an examination of the discourse that touches on South African AIDS myths reveals that it includes themes that resonate
with derogatory notions of Africa and Africans and are characterized by apartheid-era narratives that still persist today.
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1 Introduction

South Africa has the highest number of HIV infections in the world (Shisana et al. 2014). Besides having a high HIV prevalence rate, South Africa has also drawn attention – especially after the first years of the 2000s – for claims of its high level of so-called ‘AIDS myths’, also called beliefs, rumours, legends or misconceptions¹ (see, for example, Ashforth 2002; Leclerc-Madlala 2002; Pitcher and Bowley 2002; Fassin and Schneider 2003; Stadler 2003; Robins 2004; Niehaus and Jonsson 2005; Parikh and Whiteside 2007; Dickinson 2011; Bogart et al. 2011; Grebe and Nattrass 2012; Nattrass 2013). These myths are typically understood as misconceptions about the disease which spread easily among people and affect people’s behaviour related to the disease, consequently leading to an increase in the number of HIV infections in the country.

The aim of this thesis, AIDS Myths and Myths about AIDS Myths: A Study about AIDS-related Perceptions in South Africa, is to examine the nature and mechanisms of, reasons behind, and processes related to the effects and manifestations of South African AIDS myths. The theoretical framework of this thesis is grounded in the folkloristic approach, which gives value to interpreting the nuances of verbal and textual expressions as a part of cultural settings influenced by both historical and present-day meanings and circumstances. The observations discussed in this study draw mainly upon ethnographic fieldwork conducted in townships in Cape Town. This part of the study examines the appearance and expressions of AIDS myths, as well as possible explanations for their existence. The study also includes a discourse analytic section that aims to shed light on how South African AIDS myths have been presented by those researching it.

The purpose of this summarizing report is to function as a core and analytical introduction for the thesis that consists of four separate articles. In this report, I will present the aims and objectives of the dissertation, as well as its methodological and theoretical framework, and discuss the results and their relevance. The summarizing report is organized as follows: In the remainder of this 1st section, ‘Introduction’, I describe the relevant aims and objectives of the thesis. In the

¹For the sake of clarity and coherence, in this thesis I call them call them ‘AIDS myths’, with the exception of Article I, where I discuss similarities between AIDS myths and the narrative genre of urban legends and I call them ‘AIDS legends’.
2nd section, ‘Background and research environment’, I give an outline of the HIV/AIDS situation in South Africa, describe the main lines of the historical development in South Africa today, and present an overview of studies in the field that are relevant for the thesis. In the 3rd section, ‘Conducting the research’, I describe the methodological and empirical environment relevant to the thesis, specify the limits and boundaries of the thesis, and discuss ethical issues related to the research. In the 4th section, ‘AIDS myths – reality and representations’, I present the central contents and results of the individual articles.

The thesis is constructed around four articles. Each article functions as an individual study focusing on a specific topic. In Article I, ‘Infected Condoms and Pin-Pricked Oranges: An Ethnographic Study of AIDS Legends in Two Townships in Cape Town’, I approach South African AIDS conspiracy myths as a narrative form of resistance against the disease by discussing the themes and motifs that can be identified in them. This article is based on data gathered through ethnographic fieldwork in the townships of Masiphumelele and Khayelitsha in Cape Town. The most commonly occurring expressions about HIV/AIDS that I identified, based on previous studies as belonging to the category of AIDS myths, were different kinds of conspiracy theories about the disease. Such AIDS conspiracy theories included suspicions about the disease being manufactured by Americans, the apartheid regime or the drug industry, whose aims were, for example, to spread HIV/AIDS among black South Africans and, eventually, to return the displaced apartheid regime to power.

The current discussion about the nature of the South African AIDS myths proposes that there is a rather direct relationship between, for example, political statements about HIV/AIDS and the rise and existence of AIDS myths. I argue that the HIV/AIDS-related expressions, referred to by many scholars as ‘AIDS myths’, bear similarities with the narrative genre of urban legends. These similarities emerge through themes and the motifs appearing in them, but become apparent also through the manner in which they are told. By interpreting the themes and motifs

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2 I refer to these articles with roman numerals (I–IV). For the references, see the publications listed on page 5 in this report.
appearing in AIDS conspiracy myths, I strive to show how they convey ideas of resistance that are expressed as so-called counter-narratives.

In Article II, ‘Silence, blame and AIDS conspiracy theories among the Xhosa people in two townships in Cape Town’, I pursue this examination of AIDS conspiracy theories and discuss their counter-narrative nature. This article builds upon my observation that conspiracy theories about HIV/AIDS are more common among men than among women. Like Article I, Article II is based on ethnographic fieldwork conducted in the Masiphumelele and Khayelitsha townships in Cape Town. I argue that culturally and gender-conditioned dynamics of communication should be taken into consideration in the discussion about the reasons behind AIDS conspiracy theories in South Africa and why they are more common among men. I build my argument on the notion that communicating about matters related to sexuality, including HIV/AIDS, is restricted among Xhosa by a culturally conditioned model of silence and respect, known as *isihlonipho*. Men having multiple sexual partners, acting dominantly in sexual relationships and being reluctant to use condoms have been recognized as factors behind the prevalence of HIV/AIDS in South Africa (Mooney 1998; Bhana 2005; Jewkes et al. 2010; Zembe et al. 2012). As a consequence of this, men in general are held to be responsible for the rapid spread and high incidence of HIV/AIDS there. I propose that this, together with an atmosphere of culturally imposed silence surrounding the disease (when interpreted as a factor that limits the possibilities to talk about it), may explain why AIDS conspiracy theories appear more commonly among men.

Based on previous studies, I got the impression that myths about HIV/AIDS would be abundant and influential among people living in townships. This was, however, not the case. Instead, fieldwork in Masiphumelele and Khayelitsha revealed that AIDS myths appeared to be much less common and, more importantly, less influential than I had presumed, and that my informants’ perceptions about the disease were most often congruent with how the disease is understood in Western medicine. In Article III, ‘Dangerous AIDS Myths or Preconceived Perceptions? A Critical Study about the Effect of AIDS Myths in South Africa’, I strive to increase understanding of the mechanisms surrounding AIDS myths in South Africa and their
possible impact on people’s behaviour. A number of scholars put forth that AIDS myths should be considered a significant problem related to HIV/AIDS in South Africa (see, for example, Pitcher & Bowley 2002; Robins 2004; Parikh & Whiteside 2007; Dickinson et al. 2011; Bogart et al. 2011). Such a presumption presupposes that AIDS myths have a considerable and straightforward effect on people’s behaviour.

I propose that the relationship between knowing AIDS myths and actually acting in accordance with them may not be as straightforward as suggested. According to my findings, the notion that people who know about AIDS myths would automatically endorse them and act in accordance with them, along with the more or less causal relationship suggested to be found between the existence of AIDS myths and the high prevalence of HIV in South Africa, is exaggerated; even if people are aware of AIDS myths, it does not automatically mean that they have a direct impact on their behaviour. The article shows that there is a difference between knowing about AIDS myths and actually endorsing them and acting in accordance with them.

Article IV, ‘Myths about AIDS Myths: Traditionalizing and Patronizing Discourse Surrounding AIDS in South Africa’, is the only one of the studies that does not directly draw upon data gathered through ethnographic fieldwork. Instead, this article examines the language used to describe the AIDS myths by certain academic contributions that touch on AIDS myths in South Africa. Examining this AIDS myth discourse reveals that it includes themes that resonate with historical representations of Africa and Africans. Such a discourse, regarded against the apartheid-era legacy, may contribute to creating an atmosphere surrounding AIDS myths that transmits underlying meanings of power, injustice and inequality, which could also contribute to exaggerated notions about the existence and influence of AIDS myths among black South Africans.

Some clear demarcations around the scope of the thesis have been made, particularly concerning its focus and research setting. The most significant of these involves the attention mainly being directed at conspiracy theories, especially in the two first articles. I made this decision for two reasons: 1) conspiracy theories about HIV/AIDS were clearly the most prominent expressions about the disease that could be considered as belonging to the category of AIDS myths that I
encountered during my fieldwork, and 2) I wanted to narrow the focus to a specific topic in order to be able to grasp the texture and mechanics of AIDS myths more rigorously. The alternative would have been to make more comprehensive – but, at the same time, much more superficial – interpretations of a larger variety of myths. The research setting constitutes another demarcation in the scope of my thesis. I decided to focus exclusively on urban township areas instead of conducting the study in a rural village environment or both rural and urban areas. Also, in the urban setting my study has been restricted to two discrete settings: the relatively small township of Masiphumelele and a clinic for HIV testing for men in Khayelitsha, both located in Cape Town.
2 Background and research environment

More than six million South Africans – that is, more than 10 percent of the population in the country – are infected with HIV (Shisana et al. 2014). This means that South Africa has the highest number of HIV infections in the world. During the 1990s, the number of HIV infections rapidly increased from less than one percent to around ten percent by the end of the decade. During the last years, South Africa has made progress in fighting HIV/AIDS, which can be seen, for example, in a decline of HIV infections among young people (Ibid). Despite this, the HIV/AIDS situation is still the single most significant public health issue in South Africa, touching a great number of people living in the country.

There are considerable differences in how HIV infections are spread in South Africa and among South Africans. While the overall HIV prevalence in KwaZulu-Natal is 16.9 percent, Western Cape has an overall HIV prevalence of only five percent (Shisana et al. 2014). Statistics also show that HIV prevalence is, in general, greater in rural areas than in urban areas. However, a much more notable difference – a difference that also outweighs regional ones – can be found in how the number of HIV infections is divided among the different racial groups in South Africa; compared to the other racial groups (coloured, white and Asian), HIV prevalence is clearly the highest among black South Africans. Statistically significant data from the South African Human Sciences Research Council shows that while HIV prevalence is 0.3 percent among white South Africans, 0.8 percent among Asian South Africans and 3.1 percent among coloured South Africans, it is 15 percent among black South Africans (Ibid.). In other words, HIV/AIDS is a health issue that concerns first and foremost the black population of South Africa.

2.1 The South African context

South Africa is a diverse country in regards to geography, culture and demographic diversity. Around 55 million people live in South Africa (Statistics South Africa 2015). The sizes of the population groups, based on apartheid-era racial categories (still applied in official contexts in South Africa today), are quite asymmetrical: 80 percent are black, around 9 percent coloured, around 9 percent white and 2.5 percent Asian. It is estimated that more than two million illegal
immigrants live in South Africa (Lehohla 2012). Approximately 40 percent of South Africans live in rural areas, with the remaining 60 percent in urban areas (Statistics South Africa 2015).

South African society and culture today are still affected to a considerable extent by its colonial and apartheid-era history. Colonization of South Africa began in the 17th century with the disembarkation of the Dutch East India Company on the shores of what was to become the city of Cape Town. The 17th-century outpost for the Dutch East India Company later evolved into a colony that came to attract hundreds of thousands of European immigrants to South Africa (Western 1996). This started a centuries-long era of white oppression in South Africa that culminated in the apartheid era, launched formally in 1948.

The foundation of the apartheid ideology lay in racial categorization and segregation; the Afrikaans word apartheid means ‘keeping apart’ in English. During apartheid, South Africans were divided into four separate racial groups: white, coloured, Asian and black. The aim of apartheid-era policies and legislation was to keep the racial groups separated in as many fields of life as possible, in order to ensure that the white minority maintained political and economic power in the country. One of the most influential individual policies of the apartheid regime was the Group Areas Act passed in 1950, which assigned specific and separate residential areas for the different racial groups. In Cape Town, this materialized in non-white people being deported to less developed areas further away from the city centre. As a consequence, separate, new residential areas were founded, mostly outside the city centre. In Cape Town, most of the non-whites were deported to different areas in the Cape Flats, east of central Cape Town, and assigned to their respective residential areas (Western 1996). Black South Africans were assigned to different townships, the largest of which came to be Khayelitsha, founded on the eastern side of Cape Town.

The Group Areas Act created separate spaces and living conditions for non-white South Africans, which were distinguished by marginalization, poverty, poor living conditions and poor infrastructure. Still today, more than 20 years after the end of the apartheid era, the segregating policies, including the Group Areas Act, continue to have considerable cultural and socio-political effects, materializing in marginalization, exclusion, crime, poverty, and poor outlook in life in general (see, for example, Samara 2011).
2.2 AIDS myths studies

My first contact with South African AIDS myths was in 2002 when I read in academic articles (see, for example, Leclerc-Madlala 2002; Pitcher and Bowley 2002) and media reports (see, for example, McGreal 2001; Little 2002) about children being raped by men who believed that sexual intercourse with a virgin could cure them of HIV. Other matters, such as conspiratorial thinking related to HIV/AIDS and witchcraft, were also discussed by news media and scholars, suggesting that confusion about the disease in the form of different myths was common in South Africa.

Other reports related to the topic spoke of concerns about statements made by South African politicians that could have a harmful impact on how people behaved in connection with the disease. These statements included a speech on the reasons behind HIV/AIDS given by the former South African president Thabo Mbeki at an international AIDS conference in Durban in 2000; the former Minister of Health Manto Tshabalala-Msimang’s promotion of garlic, lemon and beetroot to treat HIV at another AIDS conference in Canada in 2006; and the remark by Jacob Zuma, the South African vice-president at that time, about having showered after sex with an HIV-positive woman, suggesting that this reduced his risk of becoming infected with HIV. Zuma made this statement in 2006 during a trial for the rape of an HIV-positive woman (Iliffe 2006, 146-147; Baleta 2006, 620; BBC 2006; Robins 2008).

South African AIDS myths are not a recently discovered phenomenon. Accounts of HIV/AIDS-related rumours in South Africa date back to the early 1990s. Russell Kaschula reports, for example, that rumours about oranges infected with HIV-positive blood were current already in 1993 (Kaschula 2008). It was not, however, until the early years of the 21st century when a discussion evolved around the so-called virgin cure myth that the notion of South African AIDS myths became well-known. Aside from some critical voices, the essence of this discussion was that children and infants were being raped increasingly in South Africa due to the popularity of the myth (see, for example, Pitcher & Bowley 2002). The discussion surrounding the virgin cure myth can be understood as having launched interest in South African AIDS myths by both scholars and the media.
Jonathan Stadler (2003) and Isak Niehaus (2005) made some of the first ethnographic studies about AIDS myths, rumours and beliefs in South Africa. Stadler has conducted ethnographic fieldwork in the north-eastern lowveld of South Africa, in the Bushbuckridge municipality in the Mpumalanga province. He suggests that HIV/AIDS is surrounded by a great deal of confusion and that a ‘crisis of meaning’ is revealed in how villagers in the South African lowveld talk about the disease, a crisis which manifests through rumours and gossip about HIV/AIDS. Besides the virgin cure myth, conspiracy theories have become another distinct research subject related to AIDS myths in South Africa. Isak Niehaus and Gunvor Jonsson (2005), who conducted an ethnographic study of AIDS conspiracy theories in the Mpumalanga province in the north-eastern part of South Africa, have found that men expressed conspiratorial thoughts about the disease more often than women. Women, on the other hand, supported biomedical explanations about HIV/AIDS. Niehaus and Jonsson propose that men, through conspiracy theories that place blame on ‘translocal forces’, expressed ‘their adverse experiences of deindustrialisation’, as unemployment, driven by a decrease of traditional mining jobs in South Africa, weakened the role of the man as a provider (2005, 182). Nicoli Nattrass has done an extensive job examining AIDS conspiracy theories in South Africa based on quantitative interpretations. Together with Eduard Grebe, Nattrass has examined, for example, to what extent AIDS conspiracy theories lead to an increase in unsafe sexual behaviour among young adults in Cape Town (Grebe and Nattrass 2012). Their study is based on a so-called AIDS conspiracy belief index, which aggregates the values of responses to three statements about the conspiratorial nature of AIDS: 1) ‘AIDS was invented to kill black people’, 2) ‘AIDS was created by scientists in America’, and 3) ‘AIDS was deliberately created by humans’. Their study shows that the likelihood of using condoms or having been tested for HIV was considerably lower among people who endorsed AIDS conspiracy theories and held denialist perceptions.

The studies described above, based mainly on ethnographic and quantitative social scientific studies conducted by South Africans in South Africa, have evolved into a specific strand of research, and, most notably, have contributed strongly to the creation of a clearly distinguishable research subject, the study of South African AIDS myths.
Paula Treichler’s rigorous work, *How to Have a Theory in an Epidemic*, is one of the first – and probably most extensive – interpretations of the cultural and narrative properties of HIV/AIDS. Treichler does not deny the fact that HIV/AIDS exists in real life – in the clinical sense, that is – and that it makes people ill and kills them. However, she emphasizes the importance of taking into account the narrative dimension of HIV/AIDS; as ‘the very nature of AIDS is constructed through language’, the disease constitutes, besides an epidemic in the clinical sense, also ‘an epidemic of meaning and signification’ (1999, 11). In addition, Diane E. Goldstein has conducted one of the most notable folkloristic studies about what she calls AIDS legends (2004). In her study, based on data gathered in Newfoundland, Canada, Goldstein shows that AIDS legends form a part of the (urban or contemporary) legend genre. Patricia Turner understands urban legends as ‘unsubstantiated narratives with traditional themes and modern motifs that circulate orally (and sometimes in print) in multiple versions and are told as if they are true or at least plausible’ (1993, 5).

The terms ‘motif’ and ‘theme’ describe different aspects or functions of a narrative. The difference is most apparent on the level of abstraction, with a theme being the central idea of a narrative: for example, good always wins over evil, or Africa is a diseased continent, or there is an abundance of AIDS myths in South Africa (Abbott 2008, 95–97; Kirszner & Mandell 1993, 3–4). Themes are not necessarily – or even often – expressed explicitly, but rather speak to people through the meanings they convey in and about a specific cultural context. Motifs are the concrete ‘stuff’ or units that themes are built of (Abbot 2008), for example, a knight in shining armour who arrives and saves the kingdom, the rape of a child or an HIV-infected condom. Themes and motifs work on different levels, but towards the same goal; motifs make suggestions, have connotations, anchor the narrative in reality and support the general idea of the narrative, the theme.

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3. This discussion also relates to terminology applied in medical anthropology where a distinction is made between the terms ‘disease’ and ‘illness’ (Helman 1981). Disease is understood as a pathological and clinical condition that results in specific biological, chemical or other evidence of ill health. Illness is understood as the subjective experience of ill health that a person has in a specific cultural context. As this thesis does not explicitly address this matter, I use the term ‘disease’ here. The distinction between disease and illness is still interesting, however, as it highlights the culturally conditioned dimensions of HIV/AIDS.
Urban legends are understood to express desires, fears, anxieties, psychological problems and other attitudes in a specific cultural context (Tangherlini 1990, 381; Dégh 2001, 21, 87; Goldstein 2004, 31, 36). Besides such features, one of the fundamental and inherent qualities of folk narratives is to offer a possibility of expressing alternative views of explaining the world (Limón 1983). Goldstein notes that the conventional understanding of legends as expressions of fears, concerns and so forth should be broadened to also include expressions of resistance and critiques of ‘dominant definitions and authoritative constructions of truth’ (2004, 149).

Moreover, AIDS myths should not only be regarded as narrative responses to the disease, but also as part of a larger narrative corpus that conveys and constructs meanings about the disease and the people who live in South Africa today.

Luise White’s study about vampire rumours in Kenya, Zambia and Uganda offers interesting reading concerning questions about truth, experience, evidence and an interpretation of such accounts – that is, how rumour-related narratives should, and should not, be read (2000). Even though vampire stories in East Africa might appear to be a response to colonial oppression, White goes beyond merely seeing these stories as obvious and clear-cut representations and metaphors for concerns about dominance in colonial Africa. They are much more than that.

White’s invaluable insight reminds of the difficulties of making conclusions about something that has already been garbled by many layers of interpretation before falling into the hands of the researcher; stories, such as the ones about vampires, do not appear out of ‘thin air’, but are grounded in local epistemologies (Ibid., 18). Nor can their origin alone, if it were possible to track down, explain the meaning and popularity of such stories. White understands people’s talk about vampires not as a question of whether a specific story is true or not; people speaking about bloodsucking vampires in East Africa do not ‘speak with truth, with a concept of the accurate description of what they saw, to say what they mean, but they construct and repeat stories that carry the values and meanings that most forcibly get their point across’ (Ibid., 30).

The question of whether a specific story is true or not thus becomes, if not irrelevant, at least not as interesting as asking what meanings it conveys and how it is interpreted each time it is repeated. In other words, stories such as these could best be described as ‘glimpses of the world the speakers imagined and saw’ – glimpses that include much more than responses to colonial
oppression, glimpses that convey perceptions and concerns that are true for the person who speaks about them at a given time and place (Ibid., 50).

It is also the freedom from being bound to the truth that makes the nature of such stories much more invasive than other kinds of evidence (Ibid., 312). White proposes that it is the very falseness of the vampire stories that gives them meaning; ‘they are a way of talking that encourages a reassessment of everyday experience to address the workings of power and knowledge’ (Ibid., 43). But it is not only what is semantically expressed that counts. White remarks on the Foucauldian perspective of the meaning of talking by emphasizing that silence should also be taken into account, as together with speech it constitutes a discourse. Speech alone does not do that (Ibid., 74–78).
3 Conducting the research

Folklore studies forms the theoretical backbone of this thesis. Folkloristics is the academic study of folklore, that is, the study of non-material, often oral, traditions of a certain group of people. By definition, folklorists examine the ‘lore’ of the ‘folk’, that is, the stories, beliefs and other narratives and traditions typical of a specific society or culture. The methodologies applied in this thesis also draw from anthropology and, in particular, ethnographic fieldwork. The ethnographic aspect is accentuated especially in the gathering of data through fieldwork in two townships in Cape Town, conducted through interviews and participant observation. In the following, I will first point out certain features that are typical of folkloristic studies and explain how it differs from cultural anthropology, in order to sharpen the description and define the analytical positioning of this thesis. Then I will describe the data gathering and the research setting.

3.1 The folkloristic and ethnographic approach

The study of folklore was born in the late 19th century out of the assumption that ‘traditions’ were disappearing into oblivion due to modernity and that they must, therefore, be preserved, if not salvaged, for future generations (see, for example, Honko 1997, 249–250). Consequently, the early folklore scholars were mostly collectors of the oral traditions of peasants, who were considered the bearers of ‘real’ and ‘genuine’ folk culture. At that time, emphasis was put more on compiling vast amounts of data than on understanding or analysing their mechanics. The difference between folkloristics and anthropology can be understood by looking at the backgrounds of the two disciplines.

One difference between the two disciplines can be found in how they chose their research subjects, the people of anthropologists and the folk of folklorists. While the people of the early cultural anthropologists most often lived in a very distant corner of the world (at least from a Western perspective), the folk of the folklorists were by rule found much closer to home.

Another historical difference has been the primary topics of interest for the two fields of study. While early folklorists mostly gathered data by recording extracts of folk traditions such
as legends, folk songs or riddles, early 20th-century cultural anthropologists were more interested in how societies and their mechanics were structured (for example, through kinship).

Context and how to relate to the surrounding world – namely, the research setting – is a third aspect that has historically separated the two disciplines. While early folklorists more or less disregarded questions relating to the research context or, at most, regarded it as a necessary evil, cultural anthropologists have been almost obsessed with it. For a long time the methodological approach in cultural anthropology was affected by the thought of scholars such as Bronislaw Malinowski, who stated that the proper conditions for early 20th-century anthropologists could only ‘be achieved by camping right in their villages’ (1922, 6), and Clifford Geertz, who emphasized the importance of gathering data through extensive ethnographic fieldwork in order for the anthropologist to understand ‘a multiplicity of complex conceptual structures, many of them superimposed upon or knotted into one another, which are at once strange, irregular, and inexplicit, and which he must contrive somehow first to grasp and then to render’ (1973, 10).

As the archived treasure trove of 19th-century folk culture was exploited and began to be exhausted in the 1960s and 1970s, folklorists such as Alan Dundes were keeping their eyes open for contemporary cultural phenomena which could be interpreted as interesting from the perspective of folklore studies. A broadening of focus slowly developed with Alan Dundes’ redefinition of folklore, which specified the meaning of ‘folk’ as ‘any group of people’ instead of the vanishing peasant (1965, 2). Even though this simple notion may seem self-evident for many cultural scholars today, Dundes’ clarification of the meaning of the ‘folk’ in folklore and folkloristics can be considered as a notable milestone in the history of the discipline, which has gradually expanded from interest in classification, genre construction and comparative analysis of textual fragments to also include interpretations about contemporary subjects and living people (Dundes 1965; Bauman 1975).

Differences between methodological issues and matters of interest within the two fields of study have since then become less distinct; it is not uncommon for a folklorist to study people living in other countries and it is not impossible for a cultural anthropologist to examine cultural fragments, such as riddles. The original interest in cultural ‘fragments’ in folklore studies has,
however, steered the mindset towards and offered tools for scrutinizing the smaller elements, such as themes and motifs, that appear in manifestations of (folk) culture. William Bascom effectively notes that the strength of folklore studies lies in its potential of providing a ‘means of getting at esoteric features of culture which cannot be approached in any other way; it reveals the affective elements of culture, such as attitudes, values, and cultural goals and, moreover, may verbalize these in a form which needs only to be translated and quoted as evidence of a consensus of opinion’ (1965, 284).

In my own approach, I strive to combine the folkloristic, more text-oriented and ‘microscaled’ perspective with ethnographic data-gathering practices of participant observation and interviews. On the one hand, ethnographic methods ensure better access to the social and cultural reality of the informants than any purely textual piece of data ever can. On the other hand, the folkloristic approach offers more precise possibilities of understanding how the multiplicity of complex conceptual structures are expressed through particular aspects of tradition.

3.2 Ethnography in Cape Town

The empirical core of this thesis consists of data gathered through ethnographic fieldwork conducted in Masiphumelele and Khayelitsha townships in Cape Town in 2009, 2011 and 2012. The fieldwork lasted a total of five months, during which time I gathered data by means of group discussion sessions, individual interviews (with a total of 64 persons) and participant observation among a much larger group of people. The discussions and interviews were loosely structured, especially in the beginning, with the purpose of letting the respondents share their general views on the disease and its meaning. Participants were mainly young and middle-aged adults, most of them with origins in the Eastern Cape and currently residing in Cape Town. Young and middle-aged adults were chosen as the target group for a number of reasons, the most important being that, after children, adults aged between 20 and 39 represent the largest group of residents in South Africa (Shisana et al., 2012; Statistics South Africa 2015). It is also this group that is

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4 Pseudonyms are used for all informants referred to in this thesis in order to ensure anonymity. All informants were also reminded that participating in interviews was voluntary.
considered most sexually active and, hence, also prone to concerns related to AIDS in South Africa (see, for example, Shisana et al., 2012; Grebe & Nattrass 2011). Furthermore, considering the fact that communicating about matters related to sexuality is affected by certain cultural models, such as isihlonipho (see section 4.2 below), conducting interviews among informants that were not much older than myself was more feasible; in practice, younger people were much more approachable than older ones when talking about matters related to sexuality, such as HIV/AIDS.

From the start of the ethnographic fieldwork and while still conducting it, I listened to the recorded interviews and read field notes in order to recognize characteristic features. During fieldwork, this helped me improve the fieldwork process by adjusting my approach and by focusing interview questions. From the data, certain themes arose more clearly than others, and relevant parts were transcribed in order to allow further analysis, avoid errors, and improve accuracy and reliability.

Ethnographic fieldwork requires working closely and perseveringly with the people who are studied in their everyday and natural setting (see, for example, Geertz 1973; Fetterman 2010). As a method of data collection, ethnographic fieldwork is especially suitable for studying AIDS-related perceptions and expressions, as it allows the researcher to get into very close proximity with the informants and interact with them in an environment that includes all its ‘real-world incentives and constraints’ (Fetterman 2010, 33). HIV/AIDS comprehends much more than just the clinical or pathological features of the disease; it is closely related to sexuality, and it bears a stigma for many of those who are infected. Ethnographic fieldwork enables the researcher to grasp the multiplicity of these ‘complex conceptual structures’ (Geertz 1973, 10), in their natural environment.

Together with my wife and our then almost three-year-old daughter, I arrived in Cape Town in mid-November 2009. It was our first visit to South Africa. We had made arrangements to stay in Noordhoek, a small community with scattered houses on the western coast of Cape Peninsula, around 30 kilometres south from the centre of Cape Town. Our first sojourn was scheduled to
last one month. My intention was to conduct preliminary interviews and observations in the township of Masiphumelele, not far from our lodging in Noordhoek.

On a Thursday in the end of November 2009, I made my first visit to Masiphumelele. I was fortunate to make contact with a woman named Sesethu, who was active in the local community. She promised to help me with my initial venture of getting familiar with the township and to tell me about the community and its history, people and daily life.

Figure 1: Street view of Masiphumelele
Masiphumelele was not one of the ‘official’ townships founded during the apartheid era. Its history goes back to the early 1980s when a couple hundred people, most of whom had come from the apartheid-era Bantustan Ciskei in the Eastern Cape province, started living around where Masiphumelele is situated today. Apartheid-era legislation did not allow this, however, and the settlers were forcibly moved to Khayelitsha. Many persistently returned and, in the end, a small township which came to be known as Masiphumelele arose north of the road that runs from Noordhoek and Fish Hoek to Kommetjie. With an estimated 30,000–50,000 residents today, Masiphumelele is a small township on a South African scale. The name Masiphumelele derives from the Xhosa word siphumelela, meaning ‘we will succeed’. I have always thought it has to do with the persistence of the first residents that did not agree to be moved away.

I must admit that, taking the first steps in Masiphumelele, a white guy from Finland wearing sandals, shorts and a sun hat, I felt out of place. Masiphumelele was not far from where we were staying in Noordhoek, just a five to ten-minute drive away, depending on the traffic. However, within the walls of Masiphumelele the distance to the outside world appeared immense. I was aware of the fact that townships, almost twenty years after the end of apartheid, were still residential areas characterized by poverty, poorly developed infrastructure, overpopulation, crime, sickness and an overall sensation of despair. Yet the reality struck me much harder than I expected. Maybe it was the noise, maybe the different smells, or possibly the motion and restlessness around me.

It was not crowded, but it still felt as if everything was moving about. Children without shoes and only rags for clothes ran after chickens in the street. Just in time they dodged out of the way of a battered pickup truck, which sped past them. A makeshift braai (the word for barbecue in South Africa, serving as both noun and verb) made out of half of an oil barrel was smoking on the side of a road with slabs of meat. It was both seducing and nauseating; burning fat and a piquant scent of spices, maybe capsicum and cumin, filled the hot, heavy air. Beside the barbecue was a goat’s head, which seemed to be leering at me (I later learned that they were called ‘smileys’ because the facial skin of the goat is pulled back when it is boiled, giving it a rictus grin). There was a rattling sound of loud dance music coming from speakers wrapped in
plastic and sitting outside a small brick house. It was a completely new world for me, a world that had very little in common with the world outside the township wall.

It was thanks to Sesethu that I found my first contacts in Masiphumelele, and her help was invaluable at the outset when I was still familiarizing myself with the place. I must admit that in the beginning it was hard to find people who wanted to talk about HIV/AIDS. One encounter, however, snowballed into a new one, and quite soon making acquaintances was not a problem at all; in fact, quite many people seemed to be curious about what I was doing in their small community. Later, during the fieldwork in 2011 and 2012, I was assisted by another local woman, Zandile, a 19-year-old student, who helped me to find contacts, organize interviews and interpret them when necessary. Most importantly, she helped me to understand how perceptions and expressions intertwined with each other and with the local traditions and meanings. Soon the local handicraft workshop, the soup kitchen, the library and many other places that structure the daily life of the residents in Masiphumelele became regular stops for me when I was in the township. Due to the relatively small size of Masiphumelele, which I consider an asset compared to conducting similar research in a much bigger township, many of the faces became familiar.

Figure 2: Masiphumelele Library
On the very same Thursday in November 2009, my first day of fieldwork, I got the chance to visit a health clinic where HIV-positive women received counselling from their peers, that is, from other HIV-positive women. On this occasion, I witnessed a young HIV-positive mother being instructed on how to reduce the risk of passing the infection to her baby while nursing and feeding. Meeting the young HIV-positive mother, her child and the peer-counsellor triggered in me an impression that would become pervasive throughout my stay; in many encounters, especially the most sensitive ones, I felt that I was admitted into a very close relationship with the lives of the people whose thoughts, ideas and expressions about HIV/AIDS I was studying. Considering the delicate and stigmatizing nature of the subject, I was surprised by how uninhibited some of the people were while talking to me. I soon noticed, however, that this uninhibitedness was only one side of the truth; even if many of the women appeared rather unreserved when we talked about HIV/AIDS, many of the men often remained completely silent, especially during group discussions where women were also present (see section 4.2 and also Niehaus and Jonsson 2005). This forced me to revise my research setting, as I was not planning to restrict my research to only women.

Besides the fieldwork in Masiphumelele, I ended up conducting part of my fieldwork at an HIV-testing clinic at Site C in Khayelitsha. This so-called ‘male clinic’ consisted of a few conjoined shipping containers. The clinic functioned as a low-threshold HIV-testing and information centre. Two or three counsellors worked full-time at the clinic. At the clinic, I was provided with the possibility to conduct discussions or interviews with men who came there as clients.
The choice of field sites was steered both by practical reasons and the limited scope of the research. Masiphumelele and Khayelitsha are very different in terms of their size and ambiance. While Masiphumelele is a small township, Khayelitsha is one of the biggest in South Africa. Cautious estimates give Khayelitsha less than half a million residents (2011 Census), but the real number is probably much higher. And even if the two townships are located on very different sides of Cape Town – Masiphumelele on the southern part of Cape Peninsula and Khayelitsha on the western side, on the Cape Flats – both are equally far away from central Cape Town.
Conducting more ‘traditional’ ethnography, where the researcher interacts with and, in practice, moves rather freely within the community – for example, by walking around and interacting with people – was much more feasible in Masiphumelele, not the least with regard to personal safety. Personal safety is a matter that has to be considered a priority while planning and conducting fieldwork in a township in South Africa, where there is a considerable possibility of encountering crime and violence. The small size of Masiphumelele township made it a relatively safe place to be and move around in. Conducting the same kind of fieldwork would have been impossible in Khayelitsha, if only due to the size of the township. For this reason, fieldwork in Khayelitsha had to be restricted to specific places. In the best of worlds, the number of field sites in Khayelitsha would not have been restricted to the HIV-testing clinic. However, it did serve to narrow the fieldwork to fit the scope of my overall research for the PhD dissertation. There was also a question of either getting to know a field site well, which requires in-depth engagement...
with the community being examined, or having a larger number of field sites with the risk of not being able to gain a detailed, profound and localized knowledge of them.

3.3 Fear and loathing in Khayelitsha

Conducting the fieldwork not only consisted of one interesting encounter snowballing into another, making it possible for me to observe and interpret how people talked about the disease. The fieldwork also revealed something significant about the setting where I conducted the research. It was a world characterized by a number of different meanings and expressions, many of which had their roots in apartheid-era policies and legislation.

In December 2009, I spent three consecutive days in Khayelitsha. It was the only time during my fieldwork that I stayed there overnight. I decided to book a room at a bed and breakfast run by a woman called Vicky. She was a well-known person in her community, who had hosted numerous people in her B&B, mostly tourists but also researchers who wanted to get more closely acquainted with township life.
Khayelitsha was much more hectic than Masiphumelele, especially during the day. There was a lot of traffic, big roads, and the constant feeling of rushing. Compared to Khayelitsha, Masiphumelele seemed like a village. In the evening, however, the ambiance of the small neighbourhood in Site C where I was staying came to remind more and more of Masiphumelele, with people standing beside *braais* cooking meat, the sound of rattling music in the background, corrugated iron siding painted in lively colours, patched roofs and old window holes in walls.

On my first night in Khayelitsha, I was driving around with a local man named Mcebisi. He was in his 20s and, like a considerable number of the young township residents who did not study, he was unemployed. We mostly sat in the car and drove around in the dark and almost deserted township – the quietness was incredible, considering how lively it was during the day.
At some point we went to the local shebeen (illicit bar or pub common in the townships in South Africa) to eat chicken wings and drink a couple beers. It was full of young people. Many were dancing, shouting, drinking and laughing. During this evening, I tried to talk to Mcebisi about life in the townships in general and also about HIV/AIDS. He clearly did not want to talk much about it or his life situation, but about the disease he had a definite opinion: ‘AIDS is a huge problem here. But you know, it was brought here by the whites. AIDS was brought here during apartheid by the whites.’ The tone of his comment was almost aversive.

The neighbourhood was ragged and torn up. This was actually quite typical for both Masiphumelele and Khayelitsha; behind the sometimes clean and proper facades of the main road was a world filled with provisional constructions: electric cables hanging haphazardly from poles, muddy pavement, tarpaulins where a roof should be, and other run-down and makeshift solutions.

The very next day, I went to pick up some meat for the braai with the B&B hostess’ husband, Lwazi. After getting his old Toyota started, Lwazi and I drove around for a while in Khayelitsha. He was not keen on talking about anything actually. His comments were curt and evasive. But like Mcebisi, he was certain about one thing: ‘Yes, AIDS is a big problem here, but it came from other parts of Africa. It was brought here by people coming from other parts of Africa.’ This particular stay revealed something that I consider emblematic of the way in which many, especially male, informants talked about HIV/AIDS; they were not enthusiastic to do so, but when they did talk about HIV/AIDS, their expressions were more often than not filled with mistrust, accusations and a lack of interest than with obscure or brutal notions of how to cure HIV/AIDS.

Three years later, in November 2012, when I returned to Cape Town for the third fieldwork trip, an article in the local newspaper told that Lwazi had killed his wife Vicky, the hostess of the B&B where I had stayed, by stabbing her numerous times. This came as a shock, as I had specifically hoped to return there this time. This was not, however, the only time that violence affected my fieldwork. Another victim was Steve, who worked for the NGO in Khayelitsha that administered the work at the male clinic, and with whom I met frequently during my stays in Cape Town.
On a Monday morning in February 2011, I was at the male clinic conducting interviews. It had been an especially lively weekend in Khayelitsha, due to a football match between Ajax Cape Town and the Free State Stars at the Athlone Stadium in Cape Town. A lot of people had been partying during the weekend, or ‘enjoying themselves’, as the young men at the male clinic used to say. Besides being an exceptionally busy morning, there was also something else: the staff at the clinic seemed much more distressed than normal. The reason was soon revealed: Steve had been stabbed during the weekend. Nobody knew the details, other than that he was alive.

I met Steve a couple days later. He had been stabbed in the head and the hand. The injuries were not life-threatening, but he was wounded and clearly in shock. On the way home the previous Friday evening, he had been approached by a group of younger boys. The group had tried to rob Steve, and in the tumult Steve had been stabbed. Luckily for Steve, he was not injured more seriously. But his misfortune did not end there. In November 2012, when I was in Cape Town again, one of the first things I did was to call Steve. He did not say much on the phone, but we decided to meet and catch up. We had a brief meeting, during which Steve told me that since we had last met, he had become unemployed as the NGO he had worked for had moved away from Khayelitsha. Also his younger brother had been killed in gang-related violence and his mother had died of a heart disease.

My experiences in Khayelitsha and Masiphumelele revealed more than just different kinds of reports about HIV/AIDS. The encounters depicted above give a small glimpse of how township life looks in today’s South Africa, a life where violence, mistrust, frustrations, and unemployment are tangible and affect the lives of many. This area still bears the heavy burden of apartheid-era legacies, where old misfortunes and hardships have developed into new ones and manifest today, aside from crime and inequality, in interracial tensions, xenophobia and public health issues, such as HIV/AIDS (Samara 2011; Zembe 2013B).

This is the setting that breeds different expressions about HIV/AIDS, including AIDS myths, as narratives deriving from apartheid-era policies of segregation express and constitute to a considerable extent the sense-making in present-day South Africa. It is on this battleground that different perceptions grow and flourish.
3.4 Access, ethics and validity

A considerable part of my data collection consisted of ethnographic fieldwork conducted through interviews, group discussions and less formal talks with residents in Masiphumelele and men visiting the HIV-testing clinic in Khayelitsha. Conducting interviews was very important, of course. Through them I was able to access longer and more articulate contemplations about the disease, which placed it within wider narratives – about being black in South Africa today, about gender roles, and about violence, mistrust, poverty and a poor outlook on life – that provide a background for life in the townships.

I cannot, however, emphasize enough the importance of the informal encounters that I had during my fieldwork. Besides almost daily visits to both Masiphumelele and Khayelitsha, conducting interviews and meeting people, I spent a lot of time just ‘hanging around’ in my field sites with my informants, or with random people I met in Masiphumelele or around the male clinic in Khayelitsha – just sitting in the shade outside the male clinic in Khayelitsha talking about an upcoming football game, eating a sandwich outside Masiphumelele library, or walking around the informal settlement in Masiphumelele.

Access to the social and cultural world of the informant is always something that requires both methodological and ethical efforts by the researcher. Charlotte Davies stresses the importance of less formal encounters with the sober reminder that ethnographers should consider whether interviewing is a ‘known cultural activity’ in all societies (1999, 109). Through informal encounters, and by trying to make the interview sessions less formal, I felt I was able to access more spontaneous and candid expressions about HIV/AIDS. I consider this a huge benefit in my efforts to understand how people perceived and talked about a difficult topic, which is closely related to both sexuality and shame.

The informal encounters during fieldwork led me to contemplate the ethical aspect of my thesis. Interview sessions are much more clear-cut when it comes to research ethics; before initiating an interview or discussion session, it is easy to go through matters relating to the purpose of the research, the voluntary nature of participating in it, consent and anonymity (Fine
1993). Matters concerning consent, for example, are much more complex when it comes to informal encounters. If I had not disclosed my motives, people would have probably been less reserved, but then again, this would not have been ethically sound. Gary Alan Fine (1993) addresses the issue of ethics in qualitative methodology in general and ethnography in particular. His concern is that ‘many standard operating procedures’ in ethnography deviate from many regular research ethical practices in order to create an illusion of controlled and sound research. Ethnography does not, in Fine’s opinion, lack possibilities of deception and, as a consequence of this, ‘much information – unknown to the reader – is censored by a self-concerned ethnographer’ (1993, 282). I recognize this concern, as there were definitely occasions when I might have been told more or different things had I kept quiet about my motives. I strived, however, to disclose more than just the rough outline of my research whenever I met a person whose insights I thought could be of value for my research. And if the encounter did develop into a more profound researcher-informant relationship, I would go through matters of consent and anonymity more thoroughly.

But what was it that I could interpret from my informants? In what they said about HIV/AIDS, what was it that I should focus on? Instead of asking if a question tells the truth, it should instead be asked what the question tells the truth about (Kvale 1989, 78). Interpreted as an interview situation rather than a literary text fragment, Kvale illustrates this with a fragment from Hamlet:

*Hamlet:* Do you see yonder cloud that's almost in shape of a camel?
*Lord Polonius:* By the mass, and 'tis like a camel, indeed.
*Hamlet:* Methinks it is like a weasel.
*Lord Polonius:* It is backed like a weasel.
*Hamlet:* Or like a whale?
*Lord Polonius:* Very like a whale.
*Hamlet:* Then I will come to my mother by and by. They fool me to the top of my bent.
If the *what* in this interview were the shape of the clouds, Hamlet’s method would be, according to Kvale, very unreliable (Ibid.). But, if the *what* were instead the personality of Polonius, would Hamlet’s method to test this be more reliable? This is a sharp reminder of the difficulties related to conducting fieldwork. Indeed, *what* is it that I, a white European man in my thirties, can expect to accomplish in terms of interpreting HIV/AIDS-related myths in two township settings in Cape Town? This was a question I had to return to repeatedly. I must admit that I also felt uncomfortable with the historical resonance conveyed when a white man from Europe comes to study black people in Africa and their diseases and misfortunes. This constellation includes a number of connotations which I was forced to take into account in my encounters with informants. How do my informants see me and how does this affect the outcome of the fieldwork? There was a clear asymmetry in many aspects related to the fieldwork. Compared to my informants, I came from a very privileged background and a place from where it was, in fact, possible to travel to the other side of the world to study what people there thought about certain things. At the end of this research, I would get a PhD. Besides a sandwich and a soda, which I normally offered the people I interviewed, my informants gained very little in a practical sense. Moreover, the fact that I was doing research appeared to sometimes have a certain effect on the atmosphere during an encounter; even though I was not necessarily older than an informant, I still often felt that I was regarded as ‘senior’.

The sum of these reflections added up to something that I noticed in the beginning of my fieldwork; when I asked an informant about HIV/AIDS, I frequently got the impression that my informants thought that I was testing their knowledge about the disease: how to treat it, how to prevent it, how it spread. As examining this was not the purpose of my study, I had to be sensitive about how I talked with my informants, what I wanted to know and how I should pose specific questions. Instead of, for example, asking directly if my informant had heard any kind of rumours about HIV/AIDS, I had to approach the matter more indirectly and discreetly. Starting with more general topics, such as life in Cape Town and its townships, I tried to steer the conversation towards HIV/AIDS in general, and then slowly towards different perceptions about the disease, such as by asking if the informant had maybe heard someone talking about the disease and if something had caught his or her attention. At times, if I considered the situation
appropriate, I also presented a specific ‘myth’ that I had heard in order to gauge the informant’s opinion and reaction to it.
4 AIDS myths – reality and representations

In the following, I will present the central contents and results of the articles that comprise my thesis. By highlighting the most relevant findings and interpretations, I hope to reveal the essence of the individual articles, but also the overall contents and significance of the study. Complete documentation of the methods, data and interpretations is found in the original articles.

4.1 Legends of resistance

One of the notions put forth in previous studies touching on AIDS myths in South Africa is that different statements made by South African politicians about the disease, mainly the one made by ex-president Thabo Mbeki, have, more or less causally, increased the prevalence of AIDS myths in the country. Scholars such as Parikh and Whiteside have proposed that people have found comfort in the controversial messages conveyed by the statements, which thus had negative effects on people’s behaviour related to the disease (2007, 67). Other scholars, such as Robins (2004, 2008) and Pitcher and Bowley (2002), have also understood the relationship between the political statements and the commonness of AIDS myths as being very strong. Robins argues that President Mbeki’s controversial stance towards HIV/AIDS in particular made popular understandings of HIV/AIDS more credible. Pitcher and Bowley note that the actions of the South African government made the ground fertile for ‘bizarre and dangerous myths’ (2002, 274–275).

I do not protest the possible impact that controversial political statements may have had on the existence of AIDS myths – as public comments doubtlessly have an impact on what and how people perceive things. Instead, my beef is with how the relationship between the statements and the existence of the myths has been put forth as straightforward and unequivocal. The underlying problem here is that a fundamental gap has been left in the process of trying to unravel the reasons behind AIDS myths in South Africa: it has not been discussed what AIDS myths are, in fact. Instead of first discussing the nature of the South African AIDS myths, scholars have directly jumped to conclusions about their origins and impact. By thoroughly examining the characteristics of AIDS myths, it is possible to reveal that their nature and existence is more multifaceted than has previously been proposed.
In the first part of my thesis, in Articles I and II, drawing upon ethnographic fieldwork in Masiphumelele and the male clinic in Khayelitsha, I focus on the texture of the conspiracy narratives about HIV/AIDS and the reasons for their existence among my informants. My first article has two main purposes: 1) to discuss the character of South African AIDS myths and the similarities they have with the narrative genre of urban legends and, drawing from this, 2) to present my preliminary interpretations about AIDS myths in South Africa as a kind of counter-narratives.

Conducting the fieldwork, I encountered expressions about the disease that, in light of previous studies, I could identify as belonging to the category of AIDS myths. Collecting these AIDS myths from my informants, I also noticed that their contents had certain thematic similarities with narrative items belonging to the genre of urban legends; the appearance of the reports about the disease – their brevity, simplicity, casual nature and persuasiveness – reminded of that of urban legends, described by Tangherlini as ‘short (mono-) episodic, traditional, performed in a conversational mode’ (1993, 5). The term ‘urban’ in this context does not imply that the narratives only circulated in or were generated from an urban environment. Instead, the word ‘urban’ in urban legend is understood in folklore studies to indicate that the narratives are contemporary, as opposed to folklore from the past. Besides being defined as narratively distinguishable expressions that convey a multiplicity of psychological sentiments, such as fears, anxieties and frustrations (Dégh 2001, Goldstein 2004, Tangherlini 1990), urban legends are understood to appear and circulate globally, which means that legends with similar contents can be found in very different places (Kroeger 2003, Goldstein 2004). Most importantly, urban legends – like other types of folk narratives – are by default interpreted through the themes and motifs appearing in them. It is this insight that I believe is crucial when trying to understand them.

Reports about condoms being infected with HIV were incontestably the most common account in the corpus of AIDS myths I encountered during my fieldwork. Such reports all expressed the same idea: condoms were deliberately infected with HIV in order to infect the persons using them with the virus. A similar or identical kind of AIDS myth has been attested outside South
Africa, for example, in Tanzania already in the 1990s (Setel 1999, 240) and in Mozambique in 2007 (McGreal 2007).

The other conspiratorial AIDS myth I examine in this article is about HIV-infected, pin-pricked oranges. According to these reports, oranges were deliberately infected with HIV with a syringe. The urban legend corpus includes examples of similar depictions of pin-pricked citrus fruits. Besides occurring in South Africa already in the 1990s, urban legends about intravenous drug users cleaning their syringe needles by pushing them into lemons in grocery stores circulated around the world (Flanagan 2003). The reports about pin-pricked oranges I encountered, however, suggested much more planning and sinister motives: in line with other conspiracy theories about HIV/AIDS in South Africa, these reports included suspicion of an external actor aiming to deliberately spread HIV among black South Africans.

Both types of reports can be understood as reflecting the fear and anxiety of being infected by the disease. Condoms are billed as one of the principal ways to protect oneself from HIV/AIDS; ‘making’ them a device of infection rather than protection reverses their purpose, and may be related to signs of insecurity and fear of getting infected. Similarly, the reports about pin-pricked oranges can be interpreted as expressing worry about syringes as a means of transmitting an HIV infection.

Many encounters during fieldwork, however, also conveyed a strong feeling of unease and distress. A considerable number of potential informants were dismissive when I told them that I was conducting research about HIV/AIDS and that I wanted to talk with them about the subject. Aside from simply refusing to talk with me about HIV/AIDS, some people reacted by shaking their head, grunting and making similar expressions of dislike. Many appeared to be simply fed up with the disease – and maybe the people engaged in research on it, too. Yet not only sheer fatigue with the disease was perceptible among my informants. Their resistance was more pronounced, sometimes even reflecting aversion. Their tones of voice and body language emphasized the reactive nature of many of the conspiracy theories they shared.

The counter-narrative nature of AIDS conspiracy theories among my informants become more discernible when viewed against certain contradictions between the desired model behaviour around HIV/AIDS and how people act in real life. The hegemonic message regarding
HIV/AIDS in South Africa, which people are encouraged to comply with in order to control the spread of the disease, includes a number of ideal types of behaviour, most of them summed up by the so-called ABC of AIDS (abstinence, being faithful and using condoms). Besides this, people are also actively encouraged to get HIV tests. Nevertheless, studies show that the threshold to get an HIV test is great for many people, using condoms is not always a routine, and promiscuity is common (Jewkes and Morrel 2010; Zembe et al. 2012).

Counter-narratives are based on the idea that the significance of great Western meta-narratives has decreased and that many smaller, often mutually antagonistic, narratives have taken their place (Lytard 1984). It has also been proposed, however, that such opposing narratives can be understood as counter-reactions to dominant or hegemonic messages more generally. In his study about cholera among the Warao in Venezuela, for example, Charles Briggs (2003) has interpreted conspiracy narratives as offering a possibility to challenge official narratives. Such counter-hegemonic mechanisms are especially interesting when understood as means of empowerment.

Drawing upon Gramsci’s ideas about capitalism and the bourgeoisie maintaining control in society through a hegemonic culture which imposes certain values and norms on subordinate people and social classes, scholars such as Mikhail Bakhtin, Johannes Fabian and Jesús Martín-Barbero have discussed counter-reactive cultural mechanisms and their relationship to such concepts as power, subversion and popular culture. Bakhtin, for example, proposes that the carnival should be understood as an event where everyday social hierarchies and structures are allowed to be questioned and turned upside down (1941). The concept of the carnivalesque has its roots in medieval festivities, such as the Feast of Fools and Mardi Gras, where Christian traditions and liturgies were ridiculed. This mockery of what otherwise was considered sacred should, according to Bakhtin, be considered as a means of subverting the notions and rules imposed by the dominant culture. Jesús Martín-Barbero has examined how people create subversive and contrasting meanings to dominant cultural processes communicated through the media and communication technologies (1993). He describes people as tactical individuals who actively create opposing ideas and messages, as subversive tactics offer ways to interrupt the logic of the hegemonic social order (Ibid., 81–84). Martín-Barbero makes the very valid point
that even though processes related to hegemonic and counter-hegemonic culture should not be understood as a relationship of pure, one-way repression from above, but rather as a process where ideas circulate between these two categories, it is still the hegemonic culture that sets the standards for what is ‘noble and what is vulgar’ (Ibid., 1999).

Even though AIDS myths and conspiracy theories may not include an ingredient of humour, such as the Bakthinian carnival, or be exclusively bound to processes of mass communication, notions like the above about the processes and dynamics related to concepts, such as hegemony and subversion, help to explain the very nature of counter-narrative mechanisms and the questioning of dominant rules and culture when actions are regarded as a means of empowerment of an oppressed group.

Johannes Fabian has examined how people through popular culture – when understood as a form of counter-hegemonic act – can strive to preserve self-respect in an environment distinguished by and built upon colonial structures and a postcolonial environment of humiliation (1997). Elisa Sobo proposes that through alternative and opposing understandings of a situation, people can withhold dignity and self-esteem where few other options exist (Sobo 1993).

AIDS in South Africa, or disease in Africa in general for that matter, conveys a number of hegemonic colonial and postcolonial meanings. The relationship between Europe or the West and the ‘Dark Continent’ has from the beginning of colonization been characterized by that of helping and being helped. HIV/AIDS does not contradict this constellation. On the contrary, the HIV epidemic in Africa has from the start been a relationship where poor and helpless Africa receives help and advice from a powerful and resourceful West, a relationship where the colonizer has been able to colonize not only material aspects of life, but the consciousness of South Africans with ideological and semantic understandings (Comaroff & Comaroff 1991).

4.2 Gender-driven communication and male conspiracy theories
Many of the conspiracy theories about HIV/AIDS that I encountered included themes and topics that resonated with matters, such as conflicts, fears, anxieties, hatred and other negatively characterized aspects, but also striking was that they appeared to be more common among men than among women. To date, societal problems, tensions and perceived injustices have been
regarded by many scholars as explanations – taken at face-value – for the existence of AIDS conspiracy theories in South Africa (see, for example, Fassin & Schneider 2003, Nattrass 2013). However, the ethnographic data that I gathered suggests that interpretations of AIDS conspiracy theories would benefit from also taking into account local gender dynamics and sexual culture.

In Article II, I examine why AIDS conspiracy theories are clearly more common among male than among female informants (besides my own observations, see, for example, Niehaus and Jonsson 2005). I propose that gender-conditioned manners of communication and the blame put on men for spreading the disease should be taken into consideration when interpreting the reasons behind this phenomenon.

Talking about matters related to sexuality, including HIV/AIDS, appeared hard for many of my informants. The silence was especially evident among men, and even more so when women were around. I have interpreted that this reluctance to talk is related to *isihlonipho*, a cultural model of communication and behaviour among Xhosa. Heinz Kuckertz, who has studied beer-drinking rituals in Mpondo, South Africa, points out that *isihlonipho* should not be regarded as an expression of morality itself, but rather as an idiom which is available for moral reasoning (1997). As a kind of underlying model for reasoning about gender, age and sexuality, *isihlonipho* leads men and women to communicate in a certain way about sexual matters, for example, but it has also resulted in an atmosphere of silence surrounding HIV/AIDS-related communication (Kroeger 2003) and imposed linguistic avoidance and a ‘right way of talking’ among family members (Finlayson 1995; Lambert and Woods 2008, 228).

Examinations of the effects of gender-conditioned communication and culturally conditioned manners of sexual behaviour among Xhosa in South Africa could benefit from being regarded against the background of sexual culture in a specific South African context, promoting male dominance and multiple sexual partners, which has been influenced by centuries of political and legal racial oppression.

According to Yanga Zembe, Lorraine Townsend, Anna Thorson, and Mia Ekström, historical and political processes in South Africa, such as colonization, apartheid and the post-colonial era, have influenced and constructed ‘the configuration of sexual relationships in South Africa’ (2013a, 2). Laws during colonization and apartheid forced South African men and
women to live apart; women were not allowed to join their husbands who worked in urban areas. This separation of spouses led to increased demand for commercial sex work in urban areas and contributed to phenomena such as transactional sex and multiple sexual partnering (Ibid.), but it also constructed hegemonic models of masculine behaviour, including ‘controlling and exercising total power over a woman, being ever-ready to act on opportunities for sexual encounters (e.g. through multiple concurrent sexual partnerships), demonstrating his ability to afford material demonstrations of his wealth (e.g. by showering sexual partners with gifts), and by punishing disobedience and non-compliance’ (Zembe 2013b, 23–24). Zembe et al. have studied the factors behind multiple concurrent sexual partnering among young women in the Western Cape province in South Africa (2012). According to their study, there is evidence that ‘traditional’ sexual practices, emphasizing ‘male partners to be dominant, controlling, and emotionally reserved, whilst requiring women to be sexually timid, submissive and tolerant of their main partners’ misbehavior’, are socially constructed (Ibid., 5). Reasons behind multiple concurrent sexual partnering among women may lie in so-called transactional sex, where young women strive to meet a variety of needs, such as gaining ‘material rewards’ or insuring themselves ‘against abandonment by their current main sexual partner’ (Ibid.).

During fieldwork, I encountered a number of informants who wondered why the disease was so widespread in South Africa in particular. During these discussions, a clear distinction emerged: a noticeable segment of the men believed in conspiratorial plots involving malevolent actors, such as the Americans, the FBI, the CIA, the defunct apartheid-era regime, or white people in general. Most women, on the other hand, thought that the reasons behind the high prevalence of HIV/AIDS were much less suspicious. In fact, it was striking how most of the women I talked to thought that men should be understood as largely responsible for the high incidence of HIV/AIDS. Many of the women had personal experiences of men being unfaithful, abusing alcohol and acting negligently and dominantly in relationships. Scholars have also recognized male behaviour as the main reason behind the high prevalence of HIV/AIDS, as it entails a significant degree of the high-risk sexual conduct connected to the disease (Whelan 1999, Mooney 1998, Bhana 2005, Jewkes et al. 2010).
Gendered models of communication that limit men’s possibilities to talk about HIV/AIDS may be understood as creating fertile ground for offensive narrative expressions. Drawing upon sociological and psychoanalytic interpretations of emotions and behaviour (Scheff 1990, Scheff 1997, Turner 1999, Turner 2002), Turner and Stets (2006) suggest that negative emotions, such as guilt and shame, can give rise to defensive behaviours. Furthermore, they argue (Ibid.), repressed negative emotions can increase people’s tendencies to blame others. Also looking at narrative expressions of AIDS, Paul Farmer (1992) similarly understands AIDS conspiracy theories among Haitians to be a counter-accusation to the idea that Haitians are guilty of introducing HIV/AIDS to the United States, or at least greatly increasing its prevalence there.

Understood as repressing the possibilities to communicate about the disease, the culturally imposed model of silence, isihlonipho, and the blame cast on men for spreading the disease should be considered as reasons for AIDS conspiracy theories being more common among men; by placing the blame outside themselves, men seek to relocate the blame put on them for the HIV/AIDS epidemic in South Africa.

However, isihlonipho is more than just a moral code or model for communication between people of different sexes. It is also something that steers how people from different age groups speak – and do not speak – to each other. This is a factor that has an effect not only on how communication itself should be understood, but also on how the premises of data collection may affect its outcome.

At the time of the fieldwork, I was just over 30 years old. Most of my informants were around the same age as I was or a bit younger. How did this affect the outcome of the research? What if I had been much older or younger than my informants? Or how did my being male affect the outcome of the data gathering? The fact that I was more or less the same age as many of my informants likely made conducting the fieldwork smoother; an informant being much younger or older than me would have probably had an impact on how they talked to me. Men also probably felt more at ease talking with a man. But how were the women I talked to affected by a male researcher? There are a number of things that could have had an impact on how informants talked to me (see section 3.4) – even if we were the same age or sex. My study offers one
gender-oriented perspective on how cultural models of communication and behaviour affect people’s perceptions about AIDS and conspiratorial thinking related to the disease. Future research about AIDS-related perceptions, especially those that consider how cultural models such as isihlonipho work, should also take into account aspects such as age and other forms of etiquette that influence how people behave and communicate about matters related to sexuality and HIV/AIDS.

4.3 Dangerous AIDS myths or preconceived perceptions?

Previous studies and media reports that have touched on the subject largely convey the notion that AIDS myths are abundant in South African townships and villages, that is, among black South Africans (see, for example, Ashforth 2002; Fassin and Schneider 2003; Robins 2004; Parikh and Whiteside 2007; Dickinson 2011). People are said to act upon these myths and, consequently, AIDS myths are considered to constitute a major challenge for HIV/AIDS prevention and work in the country. Even though AIDS myths have been widely discussed by both academics and the media, in many of these discussions the factual effect that AIDS myths have on people’s behaviour has not been considered or questioned. Instead, a number of studies appear to assume that AIDS myths should be regarded as a significant factor behind the high prevalence of HIV/AIDS in South Africa (see, for example, Pitcher & Bowley 2002; Robins 2004, Parikh & Whiteside 2007; Dickinson et al. 2011, Bogart et al. 2011). Such assumptions presuppose that people’s behaviour actually complies with the content of the myth. According to Dickinson, for example, ‘there are a number of myths of origin for HIV and AIDS’ among black South Africans, and stories about HIV/AIDS ‘have potential beyond being a tool to engage individuals’ attention, with the possibility to influence their behaviour’ (2011, 336). Many of these contributions, however, lack a thorough discussion about the mechanisms relating to AIDS myths that would support such assumptions.

How and to what degree AIDS myths actually have a negative effect on people’s behaviour is a question I deal with in Article III. This study stems from a discrepancy between my own observations about the prevalence and presumed effect of AIDS myths and the commonly held proposition that AIDS myths are abundant and powerful among black South
Africans living in townships and villages, and that they have a considerable negative effect on people’s behaviour. I did not perceive the situation to be exactly like this; yes, some people, especially men, shared AIDS conspiracy theories and many knew about other AIDS myths. But there still seemed to be a big difference between knowing AIDS myths and actually acting upon them – or at least the relationship did not appear to be as clear-cut as presented. This became apparent in the way that informants reasoned about the myths; many still appeared to make a clear distinction between myth and reality – for even if they could repeat different AIDS myths they had heard, many seemed to know that they were just myths. What is more, there also appeared to be a great difference between different myths and their potential effect.

My first example is from the male clinic in Khayelitsha. At the clinic, I often talked to the two counsellors that worked there, Mpilo and Kwazi. Both of them had years of experience of working with the disease. Their notions about the disease appeared rather pragmatic with down-to-earth opinions about where the shoe was pinching when it came to HIV/AIDS. Surprising was that very little in our conversations ever implied that they thought that HIV/AIDS myths were a serious problem. On the contrary, they often seemed rather baffled and perplexed when I presented this notion to them. Instead, they mostly worried about excessive drinking and careless sexual behaviour – and the interplay of these. This impression was reinforced by other informants during the fieldwork as well: ignorance, irresponsible sexual attitudes, hegemonic masculine behaviour and alcohol abuse were considered much bigger issues than AIDS myths. Nevertheless, what I found interesting was how familiar the idea of AIDS myths was to Mpilo, Kwazi, and, in fact, most of my informants; almost everybody knew a number of AIDS myths, mostly different conspiracy theories. This made me reflect more on the relationship between the myths and the effect they had or did not have on people’s actual behaviour.

I will illustrate this with the following encounter with Deliwe, a 24-year-old woman whom I met in December 2009 in Masiphumelele. We talked about the virgin cure myth – a topic that often came up with informants; particularly striking was how well all of my informants knew it. Deliwe first explained to me the essence of the myth: if you sleep with a virgin, you can be cured of HIV. The curing effect of virgins was, according her, related to how children symbolize what is untouched and pure in life, and that the cleansing effect of having sex with a
child stems from this untouched purity. Deliwe’s spontaneous reaction was that the belief appears commonly and that it has increased the rape of children considerably: ‘If you sleep with a virgin, you can get cured. That is why men rape children, thinking that they can get cured, even babies. Statistics show that having a child now is dangerous. You have to watch it. Because they [men] have that mentality.’ However, when we continued talking about it, Deliwe’s position did not remain as solid, and at some point she herself started laughing in disbelief.

South Africa has one of the highest incidences of rape in the world (Jewkes et al. 2009). A study by Jewkes et al. (2012) shows that 28–37% of adult men in South Africa have committed rape. Even compared to other countries with a high rape rates, the situation in South Africa is exceptional: in India 24%, in Chile 9%, and in Rwanda 9% of men have committed rape (Ibid.). Even though there are no conclusive and reliable statistics that would allow determination of the exact number of incidents of child or infant rape, making it possible to compare these numbers with other countries, there are signs that child or infant rape also occurs in great numbers in South Africa (Dartnall & Jewkes 2013). I have myself been conducting interviews at Tygerberg Hospital in Cape Town at the same time as a young girl who had been raped was receiving care in the adjoining room.

Therefore, I want to emphasize that the following discussion does not mean that children are not sexually assaulted in South Africa. Nor do I want to minimize the sufferings of those who have been victims of rape and sexual violence.

The virgin cure myth is probably one of the most known South African AIDS myths. It also emerged repeatedly as a topic in discussions with my informants. When addressing the virgin cure myth – or any other AIDS myth – it was very typical for my informants to immediately react to it, appearing familiar with the myth. However, instead of sharing first-hand information about people who had acted upon these myths – that is, pointing out where and when a child had been raped due to the myth – most of my informants appeared to base their judgement on hearsay and media reports. Also noteworthy is that many of my informants who at first confirmed the existence and impact of an AIDS myth could dismiss it as complete nonsense when challenged. The virgin cure myth, for example, was often considered a scapegoat explanation – ‘an excuse to molest children’, as my interpreter put it – given by someone who
had been caught sexually assaulting a child, rather than the content of the myth actually causing
the act. Rachel Jewkes and others propose that there is no evidence that supports that the virgin
cure myth is a significant factor behind child rapes and that reasons should instead be sought in
‘sex inequalities, a culture of male sexual entitlement, and the climate of relative impunity for
rape’ (Jewkes et al. 2002, 711). According to these authors, there is, in fact, no evidence that the
number of infant rapes has increased. Instead, they believe that the notion of a rising rate of child
rapes may be related to the publicity the media has given a few cases.

To what extent the virgin cure myth has in fact been a triggering factor for child rapes in
South Africa is hard to determine with complete reliability. There are signs, however, that the
relationship is less straightforward than claimed. Familiarity with it is so widespread that almost
everybody appears to have an opinion about it. In fact, the idea of the virgin cure myth affecting
people’s behaviour – as with other AIDS myths – appears to be so entrenched in the minds of
many that they take this as a fact; many people, informants and scholars alike, automatically take
the relationship between AIDS myths and risky sexual behaviour for granted. Even though
different types of AIDS myths can be seen as narrative reactions to the disease in its cultural
context, it is still important to acknowledge the difference between knowing them and acting
upon them.

In addition, instead of presenting AIDS myths as a homogenous corpus where different
types of AIDS myths are regarded as having more or less similar features and impact, the
discussion about the possible impact of AIDS myths would benefit from taking better into
account the differences between different myths. For example, conspiracy theories about AIDS
should not be put on the same level as the virgin cure myth in terms of cause, effect and
commonness. Only by treating the potpourri of different AIDS myths as a corpus that includes
distinguished narrative expressions – instead of lumping them together as an entity with uniform
properties – is it possible to recognize how different AIDS myths work and to what extent they
impact people’s behaviour.

When it comes to urban legends, it is true that they are considered efficient tools for
spreading information. This does not mean, however, that by hearing AIDS myths people would
automatically act upon them or allow the message that the myths convey to steer their behaviour.
For some people, myths, legends and rumours are just a form of entertainment – even though sometimes quite brutal.

4.4 Myths about AIDS myths

In the last part of my thesis, in Article IV, I focus on the discourse that touches on AIDS myths in South Africa. This discourse includes themes and motifs that are resonant with stereotypical – and sometimes derogatory – representations about Africa and black Africans. I examine a selection of academic articles on the South African AIDS myths, published by Ashforth (2002), Stadler (2003) and Robins (2004; 2008). The sample cannot be considered representative in the sense of giving an exhaustive picture of how AIDS myths are described in the academic discourse as a whole, but it does reflect the character and ambiance of the manner in which South African AIDS myths are often presented. These four articles have been selected for three reasons: 1) they explicitly deal with AIDS myths in a South African context, 2) they can be considered significant in this specific field of study, and 3) they include traditionalizing and patronizing features which are, at least to a certain extent, emblematic of some understandings of AIDS myths in South Africa.

From the discourse examined in Article IV, two separate narratives themes emerge: 1) traditionalization of black South Africans and 2) emphasizing mistakes made by the post-apartheid government in relation to HIV/AIDS. Both relate to a wider narrative that resonates with colonial and apartheid-era metaphors and differences claimed to exist between white and black people, non-Africans and Africans.

Already before my first fieldwork trip in 2009, I noticed something that characterized the way in which people – friends, relatives and colleagues – talked about South African AIDS myths: ‘you shouldn’t have trouble finding any’ or ‘they believe in all kinds of strange things over there’ was the essence of many reactions to my study. Similar notions are found in media reports on the subject: South Africa, and especially its townships and villages, are filled with

5 In my use of the term ‘traditionalizing’, I draw on Richard Bauman’s description of the term traditionalization as an ‘active construction of connections that link the present with a meaningful past’ (1992, 136). When applied as a term that conveys a sense of the matter being referred to as something traditional and old – that belongs to a past era (da Silva 2012, 41–42) – traditionalization can be understood to have derogatory connotations.
strange and dangerous myths about HIV/AIDS (see, for example, Little 2002; Watts 2008; Bodibe 2012; Jokovic 2013; Hu 2013).

The objective and overall nature of Article IV is very different from the three preceding articles; while the three first articles are all based on ethnographic fieldwork, the empiric part of Article IV consists of textual data. My approach to the data examined in Article IV is inspired by both the thematic and motif-driven approach in folkloristics and critical discourse analysis. I explicitly use the word ‘inspired’ when I describe the role of the different approaches, as I am neither claiming to conduct a purely folkloristic analysis of the texts nor a full-fledged critical discourse analysis. Neither one would have been sufficient alone. The considerably detail-focused approach of folkloristics offers a fruitful way to grasp different motifs, as well as themes appearing in the texts, while critical discourse analysis offers the possibility to examine how language is used as a social practice that may express and produce unequal power relations between groups (van Dijk 1997; Fairclough 2001). Restricting the analytical approach strictly to one specific approach, ‘school’ or discipline would not have been fruitful, given the empirical background of the other three articles – and the fact that the purpose of all of the four articles is to construct a coherent body.

Narratives are comprised of different ingredients. Some of them are clearly articulated and easily noticeable. But concerning AIDS myths, it is also interesting to look at the small details and connotative nuances. It is here that motifs and themes revealing inherent power, injustice, abuse and other hierarchical structures may be found. Michael Bamberg and Alexandra Georgakopoulou have examined so-called ‘small stories’, ‘an umbrella-term that captures a gamut of under-represented narrative activities, such as tellings of ongoing events, future or hypothetical events, shared (known) events, but also allusions to (previous) tellings, deferrals of tellings, and refusals to tell’ (2008, 5). These small stories are interesting, as they complement the ‘big stories’ with small ones, even if they may involve everyday and colloquial matters, revealing inconsistencies, contradictions, moments of trouble and tension, and the tellers’ constant navigation and finessing between different versions of selfhood in local contexts (Bamberg and Georgakopoulou 2008).
In two of the articles I examine (Stadler 2003, Robins 2004), I pay attention to the use of terms and wordings, such as ‘local’, ‘lay’ and ‘cultural’ in descriptions of AIDS myths in South Africa. Even though probably unintentional, such rhetoric conveys the sense that the matter being described is something traditional and old, which belongs to a past era (da Silva 2012, 41–42). The use of such and similar terms is problematic, as it carries with it a connotation of a culture that is separate from Western culture, temporally and, consequently, in terms of its level of development.

Another term that I examine is ‘witchcraft’ and how this concept has been used in connection with AIDS myths. Ashforth writes that ‘as the pandemic of HIV/AIDS sweeps through this part of Africa, suspicions of witchcraft arise amongst many in the pandemic’s path. To the extent that this occurs, the pandemic becomes an epidemic of witchcraft’ (2002, 122). He continues, ‘many people believe in witches but struggle against such beliefs’ (2002, 127). Drawing upon Ashforth’s earlier ethnographic work on witchcraft in the township of Soweto in Johannesburg, for example, he understands spiritual insecurity as a kind of fear and anxiety that arises ‘from doubt about knowledge of the nature and purposes of invisible forces capable of causing harm’ (1998, 64). I do not wish to contest or diminish Ashforth’s thorough work on witchcraft as part of a ‘more general condition of spiritual insecurity involving a great many occult and supernatural forces’ (Ashforth 2002). There is no doubt that belief in witchcraft and witches is a meaningful part of people’s lives in the townships, and that people ponder what things really are, why things happen, and other questions related to the kind of epistemic anxiety Ashforth writes about. Ashforth acknowledges that many Africans argue that terms such as ‘witch’, ‘witchcraft’ and ‘witchdoctor’ are misleading and derogatory; ‘this is undoubtedly so, but the words are impossible to avoid’, he concludes (2002, 126). It might be very true that the words as such are impossible to avoid. It is not, however, the words as such that I want to draw attention to, but the way in which they are used and the meaning they are given in this specific context. Even assuming things only ‘for the purposes of discussion’, as Ashforth articulates it (2002, 135–136), using expressions such as ‘sweeping through’ and ‘epidemic of witchcraft’ and saying ‘many people believe in witches but struggle against such beliefs’ convey the opinion that
black South Africans have capitulated and are resigned to perceptions that relate to witchcraft – and, consequently, that they are also less inclined to have sound and accurate understandings of the disease. Even though the motives behind the use of such wordings or motifs may be purely stylistic, it is precisely these types of expressions that, at the very least, can be considered to be sensationalizing. Academic texts – like the ones examined in this article – should be considered as powerful instruments when it comes to consolidating and legitimizing different perceptions (for example, the understanding of how abundant AIDS myths, in fact, are).

In Article IV, I continue to examine the virgin cure myth and how it has been presented in the discourse, as well as what implications this might have for how South African AIDS myths are understood. Even if it is not as distinct as above, what is said and the wording here caught my attention. According to Robins, local and lay understandings of AIDS include the belief that sex with a virgin or infant can cure from the disease (2004, 654), and Ashforth writes about the ‘widely reported belief that sex with a virgin cures AIDS’ (2002, 132). As the academic debate about the effects of the virgin cure myth – namely, how much it has increased rape of children – is not conclusive (see section 4.3), such descriptions about the virgin cure myth may be problematic, if the myth is presented as emblematic for what kind of AIDS myths exist and how (black) South Africans act upon them, if the discussion surrounding the mechanics and impact of particular AIDS myths is disregarded. Without discussing to what extent they actually exist and influence people’s behaviour, references that imply, for example, that the virgin cure myth is both common and effective among black South Africans, even if they are made in an illustrative way or ‘for the purposes of discussion’ (Ashforth 2002, 135–136), may contribute to the perception that a vast majority of black South Africans adhere to it. Aside from taking the impact of the virgin cure myth for granted, this perception also reflects colonial notions of an Africa characterized by a primitive native with an over-emphasized sexuality and barbaric sexual behaviour (Wenham, Harris and Sebar 2009, 289). Treichler writes about the dichotomy that is created between the First World and the Third World, as ‘cultural practices are taken out of context, exaggerated, distorted and invented’ (1999, 114–117).

The fourth article also examines the discourse related to the post-apartheid government’s handling of the HIV/AIDS situation in the country. Failures attributed to the current, ANC-led
government’s handling of the HIV/AIDS situation are cited as a considerable factor behind problems of preventing the disease. Attention is primarily paid to three different events. The first one concerns the speech in 2000 by Thabo Mbeki, the former South African president, interpreted as questioning the causality between HIV and AIDS. Another concerns statements made in 2006 by Manto Tshabalala-Msimang, the health minister in South Africa then. At an international AIDS conference in Toronto, Canada, Tshabalala-Msimang said that garlic, beetroot and lemon should be considered treatments for HIV/AIDS: ‘Shall I repeat garlic, shall I talk about beetroot, shall I talk about lemon... these delay the development of HIV to AIDS-defining conditions, and that’s the truth.’ (Le Roux 2006). As a result, she was nicknamed Dr Beetroot. The third matter concerns a trial hearing in 2006 when the current South African president Jacob Zuma was accused of having raped a woman. During the trial he stated that he had showered after having had sex with an HIV-positive woman whom he was charged with raping, insinuating that showering decreased his risk of being infected with HIV.

These incidents are considered by many to have increased confusion about the disease and also, more specifically, the occurrence and effect of AIDS myths (Robins 2004; Robins 2008; Ashforth 2002). I am not contesting this as such, but I would point out that neglecting to discuss how this works also conveys another kind of notion: that black South Africans are more prone to get incorrect information and less inclined to engage in critical thinking.

Besides resonating with colonial notions of Africa and Africans, the motifs and themes recognized in this article should also be understood in a distinctly South African context, which is characterized by apartheid-era narratives that still persist. Steyn and Foster see that there are ‘distinctively resistant white discourses that inform much of white sense-making about living in post-apartheid South Africa’ (2008, 26). Discourse focusing on the deficiencies of black people in post-apartheid South Africa legitimizes and perpetuates the privileged position of white South Africans (Wale and Foster 2007, 46).

In Articles III and IV, I look at the way in which AIDS myths have been discussed and presented in certain academic contributions that touch on South African AIDS myths. There are signs that at least part of the discussion surrounding AIDS myths in South Africa may be problematic; instead of critically approaching the complex nature and concept of AIDS myths
and mechanisms related to it, a segment of the academic discourse reinforces the simplified perception that AIDS myths are exceedingly common in South Africa and that they have a considerable effect on how people think and behave.
5 Conclusion

When I started working on this thesis, I thought that the research would materialize in a straightforward and conventional way. By this I mean that I expected to find many different myths about HIV/AIDS, that these myths would dominate the way in which people in my research setting of townships in Cape Town communicated about the disease, and that my work would be to gather these myths and interpret them according to the methodological and theoretical toolbox at hand. The relevance of the research as such would have been to increase understanding about how AIDS myths function and how to address them in order to minimize their harmful effects. In the end, however, this was not how it turned out. Instead of finding townships filled with different types of AIDS myths, I encountered a variety of different perceptions, meanings and expressions about HIV/AIDS working in different directions.

The two major results of this thesis are that 1) AIDS myths are not as widespread or straightforward indicators of actual behaviour as has been presumed and claimed, and 2) current research itself contributes to a limited understanding of the mechanisms and anatomy of these myths, and that it also draws upon colonial ascriptions of Africa and Africans and also the historical context specific for South Africa.

One thing is certain: so-called myths about HIV/AIDS exist in South Africa, including its townships. The myths I encountered were mostly different kinds of conspiracy theories about the disease: where HIV/AIDS originated, how it came to South Africa, and why it had become over time one of the biggest health problems in South Africa. It is, however, less sure that these stem directly from dubious political statements or that taking their contents at face-value stands in direct relationship to their existence.

These AIDS conspiracy theories are born out of a specific cultural and social habitat, which is characterized by specific local traditions that impose and support certain kinds of communication and behaviour. The township context of South Africa today still bears the legacy of the apartheid era, which materializes in many negative circumstances – both material and ideological – that profoundly affect the lives of the people who live there. This legacy, also including specific gender-conditioned models of communication and characteristic manners of sexual behaviour, should be understood as having a significant effect on how people perceive
HIV/AIDS and communicate about it – as one of the single most significant matters affecting the lives of many black South Africans today.

South Africa is both a fruitful and difficult place to study. It is a country that still bears many associations with its distressing history. Underlying, often asymmetrical meanings which become entwined with traditional models of behaviour and communication – and with more current concerns of blame and guilt – make a breeding ground for counter-hegemonic reactions, including ones that are related to HIV/AIDS.

Counter-hegemonic narratives offer people the possibility to resist and subvert the disease in general, but also the variety of different meanings and connotations that are related to it. Through subversive AIDS myths, people are able to create their own meanings in a situation that is desperate and frustrating – and that also includes many equally negative meanings from the past.

However, even if reports that can be considered to belong to the South African AIDS myth corpus do exist, most of the people I encountered during my fieldwork expressed views about the disease that differed very little, or not at all, from what Western medicine would consider standard. This made me consider more carefully about the mechanics of AIDS myths: how they ‘work’ and what their actual impact on people’s behaviour is. I would claim that the discussion about the effects of AIDS myths has been characterized so far by impreciseness and generalization, as questions about their mechanics have more or less been disregarded. Examining the effect that they had or did not have on people’s actual behaviour reveals that just because people know different AIDS myths does not necessarily mean that they automatically act upon them. My study is a cautious first attempt to approach this topic. Yet, much more remains to be done in this field of study in the future.

It is true that AIDS myths make for interesting headlines, both in academic and media articles. But they are also an efficient way of conveying meanings about those who are proposed to believe in them, that is, black South Africans. Analysis of a selection of academic articles that touch on AIDS myths in South Africa shows that the discourse conveys traditionalizing themes.
AIDS myths grow from the interplay of many different things. They may be understood as forming a narratively expressed resistance against the disease and blame related to it, aiming to maintain dignity and self-esteem. But AIDS myths should also be regarded as part of a larger narrative, still bearing legacies of the colonial setting and the apartheid era.
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