HIV and AIDS in the context of South African indigenous religious Discourse

Magisterarbeit

Verfasserin:

Laura Pöhler

Table of Contents

List of Diagrams

1. Introduction: Fana Khaba - Died of AIDS, Killed by Witchcraft

At Fana Khaba's funeral, the only person denied entrance to the public ceremony was the witch that killed him. Ten days after his death in a Johannesburg hospital, Fana Khaba (alias DJ Khabzela) was bid farewell in Orlando Stadium. On January 24, 2004, the 40,000 people stadium was filled to the brim with fans, celebrities and politicians mourning the death of the most influential radio DJ in post-Apartheid South Africa. With his unique combination of humour and humble backgrounds, Fana Khaba had made it out of the townships into a prime time slot at Yfm, South Africa's first official radio station catering to the black youth of Gauteng province. In the wake of a new democratic area, DJ Khabzela represented the modern, educated, black South African man. His show entitled "Positive Youth of Gauteng" spoke out to the impoverished township communities, addressing issues such as crime, violence and AIDS.

When he became sick in 2003, he became South Africa's first male black celebrity to publicly disclose his positive HIV status - a decision that instantly earned him nationwide acclaim. It was also considered a big step forward for South African men, as Khaba's promiscuity was infamous around Gauteng and young men like Khaba did not acknowledge the risks that came with such a lifestyle. Partly for these reasons, Khaba's sudden death of AIDS less than one year later was a shock to many.

Supported in his decision to go public by his family and employers, Khaba had announced on his show to have started biomedical treatment. He promised to his listenership to be back on air once his health improved,[1] but he continued to be absent from public life for several months, when newspapers published disturbing pictures of the famous DJ nationwide. The pictures showed an emaciated Khaba accepting an award for his contribution to the fight against HIV. It was reported to have been sponsored by South Africa's biggest funeral company – and with the award came a free funeral for Khaba.[2]

As his biographer Liz McGregor has reconstructed after his death, Fana Khaba did not adhere to the rigorous schedule of anti-retroviral (ARV)[3] intake as promised. What Khaba did not convey to the audience in his famous broadcast, was that he was in fact

---

[1] Josh Adler, "Yfm's DJ Khabzela Is HIV Positive," *Music Industry Online*, May 16, 2003, accessed June 26, 2012, http://www.mio.co.za/article/yfm-s-dj-khabzela-is-hiv-positive-2003-05-16.

[2] Bheki Hlabane and Lauren Hills, "Ailing but Defiant HIV+ DJ accepts Award," *IOL NEWS*, December 12, 2003, accessed June 26, 2012, http://www.iol.co.za/news/south-africa/ailing-but-defiant-hiv-dj-accepts-award-1.119149#.T9DdYLVadEM.

[3] Antiretroviral medication represses the multiplication of HIV cells in the human body. The primary aim of antiretroviral therapy is the delay or prevention of the patient's progression to AIDS. See also: Chapter 2.1.

convinced to have been the victim of witchcraft. Up until his death, Khaba continued to seek out different healers in hope of finding a cure. Amongst them, according to McGregor, were biomedical specialists, African indigenous healers, Christian spiritual healers as well as a nutritionist recommended to him by the South African Minister of Health, a known opponent to ARVs. Often simultaneously to his biomedical treatment, Fana Khaba relied on an ever wider range of remedies. Among them were indigenous medicine, raw garlic, prayer, pills by the name 'Amazing Grace' and a tonic called 'African solution'. When Khaba died of AIDS related symptoms eight month later, Khaba's family suspected his long time partner and fiancée to be the witch that had killed him. Following the deceased's family's order, she was ultimately denied entrance to the stadium.

The international community anxiously watches South Africa's handling of the HIV crisis, as today it is the country most affected by the epidemic.[4] Its fate might well foreshadow the future of global public health. For this reason, the health choices made by South Africans affected by HIV and AIDS such as Fana Khaba have long caused worldwide debate. In an attempt to shed light on his health seeking behaviour, Liz McGregor's biography *Khabzela – The Life and Times of a South African* sensibly explores the individual choices and circumstances behind Fana Khaba's decisions concerning his disease.[5] She also places Khaba's supposed abnormality into perspective and clarifies: "Many South Africans go to a traditional healer before they will see a doctor. Khabzela's response was the norm."[6] Furthermore, South Africans are no exception, as reports of AIDS being read as witchcraft reach us from all over the world.[7] The South African anthropologist Adam Ashforth has even gone so far as to claim that "[t]o the extent that this occurs, the pandemic becomes an *epidemic of witchcraft*."[8]

---

[4] In this thesis, the expression 'HIV/AIDS' is avoided, as it can cause confusion. Most people with HIV do not have AIDS, and their distinction is important to the topic at hand. I will refer to the 'HIV crisis', as 'AIDS crisis' does not include the majority of those affected by the epidemic. The title of this thesis was chosen prior to this realisation.

[5] Liz McGregor, *Khabzela: The Life and Times of a South African* (Auckland Park: Jacarna Media, 2005).

[6] Liz McGregor, "Aids Death of DJ Highlights Anguish of South Africa," *The Observer*, February 29, 2004, Accessed June 26, 2012, http://www.guardian.co.uk/world/2004/feb/29/southafrica.aids.

[7] See for example: Paul Farmer, *AIDS and Accusation: Haiti and the Geography of Blame* (Berkeley: University of California Press, 1992); Christian Bawa Yamba, "Cosmologies in Turmoil: Witch-Finding and AIDS in Chiawa, Zambia," *Africa* 67.2 (1997); Richard Eves, "No Access! AIDS and Apocalypticism: Interpretations of the Epidemic from Papua New Guine," *Culture, Health and Sexuality* 5.3 (2003).

[8] Adam Ashforth, "An Epidemic of Witchcraft? The Implications of AIDS for the Post- Apartheid State," *African Studies* 61.1 (2002): 122; italics by Laura Pöhler.

Claire Laurier Decoteau has identified two common responses in explaining South Africans' choice of traditional medicine instead of, or in tandem with ARVs: First, the politics of 'AIDS denialism'[9] by South Africa's government until 2004 had caused "confusion on the ground" about the biomedical 'truth' of HIV and AIDS. It had undermined the successful implementation of ARV drugs throughout the country, instead giving way to impostors promising 'miracle cures' to desperate patients. Another common response she identifies is the idea that stigmatization through false information on AIDS was keeping patients from seeking out public health care.[10]

Fana Khaba's story, however, defies both these explanations. As his broadcasting history of awareness campaigns shows, he was very knowledgeable when it came to HIV, in terms of the disease pattern as well as different ways of contraction, prevention and treatment. Different from most South Africans, his financial security privileged him to highly effective drugs and access to some of the most distinguished biomedical specialists. He also must have known the benefits of biomedical treatment as, different from most South Africans, he got tested at a clinic, started taking ARVs and throughout his remaining life kept returning to biomedical experts. At the same time, Khaba had been convinced that his condition was caused by witchcraft. But rather than to dismiss biomedical treatment and exclusively consult an indigenous healer, he chose to access the full spectrum of health care available to him.

As Decoteau has pointed out, common explanations like the two identified above are insufficient in explaining this kind of health seeking behaviour. They inevitably entail conclusions affirmative of biomedical presumptions – in this case that a lack of knowledge leads to 'wrong' behaviour and that only through biomedical education confusion and stigmatization can be overcome. They present biomedical knowledge as the 'truth', which alone will allow those affected by HIV and AIDS to make 'rational' choices. These explanations not only blur indigenous health care with charlantry and the politics of 'AIDS denialism', but they construct indigenous and biomedical ideas of health as opposing systems of knowledge, which necessarily must avert each other.[11]

---

[9] 'AIDS denialism' describes the opinion that HIV does not cause AIDS. This claim was embraced in 2000 by the second post-Apartheid president, Thabo Mbeki, when he invited several AIDS denialist into his presidential AIDS advisory panel. His also placed a ban on the use of anti-retroviral medications in public state hospitals, which was only lifted in 2004.

[10] Claire Laurier Decoteau, *The Bio-Politics of HIV/AIDS in Post-Apartheid South Africa* (Ann Arbour: Deep Blue University of Michigan, 2008), accessed June 26, 2012, http://deepblue.lib.umich.edu/handle/2027.42/61711, 2.

[11] ibid., 2, 3.

The notion of incommensurability between two different forms of health care is also expressed by McGregor's conclusion to her biographical account of Fana Khaba's life. Despite her awareness of the multitude of health care choices available to South Africans fighting HIV, she remains committed to the exclusivity of biomedical health care.

> "I think that township spiritual eclecticism, so enriching in other ways might, in the case of HIV/Aids, be counter-productive. The urgency of impending death drove Fana's family to try an even wider range of remedies: prayer, traditional healers, white miracle pedlars as well as ARVs, when in fact what they needed was an unequivocal orthodoxy."[12]

While 'eclecticism' and 'orthodoxy' might here primarily refer to Khaba's lack in consistency of taking his ARV's, McGregor's choice of words (*'township spiritual eclecticism'* vs. *'unequivocal orthodoxy'*) points toward another dimension of the current debates concerning health and healing in South Africa. The notion of incommensurability of biomedical and indigenous forms of health care is irresolvably conjoined with a history of religion in Africa and Europe. Due to this legacy choosing the right form of health care, in McGregor's language, has become a matter of *doxa*, of belief. To explore these dimensions of the debate around the HIV epidemic and to derive its consequences for a study of AIDS and South African indigenous religious discourse is the focus of this thesis.

1.1 Project

HIV presents one of the biggest challenges to the health of the global public today, and thus, deserves the scholar's full attention. The discourse around witchcraft forms a distinctive part of this reality in South Africa. As can be seen from Fana Khaba's story, not only does this discourse seem to offer an alternative narrative of AIDS to many South Africans, but maybe more importantly, it informs social relationships and their health care choices. The interrelationship of religion and health has long been a subject to the study of religion. Much work has been done on institutionalized religion in Africa and the HIV crisis.[13] Surprisingly however, there has been very little research conducted on the role of indigenous religion in the epidemic.[14] The study of religion has long

---

[12] McGregor, *Khabzela*, 236.

[13] See for example: Felicitas Becker and Paul Wenzel Geissler, ed. *AIDS and Religious Practice in Africa.* Leiden et al..: Brill, 2009; Bartholomäus Grill and Stephan Hippler, *Gott, Aids, Afrika: Eine Streitschrift* (Köln: Kiepenheuer und Witch, 2007); Intensive Research on the role of Faith Based Organisations within and outside South Africa is curently being conducted by the 'African Religious Health Assets Program (ARHAP). Their results can be found under www.arhap.uct.ac.za, as well as detailed literature reviews to AIDS and institutionalised religion.

[14] Decoteau, *The Bio-Politics of HIV/AIDS in Post-Apartheid South Africa*, 411.

broadened its focus from studies of institutionalized religion only and expanded it to indigenous, private and informal forms of religion. As a discipline it is thus particularly equipped for the study of those aspects which do not dominate the public discourse around HIV and AIDS.

A critical study of religion, however, cannot restrict itself to analyzing those discourses describing themselves or described by the public as religious. In 2005, Bruce Lincoln provocatively put forward ten "Theses on Method" in order to emphasize the discipline's commitment to critical method. One of them reads:

> "History of religions is […] a discourse that resists and reverses the orientation of that discourse with which it concerns itself. To practice history of religions in a fashion consistent with the discipline's claim of title is to insist on discussing the temporal, contextual, situated, interested, human, and material dimensions of those discourses, practices, and institutions that characteristically represent themselves as eternal, transcendent, spiritual, and divine." [15]

 In order for this thesis to meet Lincoln's claim, it must not only critically probe those interpretations of AIDS described as religious in public discourse. It must also probe all those interpretations, which preset themselves as 'eternal, transcendent, spiritual and divine' in the struggle to make AIDS meaningful. As will become apparent below, the battle over the signification of the epidemic is first and foremost a battle about hegemony, not only in health care but also as knowledge. Biomedical health care is deeply involved in this struggle, and in its attempts to win hegemony over the HIV epidemic in South Africa claims scientific 'truth' for itself. Based on this claim, the biomedical framing of HIV will be subject to this thesis as much as the discourse around witchcraft will be. Instead of taking its 'truth' for granted, studying biomedical framings of HIV alongside religious framings as well as their demarcation throughout history, can help to understand how those in power to globally define HIV do not necessarily equal those worst affected by the epidemic and their interpretations no not necessarily resemble the victims' realities. With its self-conscious attention to problems of terminology, epistemology, methods and category formation, the academic study of religion avoids the pitfalls of partaking in battles of signification.

This thesis will explore indigenous religious discourse around witchcraft in South Africa and how it relates to the HIV crisis as well the social and economic realities the epidemic brings forth. With both religious and biomedical framings of HIV as its

---

[15] Bruce Lincoln, "Theses on Method," *Method and Theory in the Study of Religion*, Vol. 8 (1996): 225, 226.

object, certain questions come into focus, which this thesis will address. First, it will ask how the notion of a radical incommensurability of biomedical and religious health care developed in the South African context, and how this notion came to dominate the discourse around HIV and AIDS. Second, it will ask how academic concepts of witchcraft have emerged from this tradition of confrontation and what they entail for those studying HIV and AIDS. Thirdly, drawing on recent scholarship describing witchcraft as part of an African modernity, it will ask how a critical study of religion can break with this tradition. Finally, the thesis will seek to employ recent theories in order to achieve an adequate description of witchcraft and AIDS in the South African context.

1.2 Outline

This thesis is structured in five parts. The opening chapter will begin by discussing if and why a study of witchcraft in relation to AIDS is justified. It will then give a brief introduction into the medical distinctiveness of HIV and argue that HIV is exceptional in that it is highly adaptable to the biological, social and economic environment it occurs in. This will be demonstrated for the South African context, where its adaptability leads to a high degree of uncertainty in every aspect of the HIV crisis. This uncertainty is further heightened by the massive economic and social changes brought about by the epidemic, as illustrated at the end of Chapter 2.

Chapter 3 will challenge the dominant belief about the decline in biomedical knowledge throughout South Africa and suggest that this perception is based on an ideological confrontation between biomedical and indigenous healthcare. The genealogy of this confrontation will then be revealed by tracing back South Africa's history of healthcare, starting from the colonization of southern Africa, when medicine served as an important part of the colonial enterprise. The resulting confrontation of indigenous and medical healthcare was amplified throughout Apartheid, where healthcare served as divisive instruments, separating citizens from subjects. Despite the effort to merge the separate fields of healthcare as part of the post-Apartheid democratization, they remain institutionally, economically and structurally bifurcated. Those dominating the discourse on HIV and AIDS claim an incommensurability of indigenous and biomedical forms of health care for different political, ideological and economic reasons. However, those South Africans most affected by HIV prove this claim to be a myth in the way they utilize both forms of healthcare in order to survive.

Chapter 4 will analyze how current theories of witchcraft came together in scholarly discourse. Starting with colonial notions of witchcraft, it will describe how academic

concepts of witchcraft have always been part of a larger history of European concepts of African religion. It will discuss the problems involved in employing the term 'witchcraft' in an academic study of religion. Special attention will be paid at Edward E. Evans-Pritchard's work *Witchcraft, Oracles and Magic among the Azande*, as well as the debate on rationality that followed, as both signified a change in paradigm in witchcraft studies. Following recent scholarship suggesting a "Modernity of Witchcraft", the chapter will then argue that witchcraft can only be understood within the frame of contemporary social concerns.

Building on the preceding chapters, Chapter 5 will finally look at contemporary South African discourse on witchcraft. Drawing on recent ethnographic findings, different suggestions will be made on why witchcraft seems to be amongst the favoured discourses to describe AIDS in South Africa. Not only does there seem to be a structural similarity in conceptions of witchcraft and experiences of AIDS, as well as a possibility to account for social and economic change, but witchcraft might also react to social concerns arising out of the biomedical framing of HIV and AIDS.

A conclusion will summarize the thesis and give a small outlook for further research

2. The Messiness of the Message

He must have been a mess. Demented, hallucinatory, covered in suppurating sores, unable to control his ability to defecate and urinate and in severe pain - McGregor does not shy away from describing the graphic details of Fana Khaba's final stages of AIDS. "It must have been a relief to him when, at 12.10 on January 14, 2004, he finally stopped breathing," she states.[16] But while his long suffering had finally come to an end, the 'messiness of the message' his story had send out to South Africans, as McGregor claims in her book, extended far beyond Khabzela's death.[17] This was publicly illustrated at his funeral, where numerous commemorating speakers enlisted the opportunity to express their views on the epidemic that had taken the famous DJ's life. Their interpretations could not have been more diverging. Christian ministers saw Khaba's death as divine punishment for his promiscuity, members of the ANC[18] as the result of a still struggling post-Apartheid nation, and public health advocates as yet another toll to misguided politics and global inequality. The gathering also provided an excellent

---

[16] McGregor, *Khabzela,* ix.

[17] ibid., 19.

[18] African National Congress (ANC), ruling party of South Africa since the first elections in 1994.

opportunity for many to advertise a solution in front of thousands of South Africans. At Khaba's funeral, the HIV crisis was predicted to be overcome in several ways: through sex after marriage, a vote for the ANC, political revolt or the nationwide rollout of ARVs.[19]

This 'messiness' of messages and meanings surrounding AIDS is not unique to Khaba's case, nor is it unique to the South African context. In her 1988 groundbreaking essay, Paula Treichler noticed a similar abundance of interpretations of AIDS for the Europe context. HIV, according to Treichler,

> "is simultaneously an epidemic of transmissible lethal disease and an epidemic of meaning or signification. Both epidemics are equally crucial for us to understand, for, try as we may to treat AIDS as 'infectious disease' and nothing more, meanings continue to multiply wildly and at an extraordinary rate."[20]

She proceeds by giving 38 diverging significations of AIDS that were operative in Europe at the time.

In order to grasp South Africans' particular exposure to HIV and the diverse ways in which people deal with the epidemic, a study of witchcraft and AIDS has to be situated within a wider framework of health and health care in South Africa. As Hansjörg Dilger has recently pointed out:

> "the anthropological study of AIDS is about the more general challenges of caring for and supporting the sick and needy, the responsibilities of burying and remembering the dead, and the moral questions concerning social coherence and continuity in a society undergoing rapid political and economic transfer."[21]

While the South African history of heath care will be discussed later on in detail, it is worthwhile to take a closer look at HIV in general as well as in the South African context in particular. In doing so this thesis singles out HIV from other public health issues and makes a point of its exceptional nature that has to be acknowledged. This claim is not self-explanatory. While HIV has long had the status of an exceptional disease, the reasons given for this attribution are often demographic in nature and usually relate to high morbidity and mortality rates.[22] However, life in South Africa is dangerous, and there are many unnatural causes of death that trouble citizens in a

---

[19] McGregor, *Khabzela,* 18, 19.

[20] Paula Treichler, "AIDS, Homophobia, and Biomedical Discourse: An Epidemic of Signification," in *AIDS*, ed. Douglas Crimp (Cambridge et al..: MIT Press, 1988), 32.

[21] Hansjörg Dilger, "Morality, Hope and Grief: Towards and Ethnographic Perspective in HIV/AIDS Research," in *Morality, Hope and Grief*, ed. Hansjörg Dilger and Ute Luig. (New York: Berghahn, 2010), 2.

[22] ibid., 2, 3.

country with some of the highest statistics worldwide in alcohol and drug related deaths, street killings, and murder. We can only speculate, but had Khabzela been murdered like more than 20,000 other South Africans in the year of his death,[23] his commemorators might have spoken more in unison about his fate. The 'messiness of the message' seems to eminently attach itself to AIDS again and again. Dilger has suggested that HIV is more distinguishable in the plurality of reactions it provokes, rather than any other of its attributes.

> "What distinguishes the HIV/AIDS pandemic from other historical and contemporary diseases is the extraordinary variety of responses that the disease has produced in societies worldwide – on all levels of societal and political organization."[24]

In fact, it could be argued that an HIV infection – at least in its physical appearance - is in many respects less remarkable than other medical conditions. As will be shown below, AIDS is highly adaptive of the particular disease environment it occurs in and as such often not distinguishable from other afflictions. Why, then, would AIDS provoke such a plethora of responses?

This thesis argues that one of the reasons why HIV provokes an exceptional human reaction compared to other diseases might indeed lie precisely in its high adaptability, while at the same time claiming unusually large amounts of victims wherever it occurs. The following chapter will first provide some general information on HIV as well as on the medical conditions of AIDS. It will then pinpoint some distinctive features of their occurrence within the South African context. Finally, it will discuss the social and economic impact the epidemic has had on the country since its emergence.

2.1 HIV, AIDS and the Human Host

The Human Immunodeficiency Virus, commonly known under its acronym HIV, is a retrovirus, which infects and replicates within the human body. It does so mainly within CD4+T-Cells, which are responsible for the human immune system. The continued replication of HIV within the human body causes the gradual decline in CD4+T-Cells and as a result the progressive failure of the body's immune system. In its later stages the condition invites various opportunistic infections and cancers. This stage of

---

[23] South African Police Service, Crime Situation in South Africa: Annual Report, 2008-2009, accessed June 26, 2012. http://www.saps.gov.za/saps_profile/strategic_framework/annual_report/2008_2009/2_crime_situation_sa..pdf

[24] Dilger, "Morality, Hope and Grief," 9.

infection is commonly referred to as AIDS, or Acquired Immunodeficiency Syndrome, and, if not treated, is in most cases fatal.[25]

HIV is transmitted through contact with infected cells or free floating HIV, both of which can be found in blood, semen, vaginal fluid and breast milk of HIV positive patients both with and without AIDS. The most common ways in which HIV is contracted are, in order of occurrence: sexual transmission through vaginal or anal intercourse, mother-to-child transmission during birth or breastfeeding, and transmission through blood exchange, most common in intravenous drug abusers. At the end of 2010 an estimated 34 million people were living with HIV worldwide, approximately 60% of which had contracted the virus through sexual intercourse.[26]

Given the global scope of the epidemic, it is surprising how highly inefficient the sexual transmission of HIV is. Out of 100,000 single exposures less than 20 are estimated to be infectious.[27] Various biological, social and virological factors, however, often have a strong influence on the prospects of HIV transmission. Lynn Morris and Tonie Colliers name, amongst other factors, the frequency of sexual contact, the immunological status of an individual, male circumcision and the previous presence of sexually transmitted diseases.[28] Prevention strategies thus not only include barrier methods, such as male and female condoms, but attempts to reduce high risk factors such as risky sexual behaviour and STDs.[29] Mother-to-child transmission is mainly counteracted by increasing the maternal viral load through ARV intake, safer modes of delivery and the discouragement of breastfeeding.[30]

Within a short time after infection, the viral load in the patient's blood increases drastically. A sudden decline in CD4+T-Cells often leads to initial illness. Within a few weeks, however, the immune system normally responds to the virus, curtailing the viral load and increasing CD4+T-Cells. Due to this immune response, the patient can remain clinically well for many years. Despite the absence of symptoms, without treatment the

---

[25] Lynn Morris and Tonie Cilliers, "Viral Structure, Replication, Tropism, Pathogenesis and Natural History," in *HIV/AIDS in South Africa*, ed. S.S. Abdool Karim and Q. Abdool Karim (New York et al.: Cambridge University Press, 2005), 79 ff.

[26] UNAIDS, *2011 World AIDS Day Report*. 2011, accessed June 26, 2012. http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2216_WorldAIDSday_report_2011_en.pdf

[27] Morris and Cilliers,"Viral Structure, Replication, Tropism, Pathogenesis and Natural History," 85.

[28] ibid.

[29] See: Landon Myer, "Barrier Methods," in *HIV/AIDS in South Africa*, ed. S.S. Abdool Karim and Q. Abdool Karim (New York et al.: Cambridge University Press, 2005); Catherine Mathews, "Reducing Sexual Risk Behaviours: Theory and Research, Successes and Challenges," in *ibid.;* David Cotzee and Leigh Johnson, "Sexually Transmitted Infections," in *ibid.*

[30] Hoosen 'Jerry' Coovadia, "Mother-to-Child Transmission (MTCT) for HIV-1," in *ibid.,* 187 ff.

virus continues to replicate, causing a gradual decline in CD4+T-Cells. When the immune system seizes to function, different opportunistic infections occur. In absence of treatment, the time span between infection and the onset of AIDS is estimated to be between eight to ten years in Europe. Death ensues generally 18 to 24 months after a patient is diagnosed with AIDS.[31] However, the time span between these stages may vary drastically from case to case. Differences in viral subgroups, personal health and access to clean water as well as health care are only some of the factors influencing the course of an infection. In addition to the course of disease being circumstantial, AIDS manifests in the patient's body in a variety of ways. Often overlooked but crucial to understanding each local discourse around AIDS, Acquired Immunodeficiency *Syndrome* describes a medical condition rather than a defined illness. The spectrum of malignancies HIV invites are in principal not limited and depend on the health context AIDS occurs in, even though globally certain infections occur more frequently than others. [32]

There are two possible ways to prevent the onset of AIDS. One is to avoid opportunistic infections by preventing the patient's exposure to them. This is not realistic for preventing all opportunistic infections. Some infections, such as tuberculosis and herpes, are latent after prior exposure and can be reactivated in case of an HIV infection. Some infections, such as candidacies, are common side effects of a weak immune system and thus cannot be prevented. Other measures include access to safe drinking water, food hygiene, malaria control and safe sex. Anti-retroviral therapy has yet proven to be most successful, as it can help to delay the progression to AIDS and prevent death by boosting the human immune system. While ARVs can be an effective medication, they are not curative and patients will need life-long treatment. The side effects are severe in almost all patients. Treatment often requires the patient to drastically change their diet and lifestyle. Adherence is of vital importance, as the virus is highly mutation prone and drug resistance is an increasing problem. Treatment failure, intolerance and toxicity are common, especially amongst pregnant and younger patients. Under ideal circumstances, patients can remain healthy for an unpredictable amount of time. In most cases, however, treatment does not prevent clinical events.[33]

Successful treatment also depends on the patient's age and state of immune system when treatment is started. This issue further highlights the importance of HIV testing.

---

[31] Morris and Cilliers,"Viral structure, replication, tropism, pathogenesis and natural history," 85.

[32] Susan Sontag, *AIDS and its Metaphors* (New York: Farrar, Straus and Giroux, 1989), 16.

[33] Robin Wood, "Antiretroviral Therapy," in *HIV/AIDS in South Africa*, ed. S.S. Abdool Karim and Q. Abdool Karim (New York et al.: Cambridge University Press, 2005).

Knowing one's HIV status is seen as the single most important factor to mitigate the effects of the disease, in order to ensure effective treatment and change in sexual behaviour. A wide range of testing methods is available today, but except for few advances in development of home-based tests, the clinical environment remains vital.[34]

In conclusion, HIV is exceptional in that its infection, disease patterns as well as successful treatment, are highly dependent on external factors. The wide spectrum of afflictions AIDS comes with, as well as the long periods of wellbeing in between infection and the onset of AIDS, makes it difficult for the patient as well as their partners to recognize an HIV infection, and therefore testing becomes vital. It also makes it impossible to give general statements about the appearance and shape of HIV, and thus about how people should react to the epidemic. A close look at the specific local setting HIV occurs in thus becomes essential for those studying the human handling of the epidemic.

2.2 HIV and AIDS in South Africa

Decoteau has recently pointed out how difficult it is to obtain a clear picture of the scope of the epidemic in South Africa, as surveys may drastically under- or overestimate statistics. Not only does it prove difficult to survey focus groups representative of a country as large and diverse as South Africa, but many test persons are either not willing to share their HIV status or are not aware of it.[35] While there has been a large increase in test takers over the last years due to private and governmental campaigns, only 37% of South Africans aged between 19 and 49 claimed to have taken an HIV test by 2010. With older age groups, particularly in men, numbers drop as as low as 5%.[36]

UNAIDS currently estimates there to be 5.6 million people living with HIV in South Africa. Mortality throughout South Africa has strikingly increased by more than 80% between 1997 and 2006, and HIV has had a significant contribution.[37] HIV prevalence is estimated to be at 10.6% in the general population, while prevalence rates amongst pregnant women surveyed in antenatal clinics are as high as 38.7% in some areas.[38] South Africa's overall HIV epidemic is defined as being hyper-endemic. According to

---

[34] Adrian Puren, "HIV Diagnostics," in *ibid.*, 89 ff.

[35] Decoteau, *The Bio-Politics of HIV/AIDS in Post-Apartheid South Africa*, 18 ff.

[36] Republic of South Africa. *Country Progress Report on the Declaration of Commitment on HIV/AIDS: 2010 Report*. 31 March 2010, accessed June 26, 2012, http://data.unaids.org/pub/report/2010/ southafrica_2010_ country_progress_report_en.pdf.

[37] UNAIDS, *Country Situation Report South Africa*, 2009, accessed June 26, 2012, http://www.unaids.org /en/regionscountries/countries/southafrica/.

[38] UNAIDS, *Country Situation Report South Africa*,

UNAIDS, hyper-endemic scenarios refer to those areas where HIV prevalence rates exceed 15% in the adult population and are driven through extensive heterosexual multiple concurrent partner relations with low and inconsistent condom use.[39]

More than 85% of all people infected in South Africa are infected during unprotected, heterosexual intercourse.[40] Currently, more than half of all infected are women and the trend leans even more towards women in the future. This imbalance is due to differences in women's biological, social and economic situation. Generally, transmission from men to women is estimated to be seven times higher than from women to men, due to anatomical and physiological differences between the different sexes.[41] Gender is of critical importance to women's risk of infection and their access to medical and social support. According to Quarraisha Abdool Karim, there is a pronounced imbalance between the sexes in access to and control over productive forces and resources in South Africa, which has its roots already in early adolescence. This economic imbalance directly translates into fewer rights for women in their relationships and families. Particularly in sexuality decision-making authority is generally in favour of men. Paradoxically, while these strategies are the least in control of women, they bear the sole responsibility of practicing safe sex, faithfulness within partnerships, testing, and preventing transmission to their children.[42] Frequently, women find it challenging to convince their partners to use condoms and have little control over their partner's sexual contacts, as approaching both subjects is associated with a lack of trust and infidelity.[43] As a result, long term relationships are no guarantee for protection. HIV-transmission within long-term relationships is constantly increasing and more than half of all infections in southern Africa are suggested to happen within marriage or co-habitation.[44] Women also tend to have less access to information and support in order to cope once infected with HIV.[45]

With women being more affected, the majority of work done on HIV prevention has been directed towards them. Gethwana Makahye has criticized that men have been

[39] Republic of South Africa. *Country Progress Report on the Declaration of Commitment on HIV/AIDS: 2010*; UNAIDS, *Terminology Guidelines*, 2011, accessed June 26, 2012, http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2118_terminology-guidelines_en.pdf, 17.

[40] Quarraisha Abdool Karim, "Heterosexual Transmission of HIV – The Importance of a Gendered Perspective on HIV Prevention," in *HIV/AIDS in South Africa*, ed. S.S. Abdool Karim and Q. Abdool Karim (New York et al.: Cambridge University Press, 2005), 243 ff.

[41] Abdool Karim, "Heterosexual Transmission of HIV," 252 ff.

[42] ibid., 245, 246.

[43] Myer, "Barrier Methods," 166.

[44] UNAIDS, *Global Report: UNAIDS Report on the Global Epidemic 2010*, 2010. Accessed June 26, 2012. http://www.unaids.org/documents/20101123_globalreport_em.pdf, 30.

[45] Abdool Karim, "Heterosexual Transmission of HIV," 247.

widely ignored by researchers and intervention programs, even though their power within South African society would offer possibilities to make a difference.[46] Isak Niehaus and Gunvor Johnson have confirmed this argument. In their research on the cosmology surrounding AIDS deaths amongst South Africans in the northern Lowveld, they found women generally to be more knowledgeable about biomedicine then men and still women accounted for the majority of AIDS-related deaths at their research site.[47] With a rising number of female patients, onward transmission through birth and breastfeeding pose an increasing problem. Maternal transmission rates are as high as 45% and there are currently 330,000 children aged 0 to 14 years living with HIV in South Africa.[48]

Overall it can be said that poverty generally increases the risk of HIV infection, which can account for why the majority of South Africans infected are Black Africans living in townships.[49] One of the reasons is that poor South Africans are often forced to migrate between rural and urban areas in order to make their living. As a consequence there has been an increase in multiple concurrent sexual partnerships amongst those migrating and those staying at home over the last years.[50] Also, people of lower economic status, mainly women, are more likely to use sex as a commodity in order to secure their own and their families' survival.[51]

The time from infection to AIDS is estimated to be two years shorter than in Europe, probably due to virological as well as socio-economic factors, such as limited access to health care and clean water.[52] The opportunistic infections most commonly associated with AIDS in South Africa is tuberculosis. Others include candidacies, pneumonia, herpes, diarrhoea, bacteraemia and malaria. As Gary Maartens has pointed out, their occurrence varies from area to area and from person to person. For example, Malaria is geographically restricted and patients in areas with no access to safe drinking water will

---

[46] Gethwana Makhaye, "Young Men," in *HIV/AIDS in South Africa*, ed. S.S. Abdool Karim and Q. Abdool Karim (New York et al.: Cambridge University Press, 2005), 313.

[47] Isak Niehaus and Gunvor Jonsson, "Dr. Wouter Basson, Americans, and Wild Beasts: Men's Conspiracy Theories of HIV/AIDS in the South African Lowveld," *Medical Anthropology* 24.2 (2005), 188.

[48] Coovadia, "Mother-to-Child Transmission (MTCT) for HIV-1," 183; UNAIDS, *Country Situation Report South Africa*.

[49] Decoteau, *The Bio-Politics of HIV/AIDS in Post-Apartheid South Africa*, 21.

[50] Mark Lurie, "Population movement and the Spread of HIV in South Africa," in *HIV/AIDS in South Africa*, edited by S.S. Abdool Karim and Q. Abdool Karim (New York et al.: Cambridge University Press, 2005), 308, 309.

[51] Abdool Karim, "Heterosexual Transmission of HIV," 247.

[52] Morris and Cilliers, "Viral Structure, Replication, Tropism, Pathogenesis and Natural History," 86.

be more exposed to agents causing diarrhoea. Also, some infections may be common collectively but uncommon individually.[53]

The high variability in patients' symptoms complicates prevention and treatment in South Africa. As exposure to latent opportunistic infections is extremely high in South Africa (approximately 80% of all South Africans have been infected with tuberculosis[54]) prevention is nearly impossible. Other measures such as the access to safe drinking water, food hygiene and malaria control become less feasible in those communities subjected to poverty and thus already subjected to more diseases.[55] In addition, several factors challenge the successful implementation of ARVs in South Africa. First, the government's long history of AIDS denialism has lead to a delay in wide-spread implementation of ARV's in international comparison. Only in 2003 did the government decided to provide free ARVs to its citizens through state healthcare.[56] Second, as South Africans remain the citizens paying the highest price for ARVs worldwide, the high cost is a major constrain in widespread implementation of drugs. Finally, South Africa's size in combination with its limited infrastructure poses another impediment, particularly in rural areas. While in theory, antiretroviral treatment is available all over South Africa, in 2009 UNAIDS reported several provinces as not being able to keep up with the demand in medication.[57]

Poor adherence is thought to be the major cause of treatment failure in South Africa. While under similar conditions adherence is comparable to that in European countries, external factors such as poverty, drug and alcohol abuse, communication barriers and irregularity in drug dispersion have all shown to negatively influence adherence.[58] Again, this especially affects those areas in South Africa more subdued to poverty and thus more prone to HIV and AIDS.

Overall, South Arica's HIV epidemic is in several respects marked by a high degree of uncertainty. First off, there is great uncertainty about the scope of the epidemic, amongst researchers as well as amongst South African's themselves. Many are not only unaware of their own status, but also of that of their kids, their partners and their

---

[53] Gary Maartens, "Prevention of Opportunistic Infections in Adults," in *HIV/AIDS in South Africa*, ed. S.S. Abdool Karim and Q. Abdool Karim (New York et al.: Cambridge University Press, 2005), 454 ff.

[54] Republic of South Africa, *Country Progress Report on the Declaration of Commitment on HIV/AID*, 12.

[55] Maartens, "Prevention of Opportunistic Infections in Adults," 454 ff.

[56] Salim S. Abdool Karim, "Introduction," In HIV/AIDS in South Africa, in HIV/AIDS in South Africa, ed. S.S. Abdool Karim and Q. Abdool Karim (New York et al.: Cambridge University Press, 2005), 35.

[57] UNAIDS, *Country Situation Report South Africa.*

[58] Wood, "Antiretroviral Therapy," 514.

friends. This does not necessarily change with the onset of AIDS, as many of the opportunistic infections AIDS invites in South Africa are common in the overall population, might have already been latent and must not necessarily signify an HIV infection. Because of this, there is also great uncertainty about infection, as HIV in South Africa is primarily transmitted through sexual intercourse and mother-child-transmission. Women and children especially have little or no control over the risks of infection. Finally, for those who have tested positive for HIV, treatment is often not available and successful treatment depends on the patient's health environment, as much as on the social and economic situation the patient is in.

2.3 Mutual Pandemics of AIDS and Poverty

As already noted above, the economic situation of individuals gravely influences their risk of getting infected with HIV as well as the outcome of their affliction. As Steinberg et al have written,

> "[n]o sector of the population is unaffected by the HIV epidemic, but it is the poorest South Africans who are most vulnerable to HIV/AIDS and for whom the consequences are inevitably most severe … in already poor households HIV/AIDS is the tipping point from poverty into destitution."[59]

In South Africa, poverty not only makes one vulnerable to HIV, but infection generally impairs poverty in poor households. Due to the close connection between poverty and HIV in South Africa, Decoteau has spoken of 'mutual pandemics of AIDS and poverty.'[60] Evidence points towards the HIV epidemic having drastic long term effects on South Africa's macro- and microeconomics.

The dependency of the South African economy on the course of the epidemic can be explained in reference to the age groups most affected by HIV. In contrast to most other epidemics, HIV is most prevalent in South African's aged 15 to 49. Men's prevalence in rural South Africa peaks in those aged 25 to 29, and women's prevalence is thought to reach its peak even five to ten years earlier.[61] This leads to increased illness and death amongst working-age adults. Illness of a worker may not only impact the quality of his or her work, but their education as well as possible training systems within

---

[59] Malcolm Steinberg et al., *Hitting Home: How Households Cope with the Impact of the HIV/AIDS Epidemic*, Washington DC: Henry J. Kaiser Family Foundation, 2002, accessed June 26, 2012, http://www.kff.org/southafrica/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14028, i

[60] Decoteau, *The Bio-Politics of HIV/AIDS in Post-Apartheid South Africa*, 18.

[61] Abdool Karim, "Heterosexual Transmission of HIV," 244 ff.

his work place. This often leads to an increase in costs and a reduction in profits for employers.[62]

The impact of the epidemic on South African households is even more severe. Households affected by HIV report less regular income and an overall loss of income. Almost half report not having enough food for themselves and their children. 55% report that they had to pay for a funeral in the last year. Funeral costs are on average four times as high as the total income of a household per year and families often have to pay for several in a row. This becomes an additional strain on the already burdened household budget. While many households would be eligible for some sort of government grants, only few access them.[63] Other direct costs for the household of patients result from health care, hygiene, medicine, transportation (to and from the hospital) and increased costs in food, electricity and water. In addition, relatives are often forced to leave their workplace in order to care for the sick. As a result, while South Africa's overall economy is growing, wealth is increasingly unevenly distributed.[64] Of all South African households 23% are considered indigent and 25% of South Africans are currently unemployed.[65]

The strain which such a high incidence rate in young people puts on the South African society cannot be overestimated. According to Dilger, another distinct attribute of HIV is,

> "the suffering and dying of young to middle-aged men and women – as well as the children that survive them – who are most affected by the epidemic and who are the centre of the social and moral orders of their families, communities and he larger state formations they inhabit. What makes AIDS so exceptional from this perspective is that the disease has the power to challenge the "habitual" of everyday life and that it has become a disruptive and morally disturbing force in the productive and reproductive orders of kinship networks, community constellations and society at large."[66]

Out of numerous examples that could be listed, only few suffice to give an impression of the enormous impact the epidemic has on South African society. For example, HIV is an added burden on what is already a struggling healthcare system – to the extent that there is not only an increase in AIDS related deaths, but also in those patients not HIV

---

[62] Alan Whiteside, "The Economic Impact of AIDS," in *HIV/AIDS in South Africa*, ed. S.S. Abdool Karim and Q. Abdool Karim (New York et al.: Cambridge University Press, 2005), 405 ff.

[63] ibid., 416.

[64] ibid., 405.

[65] Decoteau, *The Bio-Politics of HIV/AIDS in Post-Apartheid South Africa*, 20; Statistsics South Africa, Quarterly Labour Force Survey: Quarter 3 (July to September), 2001. Accessed June 26, 2012. http://www.statssa.gov.za/publications/P0211/P02113rdQuarter2011.pdf.

[66] Dilger, "Morality, Hope and Grief," 2, 3.

positive. The public healthcare system often can no longer provide for them.[67] Also, there has been a drastic increase in single-parent households. While the concept of a single parent is not new to South African culture, today the single parent is often a grand-mother, taking care of her children's children, or a firstborn child, which has become the main caregiver to its siblings.[68]

As Janet Frohlich argues, "AIDS is accomplishing a sweeping undoing of the liberation of the South African people in their new democracy and the advances made in the social upliftment and development of the country."[69] Due to its devastating social and economic implications, especially for poor black South Africans, the HIV crisis has been time after time compared to Apartheid.[70] Whether this drastic comparison is expedient or not, it signals not only the devastating effects on the already more disadvantaged part of African society, but also the political challenge with which the post-Apartheid government is confronted. More than anything else, the future distribution of power in South Africa will depend on the outcome of the crisis. In this regard, the comparison might also hint at the extent to which the international community feels obligated to intervene, in case South African politics does not react to the epidemic adequately. As Thabo Mbeki's politics of AIDS denialism until 2004 and the following international outrage have shown, what is adequate in a crisis of health is not universally standardised. The following chapter will trace back the South African history of health and healthcare in order understand current debates on HIV and AIDS and to set them in perspective with the struggle of those affected worst by the epidemic.

3. 'Accurate' Knowledge on HIV

In its country situation report of 2009, one of the "notable challenges" UNAIDS identified for the South African context in the fight against HIV and AIDS was a "decline in knowledge levels across all age groups." According to the report,

> "Only 30% of male youth (aged 15-24 years) and 27% of females of the

---

[67] Mark Colvin, "Impact of AIDS – The Health Care Burden," in *HIV/AIDS in South Africa*, ed. S.S. Abdool Karim and Q. Abdool Karim (New York et al.: Cambridge University Press, 2005), 336.

[68] Janet Frohlich, "The Impact of AIDS on the Community," in *HIV/AIDS in South Africa*, ed. S.S. Abdool Karim and Q. Abdool Karim (New York et al.: Cambridge University Press, 2005), 351.

[69] ibid., 368.

[70] See for example: Chris McGreal, "AIDS: South Africa's New Apartheid," *The Guardian*, November 30, 2000., accessed June 26, 2012, http://www.guardian.co.uk/world/2000/nov/30/aids. chrismcgreal.; Phillippe Riviere, "South Africa's AIDS Apartheid: In Denial about a Deadly Future," Le Monde Diplomatique English Edition, August, 2002, accessed June 26, 2012, http:// mondediplo.com/2002/08/04aids/

same age group can correctly identify ways to prevent sexual transmission of HIV and reject major misconceptions about HIV transmission."[71]

The report relies on data from the *South African National HIV Prevalence, Incidence, Behaviour and Communication Survey of 2008*. The survey was financed by the United States President's Emergency Plan for AIDS Relief under President George W. Bush and UNICEF and was the third in a series of national population-based surveys conducted for surveillance of the HIV epidemic in South Africa. As part of the survey, more than 23,000 South Africans were tested and interviewed about their "Knowledge on HIV/AIDS." According to the survey this was important to evaluate, as "knowledge of various aspects of HIV/AIDS allows for appropriate actions to be taken in relation to prevention."[72] In order to measure South African's "accurate knowledge" on HIV/AIDS, interviewees were first asked to answer two questions and then to reject four 'myths and misconceptions' about the disease.

> "The two questions on prevention of HIV transmission were
>
> 'To prevent HIV infection, a condom must be used for every round of sex' and 'One can reduce the risk of HIV by having fewer sexual partners'
>
> while the four questions about myths and misconceptions were
>
> 'There is a cure for AIDS',
> *'AIDS is caused by witchcraft'*,
> 'HIV causes AIDS',
> and 'AIDS is cured by having sex with a virgin'.
>
> In terms of knowledge about prevention of HIV transmission, if a participant answered both questions correctly they scored '1', whereas if they answered any of the two questions incorrectly they scored '0'. Concerning misconceptions about HIV transmission, if a participant answered all four questions correctly they scored '1', whereas if they answered any of the four questions incorrectly they scored '0'."[73]

If we trust McGregor's biography and if we assume he would have spoken his mind, it is fairly safe to assume that, had Fana Khaba been amongst the 23,000 South Africans interviewed, he would have scored zero points. He would have been counted towards the majority of 25 to 49 year old males with inaccurate knowledge of HIV/AIDS.[74] Despite his detailed biomedical knowledge, identifying the 'myth' of witchcraft causing

---

[71] UNAIDS, *Country Situation Report South Africa*.

[72] Human Sciences Reasearch Council, *South African National HIV Prevalence, Incidence, Behaviour and Communication Survey of 2008*: A Turning Tide Amongst Teenagers? (Cape Town: HSRC Press, 2009), 51.

[73] ibid., 51 (italics by Laura Pöhler).

[74] Human Sciences Reasearch Council, *South African National HIV Prevalence, Incidence, Behaviour and Communication Survey of 2008*, 53.

AIDS as correct would have disqualified one of South Africa's most famous proponents of HIV prevention.

Unfortunately, the online evaluation does not indicate how many interviewees were able to answer both questions on prevention correctly, but nevertheless scored zero points for identifying witchcraft as a cause of AIDS. Hence, the outcome cannot necessarily be construed as a 'decline in knowledge level' amongst South Africans. Rather than to provide information on how many South Africans can 'correctly identify ways to prevent sexual transmission', it tells us about how many South Africans were able to do so, while at the same time rejecting what the survey identifies as 'major misconceptions'.

It could be argued that the survey tells us less about South African's knowledge on HIV than about what is considered 'accurate knowledge' by those in power to design international surveys. For this thesis, it is noteworthy that out of four South African 'myths' chosen for the survey, one refers to witchcraft. This inclusion into a major survey further indicates awareness about the significance of this discourse concerning HIV and AIDS in South Africa, even on an international level. While the survey does not specify the meaning of "is caused by witchcraft", it clearly opposes the correlation of witchcraft and AIDS to 'accurate' – that is biomedical - knowledge on HIV. From the evaluation it can also be taken that it is assumed that biomedical knowledge does not allow for any other knowledge on HIV. This survey assumes that biomedical education necessarily comes with orthodoxy.

Since knowledge about HIV does indeed 'allow for appropriate actions to be taken in relation to prevention', surveys like the one above must be evaluated carefully in order to translate them into effective public health interventions. The *South African National HIV Prevalence, Incidence, Behaviour and Communication Survey of 2008*, however, is not a one-time result of a defective questionnaire. The confrontation of biomedical and indigenous health knowledge has a long legacy, which is inextricably linked with South Africa's colonial past. The following chapter will trace back this legacy to early colonialism, when European and African forms of health care first faced each other in a time of high imperialism. The historical reconstruction of today's notion of incommensurability offers the possibility of a distinction between those ideas dominating the discourse on HIV in post-Apartheid South Africa and the everyday health choices made by those affected by the epidemic.

3.1 The Work of Evil Agents

Pre-colonial healthcare was closely connected with religious life in southern African societies, so in order to understand southern African notions of illness one must first understand the religious system. This leaves the scholar of religion with an intricate task. As Chidester has convincingly argued in *Savage Systems*, "[i]n southern Africa comparative religion was conducted on frontier battlefields. Comparisons were not merely intellectual exercises. They were entangled in the European conquest and subjugations of Africans."[75] While this process did not only involve imperial scholars and European observers, but indigenous comparativists alike, their voices left in colonial records are equally entangled in frontier situations. As a result, "[n]o pure, precontact position can be recovered for our return."[76] In order to achieve a critical perspective on the pre-colonial religion in South Africa, it cannot be separated from the colonial discourse in which it finds its academic origin.

This becomes already evident in the challenge to find a term in order to discern southern African religion from other religious traditions present in today's South Africa. Generally referred to as 'traditional' religion, this term underestimates and somewhat disguises the dynamic, changing and creative nature of religion in South Africa. The same is applicable when 'traditional' is used to discern forms of African healthcare. The association of African culture with 'tradition', rather than 'modernity', is in itself part of the history of confrontation explored in the following chapter. Thus, the terms 'indigenous' and 'African' are preferred over 'traditional' in this thesis in order to highlight the fluid nature of both South African religion and healthcare. This decision, however, is partly reached due to lack of a better term, as the classifications 'indigenous' as well as 'African' raise problematic questions about historical and regional particularities, as well as about processes of cultural appropriation.

With this being said, certain religious elements in South Africa are assumed to have had a fairly long history. Although there are historical and regional differences in healing ontologies, several authors have suggested that the similarities across southern Africa outweigh these differences.[77] Besides a widespread belief in a high god or deities,

---

[75] Chidester, *Savage Systems: Colonialism and Comparative Religion in Southern Africa* (Charlottesville et al.: University Press of Virginia, 1996), 219.

[76] ibid., 29.

[77] David Chidester, *Religions of South Africa* (London et al.: Routledge, 1992), 2, 3; See also: John M. Janzen, *Ngoma: Discourses of Healing in Central and Southern Africa* (Berkeley: University of California Press, 1992); John M Janzen, "The Need for a Taxonomy of Health in the Study of African Therapeutics," *Social Science and Medicine* 15.3 (1981); Edward Green, *Indigenous Theories of Contagious Disease* (London: AltaMira, 1999); Philip Setel et al., ed., *Histories of Sexually Transmitted Diseases and HIV/AIDS in Sub-Saharan Africa* (Westport, CN: Greenwood Press, 1999)

religious life in southern Africa first and foremost concentrated on the ancestors (in Zulu: *amakhosi*)[78] - deceased relatives who continued to watch over the living by bestowing their blessings. The ancestors, according to Bolaji Idowu, were "living persons' kith and kin".

> "Because they have crossed the borderland between this world and the supersensible world, entering and living in the latter, they have become freed from the restrictions imposed by the physical world. They can now come to abide with their folk on earth invisibly, to aid or to hinder them, to promote prosperity or to cause adversity. To some extent, they are intermediaries between Deity or the divinities and their own children"[79]

Their intermediate position turned them into "factors of cohesion in African society."[80] One could even go so far as to claim that only the interaction with one's ancestors made an individual human. The sustained interaction with the ancestors separated the domestic order of the human world from the wild, uncontrollable outside world.[81]

Chidester has outlined three basic domains of power within which South African religion operates: The homestead, the chiefdom and the disciplines of sacred specialists. Within the domestic sphere of the homestead, the living were connected to the ancestors through rituals invoking their blessings. In return, the ancestors maintained the domestic order and protected the homestead from the dangerous outside. The world outside not only held natural dangers like wild animals, but evil forces that incessantly threatened to unsettle the homestead. In between the domestic order and the wild outsides was an ambivalent border zone. From this interspace humans could contact evil forces, fight them if necessary and the wild could use it as an entrance to the domestic. When evil entered the homestead in forms of ill health or misfortune, it could either be the consequence of displeased ancestors or of evil agents, which maliciously had called upon evil forces to disrupt the domestic order.

The chiefdom encompassed several homesteads. This second domain of power represented power relations which were simultaneously political and religious in nature. The chief was responsible for the political, legal and military order as well as for the ritual strengthening of the community against evil outside forces.

---

[78] The translation of southern African religion into the English language is, as will be illustrated on the term 'witchcraft' below, part of the history of confrontation that is described in this thesis. As there are over 80 languages spoken in the area of what is the Republic of South Africa today, this thesis cannot include a complete listing of correspondent native terms. As the Zulu are the largest ethnic group in the country today, Zulu terms are included in brackets.

[79] Idowu Bolaji, *African Traditional Religion: A Definition* (London: SCM Press, 1973), 184.

[80] Bolaji, *African Traditional Religion*, 185.

[81] Chidester, *Religions of South Africa*, 4.

Finally, serving both the homestead and the chiefdom with their spiritual power, sacred specialists held a powerful marginal position within society. Diviners claimed access to the spiritual realm, which allowed them to contact the ancestors and fight the evil threatening to break into the domestic.[82]

Within indigenous religion ill health could be accounted for as part of a highly developed 'symbolism of evil.' Generally, disease could be due to natural causes such as aging or overwork. It could also be caused by the ancestors for violation of ritual obligations. In such cases, the person afflicted would be held personally responsible for their situation. In addition, however, illness or misfortune suffered by innocent people could also be accounted for as the work of evil agents.[83] Today generally referred to as 'witches'[84], these evil agents (*abathakathi*) deployed superhuman power to contact the dangerous wild and to invite evil forces into an otherwise shielded human world. With the help of spirits, demons and witch familiars they would harm people and their property.[85]

Due to the close connection of evil and ill health, healing constituted an important part of the religious practice. In the 19th and early 20th century, South Africans suffering from ill health generally consulted with a herbalist or a sacred specialist. Albeit their arts sometimes overlapped, two different kinds of healers could be distinguished. Herbalists (*izinyanga*) could be described as medical doctors specializing in indigenous medicine and healing technique. They had extensive knowledge on herbs and plants which they made available to others. Diviners (*izangoma*) were sacred specialists in addition to being herbalists. Both men and women could enter into the role of the diviner, though depending on the region one or the other tended to be more common. They became qualified through an intensive process of initiation. In order to be a sacred specialist, one had to be called to his profession by his ancestors (*ukubiza*). This call manifested itself in illness or anxiety.[86] Only after a person is healed and trained (*ukuthwasa*) through

---

[82] Chidester, *Religions of South Africa*, 4, 5.

[83] Matthews A. Ojo, "Healing in Sub-Saharan Africa." in *Encyclopaedia of African-American Religions*. ed. Stephen D. Glazier (New York, London: Routledge, 2001), 139.

[84] Throughout the thesis, the term 'witch' will be used to signify what is described above as 'evil agents, which maliciously call upon evil forces to disrupt the domestic order', and 'witchcraft' to signify practice exercised by 'evil agents'. This choice was not made in order to ignore the entanglement of these terms in colonial and post-colonial discourse (as discussed further below), but rather to ensure comprehensibility. The current use of these terms in South Africa will be discussed further in Chapter 5.

[85] Chidester, *Religions of South Africa*, 13 ff.

[86] Decoteau, *The Bio-Politics of HIV/AIDS in Post-Apartheid South Africa*, 73.

a senior diviner (*gobela*), the trainee is publicly tested and initiated as a diviner themselves into the community.

In addition to their healing abilities diviners held the power to ascertain whether illness and misfortune was a result of natural causes, displeased ancestors or the work of witches. This talent not only allowed them to protect, strengthen and heal their clients, but also to identify sources of evil and wrongdoing within South African society. It also made sacred specialists powerful arbitrators of the indigenous political and legal systems. In Zulu society, for example, individuals suspected of contacting evil forces and disrupting the domestic order were brought before the chief and his diviner. The diviner then 'sniffed out' the alleged witch in front of the community (*umhlahlo*). Once identified, the culprit faced immediate justice through punishment and sometimes execution.[87]

Due to southern African cosmology, healthcare and religious systems could not be clearly distinguished as separate systems. Indigenous medical theory and practice involved the total social and spiritual order rather than the patient and their ailments only. This conjunction was embodied in the role of the diviner, who wielded great power within southern African society. When Europeans sought after controlling southern African societies, it was the diviner whose power they had to face.

3.2 Medicine as Colonial Statecraft

In order to understand the colonial developments which resulted in the ideological confrontation of biomedical and indigenous health care, it is useful to ask where European concepts of public health originate from and how they came to be so powerful that by the 20th century, they had been exported from Western Europe to the rest of the world. Paul Slack has traced its origins back to the city states of northern Italy in the late 14th and early 15th century. The Black Death, one of the most devastating epidemics in history and followed by several further epidemics, is nowadays estimated to have killed up to 60% of Europe's population.[88] Early health commissions initially emerged in order to curb its immense threat to the city states. Different from modern health panels, these commissions were made up of influential citizens, politicians and clergymen, as Slack points out. Physicians were not made part of health panels until the

---

[87] Karen Flint and Julie Parle, "Healing and Harming: Medicine, Madness, Witchcraft and Tradition." in *Zulu Identities*, ed. Benedict Carton et al. (London: Hurst, 2009), 314; Chidester, *Religions of South Africa*, 18.

[88] Suzanne Austin Alchon, *A Pest in the Land: New World Epidemics in a Global Perspective* (Albuquerque: University of New Mexico Press, 2003), 21.

16th century and thus played little role in establishing early public health policies. Instead, Italian models of public health owed much of its success to the medieval Christian insistence that epidemics were divine punishment for human sin.

> "The Christian notions off original sin and divine chastisement [...] predisposed men to action: to search out the targets of epidemics, often to find scapegoats, but also to identify the physical as well as moral source of disease – unruly public assemblies, vagrants and beggars, disorderly slums."[89]

It was imagined that the cause of any epidemic could be identified within society and remedied. Those already condemned by society usually served as scapegoats and as a result, disease was associated with poverty, dirt and foreignness. By setting up isolation-hospitals within the city walls and by shutting off the city states to the outside world, the first health commissions tried to purify the enclosed city states of its sinners.

Isolation, while not exclusively by divine assistance, proved successful and by the 17th century, the Italian method of regulating public health had spread all over Europe and Russia. In the 19th century European public health concepts, along with European fears of paupers and foreigners as a source of disease, were being exported to the African colonies. Rajnarayan Chandavarkar has stressed how early public health interventions in colonies were often "reflecting imperialist concerns – about manpower and national degeneration at home, and about 'native' dangers abroad" rather than the reality of public health in the colonies.[90] He has strikingly illustrated this claim in an essay on the bubonic plague outbreak in India under British colonial rule around the turn of the 20th century. The disease prompted massive state intervention, which, according to the author, "often bore no direct relation to the virulence of the epidemic." Thought of as a 'disease of filth, a disease of dirt, a disease of poverty', the colonial regime was paranoid about the 'Indian' disease spreading to Europeans. As a result of Britain's fierce but misguided public health intervention, mortality exploded and enormous resistance built up amongst the indigenous population. According to Chandavarkar, underlying these events is the paradox of the 19th century, which "was a period of enormous self-confidence in medical science and, particularly, in its newly founded and burgeoning branch of tropical medicine", but at the same time, "the

---

[89] Paul Slack, "Introduction," in *Epidemics and Ideas*, ed. Ranger Terence Ranger and Paul Slack (Cambridge: Cambridge University Press, 1992), 17.

[90] ibid., 13.

measures adopted by the colonial state at the turn of the twentieth century remained highly reminiscent of the Black Death."[91] He continues,

> "Public health policies had been often conceived as the application of modern, scientific knowledge among people who were not only ignorant of the principles of hygiene, but whose traditions and modes of life were violated by them [...] It was their privileged access to knowledge and their ability to implement it with an incorruptible justice which legitimized their harshest, most vigorous measures[...]Sanitary and medical science was as integral and critical to the official perception of their statecraft as education and justice."[92]

Disguised under the cloak of 'scientific truth', but highly reminiscent of attempts to purify Christian realms of human sin in Italian renaissance, public health constituted an essential part of 19th century colonial enterprise.

Within South Africa, medicine was also an integral part of colonial statecraft. From the point when missionary penetration became well established in southern Africa, medical appointments and later forceful interventions in public health were seen part of a project of 'humanitarianism,' as Anne Digby has described in her history of medicine in South Africa.

> "Legitimation of colonial rule was assisted by the successes of biomedicine as part of what has been termed a 'constructive imperialism' during the second half of the nineteenth century, when hospitals were seen as an index for the advance of western civilization. [...] Equally, an association of disease with the indigenous population was a powerfully divisive factor in contributing to a conceptualization of African society as backward."[93]

From the beginning, indigenous forms of health care were viewed as competitive rather than complementary. The hospital not only separated 'modernized' from 'traditional' Africa, but it also served as a place of separating Africans themselves. The 'unflawed' success of biomedicine was thought of as a forceful argument for the superiority of the Christian god. Not by accident were many hospitals part of a Christian mission. As Alexander Butchart has described, the mission hospital was "constituting a sharp line of separation between two great systems of power [...] African bodies crossed this

---

[91] Rajnarayan Chandavarkar, "Plague Panic and Epidemic Politics in India, 1896 – 1914," in *Epidemics and Ideas*, ed. Ranger Terence Ranger and Paul Slack (Cambridge: Cambridge University Press, 1992), 204, 205.

[92] ibid., 214.

[93] Anne Digby, *Diversity and Division in Medicine: Health Care in South Africa from the 1800s* (Oxford et al.: Peter Lang, 2006), 30, 31.

threshold separating superstition and magic from salvation and science.”[94] The hospital was thus a site for healing, but also a site of conversion.

3.3 Taking Away the Political Engine

As Karen Flint and Julie Parle have suggested for the South African context, it was particularly their anti-witchcraft function which made Zulu diviners an early target for colonial intervention. To highlight this claim, they cite British South African administrator Theophilus Shepstone, who was also very knowledgeable in Zulu language and culture.

> “Making a direct connection between the ‘supernatural’ power of African healers to unveil *abathakathi* and the powers of the chiefs, particularly the hereditary chiefs, Theophilus Shepstone stated in 1881: ‘With independent native tribes the witchdoctor becomes a political engine in the hands of the chief. For instance, if the chief fears a strong member of his tribe, it is only necessary for him to induce the witchdoctor to point him out publicly as guilty of witchcraft to accomplish his ruin.’ In 1892, he stated his objective more bluntly: ‘Take away the engine and nothing will be left to lean upon but the power of the government.’”[95]

As Shepstone’s remarks illustrate, colonial administration in the 19th century were conscious of the connection between the diviners’ ability to identify witches and witchcraft and their political power within indigenous society. To take away the engine thus became a necessary step in order to break down indigenous resilience.

Shepstone’s words also premise further ideas of witchcraft, which had strong influences on the way colonial admissions attempted to curb the influence of diviners. To begin with, it can be understood from his comment that Shepstone did not believe in the realty of witchcraft. Rather, in his account the public accusation of witchcraft through the diviner becomes a vehicle of exercising indigenous political power, ‘a political engine in the hands of the chief.’ Furthermore, Shepstone refers to what was above described as ‘evil agents, which maliciously call upon evil forces to disrupt the domestic order’ with the English term ‘witchcraft’. In 1881, the indigenous symbolism of evil had been translated by the British with the English term ‘witchcraft’. Finally, and also of great importance to this thesis, Shepstone refers to the diviner with the English term ‘witchdoctor’. This is curious given that the diviner, as described above, was a sacred specialist who, due to his special knowledge, could identify those who practiced evil in indigenous society and undo their harm by fighting the wild outsides. The term

---

[94] Alexander Butchart, *The Anatomy of Power: European Constructions of the African Body* (London: Zed Books, 1998), 85.

[95] Flint and Parle, “Healing and Harming,” 314.

'witchdoctor', however, also suggests that the indigenous healers might not limit themselves to curing the effects of evil in their society, but that they were in fact the ones who practiced the evils of 'witchcraft' themselves. In colonial translation, sacred specialists were lumped together with agents of evil.

In combination these three assumptions correlate with the paradoxical nature of colonial anti-witchcraft legislations. While witchcraft was a crime in southern African society, to the colonial administration it was superstition As a result, witchcraft accusations became a political scheme and those who convicted witches became killers, which had to be eliminated in order to safeguard innocent victims and secure imperial power.[96] As Pels has suggested, the translation into the European term 'witchcraft' confirmed European presumptions of the irrationality of indigenous notions of evil.

> "Its effects of power are evident, since the English `witchcraft´ associates
> African practice with a European past (thus distancing it), while burdening
> it with connotations of femininity (disempowering it) and irrationality
> (disallowing it)."[97]

In a similar manner, the term 'witchdoctor' designates that the indigenous diviner, while claiming to be a 'doctor', was in fact opposing biomedical science by practicing religion, thus distancing, disempowering and disallowing indigenous health care. The term 'witchdoctor' also hints at a different kind of colonial fear – that the diviner would transgress his therapeutic skills and practices the evils of witchcraft. The imperial enterprise thus benefitted from witchcraft-legislations in two ways: On one hand it marked an attempt of the colonial administration to take over the indigenous legal system, as controlling evil forces was essential to indigenous legal power. On the other hand, witchcraft legislations served as a means to control sacred specialists and thus 'to take away the engine.'

While in the second half of the 19th century colonial administrations were mainly concerned with protecting alleged witches, from the mid-1860s the focus slowly shifted to outlawing healers and prohibiting 'witchcraft' itself.[98] Around the turn of the century, British colonial administration in South Africa systematized the legal control of witchcraft in several anti-witchcraft laws. The earliest laws were passed in 1886, 1887 and 1895 in Natal, Zululand and the Cape of Good Hope, respectively. Penalties ranged

---

[96] Karen E. Fields, "Political Contingencies of Witchcraft in Colonial Central Africa: Culture and State in Marxist Theory," *Canadian Journal of African Studies*, 16.3 (1982): 572.

[97] Peter Pels, "The Magic of Africa: Reflections on a Western Commonplace," *African Studies Review*, 41.3 (1998): 201.

[98] Flint and Parle, "Healing and Harming," 314.

from 2£ to 10£ and up to three month imprisonment. The laws served to punish both the practice of witchcraft as well as the identification of witchcraft.[99]

By avoiding any clear definition of 'witchcraft' the legislations allowed for broad interpretations in favour of the prosecutor. The Witchcraft Suppression Act of 1895 passed in the Cape of Good Hope illustrates these laws' schizophrenic nature.

> "Witchcraft. THE Witchcraft Suppression Act, 1895 (No. 2), imposes a penalty on whoever -
> (a) Imputes to any person the use of non-natural means in causing any disease in any person or animal, or in causing any injury to any person or property, *i.e.* names or indicates any other person as being a wizard or witch;
> (b) Having so named or indicated any person, is proved to be by habit or repute a witch doctor or witch finder;
> (c) Employs or solicits any witch doctor or witch finder to name or indicate any person as a wizard or witch;
> (d) Professes a knowledge of so-called witchcraft, or of the use of charms and divinations, or undertakes to advise any person applying to him how to bewitch or injure any other person or their property, including animals;
> (c) On the advice of a witch doctor or witch finder, or in the exercise of any pretended knowledge or witchcraft, or of the use of charms, uses or causes to be put into operation such means or processes as he may have been advised, or may believe to be calculated to injure person or property.
>
> Money received as payment or reward for witchcraft is to be deemed to have been obtained by false pretences."[100]

This law not only condemns whomever "*names* or *indicates* any other person as being a wizard or a witch", but whomever "is proved to *be* by habit or repute a witch *doctor* or witch *finder*", whomever "professes a *knowledge* of so-called witchcraft" and whomever acts "on the *advice* of a witchdoctor" alike. From a post-colonial perspective, it seems almost like the colonial administration could not decide whether to believe in witchcraft or not.

The fact that the legislations avoided a clear statement about whether witchcraft was real or not and a clear definition of what exactly constitutes 'witchcraft', did not go unnoticed by those accused of practicing it. Anne Digby has illustrated an example for this from the Bechuanaland Protectorate (today's Botswana), where "three Tswana chiefs protested against the fluid and wide-ranging character of the proclamation of 1927, in a meeting in Cape Town with the British High Commissioner."

> "'Chief Tashekedi [from Bechuanaland] began by remarking that 'We do

---

[99] Isak Niehaus, "Witchcraft in the New South Africa. From Colonial Superstition to Postcolonial Reality?" in *Magical Interpretations, Material Realities*, ed. Henrietta L. Moore and Todd Sanders (London et al.: Routledge, 2001), 186.

[100] Ilbert Courternay, "Legislation of the Empire," *Journal of the Society of Comparative Legislation*, Vol. 1 (1896 - 1897): 90.

not understand the recent law on the subject. It is a difficult law to consider because we cannot find what is meant by witchcraft.' The high commissioner's reply to the chiefs' representations was presented in a very lengthy prepared 'Address', whose didactic paternalism was obviously intended to silence opposition. It revealed that British imperial authority viewed biomedicine as the only medicine, although 'the Proclamation is not intended to interfere with honest persons who use medicines for the purpose of curing their fellows. [...] Although the government does not think that honest African doctors do much good with the medicines they give the Africans, it is not proposed to forbid them treating their African patients, provided they do not indulge in malicious practices'"[101]

While it seems almost comical that those accused of witchcraft express their bewilderment about the mere term itself, the conversation in fact clearly points towards the legacy of colonialism for today's discourse on HIV and AIDS in South Africa. The high commissioner's reply indicates that African doctors not only could often be found 'indulging in malicious practices' but that even 'honest African doctors', those who use medicine not for witchcraft but 'curing', did not 'do much good'.

Despite the severity of colonial witchcraft legislations, they were often not followed up upon. Throughout the colonial regime, sacred specialists continued to hold an important position in South African society. Karen Fields has suggested that the colonial regime depended in part upon their indigenous legal authority, as they could not afford to rule solely by force. As a result, diviners often remained as accepted African authorities and paradoxically helped to establish the civilizing mission.[102] Their continued existence and influence, however, did not lead to the recognition of their therapeutic, medical or physiological services to indigenous society. Traditional healthcare was condemned by the colonial administration and biomedical health care was seen as the only legitimate form of health care. This confrontation also becomes apparent in the English misnomer of 'witchdoctor', which was applied by colonial missionaries, administrators and medical practitioners to their African counterparts.

3.4 Apartheid

By implementing the segregation of citizens and subjects within the South African state, Apartheid reproduced and amplified colonial ideology in that it ideologically and physically separated two forms of healing. Indigenous healing was tolerated but ridiculed, and biomedical health care was the only legitimate form of health care. Biomedicine continued to serve as statecraft, as 'hygiene' considerations were the

---

[101] Digby, *Diversity and Division in Medicine*, 320, 321.

[102] Fields, "Political Contingencies of Witchcraft in Colonial Central Africa," 569.

primary rationale offered for physical segregation. Belinda Bozzoli has pointed out that the physical segregation of white citizens and subjects of colour in the early 20th century was initially justified with the idea that Africans in urban areas posed a health risk for the white population.

> "In a coincidence of racial symbolism and caste-like purity, it was sometimes said to be necessary to build such townships because of the dire problems of health and disease caused by inner city slum growth - the 'sanitation syndrome' as it has been called."[103]

The 'rural' African, believed to be incapable of his own hygiene in an urban environment, was removed from the city centres into townships, where his prone-to-disease-lifestyle could no longer endanger the 'modern' white man.

But townships were also the centre of contradiction in the Apartheid field of health and healing. While the perception of African medical system as inferior offered a justification for apartheid politics, in order to uphold the Apartheid system, the labour force it depended upon had to be reproduced and thus minimal health care had to be ensured. [104] This led to the establishment of clinics in townships, which would introduce large sections of the southern African population to biomedical forms of health care for the first time. In addition, while earlier colonial witchcraft legislations were amended during Apartheid in 1957 and again 1970, much like in colonial times these laws were not strictly enforced. Diviners were needed in order to secure indirect rule and keep up a minimum standard of health care.[105]

Frantz Fanon has suggested that medicine may become a site of political contestation in that colonized subjects reject biomedicine as it represented a tool of Western domination which threatens the established social and cultural identity.[106] According to Anne Digby, there is no evidence for this in South Africa. Colonized South Africans had never rejected biomedicine in general. Digby stresses that the binary opposition of 'western' vs. 'African' medicine, exaggerates the separateness of the systems themselves. [107] Practitioners from both sides selectively appropriated from each other, for instance, indigenous healers appropriated pharmaceutical drugs in their healing. Also, as Chidester has observed, the emphasis on health care for South Africans

---

[103] Belinda Bozzoli, "Why were the 1980s 'Millenarian'? Style, Repertoire, Space and Authority in South Africa's Black Cities," *Journal of Historical Sociology* 13.1 (2000): 82.

[104] Fields, "Political Contingencies of Witchcraft in Colonial Central Africa," 569.

[105] Decoteau, *The Bio-Politics of HIV/AIDS in Post-Apartheid South Africa*, 62-64; Bozzoli, "Why were the 1980s 'Millenarian'?," 82 ff.

[106] Frantz Fanon, *A Dying Colonialism* (New York: Grove Press, 1965), 121 ff.

[107] Digby, *Diversity and Division in Medicine*, 32.

with otherwise limited access to alternatives altered indigenous healing practices. "In many cases, [...] the criminological work of the sacred specialist was replaced by an exclusive emphasis on the medical and psychological services."[108] Similarly, biomedical practitioners from the very beginning showed a strong interest in indigenous use of plants and animals, especially those potent against 'tropical' diseases. Generally, as already pointed out above, indigenous medicine was perceived as obscurantist.

In her analysis of the South African field of health and healing, Decoteau has made a point that the prevalent usage of both health care systems during apartheid did not signify a merging of the segregated fields of healing.

> "Due to the structure of the apartheid system, indigenous healing was institutionally, spatially and ideologically circumscribed as 'traditional', i.e. tribal. Because it belonged, according to apartheid logic, to the 'Bantu', it was materially and symbolically isolated into its own sphere of practice, segregated wholly and completely from the biomedical, 'modern' health system, which was only made available to Africans in order to preserve their labour power. Each form of healing constituted its own field until the breakdown of the apartheid system."[109]

While indigenous healing was largely tolerated as an important part of African culture, it was ridiculed and remained "peripheral, informal, and ostracized [...], utilized clandestinely by the African population."[110]

3.5 Merging of the Fields

The transition to a democratic, post-Apartheid South Africa asked for the division between biomedical and indigenous fields of health care to be merged into one 'South African' field as part of the effort to resolve the segregation of white citizens and subjects of colour. Former categories of segregation, such as 'white' and 'coloured' and 'black', 'modern' and 'traditional', 'European' and 'African', had to be reconciled together as 'South African'. This step was also necessary in order to legitimize the new African government, as more than 80% of South Africans had primarily utilized indigenous forms of health care until the breakdown of Apartheid.[111]

Shortly after being elected into office, the ruling African National Congress published a *National Health Plan for South Africa*. With this plan the government

---

[108] Chidester, *Religions of South Africa*, 20, 21.

[109] Decoteau, *The Bio-Politics of HIV/AIDS in Post-Apartheid South Africa*, 66.

[110] ibid., 63.

[111] ibid., 67, 68.

formalized its idea to integrate indigenous forms of healthcare, as can be seen from the following excerpt regarding 'Traditional Practitioners.'

> "Traditional healing will become an integral and recognised part of health care in South Africa. Consumers will be allowed to chose whom to consult for their health care, and legislation will be changed to facilitate controlled use of traditional practitioners."[112]

Since 1994, the South African government has aspired to enforce this claim. In her dissertation *The Bio-Politics of HIV/AIDS in Post-Apartheid South Africa* of 2008, Claire Laurier Decoteau has argued that today's field of health and healing is *de facto* an integrated field. Nevertheless the field remains highly bifurcated - in institutional, economical, cultural and structural ways – as well as being geographically, racially and socioeconomically structured.[113] The following chapters will strongly draw from her excellent analysis (deploying Pierre Bourdieu's concepts of field, capital and habitus) of the present situation of health and healing with particular attention to the HIV epidemic.

According to Decoteau, the members of the post-Apartheid field of health and healing compete over a hegemonic ontology of the body, the signification of disease – in particular HIV - , and the boundaries of the field.[114] The limits of the field are defined by criteria of eligibility, which, due to its historical and global dominance, are conformed to biomedical healthcare. Biomedical criteria of eligibility have long been institutionalized in the country in specific educational degrees. Biomedical staff can only participate in the field by completing certain nationally standardized requirements. Indigenous healing, as previously mentioned, has its own criteria of eligibility, including the calling, training and initiation of a healer. Different from biomedical science, however, these criteria are not nationally standardized. This poses a problem to the integration of indigenous health care. The post-Apartheid government was thus forced to take measures in order to institutionalize indigenous health care. The *Traditional Health Practitioner's Act* passed in 2005 stands out most prominently here. Its purpose was to establish a council that controls the training and practice of indigenous health practitioners, their fees, professional conduct and ethic.[115] Most of these measures, however, have not been successful yet. While the *Traditional Healers Organization,* which

---

[112] African National Congress (ANC), *A National Health Plan for South Africa* (Johannesburg: African National Congress, 1994)

[113] Decoteau, *The Bio-Politics of HIV/AIDS in Post-Apartheid South Africa*, 68, 410.

[114] ibid., 70.

[115] Republic of South Africa., *The Traditional Health Practitioners Act*, 2004 (Cape Town: Governmental Gazette. No. 476.27275 (2005) Accessed June 26, 2012. http:77www.doh.gov.za/docs/bills/thb.html.

was founded in reply, claims more than 25,000 members, its guidelines and policies are neither recognized by the state nor the biomedical health sector. While state and indigenous healers are profoundly invested in the process, the integration of the fields is thus still very much "in process", according to Decoteau.[116]

A core problem that remains in terms of integration is that the attempts to reconcile both modes of healthcare operate within a biomedical paradigm. A Chidester notes, often the social, spiritual and ritual dimension of indigenous healthcare are marginalized in the field.[117] In addition, there are ontological contradictions between biomedical and indigenous health care, which further impede the integration of indigenous healers. They concern mainly ideas of sexuality, contagion and pollution of the body and thus become particularly problematic in the case of the HIV crisis.[118]

In terms of capital, the South African field of health and healing is clearly dominated by biomedical science. "Biomedical capital is convertible in social, economic and political capital," Decoteau stresses.[119] This is true not only for producers of biomedical healthcare, who can reap massive amounts of capital from the international community, but also for its consumers. With biomedical treatment you can not only get access to medication, but food parcels, social security grants, jobs, social recognition and jobs in the newly developing AIDS service industry.

Indigenous healing, at the same time, faces enormous constrains. It lacks economic and political capital, on a national as well as international level. Exacerbated by the South African media and the biomedical sector, in public discourse it continues to be associated with charlantry and the evil practices of witchcraft. In addition, so-called 'miracle-cures' by impostors often refer to 'traditional' or 'African' knowledge for legitimisation. Charlantry is on the rise all throughout South Africa, as tremendous profits can be made from South Africa's health crisis and due to the already mentioned small degree of codification it is difficult for patients to identify impostors.[120]

Decoteau argues that South Africa's field of health and healing is first and foremost unique in its disjuncture between the sub-fields of health *production* and of health *consumption* (see Diagram 1 and 2).[121] In the field of health *production*, as shown in

---

[116] Decoteau, *The Bio-Politics of HIV/AIDS in Post-Apartheid South Africa*, 80 ff.

[117] Chidester, Religions of South Africa, 20, 21

[118] Decoteau, *The Bio-Politics of HIV/AIDS in Post-Apartheid South Africa*, 117 ff.

[119] ibid., 87.

[120] ibid., 107 ff.

[121] According to Decoteau, *The Bio-Politics of HIV/AIDS in Post-Apartheid South Africa*, 92, 93.

Diagram 1, the sub-field of biomedical healing dominates the field of power. This means that it has the majority of economic, social and political capital at its disposal. This situation is not unique to South Africa, but resembles the international dominance of biomedical healthcare. Biomedical dominance in South Africa is partly due to the economic extension of its international dominance. Surprisingly though, the field of consumption indicates that while biomedical healthcare holds disproportionate control over resources, it caters to a smaller fraction of consumers, of which only few utilize biomedical treatment exclusively. On the other hand indigenous healthcare is almost excluded from the field of power, but it is estimated that 80% of South Africans utilize some sort of indigenous healthcare and that there is a far larger number in indigenous producers.[122]

There are several reasons which can account for this disjuncture. Within South Africa, biomedical health care caters to a much smaller, but overall wealthier consumer base. As the economic capital lies with the minority of its consumers, is in itself highly bifurcated – on an economic as well as social, geographical and institutional level. The bulk of power lies with private, rather than public biomedical care. Only few South Africans have access to private health care due to lack of funds. As a result, public health care is overcrowded, while being understaffed and under-resourced.[123] In addition, people living in the countryside, the townships and informal settlements are often geographically distant to public health care facilities.[124] Finally, owing to apartheid health politics, biomedical health care lacks legitimacy with the masses. According to Decoteau, it is generally associated with Western imperialism, while indigenous healing is understood "to be synonym with African identity."[125]

Indigenous healing, on the other hand, wields a "particular form of cultural and symbolic capital." Its consumer base is larger, but generally less wealthy than that of biomedicine. It is often more accessible to those South Africans, who otherwise are restricted to the public sector of biomedical health care. Some authors also suggest that indigenous health care is more affordable.[126]

---

[122] Decoteau, *The Bio-Politics of HIV/AIDS in Post-Apartheid South Africa*, 83.

[123] In Diagram 2 those parts of the biomedical sub-field which cater to South Africa's majority are located outside the field of power.

[124] Decoteau, *The Bio-Politics of HIV/AIDS in Post-Apartheid South Africa*, 96 ff.

[125] ibid., 88.

[126] Not all authors confirm this to be the case. Compare to Adam Ashforth, "On Living in a World with Witches: Everyday Epistemology and Spiritual Insecurity in a Modern African City (Soweto)," in *Magical Interpretations, Material Realities*, ed. Henrietta L. Moore and Todd Sanders (London et al.: Routledge, 2001)

The South African field of health and healing, though integrated in principal, remains highly bifurcated, concerning production as well as consumption. If one was to locate Fana Khaba in the field of health consumption, different factors independent from his personal health preferences would predetermine his position. As an employee and resident of Johannesburg, South Africa's capital, he was located nearby the entire spectrum of South African healthcare. His social and economic capital as a famous DJ would privilege him to access private biomedical health. Even though he was Zulu and grew up in Soweto[127], his choice to advertise biomedical healthcare on air leads to the conclusion that different from other South Africans he did not mistrust biomedicine based on his experiences under Apartheid. Thus, Fana Khaba was one of the few South Africans with access to the field of power. Based on his biography, however, Fana Khaba continued to utilize indigenous and other forms of healthcare, even though he could have confined his health seeking behaviour to biomedical healthcare – a choice which due to the strong economic bifurcation of the field would not have been possible for most South Africans.

While accessibility and affordability are certainly explanatory factors for the popularity of indigenous healthcare, they cannot fully account for it. As Robert Thornton stresses,

> "[t]raditional healers are themselves distributed throughout South African society and at all economic levels, so it is not possible to generalize about the economic or social status of their clientele."[128]

Fana Khaba would be located in the area marked grey in Diagram 2. Representing those South Africans who utilize both biomedical and indigenous healthcare, this area is not located at the margins of the field, but in its middle. As it accounts for a large share in the field of power it unlikely represents only those South Africans forced to 'eclecticism' by their economic situation, their confusion or their misinformation. The health seeking behaviour of these consumers presents a puzzle to established explanations. It has become explosive in debates around the prevention of HIV and AIDS in South Africa. In order to circumnavigate prevalent theories on an incommensurability of indigenous and biomedical forms of healthcare, exploring the grey area becomes all the more essential to a study of witchcraft and AIDS.

---

[127] Soweto stands for 'South Western Townships', a township bordering Johannesburg's mining belts in the South.

[128] Thornton, "Traditional Healers, Medical Doctors and HIV/AIDS in Gauteng and Mpumalanga Provinces, South Africa," 2.

FIELD OF POWER

Sub-Field of Biomedical Healing

Private Health Care
Biomedical Health Advocates

Doctors in Public Health Care

Nursing Staff in Public Health Care

Field of Healing

Sub-Field of Indigenous Healing

Traditional Practitioners in Organizations

Unregistered Traditional Practitioners
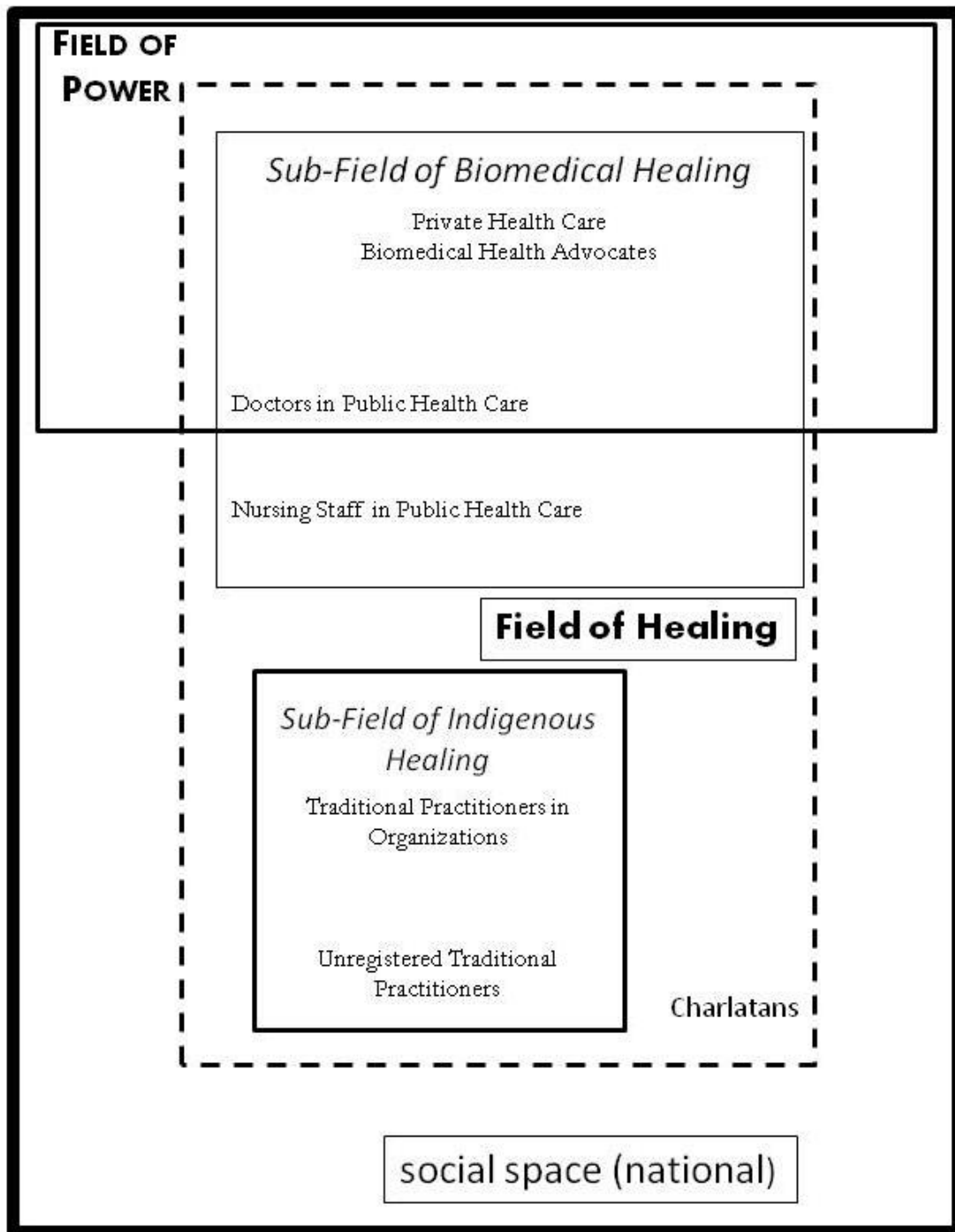
Charlatans

social space (national)

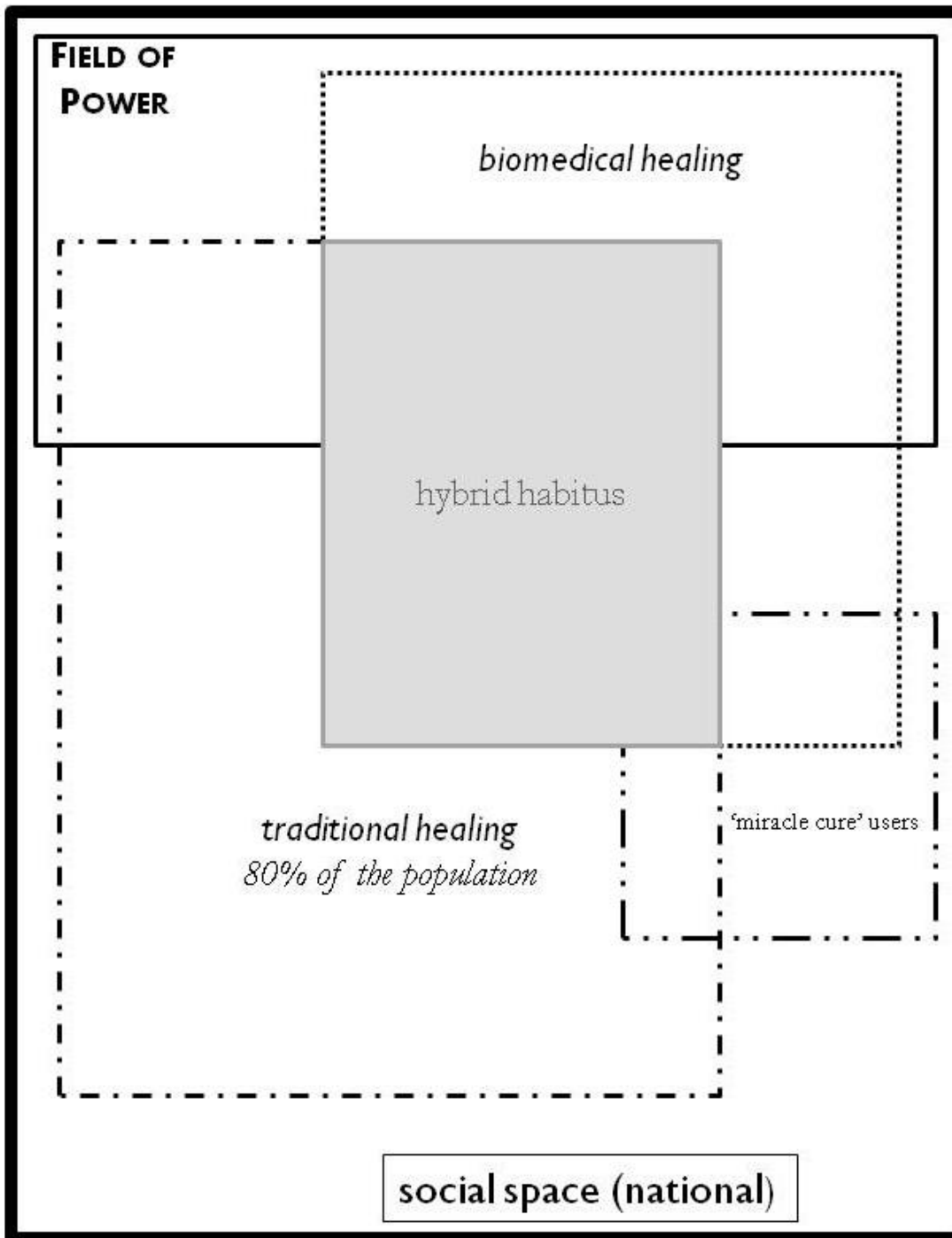Diagram 1: South African Field of Health **Production**

Diagram 2: South African Field of Health **Consumption**

3.6 The Myth of Incommensurability

Drawing on her own experience as a cancer patient, in 1978 Susan Sontag published *Illness as Metaphor*, in which she argues that the language used by Western societies to describe cancer, implies that the patient is to blame for their condition. She demands that disease must not be confused with its 'metaphoric trappings,' which do not represent the patients' experience and can harm them[129] In 1989, she expanded her argument to *AIDS and its Metaphors*. In this book, Sontag ascribes the 'metaphoric trappings' of AIDS to its status as a not-yet-understood disease, as according to her "[e]ven the disease most fraught with meaning can just become an illness."[130]

While Sontag's book on AIDS was immensely important to uncover the reading of HIV as a disease of the gay male promiscuous body, underlying her work is the assumption that one can avoid metaphor all together and refer to the 'real' disease instead. As Paula Treichler has put forward, there is no such solution as the simple retreat to AIDS' 'reality', as "illness *is* metaphor, and this semantic work – the effort to make sense of 'AIDS' – has to be done."

> "[…] AIDS is not merely an invented label, provided to us by science and scientific naming practices, for a clear-cut disease entity caused by a virus. Rather, the very nature of AIDS is constructed through language and in particular through the discourse of medicine and science; this construction is true or real only in certain specific ways - for example, insofar as it successfully guides research or facilitates clinical control over the illness."[131]

Rather than to deny its empiric existence, Treichler's approach stresses the impossibility of communicating AIDS' manifold reality outside metaphor. She emphasizes that this is also true for biomedical significations of AIDS, even though they claim to and are taken for granted as 'reality'.

> "Our social constructions of AIDS […] are based not upon objective, scientifically determined "reality" but upon what we are told about this reality: that is upon prior social constructions routinely produced within the discourse of biomedical science.

As Treichler's analysis of Western constructions of AIDS shows, people all over the world struggle to find an understanding of the epidemic, including those where biomedical healthcare is undisputed in its 'truth'. As part of this struggle, they produce multiple, diverging and often contradicting significations.

---

[129] Susan Sontag, *Illness as a Metaphor* (New York: Farrar, Straus and Giroux, 1988).

[130] Sontag, *AIDS and its Metaphors*, 93.

[131] Treichler, "AIDS, Homophobia, and Biomedical Discourse," 31.

This is also true for the South African context. However, only against the country's historical and political background does it become possible to understand the polarization of significations in the dominant discourse. In a unique coincidence, the country was struck by the epidemic at the time of its transition to a capitalist economy. When the ANC took government in 1994, it was faced with the double tasks of overcoming inequality as well as entering the global market by adapting neoliberal economics. In order to achieve this task, South Africa embraced two inherently contradictory ideologies, as Decoteau has explained: On one hand it adapted a pan-African ideology, which asks for the critique of Western cultural imperialism; but on the other hand it adopted economic liberalism, which opened the country up to international capital and the ideologies accompanying it.[132] The simultaneous onset of the HIV epidemic, which has had massive social and economic consequences on all levels of society, heightened this dilemma. Decoteau explains:

> "By exposing South Africa's schisms of contemporary inequality, AIDS undermines the state's claims to a successful liberation, a narrative upon which its national identity depends. But in addition to a symbolic and ideological menace, AIDS jeopardizes South Africa's economic and social security."[133]

The post-colonial bifurcation of the South African field of health and healing is most drastically exposed by the HIV crisis. The dilemma of creating a democratic state, while maintaining its economic growth results in the HIV epidemic being the main signifier of the economic as well as political future of the country.

While South Africa is struck harder than any other country, HIV takes its devastating toll worldwide. Those who are able to offer some relief, such as pharmaceutical companies producing ARVs, reap economic rewards. Likewise those who are financially advantaged, both with and without HIV, will be less affected by the epidemic. More than anywhere else, though, in South Africa those who win the battle over the signification of AIDS will reap not only economic rewards but power over the South African state. The outcome of the struggle against HIV could well have impact on "state power, the economic system, the application and implementation of sovereign- and bio-power, and the signification of national identity."[134]

More than any other place struck with the HIV epidemic, these circumstances turn the South African battle over the signification of AIDS into a battle over hegemony. It

---

[132] Decoteau, *The Bio-Politics of HIV/AIDS in Post-Apartheid South Africa*, 408, 409.

[133] ibid., 407.

[134] ibid., 125.

is dominated by a denialist state on the one side, supported by indigenous healthcare authorities, and the proponents of biomedical science on the other. In the battle, colonial ideology of 'tradition' vs. 'modernity', 'African' vs. ''European' and 'religion' vs. 'medicine' is rearticulated by both parties, as Decoteau points out.

> "The dominant insists that the merging of the fields result in the symbolic annihilation of alternative approaches; therefore the myth of incommensurability operates in order to attempt to secure hegemonic legitimation of one approach, at the wholesale expense of the other."[135]

The insistence on a segregation of different forms of healing becomes necessary warfare in order to secure exclusive victory.

In South Africa, therefore, different parties want to 'solve' HIV and thus win the battle over its signification. Due to the simultaneous onset of the HIV epidemic and the transition to a post-Apartheid state, South Africa's struggle of signification over AIDS has turned into a battle for hegemony. The myth of incommensurability, rather than being representing South African's reality, is part of the warfare used in the battle. While the South African state and the adherents of biomedicine are engaged in the battle of signification, the majority of South Africans are engaged in the daily struggle of survival. The public discourse is dominated by few, but "the communities most impacted by the disease are nowhere to be seen. While they are certainly used as pawns of political warfare, they have no voice or presence in the symbolic struggle taking place in the public sphere."[136] It remains to be understood, how South Africans escape the trenches dug by those dominating the public discourse in their health seeking behaviour and where the discourse on witchcraft and AIDS can be incorporated.

3.7 Habitus in Disruptive Hybridity

In the light of the political severity with which the myth of incommensurability is rearticulated by both the South African state and biomedical healthcare, and in addition to the existing economic and ontological differences between indigenous and biomedical healthcare, it becomes even more surprising that South Africans do not submit to either side of the battle. How do South Africans utilize both forms of

---

[135] Decoteau, *The Bio-Politics of HIV/AIDS in Post-Apartheid South Africa*, 309.

[136] ibid., 236.

healthcare, "without experiencing any radical incongruity?"[137] Furthermore, where does the discourse around witchcraft and AIDS fit in?

In order to answer the first question, this thesis will again follow Decoteau. She proposes that a complex 'hybrid habitus' emerged within the post-Apartheid field of health and healing, which undermines the binaries constructed and maintained within the field itself. As the hybridity reproduces the disjuncture between the dominant voices in the discourse around healthcare and the reality South Africans live in the times of HIV, she describes the habitus as in *hysteresis*. To Decoteau, hysteresis refers to "a habitus that once was fitted to its field, but has somehow managed to survive despite the structural changes the field has undergone."[138] The hybrid habitus of many South Africans concerning their health reflects a habitus, which, according to Decoteau, first emerged out of the apartheid segregation. As described above, while medical systems were physically and ideologically separated, they were simultaneously deployed in African townships.

While post-apartheid South Africa intended to bridge this segregation structurally as well as ideologically, the AIDS crisis causes the reinforcement of the myth of incommensurability.[139] The hysteresis of South Africans habitus, however, reveals a radical disjuncture between the dominant voices in the field of health and healing and the reality of most participants. Decoteau argues that, "embodied structural ambivalence and contradiction do not necessarily reconcile over time" and that habituses can remain more permanently 'cleaved'.[140] She stresses that indigenous and biomedical healing are not reconciled, but reside autonomous, alongside one another, inside the habitus.[141] South Africans' hybridity is thus a 'taste in its own right', as opposed to merely a strategy of survival. She also points out that there are no theories available yet that manage to account for "multiply inscribed habituses, created by a situation in which people live within and between contradictory discourses of the body."[142]

South Africans affected by AIDS are in a unique situation. There are two authoritative discourses to which they must content – that of a pan-Africanist state that is critical of Western imperialism, and that of a neo-liberal state, which invites Western ideology. But

---

[137] Decoteau, The Bio-Politics of HIV/AIDS in Post-Apartheid South Africa, 245

[139] ibid., 309.

[140] ibid., 300.

[141] At this point Decoteau abandons Bourdieu's theory on hybridity. Compare ibid., 410.

[142] ibid., 272.

rather than to collapse their differences, South African's hybrid habitus reconfigures and resists their contradictory logics.

> "Post-apartheid hybridity, then, involves playing each off the other, performing them both ineptly, and strategically embodying the contradictions in this dual inscription in order to undermine and expose post-colonial authority. And as such, a new form of disruptive hybridity is created, embodied and performed."[143]

In the final chapters, this thesis will explore how this 'disruptive hybridity' - in the habitus of people who navigate their health choices between diverging and contradictory discourses of what the 'truth' of and the 'solution' to AIDS is - and the South African discourse around witchcraft relate. In order to escape the myth of incommensurability as a scholar of religion, the next chapter will explore how the academic history of witchcraft was part of its creation.

4. The Academic History of Witchcraft

While theories of religion have always been an essential part of cultural contact, the scientific study of religion emerged at a time, when, more than ever before, Europe saw itself presented with 'savage' religion at its outskirts. In the second half of the 19th century, comparative study of African religions promised knowledge of and power over Africans in a period of high imperialism. As Chidester has shown in South Africa, the early study of religion was an important part of the imperial enterprise. Not only was comparative religion present on colonial frontiers as a 'science of control', but categories of religion were produced in these frontier zones and utilized as tools of knowledge and power.[144] The complexity of knowledge production on African religion was later obscured in the process of theory building, as Chidester has recently pointed out.

> "Although clearly dependent upon colonization, the theorists of imperial comparative religion consistently erased any traces of that dependence by developing theories about the prehistoric rather than the historical situation of empire in which they were operating."[145]

Just like the diviner was ridiculed and persecuted on colonial frontiers, locating African religion in the prehistoric by means of comparative religion served the purpose of exorcising what posed a serious threat to imperial power. Both practices (colonial

---

[143] Decoteau, *The Bio-Politics of HIV/AIDS in Post-Apartheid South Africa*, 272.

[144] Chidester, S*avage Systems,* 5 ff.

[145] David Chidester, *Empire of Religion* (forthcoming), 6.

admission and imperial science) equally legitimized what was thought of as the 'civilizing mission' and thus colonial enterprise.

As part of this process, witchcraft was from the very beginning perceived as a threat to and designed in opposition to Western rationality and science. The notion of witchcraft as something prehistoric, medieval and irrational, continues to trouble perceptions of religion in Africa today. This notion presents a particular challenge to the study of AIDS and witchcraft. As was illustrated above, the current battle of signification in South Africa is dominated by two parties, which both uphold the colonial myth of the incommensurability of 'tradition' and 'modernity'. Since the concept of witchcraft derives from this legacy, a study of witchcraft risks a mere reiteration of those voices already dominant if it does not carefully probe the categories applied. In order to facilitate a critical perspective, the following chapter will explore academic concepts of witchcraft throughout history and pay particular attention to how it was defined in relation to science.

4.1 Locating African Religion in the 'Prehistoric'

The tendency to identify African indigenous religion as an indicator of 'primitive' thinking can be traced back to European philosophy of Enlightenment. With an increased emphasis on reason and cause and effect, a more systematic study of cultures emerged and brought forth pseudoscientific theories of race. In these theories, Africans were frequently presented as inferior to other races. Pseudoreligious arguments about the biblical damnation of the African people often supported these claims. Building on the 'Myth of the Dark Continent' generated through early travel reports (in many cases written by Christian missionaries) African religion was presented in these studies as opposing European 'rational' thinking.[146]

In the 19th century theories on social and cultural evolution consolidated previous images of Africans' intellectual inferiority within the human sciences.[147] They were grounded in the underlying assumption of an inbuilt *telos* which allowed all societies to evolve in a linear line from 'primitivism' to 'modernity'. It was believed that every society would eventually undergo the same stages of development, but at different rates. Western culture was believed to be the contemporary pinnacle of evolution and sciences was regarded as an indicator of its modernity. It was predicted that Africans and other

---

[146] Frieder Ludwig and Afe Adogame, "Introduction: Historiagraphy and European Perceptions of African Religious History," in *European Traditions in the Study of Africa*, ed. Frieder Ludwig et al. (Wiesbaden: Otto Harrassowitz, 2004), 3 ff.

[147] Birgit Meyer, *Translating the Devil: Religion and Modernity amongst the Ewe in Ghana* (Edinburgh: Edinburgh University Press, 2010), 62.

'primitive' people would eventually undergo the same unilinear development as Western societies had already done. The project of evolution was to be brought about in Africa through educational, economic and, as already discussed above, medical interventions. In the course of this modernization, religion would ultimately disappear and science would reign. The essence of this idea is probably expressed with most clarity in what Max Weber later termed the 'disenchantment' of modernity, a state in which "one can in principle master all things by calculation." He elaborates in his description:

> "One need no longer have recourse to magical means in order to master or implore the spirits, as did the savage, for whom such mysterious powers existed."[148]

'Magic' here belongs clearly to the still enchanted, primitive savage.

Much prior to Max Weber's notion of disenchantment, within the study of religion 'magic' had emerged as a conceptual field that defined an antithesis to modernity. Different theories developed within this field of inquiry (such as 'fetishism', 'animism', 'totemism' and 'shamanism') all serving to prove the primitives' incapability to rational, scientific thinking. Instead, theories on magic confined Africans to religion, which was uncloaked as delusional in numerous publications. Locating African religion in the pre-modern was not only an attempt to justify the colonial enterprise, but it was also necessary to theoretically underpin the attempts of banning what was perceived as an actual threat on colonial frontiers. Hence it was not by chance that popular British theorists of religion (such as Edward B. Tylor, James G. Frazer and Andrew Lang) often sought evidence for 'primitive religion' within British colonies. Frequently referring to southern Africa, their theories branded Africa as a place of magic for the following decades.[149]

As the witchdoctor continued to exercise power in southern African societies, the horrors of African religion were all too present on colonial frontiers to be ignored. The banishment of magic from modernity by evolutionary theorists was all along balanced by less dominant arguments about magic's universality.[150] According to Talal Asad, the 19th century scientific notion of a disenchanted modernity was firmly linked to the

---

[148] Max Weber, "Science as a Vocation," in *From Max Weber: Essays in Sociology*, ed. and trans. by H. H. Gerth and C. Wright Mills (London: Routledge & Kegan Paul, 1948), 139.

[149] See for example: Edward B. Tylor, *Primitive Culture* (New York: Harper and Row, 1958 (1817)); James G. Frazer, "South African Totemism," *Man* 1 (1901): 135-36; Andrew Lang et al., "Bantu Totemism," *Folklore* 15.2 (1904): 203-205.

[150] Peter Pels, "Introduction," in *Magic and Modernity: Interfaces of Revelation and Concealment*, ed. Birgit Meyer and Peter Pels (Stanford: Stanford University Press, 2003), 4.

growing habit of reading imaginative literature, which, by means of enchanting what was thought of as pre-modern, reinforced ideas of secularization.[151] A wide corpus of gothic literature responded to European fascinations with the occult at the time and reflected the ambiguous nature of Enlightenment. Imperial literature located magic in the past, the foreign and the other. Again, British authors frequently chose to locate magic in the British colony of South Africa. Simultaneously it presented magic as something fascinating, something threatening to break through the rationality of modern society.

In an essay on the academic genealogy of African witchcraft, Peter Pels has suggested that African religion was first presented to a wide readership under the term 'witchcraft' in imperial adventure novels, rather than anthropological literature. While it only emerged as an object of scientific inquiry at the beginning of the 20th century, present scientific notions of 'witchcraft' in Africa can be traced back to late 19th century British literature.

The 1887 adventure novel *She* by Henry Rider Haggard, illustrates this for the South African context. *She* tells the story of a South African witch that is so powerful, she threatens to colonize Europe with her witchcraft. In the plot, the terrifying, but beautiful witch is confronted with a European scholar, who attempts to counter her religious power by fighting it with rationality. He fights in vain, as ultimately the threat posed by her witchcraft is not generated through its reality and thus cannot be curbed through exposure. Instead, it is generated through the witch's imaginativeness, with which she creates terror and gains political power amongst the indigenous people of southern Africa.[152]

The novel illustrates the central paradox in the European handling of the continuous presence of African religion. On one hand, the author confronts witchcraft with science, thus exposing the imaginary nature of African religion. But rather than letting this dissolve the witch's power, this exposure reveals the actual threat of African religion: Witchcraft, despite its irrationality, continues to wield political power!

By adopting 'witchcraft' as a term to signify African religious practice from British imperial literature, the study of religion would later inherit this paradoxical notion, as Pels suggests.

> "The translation of African magic as 'witchcraft' threatens European understandings of self and other just as much as this translation is an

---

[151] Talal Asad, *Formations of the Secular: Christianity, Islam, Modernity* (Stanford: Stanford University Press, 2003), 14, 15.

[152] Henry Rider Haggard, *She: A History of Adventure* (Oxford: Oxford University Press, 1998 (1886/1887)).

attempt to contain the African occult within imperial, colonial, or neo-colonial discourses."[153]

Indeed, African's belief in witchcraft did not recede politely with the increase of colonial control. Until the end of World War I evolutionists' ever precarious confidence was further unsettled by successful struggles of independence in Asia. To make matters worse, Mohandas Ghandi, fresh from South Africa, was uniting Indians by evoking their shared religious identity. Nationalistic ideas in Africa that incorporated ancestral religion could not claim the same success, but they nevertheless caused doubts with European colonialists about their success of disenchanting Africa.[154] In the early 20th century, African religion suddenly had to be taken serious on a whole other level.

4.2 The Rationality of Witchcraft

To their surprise, colonial administrators all over Africa were faced with an increase in witchcraft. As a British officer noted in the 1930s in Northern Rhodesia, witchcraft and magic had "actually increased by contact with the white civilization, and the resultant economic and social changes."[155] Different from what was predicted, European presence did not lead to the disenchantment of Africa. With time evolutionary theories were challenged by colonial experience. This happened most notably in E.E. Evans-Pritchard's 1937 work entitled, *Witchcraft, Oracles and Magic among the Azande*. His ethnographic work amongst the Azande in Southern Sudan would be a benchmark for further study of religion in Africa. His book was also the first major treatise written on the topic of witchcraft and for a long time dictated its definition.

In his account of Azande 'mystical beliefs', Evans-Pritchard broke with out-dated presumptions about the general irrationality of African thinking. His predecessors, including Edward B. Tylor, James G. Frazer and Bronislaw Malinowski, had accounted for religion as psychological phenomena, deriving from the Africans' need to control what Europeans long had calculated with their rationality. Contrarily, Evans-Pritchard showed that the Azande did not fail to recognize empirical causation. They followed the same inner logic, which according to Evans-Pritchard, was universal to all cultures. To Evans-Pritchard, Azande mentality was indistinguishable from European mentality.

Evans-Pritchard argued that in the Azande's system of thought, witchcraft could account for inexplicable occurrences of misfortune. He insisted that, while witchcraft

---

[153] Peter Pels, "The Magic of Africa: Reflections on a Western Commonplace," *African Studies Review*, 41.3 (1998): 193.

[154] Ludwig and Adogame, "Introduction," 8.

[155] Audrey Richards, "A Modern Movement of Witchfinders," *Africa*, 8.4 (1935): 460.

marked some sort of causative factor, "Zande belief in witchcraft in no way contradicts empirical knowledge of cause and effect."[156] Rather, witchcraft replaced what was referred to as 'coincidence' in scientific thinking. Witchcraft, like a coincidence occurred whenever an explanation was needed for the intersection of two chains of causation that otherwise had no interdependence.[157] His now famous example on Azande granaries illustrates this: In hot weather, people often sought shadow under the granaries, which in Azande society were raised on top of wooden stakes. Sometimes the granaries would collapse due to termites over time eating away the pillars. When a man was killed under a granary, the Azande acknowledged that the termites had destroyed the pillars. However, they did not see the cause of death in the termite infestation. According to Azande thinking, their presence did not explain why this particular man was killed at this particular time. Instead, they attributed the disaster to witchcraft.

While he acknowledged that the notion of witchcraft was incompatible with scientific modes of thought, Evans-Pritchard remained that Azande notions of occurrences was comparable to that of Europeans. In Evans-Pritchard's account of Azande witchcraft, African religion became rational and socially relevant. *Witchcraft, Oracles and Magic among the Azande* would change the study of other cultures. It would also give important impulse to socially oriented studies of witchcraft.

Against science, however, witchcraft remained to be found wanting. Evans-Pritchard showed Africans as committed to the same universal rationality as modern Western men, but he didn't abandon the idea of a context-independent notion of 'reality'. The truth of this 'reality' was still ultimately established by science. His conviction of the irreconcilability of religion and scientific 'truth' is evident throughout his writing.

> "Zande behavior, *though* ritual, is consistent, and the reasons they give for their behavior, *though* mystical, are intellectually coherent."[158]

Compared to the truth of science, Azandes' thinking came with limitations. He accounts for this deficit by arguing that Azande reason stayed within a religious system. Any contradictions between their 'mystical notions' and empirical evidence experienced by them, Azande explained again in reference to religion. Thus, Azande were never led to the conclusion of an external reality. Unlike scientists, "they reason excellently in the

---

[156] Edward E. Evans-Pritchard, *Witchcraft, Oracles, and Magic among the Azande* (Oxford: Clarendon Press, 1937), 73.

[157] ibid., 70.

[158] ibid., 336; italics by Laura Pöhler.

idiom of their beliefs, but they cannot reason outside, or against, their beliefs because they have no other idiom in which to express their thoughts."[159]

Imperial literature had left Europeans with a fearsome puzzle. As Pels has summarized,

> "What is the terror of magic, anyway: the possibility of 'witchcraft's' being true or the possibility of the fraud's being believed in by so many in African society?"[160]

With *Witchcraft, Oracles and Magic among the Azande*, Evans-Pritchard tried to meet both questions at once. By proving its rationality and attesting it to be a social institution, he explained the persistence of African belief in witchcraft into the colonial present. By revealing at once that only his outsider position as a scientist privileged him to acknowledge this logic, but for the Azande (caught up in the prison of their beliefs) witchcraft was 'real' and a natural phenomenon, he once again proved the superiority of Western science.[161]

4.3 The Witchcraft Paradigm

Following *Witchcraft, Oracles and Magic among the Azande*, the so-called 'witchcraft paradigm' brought forth numerous works that aimed to demonstrate that "witchcraft is something more than meaningless superstition."[162] The problem of controlling and modernizing African colonies remained a central issue, especially when anthropology became more intertwined with colonial administration after 1945.[163] In the spirit of post-World War II optimism, the ambiguous approach to magic reflecting the dialectics of Enlightenment, which was still prevalent less than half a century earlier, had been traded for theories of modernization. Rather than concerning themselves with the prior annoyance of Africans holding onto primitive religion, scholars now focused on the more practical question of what effect these beliefs were having on African societies.

In the 1950s and early 1960s, structural-functionalist scholars emphasized the way witchcraft beliefs functioned in local settings. Based on Evans-Pritchard's emphasis on its social nature, witchcraft was primarily analyzed as a social phenomenon. Material was still harvested within colonial infrastructure, as it had been 50 years earlier. Paul Stoller

---

[159] Evans-Pritchard, *Witchcraft, Oracles, and Magic among the Azande*, 338.

[160] Pels, "The Magic of Africa," 199.

[161] Till Förstner, "From Rationality to Creativity: Ritual Activity and Religious Experience in the Work of Edward Evans-Pritchard (1902 – 1973) and Victor Turner (1920 – 1983)," in *European Traditions in the Study of Africa*, ed. Frieder Ludwig et al. (Wiesbaden: Otto Harrassowitz, 2004).

[162] Krige, J.D., "The Social Function of Witchcraft," *Theoria* 1 (1947): 8.

[163] Pels, "The Magic of Africa," 198 ff.

has argued that field's limitation to records formally documented with colonial authorities might have lead to an overemphasis in studying witchcraft accusations brought to the attention of the colonial administration. As a result witchcraft was generally interpreted as a socially conservative force. Witchcraft accusations were imagined to serve Africans as a means of controlling individuals gone astray in what was envisioned as egalitarian, small scale societies. Stoller has termed this bias the 'homeostasis perspective' on witchcraft.[164]. Increase in witchcraft accusations was thus interpreted as a local reaction to the disruption of social relationships due to colonial modernization. The belief in witchcraft was seen as an instrument for the indigenous societies to oppose political control as well as to resist new forms of consumption and production.[165]

Henrietta L. Moore and Todd Sanders have pointed out that structural-functionalism has brought a sustained focus on the connection of witchcraft and social tension, which continues to engage present scholarship. They criticize that structural-functionalism had placed strong emphasis on local witchcraft discourse as a symptom of moral breakdown in the once egalitarian African society. This in turn led to a tendency in the study of witchcraft to negatively portray any form of social change.[166] According to structural-functionalists, African religion was not part of modernity in Africa, but rather an African way to resist it. This again reinforced older images of Africa as a place of 'tradition' and once again witchcraft was seen as an indicator of its 'traditional' nature.

4.4 Debating Rationality

In the 1960s, the flush of witchcraft studies following Evans-Pritchard was disrupted. Instead of re-thinking modernization theories, scholars of witchcraft once again thought about rationality. The problem of a universal rationality, which had accompanied studies on witchcraft all along and was raised again by Evans-Pritchard in 1937, emerged once again. This time, a fierce debate erupted that would only calm down 30 years later and change not only the study of religion, but social sciences as a whole.

---

[164] Farmer, *AIDS and Accusation*, 9,10.

[165] Knut Christian Myhre, "Disease and Disruption: Chagga Witchcraft and Relational Fragility," in *Dealing with Uncertainty in Contemporary African Lives*, ed. Christian Bawa Yamba and Liv Haram (Uppsala: Nordic Africa Institute, 2009), 119

[166] Henrietta L. Moore and Todd Sanders, "Magical Interpretations, Material Realities: An Introduction," in Magical *Interpretations, Material Realities*, ed. Henrietta L. Moore and Todd Sanders, (London et al.: Routledge, 2001), 8; Mary Douglas, *Witchcraft: Confessions and Accusations* (London: Travistock Publications, 1970), xx.

In his introduction to an anthology summarizing the controversy around rationality for a German audience, Hans G. Kippenberg highlights an essay as an exemplary starting point of the debate.[167] "Religion and Ritual: The Definitional Problem" by James Goody was published in 1961 and features (amongst other things) a critical re-reading of *Witchcraft, Oracle and Magic among the Azande*. In his essay, Jack Goody claims that the sociological distinction made between 'the sacred' and 'the profane', "a deceptively simple dichotomy that has had a distracting effect on the development of a comparative sociology of magico-religious institutions," had been overemphasized by and thus hindered scholarship.[168] Goody noticed that the distinction itself as well as the categorization of acts and beliefs as religious or not following this distinction, was not intrinsic to objects of scientific inquiry. Rather, the distinction was made by the scientist and assigned to the society studied. The sacred-profane dichotomy was not universal, as Goody argues, but could only be understood from its religious background in Western Europe. The assumption of a universal rationality had far-reaching consequences for the study of religion, as Goody stresses throughout his book.

> "While in the light of the essentially external character of the dichotomy, the attribution of a 'symbolic' or 'expressive' element to ritual or religious (i.e. 'non-rational') behaviour often turned out to be no more than a way of announcing that the observer is unable to make sense of an action in terms of an intrinsic means-end relationship, a 'rational' cause and effect nexus, and has therefore to assume that the action in question stands for something other than it appears to; in other words, that it expresses or is symbolic of something else [...] What happens, then, is that symbolic acts are defined in opposition to rational acts and constitute a residual category to which 'meaning' is assigned by the observer in order to make sense of otherwise irrational, pseudo-rational or non-rational behaviour."[169]

The distinction of religion was thus a criterion external to the object, which revealed more about the differences between the scientists culture and the culture studied, than about the culture itself. Rationality, as a result, became an honour awarded by the scientist to societies with similar religious background as his own. It could therefore no longer be bargained as an objective criterion along which science could judge the others' capability of logic.

As Hans G. Kippenberg has noted in his discussion of Goody's essay, the witchcraft paradigm indirectly affirmed earlier distinctions made between social 'reality' and

---

[167] Hans G. Kippenberg, "Einleitung: Zur Kontroverse über das Verstehen Fremden Denkens," in *Magie*, ed. Hans G. Kippenberg and Brigitte Luchesi (Frankfurt am Main: Suhrkamp, 1987), 38 ff.

[168] Jack Goody, "Religion and Ritual: The Definitional Problem," *The British Journal of Sociology*, 12.2 (1961): 143.

[169] Goody, "Religion and Ritual," 156, 157.

religious 'appearance'.[170] Goody abandoned this distinction as a whole. The debate following this step ultimately concerned what Stanley J. Tambiah has called "the grand problem at the heart of anthropological enterprise."

> "How do we understand and represent the modes of thought and action of other societies, other cultures? Since we have to understand this task from a Western baseline so to say, how are we to achieve 'this translation of cultures,' i.e. understand other cultures as far as possible in their own terms but in our language, a task which also ultimately entails the mapping of the ideas and practices onto Western categories of understanding, and hopefully modifying these in turn to evolve a language of anthropology as a comparative science?"[171]

For the first time in the study of magic, a scholar had made explicit what had accompanied this conceptual field since its emergence a century earlier: The scientist's ever present apprehension of the relativity of scientific rationality; the fear that science was only one way to order reality amongst many others.

The radical change in paradigm was also reflected in the study of witchcraft in Africa. With the arrival of the critical theories in the 1960s, studies of witchcraft and their often pejorative connotations became an embarrassment to social scientists. They remained widely neglected until the end of the 20th century, except for few exceptions. Post-modern scholars (such as Paul Stoller and Carlos Castaneda), Pels has noted, felt confident that "the most radical form of critique was one that pretended to reverse centuries of Western disrespect by arguing for the real or potential truth of magical, witchcraft, or shamanic practices"[172] Pels has acknowledged that these authors in a way further unsettled gridlocked confidence in Western scientific rationality. However, their affirmative accounts of the occult in foreign cultures also upheld Eurocentric perceptions of the incommensurability of foreign religion and Western science. Much in the manner of the imperial adventure novels discussed above, these studies of witchcraft suggested that a radical translation of African religion could threaten Western rationality. Instead of addressing the puzzle of how witchcraft *belongs* to modernity, these postmodern authors participated in a revival of 19th century occult thinking.[173]

The rationality debate at the same time cleared the way for a new kind of witchcraft studies. Tambiah's *Magic, Science, Religion and the Scope of Rationality* sums up a different

---

[170] Kippenberg, "Einleitung," 39.

[171] Stanley J. Tambiah, *Magic, Science, Religion, and the Scope of Rationality* (Cambridge et al.: Cambridge University Press, 1990), 3.

[172] Pels, "Introduction," 14.

[173] Pels, "The Magic of Africa," 203 ff.

kind of critique passed on Western rationality. In a lecture held in 1984 and later published with great success, Tambiah describes how within the West, positive science functioned as the quintessential marker of 'rationality'. Scientific methodology, most of all the notion of 'causality', became the only approved form of knowledge production. Tambiah stresses, that the alleged incompatibility of science and religion, as well as the paradigms of 'secularization' and 'rationalization', could only be understood as part of Western history. He shows that the framework of causality does not exhaust rationality. He argues that, in the attempt to understand cultures less dominated by science, the totalitarian view described above would block other 'orientations' from the anthropologist's view.

> "Now it is when we transport the universal rationality of scientific causality, and the alleged rationality of surrounding moral, economic and political sciences with their claims of objective rules of judgment (which in fact are colored by special cultural and social presuppositions), and try to use them as yardsticks for measuring, understanding and evaluating other cultures and civilizations that we run into the vexed problems of relativity, commensurability, and translation of cultures."[174]

Symptomatic for the change in paradigm, instead of delivering yet another perspective on magic and religion, Tambiah's overview of the debate concludes with a critical view of rationality and science. It also caused quite a stir in the study of religion.

In the late 1980s and early 1990s, research on witchcraft was revived by several scholars, all of whom emphasized, once again, the presence of witchcraft in modernity. Now for the last 20 years, witchcraft has remained a central topic in the study of Africa. In many respects, these studies rely on previous theories, particularly in the way they continues to describe witchcraft as closely connected to kinship and as an indicator of the social change and conflict accompanying modernity.[175] At the same time recent research also differs radically from its functionalist ancestors. As rationality was uncloaked as culturally bound, witchcraft was suddenly freed from its banishment to the prehistoric. While witchcraft's rationality did not have to be proved any longer, a new challenge awaited the study of religion: Witchcraft was as evident and as powerful as ever and finally had to be related to modernity.

---

[174] Tambiah, *Magic, Science, Religion, and the Scope of Rationality*, 152.

[175] Moore and Sanders, "Magical Interpretations, Material Realities," 10, 11.

4.5 Witchcraft and Modernity

As pointed out throughout this chapter, the study of magic had always been characterized by less dominant, but persistent voices locating magic *in* modernity. As Pels has observed, "[r]arely, however, has magic been theorized as being explicitly *of* modernity, that is, not merely tolerated (as a universal human trait) among modern institutions but culturally *at home* in the institutions and practices we associate with the Occidental world."[176] Today, studies on African witchcraft not only attempt to describe how witchcraft is produced by modernity, but argue that witchcraft in fact partly produces Africa modernity.

As academic notions of witchcraft were from the beginning constructed in opposition to modernity, this recent change in focus first and foremost demanded a new understanding of modernity. While debates on rationality were running high, scholars had also increasingly discredited theories of modernization. With the revision of rationality's universality, the grand narratives of enlightenment, development, and evolution lost their credibility. Academics instead became conscious of globalization and of the way in which modernity could be 'at large', as Appadurai has famously described.[177]

The 1993 anthology *Modernity and its Malcontents* ,was a pioneering work in the study of Africa, as for the first time it brought together what had then seemed like methodological counterpoints - 'ritual' and 'modernity'. Witches were prominently featured throughout the anthology, and *Modernity and its Malcontents* served as a vector to many subsequent studies on the topic. Symptomatic for postmodern studies on witchcraft, the editors introduce the book with a discussion of concepts of 'modernity.' They criticize the entanglement of prevalent concepts in the 'optimistic master narrative' of modernization and conclude that, "because it is so closely connected to Western ideologies of universal development, modernity serves ill as an analytic tool for grasping European expansion, most of all from the vantage of the colonized."[178] Simultaneously, however, they emphasize the contradiction that, despite this new critique of the ideological and historical nature of concepts of modernity, 'modernity' served as "a metaphor of new means and ends, of new materialities and meanings" all over the

---

[176] Pels, "Introduction," 4.

[177] Arjun Appadurai, *Modernity at Large: Cultural Dimensions of Globalization* (Minneapolis: The University of Minnesota Press, 1996).

[178] John L. Comaroff and Jean Comaroff, "Introduction," in *Modernity and its Malcontents: Ritual and Power in Postcolonial Africa,* ed. Jean and John Comaroff (Chicago et al.: University of Chicago Press, 1993), xii, xiii.

world.[179] The authors stress that this posed a particular challenge to the study of Africa, where notions of 'modernity' seemed to heighten concerns about seemingly 'traditional' cultural practices, such as witchcraft.[180]

As the dualism of 'tradition' and 'modernity' plays an central role in vindicating the myth of incommensurability; the challenge of remaining conscious of the ideological nature of modernity concepts while trying to grasp contemporary experience of modernity is intensified in a study of AIDS and witchcraft. Peter Geschiere, Birgit Meyer and Pels have addressed this problem explicitly in their introduction to a reader on the plurality of *Modernity in Africa*. They similarly stress the necessity of an alternative approach in order to understand the everyday impact of notions on 'becoming' or 'being modern' in Africa. However, these authors argue that the repeatedly proposed concepts of 'multiple', 'plural' or 'local' modernities of recent were not expedient for this purpose, as "to speak of 'modernities' in the plural creates an illusion of relativist equality."[181] According to the authors, this relativist equality does not correlate with African reality, as modernity was usually used both empirically and analytically as a "master-narrativ[e] of temporal inequality". They suggest that what was needed was a concept of modernity outmanoeuvring "the illusory unity of a singular modern package exclusively transferred from the West and the denial or relativization of modernity's manifestation in Africa."[182] Instead they propose what they call 'relational' understanding of modernity.

> "A relational concept of modernity starts from the assumption that the extra-ordinary effectiveness and spread of notions of the modern in Africa have to be understood as an effect of the illusory unity of modernity, as it is supposed to manifest itself some time in the future, and that the power of these notions lies in their capacity to articulate temporal inequalities: of classifying some as modern and other's as 'not yet'. [...]
> Thus, a relational study of modernity in Africa combines the awareness and empirical study of 'hyperreal' modernity in Africa with critical research into the forms of globalization, extraversion and appropriation by (temporary or permanent) inhabitants of the African continent and its 'others', and the creative recombinations of elements of the modern package with its local or global alternatives." [183]

In order to realize this relational concept of modernity in research, the scholar first needed to pay close attention to the genealogies of modernity and how they were related to an African-European history. Based on these genealogies, the scholar then had to

---

[179] Comaroff and Comaroff, "Introduction," xiii.

[180] ibid., xiv.

[181] Peter Geschiere, Birgit Meyer and Peter Pels, "Introduction," in *Readings in Modernity in Africa*, ed. Peter Geschiere et al. (Bloomington and Indianapolis: Indiana University Press, 2008), 3

[182] ibid.,

[183] ibid.

describe how "these relationships manifest themselves in local struggles over the denial of coevalness that is characteristic of developmental or modernist discourse."[184] Underlying this concept is the authors' shared experience that, while Africa did not bow to European ideologies of progress, discourses of modernity were 'deeply incorporated in African life worlds'.[185] It is only with such a relational understanding of modernity, that a study of witchcraft and AIDS can avoid the pitfalls of partaking in the South African struggle of signifying HIV.

Most empirical studies of witchcraft insist upon its close tie to everyday notions of modernity and many of them argue that witchcraft discourse reacts precisely on the chasm between modernity as an ideology and as a day-to-day experience. In a much cited passage, Jean and John Comaroff first argued that African discourse on witchcraft plays a complex role in the appropriation and aspiration of modernity.

> "Witches are modernity's prototypical malcontents. They provide – like the grotesque of a previous age – disconcertingly full-bodied images of a world in which humans seem in constant danger of turning into commodities, of losing their life blood to the market and to the destructive desires it evokes. But make no mistake: these desires are eminently real and mortal. Nor, it should be stressed again, are witches advocates of 'tradition', of a life beyond the universe of commodities. They embody all the contradictions of the experience of modernity itself, of its inescapable enticements, its self-consuming passions, its discriminatory tactics, is devastating social costs."[186]

The flexibility of witchcraft discourse enables it to embody the contradictions of modernity, as the authors put it. This continues to be confirmed by various researchers who emphasize a close conceptual link between witchcraft and such contradictory modern realms as the market, local and global politics and the media.

This enormous flexibility at the same time complicates the identification of basic elements of witchcraft. According to Geschiere, no matter in which context, witchcraft "refers to hidden aggression by human actors, often acting from close by, from within one's intimacy."[187] Overall, however, recent scholarship moved away from the previous tendency to over-systematize witchcraft. Authors generally stress the ambiguity of witchcraft and many describe it as a local discourse, rather than a firm set of beliefs. This discourse is neither fully modern nor traditional. Geschiere, for example, acknowledges the historicity of modern witchcraft notions, such as the continued

---

[184] Geschiere et al., "Introduction," 3

[185] ibid., 2.

[186] Comaroff and Comaroff, "Introduction," xxix.

[187] Geschiere, "Globalization and the Power of Indeterminate Meaning," 214

connection to the enduring role of kinship. In his publications, however, he remains focused on what he once terms witchcraft's "tricky ambiguity".[188]

> "[T]here is a staggering production of meaning, highly unsystematic and contradictory but, precisely because of this, extremely powerful: witchcraft discourses [...] allow for so many interpretations that they can explain any course of events and are therefore impossible to falsify. This exuberance of meaning excludes any essentialist interpretation, pinning witchcraft down to a fixed essence."[189]

Just like modern changes, witchcraft is generally perceived as morally ambivalent (rather than something plain evil, as the English translation might suggest). Witchcraft is something fascinating, that everyone is talking about, but at the same time it is secret and can prove dangerous to talk about. Much like the 'modern man', everyone could be a witch, but no one knew how to and if, he would not share his knowledge with the community. This ambiguity, Geschiere argues, makes the study of witchcraft a pivotal entrance point to the study of Africa and globalization.

> "New witchcraft imageries [...] do not just express some sort of longing for a 'traditional' past. On the contrary, their ambiguity, expressing both horror and fascination with the new opportunities, highlight's people's effort to cope with the modern changes. In such a perception it becomes the entire more urgent why witchcraft has such an elastic capacity for capturing novel elements introduced from outside: why is it such an obvious form of discourse for many people in order to cope with modern changes?"[190]

While witchcraft continues to be linked to relatively recent social changes, it no longer has to serves a conservative force. Rather, it is seen as an attempt to redress imbalance and alienation arisen from social change According to Moore and Sanders, "the impact of increasing social differentiation brought on by modernity [...] and the troublesome articulation of local means of production with more distant (often international) sources of power and value have provided the background for interpretation."[191] The authors propose the concepts of witchcraft as a 'social diagnostic,' reacting to social and economic changes.

> "Witchcraft and the occult in Africa are a set of discourses on morality, sociality and humanity: on human frailty. Far from being a set of irrational beliefs, they are a form of historical consciousness, a sort of social diagnostics. In this sense, they strongly resemble other forms of social, economic and political diagnostics, originating in the academy and without, that try to explain why the world is the way it is, why it is changing and

---

[188] Geschiere, "Witchcraft and Modernity," 59

[189] Geschiere, "Globalization and the Power of Indeterminate Meaning," 214

[190] Geschiere, "Witchcraft and Modernity," 60

[191] Moore and Sanders, "Magical Interpretations, Material Realities," 9

> moving in a particular manner at the moment. These theories, most of
> them originating in the social sciences, are equally concerned with value
> and growth, with consumption and power, and with the impact of the
> world on the lives of individuals and communities: in short, with the major
> concerns of witchcraft!"[192]

Again, this function as a social diagnostic comes in ambiguous forms: While witchcraft is discussed as a levelling force and a way to undermine inequality in wealth and power, it is also feared for being used for the illicit accumulation of wealth and power.[193]

With the recognition of witchcraft's ambiguity and modernity, the methodological focus of the field of study also had to change. An important shift in recent studies has been the recognition that Africans have no monopoly on witchcraft. While the fact that most studies still draw their material from sub-Saharan Africa reflects on the legacy of Africa's image as a place of magic, recent studies have emphasized that witchcraft is not restricted to the 'Third World' and the troubles associated with 'underdevelopment'. These studies have found witchcraft in the very societies, which once claimed to be enchanted, and by doing so they challenged antiquated theories of witchcraft as social superglue for societies broken by modernity.[194] With the recognition of witchcraft not only as a destructive, but as a dynamic force, researchers also started to look beyond small-scale communities to the urban realm. Witchcraft is now not only found in accusations, but in gossip, rumour, narrative and the media. Today, witchcraft is often recognized as a means of relating the village to the urban and the local to the global in highly imaginative ways.[195]

Due to this strong emphasis placed on witchcraft's engagement with modernity, some authors have stressed the historicity of witchcraft discourses once again.[196] However, Geschiere calls attention to the fact that while the recognition of the historicity of

---

Moore and Sanders, "Magical Interpretations, Material Realities," 20

[193] Moore and Sanders, "Magical Interpretations, Material Realities," 15 ff.; Geschiere, "Globalization and the Power of Indeterminate Meaning," 213

[194] Pels, "Introduction," 13; Moore and Sanders, "Magical Interpretations, Material Realities," 3; James Kiernan, „Introduction," in *The Power of the Occult in Modern Africa: Continuity and Innovation in the Renewal of African Cosmologies*, ed. James Kiernan (Berlin et al.: LIT, 2006), 1.; see for example: Jean Comaroff and Michael Lambeck, "Consuming passions: Child abuse, fetishism, and the new world order," *Culture* 17.1/2 (1997); also Geschiere, „Globalization and the Power of Indeterminate Meaning, " for a comparative approach of African and Asian witchcraft

[195] Peter Geschiere, „Witchcraft and Modernity: Thoughts about a Strange Complicity," in *The Power of the Occcult in Modern Africa*, ed. James Kiernan (Berlin: Lit Verlag, 2006), 12; Moore and Sanders, "Magical Interpretations, Material Realities," 11.

[196] See for example: Myhre, "Disease and Disruption,"; 120, 121; Moore and Sanders, "Magical Interpretations, Material Realities,"12, 13

witchcraft is important, this does not allow for a fallback into binary modernity-tradition concepts. According to Geschiere,

> "people insist on the novelty of these horrendous witchcraft threats and their differences with older forms. Yet, it is clear that, at least in certain respects these representations build on old elements. It is striking, moreover, that it is precisely these continuities that allow for a quite surprising intertwinement with the growing impact of the market. In many respects, the 'traditional' witchcraft discourse does not constitute the opposite of capitalist logic – on the contrary: it can be grafted upon in unexpected ways."[197]

Geschiere stresses, that this connection of witchcraft and modernity is not just yet another structural-functionalistic attempt to make sense of witchcraft in modernity. It is indeed difficult for the scholar to affirm, if there has been an increase in witchcraft discourse in Africa in recent years, especially since witchcraft is so closely related to kin and thus discussed in private. However, the increase in studies on witchcraft in recent years document that witchcraft discourses are more out in the open then they used to be. As Geschiere observed, witchcraft "imposes itself in often quite dramatic and also unpleasant ways in the field. [...] [D]uring the last two decades, this occult discourse has invaded the public domain."[198] As Fana Khaba's story shows, this is also true for the South African context. While a relational understanding of modernity allows for witchcraft to be culturally *at home* in modern South Africa, certain questions remain. In public discourse, what is witchcraft and what does it do? Why does this particular discourse forces itself into the public domain with such severity now that there is a public health crisis? And, to rephrase Geschiere, why is it such an obvious form of discourse for many people in order to cope with AIDS?

5. AIDS in Indigenous Religious Discourse

Given the legacy of the term witchcraft, it is not self-explanatory why it should be employed after the arrival of a relational understanding of modernity. There are valid arguments for abolishing 'witchcraft' as a scientific term altogether. Geschiere, who made similar observations for Cameroon and the French translation into 'sorcellerie', rejects the moralizing connotations of both terms, as 'witchcraft' as well as 'sorcellerie' would not do justice to the already mentioned ambivalence of witchcraft discourse in Africa. He cautions, however, against an artificial re-translation into indigenous terms, as

---

[197] Geschiere, „Witchcraft and Modernity," 58.
[198] ibid., 47, 48.

"the social scientist would isolate himself from daily discussions in the societies concerned, where one does use diffuse but heavily loaded terms like *witchcraft* or *sorcery*."[199] Also, as Adam Ashforth has pointed out, it is almost impossible to avoid the term in the study of South African indigenous religion. 'Witchcraft' is a common English word used by many South Africans on a daily basis. In addition, indigenous terms such as the Zulu word *abathakathi*, according to Ashforth's research, by now have taken on notions derived from the English translation into 'witchcraft,' such as the immediate association with evil ends.[200]

In the South African context, witchcraft has to be understood as a discourse, rather than a firm set of beliefs and practices. Its elusiveness, as will be shown below, is in part what makes South African discourse on witchcraft so adaptable to different social situations. For the purpose of developing potential questions to guide further research, this thesis will rely on Ashforth's ethnography and his description of the witchcraft discourse in Soweto.

> "Witchcraft, as most people with whom I have discussed the matter in Soweto seem to understand it, is a term loosely applied to the field of illegitimate action engaging capacities of human persons to cause harm or accumulate wealth and power by mysterious means. In common Sowetan usage, the term – whether expressed in English, or Sotho (*boloi*) or Zulu (*ubuthakathi*) equivalents - refers to practices wherein human action directed towards evil ends engages with invisible forces that are variously conceived of as either physical, human, or extra-human (spiritual) in nature. Amongst other things, witchcraft can refer to the malicious manipulation of the powers of herbs and other substances generally referred to as *muthi* (the same word as used for healing medicines), to pacts with devils and demons, to innate supernatural powers, or to collective action by persons engaging all of these forces. When people speak of witches at work, they typically say people are 'using *muthi*' although they may have radically different understandings of the active power of *muthi* as anchored in either chemistry, magic, or demonic powers."[201]

Witchcraft in Soweto, as described here, possesses the characteristics Geschiere has defined as universal to witchcraft discourses worldwide (see Chapter 4.6). The agent, meaning the witch, is a human person. Her actions are 'illegitimate' and they are 'directed towards evil ends'. It can be understood from Ashforth's flexible definition that, besides these basic elements, witchcraft can imply a large variety of things to Sowetans. While a certain spectrum of practices seems to be associated with witchcraft, none of them are fixed. The ways and means by which the agent causes harm remain

---

[199] Peter Pels, "Introduction," 14
[200] Ashforth, „On Living in a World with Witches," 222.
[201] ibid., 206, 207.

'mysterious'. They involve some sort of invisible force, but this force could be 'physical', 'human' or 'extra-human'. Witchcraft might also involve the use of herbs. However, this *muthi* is not solely used by witches, but also by healers and could therefore be used to harm as well as to heal. In addition, there are 'radically different understandings' amongst Sowetans of the active power of *muthi*. Its force could be magical, demonical as well as chemical.

This flexibility is further stressed by the fact that anyone can become a witch. All a person needs in order to become a witch is the desire to kill and the capacity to do so. The desire is said to arise out of personal motives such as jealousy, envy and hatred.[202] Once the feeling has emerged in the witch, the desire is kept secret by the witch, as Ashforth explains. "Not only is it hidden by virtue of the fact that one can never truly penetrate the depths of another's being, but if the bitterness motivating the desire to perpetrate witchcraft is in fact present, the witch, in order to avoid counteraction or punishment of his or her evil deeds, will keep it secret."[203] The secret nature of witchcraft further complicates the identification of a witch, but the strong incentive needed for witchcraft also confines the circle of suspects to the victim's family and close friends. In order to determine an agent behind any perceived signs of witchcraft, the only possibility for the victim to gain certainty is to assess the probability of their kin and friends bearing any hatred against them.[204]

Despite the flexible nature of witchcraft and the possibility of anyone becoming a witch, Sowetans distinguish clearly between witchcraft and other forms of involving the occult, as not every hardship is automatically interpreted as resulting from witchcraft.

> "Many uses of occult powers and interactions with invisible forces or entities are considered legitimate in Soweto, most notably in prayer, divination, and healing. Sometimes, too, suffering can be inflicted upon people by invisible powers as a form of legitimate punishment.[...] When something is described as witchcraft, however, the import of the statement is that a human interaction with unseen forces has taken place which is unambiguously evil and directed towards causing serious harm to others."[205]

While there is an agreement about the witch's incentive being inherently evil[206], the 'tricky ambiguity' of witchcraft highlighted by recent scholarship still applies to Sowetan witchcraft in different ways. First, there is an intrinsic ambiguity in the practice of

---

[202] Ashforth, „On Living in a World with Witches," 216.

[203] ibid.

[204] ibid.

[205] ibid., 207

[206] This emphasis on might be due to the adaption of meaning from the English term 'witchcraft', as described by Ashforth and recited further above.

witchcraft itself. The witch's use of occult powers might be considered legitimate under different circumstances and *muthi,* while being used by the witch as a weapon, could also be healing medicine. A witch can thus not be identified by their art. Second, there is ambiguity in the effects of witchcraft. While generally illness, misfortune and death may be caused, they are not exclusively interpreted in terms of witchcraft, but could also be 'a form of legitimate punishment', for example through displeased ancestors. A witch can thus not be identified by their crime either. Finally, anyone has the capacity as part of their human nature to become a witch. A witch can therefore neither be recognized from other humans.

Due to this total ambiguity, there is constant speculation about, but never knowledge of the dealings of witchcraft in Soweto, as Ashforth affirms. "Knowing when to ascribe an unfortunate event to witchcraft [...] is no easy task. Typically the action of a witch is surmised in retrospective, after the onset of an illness or affliction and confirmed by the diagnosis of a diviner."[207] Witchcraft can only be recognized once the harm is done. As a result, even in the absence of misfortune and illness Sowetans live constantly in the awareness of other's potential to cause harm. That there is no general agreement about the nature of witchcraft or witches does not indicate Sowetans indifference towards it, Ashforth emphasizes. "And while most people do not have access to sophisticated and fully elaborated cosmologies which they could present to inquisitive outsiders fully formed, they are generally mindful of the fact that they live in the world with witches."[208]

Today, Sowetans not only live in a world of witches, but in a society ravaged by the HIV crisis. With the high prevalence of misfortune and illness due to the epidemic, a heightened awareness about witchcraft seems obvious. As shown in Chapter 3, however, South Africans are presented with a variety of significations of HIV and AIDS. Those affected worst by the mutual pandemic of AIDS and poverty, as has been suggested, are to a great extent aware of not only indigenous significations, but biomedical significations as well. As the adherence of biomedical signification allows patients to reap superior economic, as well as social rewards, the question remains to be answered why witchcraft persists to be an obvious form of discourse for so many South Africans. In this last part of the thesis, some suggestions will be made on which basis further research could be conducted.

---

[207] Ashforth, „On Living in a World with Witches," 207
[208] ibid., 208

5.1 Uncertainty, Responsibility

Ashforth has described Sowetans' awareness of the constant threat of evil as follows.

> "For people who live in a world of witches, the fact that evil forces are not ordinarily visible in no way diminishes the possibility of accurately discerning their actions in shaping the fortunes and misfortunes of life. Invisibility, however, does present definite problems of interpretation. Typically, revelation of the action of invisible forces involves the interpretation of visible, audible, or generally tangible and intelligible signs. But these signs are themselves inherently ambiguous, for the sign is not the power itself. The sign is always originated by something else, the hidden reality that lies behind the appearance of its manifestation." [209]

Living in a world of witches, this thesis would like to suggest, might be similar to living in a world of HIV in South Africa. Drawing on Chapter 2, this claim will be illustrated following Ashforth's description above.

South Africans, who live in a world of HIV, are living with great uncertainty concerning every aspect of the epidemic, as illustrated in Chapter 2. Much like witchcraft, HIV is 'not ordinarily visible', but its presence is ever more clear due to the drastic economic and social impact it has on South African society. However, the invisibility of HIV also 'presents definite problems of interpretation.' Everyone knows that, like witchcraft, HIV is out to kill.[210] In his book, *The Modernity of Witchcraft*, Geschiere has described witchcraft as the 'dark side of kinship.'[211] Knut Christian Myhre has commented on this phrase.

> Witchcraft is not a distant phenomenon of foreign origin, but a social fact that lies at the heart of relationality itself. Social relations are fragile phenomena that can always be subverted and disrupted. Moreover, these disruptions are perpetrated from within, by the parties of the social relationships. Shadowing the network of social relations, there is a web of mutual suspicion, and each person is implicated in the latter by virtue of being entangled in the former."[212]

Again, this applied to HIV in a sinister coincidence. HIV is not a water or airborne disease, which can be caught in any public place. In South Africa, sex and birth are the two moments where individuals become vulnerable to HIV. While there are effective ways to prevent infection in both moments, for many South Africans they are not available due to different reasons discussed previously. There is constant awareness of others HIV status, but particularly because it is in moments of great intimacy, it

---

[209] Ashforth, „On Living in a World with Witches," 219.

[210] For further information concerning the association of HIV and death, see next chapter.

[211] Geschiere, *The Modernity of Witchcraft*, 11.

[212] Knut Christian Myhre, "Disease and Disruption: Chagga Witchcraft and Relational Fragility, " in *Dealing with Uncertainty in Contemporary African Lives*, ed. Christian Bawa Yamba and Liv Haram, (Uppsala: Nordic Africa Institute, 2009), 133.

becomes impossible, especially for women, to act n account of this suspicion. As a human being engaged in sexual relationships with other human beings, there is virtually no escape for infection. Also, in such environment, it is easier said than done to protect one's family or sexual partner from infection. In the absence of condoms, the economic need to trade sex for money and with the economic and social value placed on childbearing, refrain from sex is an impossible thing to ask of people. People, who in addition are deprived of many enjoyable spare time activities due to the hardship imposed on them.[213] Anyone can thus become a transmitter of HIV, given the limited course of actions available to many South Africans.

In addition, unlike other epidemics as destructive, HIV can remain hidden in the human body for many years. The only way to know your status is through testing. The only way to know somebody else's status, is through positive affirmation. This again, resembles the positive affirmation needed to be certain of a witch, as neither their art, nor crime or looks can give the witch away. In absence of testing facilities, however, most South Africans depend on 'interpretation of visible, audible, or generally tangible and intelligible signs'. This can either be done by interpreting one's own body, or that of a sexual partner or a child. But, much like the effects of witchcraft these 'signs are themselves inherently ambiguous.' Once the symptoms of an HIV infection become visible, they may not stay visible, but can go in hiding again for an unknown period of time. The onset of AIDS in a patient, as discussed in Chapter 2, must not change the invisibility of HIV, as AIDS often invites opportunistic infections already latent in the patient's body. As the most frequent opportunistic infections are generally common in those parts of South African society affected worst by HIV due to an absence of adequate healthcare, being sick must not be an indicator for HIV. To put it more clearly, when two people fall sick with tuberculosis, one of them due to the onset of AIDS, they still both have tuberculosis. Again like with witchcraft, with AIDS 'the sign is not the power itself.'

Finally, HIV's sign is 'always originated by something else, the hidden reality that lies behind the appearance of its manifestation.' This parallel could be drawn in numerous ways. First, it could be interpreted in biological terms. HIV in itself is not the cause of a patient's death, but by an opportunistic infection invited by the stage of AIDS. However, this could also be said for the social reality behind the HIV epidemic in South

---

[213] From my own experiences working as a volunteer in Munich, Germany, with HIV positive men, I know that there has been a neglect in addressing sexuality of HIV positive people. Given the fact that ARVs can offer a healthy life now, I believe this topic cannot be ignored any longer, as HIV positive people too, so I believe, have a right to participate in the basic actions of social life.

Africa. The hidden reality could amongst many others refer to the fact that, being a woman in South Africa might be the true reason for being HIV positive. And finally, it could also point at the economic reality hiding behind the scope of HIV.

Ashforth himself has stressed this structural similarity between AIDS and witchcraft more than any other scholar. "A disease or complex of symptoms better suited to interpretation within the witchcraft paradigm than AIDS would be hard to imagine," he writes.[214] In addition to some of the analogies stressed above, he has called attention to further important similarities between witchcraft and AIDS. He points to the widely neglected fact that, while HIV rates are staggering in South Africa, few of those infected have had any symptoms as of yet. He suggests that different from other diseases which afflict all equally and instantly, AIDS singles out individuals from intimate social networks and often, those most innocent, like children, are affected the worst. Thus, AIDS would not lend itself to theories of communal punishment, but rather lead to the suspicion of malicious individuals breaking up kinship bonds.[215]

He also noticed that there is a conflict between HIV awareness campaigns and people's experience of AIDS. While campaigns stressed the sexual transmission of HIV, the actual symptoms of AIDS "resonate within an entirely different realm of experience from sex."[216]

In line with the ambiguous nature of witchcraft discourses, it would also be interesting to see how notions of witchcraft have changed with the outbreak of AIDS. As James Kiernan has noted in relation to the impacts of modernity on village-level societies, in rapidly changing contexts it was "not uncommon to hear concerned voices that witchcraft is out of control and running riot."[217] As Debie LeBeau reports from her field research on AIDS and local cosmologies in Namibia, similar concernes were voiced there. When she asked research participants how they could differentiate between witchcraft and AIDS, she was told that it had become nearly impossible. Witches had adapted techniques similar to HIV, so to confuse victims about their doing.[218] This notion of witchcraft as constantly upgrading in order to avoid its defeat would further resonate with the highly mutation prone virus, which is far from being defeated.

---

[214] Ashforth, "An Epidemic of Witchcraft?": 128.

[215] ibid.

[216] ibid., 129

[217] James Kiernan, „Introduction," In *The Power of the Occult in Modern Africa: Continuity and Innovation in the Renewal of African Cosmologies*, ed. James Kiernan (Berlin et al.: LIT, 2006), 9

[218] Debie LeBeau, *Dealing with Disorder: Traditional and Western Medicine in Katutura (Namibia)* (Köln: Rüdiger Köppe Verlag, 2003), 142.

While these are just some suggestions why witchcraft might be a favored discourse for those infected and affected by HIV and AIDS, it is particularly interesting that many of these points seem to relate in one way or another to 'relationality', as Myhre was quoted above. Given the strong emphasis of biomedicine on the body of the individual, it is possible that biomedicine neglects the way in which HIV and AIDS affect not only those infected, but also their relationships to kin and friends. Incidents of illness and accounts of witchcraft, as Myhre has noticed, make people question the social relationships around them in similar ways.[219] Why Evans-Pritchard stressed the questions 'Why me?' and 'Why now?' in relation to witchcraft explanations among the Azande, it could also be productive to think about the extent to which AIDS raises the question of 'Why me in this social environment/in this relationship/ in this marriage?' This again might be partly due to a rupture between the biomedical discourse around HIV and AIDS, which stresses personal responsibility for infecting others and getting infected, and the social and economic reality of those South Africans affected the most by the epidemic.

5.2 Agency

Isak Niehaus has pointed out a further connection between the biomedical framing of HIV and AIDS and local interpretations of AIDS as witchcraft. In his essay "Death before Dying: Understanding AIDS Stigma in the South African Lowveld", Niehaus explores the intense stigma attached to AIDS patients in South Africa, which is seen as one of the main undermining factors of successful implementation of care and treatment. Often, patients are neglected and hidden by their families and communities. Deaths due to AIDS are seldom reported and funerals of victims are done in absence of any visitors in order to avoid gossip. The fear of being associated with HIV also keeps many patients from getting tested in the first place.[220]

While it is generally argued that this stigma is due to the association of AIDS with sexuality, and promiscuity in particular, Niehaus argues that the reason is to be sought in the chasm between the biomedical framing of AIDS and patients experience of AIDS. In order to change South Africans sexual behaviour, biomedical awareness campaigns in South Africa had treated AIDS, above all else, as a terminal disease.

> "AIDS Awareness campaigns have singled out AIDS for excessive

---

[219] Myhre, "Disease and Disruption, 133, 134.

[220] Isak Niehaus, *Death before Dying: Conceptions of AIDS in the South African Lowveld*, Research paper presented at the University of Camebridge (May 5, 2007), 1

As a result, the South Africans with whom Niehaus spoke perceived members of their community, of whom they knew to be HIV positive, as terminally ill, independent from their current condition.[222] The reason for this, says Niehaus, could be found in South African concepts of death and dying. In the South African Lowveld, as in many other societies throughout Africa, death is not a singular event, but a slow process. In most cases, the biological death precedes the social death, as the deceased continue to be present in social life as ancestors.[223] However, in the case of terminal illness, the social death precedes the biological death, as the moment of dying is generally perceived as a moment of great danger to the community, as the aura emanating from the corpse during the process of death could contaminate anyone it came in contact with.[224] As a result, people took great care not to be in touch with dying or dead people, separating them from their home and their community and excluding them from social life in that they are not allowed to touch kids, to have sex or to work.

Given the medical nature of HIV, the interpretation of AIDS as a terminal disease, creates different problems, as Niehaus suggests. Due to the perception of a dying person being contagious, he reports that generally his informants over-estimated the contagiousness of AIDS. "Excessive avoidance behaviour", as Niehaus writes, was the result. This included everything from refraining to talk to HIV positive people to avoiding to touch anything they had previously touched.[225]

This happened to the extreme that people perceived HIV positive community members as 'living corpses,' living in-between life and death.

> "Local residents perceived the transformation of people into zombies (*ditlothwane*) as the most reprehensible form of witchcraft. They alleged that witches first captured the victim's aura ad then took hold of different parts of his or her body, until they possessed the entire person. However, witches deceived the victim's kin by leaving behind an image of him or her. [...] Meanwhile, at home, witches cut the tongues of their victims, rendering them mute. Witches hide their zombies during the day, but employ them at night to perform the mindless tasks of domestic servants and unskilled labourers. All zombies are only a meter tall and similar in

---

[221] Niehaus, *Death before Dying*, 4.

[222] ibid., 8.

[223] ibid., 2.

[224] ibid., 9

[225] ibid. 11

> appearance, indicating their childlike status of absence of uniqueness. [...]
> Zombies were portrayed as socially dead but physically alive: forever stuck
> in a hidden parallel world."[226]

On the basis of Niehaus' description, only few suggestions for further research rather than a full analysis are possible. However, these stress the extent to which a study of witchcraft and AIDS is of vital importance to the adequate handling of the HIV crisis in South Africa.

Niehaus example shows clearly that there is no such thing as an 'objective truth' of HIV. The biomedical signification of HIV, which claims this objectivity for its own, is always interpreted in local terms. Instead of promoting biomedical health behaviour, in this example it actually undermines it in complex ways. The singling out of HIV as a terminal illness has here not lead to increased caution in sexual behaviour, but to the isolation of those infected and silence about HIV. As Niehaus describes,

> "The symbolic load of AIDS is so overpowering that labelling immediately
> signifies social death. Even the newly infected person is 'tainted with
> death', and he or she is described as 'dead before the real death.'[227]

This perception of HIV, however, does in no way represent the experience of those affected. HIV positive South Africans, given the right circumstances, can remain healthy and fully capable of life. In order to ensure this, testing is of vital importance. However, as Isak Niehaus has reported in this regard, the fear of social isolation kept many South African's from taking a HIV test. Niehaus' account highlights the importance of further research being conducted regarding biomedical ideology and indigenous religious perceptions.

To this thesis, it is of great interest that those associated with HIV are perceived by their community as the victims of witchcraft. In this account, the witch intrudes the safe space of the home and steals a member of the family. She needs the victim, in order to work for her and leaves only the empty body behind. Geschiere has reported a similar notion of witches making their own working slaves in Cameroon.[228] Together with Diane Ciekawy, he has pointed out that zombie-witchcraft was a popular way in Africa to interpret modern market economy: "Like the market, witchcraft conjures up the idea of an opening, a leakage through which people or resources are withdrawn from the community and disappear into the outer world."[229] Given the strong economic impact

---

[226] Niehaus, *Death before Dying*, 10.

[227] ibid.

[228] Geschiere, "Globalization and the Power of Indeterminate Meaning," 222.

[229] Diane Ciekawy and Peter Geschiere, "Containing Witchcraft: Conflicting Scenarios in Postcolonial Affrica," *African Studies Review* 41.3 (1998): 3.

AIDS has on South African households, it would be interesting to explore the ways in which witchcraft discourse allows those affected to articulate their economic struggle.

The physical appearance of the zombies is further of great interest. Here, zombies are small and childlike. They can neither speak for themselves, as the witch has cut out their tongue, nor can they be recognized, as they all look the same. Given the social and economic situation of those South Africans affected worst, questions of agency are of great interest here. Hanne O. Morgensen has noted: "Whether and how one talks about being HIV positive is inextricably linked to the need to be recognized as somebody who matters in life and the desire to continue living even when suffering from a deadly disease."[230] The image of the zombie might signal feelings of helplessness, voicelessness and loss of identity.

The analysis of these witchcraft discourse might help in understanding the reality of those infected and affected, as little is yet known about the way HIV positive people in South Africa perceive themselves nor about the way they are perceived by their social environment. Witchcraft discourses, rather than being a sign of lack in biomedical knowledge, might be a favoured discourse by many South Africans in order to deal with the social and economic realities the epidemic brings forth. Not only do narratives of witchcraft offer a way to address implications of HIV the biomedical discourse does not cover, but they might be a way to react on the gulf experienced by South Africans between their experience of AIDS and the omnipresent interpretation by the biomedical discourse.

Witchcraft discourse, this thesis would like to suggest, should be further explored as part of what Decoteau has described as hybrid habitus employed by South Africans. It seems to concentrate precisely at those points, where conflicting ideologies and ontologies meet in South African's experience of the epidemic. Witchcraft discourse not only allows those affected to make sense of their misfortune, but offers them agency in that it deflects blame from the individual and reopens the possibility of defeating what in biomedical discourse is written off as terminal illness.

6. An Epidemic of Witchcraft: Conclusion

This thesis has started out by claiming that the common responses to South Africans' choice of traditional healthcare instead, or in tandem with biomedical healthcare are not

---

[230] Hanne O. Morgensen, "New Hopes and New Dilemmas: Disclosure and Recognition in the Time of Antiretroviral Treatment." in *Morality, Hope and Grief*, ed. Hansjörg Dilger and Ute Luig (New York: Berghahn, 2010), 77

sufficient in explaining South Africans' health seeking behaviour in the current HIV crisis. Underlying common explanations was the assumption that biomedical knowledge was the only 'true' knowledge of HIV and AIDS and that only biomedical education allowed those affected to make rational choices regarding their affliction. This assumption not only confused indigenous healthcare with charlantry and AIDS denialism, but constructed indigenous knowledge as opposing and averting biomedical knowledge of AIDS. Based on this observation, the thesis set out to explore indigenous religious discourse regarding HIV and AIDS and in particular South Africans' interpretation of AIDS as witchcraft.

It was argued that, while HIV and AIDS could not be isolated from a more general context of health and healing, HIV and AIDS should be considered separately by the social sciences, as AIDS especially seems to attract an extraordinary variety of cultural, social and political responses in every society it occurs. It was then argued that the variety of interpretations might be due to the unique medical nature of the virus, which, (instead of bringing forth an exceptional disease), results in its appearance, transmission and treatment being highly dependent on the environment it occurs in. In South Africa, HIV is marked by a unique degree of uncertainty concerning every aspect of the epidemic. Due to different social, economic and cultural reasons, most South Africans are not aware of their status and have little or no control over being infected. In case their positive HIV status is confirmed, there is often no treatment available. The uncertainty concerning HIV is drastically aggravated by the severe poverty most South Africans live in. The scope of the epidemic impairs poverty in those parts of society affected worst and has devastating social consequences.

The rapid spread of HIV is often said to be the result of a lack in biomedical knowledge in the overall population. It was suggested, however, that this allegation was made on the assumption that biomedical knowledge would necessarily eliminate any other forms of knowledge on HIV. In the South African context, the myth of incommensurability of biomedical and other forms of knowledge could be traced back all the way to early colonial encounters. In indigenous southern African society, a sharp separation of the religious systems and healthcare could not be observed, as ill health could be accounted for in religious terms. Illness could be caused by evil individuals, which in order to heal the patient, had to be identified by a healer and penalized. Indigenous medical theory and practice thus involved the total social order and sacred specialists were powerful arbitrators of the indigenous legal and political system.

It was shown that in Europe, too, public health can be traced back to Christian notions of divine punishment. While the religious association of disease with sin, poverty and foreignness continued to trouble European expansions of public health to Africa in the 19th century, they were veiled under the cloak of bringing health and Christianity to people incapable of their own hygiene. Since early colonial contacts, medicine served as part of the colonial statecraft. Indigenous healthcare was seen as competitive, rather than complementary. In addition, the political power of indigenous healers posed a problem to the enforcement of total colonial rule. Administrators thus tried to curb their power by outlawing the practice of identifying evil in society. It was suggested that the English misnomer 'witchdoctor' can be seen as part of the attempt to ridicule and illegitimate indigenous healthcare, as the term invokes associations with a European past, femininity and irrationality.

Apartheid further emphasized this ideological confrontation in its physical separation of healthcare. Indigenous healthcare was institutionally and ideologically circumscribed as 'traditional' and belonging to the 'African' part of South African society. In the need to uphold labour power, however, clinics were installed in the townships and in this way many Africans were introduced to biomedical healthcare. While South Africans utilized both forms of healthcare, the fields remained separate.

With the transition to post-apartheid South Africa, efforts were made to merge the separate fields. As has been shown, however, the South African field of health and healing remains highly bifurcated - ideologically, as well as economically and culturally. Due to the simultaneous onset of HIV and South Africa's transition into a capitalist economy, this bifurcation has been most drastically exposed. As the power over the South African state depends on the defeat of the epidemic, the signification of HIV and AIDS has become a battle of hegemony between proponents of biomedical healthcare and indigenous healthcare. In order to win this battle of hegemony, both parties reiterate the colonial ideology of 'tradition' versus 'modernity'. As a result, the myth of incommensurability is created by the dominant members of the field.

Remarkable about the South African field of health and healing is that, while the field of health production is highly bifurcated, the field of health consumption does not reflect this bifurcation. Many South Africans seem to employ both forms of healthcare, despite the presence of the myth of incommensurability, without feeling any sense of incongruity. It was then suggested that South African's hybrid habitus navigates between, rather than collapses, the dominant but contradictory discourses on HIV in

South Africa. It was further suggested that the discourse on witchcraft might play a part in this navigation.

As the myth of incommensurability heavily relied on the confrontation of 'tradition' and 'modernity', and the English translation of 'witchcraft' derived from this legacy, it was necessary to look at the history of academic concepts of witchcraft before attempting a critical look at witchcraft in relation to AIDS. While witchcraft only appeared in academic literature in the 20th century, its notions can be traced back to British imperial literature, which emerged just at the moment when colonial administrators saw themselves threatened by indigenous religion and healthcare on colonial frontiers. As part of the conceptual field of 'magic', witchcraft was constructed in opposition to 'modernity' and 'rationality' and taken as a sign of Africa's backwardness. This notion was only challenged in the 20th century, when, despite the long colonial presence of Europeans, witchcraft discourses had not seized to exist in indigenous societies. Following Evans-Pritchard's work showing the rationality of witchcraft, structural functionalists made a point that African belief in witchcraft was a way to resist European modernity. Only after postcolonial critique of the assumption of a universal rationality and modernization theories did it become possible to theorize witchcraft as part of an African modernity. In order to do so, this thesis has suggested, a relational understanding of modernity is required, which not only is aware of the ideological nature of concepts of modernity, but of the impact notions of modernity has on everyday life in Africa. Only on this basis can witchcraft be understood as a discourse which does not reject, but address the changes that come with globalization.

Finally, several suggestions were made why witchcraft might pose a convenient discourse for so many South Africans to address AIDS. Besides a structural similarity of witchcraft and AIDS, that seems to make AIDS easily translatable into witchcraft narratives, it was also suggested that the dominance of the biomedical framing of AIDS favours witchcraft discourses in that it is not congruent with patient's experience of AIDS.

> "If the AIDS epidemics have done nothing else they have emphasized the interpretation of science and power in all of its forms, including the politics of reality, and in this emphasis have demonstrated that the authority claims of the sciences rest in large measure upon their appearance as objective, detached, and pure of purpose. This is not a new recognition, but it takes on a greater salience at the current moment because Science as constituted in certain research communities has become identified as the lead agency in providing solutions for the epidemics."[231]

> "[t]he experience of this trouble should be understood as a trouble, not a pain. The ultimate pain of the epidemic are inflicted on those who are living with and dying of HIV/AIDS; other pains, even those experienced by those most intimate with those who are living and dying with the disease, usually recede, albeit slowly, with forgetfulness."[232]

This thesis set out to explore the way indigenous religious discourse in South Africa relates to HIV. Throughout this thesis it has become apparent that in the South African field of health and healing, religion plays a key role, but not merely in those interpretations of AIDS publicly acknowledged as religious. Biomedicine, while ever more concerned with constructing its contrariness to religion, throughout history has represented itself as 'eternal, transcendent, spiritual, and divine.'[233]

The study of religion could particularly contribute to the HIV crisis in South Africa by not only analyzing the role indigenous religion plays in the epidemic, but by analyzing the way adherents of biomedicine and indigenous medicine legitimize their claim to hegemony over the signification of HIV and AIDS. This would be of great importance because, as shown in Chapter 5, the dominant voices in the discourse may not represent the reality of those most affected but can still affect their reality in significant ways. By doing so, the study of religion surely risks displeasing those identified as leading agencies to provide solutions in the epidemic. This might be uncomfortable, especially since ruining one's chances with biomedicine, as the example of South Africa clearly shows, will deprive one of countless resources. It might also raise questions on scientific responsibility, as, despite the ideological nature of biomedical discourse, biomedicine nevertheless can teach us better than many other sciences how to survive with HIV.

According to Bruce Lincoln, however, and as it was included as a guideline in the introduction of this thesis,

> " [t]o practice history of religions in a fashion consistent with the discipline's claim of title is to insist on discussing the temporal, contextual,

---

[231] John H. Gagnon, "Epidemics and Researchers: AIDS and the Practice of Social Science," in *The Time of AIDS,* ed. Gilbert H. Herdt and Shirley Lindenbaum (Newbury Park et al.: Sage, 1992), 27

[232] Gagnon, "Epidemics and Researchers," 38

[233] See Chapter 1.1 for reference

situated, interested, human, and material dimensions of those discourses, practices, and institutions that characteristically represent themselves as eternal, transcendent, spiritual, and divine."[234]

A study of religion and AIDS should first and foremost have the wellbeing of humans at its heart. As the example of South African witchcraft shows, however, this might include the critical analysis of those in power to define the future of HIV.

---

[234] Lincoln, "Theses on Method," 225

Bibliography

Abdool Karim, Quarraisha. "Heterosexual Transmission of HIV- The Importance of a Gendered Perspective on HIV Prevention." In *HIV/AIDS in South Africa*, edited by S.S. Abdool Karim and Q. Abdool Karim, 243-61. New York et al.: Cambridge University Press, 2005.

Abdool Karim, Salim S. "Introduction." In *HIV/AIDS in South Africa*, edited by S.S. Abdool Karim and Q. Abdool Karim, 31-6. New York et al.: Cambridge University Press, 2005.

Adam, Ashforth. "Spiritual Insecurity and AIDS in South Africa." In *Morality, Hope and Grief*, edited by Hansjörg Dilger and Ute Luig, 43-60. New York: Berghahn, 2010.

Appadurai, Arjun. *Modernity at Large: Cultural Dimensions of Globalization*. Minneapolis: The University of Minnesota Press, 1996.

Asad, Talal. *Formations of the Secular: Christianity, Islam, Modernity*. Stanford: Stanford University Press, 2003.

Ashforth, Adam. "An Epidemic of Witchcraft? The Implications of AIDS for the Post-Apartheid State." *African Studies* 61.1 (2002): 121-43.

Ashforth, Adam. "On Living in a World with Witches: Everyday Epistemology and Spiritual Insecurity in a Modern African City (Soweto)." In *Magical Interpretations, Material Realities*, edited by Henrietta L. Moore and Todd Sanders, 206-225. London et al.: Routledge, 2001.

Ashforth, Adam. Witchcraft, *Violence and Democracy in South Africa*. Chicago: University of Chicago Press, 2005.

Austin Alchon, Suzanne. *A Pest in the Land: New World Epidemics in a Global Perspective*. Albuquerque: University of New Mexico Press, 2003.

Azenabor, Godwin Ehi. "The Idea of Witchcraft and the Challenge of Modern Science." In *Studies in Witchcraft Magic, War and Peace in Africa*, edited by Beatrice Nicolini, 21-35. Lewiston, New York et al.: Edwin Mellen Press, 2006.

Becker, Felicitas and Paul Wenzel Geissler. "Searching for Pathways in a Landscape of Death: Religion and AIDS in Africa." In *AIDS and Religious Practice in Africa*, edited by Felicitas Becker and Paul Wenzel Geissler, 1-25. Leiden et al.: Brill, 2009.

Behrend, Heike. "The Rise of Occult Powers, AIDS and the Roman Catholic Church in Western Uganda." In *AIDS and Religious Practice in Africa*, edited by Felicitas Becker and Paul Wenzel Geissler, 29-47. Leiden et al.: Brill, 2009.

Berridge, Virginia. "AIDS: History and Contemporary History." In *The Time of AIDS,* edited by Gilbert H. Herdt and Shirley Lindenbaum, 41 – 64. Newbury Park et al.: Sage, 1992.

Berridge, Virginia. "The Early Years of AIDS in the United Kingdom 1981-6: Historical Perspectives." In *Epidemics and Ideas*, edited by Ranger Terence Ranger and Paul Slack, 303-28. Cambridge: Cambridge University Press, 1992.

Bolaji, Idowu. *African Traditional Religion: A Definition*. London: SCM Press, 1973.

Bond, Georg Clement and Diane M. Ciekawy. "Conclusion: Fabricating the Occult, Distancing the Familiar." In *Witchcraft Dialogues*, edited by Georg Clement Bond and Diane M. Ciekawy, 316-32. Athens: Ohio University Center for International Studies, 2001.

Bond, Georg Clement and Diane M. Ciekawy. "Introdcution: Contested Domains in the Dialogues of 'Witchcraft'." In *Witchcraft Dialogues*, edited by Georg Clement Bond and Diane M. Ciekawy, 1-38. Athens: Ohio University Center for International Studies, 2001.

Bongmba, Elias K. "African Witchcraft: From Ethnography to Critique." In *Witchcraft Dialogues*, edited by Georg Clement Bond and Diane M. Ciekawy, 38-79. Athens: Ohio University Center for International Studies, 2001.

Bongmba, Elias K. "Evans-Pritchard and the Theoretical Demise of the Concept of Magic." In *The Power of the Occult in Modern Africa: Continuity and Innovation in the Renewal of African Cosmologies*, edited by James Kiernan, 19-44. Berlin et al.: LIT, 2006.

Bozzoli, Belinda. "Why were the 1980s 'Millenarian'? Style, Repertoire, Space and Authority in South Africa's Black Cities." *Journal of Historical Sociology* 13.1 (2000): 78-110.

Butchart, Alexander. *The Anatomy of Power: European Constructions of the African Body*. London: Zed Books, 1998.

Carton, Benedict, John Laband and Jabulani Sithole. *Zulu Identities: Being Zulu, Past and Present*. London: Hurst, 2009.

Chandavarkar, Rajnarayan. "Plague Panic and Epidemic Politics in India, 1896 – 1914." In *Epidemics and Ideas*, edited by Ranger Terence Ranger and Paul Slack, 203-40. Cambridge: Cambridge University Press, 1992.

Chavunduka, Gordon L. *Traditional Medicine and Modern Zimbabwe*. Harare: University of Zimbabwe Press, 1994.

Chidester, David. *Empire of Religion. forthcoming.*

Chidester, David. *Religions of South Africa*. London et al.: Routledge, 1992.

Chidester, David. Sa*vage Systems: Colonialism and Comparative Religion in Southern Africa*. Charlottesville et al.: University Press of Virginia, 1996.

Ciekawy, Diane and Peter Geschiere. "Containing Witchcraft: Conflicting Scenarios in Postcolonial Affrica." *African Studies Review* 41.3 (1998): 1-14.

Colvin, Mark. "Impact of AIDS – The Health Care Burden." In *HIV/AIDS in South Africa*, edited by S.S. Abdool Karim and Q. Abdool Karim, 336-50 . New York et al.: Cambridge University Press, 2005.

Comaroff, Jean and Michael Lambeck. "Consuming passions: Child abuse, fetishism, and the new world order." *Culture* 17.1/2 (1997): 7-25.

Comaroff, Jean. "Beyond Bare Life: AIDS, (Bio)Politics, and the Neoliberal Order." In *Morality, Hope and Grief*, edited by Hansjörg Dilger and Ute Luig, 21-42. New York: Berghahn, 2010.

Comaroff, Jean. *Body of Power, Spirit of Resistance: The Culture and History of a South African People*. Chicago: University of Chicago Press, 1985.

Comaroff, John L. and Jean Comaroff. "Introduction." In *Modernity and its Malcontents: Ritual and Power in Postcolonial Africa,* edited by Jean and John Comaroff, xi-xxxii. Chicago et al.: University of Chicago Press, 1993.

Comaroff, John L. and Jean Comaroff. *Modernity and its Malcontents: Ritual and Power in Postcolonial Africa*. Chicago et al.: University of Chicago Press, 1993.

Comaroff, John L. and Jean Comaroff. *Of Revelation and Revolution: The Dialectics of Modernity on a South African Frontier*, Volume Two. Chicago: University of Chicago Press, 1997.

Coovadia, Hoosen 'Jerry'. "Mother-to-Child Transmission (MTCT) for HIV-1." In *HIV/AIDS in South Africa*, edited by S.S. Abdool Karim and Q. Abdool Karim,183-92. New York et al.: Cambridge University Press, 2005.

Cotzee, David and Leigh Johnson. "Sexually Transmitted Infections." In *HIV/AIDS in South Africa*, edited by S.S. Abdool Karim and Q. Abdool Karim,193-203. New York et al.: Cambridge University Press, 2005.

Courternay, Ilbert. "Legislation of the Empire." *Journal of the Society of Comparative Legislation*, Vol. 1 (1896 - 1897): 90-98.

Crimp, Douglas. *AIDS: Cultural Analysis, Cultural Activism*. Cambridge et al.: MIT Press, 1988.

Decoteau, Claire Laurier. *The Bio-Politics of HIV/AIDS in Post-Apartheid South Africa*. Ann Arbour: Deep Blue University of Michigan, 2008. Accessed June 26, 2012. http://deepblue.lib.umich.edu/handle/2027.42/61711.

Digby, Anne. *Diversity and Division in Medicine: Health Care in South Africa from the 1800s*. Oxford et al.: Peter Lang, 2006.

Dilger, Hansjörg and Bernhard Hadolt. *Medizin im Kontext: Krankheit und Gesundheit in einer vernetzten Welt*. Frankfurt am Main et al.: Lang, 2010.

Dilger, Hansjörg and Ute Luig, ed. *Morality, Hope and Grief: Anthropologies of AIDS in Africa*. New York: Berghahn, 2010.

Dilger, Hansjörg. "'My Relatives are running Away from Me!': Kinship and Care in the Wake of Structural Adjustment, Privatisation and HIV/AIDS in Tanzania." In *Morality, Hope and Grief*, edited by Hansjörg Dilger and Ute Luig, 102-124. New York: Berghahn, 2010.

Dilger, Hansjörg. "Morality, Hope and Grief: Towards and Ethnographic Perspective in HIV/AIDS Research." In *Morality, Hope and Grief*, edited by Hansjörg Dilger and Ute Luig, 1-18. New York: Berghahn, 2010.

Dilger, Hansjörg. *Besser den Vorhang im Haus als die Fahne im Wind: Geld, AIDS und Moral im ländlichen Tansania.* Hamburg: Lit Verlag., 1999.

Dilger, Hansjörg. *Leben mit Aids: Krankheit, Tod und Soziale Beziehungen in Afrika, eine Ethnographie.* Frankfurt et al.: Campus-Verlag, 2005.

Douglas, Mary. "The Self as Risk-Taker: A Cultural Theory of Contagion in Relation to AIDS." In *Risk and Blame: Essays in Cultural Theory*, edited by Mar Douglas, 83-101. London et al.: Routledge,1994.

Douglas, Mary. "Witchcraft and Leprosy: Two Strategies for Rejection." In *Risk and Blame: Essays in Cultural Theory*, edited by Mar Douglas, 102 – 121. London et al.: Routledge,1994.

Douglas, Mary. *Witchcraft: Confessions and Accusations.* London: Travistock Publications, 1970.

Evans-Pritchard, Edward E. **Witchcraft, Oracles, and Magic among the Azande**. Oxford: Clarendon Press, 1937.

Eves, Richard. "No Access! AIDS and Apocalypticism: Interpretations of the Epidemic from Papua New Guine." *Culture, Health and Sexuality* 5.3 (2003): 249-64.

Fanon, Frantz. *A Dying Colonialism*. New York: Grove Press, 1965.

Farmer, Paul. "AIDS and Accusation: Haiti, Haitians, and the Geography of Blame." In *Culture and AIDS,* edited by Douglas Feldman**,** 67-91. New York et al.: Praeger, 1990.

Farmer, Paul. "New Disorder, Old Dilemmas: AIDS and Anthropology in Haiti." In *The Time of AIDS,* edited by Gilbert H. Herdt and Shirley Lindenbaum, 287-318. Newbury Park et al.: Sage, 1992.

Farmer, Paul. *AIDS and Accusation: Haiti and the Geography of Blame*. Berkeley et al.: University of California Press, 2006.

Feldman, Douglas A. "Introduction: Culture and AIDS." In *Culture and AIDS*, edited by Douglas A. Feldman, 1-7. New York et al.: Praeger, 1990.

Feldman, Douglas A.*Culture and AIDS*. New York et al.: Praeger, 1990.

Fields, Karen E. "Political Contingencies of Witchcraft in Colonial Central Africa: Culture and State in Marxist Theory." *Canadian Journal of African Studies*, 16.3 (1982): 567-93.

Flint, Karen and Julie Parle. "Healing and Harming: Medicine, Madness, Witchcraft and Tradition." In *Zulu Identities*, edited by Benedict Carton, John Laband and Jabulani Sithole, 312-21. London: Hurst, 2009.

Förstner, Till. "From Rationality to Creativity: Ritual Activity and Religious Experience in the Work of Edward Evans-Pritchard (1902 – 1973) and Victor Turner (1920 – 1983)." In *European Traditions in the Study of Africa*, edited by Fieder Ludwig et al., 245-54. Wiesbaden: Otto Harrassowitz, 2004.

Frazer, James G. "South African Totemism." *Man* 1 (1901): 135-36.

Frohlich, Janet. "The Impact of AIDS on the Community." In *HIV/AIDS in South Africa*, edited by S.S. Abdool Karim and Q. Abdool Karim, 351-70. New York et al.: Cambridge University Press, 2005.

Gagnon, John H. "Epidemics and Researchers: AIDS and the Practice of Social Science." In *The Time of AIDS*, edited by Gilbert H. Herdt and Shirley Lindenbaum, 27-40. Newbury Park et al.: Sage, 1992.

Geschiere, Peter, Birgit Meyer and Peter Pels, ed. *Readings in Modernity in Africa*. Bloomington and Indianapolis: Indiana University Press, 2008.

Geschiere, Peter, Birgit Meyer and Peter Pels. "Introduction." In *Readings in Modernity in Africa*, edited by Peter Geschiere, Birgit Meyer and Peter Pels, 1-16. Bloomington and Indianapolis: Indiana University Press, 2008.

Geschiere, Peter. "Globalization and the Power of Indeterminate Meaning: Witchcraft and Spirit Cults in Africa and East Asia." In *Globalization and Identity: Dialectics of Flow and Closure*, edited by Birgit Meyer and Peter Geschiere, 211-37. Oxford and Malden: Blackwell Publishers, 1999.

Geschiere, Peter. "Witchcraft and Modernity: Thoughts about a Strange Complicity." In *The Power of the Occult in Modern Africa*, edited by James Kiernan, 45-74. Berlin: Lit Verlag, 2006.

Geschiere, Peter. *The Modernity of Witchcraft*. Charlottesville and London: University of Virginia Press, 1997.

Goody, Jack. "Religion and Ritual: The Definitional Problem." *The British Journal of Sociology*, 12.2 (1961): 142-64.

Green, Edward. *AIDS and STDs in Africa: Bridging the Gap between Traditional Healing and Modern Medicine*. Boulder, CO: Westview Press, 1994.

Green, Edward. *Indigenous Theories of Contagious Disease*. London: AltaMira, 1999.

Grill, Bartholomäus and Stephan Hippler. *Gott, Aids, Afrika: Eine Streitschrift*. Köln: Kiepenheuer und Witch, 2007.

Haggard, Henry Rider. *She: A History of Adventure.* Oxford: Oxford University Press, 1998 (1886/1887).

Hemshorn de Sánchez, Britta. "Violence, Trauma and Ways of Healing in the Context of the Transformative South Africa: a Gender Perspective on the Dynamic and Integrative Potentials of 'Healing' in African Religion." In *Religion and the Political Imagination in a Changing South Africa*, edited by Gordon Mitchell and Eve Mullen, 35-55. Münster et al.: Waxmann, 2002.

Herdt, Gilbert H. and Shirley Lindenbaum. *The Time of AIDS: Social Analysis, Theory, and Method.* Newbury Park et al.: Sage, 1992.

Janzen, John M. "The Need for a Taxonomy of Health in the Study of African Therapeutics." *Social Science and Medicine* 15.3 (1981): 185-94.

Janzen, John M. *Ngoma: Discourses of Healing in Central and Southern Africa.* Berkeley: University of California Press, 1992.

Kiernan, James, ed. *The Power of the Occult in Modern Africa: Continuity and Innovation in the Renewal of African Cosmologies.* Berlin et al.: LIT, 2006.

Kiernan, James. "Introduction." In *The Power of the Occult in Modern Africa: Continuity and Innovation in the Renewal of African Cosmologies*, edited by James Kiernan, 1-18. Berlin et al.: LIT, 2006.

Kippenberg, Hans G. "Einleitung: Zur Kontroverse über das Verstehen Fremden Denkens." In *Magie*, edited by Hans G. Kippenberg and Brigitte Luchesi, 9-51. Frankfurt am Main: Suhrkamp, 1987.

Kippenberg, Hans G. und Brigitte Luchesi, ed. *Magie: Die sozialwissenschaftliche Kontroverse über das Verstehen fremden Denkens.* Frankfurt am Main: Suhrkamp, 1987.

Kohnert, Dirk. "Occult Beliefs, Globalisation and the Quest for Development in African Societies: The Example of South Africa." In *Religion and the Political Imagination in a Changing South Africa*, edited by Gordon Mitchell and Eve Mullen, 167-87. Münster et al.: Waxmann, 2002.

Kohnert, Dirk. "On the Renaissance of African Modes of Thought: The Example of Occult Belief Systems." In *Witchcraft in Modern Africa*, edited by Burghart Schmidt and Rolf Schulte, 32-54. Hamburg: DOBU, Wissenschaftlicher Verlag Dokumentation und Buch, 2007.

Krige, J.D. "The Social Function of Witchcraft." *Theoria* 1 (1947): 8-21.

Lang, Andrew, N. W. Thomas, and G. W. Stow. "Bantu Totemism." *Folklore* 15.2 (1904): 203-05.

LeBeau, Debie. *Dealing with Disorder: Traditional and Western Medicine in Katutura (Namibia).* Köln: Köppe, 2003.

Leclerc-Madlala, Suzanne. "AIDS in Zulu Idiom. Etiological Configurations of Women, Pollution and Modernity." In *Zulu Identities*, edited by Benedict Carton, John Laband and Jabulani Sithole, 554-65. London: Hurst, 2009.

Lincoln, Bruce. "Theses on Method." *Method and Theory in the Study of Religion*, Vol. 8 (1996): 225-27.

Ludwig, Frieder and Afe Adogame. "Introduction: Historiography and European Perceptions of African Religious History." In *European Traditions in the Study of Africa*, edited by Frieder Ludwig et al., 1-22. Wiesbaden: Otto Harrassowitz, 2004.

Ludwig, Frieder, Afe Adogame, Ulrich Berner and Christoph Bochinger. *European Traditions in the Study of Africa*. Wiesbaden: Otto Harrassowitz, 2004.

Lurie, Mark. "Population movement and the Spread of HIV in South Africa." In *HIV/AIDS in South Africa*, edited by S.S. Abdool Karim and Q. Abdool Karim, 298-312. New York et al.: Cambridge University Press, 2005.

Maartens, Gary. "Prevention of Opportunistic Infections in Adults." In *HIV/AIDS in South Africa*, edited by S.S. Abdool Karim and Q. Abdool Karim, 454-62. New York et al.: Cambridge University Press, 2005.

Makhaye, Gethwana. "Young Men." In *HIV/AIDS in South Africa*, edited by S.S. Abdool Karim and Q. Abdool Karim, 313-18. New York et al.: Cambridge University Press, 2005.

Mathews, Catherine. "Reducing Sexual Risk Behaviours: Theory and Research, Successes and Challenges." In *HIV/AIDS in South Africa*, edited by S.S. Abdool Karim and Q. Abdool Karim,143-65. New York et al.: Cambridge University Press, 2005.

Max Weber. "Science as a Vocation." In *From Max Weber: Essays in Sociology*, edited and translated by H. H. Gerth and C. Wright Mills, 129-56. London: Routledge & Kegan Paul, 1948.

McGregor, Liz. *Khabzela: The Life and Times of a South African*. Auckland Park: Jacarna Media, 2005.

Meyer, Birgit and Peter Pels. *Magic and Modernity: Interfaces of Revelation and Concealment*. Stanford: Stanford University Press, 2003.

Meyer, Birgit. *Translating the Devil: Religion and Modernity Amongst the Ewe in Ghana*. Edinburgh: Edinburgh University Press, 2010.

Mogensen, Hanne O. "New Hopes and New Dilemmas: Disclosure and Recognition in the Time of Antiretroviral Treatment." In *Morality, Hope and Grief*, edited by Hansjörg Dilger and Ute Luig, 61-79. New York: Berghahn, 2010.

Moore, Henrietta L. and Todd Sanders, ed. *Magical Interpretations, Material Realities: Modernity, Witchcraft and the Occult in Postcolonial Africa*. London et al.: Routledge, 2001.

Moore, Henrietta L. and Todd Sanders. "Magical Interpretations, Material Realities: An Introduction." In *Magical Interpretations, Material Realities*, edited by Henrietta L. Moore and Todd Sanders, 1-27. London et al.: Routledge, 2001.

Morris, Lynn and Tonie Cilliers. "Viral Structure, Replication, Tropism, Pathogenesis and Natural History." In *HIV/AIDS in South Africa*, edited by S.S. Abdool Karim and Q. Abdool Karim, 79-88. New York et al.: Cambridge University Press, 2005.

Myer, Landon. "Barrier Methods." In *HIV/AIDS in South Africa*, edited by S.S. Abdool Karim and Q. Abdool Karim,166-82. New York et al.: Cambridge University Press, 2005.

Myhre, Knut Christian. "Disease and Disruption: Chagga Witchcraft and Relational Fragility." In *Dealing with Uncertainty in Contemporary African Lives*, edited by Christian Bawa Yamba and Liv Haram, 118-40. Uppsala: Nordic Africa Institute, 2009.

Niehaus, Isak and Gunvor Jonsson. "Dr. Wouter Basson, Americans, and Wild Beasts: Men's Conspiracy Theories of HIV/AIDS in the South African Lowveld." *Medical Anthropology* 24.2 (2005): 179-208.

Niehaus, Isak. Death *before Dying: Conceptions of AIDS in the South African Lowveld*. Research paper presented at the University of Camebridge, May 5, 2007.

Niehaus, Isak. "Leprosy of a Deadlier Kind: Christian Conceptions of AIDS in the South African Lowveld." In *AIDS and Religious Practice in Africa*, edited by Felicitas Becker and Paul Wenzel Geissler, 309-32. Leiden et al.: Brill, 2009.

Niehaus, Isak. "Perversion of Power: Witchcraft and the Sexuality of Evil in the South African Lowveld." In *The Power of the Occult in Modern Africa: Continuity and Innovation in the Renewal of African Cosmologies*, edited by James Kiernan, 75-111. Berlin et al.: LIT, 2006.

Niehaus, Isak. "Witchcraft in the New South Africa. From Colonial Superstition to Postcolonial Reality?" In *Magical Interpretations, Material Realities*, edited by Henrietta L. Moore and Todd Sanders, 184-205. London et al.: Routledge, 2001.

Niehaus, Isak. *Witchcraft, Power, and Politics: An Ethnographic Study of the South African Lowveld*. Johannesburg: University of Witwatersrand Press, 2001.

Ojo, Matthews A. "Healing in Sub-Saharan Africa." In: *Encyclopaedia of African-American Religions*. edited by Stephen D. Glazier, 139-44. New York, London: Routledge, 2001.

Pels, Peter. "Introduction." In *Magic and Modernity: Interfaces of Revelation and Concealment,* edited by Birgit Meyer and Peter Pels, 1-38. Stanford: Stanford University Press, 2003.

Pels, Peter. "The Magic of Africa: Reflections on a Western Commonplace." *African Studies Review*, 41.3 (1998): 193-209.

Puren, Adrian. "HIV Diagnostics." In *HIV/AIDS in South Africa*, edited by S.S. Abdool Karim and Q. Abdool Karim, 89-108. New York et al.: Cambridge University Press, 2005.

Ranger, Terence and Paul Slack, ed. *Epidemics and Ideas: Essays in the Historical Perception of Pestilence*. Cambridge: Cambridge University Press, 1992.

Ranger, Terence. "Plagues of Beasts and Men: Prophetic Responses to Epidemic in Eastern and Southern Africa." In *Epidemics and Ideas*, edited by Ranger Terence Ranger and Paul Slack, 241-68. Cambridge: Cambridge University Press, 1992.

Reid, Graeme. "Gossip, Rumour and Scandal: The Circulation of AIDS Narratives in a Climate of Silence and Secrecy." In *Morality, Hope and Grief,* edited by Hansjörg Dilger and Ute Luig, 192-215. New York: Berghahn, 2010.

Richards, Audrey. "A Modern Movement of Witchfinders." *Africa*, 8.4 (1935): 448-61

Rödlach, Alexander. *Witches, Westerners, and HIV: AIDS and Cultures of Blame in Africa*. Walnut Creek, CA: Left Coast Press, 2006.

Setel, Philip, Milton Lewis, and Maryinez Lyons, eds. *Histories of Sexually Transmitted Diseases and HIV/AIDS in Sub-Saharan Africa*. Westport, CN: Greenwood Press, 1999.

Slack, Paul. "Introduction." In *Epidemics and Ideas*, edited by Ranger Terence Ranger and Paul Slack, 1-20. Cambridge: Cambridge University Press, 1992.

Sontag, Susan**.** *AIDS and its Metaphors*. New York: Farrar, Straus and Giroux, 1989.

Sontag, Susan. *Illness as a Metaphor*. New York: Farrar, Straus and Giroux, 1988.

Stoler, Ann Laura. *Race and the Education of Desire: Foucault's* History of Sexuality *and the Colonial Order of Things*. Durham, NC: Duke University Press, 1995.

Tambiah, Stanley J. *Magic, Science, Religion, and the Scope of Rationality*. Cambridge et al.: Cambridge University Press, 1990.

Taussig, Michael. "Viscerality, Faith and Skepticism; Another Theory of Magic." In *Magic and Modernity: Interfaces of Revelation and Concealment,* edited by Birgit Meyer and Peter Pels, 272-306. Stanford: Stanford University Press, 2003.

Thornton, Robert. "Traditional Healers, Medical Doctors and HIV/AIDS in Gauteng and Mpumalanga Provinces, South Africa." Final Report to the Margaret Sanger Institute. Johannesburg: University of the Witswatersrand. *forthcoming*.

Treichler, Paula A. "AIDS, HIV, and the Cultural Construction of Reality." In *The Time of AIDS,* edited by Gilbert H. Herdt and Shirley Lindenbaum, 65-98. Newbury Park et al.: Sage, 1992.

Treichler, Paula A. "AIDS, Homophobia, and Biomedical Discourse: An Epidemic of Signification." In *AIDS*, edited by Douglas Crimp, 31-70. Cambridge et al.: MIT Press, 1988.

Tylor, Edward B. *Primitive Culture*. New York: Harper and Row, 1958 (1817).

Van Binsbergen, Wim. "Witchcraft in Modern Africa as Virtualized Boundary Conditions of the Kinship Order." In *Witchcraft Dialogues*, edited by Georg Clement Bond and Diane M. Ciekawy, 212-63. Athens: Ohio University Center for International Studies, 2001.

Vaughan, Megan. "Syphilis in Colonial East and Central Africa: The Social Construction of an Epidemic." In *Epidemics and Ideas*, edited by Ranger Terence Ranger and Paul Slack, 269-303. Cambridge: Cambridge University Press, 1992.

Wardorp, Joan. "Soweto Witchcraft Accusations in the Transition from Apartheid through Liberation to Democracy." In *Witchcraft in Modern Africa*, edited by Burghart Schmidt and Rolf Schulte, 213-29. Hamburg: DOBU, 2007.

Whiteside, Alan. "The economic impact of AIDS." In *HIV/AIDS in South Africa*, edited by S.S. Abdool Karim and Q. Abdool Karim, 405-18. New York et al.: Cambridge University Press, 2005.

Wiles, Jahsa. "An African Renaissance of Occult Cosmology? On the Continuity and Divide of Traditional Belif Systems in South Africa, 2000." In *Religion and the Political Imagination in a Changing South Africa*, edited by Gordon Mitchell and Eve Mullen, 189-220. Münster et al.: Waxmann, 2002.

Wood, Robin. "Antiretroviral Therapy." In *HIV/AIDS in South Africa*, edited by S.S. Abdool Karim and Q. Abdool Karim, 504-23. New York et al: Cambridge University Press, 2005.

Yamba, Christian Bawa. "Cosmologies in Turmoil: Witch-Finding and AIDS in Chiawa, Zambia." *Africa* 67.2 (1997): 200-23.

Zenker, Julia. "Traditionelle Medizin und Afrikanische Renaissance in Südafrika." In *Medizin im Kontext*, edited by Hansjörg Dilger and Bernhard Hadolt, 223-43. Frankfurt am Main et al.: Lang, 2010.

Newspapers

Adler, Josh. "Yfm's DJ Khabzela Is HIV Positive." *Music Industry Online*, May 16, 2003. Accessed June 26, 2012. http://www.mio.co.za/article/yfm-s-dj-khabzela-is-hiv-positive-2003-05-16.

Hlabane, Bheki and Lauren Hills. "Ailing but defiant HIV+ DJ accepts award." *IOL NEWS*, December 12, 2003. Accessed June 26, 2012. http://www.iol.co.za/news/south-africa/ailing-but-defiant-hiv-dj-accepts-award-1.119149#.T9DdYLVadEM.

McGregor, Liz. "Aids death of DJ highlights anguish of South Africa." *The Observer*, February 29, 2004. Accessed June 26, 2012. http://www.guardian.co.uk /world/ 2004/feb/29 /southafrica.aids.

McGreal, Chris. "AIDS: South Africa's New Apartheid." *The Guardian*, November 30, 2000. Accessed June 26, 2012. http://www.guardian.co.uk/world/2000/nov/30/aids. chrismcgreal

Riviere, Phillippe. "South Africa's AIDS Apartheid: In Denial about a Deadly Future." *Le Monde Diplomatique English Edition*. August, 2002. Accessed June 26, 2012. http:// mondediplo.com/2002/08/04aids/

Archives

African National Congress (ANC). *A National Health Plan for South Africa*. Johannesburg: African National Congress, 1994.

Human Sciences Research Council. *South African National HIV Prevalence, Incidence, Behaviour and Communication Survey of 2008*: A Turning Tide Amongst Teenagers? Cape Town: HSRC Press, 2009.

Republic of South Africa. *Country Progress Report on the Declaration of Commitment on HIV/AIDS: 2010 Report*. 31 March 2010. Accessed June 26, 2012. http://data.unaids.org/pub/report/2010/southafrica_2010_country_progress_report_en .pdf.

Republic of South Africa. *The Traditional Health Practitioners Act*, 2004. Cape Town: Governmental Gazette. No. 476.27275 (2005). Accessed June 26, 2012. http://www.doh.gov.za /docs/bills/thb.html.

South African Police Service. *Crime Situation in South Africa: Annual Report*. 2008-2009. Accessed June 26, 2012. http://www.saps.gov.za/saps_profile/strategic_framework/ annual_report / 2008_2009/ 2_crime_situation_sa.pdf.

Statistics South Africa. *Quarterly Labour Force Survey: Quarter 3 (July to September), 2001*. Accessed June 26, 2012. http://www.statssa.gov.za/publications/P0211/ P02113rdQuarter2011.pdf

Steinberg, Malcolm, Saul Johnson, Gill Schierhout, David Ndegwa, Katherine Hall, Bev Russell, and Jonathan Morgan. *Hitting Home: How Households Cope with the Impact of the HIV/AIDS Epidemic*. Washington DC: Henry J. Kaiser Family Foundation, 2002. Accessed June 26, 2012. http://www.kff.org/southafrica/ loader. cfm?url=/commonspot/security /getfile.cfm&PageID=14028.

UNAIDS. *2011 World AIDS Day Report*. 2011. Accessed June 26, 2012. http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/ 2011/JC2216_WorldAIDSday_report_2011_en.pdf.

UNAIDS. Country Situation Report South Africa. 2009. Accessed June 26, 2012. http://www.unaids.org/en/regionscountries/countries/southafrica.

UNAIDS. *Global Report: UNAIDS Report on the Global Epidemic 2010*. 2010. Accessed June 26, 2012. http://www.unaids.org/documents/20101123_globalreport_em.pdf.

UNAIDS. *Terminology Guidelines*. 2011. Accessed June 26, 2012. http://www.unaids.org /en/media/unaids/contentassets/documents/unaidspublication/2011/JC2118_terminol ogy-guidelines_en.pdf.