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1. INTRODUCTION

“AIDS has from the outset been as much a battle of ideas as a battle about bodies, organisms and cells” (qtd. in Grünkemeier 10). There are approximately thirty-five million people living with HIV in the world, and around six million of them live in South Africa (South Africa 2012). Almost one fifth of the South African population dies of AIDS-related diseases and the number of new infections continues to grow (South Africa: Statistics 2012). Despite having the highest adult HIV prevalence in the world there is a lack of literary representations of the epidemic in South African literature. Because what is absent is just as important as what is present, this lack of a literary response stimulates further research (Storey 72).

In 1994, the apartheid regime came to an end. The collapsed walls of the oppressive system revealed several previously hidden issues. Among them was the HIV/AIDS epidemic, but in the midst of celebrating the newly acquired freedom, such a negative topic was not a top priority for politicians. The lack of a fast and concrete response from the political leadership, resulted in slow and weak social and cultural responses, as well as constructing the epidemic as a taboo topic. This thesis will research all these responses. Literature mirrored this development and thus, it was not until the early 2000s when the first books about the epidemic emerged. The main aim of this thesis is to take a closer look at the literary responses to HIV and AIDS through the prism of five post-apartheid works of fiction; Phaswane Mpe’s *Welcome to Our Hillbrow* (2001), Niq Mhlongo’s *Dog Eat Dog* (2004) and *After Tears* (2007), Sindiwe Magona’s *Beauty’s Gift* (2008) and Kgebetli Moele’s *The Book of the Dead* (2009). The importance of analyzing such literary representations lies in their power to influence people’s attitudes and opinions and help contest the stigmatization and marginalization of the epidemic (Grünkemeier 5).

Literary texts provide an inside view, a personal experience of the epidemic. This research draws from literary theory and criticism, as well as postcolonial and cultural studies. Although HIV stands for Human Immunodeficiency Virus, and AIDS means Acquired Immunodeficiency Syndrome, the two words are often written together as one word in this thesis, to showcase that the focus is not on their medical, but their cultural connotations. When necessary they are written separately. The research in this thesis is limited to literary representations from chosen works of fiction. Another important thing is that all the chosen texts are written in English, which represents only one of the eleven official languages of South Africa, spoken by less than 10% of its 54 million inhabitants (Grünkemeier 8).

The rough layout for this Master thesis was created by an interview conducted especially for this work with writer Sindiwe Magona in 2014. Among the publications that most influence this research are Ellen Grünkemeier's *Breaking the Silence: South African Representations of HIV/AIDS* (2013), Tim Woods's *South African Literature in the Time of AIDS* (2013), a collection of interviews *Trauma, Memory, and Narrative in South Africa: Interviews* (2010) by Ewald Mengel, Michela Borzaga, and Karin Orantes, *Implementing AIDS policy in post-apartheid South Africa* (2001) by Helen Schneider, and Joanne Stein, as well as works by Kulukazi Soldati-Kahimbaara, Lizzy Attree, and Frédéric Le Marcis. This study draws from various academic fields such as history, politics, sociology, and gender studies, with the theoretical background being provided by Andrew Bennett, and Nicholas Royle and their *An Introduction to Literature, Criticism and Theory* (2009), Peter Barry's *Beginning Theory: An Introduction to Literary and Cultural Theory* (1995) and John Storey's *Cultural Theory and Popular Culture: An Introduction* (2009). The statistical data is taken from the World Health Organization, UNAIDS and mid-year population estimates by Statistics South Africa.

The Master thesis is divided in six parts. It starts by focusing on facts and statistics about HIV/AIDS in South Africa. Explaining some key terms about the disease, there is also an explanation of the historical circumstances that allowed the epidemic to bloom. The following chapter takes a closer look at the highly criticized, and at times controversial, political responses of the governments of Nelson Mandela, Thabo Mbeki and Jacob Zuma. The fourth section will analyse the social responses to the epidemic and point out the successful HIV/AIDS awareness campaigns, while the fifth section is a summary of cultural responses. The main body of the text, the sixth chapter, focuses on literary representations of the epidemic in selected works of fiction. Using excerpts from chosen texts the research analyzes where the HIV virus originates and why AIDS is still considered a taboo topic. The following subchapters investigate how different characters, their families, friends, and the readers, react to an HIV positive diagnosis. They also describe the physical and psychological decay one endures because of the epidemic and how that can be prevented. Furthermore, they show how in a broader socio-cultural context, women can be empowered by the ever-growing epidemic.

2. HIV/AIDS IN SOUTH AFRICA

According to the World Health Organization (WHO) there were 35 million people living with HIV/AIDS at the end of 2013 (HIV/AIDS 2013). So far the epidemic has taken over 39 million lives, 1.5 million lost in 2013 alone while in the same year 2.1 million became newly infected (HIV/AIDS: Key facts 2014). Sub-Saharan Africa is the region where 70% of all new infections occur and where 24.7 million people are infected with the virus (HIV/AIDS: Key facts 2014). While there is no cure for HIV, a treatment with antiretroviral drugs increases the possibility of a healthy life and prologues the outburst of AIDS. Acknowledging WHO's data, 28 million people were eligible for antiretroviral therapy (ART) in 2013, but in low- and middle-income countries only 11.7 million received it (HIV/AIDS 2013). Even though, there is a big gap between the percentage of adults (37%) and children (23%) receiving ART, 67% pregnant women were able to receive the right medication to prevent infection of their unborn children (HIV/AIDS: Data and statistics 2014). In 2013, nearly 2 million people "[...] newly enrolled on antiretroviral treatment [...] the largest ever annual increase" (HIV/AIDS: Data and statistics 2014).

HIV stands for Human Immunodeficiency Virus that "[...] targets the immune system and weakens people's surveillance and defence systems against infections and some types of cancer. As the virus destroys and impairs the function of immune cells, infected individuals gradually become immunodeficient" (HIV/AIDS: Key facts 2014). HIV is a lentivirus meaning it can never be completely eliminated from the body (Grünkemeier 13). HIV's main activity is not to kill its host but to replicate itself and the fact that activity causes damage to the host organism is a mere side effect (Grünkemeier 13). As Shula Marks highlights about HIV:

[...] by becoming part of the genetic material of the person it infects, it has what has been termed the 'ultimate camouflage'. People who carry the virus have few if any obvious signs of infection, and many may well be unaware of their infection, but can still pass it on to others. Meanwhile the virus itself constantly changes, thus evading the armoury of the host sophisticated of modern drugs. All this makes it the ideal killer. (qtd. in Grünkemeier 13)

Immune function is usually measured by CD4 cells also known as 'helper' cells, because they find the germs in human bodies and kill them (Le Marcis 193). The role of HIV is that it "[...] invades the cells, reproduces itself within them, and eventually kills them" (Le Marcis 193). The decreasing number of CD4 cells marks the different stages of the HIV infection "A healthy body has a CD4 count of 1,000-1,500 cells per cubic millimeter of blood. A CD4 count below 200 indicates that a person has reached the fourth stage of illness. This

person would be said to have AIDS (i.e., he or she is no longer simply HIV-positive)” (Le Marcis 193). The result of immunodeficiency is that infected bodies can no longer fight off simple infections normal healthy bodies can. It can take from two to fifteen years to get to the most advanced stage of HIV infection resulting in Acquired Immunodeficiency Syndrome (AIDS) which is then “[...] defined by the development of certain cancers, infections, or other severe clinical manifestations” (HIV/AIDS: Key facts 2014). South Africa’s Department of Health statistical report for 2014 predicts “[...] 10.5 years for men and 11.5 years for women” as the median time from HIV infection to death (Mid-year population estimates 2014 5).

The signs and symptoms of having contracted HIV depend on the stage of infection. Even though a person is the most infectious during the first few months it is quite common that people are unaware of their status because the symptoms following the first weeks after infection are ‘normal’ diseases such as influenza, fever, headache, sore throat or rashes (HIV/AIDS: Key facts 2014). While the virus progresses, the immune system gets weaker and weaker causing “[...] swollen lymph nodes, weight loss, fever, diarrhea and cough. Without treatment, they could also develop severe illnesses such as tuberculosis, cryptococcal meningitis, and cancers such as lymphomas and Kaposi’s sarcoma among others” (HIV/AIDS: Key facts 2014).

HIV can be transmitted by: “[...] body fluids from infected individuals, such as blood, breast milk, semen and vaginal secretions,” but it is important to emphasize that one does not “[...] become infected through ordinary day-to-day contact such as kissing, hugging, shaking hands, or sharing personal objects, food or water” (HIV/AIDS: Key facts 2014). Risk factors of contracting HIV include having unprotected sexual intercourse, sharing infected needles or syringes, having other sexually transmitted diseases, receiving unsafe injections, blood transfusions or even accidental needle stick injuries (HIV/AIDS: Key facts 2014). HIV testing is never mandatory but voluntary with the results of tests always staying confidential.

There is antiretroviral-related prevention but the most simple way of avoiding getting HIV is by using a male or female condom with the former having almost 90% prevention efficiency (HIV/AIDS: Key facts 2014). Learning about an individual’s infection status is important for knowing about prevention and possible future steps and therefore testing and counselling for HIV are recommended (HIV/AIDS: Key facts 2014). Voluntary medical male circumcision by trained health professionals can reduce the risk of infection by almost 60% (HIV/AIDS: Key facts 2014). Vertical or mother-to-child transmission from an HIV-positive mother to her child during pregnancy can be avoided if mothers receive ARV’s during

pregnancy and breast-feeding periods. For HIV positive women it is best if they receive antiretrovirals throughout all their productive years (HIV/AIDS: Key facts 2014). Without intervention the transmission rates of pregnant women can range from 1 up to 45 percent (HIV/AIDS: Key facts 2014). However, in 2013, 67% of pregnant women living with HIV received effective antiretroviral drugs (HIV/AIDS: Key facts 2014).

Antiretroviral treatment (ART) consists of three or more antiretroviral drugs, and it is important to recognize that “ART does not cure HIV infection but controls viral replication within a person’s body and allows an individual’s immune system to strengthen and regain the capacity to fight off infections. With ART, people living with HIV can live healthy and productive lives” (HIV/AIDS: Key facts 2014). One in four children, compared to one in three adults, receives antiretrovirals together forming 11.7 million people receiving treatment (HIV/AIDS: Key facts 2014).

The World Health Organization suggests starting antiretroviral treatment when a person has a CD4 count below 400 (HIV & AIDS in South Africa 2012). In 2009, statistics showed that people starting ART had an average 87 cells/mm³ which made recovery almost impossible (HIV & AIDS in South Africa 2012). Sometimes people even decline health treatment saying they ‘feel healthy’ (HIV & AIDS in South Africa 2012). In addition to the HIV epidemic, South Africa is a country with the third largest tuberculosis (TB) epidemic in the world (HIV & AIDS in South Africa 2012). It is important to point out that HIV fuels TB and “[...] 70 percent of people living with HIV in South Africa are co-infected with TB,” prompting Nelson Mandela to allude to the nation “We cannot fight AIDS unless we do much more to fight TB” (qtd. in HIV & AIDS in South Africa 2012).

Currently, South Africa has “[...] the largest antiretroviral treatment rollout programme in the world” (HIV & AIDS in South Africa 2012). It should not go unnoticed that most of the money given for HIV/AIDS comes from domestic resources as the country annually invests up to a billion Rands in prevention programs, and only 25% are worldwide donations (HIV & AIDS in South Africa 2012). This is made possible with the introduction of “[...] a three-in-one or fixed-dose combination (FCD) drugs helping to reduce the pill burden and improve adherence” (HIV & AIDS in South Africa 2012). This highly active ‘cocktail’ antiretroviral therapy predicts taking a combination of pills instead of monotherapies where every single medication requires its own therapy, and saves South Africa a lot of money while still producing positive results (Grünkemeier 14).

Sindiwe Magona, one of South Africa's most famous writers, questions South Africa's policy of medication by highlighting people often don't understand how the medication they get works. In her opinion people believe that taking ARV's cures AIDS because nobody takes the time to explain to them how exactly they work (Zajec 84-85). She also points out that while antiretrovirals are now free, the right food and nutrition accompanying them is not (Zajec 86). The lack of money among most of the infected makes the right combination of ARV's and food impossible and therefore minimizing the effect of the drugs.

According to the mid-year estimates for 2014 from Statistics South Africa, "The overall HIV prevalence rate is approximately 10,2% of the total South African population. The total number of people living with HIV is estimated at approximately 5,51 million in 2014. For adults aged 15-49 years, an estimated 16,8% of the population is HIV positive" (Mid-year population estimates 2014 2). In July 2014, the total population of South Africa was approximately 54 million people, 51 percent of them were female (Mid-year population estimates 2014 2).

A little bit over four million people were HIV positive in 2002. South African mid-year statistics for 2014 show that the number has gone up to 5.51 million people out of which 1.1% are new infections (7). Among the youth aged between 15 and 24 the prevalence rate is 8.7%, but amongst women aged from 18 to 49 the prevalence rate is 18.5% showing that almost a fifth of women in their fertility years are infected with HIV and that the epidemic is more felt amongst women (Mid-year population estimates 2014 7). The prevalence among women is almost twice the number as the male prevalence, while young females between the ages of 15 and 25 are more than four times at a greater risk of getting infected with HIV than their male peers (HIV & AIDS in South Africa 2012). Women constituted a quarter of all new infections in 2012 (HIV & AIDS in South Africa 2012). Altogether, almost eleven percent of South Africa's population lives with HIV according to South African mid-year population estimates for 2014 (7).

In comparison, the results of UNAIDS, a special worldwide organization dedicated to HIV/AIDS co-funded by the World Health Organization and the United Nations, for 2013 show a larger number of people living with HIV in South Africa, namely 6.3 million, and a prevalence rate 19.1% for adults aged between 15 and 49 (South Africa 2012). According to their statistics there are about 5.9 million adults aged over 15 living with HIV in Africa's richest country and 3.5 million of them are female (South Africa 2012). UNAIDS data claim that almost four hundred thousand children aged below 14 live with HIV, while there are 2.4

million orphans aged below 17 due to AIDS (South Africa 2012). The development of such orphans is marked by siblings being separated and frequently moved (HIV & AIDS in South Africa 2012).

UNAIDS estimates that there are 200 000 deaths yearly due to AIDS (South Africa 2012). Statistics South Africa reveal the total number of AIDS related deaths in a year between mid-2013 and mid- 2014 was 171 733, which is considerably lower than 363 910 from mid-2005, the first year of the national rollout of antiretroviral treatment, to mid-2006 (6). Life expectancy at birth in 2014 was approximately 63 years for women and 59 years for men (Mid-year population estimates 2014 6). This means a considerable increase from 2002 when life expectancy was 51 years for males and almost 56 for females (Mid-year population estimates 2014 6). Life expectancy declined from 2002 until 2005 when antiretrovirals were made available to all, while since then life expectancy has been increasing (Mid-year population estimates 2014 5). We are now also able to calculate the approximate life expectancy at birth without HIV which would be 65 years for males and 71 for females in 2014 making the impact of HIV on life expectancy quite clear (Mid-year population estimates 2014 4).

KwaZulu-Natal has the highest prevalence rate among South Africa's provinces followed by Mpumalanga and Free State (van der Linde). The rate has increased in all provinces, even in Western Cape with the lowest prevalence (van der Linde). The Human Sciences Research Council conducted an individual research highlighting "A very disturbing finding [...] that HIV prevalence among unmarried persons is twice that of married persons, 19.2% compared with 9.8%. The proportion of unmarried persons in South Africa is high at 64.4% of the population aged 16 years," and that "[...] people who are unmarried are more likely to report having multiple sexual partners within the last 12 months" (van der Linde).

A negative tendency of not using condoms for protection is becoming more and more popular, therefore, explaining the increasing number of new infections. There are positive results in the young adults age group from 15 to 24 years that use condoms in almost sixty-five percent cases. At the same time 34.6% members of that age group admit having multiple sexual partners (van der Linde). The groups most affected by the epidemic include homosexuals, closely followed by another key affected population, sex workers which in 2010 accounted for an estimated twenty percent of all new HIV infections in South Africa (HIV & AIDS in South Africa 2012). The HIV prevalence is also high among people who inject drugs (HIV & AIDS in South Africa 2012).

Reliable empirical data is hard to get, especially because of the shame and stigma surrounding HIV/AIDS (Grünkemeier 30). Statistics South Africa is released by the Department of Health that bases its findings on HIV/AIDS prevalence, meaning the number of all people affected by the virus or syndrome, that are based on results gathered from pregnant women going to public antenatal clinics (ANC) since 1990 which scientists then project to the general population (Mid-year population estimates 2014 5). Using the cohort-component methodology to estimate the 2014 mid-year population means that:

[...] a base population is estimated that is consistent with known demographic characteristics of the country. The cohort base population is projected into the future according to the projected components of change. Agreed levels of fertility, mortality and migration are used as input to the cohort component method [...] the AIM component [...] is used to incorporate the impacts of HIV and AIDS on fertility and mortality. (Mid-year population estimates 2014 4)

Consequently, such data are biased because the prevalence predictions are based on a smaller sample of pregnant women attending public health clinics, even though the final results are fixed “[...] by adjusting for relative attendance rates at antenatal clinics and for the difference in prevalence between pregnant women and the general adult population” (Mid-year population estimates 2014 5). Such results of mathematical formulae cannot be perceived as ‘facts’ and are left for interpretation and projection thus becoming a construction of HIV/AIDS (Grünkemeier 30).

As a tool of the state, statistics can be used as a political weapon like for example preferring to show the prevalence rate that can change for many different reasons in opposition to the incidence rate, the number of new infections in a particular period of time, that are harder to adjust and show exactly how successful new government HIV prevention strategies are (Grünkemeier 31). For correct incidence rates one would need regular testing, monitoring, adequate documentation, a wide and well-functioning health care and the removal of the stamp of stigma from the epidemic (Grünkemeier 32). Unfortunately, to date there has been no broad reliable research looking just into incidence rates instead of prevalence, not by South Africa, UNAIDS or WHO. By not publishing such statistics governments and international organizations avoid responsibility. If their HIV prevention measures are unsuccessful they can only show the ones that speak in their favor (Grünkemeier 31). Nevertheless, the statistical prevalence figures we get inform us with the trends of the epidemic.

In 2010 South Africa launched its HIV counselling and testing campaign (HTC) which has been successful because between the years 2008 and 2012 HIV testing has risen “[...] from an estimated 19.9 percent to 37.5 percent among men, and from 28.7 percent to 52.6 percent among women” (HIV & AIDS in South Africa 2012). An improvement in the general standard of living would help get more people to test for HIV proven by the fact that “In South Africa, the link has also been made between an individual’s socio-economic background and the likelihood that they will test for HIV. Those who have taken an HIV test and know their status, are more likely to have a higher level of education, be employed, have accurate HIV knowledge and a higher perception of risk” (HIV & AIDS in South Africa 2012). The link between testing and where a person lives has proven that an individual living in an urban area is more likely getting tested than one living in rural settlements (HIV & AIDS in South Africa 2012). Helping in solving that problem are the mobile HIV testing units and the experimental home-based HIV testing project (HIV & AIDS in South Africa 2012).

2.1. HISTORICAL CIRCUMSTANCES

The colonization of South Africa started in 1652 with the first European settlement lead by Jan van Riebeeck at Table Bay (Grünkemeier 22). From then on the indigenous people of South Africa have suffered oppression, elimination and separation from the whites. John Storey is fast to point out that “Difference exists whether it is made to signify or not. But how it is made to signify is always a result of politics and power, rather than a question of biology” (167). In his groundbreaking book *Orientalism* (1978), Edward Said already sets the agenda making it clear that we live in a Western discourse, a Western body of knowledge and power relations. His Orient is a contrast image of Europe just as South Africa’s indigenous people were to the European newcomers. Seeing the former as primitive, backward, mysterious and ultimately inferior, as ‘the other’ or the id. Such power relations are in interest of the West as it legitimizes colonization. By such circumstances “European culture gained in strength and identity by setting itself off against the Orient as a sort of surrogate and even underground self” (qtd. in Storey 171).

In the 20th century it all culminated in 1948 with the victory of the Afrikaner Nationalist Party. The Party introduced:

[...] a state policy of separateness, or ‘apartheid’ as it is called in Afrikaans, which was designed to separate South Africans in virtually all spheres of social life on the basis of race classifications. Laws passed to implement this government policy were, among others, the Population Registration Act (1950), which classified citizens by race as white, Coloured, Asian or black; the Group Areas Act (1950), an attempt to

physically separate these racial groups; and the Bantu Education Act (1953), introducing an unequal educational system that bred conflict and later led to the student protests in Soweto in 1976. (Grünkemeier 23)

The Soweto uprising was the spark that was needed to start the avalanche that brought down apartheid. In 1990 the ban of the African National Congress (ANC) was lifted and the first democratic elections were held in 1994 making Nelson Mandela the first democratically elected President of South Africa (Grünkemeier 23). The end of apartheid brought freedom to the ‘Rainbow Nation’ but also unmasked some severe problems, like HIV and AIDS, hidden by the façade of political issues.

AIDS was first reported in 1981 in the United States of America when an immune suppression was discovered among young homosexuals (Grünkemeier 12). HIV first came to South Africa in the 1980s. The epidemic started in Western Europe and Northern America with a clade B virus, which transformed into clade C virus in East and Central Africa from where it came to South Africa (Schneider 725).

The first two cases of a diagnosis with HIV in South Africa appeared in 1982. Because they were discovered with two homosexual men, flight stewards flying from the United States, subconsciously connections were immediately made linking the epidemic with sexual orientation deviance (History of HIV & AIDS in South Africa 2014). AIDS later appeared among people outside of ‘normal’ society like truck drivers, prostitutes and drug users and thus HIV/AIDS was marked by isolation, blame and promiscuity (Grünkemeier 12). In South Africa, such associations made it easier for the apartheid government to wash its hands from any intervention. The associations also caused severe damage among the general population leaving the majority completely unaware of the dangers and consequences of infection because this was merely a ‘gay disease’. Only the appearance of infections among hemophiliacs, contracting HIV through blood transfusion, draw attention of the public eye as they were seen as ‘innocent victims’ (History of HIV & AIDS in South Africa 2014). By 1991, homosexual transmission equaled heterosexual, and ever since “HIV transmission between heterosexual people has become the dominant transmission route in South Africa” (History of HIV & AIDS in South Africa 2014). Lizzy Attree shows that on the one hand, we have a representation of the white ‘Western’ AIDS affecting gay people in Europe and America (Rahman 330). While on the other hand, we have “[...] the AIDS discourse of Africa [...] predictably counter-created as a racialized and gendered series of statistics that simplifies

the AIDS pandemic in Africa as an affliction whose subjects are the ill-educated, wildly sexual barbarians of a dark continent” (Rahman 330).

Chris Hani, the then head of the ANC’s armed wing, rightfully feared the epidemics death toll interfering with the grand plan his party envisioned so in 1990 when they were still in exile in Maputo, Mozambique, the African National Congress called together a conference and released the *Maputo Statement on HIV and AIDS in Southern Africa*, stressing the need to act on the epidemic in the whole region (Schneider 725). In 1992, a surprising unity between the apartheid’s Department of Health and the ANC resulted in a conference on AIDS in South Africa attended by more than 450 professionals and analysts that together established the NACOSA - The National AIDS Committee of South Africa (Schneider 725). The committee was supposed to lead the fight against AIDS in the country, providing a far-reaching AIDS plan in hope of spreading through the nation. The plan was based on experiences of other African countries with the epidemic (Schneider 725). The tactic was a ‘co-operation-and-inclusion’ strategy and planned to give voice to the HIV infected and give them the power to develop future policies with a special focus on infected women (Schneider 725). This AIDS plan gave the central role to the government at the national and provincial level (Schneider 725). With a promise to employ highly skilled professionals the plan would be implemented in four key ministries – Health, Education, Welfare and Defence, with the “[...] final authority with a coordinating structure in the President’s office nationally, and the Prime Ministers’ offices at provincial level” (Schneider 725).

In the negotiations between 1990 and 1994, there were two conditions demanded to stay intact before the hand-over of power “The first was that jobs of civil servants would be protected in the first five-years after 1994, and the second was the establishment of a quasi-federal political system to satisfy minority political interests” (Schneider 724). The first condition resulted in an administration apparatus that was still based on white supremacy, where a lot of the workers were incompetent for their jobs and put into positions only because of good connections. This also reflected in hatred of health-workers by the black majority. The second condition was a division of power which resulted in the creation of nine provinces. Therefore, the implementation of AIDS programs did not come under the jurisdiction of the national government but to the provinces (Schneider 724). How the money allocated to the provinces for AIDS gets spent is not controlled.

When apartheid came down in 1994 it was expected from the African National Congress to present a well-structured plan of action about the future spread of the HIV/AIDS

epidemic. Prior to 1994 “[...] strong networks between non-governmental organisations, researchers, sympathetic health workers, an infrastructure of AIDS counseling and information centres in metropolitan local governments,” was put up (Schneider 723). Yet, four years into the work of the democratically elected government all the plans were seen as merely “[...] a neat book on the shelf” (qtd. in Schneider 724). When asked about why it seems like the question of AIDS was pushed aside after the fall of apartheid, and if other issues rather than AIDS seemed more pressing to the government of Nelson Mandela, author Sindiwe Magona replied:

We fought so long for freedom. The fall of apartheid came as a surprise for everybody. Nobody believed apartheid was going to end during our lifetime, nobody. And so we struggled when it happened and tried to get along with the best of our abilities. Most of the people in the government didn't know what they were doing. We had a government that was in chains five minutes ago and they simply could not cope with all the issues at the same time. (Zajec 89-90)

In Magona's opinion there have been some patchwork attempts of fixing things but ignoring the root causes using excuses that everything is the fault of the previous regime (Orantes 43). She also points out that while renaming streets and airports help with tearing down old symbols; re-building the state by focusing on health, education or transport, things ordinary citizens are most affected by, has yet to be done (Orantes 44).

South Africa has the highest adult HIV infection rate in the world (Grünkemeier 3). There is no doubt that the apartheid regime did little to prevent the epidemic. Forcefully moving people across the country for re-organization or work, oppressing them and thus consequently sparking resistance, fueled the rapid spread of new infections as well as doing little for preventing them (Grünkemeier 3). Magona suggests that South Africa has the highest infection rate among all the African countries because, compared to the other countries on the continent, they are rich (Zajec 84). She points her finger towards political and religious leadership and the risky sexual activities of the population. Maintaining several partners requires money, and apparently South Africans have enough of it. The epidemic is preventable if sexual intercourse is approached carefully. And while Magona makes it clear that being infected is nothing to be ashamed of, being infected and irresponsible should be condemned (Zajec 84).

AIDS affects people on several levels such as “[...] physical, psychological, societal, economical and political” and sometimes still conveys “[...] negative images of dirt, contamination, punishment for wrong doing, and painful death” (Soldati-Kahimbaara 165).

Even though, HIV/AIDS is usually primarily connected with medicine there are several other fields influencing the epidemic, like history, economics, politics, sociology, psychology, ethics and culture to name a few (Grünkemeier 10). Paula Treichler named HIV/AIDS the ‘epidemic of signification’ echoing Edwin Cameron’s judgement that “AIDS has from the outset been as much a battle of ideas as a battle about bodies, organisms and cells” (qtd. in Grünkemeier 10).

Throughout history societies have always found one disease to blame for all their misfortunes from the plague, to syphilis, cholera, influenza, and modern day cancer (Grünkemeier 11). Because there was no cure for any of those diseases in the times they caused havoc and devastation, they were seen as a great evil. Something similar can be said about the HIV/AIDS epidemic today. It is ‘the’ disease of our time. HIV cannot be cured with antiretrovirals, or with vaccines or antibiotics like bacterial infections. As a viral infection it develops in a syndrome constituted by several illnesses making it impossible to blame only one factor. Grünkemeier highlights several key notions about the epidemic:

As the virus is transmitted through body fluids, with sexual intercourse as the most likely way of infection, HIV/AIDS is not only a global phenomenon but ‘also the most personal’ [...] and thus gives rise to certain associations. Like other sexually-transmitted infections, AIDS is surrounded by stigma, including shame, secretiveness and denial [...] precisely because the virus is transmitted sexually, it makes government and indeed public health intervention particularly fraught [...] HIV/AIDS is therefore not limited to medical matters and cannot be viewed in isolation. The epidemic is a multi-faced phenomenon that is interrelated with broader social issues and taboos. Nourishing secrecy and concealment, the epidemic is ‘distinctive in that it is unseen’. (13-14)

Sometimes a discussion about the cultural impact and the representations of the HIV/AIDS epidemic seems useless because it is clear that cultural studies cannot cure AIDS. Stuart Hall, one of the founding fathers of cultural studies, points out that: “The question of AIDS is an extremely important terrain of struggle and contestation. In addition to the people we know who are dying, or have died, or will, there are many people dying who are never spoken of. How could we say that a question of AIDS is not also a question of who gets represented and who does not?” (Grünkemeier 20). Or as John Storey highlights, what is absent is just as important as what is present (72).

When talking about representations of HIV/AIDS and considering literary, cultural and postcolonial studies in the post-apartheid period, “Questions of power and resistance, of dominance and subordination, of inclusion and exclusion are relevant” (Grünkemeier 16). It often seems that the debate about the epidemic in the public sphere hasn’t got much to do with

HIV or AIDS. It is more a clash of the past and the present, the shifting of ideological and political responsibilities from the current regime to the one before. Furthermore, South Africa hasn't dealt with its past properly and thus all the old resentments resurface in the HIV/AIDS debate. This intertextuality proves that "[...] the problem of AIDS in South Africa [...] can only be grasped as a problematization of the contemporary world involving relations between history and memory, power and knowledge, truth and suspicion, inequality and violence" (Woods 309).

A regulated system of representations would present an ideology that is profoundly unconscious. Ideology "[...] is the way we live our relationship to the real conditions of existence at the level of representation" (Storey 71). How AIDS is represented in politics, cultural texts, and literary works is ideological. Ideology works as a closed system - it sets problems it can answer (Storey 72). Consequently, it stays silent on questions that threaten to take it beyond its boundaries, which is exactly what HIV/AIDS is doing (Storey 72). The influential French philosopher Louis Althusser presented ideology as lived, material practices through rituals, customs, patterns of behavior, or ways of thinking, reproduced through education, religion, politics or family (Storey 78). Althusser famously stated: "All ideology has the function [...] of 'constructing' concrete individuals as subjects. Ideological subjects are produced by acts of 'hailing' or interpellation" (qtd. in Storey 78). This would mean that the reception of HIV/AIDS in the public eye has been pre-constructed and the public thought what to think about people who are infected with HIV/AIDS. It really doesn't matter what our personal stance on the epidemic is, because the opinion of the masses has already been made. Marked by the stamp of disapproval "The history of AIDS in South Africa constitutes a web of meaning that extends well beyond the country borders and the disease itself. It recounts a political world order composed of both social configurations and symbolic arrangements, relations of knowledge and power, representations of the self and discourses on the other" (qtd. in Woods 309).

After the fall of apartheid and the removal of white leadership, black leadership has adopted processes of power in which a dominant group doesn't rule by force but leads by consent (Storey 79). What seems natural is actually constructed. Grünkemeier points out that meaning is not something given, something that never changes, but is always opened to transformation depending on the time and place in which it is (21). Thabo Mbeki's Presidency is the perfect example of how a leading figure's opinion can shape the public opinion. Representation of HIV/AIDS in such a situation then transforms into an arena of struggle and

negotiation between the interests of dominant groups and the interests of people who are affected/infected by HIV/AIDS as a subordinate group (Storey 81). South Africa is now such an arena and a site of resistance, dissidence and incorporation by making, maintaining or reproducing dominant representations of the epidemic (Storey 82).

Works of fiction incorporate colonial and postcolonial ideas. Stuart Hall's concept of articulation makes it clear that cultural texts do not have meaning by themselves, their meaning is articulated, made to mean by context. Mixing, expressing meanings and temporary connections, result in completely different things in different contexts. Partial fixing of meanings brings together dominant articulations like white as superior and black as inferior. They construct realities with material effects such as naturalization. Dominant connotations thus construct the norm and create naturalized identities. Therefore, literature is a special case because it "[...] does not simply work as a 'mirror' but absorbs, appropriates and inscribes aspects of the 'other' culture, creating new genres, ideas and identities of the process" (qtd. in Grünkemeier 25).

The spread of HIV/AIDS in South Africa has been described as a bomb waiting to go off with its complex social history helping the incredulously fast spread (Grünkemeier 32). When people finally got their freedom, they did not expect they would be facing an even bigger danger in the not so far future, the HIV/AIDS epidemic. Post-apartheid South Africa faces many issues, from poverty, hunger, social inequality, to unemployment and migration for work, the ever-growing violence rates and a crashing health system, to name just a few (Grünkemeier 32). Nevertheless, Tim Woods makes it clear that "Coming to terms with HIV/AIDS is intricately intertwined with survival and adaptation in a post-apartheid society, demystifying signifiers and discourses that have underpinned an apparently 'natural' status quo, as well as envisaging the need for new social relationships, a reorganization of domestic hierarchies, and a conceptualization of domestic patterns of trust and loyalty" (Woods 312).

Magona regrets the views of the World on South Africa and its exceptionally high HIV/AIDS statistics. Together with the not completely forgotten apartheid legacy the famous female writer suggest serious self-reflection on the part of South Africa "I believe we really need to rethink who we are as a nation. We need to fulfill Mandela's dreams. And we need to start working on it now. Apartheid did not end overnight in 1994; it is still a work in progress. And the same goes for HIV/AIDS it will not go away overnight just because we want it to. We need to work on it day by day" (Zajec 88). As Adam Levin, a pioneer of autobiographical writing on HIV/AIDS in South Africa puts it: "AIDS is a riddle. It is invisible and yet it is

everywhere, all around us, in people we love, in me. It doesn't matter if you are HIV-positive or negative. The world has AIDS" (Attree 106).

3. POLITICAL RESPONSES

Political influence on South Africa's battle with HIV and AIDS has been very particular and has had far reaching consequences on how the epidemic is presented and approached. Between 1990 and 1994 it seemed like the cooperation between the politicians of the African National Congress, scientists, the media and several activists would lead to positive results and created a feeling of optimism for future problem solving connected with the epidemic. 1992 saw the beginning of a national helpline for AIDS and in 1993 NACOSA wrote a strategic plan of action. However, after the first free election when Nelson Mandela took over as South Africa's new President, other issues became more pressing. In an effort to create a 'Rainbow Nation' where all would be equal, attention was paid more to the general health system than specifically to the epidemic that came lurking form behind. What seemed like a large-scale cooperation before 1994, faltered in the post-apartheid reality.

3.1. NELSON MANDELA'S PRESIDENCY

It is understandable that directly after the fall of apartheid it was easier for the government to promote positive changes and programmes and not talk about an epidemic that might kill millions or interfere in people's private lives claiming they should practice safe sex if they wish to stay alive. In the euphoria of the moment, HIV and AIDS were not favorable topics.

Nevertheless, the AIDS Plan was supposed to be one of the priorities of Mandela's Presidency. In 1994 a National AIDS Programme Director was appointed, but even though the AIDS Plan placed him in an inter-sectoral position, he was given a position inside the Health Department (Schneider 725). The provincial coordinators for AIDS were appointed only in 1996 and chosen among old bureaucrats instead from the large group of activists or scientists very familiar with the topic (Schneider 725). The power and influence of these local coordinators was low. While prior to 1994 AIDS was considered as a special case, the fall of apartheid blended it as just one of the many concerns of the health system (Schneider 726).

In the period between 1994 and 1997, South Africa had a problem spending the international funds allocated to the AIDS Programme (Schneider 726). For example, in the period between 1995 and 1996, only half of the funds given by the principal donor, the European Union, were actually used (Schneider 726). By 1998 the actualization of the AIDS

Plan was only wishful thinking with a slow pace lacking co-operation across sectors. This problem was not unique only to AIDS but to the whole public sphere post-1994 (Schneider 726). With a lack of multi-sectoral action, AIDS was predestined to remain a silent killer lurking from the shadows.

The early media coverage of AIDS-related topics only focused on the scandalous ones (Schneider 727). Politicians proved over and over again that in an effort to hide their lack of action, they only searched for short-term solutions (Schneider 727). Unfortunately, the first big media attention HIV and AIDS got in Mandela's Presidency surrounded the controversial AIDS awareness musical *Sarafina II*. It became known to the public that 14 million Rands, given to South Africa by the European Union, had been given to the production from the Ministry of Health (Grünkemeier 32). The costs were seen as too high for a musical but also made clear to the public how unaware they are about how the ministry's money gets spend (Grünkemeier 32). After this became public the musical never got made. The use of such extensive European funds for *Sarafina II* generated a broad outcry from the general public, the media, and the political opposition. Even though *Sarafina* never saw a premiere, it did become the face of HIV/AIDS in South Africa as it "[...] represented the public face not only of the AIDS programme, but also of the Health Department generally. President Mandela, in review of 1996, cited it as one of the ANC's key mistakes of the year" (Schneider 728).

Controversy continued to whirl round HIV and AIDS, especially in 1997 when a group of scientist developed a cure called Virodene. Virodene was tried on skin patches of several AIDS patients, but it was later revealed that, much like the Kenyan anti-AIDS drug Kemron, Virodene "[...] had not passed the most elementary biological and animal experimentation" (Schneider 728). South Africa's "[...] Medicines Control Council (MCC) was doubtful as to its effectiveness and safety and therefore rejected further clinical trials" (Grünkemeier 33). This led to a clash of opinions with the then Deputy President Thabo Mbeki who saw Virodene as a way of "[...] championing African-initiated science in the context of the agenda for an African Renaissance" (qtd. in Grünkemeier 33). In the end, there was no proof that Virodene was effective and it has therefore never been used as an antiretroviral drug. Nevertheless, the dispute over this South African cure has had far reaching consequences, re-surfacing issues about which way is the most appropriate to deal with the epidemic as well as the growing mistrust between Mbeki and the MMC (Grünkemeier 33).

Together, the Sarafina scandal and the polemics surrounding Virodene resulted in the removal of the director of the AIDS Programme, the Chair of the Medicines Control Council

and the closure of the AIDS Advisory Committee (Schneider 728). The Virodene controversy also shed a light on Mbeki's future stands on the epidemic with his "[...] mistrust of mainstream western HIV/AIDS science [...] giving rise to prominent myths about alleged cures and alternatives to antiretroviral treatment" (Grünkemeier 34).

The lack of attention towards stopping the spread of HIV and AIDS has been described as a "[...] missed opportunity" by Mandela and he has apologized for it (Grünkemeier 34). In 2005 his son died of AIDS (Grünkemeier 34). The start of the epidemic goes hand in hand with the protests starting in the 1980s in the townships. While the Mandela government, just as any other government in the world, certainly had flaws, the nation as a whole was still celebrating the political decisions that brought down apartheid, and having the power to vote, so that not only the epidemic, but many broad socio-economical issues were simply overlooked. Even a government that would hypothetically solely focus only on HIV/AIDS could not be able to completely stop its spread, especially since the whole sub-Saharan Africa battled the same problem.

What was missing was what Schneider described as "[...] management of meaning" (729). She explains that this means having "The ability to mobilize and co-ordinate a range of actors, across a multitude of social and sectoral divides around a common vision" (Schneider 729). Quite surprisingly, South Africa did not have problems gathering international funds and making grand action plans. All the prerequisites were there but that is also where it started and ended. Of course, it is difficult to implement an effective AIDS policy in a country going through transition from tyranny to democracy and where leaders wish to be seen as active, even though the state apparatuses they want to use are in ruins (Schneider 729). Nevertheless, an awareness in seeing "[...] policies and plans as starting, rather than end points" is advised (Schneider 729). First of all, that would mean using the grand narrative of the government's AIDS Plan, inter-sectoral action and a level of political commitment. This should then be followed by applying those factors to the local small narratives with specific dynamics, contexts, throughout different temporal periods, which might result in future success (Schneider 729).

In Schneider's opinion the real problem of AIDS implementation in South Africa is not the degree of political concern but in its quality (728). It is not that there was no political commitment, because there was, but its execution was bad. Thus this, among other things, resulted in the lack of a more broad social response to the epidemic. The public and the media

only focused on the scandals around AIDS and completely forgot about the actual epidemic that was taking more and more South African lives.

3.2. THABO MBEKI'S PRESIDENCY

The second President of South Africa, Thabo Mbeki (1999-2008), is a very controversial character in the development of acting against the AIDS epidemic in South Africa. The prevalence rates kept on rising during his two presidencies and the reports of the World Health Organization and the United Nations started drawing international attention (Grünkemeier 35). Even though the domestic and international public expected action concerning the epidemic, Mbeki's response is often marked as the era of denial causing "[...] major political controversy, leading to his administration often being singled out and blamed for the unchecked spread of the epidemic" (Grünkemeier 35). As Grünkemeier puts it, his "[...] connections, decisions, pronouncements and silences have continued to shape the ambiguous public perception of HIV/AIDS in South Africa," and that "Views that had previously existed as 'fringe notion' in the global AIDS debate were brought into mainstream South African AIDS policy deliberations" (35).

His probably most famous statement was that the HIV virus does not cause the AIDS syndrome. He opened the Durban International AIDS conference in 2000 stating "[...] it seemed to me that we could not blame everything on a single virus" (qtd. in Grünkemeier 35). He instead blamed poverty as the main cause of AIDS. His unwillingness to accept the Western virology of AIDS was clear in his political decision making. In forming the South African National AIDS Council in 2000, no AIDS scientist or activist was invited to participate (Grünkemeier 35). The Presidential AIDS Advisory Panel was intentionally made up of members who shared Mbeki's views, and was continually a target of many critics because many members, like Peter Duesberg and David Rasnick, spread rumors about the lack of linkage between HIV and AIDS and the unsuitableness of ARV's as the official prevention medication (Grünkemeier 35). With the right medication, people infected could live longer and help fight the stigma surrounding the disease. However, Mbeki questioned antiretrovirals, remarking that they are western-made pills with no positive effects that involve many risks (Grünkemeier 36).

A special focus should be given to the role of the Minister of Health in the Mbeki government, Manto Tshabalala-Msimang (Grünkemeier 36). By distancing herself from the Western notions of HIV/AIDS and from medications required to help the spread of the

disease, she used a different method of approaching the epidemic. Later known as ‘Dr. Beetroot’ she claimed that “[...] a healthy nutrition of beetroot, lemon, garlic and African potato,” can replace antiretrovirals while still having the same effect (Grünkemeier 36). At the 2006 International AIDS conference in Toronto, South Africa presented this diet as the official strategy of coping with the infection, even though there was no scientific proof of it actually being effective. This finally brought international attention to the mechanisms South Africa has been using to fight the epidemic (Grünkemeier 36).

Even though Mbeki’s government has been skeptical to the use and effectiveness of antiretrovirals, this was not the only reason such medication was not used. In order for ARV’s to be effective, South Africa needed to fix several issues still remaining from apartheid presenting “[...] major challenges that range from establishing, improving and maintaining health care facilities to meeting people’s basic needs concerning, among others, nutrition, water, housing and social security” (Grünkemeier 36). Another issue was the cost of antiretroviral medication. In 2000 it would cost South Africa 4000 Rand per person to have a national antiretroviral programme (Grünkemeier 36). At the time, this was simply too big of a burden for the national budget. However, in 2003 after a long period of pressure from the international community on pharmaceutical companies, the price fell to 1000 Rand per person; a price the South African health care system could manage (Grünkemeier 36).

But even that did not help as Mbeki’s government perceived allowing a national antiretroviral rollout as giving over a part of power originally belonging only to them. Iliffe highlights that the Mbeki regime feared the loss of authority as their development programme was questioned and thus endangered (Grünkemeier 37). Such argumentation only shows that instead of being about helping the sick, the AIDS problematic was always about power and money. Developments in AIDS-prevention drawn the curtains and finally reveal that politics, and not science, were the real reason why there was no national rollout of antiretrovirals (Grünkemeier 37).

Sometimes it almost seems like the Mbeki government wanted to control South Africa’s political arena and the society in general through a panoptical machine. The concept that was created by Jeremy Bentham in 1787 can be understood in a South African context through the explanations offered by the French historian and philosopher, Michel Foucault, who was also a victim of AIDS (Storey 131). His explanation of panopticism draws parallels with a state of permanent visibility, of an automatic functioning of power (Storey 132). In such a state one is always being observed, is always controlled. Mbeki wanted a disciplinary

society with the Panopticon as a model where surveillance becomes the dominant mode of the operation of power (Storey 132). The intrusion of the international public, pharmaceutical companies and the general South African public into such a system would result in its demise, which is exactly what the Mbeki government was afraid of.

Mbeki's insistence on poverty being the one to blame for HIV and AIDS went hand in hand with his refusal of ARV's as the correct cure and continued until 2002 when a court decision forced the government to start supplying antiretroviral drugs (Le Marcis 117). As Le Marcis points out, the more Mbeki insisted on his view, the less believed he was, thus giving ammunition to his opposition (181). The debate around the delivery of antiretrovirals did not stir up only because of Mbeki's distrust of Western science, but also because of the "[...] deeply inscribed [...] history of race relations in South Africa and more generally in the context of North-South relations" (qtd. in Le Marcis 181).

Mbeki denialism went so far that in the townships an idea of a "[...] government conspiracy" against poor HIV-positive people started to circulate (Le Marcis 193). The nonintervention policy of the government was seen as "[...] an attempt to reduce the number of poor people in South Africa" (Le Marcis 193). Didier Fassin argues that the crisis ignited by Mbeki "[...] is far more than a confrontation between different explanatory models. It is a confrontation between worldviews, ways of relating to history and memory, definitions of morals and politics" (qtd. in Woods 309). In his book *When Bodies Remember: Experiences and Politics of Aids in South Africa* (2007), Fassin sheds a different light to the politics of South Africa's second democratically elected President "Mbeki's frustrations with what he perceived as a racist pathologization of Africa were understandable if not acceptable when one considers the history of health treatment projects in South Africa and their link to political projects, projects designed to put a 'safe' distance between the masters and a pool of physically strong labourers" (Woods 309).

As mentioned before, in 2002 a "[...] Constitutional Court ruling ordered the Department of Health to provide a national prevention programme, finding that the government's policy had not met its constitutional obligation to advance adequate access to health care services" (Grünkemeier 37). This led to the introduction of antiretroviral medication for HIV-positive pregnant women in 2002, but it took more negotiation to make ARV's accessible for all people living with HIV/AIDS (Grünkemeier 37). The national rollout of medication started in late 2004 and continued in early 2005, but came to different results. In the Western Cape every second person that needed ARV's received them, while in

the most affected provinces such as KwaZulu-Natal, Mpumalanga, Free State and Eastern Cape only every fifth person in need of medication actually received it (Grünkemeier 38).

After the court ruling, the Operational Plan for comprehensive HIV and AIDS care was drawn up in 2003, but it wasn't until 2005 that then Health Minister Manto Tshabalala-Msimang, under the pressure of the *Treatment Action Campaign's* (TAC) March on Parliament demanding access to ARV's, confirmed that upon agreeing on a final price with pharmaceutical companies all public hospitals will be supplied with prevention medication (Woods 319). Nevertheless, the government's policy on HIV and AIDS only started showing real signs of change in 2007 though still not reaching the World Health Organization's recommendations (Woods 319).

Denialism did not pass unnoticed and the public was angry. Writer Sindiwe Magona makes her anger clear in her novel *Beauty's Gift* claiming that if the AIDS epidemic had broken out in the time of apartheid everyone would be accusing them of mass murder for not acting on it (86). She claims the domestic and international community would condemn a government that would do nothing whilst facing thousand deaths and fails to understand "Why are we lip sealed now? How is it that we let this government, *our* government, get away with murder? A genocide of the poor?" (Magona 86). Magona wonders why money is spent on weapons instead of medication "Are we going to stand and let AIDS do what even apartheid could not do? Are you going to lose a war that can be so easily won? What will history say of us? [...] To all of us, I say: go and fight! And fight to win!" (86-87).

It seems like South Africa had to learn the hard way. The lesson the Mbeki government had to learn is that their hegemony does not just passively exist as a form of dominance. It has to be "[...] continually [...] renewed, recreated, defended and modified" while at the same time it is "[...] continually resisted, limited, altered, challenged" (Williams 112). In order to maintain his strong 'body politic' Mbeki became a person Kantorowicz would once characterize as a God, for those who believed his views and followed his denialism example, yet a fool, for those who disagreed with him entirely and saw his stance on HIV and AIDS as flawed (25-27). The battle for the use of antiretrovirals in South Africa was fought in an arena of struggle and negotiation between the interests of a small dominant group and the interests of much larger subordinate groups. It is an arena in which hegemony may be won or lost. Finding the, what Antonio Gramsci calls compromise equilibrium, between structure and agency, incorporation and resistance, was a great challenge for South Africa; one that may have cost it many human lives (Storey 82).

3.3. JACOB ZUMA'S PRESIDENCY

From 2009 South Africa's President is Jacob Zuma. Although often seen as having a more progressive stand on HIV and AIDS than Mbeki, his political career has not been without scandals. In 2006 he was accused of rape (Grünkemeier 40). During the trial, he stated that even though he knew the woman he had sexual intercourse with was HIV-positive, he did not use a condom (Grünkemeier 40). Raising even more outrage was his statement that in order to protect himself from contracting the disease he simply took a shower afterwards (Grünkemeier 40). His behavior polarized the public and generated a public outcry against him. After he was found not guilty, as the sexual relationship was considered to be consensual, he apologized "[...] for being irresponsible and not using a condom," but the damage of his statements had far-reaching consequences (Grünkemeier 40). As Grünkemeier points out, it is quite paradoxical that "Zuma used to head the National AIDS Council that advocates the use of condoms" (40).

He distanced himself from the previous government's views of replacing antiretrovirals with diets and nutrition, while still highlighting the importance of the right combination of both (Grünkemeier 41). On World AIDS Day in 2009 he had a presidential speech that many considered as a beginning of a new era of national policy about HIV/AIDS (Grünkemeier 41). He urged for a stop of the politicization of the epidemic calling out "Let there be no more shame, no more blame, no more discrimination and no more stigma [...] Let this be the start of an era of openness, of taking personal responsibility, and of working together in unity to prevent HIV infections and to deal with its impact" (Grünkemeier 41). This highly rhetorical speech brought him and the new South African stance on the epidemic, international approval. However, it did not convince everyone. Especially critical was the domestic public, tired of speeches and hungry for action.

During Zuma's first presidency the National HIV Counselling and Testing Campaign was launched (Grünkemeier 41). It promotes routine testing at any health facility and is always accompanied with counselling (Grünkemeier 41). It is always voluntary and is becoming a part of a regular health practice not only aiming at certain risk groups (Grünkemeier 41). It has received general support even though there were doubts if the South African health system can take on such a financial burden. Mark Heywood of the South African National AIDS Council (SANAC) defended the campaign by saying: "We can't say that because we are not 100% ready, we can't do this. We know for a fact that almost 1000 people die of AIDS on a daily basis because they're avoiding testing for HIV and they don't

understand how treatment works. There is a big price to pay for doing nothing or doing too little” (qtd. in Grünkemeier 41). In 2010 Zuma publicly declared his HIV status, which was negative, and urged the nation not to be ashamed but go and test (Grünkemeier 42).

The National Strategic Plan (NSP) 2007-2011 “[...] oversaw a dramatic scaling up of South Africa’s antiretroviral treatment (ART) programme which is now the biggest in the World” (History of HIV & AIDS in South Africa 2014). The NSP for 2012-2016 sets its goal on the UNAIDS policy of “Zero new HIV infections, zero discrimination, zero AIDS-related deaths” (History of HIV & AIDS in South Africa 2014). By 2012, over 2.5 million people in South Africa were receiving antiretrovirals with the world’s biggest antiretroviral programme that is almost entirely self-funded, which was made possible with the reduction of the prices for fixed-dose combination ARV’s (HIV & AIDS in South Africa 2012). Mother-to-child transmission is almost eliminated, and life expectancy has risen to about 80% of normal life expectancy (HIV & AIDS in South Africa 2012). Considering the complicated HIV prevention path South Africa has taken these results are very encouraging.

While many focus only on the positive sides of Jacob Zuma’s Presidency and attribute him the success South Africa has been making recently regarding HIV/AIDS there are many others that are not so taken with Zuma. Writer Sindiwe Magona claims she was personally influenced by political leadership because she is angry and annoyed at the never-changing personal attitude of politicians (Zajec 85). She has not yet forgiven Zuma for his past mistakes “If a political leader is accused of rape, even if it was later said it was consensual, with an HIV positive woman without using protection but only showering after, what kind of message does that send to the people?” (Zajec 85). As Magona points out in an interview with Karin Orantes, when we have examples of people in high positions behaving badly, even if they are intellectuals, it makes everyone think “If the president does it [...] why shouldn’t I?” (42).

Since the fall of apartheid, South Africa’s presidents have had a very particular stance on the epidemic and it is hard to pin down exactly how important or how big the responsibility of the politicians is in the perception of HIV and AIDS by the general public. Magona tries to look for answers but concludes that:

It is hard to say, especially because people don’t say ‘I behave in this and this manner because of this and this person’. But we take from them, we see how they behave and think where there is smoke there is also fire. And unintentionally you start behaving like them. Even without knowing it, we are influenced far beyond what we know. It can be as simple as the way we walk but we still copy it. And that is why political

leadership is so important, they are role-models if they are aware of it or not. And they are not doing a very good job. (Zajec 85)

Even though there have been plenty of changes for the better it is obvious that the chessboard has been set, the pieces have started moving forward, but there is still a long way to go to the political checkmate winning position.

4. SOCIAL RESPONSES

The social responses to the HIV/AIDS epidemic in South Africa have been very diverse. What brings all of them together, from large worldwide to small non-governmental organizations, support groups, church-based groups or volunteers, is an effort to create an atmosphere in which HIV/AIDS patients realize they are not alone and that theirs is not an “[...] isolated experience” (Mengel 8). André Brink brings attention to this issue by saying that one must be aware that “What I am going through is not unique. There *are* other people who *have* experienced this and *are* experiencing this” (Mengel 8). Brink points out that this kind of thinking “[...] alleviates the terrible burden of your experience by being able to relate it to the experience of other people” (Mengel 8). Or as Sindiwe Magona puts it “You want to change the way people think, change the way they see themselves, the way they see things” (Zajec 86).

One of the ways change is encouraged in South Africa concerning HIV/AIDS is by listening to what the international community is saying about the epidemic. Held every second year since 1985 the International AIDS Conference, co-organized by the International AIDS Society and UNAIDS, is the key event in the international HIV/AIDS community (Grünkemeier 1). It has been held all around the World from Yokohama to Bangkok, Toronto, Mexico City, Vienna, Washington and Melbourne in 2014, to name just a few (Grünkemeier 1). For South Africa the 13th International AIDS Conference in 2000 was especially important as it was held in Durban. It was also the first International AIDS Conference organized on the African continent as well as being the first conference in one of the sub-Saharan countries most affected by the HIV/AIDS epidemic.

During the Durban conference there were two events that really stood out. The first one was a statement signed by over 5000 scientists later known as the *Durban Declaration* (Grünkemeier 39). In 2000, Mbeki’s denialism views in South Africa have gained too many supporters in the eyes of the scientists and therefore, they decided to sign a declaration that would gather all the then-known “[...] established HIV/AIDS science,” hoping it will change

the path South Africa was on (Grünkemeier 39). Even though the declaration was published in the prestigious scientific journal *Nature* and received wide international attention, the majority of the South African leadership was left unimpressed and determined to continue on the path Mbeki has set (Grünkemeier 39).

The second notable event was a speech by Nkosi Johnson. Born in a township in Johannesburg, Nkosi was HIV- positive from birth. His mother died of AIDS and he was adopted by a volunteer named Gail Johnson (Nkosi Johnson's History 2015). When Johnson tried to enroll him in a school in Johannesburg's Melville suburb, his HIV-positive status was revealed (Nkosi Johnson's History 2015). The school refused to accept him after an uproar from other parents who did not want their children interacting with an HIV infected child, and it was only after Johnson and Nkosi achieved victory in court that he was allowed to attend the school (Nkosi Johnson's History 2015). Consequently, his stigmatizing experiences have made him a spokesperson for the rights of HIV-positive people, and during the Durban Conference the then 11-year old "[...] spoke out about the stigmatization of the virus and discrimination against people living with HIV/AIDS; he also called on the South African Government to provide antiretrovirals to prevent the transmission of the virus from mother to child" (Grünkemeier 39).

Speaking in front of 10000 delegates Nkosi concluded his speech with the words "Care for us and accept us – we are all human beings [...] We are normal. We have hands. We have feet. We can walk, we can talk, we have needs just like everyone else. Don't be afraid of us - we are all the same" (Nkosi Johnson's History 2015). He died of AIDS a year later, the same year he was posthumously awarded the 'Children's Nobel Prize' - the World's Children's Prize for the Rights of the Child (Grünkemeier 39). Unlike the *Durban Declaration* which passed almost unnoticed by the general public in South Africa, Johnson was made a hero and continues being one of the most visible figures of the fight against stigmatization of HIV/AIDS patients and was one of the most empowering symbols of the fight for free antiretrovirals that emerged in South Africa after his death. His non-governmental organization is called *Nkosi Haven* and has been offering refuge and help to HIV positive children and their mothers since 1999 (Nkosi Johnson's History 2015).

While the United Nations and the International AIDS Society focus more on HIV and AIDS in general, the main organization inside South Africa is the *Treatment Action Campaign* also known as TAC. Described as the "[...] largest civil society body and the most effective national formation for organizing people around HIV/AIDS in South Africa," the

TAC was first part of the *National Association of People with AIDS* (NAPWA) funded by the government in 1994 (Grünkemeier 39). However, the *Treatment Action Campaign* decided to become an independent organization in 1998 after NAPWA failed to achieve antiretrovirals to prevent mother-to-child-transmission (Grünkemeier 39). One of its co-founders, Zackie Achmat, would later even become a Nobel Peace Prize nominee for his work in the organization (History of HIV & AIDS in South Africa 2014). Achmat publicly revealed his HIV-positive status and refused to take antiretrovirals until all South Africans would be able to get them as well (History of HIV & AIDS in South Africa 2014). He finally accepted the medicine in 2003, but continued his fight for ARV's against the Mbeki's government.

Nevertheless, this does not mean that the TAC always criticized the government. In 2001 they sided with them in a legal fight against the international pharmaceutical companies which refused to reduce the price of antiretrovirals for poor African countries including South Africa (Grünkemeier 39). Together the government and the *Treatment Action Campaign* achieved victory and the prices were reduced. Expecting a national rollout of ARV's the TAC was disappointed when Mbeki's government refused to take action after the big win.

This resulted in a law suit against the government at the Constitutional Court by the *Treatment Action Campaign*. They were encouraged to do so by the *AIDS Law Project* at the University of Witwatersrand (Le Marcis 189). The project seeks to “[...] establish legal precedent in the area of HIV/AIDS-based discrimination” and offers free legal advice to all who feel they have been discriminated on the basis of their HIV status (Le Marcis 189). Together, the TAC and the *AIDS Law Project* won the suit and as a result all HIV-positive pregnant women were granted free ARV's (Grünkemeier 40). On the wings of this victory, in 2003, the TAC started a “[...] civil disobedience campaign,” when “[...] they organized demonstrations, occupied government buildings and police stations and interrupted speeches of leading politicians, especially Manto Tshabalala-Msimang” (Grünkemeier 40). This continued until “[...] a march on Parliament to demand greater access to anti-retroviral treatment (ART)” in 2005 (Woods 219). Two days later, on the 18th February 2005, the South African Health Minister Tshabalala-Msimang announced the end of negotiations with pharmaceutical companies agreeing to supply state hospitals with ARV's (Woods 319). Further delays followed and it was not until 2007, when the National Strategic Plan for South Africa 2007-2011 was adopted, that a national rollout of ARV's happened (Woods 319).

The *Treatment Action Campaign* has received international support and was one of the main contributors, if not even the main contributor, in the fight for free antiretrovirals for all

in South Africa. Grünkemeier recognizes the TAC “[...] was able to mobilize social and political pressure, as well as utilize the power of the courts to force government to alter its decision” (40). Woods goes even a step further and acknowledges that the *Treatment Action Campaign* “[...] played a decisive role in affirming the presence of people living with HIV/AIDS, to the point where HIV/AIDS today is no longer understood as a death sentence but as a chronic manageable illness” (306).

Even though the government funded the *National Association of People with AIDS*, the non-governmental organizations, also known shortly as NGO’s, were the ones that played a decisive role in the South African battle with AIDS (Schneider 728). It is reported that in 1996 there were almost 700 organizations focused on AIDS related topics, including “[...] a number of prominent AIDS-specific NGOs, a network of government supported AIDS Training Information and Counselling Centres as well as numerous workplace, community based, clinical, religious, academic and other groups” (Schneider 728). In South Africa there is also a strong AIDS human rights lobby.

NGO’s often face a dilemma. On the one hand, they want to remain critical if the government is not doing a good job concerning HIV and AIDS. On the other hand, it is hard to be critical when they are funded by the government (Schneider 729). A good example is the generally positive attitude the NGO’s have to the National Department of Health’s broad help policies, compared to the negative feed-back concerning the actions taken to fight against HIV/AIDS (Schneider 729). Nevertheless, Schneider points out conflicts are not always bad (729). They highlight the flaws, the cracks, and show where the systems are weakest.

All these organizations, like the NAPWA or TAC and even most of the NGO’s, are based on smaller support groups for people living with HIV or AIDS. Le Marcis sums up the activities of these groups “[...] which vary according to their coordinators and institutional affiliations, include the exchange of information, advice, and experiences of patients, organizing home care, and delivering food care” (178). Generally, a mode of ‘healthy lifestyle’ is promoted focusing on health, nutrition, positive thinking, finding a social support system, abstinence from alcohol and tobacco, and the use of condoms (Le Marcis 178). Groups often prepare meals together with the participants to show them how nutritional problems can be solved.

Support groups also offer knowledge about the HIV/AIDS epidemic as well as help with financial issues, and often search for ways to earn money for the sick (Le Marcis 178). A

lot of participants travel long journeys to attend meetings for fear of somebody recognizing them, or for avoiding their families or friends finding out about their HIV status (Le Marcis 179). Very often they rather say they have tuberculosis or some other disease to hide the truth. Many members of such support groups go on and become activists, participants in public information campaigns, have public speeches or attend other awareness meetings and thus embracing their HIV status (Le Marcis 189). Members communicate via text messages (Le Marcis 190). A trend of attending funerals of HIV/AIDS victims is on the rise. Members of the TAC or the NAPWA wear their shirts, distribute red ribbons or condoms, sing songs, exclaim the Department of Health's 'I care, do you?' slogan or even perform *toyitoyi*'s, a dancing demonstration rooted in the townships in the time of apartheid singing social-awareness slogans (Le Marcis 194).

Le Marcis highlights that the lack of medicine or immune system boosters in the public health sector often leads patients to seek out illegal treatments or medication (191). While the epidemic can be measured through support groups, visits to the clinics, hospitals or social service agencies, these unofficial paths are hidden behind domestic walls. More and more HIV/AIDS patients participate in illegal therapeutic trials or buy unauthorized products sending a help signal to the government (Le Marcis 191). Nevertheless, the support groups are becoming a positive trend and are increasingly more popular as they "[...] are one of the few sites where churches, pharmaceutical companies, and social science and medical researches come into contact with sufferers" (193).

An important role in raising social awareness about HIV and AIDS is also played by churches. One of the many religious help centers is the *Hope House Hospice* care centre in Manzini, Swaziland. It can be perceived as a model of how a church-led organization works. Such centres are becoming increasingly popular. Promoted as "A place of peace for all people living with a terminal illness including HIV and AIDS," the *Hope House Hospice* is a faith based residential hospice facility initiated by the Catholic Church and a part of Caritas Swaziland (Hope House Hospice 2012). They take care of HIV and AIDS patients regardless of their faith. They offer residential palliative care, counseling patients and their caregivers, training caregivers on how to support the person with a terminal illness on discharge, and offer dietary and nutritional advice (Hope House Hospice 2012).

Such religious help-centers do not only focus on the physical aspect of the disease, but pay attention to the patients spiritual needs as well. The patients are expected to bring a letter of referral from a doctor, hospital or clinic, recent medical documentation, toiletries, clothes

and food, and should always be accompanied by someone close to them as they “Train family members or friends to enable them to provide care and support in the community when the client is discharged” (Hope House Hospice 2012). Patients are asked, if they can, to contribute a small amount of money as such establishments are entirely based on international donations and most of the employed staff work on a volunteer base. Nonetheless, once again there is a pattern of HIV/AIDS patients refusing to go to help centers such as the *Hope House Hospice* because they are afraid of what the community will think of them, because going to such a specific clinic equals admitting that you have HIV or AIDS. The *Hope House Hospice* fights against the stigma and shame of HIV/AIDS by saying it is “[...] not only a place of refuge for the sick; it also provides us with a practical way to show our love and concern for one another” (Hope House Hospice 2012).

This lack of a wider spectrum of social responses to HIV and AIDS shows that there is still plenty to be done before change will come. Writer Sindiwe Magona suggests change as “[...] something national, something robust, something huge that sweeps through the whole country. Village by village, hamlet by hamlet, town by town, so that nobody is left untouched” (Zajec 90). One of the ways South Africa has tried to bring about this change is by launching several awareness campaigns.

4.1. AWARENESS CAMPAIGNS

One of the most successful awareness campaigns in South Africa is the ‘edutainment’ programme called *Soul City* (Schneider 729). Starting in 1994 “It uses five media - television, radio, newspapers, public relations/advertising and education packages - to convey health and social messages through the basic format of a soap opera” (Schneider 729). Responsible for the programme is *The Soul City Institute for Health and Development Communication* (SCI), a “[...] nongovernmental organization and the largest social change communication project in Africa” (Soul City 2011).

Set in a fictional Soul City township, there have been 11 series in the period between 1994 and 2011 (Soul City Television Series 2011). *Soul City* deals with ‘pro-social’ messages, like female empowerment, community action, health, development, and other taboo topics, with a special focus on HIV and AIDS (Schneider 729). Concerning the topic of HIV and AIDS there were several episodes focused on prevention, care, and support of people living with either, how to prevent mother to child transmission, how male circumcision can help, on multiple concurrent sexual relationships, how treatment looks like, and how to get rid of the

stigma surrounding the epidemic (Soul City Television Series 2011). Schneider points out that “The initiative has enjoyed phenomenal success - it has penetrated the most rural parts of South Africa, consistently outstripped other soap operas in viewership, and won numerous awards” (729). Some went even as far as saying that *Soul City* could be “[...] the leading source of information on HIV and AIDS in South Africa” (HIV & AIDS in South Africa 2012). The programme is widely popular and broadcasted “[...] at prime time to maximize its reach” (HIV & AIDS in South Africa 2012). It has been especially successful in reaching people living in rural areas and conveying messages to people without formal education (HIV & AIDS in South Africa 2012). It is believed that the knowledge about HIV and AIDS has increased because of the series showing “[...] significant changes in self-reported behavior such as usage of condoms” (Schneider 729).

Even more successful than *Soul City* was its spin-off series targeting children aged between 8 and 12, called *Soul Buddyz* (HIV & AIDS in South Africa 2012). *Soul Buddyz* is considered as “[...] the most successful family television show to be produced in South Africa,” with each episode attracting approximately 4 million viewers (HIV & AIDS in South Africa 2012). *Soul Buddyz* promotes the principles of the International Convention on the Rights of the Child, and has continuously focused on HIV/AIDS related topics in its five series aired nonconsecutively between 2000 and 2011. According to the shows website “[...] 90.5% of parents exposed to the Soul Buddyz material, felt that Soul Buddyz made it easier for them to discuss difficult and sensitive issues with their children [...] A similar proportion of teachers agreed” (Soul Buddyz 2011).

The Soul City Institute for Health and Development Communication is also behind the *OneLove* awareness campaign. According to UNAIDS, *OneLove* “[...] aims to get people talking about the trend of having more than one sexual partner at a time. The overall goal is change this behavior which is a factor in the transmission of HIV in the region” (Talking about OneLove 2009). The campaign uses social media to get people talking about having multiple partners and helping them see the risks this presents, as chances of getting infected with HIV are highly increased when one has multiple sexual partners (Talking about OneLove 2009).

From 1997 until 2000 the Department of Health, and within it the HIV/AIDS Directorate, stood behind a “[...] state-funded multimedia campaign, known as *Beyond Awareness Campaign*, to promote social change. Cooperating with non-governmental organisations and community initiatives, the campaign developed multilingual

communication materials and promoted participatory activities such as the AIDS Memorial Quilt” (Grünkemeier 38). Nowadays, in most of the public toilettes across South Africa free condoms are available, as well as on most of the highway stops, borders or any other public place many people visit. But when the epidemic first started spreading in the havoc caused by the fall of apartheid, the provinces were left alone to deal with the HIV/AIDS problem. Even though there was a lot of controversy surrounding the distribution of ARV’s in South Africa, the government of the Western Cape, taking advantage of the loosening centralization, was the first one that made antiretroviral medication for pregnant women with HIV/AIDS available for free since the year 2000 (Grünkemeier 38).

Another notable attempt of the government to make a change was the awareness campaign called *Khomanani*, meaning ‘Caring Together’ (Mseleku 2015). It was firstly quite unsuccessfully launched by the Department of Health and then re-launched in 2007 at the beginning of the execution of the 2007-2011 National Strategic Plan for HIV/AIDS. The campaign received 190 million Rands and aimed to accelerate HIV and AIDS prevention (Mseleku 2015). The campaign also focused on care, support and treatment of the patients affected by the epidemic while providing them with nutritional advice (Mseleku 2015). The overall aim of *Khomanani* was “[...] to achieve a 50% reduction in the rate of new infections and provide an appropriate package of treatment, care and support services to at least 80% of people living with HIV and AIDS and their families by 2011” (Mseleku 2015). However, the campaign has failed to meet those goals (HIV & AIDS in South Africa 2012).

As a part of the *HIV and AIDS Life Skills Education Programme*, most of the primary and secondary schools in South Africa implement “[...] HIV and AIDS education into the school curriculum as a means of averting new HIV infections as well as to provide care and support for pupils already living with HIV” (HIV & AIDS in South Africa 2012). These topics are included in the Life Orientation lectures, and teachers have suggested a Life Orientation module during their teacher training so that they are able to better understand the topic as well as explore it more in depth (HIV & AIDS in South Africa 2012). Despite all the efforts made high dropout rates in schools compromise the effectiveness of including talking about HIV, AIDS, and sex education in schools.

Beginning in 1999, *LoveLife* is one of South Africa’s largest prevention and education HIV/AIDS programmes especially targeting youths between the ages of 12 and 19. The campaign is privately funded and reaches among the youth by including peer educators and opening a number of centres “[...] providing sexual health information, clinical services and

skills development” (HIV & AIDS in South Africa 2012). They work on the basis of ask/learn and watch/listen techniques and offer socializing through youth popular social media platforms such as Facebook, Twitter or Youtube (LoveLife 2015). Currently they have over 15 running programmes and also offer jobs, internships, volunteer work, plus organize several events each month (LoveLife 2015).

There are several other places around South Africa that provide information and spread awareness about HIV and AIDS. In Johannesburg the *AIDS Consortium* is the central organ where one can get information regarding the epidemic (Le Marcis 189). *The Desmond Tutu HIV Foundation* (DTHF) was one of the first organizations that started mobile testing clinics (HIV & AIDS in South Africa 2012). From 2008, when the *Tutu Tester Mobile Clinics* were first introduced, until the end of 2012 more than 35.000 people have visited them (HIV & AIDS in South Africa 2012). It helps that the clinics offer not only immediate HIV testing, but also test for other diseases like tuberculosis, high blood pressure or diabetes so people can avoid the stigma otherwise connected with HIV testing (HIV & AIDS in South Africa 2012).

Despite all efforts, statistical information shows that until now, however successful the campaigns may be, they have not had long term positive effects. Sindiwe Magona even suggest a “[...] mini United Nations just for South Africa” (Zajec 90). She makes it clear that the government needs help and would need an additional institution dedicated solely to the HIV/AIDS problematic. Magona concludes by saying the time of speeches is past and real action is needed “We don’t just need someone who is currently leading the government or the Ministry of Health, what we need is a social movement” (Zajec 90). However, Tim Woods argues that the “[...] shift in public consciousness and the ways in which HIV/AIDS is represented is due in large part to the existence and increasing visibility of social activist movements like the TAC in South Africa, which protests against denialism and seeks to build bridges to cross the chasms of silence on HIV/AIDS” (Woods 320).

The appreciation of thousands of people who help and spread the positive messages about HIV/AIDS is needed in South Africa. A simple overview of awareness campaigns shows that despite the negative trend in prevalence and incidence rates in the last few years, the future is bound to be better. Starting with the education of youth about the HIV/AIDS problematic while slowly changing the habits and opinions of the rest of the population, awareness campaigns are the lighthouse for a ship caught in stormy seas, and carve the path for future positive changes.

5. CULTURAL RESPONSES

We can often see a kind of revisionism in South African culture, a rethinking or repackaging of some basic concepts in a more subtle and flexible form (Barry 165). It seems that while the ‘old struggle’ against apartheid in South Africa is finished, HIV/AIDS is considered as the ‘new struggle’ and the battle against it has yet to be won. There is a pattern of using the old against-apartheid symbols and tools and re-using them in the fight against the epidemic. A good example is the cartoonist Zapiro’s re-use of the iconic Sam Nzima’s photograph of Hector Pieterse during the Soweto uprising. With writing HIV/AIDS on Pieterse’s chest and entitling the cartoon *The New Struggle*, he gives the image a completely different connotation (Grünkemeier 106-107). Grünkemeier elaborates on this by saying that this struggle metaphor “[...] not only connotes stigmatization and victimization of the virus and those living with it; it also draws on a shared South African history and cultural memory of the old struggle and its positive outcome [...] As such it gives hope for the future and promises possible success in dealing with the HIV/AIDS epidemic” (107). From satirists, like Pieter-Dirk Uys, doing sketches on the topic of the epidemic, to advertisements in newspapers, like *Cape Argus* and *The Star*, to films like *A Luta Continua*, the message is clear - just like bringing down apartheid in the past, the epidemic can be beaten in the present.

In cultural studies what is included and what not, plays a decisive role. The opinions, voices, experiences and works excluded or marginalized are just as important in forming culture as a whole as those who are part of the mainstream formation. As Stuart Hall puts it “[...] the question of politics of culture or the culture of politics [...] is at the centre of cultural studies” (qtd. in Grünkemeier 16). The fact that HIV/AIDS related topics have been excluded from the mainstream culture in South Africa does not mean that they are not important. It does, however, prove that political pressure has made culture push the epidemic into the shadow with some rare exceptions.

Among the first to respond to the ever-growing HIV/AIDS epidemic in South Africa were street artists by using graffiti and cartoons, even billboards as a mode of expression (Woods 306). Photography was also one of the most used media to respond to the epidemic. The *Nelson Mandela/HSRC Study of HIV/AIDS* study showed that in “[...] urban formal surroundings, 60.5% of the people indicate that they are exposed to HIV/AIDS information via murals and billboards” (Grünkemeier 103). Combining street art and photography, artist Sue Williamson started her photographic series *From the Inside*, not only taking pictures of the people infected, but spending time with them and collecting their thoughts and opinions

on the disease (Grünkemeier 58). Williamson had “[...] their statements about the virus painted on walls in public places around Cape Town and Johannesburg,” thus breaking the silence of HIV/AIDS victims (Grünkemeier 58). In 2002 the *Johannesburg Art City Project* joined the initiative by making banner size photographs and hanging them around the city (Grünkemeier 59). Even though the photographic series has been displayed at various exhibitions, galleries, and was even shown in Johannesburg’s Joubert Park, it was not always warmly received (Grünkemeier 63). Especially statements openly attacking the Mbeki government’s decision making concerning HIV and AIDS, were often deleted or painted over, showing that not everybody was ready to openly discuss such topics (Grünkemeier 63).

Artists have often pointed out that performative arts are in an advantage because more people see them. In a country where a lot of people are not able to read, listening or seeing a performance, can reach a much broader public. This is confirmed by the words of writer Sindiwe Magona, whose HIV/AIDS awareness book *Beauty’s Gift* was to be made into a musical. Despite the scandal surrounding *Sarafina II.*, musicals are a very popular art form in South Africa, and it was therefore believed that a musical based on *Beauty’s Gift* would reach even more people than the book (Zajec 86). However, the project failed due to lack of financial support. Another one of Magona’s books, *Mother to Mother*, did make it as a stage play and was performed at the Baxter Theatre in Cape Town (Orantes 45).

The project *DramAidE*, short for Drama in AIDS Education, is a non-profit organization championed by the University of KwaZulu-Natal and the University of Zululand. Their “[...] main aim and objective is to use participatory drama and other interactive educational methodologies for HIV/AIDS, life-skills and sexuality-education. These methodologies are participatory, non-judgmental, culturally sensitive and accessible to all ages, levels of education and cultural backgrounds” (DramAidE 2015). The organization uses “[...] participatory theater,” as a means of promoting HIV/AIDS awareness, using “[...] oral narratives, songs, dances and plays” and thus combines culture and public health (Grünkemeier 8).

Another successful way of incorporating the epidemic in the cultural sphere is by introducing HIV-positive characters in already established television programmes. A good example is *Takalani Sesame* “[...] the South African adaptation of the internationally acclaimed children’s educational media programme, Sesame Street” (Who We Are 2014). The show introduced Kami, one of the leading role Muppets, as being HIV-positive. Her character is described on the show’s official webpage as “[...] HIV positive, non-

symptomatic, and has a wealth of accurate information about living with the illness” (Kami 2014). In the general public, a popular show of support is wearing the ‘H.I.V. POSITIVE’ t-shirt designed by the *Treatment Action Campaign* (Grünkemeier 85). Worn not only by those infected but by anyone in any way concerned by the epidemic, including Nelson Mandela, the shirt is a real South Africa phenomenon and one of the biggest symbols of the fight against HIV and AIDS.

In written form, there are two anthologies that deserve to be mentioned, as they have quite severely influenced the cultural response to HIV and AIDS. The first one is *Telling Tales* published in 2004 (Grünkemeier 43). It is a collection of stories by famous writers, including Gabriel García Márquez and José Saramago, and was even supported by the then Secretary-General of the United Nations, Kofi Annan (Grünkemeier 43). Even though the stories contributed to this anthology are not necessarily about AIDS, all the profits from sales of the book were given to the *Treatment Action Campaign* in South Africa (Grünkemeier 43). The second anthology entitled *Nobody Ever Said AIDS* was also published in 2004. However, the central theme of all the stories and poems is the HIV/AIDS epidemic, which makes it very different from *Telling Tales*. *Nobody Ever Said AIDS* is a groundbreaking book because it was one of the first books openly addressing the epidemic in South Africa and is furthermore one of the first attempts to fictionalize the disease as well as address the stigma surrounding it (Grünkemeier 43). Its publication started a trend and in 2006, even the *Sunday Times* launched a campaign called *Everybody Knows Somebody* encouraging people to submit stories about the epidemic whether they personally were infected, know somebody who is, or simply have an opinion about HIV and AIDS (Grünkemeier 42).

How the cultural, social and political spheres in South Africa interact can be seen in examples when an early death of a famous person is immediately connected with those having AIDS. One of such cases was the death of the author Phaswane Mpe in 2004 who died aged only thirty-four, but the reason behind his death, despite the numerous rumors of him having AIDS, was never revealed (Grünkemeier 47). Even more prominent was the early death of one of the leading politicians of the Mbeki government, Pakamile Mankahlana (Grünkemeier 47). He was a well-known public figure and his loyal stance on Mbeki denialism made the truth about his “[...] long illness” impossible to know (Grünkemeier 47). The public speculation about the cause of Mankahlana’s death is closely linked to the death of Peter Mokaba, a Member of Parliament and the ANC, and a former deputy minister in Mandela’s government (Grünkemeier 48). His death at the age of forty-three was a hot topic and the

public debate surrounding it was captured by the cartoonist Zapiro in the *Sunday Times* in 2002, when he published a cartoon of several people guessing if Mokaba died either of asthma, or pneumonia, or even acute malaria, before finally ironically concluding that he probably died of denial (Grünkemeier 48-49). As is usually the case with Zapiro's cartoons, this one "[...] invites and even provokes reflection on roles, attitudes and behaviors towards HIV/AIDS" (Grünkemeier 48).

One of the most accepted symbols of the HIV/AIDS epidemic is the red ribbon. Grünkemeier highlights the history of the red ribbon "[...] originally designed in New York City in 1991 by Visual AIDS, a group of artists and art professionals," who were "Inspired by yellow ribbons worn by US-Americans during the Gulf War in support of the country's soldiers" (67). The idea for the red ribbon took from that and was then created to "[...] raise people's awareness of HIV/AIDS and to express solidarity with those living with the virus" (Grünkemeier 67). In a research conducted by *The Nelson Mandela/HSRC Study of HIV/AIDS*, almost 85% of people in urban, and approximately 70% in rural areas, are familiar with the symbol and are also exposed to it regularly (Grünkemeier 68-69).

The red ribbon has penetrated into every pore of life in South Africa. In small villages the red ribbon mark can be seen on walls, sidewalks, statues, and is even included on exam sheets in primary and secondary schools. In 2000, during the International AIDS Conference in Durban "[...] the city hall was 'tied' with a red ribbon 500 meters long and weighing 700 kilos" clearly showing what was the most talked about topic in the city at the time (Grünkemeier 69). In 2001, a short documentary film *A Red Ribbon Around My House* was released featuring several stories related to the epidemic (Grünkemeier 69). Brett Murray made use of the red ribbon symbol in 1994 during the creation of his AIDS Memorial in Company's Garden in Cape Town, when he sculptured a sort of gravestone of white marble without any inscription of names or dates but only a metal red ribbon, and also attached the red ribbons to the lamps in the park (Grünkemeier 73). By doing this he tried to step away from the individual infected by the epidemic and address it as a public problem affecting everybody. Photographer Penny Siopis used the red ribbon in her photo entitled *Baby In Red* in 2000 when she wrapped a baby in it, thus making the baby unable to move, just like children when they are born are unable to protect themselves from getting the HIV virus (Grünkemeier 78). By doing so, Siopis called attention to mother-to-child transmission prevention as well as criticized the slow response of governments that let innocent children die.

Both, *The South African National Gallery* in Cape Town and the *Durban Art Gallery*, as well as many other establishments around the country, have played an important role in slowly bringing HIV/AIDS art closer to people. The red ribbon symbol has been accepted as a pattern in traditional craftsmanship, with the trend starting during the AIDS Conference in Durban, when it was first incorporated in Zulu beadwork with sales profits going towards helping fight the epidemic. Basket weaving and the newer telephone-wire basketry, as well as Imbenge pot lids have made similar attempts in including the red ribbon (Zulu Imbenge Pot Lids 2015). These traditional artefacts often include messages like ‘AIDS Kills’ or ‘HIV/AIDS Is A Killer’ and are sold as souvenirs in African Art Centres across the country (Grünkemeier 84).

Raymond Williams has called culture “[...] one of the two or three most complicated words in the English language” (qtd. in Storey 1). For him, culture are “[...] the works and practices of intellectual and especially artistic activity [...] texts and practices whose principal function is to signify, to produce or to be the occasion for the production of meaning” (qtd. in Storey 2). This culture as the sum of “[...] signifying practices” takes under its umbrella everything from poetry and novels, to the opera and ballet, fine arts, soap operas, pop music or comics (Storey 2). HIV/AIDS can still be considered a taboo topic in South African culture, but there are more and more examples of breaking with the taboo, breaking with the culture of silence (Grünkemeier 113). By using films, stage-plays, music and musicals, the topic is brought closer to people and makes the disease more familiar as well as more understandable. The cultural response to HIV/AIDS can be understood in terms of what Ted Gott replied when asked about why the red ribbon is used as a symbol of the fight against the epidemic. Just like culture on its own, the red ribbons worn on chests “[...] don’t protect anyone or provide a cure from AIDS and discrimination but they are a gesture [...] a visible sign of awareness [...] it can mean anything from I’m angry to I sympathize, it covers the spectrum of emotions surrounding AIDS” (Grünkemeier 68). In culture, and in the most known symbol of the fight against HIV and AIDS the “[...] color red is not only for blood but for anger, passion and love as well,” while still keeping in mind that the ribbon is shaped as an “[...] inverted ‘V’ because there has been no victory” (Grünkemeier 68).

6. LITERARY RESPONSES

In a field of struggle and contestation, literary intervention can become the transformative tool in “[...] contesting the marginalization of victims, renewing attention to silences and differences, and imagining new patterns for political change and innovative possibilities for social agency” (Woods 306). Literary representations take personal experiences and present them to the public. By doing this they can humanize the epidemic and bring it closer to people, make the epidemic easier to understand (Woods 208). By adding a new abstract dimension, literary representations bypass the statistics and give HIV and AIDS names, human faces, open doors and offer understanding, mourning, and awareness (Woods 315). They invite us to become active. The true power of such narratives is not simply in their roles as texts, but as an intervention in the public sphere that shape the politics and culture of their time (Woods 320).

Literature can be seen as “[...] a medium of sharing,” as it helps people realize they are not alone, and that theirs is not an isolated experience (Mengel 8). Knowing that someone else, somewhere else is going through the same, or at least similar thing, makes people feel less alone and more empowered. What HIV/AIDS literature is trying to achieve is equilibrium. Readers may have thoughts, questions they are ashamed to ask out loud, but can find solace in knowing someone out there asks them. They want to get answers to questions not only the books, but also life in general, has asked.

Helen Moffett made an ambiguous statement saying “Literature can do everything, and literature can do nothing” (Borzaga 245). Yet, when debating whether writing HIV/AIDS fiction is relevant, Sindiwe Magona wonders how a world in which writers stop writing about important things would look like and asking “[...] how will history judge us, who said nothing, who did nothing?” (Orantes 41). While she admits that there is more understanding of the epidemic nowadays, people’s attitudes have not changed (Zajec 83). She is determined that, even if the majority of people infected or affected by HIV/AIDS can’t read, it is important their stories are written down not necessarily for now, but for the future (Orantes 45).

By highlighting Antonio Gramsci’s words about “[...] the strange phenomena that are released in a state of tension and emergency,” writer André Brink compares writing in contemporary South Africa to being “[...] caught in the heart of the whirlwind [...] almost a matter of reporting from the war zone” (Mengel 3-4). War metaphors, as violent as they may

be, do have a place in literature of the HIV/AIDS epidemic. South Africa has won the war against apartheid, but the war against HIV and AIDS has ongoing battles on all fronts. The role of literature in this war is to report from the fronts, to write of the battles, tell the stories of the injured. Acknowledging the political and social importance of writing can be seen in the words of an old man from Chinua Achebe's book *Anthills of the Savannah* saying "The sounding of the battle-drum is important; the fierce waging of the war itself is important; and the telling of the story afterwards - each is important in its own way" (qtd. in Bennet, Royle 60).

It seems that HIV/AIDS, in South Africa in general and in its literature, is a very uncanny topic. It is surrounded by mystery, by a fundamental disturbance, a troubling of definitions, a lurking strangeness (Bennet, Royle 35). Therefore, literature that dares to tackle the sensitive topic of the HIV/AIDS epidemic, "[...] most persistently and most provocatively engages with the uncanny aspects of experience, thought and feeling" (Bennet, Royle 36). Being transmitted through sexual intercourse HIV/AIDS is such a taboo topic because it, in the words of the Russian formalist Viktor Shklovsky, defamiliarizes something very familiar "[...] it challenges our beliefs and assumptions" (Bennet, Royle 36). Talking about HIV/AIDS can often be understood as a disturbance of public sphere stability. The epidemic is like Pandora's Box that should remain secret and closed for public debate, but literature opens it and brings it to light. Nevertheless, the uncanniness of HIV and AIDS is not something present (Bennet, Royle 42). It is an effect. Something that the reader feels when, he or she, reads a text about the epidemic. Bearing this in mind, the uncanny aspect of the epidemic most of all has to do with the "[...] effects of reading, with the experience of the reader" (Bennet, Royle 42).

AIDS is responsible for millions of personal tragedies and therefore it is not surprising that it "[...] has generated personal literary forms of writing such as memoirs, poetry, and written, staged, and filmed fictions that focus on the effects of AIDS on individuals infected or affected by it" (Soldati-Kahimbaara 163). However, the following chapter will focus on five examples of South African fiction about HIV/AIDS that have emerged in the post-apartheid era.

Phaswane Mpe's *Welcome to Our Hillbrow* was one of the first novels to deal with the epidemic and the xenophobia surrounding it when it was first published in 2001. Niq Mhlongo, a young and inspiring writer, brought a breath of fresh air on the South African writing scene with his hard-hitting realism, which includes bluntly writing about HIV and

AIDS that will be closely analyzed in two of his books, *Dog Eat Dog* (2004) and *After Tears* (2007). Sindiwe Magona's novel *Beauty's Gift* (2008) has been highly praised and called a book "[...] that needs to be read, reread and retold if we are to fight and win the war against HIV/AIDS" (Ngwenya 1). The fascinating yet terrifying novel *The Book of the Dead* (2009) by Kgebetli Moele takes the epidemic by the horns and shows how the disease can deteriorate a person to become something close to a serial killer.

The following chapter will focus on different themes noted in the books mentioned above. Where the virus originates, why it is still surrounded by taboos, how is it received and how can it be prevented, how people get broken psychologically and physically by it, and how women can be empowered by it will be the questions that will fill the following pages. Literary texts are part of the time and place in which they are written. However as new historicists argue, it should not be forgotten that nothing is certain and everything changes (Bennet, Royle 119). As the circumstances change, the texts change with them. They absorb change and become "[...] both products of and influences on a particular culture" (Bennet, Royle 119). They are not simply a reflection of a certain time and place. What works of fiction about HIV and AIDS are trying to be is "[...] sites of conflict and difference, places where values and perceptions, beliefs and prejudices, knowledge and social structures are represented," and hopefully, in the process, become places of transformation (Bennet, Royle 206).

6.1. THE ORIGIN OF HIV/AIDS

In Kgebetli Moele's *The Book of the Dead*, we experience how the HIV virus as a first person narrator is talking about its mission. The virus is like a haunting whisper saying "I. I live amongst you, waiting like a predator. I am faceless. I am mindless and thoughtless. But I am feared and despised. You hate me. But then I put on a face - wear a human face - and I am respected, appreciated and valued. I am I" (Moele 77). The virus describes how it loves its job and how it patiently waits until it is invited (Moele 77). He warns us that it is not only after the poor and promises to penetrate all preventive measures on its way (Moele 77). The virus parts from the pages of the book with a suspenseful warning saying "I am coming for you. This is a promise. I promise you that I am coming for you" (Moele 78).

There are several myths regarding the origin of HIV and AIDS. Othering, as a means of freeing oneself from responsibility and consequences, is a common device for putting blame on others. When something comes from a different, unknown world it has to be a

deviant, something no one can explain. This is what happened to the HIV/AIDS epidemic. While there are some scientific theories about the true origin of the virus, none of them is certain. All this gave wind to rumors and whispers one would usually simply ignore, but given the extent and fast spreading of the disease the rumors have come to life and pushed the research on the actual origin on the side. Literature is not immune to such speculation, as it has become a part of everyday life in South Africa, and this chapter will explore how the origin of HIV/AIDS is described in selected post-apartheid works of fiction.

The mystification of HIV/AIDS draws parallels to the medieval plague as both present the idea of devious immoral individuals corrupting the whole population. As Grünkemeier points out, the term ‘African AIDS’ “[...] says little about the African epidemic” but it does say “[...] much about those who create, perpetuate and benefit from this construct because the virus is being used to solidify dichotomies and power relations” (123).

Firstly, the most popular belief, in the European/American sphere and even in South Africa, is that the origin of HIV/AIDS is Africa. The theory is often seen as a remnant of old colonial dichotomies of white versus black, or ‘West’ versus Africa, where Africa is presented as an antagonist to the perfect Western world, where such a killer disease could have never originated (Grünkemeier 122). In such a world, a black person is never seen as an equal to a white one because he is presented as a primitive, overtly sexual being, whose immoral behavior has led to the beginning of HIV and AIDS (Grünkemeier 120). “Black in human skin colour, but also black in morals” the disease comes as a biblical punishment to all humanity because of the sins of the black men (Mpe 103).

This is referred to in Niq Mhlongo’s book *Dog Eat Dog*, when the protagonist Dingz is returning home to Soweto from Johannesburg by a Metrorail train. He enters a carriage where he knows a religious service is always going on because he feels safer there than in the other carriages. During his sermon the preacher reveals he believes that there will never be a cure for AIDS because “AIDS is a punishment from God because the world today has become wicked,” referring to “[...] the ancient cities of Palestine called Sodom and Gomorrah, which were destroyed for their wickedness” (Mhlongo 207). In the opinion of this preacher no medication or condom will be able to stop God from punishing black people for their sins.

Stuart Hall’s theory on articulation highlights that things are always made to mean in a certain context. Different things convey different meanings in different times or situations. By putting itself in opposition the West re-instates itself as the centre, as an ideal to which Africa

should strive (Storey 171). In *Orientalism* Edward Said explains how questions of power built on the illusion that “[...] the West [...] is rational, developed, humane, superior, and the Orient [...] is aberrant, underdeveloped, inferior” (qtd. in Storey 172). In the HIV/AIDS scenario, Africa represents the Orient, and the Western world’s desire to have power over it simply shows that they wish to always have the upper hand in matters concerning the epidemic, containing it inside the walls of the African continent, while at the same time doing everything to get rid of it in Western countries.

The logic of such thinking is that this lethal disease could have not originated in the civilized West but is better suited for the African ‘other’ presented as non-human, almost bestial. Bennet and Royle point out that while the other is represented as threatening, disturbing and dangerous, simply defining oneself by standing in opposition to something different usually means that there are some key points that draw the two poles together (237). The cultural meaning of the virus cannot simply belong to one or the other side, but is a construct of both of them merging. Such a questioning of binary oppositions is what Said called ‘contrapuntal reading’ “[...] guided by an acceptance of multiplicity [...] and an affirmation of radical otherness” (Bennet, Royle 240).

However, such multiplicity is not a part of the most widely spread scientific theory about the origin of HIV/AIDS. According to popular belief the epidemic was started by green monkeys living in eastern, western and central Africa, more specifically somewhere between “[...] Rwanda, Burundi and Congo-Kinshasa” (Grünkemeier 121). The simian immunodeficiency syndrome found in these types of monkeys is closely linked to the human immunodeficiency virus (Grünkemeier 128). There are several ways how humans could have come in contact with this simian virus. One is through eating the meat of green monkeys what some of the tribes living in those areas traditionally do. The virus could have been transmitted through monkey bites, or it could be that hunters hunting down green monkeys got cut in the process and came in contact with the monkeys blood (Grünkemeier 128). This theory is reflected upon in Phaswane Mpe’s *Welcome to Our Hillbrow* when he observes that “[...] strange illnesses courted in Hillbrow” (3). Mpe takes up the theory of eating green monkey meat in Western Africa (4). Their germs then travel from Western and Central Africa to Hillbrow (4).

As a response to such theories, the Africans came up with a counter-theory about the origin of AIDS. Some of them are convinced that the HIV/AIDS epidemic is a Western made disease. The West supposedly created the virus in their laboratories as “[...] bacteriological

warfare” and intentionally fabricated the virus “[...] as a means to scare (black) Africans away from sexual intercourse and reproduction in order to reduce their numbers and to further their marginalization” (Grünkemeier 123). This myth has gone so far that some people actually believe that the acronym AIDS stands for ‘American Intervention to Discourage Sex’ (Grünkemeier 123). While the first reported cases of the virus have been documented in the United States of America, the common explanation given by Western science is that the virus was brought from central Africa to Haiti by volunteers and international organization workers, and from the Caribbean it was then spread to the United States (Grünkemeier 121-122).

There are also continuous voices calling out that the HIV/AIDS epidemic was spread by Western medical personnel during the “[...] mass vaccination campaigns in the late 1950s” (Grünkemeier 128). Some even say that the West intentionally planted the virus in Africa to try out new medication on people, perform experiments, tests and make profits for pharmaceutical corporations. These conspiracy theories have made its way in everyday life and have found its place in works of fiction. Writer Niq Mhlongo does not shy from this topic but includes it in his stories of street life in Johannesburg.

In his book *Dog Eat Dog* Dingz is drinking with his friends at their favourite bar in Braamfontein, and their drunken discussion touches upon the topic of AIDS. His friend Dworkin explains to the group that he believes that the abbreviation AIDS actually stands for ‘American Invention for Discouraging Sex’ or even ‘Academic Imaginary Death Sentence’ (Mhlongo 142). He echoes the voice of many in Hillbrow when he claims the academics supported by the rich created the epidemic so they will be the only ones enjoying sexual intercourse because everybody else will be afraid (Mhlongo 142). Dworkin also takes on the American pharmaceutical companies that refused to reduce the prices of antiretroviral medicines, even though it became more and more obvious that the South African epidemic is spreading uncontrollably. He calls America’s actions “[...] economical fundamentalism,” and names AIDS the “[...] discriminatory disease of the poor” (Mhlongo 144-145). Such opinions are further described in Mhlongo’s sequel to *Dog Eat Dog*. In *After Tears*, Bafana’s family and friends are all gathered in his uncle’s garden when they start arguing about AIDS. One of the family friends named Dilika furthers the conspiracy theories by revealing there is a cure for AIDS but it is used only in the West and not in Africa (Mhlongo, *After* 88). When Bafana’s mother Rea protests that she has read of celebrities dying of the epidemic overseas Dilika counters by yelling “These bastards developed the virus as a biological weapon against us Africans, and that’s why we won’t make it. We will continue to die like flies! [...] AIDS is

no longer a death sentence in most First world countries [...] because the world is divided into continents where the disease is survivable and where it's not" (Mhlongo, *After* 89).

The origin of HIV/AIDS does not necessarily have to become a debate about differences between Africa and the Western world. Most of the time, people simply put the blame on deviant and irresponsible sexual behavior of specific groups. According to such theories the epidemic is caused by everything different from 'normal', pointing fingers at homosexuals and sex workers as the most obvious indicators of moral decay calling their actions "[...] bizarre sexual behaviour" (Mpe 4). This brings us full circle as it stigmatizes the already most stigmatized groups, making them easy prey and convenient scapegoats bearing the blame for all others.

In the books there are several more examples given about where one could get infected for instance the possibility of getting infected with a used syringe. In Mhlongo's book *After Tears* the Kuzwayo family friend PP describes how people put used syringes in the sand on beaches for revenge of the already infected (109). PP also talks about people being so poor that they deliberately have unprotected sex in the hopes of contracting HIV so they would be eligible for a state grant (Mhlongo, *After* 109). Bafana's family also believes that his Aunt Thandi contracted HIV through blood transfusion. She was involved in a car accident and lost a lot of blood making her family blame the hospital for negligence (Mhlongo, *After* 20). She died of AIDS and her son Yuri was thus born with the disease.

It should be noted that when discussing the origin of AIDS a group of friends in Mhlongo's *Dog Eat Dog* describe an interesting urban legend circulating in Soweto. While the debate starts off with the assumption HIV/AIDS started in the 1960s somewhere in Congo, Dingz's friend Themba explains a story about Vera the Ghost. In the 1980s a beautiful lady was raped by 5 men on the streets of Soweto. Instead of getting angry with them, she kissed every single one and left them believing they had done nothing wrong. The next day all five men became really sick and developed HIV. Ever since that day, Vera's ghost roams the streets of Soweto seducing young men. First she blinds them with her beauty and lures them into bed with her, but the next morning the men are covered by ash in Avalon cemetery (Mhlongo 148). Young boys in Soweto are often scared with this story and warned to abstain from sex because of it. Sindiwe Magona explains that people generally do not care anymore about where the epidemic originates from as it has been around for so long. Nevertheless, she does point out that as long as the disease will be around, such stories will circulate because

they offer “[...] a way out [...] a way to make sense of what is going on, and putting the blame on others or other issues” (Zajec 86).

Nevertheless, when previously talking about othering, there is another phenomenon that should be taken into consideration and that is South Africa versus other parts of Africa. As South Africa is arguably one of the most developed, if not the most developed African country, it seems to sometimes take on the role of the West regarding black immigrants from other African countries. South Africans often feel superior to other Africans and spread xenophobia and discrimination against them. This is closely observed in Phaswane Mpe’s *Welcome to Our Hillbrow*. Refentse’s cousin always cheers for African clubs when they play against European ones in soccer, but is quick to turn on fellow Africans and blames the immigrants when it comes to crime, drugs and moral decay spreading in Hillbrow. These *Makwerekwere* are seen as the sole “[...] bringers of the AIDS disease and immorality” (Negash xxiii). The use of the derogatory term *Makwerekwere* “[...] a word derived from kwere kwere, a sound that their unintelligible foreign languages were supposed to make, according to the locals” only furthers such xenophobic outbursts (Mpe 20).

Cousin personifies the xenophobia in modern South Africa and serves as a good example of how fast people are willing to forget the past when it suits them. During apartheid many South Africans were forced to flee the country to other parts of Africa because at home they were discriminated. Mpe highlights this by admitting that “[...] some *Makwerekwere* were fleeing their war-torn countries to seek sanctuary here in our country, in the same way that many South Africans were forced into exile in Zambia, Zaïre, Nigeria and other African and non-African countries during the Apartheid era” (19). Now, when the tables have turned, and they could be the ones offering safe haven to other Africans in need, they discriminate and work against them. Fortune’s wheel may have turned, but the people have learned nothing from the past as there is “[...] no excuse for ostracizing the innocent” (Mpe 20). By making some of his characters re-think the general xenophobia towards African foreigners Phaswane Mpe raises awareness among his readers as well.

On the other hand, it can be observed that South Africa does get a different treatment than other African countries. America and especially Europe seem to idealize South Africa, as they see it as almost an equal. Because of the history that connects Europe and its settlers in South Africa, the country seems closer to home than other parts of Africa. The number of white people still living on the most southern part of the continent make the country seem friendlier to whites. In *Welcome to Our Hillbrow*, Refilwe notices the different attitude she

receives because of her South African passport compared to other African citizens, first at Heathrow airport and then generally in Great Britain. With their passports closely checked she notices how Africans, but especially citizens of western African countries were seen as the “[...] sole bringers of AIDS and all sorts of other dirty illnesses to this centre of human civilization” (Mpe 102). Although Refilwe wishes to escape such xenophobia she is disappointed to realize that it is not only rooted in Hillbrow or South Africa, but can be experienced everywhere in the world, even in the civilized West where the term *Makwerekwere* is simply substituted with a different word that has the same connotation, and that is the word Africans (Mpe 102).

The mystery of the true origin of the HIV virus has not been solved yet. Nonetheless, examples from everyday life in South Africa and the books written there, show that one thing is still certain. And that is the echo of the words spoken by the HIV virus in *The Book of the Dead* that now seem almost prophetic as it announces “Your time is coming. I am coming especially for you. I am scheming my way into your system. That is my promise to you. I will find a way to get to you” (Moele 77).

6.2. HIV/AIDS AS A TABOO TOPIC

In Sindiwe Magona’s *Beauty’s Gift* Amanda and Beauty are best friends. When Beauty tells Amanda the truth about her illness she asks her let the other members of their Five Firm Friends group know she has AIDS (Magona 74). Even though Beauty asked her to tell them her secret Amanda questions her own actions when she fails to let the others know “What was she hiding? Surely she wasn’t protecting Beauty? Protecting her from what? Than was she, Amanda, ashamed that her closest friend had had AIDS?” (Magona 72). It is “[...] not her secret, not her shame” (Magona 61). The fact that Amanda, a well-educated young woman of good fortune, still feels that having AIDS is such a shame that she is unable to tell her friends about it, despite her dying friend’s last wish, only shows how deeply rooted and multi-layered the HIV/AIDS problematic is in South Africa. Amanda is both angry at Beauty’s husband Hamilton for infecting her with HIV, and with herself. She is aware that she did not ask Beauty if she is taking the right medication or seeking any kind of treatment because she was so shocked (Magona 61).

Magona’s “Now silence reigns” are the words with which one could describe the taboo surrounding the HIV/AIDS epidemic (48). Looking back in history, lepers were once considered as “[...] the social outcasts of the day,” and in a way AIDS is “[...] a modern day

equivalent; sufferers are rejected, regarded as untouchables” (Hope House Hospice 2012). Taboos remain because no one talks about them, because silence seems better than words. If a person’s suffering is put on paper, they could get better by writing or reading about it and try to slowly grow away from the pain (Orantes 37). When reading such texts gets too hard, they can stop reading and return to them later, unlike the actual physical pain that cannot be stopped (Orantes 37). It is true as it always was that “[...] a burden shared is a burden halved” (Orantes 37). Knowing you are not alone and that someone else has the same problems makes them easier to cope with (Orantes 37). Hopefully, the more people read about the traumatic experiences of the sufferers, the less they will stigmatize them and stop with tabooing the HIV/AIDS epidemic.

Works of fiction and their “[...] metaphorical realizations are noteworthy attempts to address the issue and break the culture of silence. Furthermore, the metaphors help to convey complex medical knowledge and give impetus to a public and well-informed discussion about the epidemic” (Grünkemeier 113). Ross Chambers once argued: “To tell a story is to exercise power” (qtd. in Bennet, Royle 59). Literature can often serve as a weapon of the weak against the strong (Bennet, Royle 59). Here the true meaning of narrative power comes into play as it is seen as “[...] the only strategy left for the weak and dispossessed: without narrative power, they may not be heard” (Bennet, Royle 60).

Grünkemeier highlights that “[...] the epidemic had long been marginalized, if not ignored, and was scarcely addressed in South African literary and cultural products”, which makes it even harder for new writers to tackle a topic that is obviously so sensitive and apparently unwanted in public debates (3). Therefore, even if the epidemic is discussed, it is mentioned like a whisper, or can be described as tiptoeing around the issue, considering being HIV positive as a death sentence (Grünkemeier 46). While the straightforward denotation behind abbreviations HIV and AIDS is clear, the connotations the two short words convey are almost endless. The equivocality hidden behind the HIV/AIDS epidemic naturally brings polyphony to every text dealing with it. The relay of producing or inventing new connotations of the epidemic happens almost daily, with the most important one still being the transformation from fatal to manageable chronic disease.

In fact, many South African films and narratives portray HIV/AIDS as “[...] a ‘death sentence’, especially in rural areas and in situations where stigma and prejudice undermine people’s willingness to get tested” (Woods 322). Such portrayals are included in Mpe’s *Welcome to Our Hillbrow* and Moele’s *The Book of the Dead*. It is still a long way to go from

seeing HIV and AIDS as a ‘chronic epidemic’ instead of a ‘fatal disease’ (Woods 322). Christopher J. Colvin from the Centre for Infectious Disease Epidemiology and Research (CIDER) at the University of Cape Town acknowledges that “The notion of HIV infection as an automatic death sentence is weakening. This isn’t to say that full nominalization has been achieved [...] only that the social forms and interpretations of the disease have changed significantly in recent years” (Woods 322). Nonetheless, even after the national rollout of ARV’s the stigma and taboo around a positive HIV diagnosis has not been removed, nor was the economic instability that comes with such a diagnosis (Woods 322).

Maintaining silence on having HIV/AIDS only prologues the denial and stigma. That is why public disclosures of HIV statuses help and why statements of noticeable public figures like Simon Nikoli, a Soweto born gay rights and AIDS activist, Edwin Cameron, a Constitutional Court Justice, or Zackie Achmat of the *Treatment Action Campaign* (TAC), are important as they have all spoken publicly of their HIV positive status (Soldati - Kahimbaara 164). But probably the most famous HIV/AIDS testimonial came from a 36-year old Gugu Dhlamini from KwaMashu near Durban, when she revealed her HIV-positive status on a Zulu radio station (Soldati - Kahimbaara 164). After her revelation in 1998 she was “[...] stoned and stabbed to death” (Soldati - Kahimbaara 164). This brought about a media uproar and even made leading politicians like Nelson Mandela and Gatsha Buthelezi, to publicly admit they have lost sons to AIDS and that there is no shame in admitting it (Soldati - Kahimbaara 164). The *Treatment Action Campaign* (TAC) responded to the Dhlamini incident, by distributing t-shirts saying ‘HIV Positive’ on the front and her picture with the words ‘Never Again’ on the back (Grünkemeier 85).

Sindiwe Magona explains that while the reactions to talking more openly about HIV and AIDS are nowadays more subtle, the epidemic still is a disease that traumatizes and stigmatizes everyone within its reach (Zajec 83). Thus, Paula Treichler’s description of the HIV/AIDS epidemic as the “[...] epidemic of signification” is still true (qtd. in Woods 316). It comes as a result of a carefree lifestyle in the early 1990’s leading to many deaths attributed to diseases such as cancer, tuberculosis or pneumonia. But behind those socially acceptable diseases there is lurking an epidemic far greater and scarier. At many funerals HIV/AIDS is never mentioned, but instead called out as “[...] ‘the whittling disease’, ‘wearing the red scarf (ribbon)’” or even “[...] ‘playing the lotto’” (qtd. in Woods 316).

The secrecy surrounding HIV/AIDS can be noticed during Beauty’s funeral. Although it is said she was ill and “[...] stolen away from us” her condition is firstly simply named

“[...] the illness” and then “[...] TB” (Magona 9-10). Until Amanda’s revelation nobody even mentions HIV or AIDS even though everybody is familiar with the symptoms. It is a secret everybody knows but no one tells. Interestingly, Soldati - Kahimbaara believes that renaming or avoiding mentioning HIV/AIDS means pushing the epidemic “[...] to the edge of fiction so that it is the effects on the life of the individual that takes the central position” (167).

When Refilwe returns to die of AIDS in Tiragalong at the end of *Welcome to Our Hillbrow*, she becomes the most talked about topic in the village. While the villagers are gossiping behind her back they fail to realize they buried many victims of AIDS already in Tiragalong but the reason for their death was simply attributed to socially more acceptable diseases (Mpe 121). The narrator is the voice of wisdom when he quietly remarks that “[...] disease is just disease. That choice is choice, and no one in particular can be blamed for the spread of AIDS” (Mpe 123). In her village Refilwe becomes an example of the evil disease “Tiragalong will in future admonish its children by saying: Now, you - do not behave like Refilwe, or you will come to the same end!” (Mpe 123). The villagers of Tiragalong remain narrow minded, pointing fingers at everyone else instead of looking for fault in themselves. Ghirmai Negash points out that “[...] however hard one might try to conceal the truth [...] the disease is not restricted to rural or urban areas but rather cuts across cities, regions, race, gender, and professions; the AIDS epidemic eventually harms everyone in its way” (xxiii).

How deeply the HIV/AIDS taboo is engraved in people is clear in Niq Mhlongo’s *After Tears*, when Bafana describes why his uncle Guava is in jail. His sister and Bafana’s aunt died of AIDS. But when her neighbors started telling people about her disease Bafana’s uncle accused them of witchcraft and burned down their house using petrol (Mhlongo, *After* 100). On aunt Thandi’s death certificate “[...] it said that she had died of tuberculosis, chronic diarrhea and pneumonia” (Mhlongo, *After* 20). There are several more cases in the book that show misunderstandings surrounding the disease. When sis Zinhle argues with family friend PP about his reckless sexual behavior, she warns Bafana not to become like PP saying you can get infected with HIV just by looking his way (Mhlongo, *After* 106).

Both, Kgebetli Moele with his *The Book of the Dead* and Sindiwe Magona with her *Beauty’s Gift*, deal with the denial and silence accompanying the HIV/AIDS epidemic. But they go about it very differently. The former uses shock techniques to show the cruelty and disillusion that follows a positive HIV result, while the latter uses a more subtle approach by “[...] gently revealing the consequences of reckless behavior on infected individuals and those who care for them” (Soldati - Kahimbaara 175).

In *The Book of the Dead* the HIV virus describes how it finds beautiful people only to “[...] eat them up, put them in bed and leave them wearing nappies” (Moele 110). Describing how tabooing influences the people infected with the virus it says “When you catch people talking about you, and they pause their conversation, you will think that they are really talking about me. You will start to stigmatize yourself” (Moele 110). The virus predicts two scenarios for its victims. The first one is denial, blaming a different disease. According to the virus this will not work because everybody today knows the symptoms of the epidemic (Moele 110). The second one is the truth, coming out and revealing an HIV positive status (Moele 110). But the virus highlights that this will not help the infected as “Their friends will admire their bravery, but they will still be concerned about their safety when they shake hands, and the women who used to hug them will suddenly prefer a handshake” (Moele 110). The virus is smart and only sees its victims as useful when they are healthy and full of life. He discards them when they give up, start avoiding friends and family, because then it has no use for them anymore (Moele 110).

The taboo connected with the HIV/AIDS epidemic also often forces people to search for alternative healers and medicine. A good example is Nkululeko, the brother of one of the girls Khutso infected in Moele’s *The Book of the Dead*. He was forced by his mother to try out several different traditional remedies that ended up completely destroying him. This topic will be more closely analyzed in the subchapter *Prevention of HIV/AIDS*.

In *Beauty’s Gift* the Sonti twins, Lungile and Lunga, both die of AIDS. Because of that people start speculating if they were homosexuals. One of the Five Firm Friends, Cordelia, is shocked by such gossip and fires back saying “And that gives them AIDS, in your opinion? Because heterosexual people don’t die of AIDS?” (Magona 44). She doesn’t manage to convince many, as the general public still agrees, that is the only way they could have both gotten the virus at the same time. This is a reference to one of the earliest stigmas connected with the epidemic, linking it with homosexuality.

Another point worth considering is that if patients decide to go public with their HIV status it is not only them who take the heat of such a confession, but also their family members and close friends that often become ostracized by society as well. It is because of this ongoing silence that the epidemic takes even more lives than necessary as people infected fear reactions of their close ones so they refuse to take ARV’s and thus simple parasitic infections, otherwise not fatal for a healthy immune system, continue to take lives.

The funeral of the second Sonti twin, Lungile, is the moment in the narrative where Magona decides to face the taboos of the HIV/AIDS epidemic. At the funeral she is personified in Mrs. Mazwi, a community leader that also taught Lungile. Mrs. Mazwi asks the crowd at the funeral how many of them have illegitimate children. When no one is brave enough to raise their hand she continues by saying “This is how it is going to be with AIDS. Very soon, all our families will have at least one person infected with HIV. One, if we are lucky. What has happened to the Sonti family will happen to many others” (Magona 85). She points out that many families have daughters and sons born out of wedlock yet nobody is brave enough to talk publicly about it. She predicts the same story for having a HIV positive member of the family. Hurtful gossip will prevent many people from testing, protecting themselves or getting the right medication in fear of being discovered. Nonetheless, she sums up her powerful speech by yelling to the crowd that “There is no stigma to fighting to stay alive. There is no stigma to illness. If you’re ill, you’re ill, not dirty! The stigma belongs to those who gossip!” (Magona 85).

André Brink talks about how hard it is to write about something objectively when you are still caught in the middle of it (Mengel 3). Authors writing books about HIV and AIDS today are caught in the eye of the storm. What literary responses are trying to do is avoid the rhetoric and formulaic responses to the epidemic, while breaking with the culture of blame excluding and trivializing sufferers (Woods 312). As Tim Woods puts it “AIDS narratives seek to reinstate people’s lives into the symbolic order that has been disrupted by the medical diagnosis, thereby inscribing meaning and re-asserting control over their lives” (315). Nevertheless, Magona suggests that “Writing is not therapy, but it can be therapeutic” (Orantes 36). She continues by pointing out that “There is something soothing talking about an ache and bringing it out under the light, holding it to the light, and seeing it for what it is. In a way it’s a form of letting go; it’s part of the process” (Orantes 36).

Unfortunately, the epidemic is still broadly considered as a taboo, something that is not talked about because it defamiliarizes what seems so fixed and natural, transforming the natural order of things. The HIV/AIDS epidemic has become the biggest killer in South Africa and yet what is even more worrying about that fact is nobody seems to care. There are too few opened discussions and this problematic is often swept under the rug. Right now the medical problematic of the disease is joined by the enormous repercussions it has in everyday life of South Africans. The injustices, the shame, the gossip, the lies, the betrayals and punishments connected with the epidemic make it clear; the words of Nelson Mandela, with

which Kgebetli Moele finishes his *The Book of the Dead*, are truer than ever that “AIDS is no longer just a disease, it is a human rights issue” (166).

6.3. RECEPTION OF HIV/AIDS

This subchapter will take a closer look at the reception of HIV and AIDS from three different perspectives. The first one will include the reactions of the characters in the books to their HIV positive status. The second perspective will focus on the reactions of all the affected characters and groups in the books that are not necessarily HIV positive but are nevertheless in most cases life-changingly affected by the epidemic. The final perspective will try and analyze how the readers respond to books that deal with HIV and AIDS.

In *Welcome to Our Hillbrow* Refilwe falls in love with Refentse but he leaves her after he finds out that she is cheating on him. Years after, Refilwe wants to rekindle their romance but is refused by Refentse because he is in love with Lerato. Hurt by his rejection and consumed by jealousy Refilwe starts spreading vicious rumors about Lerato following Refentse’s suicide. Ironically, by the end of the book Refilwe gets infected with HIV “[...] reaping the bitter fruits of the xenophobic prejudice that she had helped to sow” referencing her stories about Lerato (Mpe 113).

In Oxford, where Refilwe moves to study, she meets a Nigerian and they start a romantic relationship. Both find out that they are infected with HIV and have been for over a decade before they met, and the Nigerian goes back to “[...] waste away home” because “[...] he did not want to become someone else’s burden” (Mpe 115). When Refilwe is in a pub named *Jude the Obscure* in Oxford with her friends she recommends the owner of the pub to read Zakes Mda’s *Ways of Dying*. Her own life starts to mirror characters in the book. She is aware that her family will mourn her, though not professionally (Mpe 108). Refilwe wishes for Noria’s strength to cope with the terrible burden of the epidemic (Mpe 108).

Nonetheless, she wants to return home, “She wanted to be laid to rest in our Tiragalong, even if it meant exiting this world amidst the ignorant talk of the people who turned diseases into crimes” (Mpe 116). Because of all the backlash after Refentse’s death she was getting herself ready for the accusations coming her way (Mpe 116). Her fellow villagers judge her for being a man-eater (Mpe 116). Refilwe often wonders about her lover back in Nigeria. She wants them to die together but is aware of the fact that in Tiragalong he would be the one they would blame as he is one of the hated *Makwerekwere* and would be seen as a “Convenient scapegoat for everything that goes wrong in people’s lives” (Mpe 118).

The interesting part about Refilwe's reaction to being HIV positive is that she immediately decides that she will stay alive and not follow in Refentse's footsteps by committing suicide. Unused to the bad English weather and worried about her family back home her condition worsens by the day and she rightly presumes she does not have long to live (Mpe 117). But she remembers very well how deeply she was saddened by Refentse's decision to take his own life as well as the devastation his premature death caused among his family and friends. Therefore, she decides to stay alive for the ones she loves "For them, she would try to live as long as she could. She did not want them to have to suffer the pain she had suffered, of wondering what they could have done, or not done, said or not said, to keep her from exiting this life prematurely" (Mpe 116). Even though, Refilwe keeps a positive outlook on life following her diagnosis, her family fails to do the same. When her family picks her up at the airport in Johannesburg her brother takes a quick look at her skinny body and is already in tears (Mpe 118).

In Moele's *The Book of the Dead* Pretty has had several sexual partners before marrying Khutso, and when she finds out that she is HIV positive she confesses this to her sleepy son Thapelo by telling him to enjoy his life because the whole family is dying (72). She kills herself and Khutso only finds out about her condition by reading her journal and its last inscription saying "I AM HIV POSITIVE" (Moele 74). In stark contrast to Refilwe discussed before, Khutso takes the news extremely bad. He curses the day he met Pretty and is seriously considering suicide. He starts resenting his son Thapelo because every time he looks at him he is reminded of his deceased wife and his blood starts boiling. Finally, he decides to put Thapelo in boarding school and refuses to take him back on school holidays. Khutso's anger thus leads to the start of his planned revenge infecting of as many women possible and writing their names in his book when they die of AIDS. He even takes ARV's so he can live longer and infect the most women possible.

The reactions of characters to their positive HIV status should be understood in consideration of the situation they would be facing. For instance, hospitals often accept only HIV negative patients because there is not enough space for all who need help, with HIV positive patients simply regarded as too 'high risk' and immediately stamped with a death sentence (Le Marcis 174). However, if hospitals do admit HIV positive patients, they only do so with those who still have a high CD4 cell count and not with those who are in the most advanced stages of the disease (Le Marcis 174). The patient is then faced with hours and hours of waiting and is often moved from one health center to another feeling completely

secluded from society (Le Marcis 175). HIV/AIDS patients often feel more included in their support groups where they can share their everyday hardships. In fear of being recognized they often travel long distances and join a support group far from their actual home neighbourhood (Le Marcis 179).

Families react very differently to HIV positive status disclosures. It has been reported that they often stop sharing food with the infected member and often ask him or her to stay away from the common areas in households in fear of catching the infection (Le Marcis). The infected person's HIV status is rarely encouraged to be made public in the surrounding neighborhood in fear of the family "[...] being seen as a 'host' to the illness" (Le Marcis 179). According to Woods, it is this "[...] mixture of speculation, rumor, myth, and misinformation that governs the insidious effects on urban people's lives in 'the time of AIDS'" (314). Sometimes, when the HIV infected has died, the families decide to tell the truth about the deceased's true reason of death, but most of the times they stay silent (Zajec 87).

On the whole, in *Welcome to Our Hillbrow* there is a collection of different reactions of characters to HIV and AIDS. In the beginning the narrator tells the story of a young boy dying of AIDS in 1990 whose death was attributed to his several visits to whorehouses and romantic relationships with *Makwerekwere* women (Mpe 3). Later in the book Refentse writes a story about an HIV positive woman from Tiragalong ostracized by her village (Mpe 54). She is driven mad by their gossip and commits suicide because she is doomed being guilty for her disease because she slept with foreigners (Mpe 54). When South Africans want to enter the United Kingdom they must utter the words "Yes, I saw a doctor before I left, and no, I am definitely not HIV-friendly" (Mpe 101). Be that as it may, the narrator often defends the infected by saying that "AIDS came by accident [...]. One could not keep on condemning people for diseases that they had not purposefully passed around" (Mpe 55). But Tiragalong, Hillbrow, South Africa, and the world in general, never stop believing in the prejudices they construct.

Refilwe's homecoming makes Tiragalong finally face the truth. What Refilwe has already accepted in Oxford is now dawning on the people of Tiragalong, that foreigners are not the only ones to blame for AIDS (Mpe 118). This, what Ghirmai Negash calls the "[...] 'always already present' yet long-hidden truth within the community," is something that was, is, and will be among them, and no amount of xenophobia, mystification and stigmatization will make it go away (xxiv).

It seems that the younger generation represented in *Dog Eat Dog* accept the epidemic as something natural as it is noted that AIDS does not matter because we will all die anyway if not of AIDS, then of something else (Mhlongo 146). They only comment on how full the Avalon cemetery in Johannesburg is and that a solution must be found because otherwise people will get buried in their backyards or get cremated (Mhlongo 147). In Mhlongo's other book *After Tears* Bafana's uncle suggests that they should "[...] buy a funeral parlour and make huge profits from the tenders we'll get from the Department of AIDS because people [...] die of these worms every day" (12). In general, Bafana's uncle Nyawana is quite protective of him. He warns girls that if they wish to engage in any kind of relationship with his nephew they need to take a blood test to prove they are HIV negative (Mhlongo, *After* 69). Nyawana doesn't trust western medication. He even comments that smoking weed would be more effective in preventing AIDS than taking ARV's (Mhlongo, *After* 89). He often embarrasses Bafana by suggesting to every skinny girl that she should take an HIV test, but does bluntly tell the truth like when he reveals to Bafana "[...] why most boys here in Chi are either gay or rape women and children. It's not because they're afraid to say the three words [...] not 'HIV' but 'I love you'" (Mhlongo, *After* 94). At Nyawana's funeral his friend PP notes that he is lucky for not dying of AIDS or hunger like most South Africans do (Mhlongo, *After* 196). PP is one of the many persons later taken by the 'Prophet Elijah's wagon', which in township slang means that he is taken from this world by AIDS (Mhlongo, *After* 223).

When Khutso attends a funeral of a brother of one of his victims in *The Book of the Dead*, he notices that "At the funeral one could almost touch the anger, confusion and fear of the older generation, and it didn't help that the younger generation had come dressed to the nines to honour their Casanova" (Moele 146). To them, their dead friend Nkululeko is a hero, a really popular playboy they look up to, and his funeral is an opportunity to prey on his women that will become the new victims of this deadly game. As the narrator personified in the HIV virus ambiguously points out, the young men "[...] came 'dressed to kill'" (Moele 146). Funerals are also mentioned in *Beauty's Gift* where Magona indicates that there is a reversal of roles as the old now bury the young instead of the other way round (19).

Sindiwe Magona further notices the difference in acceptance of HIV and AIDS between the white and black communities. In her opinion most white people get infected with HIV via drugs or because of behavioral issues and not because of infidelity (Zajec 83). In her book she touches upon this subject by saying "[...] in this country, more black people are killed by AIDS than any other group, than all the other groups put together" (Magona 72). In

the black communities she attributes most of the new infections to philandering, carelessness and to the common acceptance of multiple sexual partners (Zajec 84). Even in well situated families, where the spouses are educated and have good jobs, cheating or having several illegitimate children is normal (Zajec 84). She calls for more action, more awareness and a sense of outrage, condemning such behavior repeating what one of the characters in *Beauty's Gift* points out "AIDS will continue to kill us as long as we refuse to take responsibility for our actions" (Magona 72).

Soldati - Kahimbaara singles out two styles of writing about HIV/AIDS. It is either immersive writing, where the reader is forced to confront all the horrors a HIV positive patient has to endure, or it is counter-immersive writing protecting the "[...] readers from an ugly confrontation with the subject of AIDS by using various distancing devices" (Soldati - Kahimbaara 165). Sometimes, the reader is shocked by the words on the page or how a certain character has reacted to being HIV positive. All the texts often raise questions or leave gaps the reader has to complete on his own and each reader explains them to himself differently. There is no competition between responses, as none is more valid than the other (Bennet, Royle 11). Books about AIDS are important, because people start thinking about issues they might otherwise never tackle in their minds. Quite often readers understand the books in relation to their personal experiences. Critics, such as Norman Holland or David Bleich, researched such 'identity themes' where the responses of readers are related to their "[...] personal psychic dispositions - the individual character of their desires, needs, experiences, resistances and so on" (Bennet, Royle 12). By reading a book they might start with an 'out of the box' thinking thus seeing the epidemic in a completely new light.

However, it should not go unnoticed that, as Stanley Fish argued, every reader is a part of a 'community' of readers (Bennet, Royle 13). Such 'interpretative communities' predetermine the reader's response to HIV/AIDS texts to the "[...] conventions of reading into which he or she has been educated within a particular socio-historical context" (Bennet, Royle 13). How the 'otherness' of an HIV infected individual influences the reader does, therefore, not depend only on the words written in works of fiction, but includes everything the reader has been through or has experienced until the very moment they read the book.

Perhaps a poststructuralist or deconstructive reading of an HIV/AIDS text is most appropriate. Deciding not to choose between a text as "[...] a set of instructions" or a text as "[...] fundamentally incomplete [...] remade in every reading", they decide that "[...] the reader makes the text and the text makes the reader" (Bennet, Royle 16). Ultimately a "[...]

reading is at once singular (yours and nobody else's) and general (conforming to patterns of meaning dictated by the text - a text that does not require *you* in order to function)" (Bennet, Royle 16). How a reader will be influenced by works of fiction about HIV/AIDS is a slippery terrain; one on which one might struggle to keep themselves on their feet, or on the other hand, leave it with a head held high and a new positive attitude to go with it. In light of the HIV/AIDS epidemic in South Africa, one begins to understand that Beauty's message to the reader in Magona's inspiring book truly is a gift, as she whispers from the pages to all of us "Ukhule! [...] May you grow old!" (Magona 22).

6.4. PHYSICAL AND PSYCHOLOGICAL DECAY CAUSED BY HIV/AIDS

It has been suggested that writing fiction about the physical decay of the HIV infected bodies makes the epidemic seem more personal. Furthermore, Tim Woods investigates how writing about difficulties infected people face every day is actually a part of their healing process (315). The infected take the power they are given by being sick, and try and represent their side of the story. The plain facts of a medical diagnosis suddenly get a name, a face, a home with family and friends, in fiction and need to live with the rashes, the swollen lips, the infected gums or lack of appetite on a daily basis. Literary discourses about HIV/AIDS can serve as sources of information or places of solace. Anne Hunsaker Hawkins coins the term 'patographies' describing texts about diseases or any kind of disabilities that help avoid stigmatization and marginalization and arguably "[...] play a crucial role in medical recuperation in the very act of their being written, or symbolically reorganizing the sufferer's subjectivity" (Woods 315).

In opposition to the real world, the fictional ones do not shy away from blame. In day to day life many, usually fearful of consequences, refuse to point fingers. In written form they get a voice. And they get to write about what really happens to their bodies. When Sindiwe Magona talks about the importance of including the physical decay aspect of the HIV/AIDS epidemic in *Beauty's Gift* she explains she does this "Because that is what you see. You can hide, you can deny, you can lie. But in the end you are reduced to this sorry state. All the denial will not save you from this saddest state of a human being. When you can do nothing and are almost dead" (Zajec 87).

HIV and AIDS are words that are heard very often. We have become used to them appearing in the news, talking amongst ourselves about them, and can usually even explain what the abbreviations mean and how the epidemic is transmitted. But it is still something

abstract, sugar-coated statistics revealing nothing about what exactly happens to the body once the disease progresses. In *Beauty's Gift* the Five Firm Friends first notice Beauty's illness at Amanda's birthday party on the 3rd of August 2002, when she hastily brushes off their questions about her mysterious health condition (Magona 23). She later explains to them she on-and-off wakes up with swollen lips and swelling around her eyes but as it usually disappears she pays no attention to it (Magona 29). By the 30th of August of the same year, only a month after noticing health problems, she is already so weak that she is unable to walk (Magona 46). Her lips are cracked and swollen, her gums shrunken, she cannot hold down food and her head seems unproportionally large compared to her body (Magona 46). She is so thin that if they cover her with a blanket her limbs are not visible and the blanket is flat (Magona 46). By the 12th of September 2002, Beauty is "Bone. Nothing but bone" (Magona 57). Amanda describes approaching this skeleton that used to be her best friend "The stench hits you, grows with each step you take towards the bedroom, now the sick room. The door is closed, but the odor is insistent. It is everywhere. Disinfectant, air freshener, Indian sticks, aromatic candles – nothing seems to make a difference, the suffocating smell reigns supreme" (Magona 57).

Beauty is no longer a person, but a body consisting of failing parts. Magona accentuates writing about Beauty as a "[...] stick of a body," because "People often forget that if you contract HIV you will eventually die, and you will die a slow and painful death. Where are all the things you lived for when you are reduced to that state? And also considering the aftermath; the devastation of the family, of friends" (Zajec 87). The writing of Howard Barker further supports such thinking. He emphasizes that tragedy is not pleasant and it often offends the reader (Bennet, Royle 108). Bringing hurt from a hidden place out in the open causes a disturbance in the recipient "After the carnival, after the removal of masks, you are precisely who you were before. After the tragedy, you are not certain who you are" (qtd. in Bennet, Royle 108).

The unjust end the character inevitably comes to not only shatters the world of the characters in the text, but also our world as readers (Bennet, Royle 107). Art holds a mirror to society. HIV/AIDS patients are often seen as "[...] nearly dead bodies" (Le Marcis 171). Treated with pity, they seek mercy in hospices like the *Mother Teresa House* in Johannesburg or the *Hope House Hospice* in Manzini. Unfortunately, they go there to die, or as Le Marcis puts it: "What leaves the hospice is no longer a body, but the remains, a corpse" (175-176). The sick go there after their families cannot take care of them anymore, or the visits from

volunteers are not helpful (Le Marcis 174). The cemeteries are full, and many attend funerals only in order to get free food. The care for the dying is rarely a concern of the official administration, therefore, most of the time the sick are transported to hospices. When they arrive there, they are usually in such bad condition that they only wait for death as the final resolution. While such places do not get any financial support from the government and are mostly privately funded, the funerals are sometimes provided by the Department of Social Services (Le Marcis 175).

As readers we face similar situations in books. Whilst reading we are subjected to a whole range of emotions from sympathy or fear to pity, with unavoidable and unjust deaths, and start thinking about our own society, our own death (Bennet, Royle 107-111). In Mhlongo's *After Tears* Bafana's aunt Thandi has AIDS. She continually coughs blood and slime and towards the end of her life asks Bafana to remove a huge rock from her chest (Mhlongo, *After* 20). Bafana can't see the rock, not understanding the pressure she feels is not from a rock but the disease pressing her chest. Nevertheless, he does not help her because she looks fragile like a porcelain doll (Mhlongo, *After* 20). Just a touch and she might break. Her son Yuri is HIV positive as well and throughout the book Bafana talks about how he wishes he can do something to help his cousin beat the disease.

The first entry in Khutso's 'Book of the Dead' is a report of his own physical condition. On the 3rd of October 2002, Khutso is 41 years old, his height is 174 centimeters, he has 107.7 kilograms and his CD4 count is 650 (Moele 89). The promise the HIV virus makes is as true for Khutso as for all his victims "I am in your blood and your heart pumps the death that I am to every corner. I have taken a bite of you and I will slowly take another one. You are my Cape apple, and I am going to eat you down to the core before I chuck you away" (Moele 91). The last inscription in his book is also about himself this time showing different results. On the 6th of November 2008, Khutso is 47 years old and while his height remains the same he weighs 65 kilograms and his CD4 count is 60 (Moele 165). The HIV virus parts from his host by admitting they have been very successful together and that it will be difficult to find another host as successful as its predecessor (Moele 165).

When the reader finally faces the true horrors of the disease, HIV and AIDS are no more just two meaningless words, but are killers causing pain and suffering beyond measure. The novels finally reveal their true message by confronting the epidemic instead of seeing it as a death sentence persuading readers that not only the 'high risk' groups of people like

homosexuals, drug users, truck drivers or prostitutes, are to fear infection, because anyone can become its victim (Soldati-Kahimbaara 172-174).

There is another aspect one must consider when talking about the decay HIV/AIDS cause and that is the psychological pressure and pending depression one possibly endures. In Mpe's novel, Refilwe returns from Great Britain to South Africa after she finds out she is HIV positive. She is aware of the outside changes the disease is making on her body, but seeing the shock on the faces of family members that pick her up at the Johannesburg airport unintentionally hurt and depress her (Mpe 119). Whispers follow her wherever she goes "But she is so thin! Look at how the clothes are simply hanging on her bony shoulders. And look at those sticks of legs!" (Mpe 120). Refilwe does not resent people for saying such things for they are exactly the same as the thoughts in her own mind. Even though she wants to return home, to see her beloved ones one last time before she dies, Refilwe questions her decision leaving England "[...] because you were beginning to discover that grief, incarnated in the gloomy faces of your family and friends, could be just as fatal as lightning and AIDS" (Mpe 120).

Refentse's suicide in *Welcome to Our Hillbrow* starts a chain of deaths; be it his mother 'necklaced' for being a witch, his lover Lerato's suicide because of guilt and false rumors, or Refilwe catching and dying of AIDS by the end of the novel (Woods 313). Talking about writing *Welcome to Our Hillbrow* writer Phaswane Mpe, admits that he writes in order to deal with depression (Attree, *Interview* 139). He reveals how much writing is like therapy for him. Putting the words on the page helps him heal (Attree, *Interview* 140-141). Mpe applies this technique to his book where he deals with HIV/AIDS ostracizing by writing about it. His character Refentse then repeats this pattern by writing a story about an HIV infected girl. Her decay is physical and psychological, and the gossiping villagers of Tiragalong are responsible for the fast advancement of both, although they will never admit to it. This female heroine also deals with prejudices by pouring her frustrations on paper. Grünkemeier calls this Mpe's technique 'healing with words' suggesting he uses the same pattern in several stories of the same book to show how omnipresent the HIV/AIDS epidemic is (118).

In *The Book of the Dead* Khutso talks about how he doesn't understand people who commit suicide, but when he finds out about Pretty being HIV positive via her diary, he thinks about little else than suicide for several weeks (Moele 79). Seeing her disease as betrayal, he endures pain, and fails to see a solution until he plots a revenge plan to kill others instead of himself. With Khutso the psychological decay shows itself in the worst version possible.

While others dealing with depression directly hurt only themselves and consequently only indirectly hurt others, Khutso saves himself from depression by directly hurting others. Writing the names of his victims in his 'Book of the Dead' he turns into a cold-blooded serial murderer without any visible regret. Between 2002 and 2008, Khutso ends up being a pathological killer that infects an average of seven women per week, with the record being sixteen women per week (Moele 153). Only fourteen of them we get to know by name.

Beauty is one of the few HIV infected characters that experiences only physical and not psychological decay. She stays full of hope until the end and shares this positivity with her friends so that they might be luckier than her. However, Sindiwe Magona admits she understands the link between depression and having HIV/AIDS: "You get something that is going to change your life forever, and not for the better [...] You lose your friends, your family, your whole life as you knew it, and of course you will get depressed" (Zajec 86). She also points out how financial issues can contribute to depression, because even though ARV's are now free, the right food and nutrition you need to combine with the medication come with a high price (Zajec 87). People despair and die as a result of having HIV/AIDS. But each of them is more than only a name on the epidemic's death toll. Therefore, the main aim of writing fiction about the decay HIV/AIDS brings, is to restore "[...] subjectivity to the often objectified persona of the AIDS 'victim'" (Attree, *Rev.* 105).

6.5. PREVENTION OF HIV/AIDS

With all the preventive measures available against the HIV/AIDS epidemic, Sindiwe Magona rightfully wonders how one gets infected and why those who infect others are not marked as murderers (Orantes 41). UNAIDS follow a directive of "[...] zero new HIV infections, zero discrimination, and zero AIDS-related deaths," but as the opening chapter of this thesis shows, this has not yet proven to be successful (qtd. in HIV & AIDS in South Africa 2012). Measures like free testing and counselling, free male and female condom distribution, encouraging voluntary male circumcision, free access to antiretroviral medication and basic nutritional supplements, fail to make a difference in South Africa. The real change will come only with the change of the wider socio-cultural norms and habits of South Africans.

In 2012, more than 50% of women and 35% of men were aware of their personal HIV status (van der Linde). Yet in the same survey over 50% of the asked admit to never using a condom during sexual intercourse (HIV & AIDS in South Africa 2012). Although South Africa is proud of having the worlds' largest male and female condom distribution

programme, it produces weak results (HIV & AIDS in South Africa 2012). At the same time as the number of free condom distribution rises, the number of used condoms falls. With such bad figures it is poor comfort knowing that younger people do use more condoms than people in older age groups.

The most common excuse men give for not using a condom is that it reduces pleasure during sexual intercourse and is colorfully described by Moses in *Beauty's Gift* who claims that "[...] using a condom is like eating sweets with the wrapper on!" (Magona 70). In *Welcome to Our Hillbrow*, the narrator highlights that Refentse's friend Terror risks HIV infection with every sexual encounter he has because he never protects himself. In opposition, in *The Book of the Dead*, the HIV virus as narrator, expresses anger by the use of condoms preventing it to be spread. Describing a group of Khutso's friends that often take trips to Durban seeking sexual pleasures, the virus angrily describes their insistence on using condoms every single time, and even compares their preventive measures to a religion whose god is the almighty condom (Moele 94).

In Mhlongo's *Dog Eat Dog* the protagonist Dingz is having unprotected sex with his girlfriend Nkanyi. Afterwards he feels guilty about it, especially when he remembers he has a box of free condoms from the university campus under his bed. A few days later, he starts feeling pain in his genital area. When he finally decides to visit the campus clinic he walks past a billboard promoting safe sex. He again immediately feels guilty and worried, and is relieved when the doctor reveals he 'only' has gonorrhoea (Mhlongo 163). The doctor reminds him that he is playing with his life and her prescription for him is "Use condom" (Mhlongo 179). Nevertheless, at least Dingz's experience is not in vain as he later convinces Nkanyi to also go to the doctor and get examined.

In *After Tears*, Mhlongo confronts the discrepancies between Western HIV medication and traditional medicine. Bafana's mother and sis Zinhle, a nurse, defend the former. They argue in favor of antiretroviral medication and use Yuri as an example of how one can live with an HIV positive diagnosis because of ARV's (Mhlongo, *After* 86). Sis Zinhle does admit the medication has side effects but claims they are overall beneficial. However, uncle Nyawana doesn't agree. He points out his sister Thandi died despite taking antiretroviral medication. He trusts only traditional healers and is supported in his opinion by PP and Dilika. PP also makes it clear that he refuses to get tested because he has many illegitimate children and they are all healthy, so he must be healthy as well (Mhlongo, *After* 106). In an ironic twist, by the end of the book PP dies of AIDS.

The opposition presented in the preceding paragraph is a constant in HIV/AIDS prevention. In South Africa institutionalized Western style medication centers face countless problems. As the public hospitals are usually very full, a lot of patients opt for private clinics. For example, even though the Johannesburg General Hospital is one of the most developed AIDS clinics in the country it often suffers from the overflow of patients (Le Marcis 177). NGO's, support groups, churches or hospices often take on the roles otherwise assigned to hospitals. They all provide counseling and dietary/nutritional advice to HIV/AIDS patients (Hope House Hospice 2012). The uncontrollable spread of the epidemic forces the country to take action and try and manage. Yet, without undergoing radical changes the health system in South Africa is on the verge of a collapse.

Another major issue in prevention programmes is the raise of illegal pharmaceutical trials (Le Marcis 180). Legal testing is conducted by the Perinatal HIV Research Unit (PHRU) connected with the ethics committee of the University of Witwatersrand, while the official medication for HIV/AIDS patients is controlled by the Medicines Control Council (MCC) (Le Marcis 180). With millions made every year in the pharmaceutical industry, companies scout potential patients on the streets or by visiting support groups for HIV/AIDS patients (Le Marcis 180). After they lure the devastated people in secretive trials, they provide them with experimental drugs or nutritional supplements, and use them as laboratory rabbits (Le Marcis 181). In hope of the medicine working, the patients remain silent and are often suffering from severe negative side effects. Only after finishing the trials and experiencing misuse, the patients dare to speak. HIV/AIDS medication can also be a political weapon. In the era of Thabo Mbeki, the opposition to the African National Congress supposedly financed experimental trials to find the cure, as it would give them ammunition to fight the Mbeki government. It shows how money fuels companies to play with human lives and take advantage of the devastation of the HIV/AIDS epidemic thus squashing the little hope sufferers have of getting better.

On the other hand, the traditional healers are still widely popular and works of fiction incorporate traditional medicine in order to point out some irrational 'medication' they provide. This is best shown in *The Book of the Dead*. Khutso takes ARV's, but only in order to live as long as possible so he can infect more women. Moele creates the character named Nkululeko to show how traditional medicine deals with HIV. The first healer Nkululeko visits tells him he has nothing to fear as he has guarded blood of kings (Moele 139). When his condition continues to grow worse he engages in a blood cleaning ritual, where he must wash

himself in water that he later drinks (Moele 141). He must empty his stomach of the water he drinks and is also subjected to pumping water in his colon, all in order to remove HIV from his blood (Moele 141). Again, the procedure proves to be unsuccessful. On the insistence of his mother, who is convinced he is only bewitched, he tries the most drastic way of curing himself of AIDS according to healers. At a full moon he forces himself on a white goat (Moele 143). When even this is not successful, he gives up traditional medicine and admits himself to a hospital. By then it is too late and he dies shortly afterwards.

Traditional healing is discussed in *Welcome to Our Hillbrow* where the inhabitants of Tiragalong believe the African Potato cures HIV (Mpe 118). In *Dog Eat Dog* Theks condemns traditional doctors for using unsterilized blades at circumcision rituals (Mhlongo 141). Her friends attack her for not respecting tradition, but she defends herself by saying it would not hurt the doctors performing the procedure to be better informed about AIDS (Mhlongo 141). Nevertheless, she fails to change the minds of her friends as Themba even erroneously believes that male circumcision prevents heterosexual men from catching “[...] the gay plague” (Mhlongo 139).

Works of fiction can educate and empower individuals about HIV/AIDS as they advertise condom use and continuous testing (Soldati - Kahimbaara 175). Because of her turbulent sexual past Pretty continuously tests for HIV in *The Book of the Dead*. She tests negative every single time until the fatal last test. In *Beauty's Gift*, the remaining FFF start a “No test, no unprotected sex” campaign in their homes (Magona 79). Insisting that their husbands or partners take an HIV test before their next sexual intercourse, they surprisingly encounter resistance and outrage from their partners causing severe consequences in their relationships. Nonetheless, they begin to realize that the true Beauty's gift is the realization that you must always firstly protect yourself (Zajec 87). She knocks some sense into them, making them see that safe sex should come before the wishes of their partners even if their men don't like wearing condoms. They must do everything in their power to protect themselves and stay healthy (Zajec 87). A relationship in which someone cheats is a bad one, and one must find the strength to leave such a union for the sake of their health, or in some cases, for the sake of their children (Magona 5). Trust is the key to a successful relationship; in South Africa it can even save lives (Soldati-Kahimbaara 174).

The Sonti family loses two children to AIDS. At the funeral of the first the disease is kept silent, but at the funeral of the second son they decide to educate the community (Magona 83). They distribute red ribbons, pamphlets about HIV/AIDS and other sexually

transmitted diseases, and have speakers talking about their experiences with the epidemic including Mrs. Mazwi (Magona 83-84). She labels the epidemic as the disease of the young generation and urges them to take action “Don’t let sex kill you. Use condoms. Stay faithful. Test and test again. Testing gives you a tremendous advantage. The earlier you know, the sooner you can get medical help, the better your body is able to help you stay healthy. Therefore, early detection is the best medicine” (Magona 85).

Just like her literary nemesis Mrs. Mazwi, Sindiwe Magona sees the solution in educating the young generation (Zajec 88). Talking with them about safe sex, making them open their minds and help them realize they must love themselves and others enough to remain among the living (Zajec 89). So they understand that there is meaning in a relationship beyond physical pleasure and to “[...] love your partner enough not to put them in danger by infecting them with HIV. You share with them your hopes and dreams and we do not kill the people we love” (Zajec 89). The T-shirts, red ribbons, stickers, and condoms distribution at HIV-death related funerals or the *toyitoyi* performances, are all part of the larger prevention programme. Nevertheless, perhaps Helen Moffett’s “[...] ABC approach - Abstain, Be Faithful, Use a Condom” is the best prevention formula (Borzaga 223).

6.6. HIV/AIDS AND FEMALE EMPOWERMENT

It is four times more likely that a woman gets infected with HIV than a man (History of HIV & AIDS in South Africa 2014). Each year, a quarter of all new infections in South Africa happen to young black women aged between fifteen and twenty-four (History of HIV & AIDS in South Africa 2014). Almost twenty-four percent of women aged between fifteen and forty-nine are HIV positive, while only thirteen percent of men in the same age group are infected with the virus (van der Linde). Therefore, it is safe to say that the epidemic is more felt among the women than men.

According to statistics, the HIV prevalence among unmarried people is around 20% while among married people it is around 10% (van der Linde). Almost 70% of people in South Africa are unmarried (van der Linde). When asked if they have two or more sexual partners, almost 30% of unmarried men reply with yes and 5% of married men answer affirmative (van der Linde). Answering the same question, 7% of unmarried women admit to having more than two sexual partners and less than 1% of married women (van der Linde). The 2013 and 2014 mid-year population estimates in South Africa, show that almost 20% of South African women in their reproductive years are infected with the HIV virus (Mid-year

population estimates 2013 4). Almost 60% of women test regularly, yet only 30% of men are aware of their HIV status (van der Linde). Generally speaking, women are more open to talk about the epidemic as most of the volunteers, speakers, leaders of support or discussion groups about HIV/AIDS are women (Grünkemeier 105). The *Treatment Action Campaign* (TAC) estimates that women constitute almost three quarters of their members (Grünkemeier 105).

In 2008, Sindiwe Magona's *Beauty's Gift* is published, being the first book in South Africa about HIV/AIDS written by a woman (Attree, *Rev.* 104). It offers a fresh, new perspective and its aim is giving women, especially black women, a voice. Stepping out of the shadows makes one more vulnerable, as is shown in the case of Gugu Dhlamini, but, as many backing Magona's aim, point out, the oppressive patriarchal regime keeps women in the subordinate position (Soldati-Kahimbaara 174). Patriarchal violence is a great problem as it is very likely for a woman to be killed by her partner (Borzaga 229). South Africa is facing more and more cases of rape or even gang-rape. Therefore, Helen Moffett is not far from the truth when she says that "[...] gender is a matter of life and death" (qtd. in Borzaga 228).

Magona admits she is surprised there is not more outrage or reaction against so many rape cases (Orantes 42). For her, every woman has the right to demand fidelity from her partner as well as the possibility to protect her bodily integrity (Borzaga 228). The problem goes back to childhood years when men already have more possibilities and get different treatment (Orantes 46). Parents do not teach future husbands correctly about their responsibilities. That is why Magona writes about personal stories and in them tells women to claim power in their immediate families. Small personal stories can carry strong political messages (Borzaga 245). Those who do not agree with a more feminist approach to the epidemic try to down Magona's novel by saying it concerns itself with clothes and hairstyles too much to be taken seriously. However, it is precisely these details that make her book appear to broader female audiences and make it a best-seller in South Africa (Zajec 88). Magona admits she is saddened the book is not published internationally, as the problems she deals with in *Beauty's Gift* are not South Africa-specific, but can easily be internationalized (Zajec 88).

The discrepancy between male and female HIV prevalence does not have so much to do with gender difference than with gender inequality (Woods 321). When women demand an HIV test from their partners in *Beauty's Gift* in order to protect themselves, the men do not see it as a mere loyalty test but as a questioning of their patriarchal position (Woods 318).

Going against social conservatism Magona suggests “[...] a transformative intervention in the social construction and management of female lives” (Woods 319). According to her, the public male figures of polygamy are unacceptable, yet no one condemns them for that (Orantes 40). The advantage the population has today is the possibility of education. Magona suggests to men and women to start using what they learn and apply it to everyday life (Orantes 41).

What Tim Woods calls the ‘feminization of AIDS’ pre-supposes male promiscuity and marital infidelity (317). In *Beauty’s Gift*, Beauty is presented as the innocent victim of her husband’s cheating ways. The Five Firm Friends simply blame Hamilton; however, Beauty’s mother is more careful at pointing fingers (Magona 96). Of course, women can also transmit sexual diseases. This is shown in *The Book of the Dead* where Pretty is the one infecting Khutso. Nevertheless, the social acceptance of HIV transmitting depends on gender. This is clearly shown in the use of language. If a man is with more women, even if he infects them with HIV, he is still described as a ‘player’, ‘macho’ or ‘ladies men’, while a woman is marked by the use of derogative words such as ‘whore’, ‘bitch’, ‘prostitute’ or ‘easy’ (Soldati-Kahimbaara 172). Breaking the traditional rules of sexual conduct comes with a higher price for women. Men entitle themselves with indicting a woman for her sexual transgressions, but fail to do the same for their own sex. The quote by Goodenough Mashengo Khutso chooses to start his ‘Book of the Dead’ with illustrates this argument: “‘And every bitch I ever loved, I wish an AIDS-related death.’ I wrote it in the middle of the first golden page. I underlined it. He had taken the words right out of my mouth” (Moele 87).

Khutso has no respect for women, which is clear when he writes their names in his book and accompanies inscriptions with his final ‘judgement’ of them. He mentions that infected women should blame their husbands because they were probably cheating on them anyway (Moele 91). When Khutso manages to infect his friend Ntsako’s wife Matimba, and therefore eventually kills Ntsako as well, he comments that a man’s gender is what makes him strong and weak at the same time (Moele 109). The HIV virus as the narrator expresses its frustration with the men who use condoms in extramarital sexual intercourse in order to protect their wives. For Zero, in *After Tears*, women wearing short skirts or no underwear are like advertisements for AIDS (Mhlongo, *After* 48). In *Dog Eat Dog* a priest tells people AIDS comes as punishment for cheating, as sex is only meant for married couples (207).

Beauty’s Gift’s message is clear: because Beauty’s husband Hamilton is not faithful, Beauty dies. Thus, before her death Beauty tries to convey this to her friends that they should

fight for their right to live. In her novel, Magona sets up a simple equation. Not wearing a condom kills, and therefore infidelity without condoms not only brings illegitimate children, but also risks the life of the spouse. When Zero in *After Tears* calls to a woman in the next car in a traffic junction, she tells him her name is Syphilis and that she lives in Aids View next to Gonorrhoea Park (Mhlongo, *After* 52). What several of the books try to show is not that women hate men, but that some of them, though their numbers are surprisingly low, despise their disregard for a loyal monogamous relationship (Magona 77).

The reactions of partners of the FFF in *Beauty's Gift* to their 'no test, no sex' policy show they do not understand how their reckless behavior might cost their wives or children their lives. Nonetheless, Magona is determined "No one has the right to expose another to AIDS" (90). When Doris sees how relieved Selby is when he finds out he is HIV negative after taking the test, she questions his loyalty as he previously tells her he is a virgin. In the fight that endures Selby condemns her "[...] bourgeois ideas" and labels her, in a derogatory way, as a "[...] middle-class white chick" (Magona 111). The traditional way of dealing with a cheating man is to simply ignore it and continue as if nothing is wrong. But within all the FFF, there is a change because of Beauty's death. When Amanda finds out about Zakes's two illegitimate children, her mother tries to calm her down by saying Zakes is a good man making a few mistakes (Magona 127). Amanda, seeing that her mother is not aware of the consequences his immoral acts can have for her or her son, rightfully wonders what bad men then do (Magona 127).

What Magona wishes to do with her writing is to make women assume agency (Soldati-Kahimbaara 167). Nowadays, women are educated and thus they should know better than becoming mere victims of men. Encouraging to use protection, testing, or leaving a relationship if the partner cheats, she creates Beauty's character as a reminder of what can happen to women and with a wish to prevent repetition (Soldati-Kahimbaara 168). By the end of *Beauty's Gift* all women, in one way or another, lose their partners and go away together. Magona admits she feels like she should write a sequel to her book; in the first one she points out all the issues women have in the era of the HIV/AIDS epidemic. She teaches women it is alright to leave. In her opinion, the pending, following book, tells the story of what happens when the women return to their communities. As often as one wants to pack up things and simply leave, the harder part is when one returns. Thus, Magona wishes to write a book about what happens when the women return after their time of reflection, and how they practice what they have learned (Zajec 87).

Love is a strong thing. But even love, however strong it is, cannot protect someone from infection nor can it cure AIDS (Magona 147). Magona reveals her final message to women through Amanda's metamorphosis, when Beauty's best friend realizes "I cannot afford to take risks with my life. It is the only one I have" (150).

7. CONCLUSION

Literature doesn't just simply mirror what goes on in a certain society. It absorbs changes and thus creates new ideas, new realities (Grünkemeier 25). A lot has changed in the last 20 years in South Africa since the fall of apartheid. Unfortunately, the country has thus far been unsuccessful in restraining the uncontrollable spread of the HIV/AIDS epidemic. This resulted, and still results, in many lost lives.

As Sindiwe Magona notes, the political leadership might not have been prepared to take on such a hard task. Freedom, and with it the rebuilding of the country from scratch, came with a price. By not focusing enough on the epidemic, the government of Nelson Mandela missed the opportunity for an early prevention of the outbreak of HIV/AIDS on such a large scale. However, it is his successor, President Thabo Mbeki that most damaged the 'reputation' of the epidemic, marginalizing its sufferers and condemning HIV and AIDS as taboo topics. Jacob Zuma's Presidency only furthered the stigmatization with his reckless behavior. The national rollout of antiretroviral medication was a positive change, but because of the example set by politicians, failed to produce results. South African political leadership fails to understand that even if they provide people with free condoms or ARV's, their actions have a far greater influence. The population unconsciously imitates leaders, therefore, if the leaders are not ready to start behaving differently, nor is the nation they lead. The *Treatment Action Campaign* sets an example how the epidemic should be dealt with. In the social sphere they are getting many imitators. Non-governmental organizations, churches, hospices, as well as international organizations, and privately funded help-centers continue to show the path to the South African state, in how to help the people most affected by the epidemic. Consequently, culture has also finally accepted the AIDS theme in its midst. From street artists to traditional craftsmen, AIDS and HIV are words often incorporated in their artistic products. The same goes for the red ribbon symbol.

Literature started embracing the epidemic in the early 2000s. The chosen texts show how the unclear origin of the HIV virus mixed with xenophobia causes stigmatization. Instead of finding fault in themselves and their promiscuous sexual habits, South Africans prefer to blame the start and spread of the epidemic on foreigners; either citizens of other African countries or Western European countries and the United States of America. Because of the relay of guilt they continue with the stigmatization of the infected 'other' and fail to research and deal with the epidemic, thus keeping it safely tucked away by defining it as a taboo topic. Because the epidemic is still not openly discussed, the people infected feel the need to hide

their diagnosis. This mystification of the epidemic thus affects not only the sick, but their families, friends, even whole neighborhoods. Revelations of HIV statuses are still not welcomed. One of the ways the authors of works of fiction try and break this taboo pattern is by writing about the physical and psychological decay the disease brings. By showing how patients slowly pine away in great pain or are driven mad by societal gossip and judgement, they try to arouse the reader from apathy. By repeatedly calling attention to the preventive measures one can take to not get infected, they raise awareness and serve as sources of information. Motivating women to take their lives in their own hands and start practicing safe sex while continuously testing, resembles a call to arms in the fight against HIV and AIDS.

Writing about the epidemic brings HIV/AIDS closer to the reader. We, as readers get to experience the hardships, the pain, the judgement, the stigmatization and gossip patients must endure. Such representations influence our actions and prevent future mystification of the epidemic. They demand a rethinking of sexual habits of South Africans by pointing out their consequences. If things are to change in South Africa, people's thinking and their actions need to change. Works of fiction are taking the lead in guiding the nation towards a better future where the HIV/AIDS epidemic will be beaten and remembered only as a distant memory and not a mass killer.

With its focus on contemporary post-apartheid South African literary representations, this research provides a unique and current Africa-centered perspective. This research differs from others in using new works of fiction, thus adding a few new interpretations to the mosaic of academic writing about the epidemic, providing fresh ideas and filling in some blank spaces. Literary responses to HIV/AIDS wish to convey a simple message to its readers summed up in Amanda's decision to protect herself, simply because she wants to live "She wanted to live until her hair turned gray. She wanted to live till she had earned her wrinkles and Zingisa had children of his own. She wanted Beauty's gift - ukhule!" (Magona 150). Writers therefore leave us readers with an advice to protect ourselves from HIV and AIDS, whispering from the pages of their books; readers "May you grow old!" (Magona 22).

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APPENDIX

A. INTERVIEW WITH SINDIWE MAGONA BY POLONA ZAJEC

B. ABSTRACT

C. ZUSSAMENFASSUNG

D. CURRICULUM VITAE

A. INTERVIEW WITH SINDIWE MAGONA BY POLONA ZAJEC

On the 13th of August 2014 in Marina Da Gama, Western Cape, South Africa

POLONA ZAJEC: *Since writing Beauty's Gift¹ do you think anything has changed in this field of writing about HIV/AIDS in South Africa?*

SINDIWE MAGONA: Unfortunately, I really don't think so. I don't think the behavior has changed. People's attitude hasn't changed. What has changed is better understanding especially from those who are affected, not infected. Families have more understanding of what happens and are more tolerant and maybe more supportive. There used to be a time when a member of the family was infected and everybody didn't want to have anything to do with them.

POLONA ZAJEC: *How much is it still a taboo topic surrounded by shame and stigma? Do you still think of HIV/AIDS as an 'epidemic of signification'²?*

SINDIWE MAGONA: It is not as a taboo as it was. You can talk about it more freely now. I think now the stigma, the stigma is still there but it's more subtle and people's reaction to infection is not as 'in your face'. But it is still an epidemic of signification unfortunately. And it is still affecting too many people, too many brains, too many bodies and too many young people.

POLONA ZAJEC: *If people are infected are they still trying to hide the fact that they are HIV positive or have AIDS, saying they have other diseases like tuberculosis?*

SINDIWE MAGONA: Yes, that is still here. Not to the same extent. There is a slight shift, but I would not say that it is a significant shift.

POLONA ZAJEC: *Do you think there is a difference between the acceptance between the black and the white communities in how people approach HIV/AIDS?*

SINDIWE MAGONA: I believe so. First of all there is the difference between how they get infected with HIV. In the white communities it is mostly through drugs, or it is a result of other issues, behavioral problems. But in the black communities it is harder to understand. These are the so called 'normal people'. A husband that is respectable, holds a good job,

¹ Magona, Sindiwe. *Beauty's Gift*. Cape Town: Kwela Books, 2008.

² Woods, Tim. "South African Literature in the Time of AIDS." *The Journal of Commonwealth Literature* 48 (2013): 316.

might even be in politics, in education, or in health and has a status in the community, they are considered as 'good men' and then this happens. So that's the difference. Usually in white families, happily married women don't get infected with HIV. On the other side of the line, black men are responsible when they go and cheat on their wives. That is why in the white communities they don't have such a high rate of the so called illegitimate children out of wedlock. In the white communities they act more responsible. It is sad because in the black communities everybody does this - even the people who are educated. And what I see in my community, a black community, is that people are becoming more and more tolerant to such behavior. You know your son or your husband has five children with five different women and while this is not normal it is not labeled as bad behavior. People have multiple sexual partners and this is known. People used to call them playboys, but they stopped now and in the eyes of other men such behavior is admired. We need to change, and start to label again, and we need a sense of outrage. Be stricter to the members of our family, our community. And most of all we need to condemn what needs to be condemned. As I said before we need a sense of outrage because you put yourself and other lives at risk. This also then becomes the problem of the government because people get sick and then all these problems are drained on the country. This carelessness about sexuality must change and people need to start acting more responsibly. We need to raise our voices. We must not stay silent and start participating, be active, applaud what is good and condemn what is bad. And have an open dialogue among ourselves.

POLONA ZAJEC: *Why do you think South Africa has the highest infection rate out of all the African countries, actually the highest HIV infection rate in the World³?*

SINDIWE MAGONA: Because we have more money, we can sleep around more. You need money because philandering is not cheap. Also the political and religious leadership. When you hear of a bishop with several extra marital relationships you know something is wrong. When you are sexually active you shouldn't have many partners at the same time, but most of all if you are HIV positive, you should be even more careful. HIV is preventable, and I'm not saying that we should condemn those who are infected, but we should condemn their behavior if it puts others in danger by engaging in risky sexual behavior. Another thing is the policy of medication in South Africa. It is not enough to simply give away free medication if people do

³ Out of 35 million people living with HIV, more than 6 million of them lived in South Africa by the end of 2013; among adults aged between 15 and 49 the prevalence rate was 19.1 %, making South Africa the country with the highest percentage of HIV infected adults in the world (*South Africa*. 2012. UNAIDS. 24th of June 2014. <<http://www.unaids.org/en/regionscountries/countries/southafrica/>>).

not understand how it works. Politicians need to be aware that even if they give antiretrovirals for free, the people don't understand them. They think HIV is simply cured by taking them which is not the case.

POLONA ZAJEC: *You mentioned the political leadership. Since the fall of apartheid South Africa's Presidents – from Nelson Mandela to, especially, Thabo Mbeki and the current President Jacob Zuma – have had very particular responses to HIV/AIDS in South Africa. How have they influenced the public opinion in South Africa? How important is their role and how big is their responsibility?*

SINDIWE MAGONA: It is hard to say, especially because people don't say "I behave in this and this manner because of this and this person". But we take from them, we see how they behave and think where there is smoke there is also fire. And unintentionally you start behaving like them. Even without knowing it, we are influenced far beyond what we know. It can be as simple as the way we walk but we still copy it. And that is why political leadership is so important, they are role-models if they are aware of it or not. And they are not doing a very good job.

POLONA ZAJEC: *Have you personally been influenced by political leadership? Did that make you want to write Beauty's Gift?*

SINDIWE MAGONA: Yes! Because I am angry and I am annoyed! And things need to start changing and they need to start thinking. If a political leader is accused of rape, even if it was later said it was consensual, with an HIV positive woman without using protection but only showering after⁴, what kind of message does that send to the people?

POLONA ZAJEC: *Especially President Thabo Mbeki's response to HIV/AIDS⁵ has helped giving wind to the legends of the origin of AIDS. From it being an American invention to kill Africans to it coming from green monkeys in central Africa or urban legends like 'Vera the Ghost' in Soweto. Are these legends alive among the people and do they believe them?*

⁴ The current President of South Africa, Jacob Zuma, admitted during his 2006 rape trial "[...] that he had unprotected sexual intercourse with an HIV-positive woman and took a shower immediately afterwards to reduce the risk of infection" (Grünkemeier, Ellen. *Breaking the Silence: South African Representations of HIV/AIDS*. Rochester/ NY: James Currey, 2013: 40).

⁵ South Africa's President between 1999 and 2008, Thabo Mbeki, had a "[...] distrust of mainstream western HIV/AIDS science," called "[...] into question that HIV causes AIDS," if "[...] antiretroviral therapy is the best possible therapy" instead of "[...] a healthy nutrition of beetroot, lemon, garlic and African potato" and supported the unsuccessful HIV/AIDS cure Virodene "[...] as championing African-initiated science (Grünkemeier, Ellen. *Breaking the Silence: South African Representations of HIV/AIDS*. Rochester/ NY: James Currey, 2013: 33 - 36).

SINDIWE MAGONA: Not really. People now know that you can get HIV from sexual activities. They don't really care anymore where it originates because now they are so used to it being around. But the poorest people still don't understand where it comes from and that is why these rumors are still around. People are so poor that mothers sometimes hit their stomach when they are pregnant so that they will give birth to a deformed child and therefore get more money from the government. And if the political leadership is not taking such issues seriously why should other people do so? Making up such stories is a way out, a way for 'normal people' to make sense of what is going on, and putting the blame on others or other issues.

POLONA ZAJEC: *What do you think about the role of the media in helping HIV/AIDS awareness? Do you think awareness campaigns like Khomanani⁶ or LoveLife⁷, or TV shows like Soul City⁸ or Soul Buddyz⁹ were successful?*

SINDIWE MAGONA: Well how do you judge success in cases like this? Maybe without them there would be even more infected cases. But for me, the fact that we are getting more and more infections everyday means that we were not successful. Giving out free medication, pamphlets, posters, even a free distribution of *Beauty's Gift*, those are the things that the government should be thinking about. Because maybe that could save a few lives. You want to change the way people think, change the way they see themselves, the way they see things. Because people don't think. If you had a choice between someone giving you beautiful things, a new car, a new house or losing your life, I would say it's a no brainer. Where are all these things when I'm dead? Someone said to me that we should make *Beauty's Gift* into a musical so it would reach even more people. But that was three years ago. We never got the money to do it, even though a play could reach even more people. It conveys the message of the book, yet people don't only read it but they talk about it.

POLONA ZAJEC: *Do you link having HIV/AIDS with depression?*

SINDIWE MAGONA: Yes. And I can understand it. You get something that is going to change your life forever, and not for the better. And it is expensive, having HIV is expensive. The antiretrovirals are for free, but you need the right food and nutrition. And the government

⁶ HIV/AIDS awareness campaign funded by the government.

⁷ HIV/AIDS awareness campaign that is primarily privately funded.

⁸ "[...] a multimedia 'edutainment' strategy," conveying "[...] health and social messages through the basic format of a soap opera" (Schneider, Helen, and Joanne Stein. "Implementing AIDS policy in post-apartheid South Africa." *Social Science and Medicine* 52 (2001): 729).

⁹ Using the same pattern as Soul City but targeting teenagers.

won't give you the money for the good food you need and this doesn't get across to the public. If you are only taking the ARV's but don't combine them with good food, you will start behaving badly. You lose your friends, your family, your whole life as you knew it, and of course you will get depressed.

POLONA ZAJEC: *You were very precise in writing about the physical decay in Beauty's Gift talking about the "grotesque face (26), swollen lips (29), stick of a body (46), skeleton (48, 57), the stench [...] the suffocating smell (57), Bone. Nothing but bone (57)". Why did you think it was important to point out this physical aspect of the disease?*

SINDIWE MAGONA: Because that is what you see. You can hide, you can deny, you can lie. But in the end you are reduced to this sorry state. All the denial will not save you from this saddest state of a human being. When you can do nothing and you are almost dead. People often forget that if you contract HIV you will eventually die, and you will die a slow and painful death. Where are all the things you lived for when you are reduced to that state? And also considering the aftermath; the devastation of the family, of friends. And that was the hope of *Beauty's Gift* – to knock some sense into people. The gift is coming out and telling a loyal friend, to look out and protect yourself. Do whatever it takes to stay healthy. If your partner is cheating on you, get out of the relationship. You need to respect yourself enough to get out, and get your children out. And also start practicing safer sex. Men still don't like wearing condoms. But women need to take charge and say "I can protect myself, and I will". Women often say "can't God protect us married women?", but I say God gave you brains, use them. Women can sleep around as well and spread the disease of course, but the message is that you need to protect yourself. Don't scorn yourself from any responsibility, but take charge. And again these are educated women. They can preach but they can't practice what they preach. It is the same story as with the political leaders.

POLONA ZAJEC: *What do you think of the so-called 'feminization of AIDS'¹⁰? As you wrote in Beauty's Gift women are more vulnerable. Could or should HIV/AIDS be used as a tool for female empowerment, that they should be the ones to take charge and say 'use condoms'?*

SINDIWE MAGONA: This is what was supposed to be the sequel to *Beauty's Gift*. When at the end of the book the women go away, that would be their time of reflection. To go back into their communities and practice what they have learned. That is the gift Beauty gave them and it is now up to them what to do with it. Put their decision into practice.

¹⁰ Woods, Tim. "South African Literature in the Time of AIDS." *The Journal of Commonwealth Literature* 48 (2013): 317.

POLONA ZAJEC: *Is there going to be a sequel?*

SINDIWE MAGONA: There ought to be, shouldn't it? Next year this time come back and maybe something will be written I hope.

POLONA ZAJEC: *You once talked in an interview about the lines of one of your poems saying that "Writing is not therapy, but it can be therapeutic"¹¹. If that is the case for HIV/AIDS why do so few people write about it? Do you feel like there is a lot of fiction written about HIV/AIDS?*

SINDIWE MAGONA: Not as much as there ought to be. I think it is still something that is very hard to write about. It is something we see but don't read about. Something we know but don't know. Because we don't really talk about it. Sometimes people come out and say we lost our relative to HIV, but most of the times they say nothing. It is up to you alone to draw a conclusion. But on the other hand it's so sad. And if the people who are affected don't write about it, who does? You can talk to a relative or friend, but they did not walk in their shoes, did not take the path the infected person has. It is a sign of our inability to take the upper hand on the situation. We keep running away from our issues while millions of our people are dying.

POLONA ZAJEC: *Was the response to Beauty's Gift bigger, more notable in South Africa or in the international community?*

SINDIWE MAGONA: The book was nominated for several prizes in the international community including being shortlisted for the Commonwealth Writers' Prize in 2009. And also in South Africa it was nominated for prizes. But *Beauty's Gift* has not had an international publisher. Maybe people overseas don't realize they are facing the same kinds of problems. In South Africa when the book came out it was a best-seller, but from then on it's gone down.

POLONA ZAJEC: *What do you think the next step should be for South Africa concerning its HIV/AIDS epidemic?*

SINDIWE MAGONA: I believe there is a way out of this mess we are in. If we can address and educate young people, get them to open their minds, so they grow up with the right kind

¹¹ Orantes, Karin. "The Magic of Writing – An Interview With Sindiwe Magona." *Trauma, Memory, and Narrative in South Africa: Interviews*. Ed. Mengel, Ewald; Borzaga, Michaela, and Karin Orantes. Amsterdam/NY: Rodopi, 2010: 36.

of focus, with the right attitude towards the environment they live in, then we would be experiencing a lot less issues we have now, including HIV/AIDS. If we raise them up the right way to have respect for themselves and respect for others we will be on the right path. Practice safer sex, take care of yourself, not only give into pleasure, but give your life meaning. Understanding that when you love someone and are in a relationship with them, you do not only take the physical aspect from it, but love your partner enough not to put them in danger by infecting them with HIV. You share with them your hopes and dreams and we do not kill the people we love.

POLONA ZAJEC: *Do you feel like everything you just said about HIV/AIDS is well represented in South Africa's literature?*

SINDIWE MAGONA: No, not all of it, especially the part about how we raise our children. We try and portray things and we also try to educate through our books, but we are still unable to find the missing gap. The older ones were supposed to raise the young ones, not bury their bodies. What are we still doing wrong that nothing is changing? By writing a book you give so little but you do plant hope.

POLONA ZAJEC: *You lived abroad many years. How do people from the outside see South Africa and its exceptionally high HIV/AIDS rate?*

SINDIWE MAGONA: It is very hard to listen to how other people see South Africa. What they see is only the terrible statistics. And the apartheid legacy, which is not entirely gone. So I believe we really need to rethink who we are as a nation. We need to fulfill Mandela's dreams. And we need to start working on it now. Apartheid did not end overnight in 1994; it is still a work in progress. And the same goes for HIV/AIDS it will not go away overnight just because we want it to. We need to work on it day by day.

POLONA ZAJEC: *Do you think that is also one of the reasons South Africa has the highest HIV infection rate in the world? Because AIDS was not a number one priority after the fall of apartheid? There were so many other issues the country needed to tackle that the HIV/AIDS issue was pushed aside. Even Nelson Mandela himself said he made a mistake by not focusing more on this epidemic during his two presidencies directly after the fall of apartheid¹²?*

SINDIWE MAGONA: We fought so long for freedom. The fall of apartheid came as a surprise for everybody. Nobody believed apartheid was going to end during our lifetime,

¹² Grünkemeier, Ellen. *Breaking the Silence: South African Representations of HIV/AIDS*. Rochester/ NY: James Currey, 2013: 34.

nobody. And so we struggled when it happened and tried to get along with the best of our abilities. Most of the people in the government didn't know what they were doing. We had a government that was in chains five minutes ago and they simply could not cope with all the issues at the same time. South Africa is a beautiful country and that is why I returned. I just hope that we can stand up once more and work together to change things.

POLONA ZAJEC: *Do you think it will happen? That change will come for HIV/AIDS and for South Africa in general?*

SINDIWE MAGONA: You can never stop hoping or wanting things to change. But we need to get some momentum, to get people talking about it and deciding to do something about it. A lot has been done, but everything is all over the place. We need something national, something robust, something huge that sweeps through the whole country. Village by village, hamlet by hamlet, town by town, so that nobody is left untouched.

POLONA ZAJEC: *But how to achieve that? So that nobody is left untouched?*

SINDIWE MAGONA: Well, this is the big question. It has to be a movement and the movement needs someone or a group that believes in it and can handle it and provide whatever is needed. Then spread it. We need a mini United Nations just for South Africa. We have a government, but we need something like an additional government helping with certain issues that the government can't handle. And as long as people talk and talk and just talk then nothing happens. We don't just need someone who is currently leading the government or the Ministry of Health, what we need is a social movement not a political party.

POLONA ZAJEC: *But it is quite surprising that given the fact that there is so much HIV and AIDS in South Africa that there is not a stronger social movement towards getting the word out and changing things?*

SINDIWE MAGONA: Yes. Exactly. It is surprising and sad. It is very sad that despite all these deaths, despite everything, nothing is happening. People do not care about tomorrow, what is happening now is the only thing that occupies their mind.

POLONA ZAJEC: *Thank you very much for your time and your answers.*

SINDIWE MAGONA: Thank you. And all the best!

B. ABSTRACT

There are approximately thirty-five million people living with HIV in the world, and around six million of them live in South Africa. Almost one fifth of the South African population dies of AIDS-related diseases and the number of new infections continues to grow. In unique historical circumstances the fall of the apartheid regime in 1994 left the country in ruins and the epidemic was free to spread with a fast pace. The political leadership under President Nelson Mandela saw other issues as more pressing, his successor President Thabo Mbeki sparked controversy about antiretroviral medication and virology of the epidemic, and President Jacob Zuma was caught in a scandal refusing using a condom during sexual intercourse. Therefore, there was a lack of a correct political response to the epidemic resulting in weak social and cultural responses in raising awareness about HIV and AIDS. This thesis takes a closer look at the literary responses to the epidemic through the prism of five post-apartheid works of fiction; Phaswane Mpe's *Welcome to Our Hillbrow* (2001), Niq Mhlongo's *Dog Eat Dog* (2004) and *After Tears* (2007), Sindiwe Magona's *Beauty's Gift* (2008) and Kgebetli Moele's *The Book of the Dead* (2009). The main focus of this study of the above mentioned texts is to find answers where the HIV virus originates and why AIDS is considered as such a taboo topic. This thesis investigates how different characters, their families, friends, and the readers, react to an HIV positive diagnosis. This work also describes the physical and psychological decay one endures because of the epidemic and how that could be prevented. Furthermore, it shows how in a broader socio-cultural context women can be empowered by the ever-growing epidemic. This Master thesis includes an unpublished interview with writer Sindiwe Magona conducted by the author of the thesis in 2014 in Marina Da Gama, South Africa.

C. ZUSAMMENFASSUNG

Weltweit gibt es ungefähr 35 Millionen an HIV erkrankte Menschen, etwa sechs Millionen davon leben in Südafrika. Fast ein Fünftel der südafrikanischen Bevölkerung stirbt an AIDS-verbundenen Krankheiten. Der Fall des Apartheid-Regimes ließ das Land in Trümmern und die Epidemie hatte freie Bahn sich schnell auszubreiten. Die politische Führung unter der Präsidentschaft von Nelson Mandela hielt andere Angelegenheiten für dringlicher, sein Nachfolger President Thabo Mbeki löste eine Kontroverse über antiretrovirale Medikamente und die Virologie der Epidemie aus und der Präsident Jacob Zuma wurde in einen Skandal verwickelt, als er sich weigerte, Kondome beim Geschlechtsverkehr zu verwenden. Es mangelte also an einer richtungsweisenden politischen Stellungnahme zu der Epidemie, was wiederum zu schwachen sozialen und kulturellen Reaktionen führte und somit konnte das Bewusstsein für HIV und AIDS nur schwer geschaffen werden. Die vorliegende wissenschaftliche Arbeit beschäftigt sich mit den literarischen Antworten auf die Epidemie durch das Prisma von fünf Werken der Post-Apartheid-Ära: *Welcome to Our Hillbrow* (2001) von Phaswane Mpe, *Dog Eat Dog* (2004) und *After Tears* (2007) von Niq Mhlongo, *Beauty's Gift* (2008) von Sindiwe Magona und *The Book of the Dead* (2009) von Kgebetli Moele. Der Schwerpunkt dieser Studie über die oben genannten literarischen Texte liegt in der Suche nach der Antwort, wo der HIV Virus entstand und warum AIDS als ein Tabu-Thema betrachtet wird. Die Arbeit untersucht die Reaktion der unterschiedlichen Charaktere, deren Familien, Freunde und der Leser auf die Diagnose HIV-positiv. Sie beschreibt auch den physischen und psychologischen Verfall, den der einzelne wegen der Epidemie erleiden muss und wie dieser verhindert werden könnte. Ferner wird gezeigt wie in einem vielseitigen sozio-kulturellen Kontext Frauen durch die sich stetig ausbreitende Epidemie gestärkt werden können. Die Masterarbeit beinhaltet ein unveröffentlichtes Interview mit der Schriftstellerin Sindiwe Magona, das die Autorin dieser Arbeit 2014 in Marina Da Gama, Südafrika, führte.

D. CURRICULUM VITAE

PERSONAL INFORMATION

Name: Polona Zajec

Nationality: Slovenian

EDUCATION

University of Vienna (Universität Wien), Vienna (Austria)

MA (Master of Arts) in Anglophone Literatures and Cultures Oct 2012 - Jun 2015

Faculty of Philological and Cultural Studies (Philologisch-Kulturwissenschaftliche Fakultät),
Department of English and American Studies (Institut für Anglistik und Amerikanistik)

University of Paris - Sorbonne (Université Paris-Sorbonne), Paris (France)

ERASMUS Programme + ERASMUS Scholarship Sep 2013 - Dec 2013

Department of English (UFR Etudes Anglophones), Master Recherche; Mention LLCE
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University of Maribor (Univerza v Mariboru), Maribor (Slovenia)

BA (Bachelor of Arts) in English Language and Literature Oct 2009 - Aug 2012

Faculty of Arts (Filozofska fakulteta), Department of English and American Studies (Oddelek
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BA (Bachelor of Arts) in History Oct 2009 - Aug 2012

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University of Pardubice (Univerzita Pardubice), Pardubice (Czech Republic)

CEEPUS Programme Oct 2011 - Dec 2011

(Central European Exchange Program for University Studies) + CEEPUS Scholarship

Faculty of Arts and Philosophy (Fakulta filozofická)

▪Department of English and American Studies: Programme "English for Business"

▪Institute of Historical Sciences: Programme "Modern History"

University of Bergen (Universitetet i Bergen), Bergen (Norway)

ERASMUS Programme + ERASMUS Scholarship Aug 2010 - Dec 2010

Faculty of Humanities (Det humanistiske fakultet)

▪Department of Foreign Languages: Programme "American Studies"

▪Department of Linguistic, Literary and Aesthetic Studies: Programme "Corpus Linguistics"

First Grammar School Maribor (Prva Gimnazija Maribor), Maribor (Slovenia)

2003 - 2007

Primary School OŠ Borci za severno mejo, Maribor (Slovenia)

1995 - 2003

WORK EXPERIENCE

Instituto das Filhas de Maria Auxiliadora, Namaacha (Mozambique) *Jul 2014 - Aug 2014*
Volunteer English and French Teacher, help in girl's orphanage

Europe & Me, Berlin (Germany) *2008 - 2012*
Reporter/Writer

Depaul International/Depaul Kharkiv, Kharkiv (Ukraine) *Jul 2009 - Aug 2009*
Volunteer work in an orphanage, a prison, and with children from the streets in association with Slovenian International Group Volunteer Programme POTA, Ljubljana (Slovenia)

F.A.C.E. - Federation of Associations of Young Citizens of Europe *2005 - 2006*
Slovenian Representative in the Youth Council/Member of the Slovenian Delegation in the meetings in Bratislava, Slovakia (2005) and in Ansbach, Germany (2006)

Dom Antona Skale, Maribor (Slovenia) *2003 - 2005*
Volunteer work with adolescents with intellectual disabilities and other developmental problems

LANGUAGES

Slovenian; Mother Tongue

English; Excellent

Spanish; Very Good

Russian; Very Good

French; Good

German; Good

Latin; Good

Serbian; Good

Croatian; Good

Norwegian; Basic

Portuguese; Basic

Czech; Basic

SCHOLARSHIPS

Academic Year 2012/2013: ZOIS Scholarship; National Scholarship for Talented Students of the Republic of Slovenia

Academic Year 2011/2012: Scholarship for the most talented students of the Municipality of Maribor

Academic Year 2010/2011: Scholarship for the most talented students of the Municipality of Maribor

OTHER SKILLS

1999 Slovenian National All-Around Champion in Rhythmic Gymnastics

1999 Slovenian Grand Prix Final Champion in Rhythmic Gymnastics

1998 Slovenian National All-Around Champion in Rhythmic Gymnastics