

Infected Condoms and Pin-Pricked Oranges: An Ethnographic Study of AIDS Legends in Two Townships in Cape Town

Jonas Sivelä

University of Helsinki,
Finland

Abstract

So-called AIDS myths surfaced as an outcome of the HIV/AIDS epidemic that has escalated severely since mid-1990s in South Africa. Examining these “myths” shows that they belong to the narrative genre of AIDS legends. This article focuses on AIDS legends appearing commonly among Xhosa people living in two townships in Cape Town: one about infected condoms and another concerning pin-pricked oranges. The study, based on ethnographic fieldwork, reveals that the South African AIDS legends are more multifaceted than has been presumed. By examining their motifs and themes it is possible to see how the AIDS legends convey a denotation of resistance against hegemonic messages of HIV testing, condom use, and, most importantly, the disease in general.

Introduction

With nearly six million cases of reported HIV infections (UNAIDS 2010), South Africa has the highest number of HIV-infected persons in the world. The majority of those infected are black South Africans. Besides the high infection rate, the South African HIV/AIDS situation has gained attention due to perceptions of the disease

that clearly deviate from what Western medicine would consider scientifically proven. The media and previous research have called these perceptions AIDS beliefs or AIDS myths. Earlier academic studies have given rather far-reaching interpretations of the reasons behind these AIDS myths (Parikh and Whiteside 2007; Leclerc-Madlala 2002; Niehaus 2005; Stadler 2003; Nattrass 2012). However, no one to date has thoroughly discussed what these myths or beliefs encompass; as a result, the terms “AIDS myths” and “AIDS beliefs” are rather inaccurate. Rather, my observations made during ethnographic fieldwork among the Xhosa people in Cape Town suggest that the HIV/AIDS related discourse referred to as “AIDS myths” or “AIDS beliefs” has some striking similarities with the narrative genre of legends.¹

Background

During the first years of the twenty-first century, reports of the so-called AIDS myths started to spread from South Africa, first through the media, and later in academic writing. The most noteworthy and disturbing of these was the one claiming that sexual intercourse with a child would cure the disease—the virgin cure myth—which is also assumed to have increased the number of child rapes in South Africa (Pitcher and Bowley 2002). Other reports mentioned conspiratorial thinking and traits related to traditional mythology (Leclerc-Madlala 2002; Niehaus 2005; Stadler 2003). These reports became even more interesting when they were accompanied by ambiguous statements made by leading

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South African politicians. For example, South Africa's former president, Thabo Mbeki, questioned the causality between HIV and AIDS in 2000, insinuating that the disease was part of a conspiracy to increase drug sales (Iliffe 2006, 146-147). In 2006, the health minister at the time, Manto Tshabalala-Msimang, claimed that beetroot and garlic should be considered as treatments for HIV (Baleta 2006, 620). The current president, Jacob Zuma, caused a stir when he, during a rape trial in 2006, said that he had showered after sex with an HIV positive woman, suggesting that this act had reduced his risk of becoming infected (BBC 2006).

Having examined the South African AIDS policy and its consequences, Parikh and Whiteside regard the political debate about the disease as confusing, suggesting that many people have found comfort in them and that the dubious political statements have had "negative implications for behavior change, prevention, treatment uptake, and efforts aimed at reducing stigma" (2007, 67). Pitcher and Bowley believe that the failure of the South African political leadership to acknowledge the causes, effects, and treatment of the disease has offered fertile ground for "bizarre and dangerous myths to take root and flourish" (2002, 274-275). Although Robins acknowledges that cultural interpretations of the disease are complex, he believes President Mbeki's unconventional view on AIDS, and the government's unscientific views caused profound confusion and uncertainty and possibly made popular forms of AIDS denial and alternative explanations credible (2004). The news media have also discussed the relationship between public statements and "myths"; the view

presented has often been congruent with the one above (Bevan 2006; Swarns 2000). Interestingly enough, none of these studies has actually discussed the very material and texture of these "bizarre and dangerous myths" or "alternative explanations."

Many of the previous studies also draw a rather clear line of causation between ambiguous political statements about the disease and the existence of what have been called AIDS myths. I do not contest the impact of the political discourse, but I claim that the relation is not as straightforward as proposed. What has been neglected in previous attempts to understand the presence of "AIDS myths" among politicians is the fact that the politicians in question belong the same narrative culture as the majority of the people in South Africa and are, hence, affected by the same oral traditions as everybody else.

Instead, the search for reasons behind the "AIDS myths" should start by examining more thoroughly their contents. The toolbox applied in previous studies has not been focused or sufficient enough. The "AIDS myths" I observed during ethnographic fieldwork among Xhosa people living in two different townships in Cape Town clearly belong to the global corpus of AIDS legends. In this article, I will approach these legends by scrutinizing the themes and motifs found in them. By doing this, I want to show how the AIDS legends in the townships in Cape Town can be interpreted as a narrative form of resistance against HIV/AIDS.

Fieldwork in Masiphumelele and Khayelitsha Townships

During Apartheid, South Africans were categorized into four racial groups: white, coloured, Asian and black. The 1950 Group Areas Act assigned non-white South African racial groups (blacks, coloureds and Asians) to specially designated living areas (Western 2002, 712). In Cape Town, black South Africans, the work force from the Eastern Cape, were allocated to townships normally found outside the city center. Many of the townships were already overcrowded at that time and the related infrastructure insufficient (Turok 2001, 2351). When the rules restricting the movement and residency of black South Africans were abolished at the end of Apartheid, the townships' population in Cape Town escalated dramatically. Informal settlements thus emerged on their outskirts giving rise to a variety of social problems such as unemployment, criminality, drug and alcohol abuse, and, most importantly, a high rate of HIV infections, which is also the reason why I chose to conduct ethnographic fieldwork in the townships.

In November and December 2009 and January and April 2011, I conducted ethnographic fieldwork in the townships of Masiphumelele and Khayelitsha in Cape Town. The majority of the inhabitants in both townships are Xhosa-speaking black South Africans with roots in the Eastern Cape. Masiphumelele and Khayelitsha differ in size and location. With a population of between 30,000 and 50,000, Masiphumelele is a small township on all South African scales. It is located on the southern part of the Cape Peninsula between Kommetjie and Fish Hoek. Khayelitsha, again, is one of

the largest townships in South Africa, with its residents estimated to number half a million or more. It is located on the Cape Flats, a half an hour's drive outside central Cape Town. As relics of the Apartheid era, both residential areas are still clearly secluded from the rest of the city.

Collecting the Data

Fieldwork consisted of interviews, discussion sessions, and participant observation with Masiphumelele residents and clients at the male HIV-testing clinic in Site-C in Khayelitsha. Individual and group interviews and discussions were conducted with a total of 64 people. Many others contributed through less formal encounters. During my fieldwork, two female interpreters assisted me with translating and organizing discussion sessions in Masiphumelele and, most importantly, acquainted me with the cultural landscape of the Xhosa living in the Cape Town townships.

Despite being a male, I still had great difficulties in getting men in Masiphumelele to attend my discussion sessions, even when I approached them without one of my local female interpreters. Therefore, the interviews and discussions in Masiphumelele were mainly held with women at home during the day, while their husbands were working or looking for day jobs waiting at the petrol station in Sun Valley, close to Noordhoek. Men had in general better English skills than the women, probably because many of them use English in their work outside the townships, while many of the women in the townships stay at home with children. The interviews

and the discussion sessions were held in Xhosa, English, or both, depending on how well the informant's and my language skills coincided. But, in order to capture the perceptions of HIV/AIDS as accurately as possible, Xhosa was predominantly used in the interviews and discussion sessions, especially with the women in Masiphumelele.

Masiphumelele is a small, almost village-like, township where it is possible to interact with people as an acquaintance instead of the somewhat tense relationship between interviewer and informant. It was therefore natural to consolidate the group discussions at the library by simply "being around" and talking to people. Sometimes, on rare occasions, even the men in Masiphumelele talked to me—if they were alone or in the company of other men.

However, I needed to talk more intimately to men than was possible in mere passing. Luckily, I was allowed to follow the daily routines of an HIV-testing clinic for men situated in a couple of adjoined metal barracks in Site-C in Khayelitsha. HIV testing and being aware of one's HIV status is put forward as an important part of the work against HIV/AIDS in South Africa. The purpose of the Male Clinic in Khayelitsha is to offer men a low threshold possibility to be informed of their HIV status. If needed, they can receive necessary counseling anonymously, and they are not pressured. At arrival, the clients were told who I was and what I was doing at the clinic. They were also told that they could, if they wished, participate in my research by volunteering to have an extensive discussion or interview with me about

the disease and their perceptions of it. The number of men who approached me varied greatly; some days, I had a long queue of potential informants behind my door; at other times, someone just wanted to tell me something while we sat outside in the shade. Many of the men, especially the younger ones, came to the clinic in groups. On a successful day, one good interview experience snowballed to the whole group of friends, and soon almost everyone wanted to share their thoughts on HIV/AIDS with me.

The interviews and the group discussion sessions in both Masiphumelele and Khayelitsha offered unique possibilities to record longer narratives expressing the deeper reflections on and underlying attitudes towards the disease. These also helped me to position the narratives in a cultural matrix of contemporary traditions. However, the encounters that I consider most fruitful were those when sitting in the shade outside the Masiphumelele library having a sandwich for lunch, caught in the rush hour traffic with a Khayelitsha friend, or talking about the previous evening's soccer game between Soweto's Kaizer Chiefs and Cape Town's Ajax while waiting for the clinic in Khayelitsha to open on a Monday morning. Although HIV/AIDS is intensely present in South African society, it is still a stigmatized subject that needs to be approached with sensitivity, not the least due to its close relationship to sexuality.

AIDS Legends in the Townships

Contrary to the impression I had gotten from previous studies and media coverage that reported townships filled to the brim with one "myth" more

bizarre than the other, I was surprised (and, ashamed to say, disappointed) by how well my informants were informed about the disease and its clinical properties. Although child rapes with connections to the virgin cure myth have been documented in South Africa, the only things I heard related to them were the same kind of references to reports of child rape incidents that were based on media reports I encountered back home before starting the fieldwork. My informants' awareness of the virgin cure myth could, of course, lie in the fact that many of the publicly discussed accounts happened already during the first years of the twenty-first century (McGreal 2001; Pitcher and Bowley 2002), years before I started my first fieldwork trip. The considerable publicity the child rape cases had gotten before I started my fieldwork has probably had a debunking impact on the virgin cure myth.

I was often forced to remind my informants that I was not there to check how much they had learned at the different workshops or at school, but to understand how they thought about the disease. I am, however, aware that I, a white European scholar, asking black South Africans living in townships to talk about HIV/AIDS could easily promote such a presumption and affect how people reacted when talking about HIV/AIDS; people simply did not want to appear ignorant and uneducated in front of me. However, as the fieldwork proceeded, and I became more accustomed to my informants and they started to trust and feel more comfortable around me, I learned that there were clear variations in how people talked about the disease; they did not always

focus on hard, clinical facts. The same person, who had just given me her fresh, and seemingly accurate, insights into the medical dimensions of the disease, could in the next sentence say something that clearly stood out; for example, he or she might say that the government-distributed condoms had purposely been contaminated with HIV or that Americans had manufactured the disease to return the Apartheid regime to power. I could not quite make sense of it; was there a clear pattern? Soon, identifiable shapes of legends started to appear from these crumbs. The repertoire of these legends was, however, astonishingly narrow. In this article, I have chosen to focus on two types of legends that clearly stood out from the discourse surrounding HIV/AIDS during my fieldwork: the infected condoms legend and a variety of pin-prick legends, both bearing clear resemblances to the global AIDS legend corpus.

Fear, Confusion, and Anxiety

The term urban legend received broad exposure from folklorist Jan Harold Brunvand's popular book, *The Vanishing Hitchhiker* (1981). Since then, urban legends have become a prevailing subject in contemporary folkloristics. Patricia Turner understands urban legends as "unsubstantiated narratives with traditional themes and modern motifs that circulate orally (and sometimes in print) in multiple versions and are told as if they are true or at least plausible" (1993, 5). Timothy Tangherlini describes these legends as "a short (mono-) episodic, traditional, highly ecotypified, historicized narrative performed in a conversational mode,

reflecting on a psychological level a symbolic representation of folk belief and collective experiences and serving as a reaffirmation of held values of the group to whose tradition it belongs" (1990, 375). Urban legends have a wide circulation, and those with very similar themes and contents can appear in different places, even globally. Urban legends are considered efficient tools for expressing desires, fears, anxieties, and attitudes that exist below the surface (Dégh 2001, 21; Goldstein 2004, 31, 36), and act as "an important parameter of human mentality" (Dégh 2001, 87). Tangherlini further regards them as addressing "real psychological problems associated with the geographic and social environments, acting as a reflection of commonly felt pressures" (1990, 381).

The terminology and possible differences between legends, urban legends, contemporary legends, and modern legends has been discussed in many previous studies. I agree with Linda Dégh in her argument that urban or contemporary legends appear "as the present manifestation of traditional legend, representative of the actual stage of an ongoing process that keeps the story meaningful and viable for all, but in diverse ways" (2001, 91). Nonetheless, I see that the debate surrounding the term urban legend has brought the discussion about how legends should be interpreted closer to present day conditions and, therefore, also closer to how AIDS-related misconceptions or AIDS legends should be understood. Owing to widespread information and awareness campaigns, South Africans are generally very knowledgeable about HIV/AIDS (Stadler 2003). However, detailed and often

rather clinical knowledge about HIV/AIDS does not necessarily guarantee preventative behavior through condom use, abstinence, or refraining from multiple simultaneous sexual partners—that is, through the ABCs of AIDS prevention (abstain from sex, be faithful if you do not abstain, and use a condom). As Stadler observed in his study of KwaBomaha in South Africa's Limpopo Province, even if people are able to recite "in parrot-like fashion the ABCs of AIDS prevention," there is still much confusion about the disease (2003, 358). Similarly, in a study of adolescents in Mali, Mwale observed that the information delivered through, for example, awareness campaigns did not result in behavior that was congruent with decreasing the risk of infection (2008, 297). Bennett proposes that legends of illness and body enable "people without formal knowledge of disease to understand what is wrong with them" (2005, 23).

Today, the scientific community has a fairly unanimous view of the clinical properties and origins of HIV/AIDS. The HI virus found in humans is, for example, considered to originate from a similar virus common among chimpanzees in West Central Africa (Keele et al. 2006). However, when the number of HIV infections started to increase rapidly in the early 1980s, the disease was characterized by a much greater uncertainty concerning not only its origins, but also its clinical features and the possibilities of treating it. Therefore, reasons traditionally related to legends, such as fear of infection, anxiety when encountering sickness, hopes of cure, and a general sensation of insecurity were all sentiments I continuously observed

during my fieldwork. On a general level, these sentiments can unmistakably be related to the reasons behind the legends. However, scrutinizing the themes and motifs in these legends gives more insight into the underlying reasons behind them and their mechanics.

The Infected Condoms

On 1 December 2009, the start of my empirical research, my assistant and I were strolling through Masiphumelele. This day coincided with International AIDS Day, which had slipped from my mind in the confusion of the intensive start and the fieldwork's pace. We therefore almost stumbled upon an AIDS Day function at the Masiphumelele community hall, arriving just in time to see the finale, a dance performance by a group of local girls in their early teens. Hearsay had travelled fast in the small township community, because immediately after the lively show, Thembeke, a young woman in her mid-20s who coached the dance group, approached me. She had heard that I was doing "some kind of a research about AIDS," and she wanted to share something important with me. After all the trouble I had had to start the fieldwork and find people willing to participate in the interviews, I welcomed this spontaneous reaction. After a conventional discussion about the distressing HIV/AIDS situation in the townships, I was perplexed when Thembeke, with evident authority, said:

I have heard that condoms are not right. The condoms can spread HIV/AIDS. I do not know why. I do not like condoms, because of that oily thing. So, some people say that this oily thing is HIV. It is that oil that spreads AIDS.

They say so. And I think, yes, it is true. Because, you know, when the condoms came, the level of HIV went up. I think it is the white men. They say so. The white men do so. You see, the black people have the most HIV. That is why you have put the oil on the condoms, to spread HIV.

Thembeke's account of infected condoms seemed strangely familiar. Had I not heard it before? A couple of years earlier, in 2007, the Archbishop of the Roman Catholic church in Mozambique, Francisco Chimoio, had made the headlines by claiming that European-manufactured condoms were deliberately infected with HIV in order to "finish quickly the African people" (McGreal 2007). Condoms infected with HIV or other diseases have also been mentioned on websites promoting conspiratorial thinking (Nakash 2006; Taylor 2012).

The infected condom legend was clearly the most popular legend among my informants. It is difficult to determine how many, in fact, believed that condoms are infected with HIV; while some of my informants clearly believed in it, others told me that they thought it was "just a silly rumor," and some did not know what to believe. But, almost all of my informants had heard about condoms being allegedly infected with HIV. The legend most often included the same repertoire of motifs: that the HIV virus was added to the lubricant, only government-distributed condoms were infected, and behind the HIV-infected condoms was a conspiracy to infect a targeted black population. Thembeke bases her assumption that condoms are infected with HIV on the causation she has observed between the increased

number of HIV infections and the commencement of condom distribution. Government sponsored condoms, called Choice condoms, are a cornerstone in the fight against HIV/AIDS in South Africa. Choice condoms are abundantly distributed in townships in Cape Town. They can be found in health care centers, clinics, and other public institutions, such as libraries and even schools. The number of HIV infections has been rising steadily since the beginning of the epidemic. In this sense, Thembeke's suspicion is understandable; there is a connection between the HIV infections and the distribution of condoms. However, there is nothing suggesting that the distribution of condoms would be the reason behind the increased number of HIV infections. Instead of seeing the condom distribution as a way to constrain the rising number of HIV infections, Thembeke sees a conspiratorial and racialized plot behind the allegedly infected condoms.

The very same legend about the infected condoms has also been observed in Tanzania by Philip Setel already ten years earlier (1999, 240). In a very similar legend, picked up by Jonathan Stadler (2003) in the Limpopo Province and by Isak Niehaus (2005) in the Mpumalanga Province in the Northern parts of South Africa, the HI virus can be made visible to the bare eye in the form of small worms by filling the condom with water or by putting the condom in hot water or in the sun. I heard this variant only a couple of times during my fieldwork in Cape Town. But, it is probable that the legend about the water filled condom is an extended variant of the infected condom legend I observed during my fieldwork.

For someone to be infected with HIV the HI virus must be transmitted from a HIV positive person, for example, through unprotected sex. Generally, condoms are considered the most efficient way to prevent the virus from being transmitted between two persons having sexual intercourse. Besides blood, body fluids occur commonly in the discourse surrounding HIV/AIDS as an agent that carries and transmits the disease. Condoms are coated with lubricant and packed in plastic wrap. The lubricant applied on the condoms gives them that "oily" feeling mentioned by Thembeke and many other informants. Considering this suspicion and, even more particularly, the worms that appear in the Stadler's version, it is not difficult to see the mechanical connection between the lubricant and the "oily" virus on the condoms. However, in order to start understanding the reasons behind the legend, we must move to the other legend type I observed in Cape Town, the pin-prick legends.

Pin-Prick Legends

Even if the legend about the infected condom did not normally include detailed information about how the virus had been implanted in the condom, in some accounts, a needle was used to inject the virus into the condom, as in this report given in February 2011 by a thirty-five-year-old woman called Cebisa in Masiphumelele:

Most of the time, the people, if you give them the condom, the Choice [the government distributed condom brand] at the clinic, they do not like those condoms, they rather buy it at the chemist or at the clinics ...//...

Because they say sometimes that there are people who inject the condom, so the HIV is there.

Although pin-prick legends are not considered among the most common among the otherwise vast variety of legends, they are still recognized as a distinguishable part of the global legend corpus that accompanied the birth and progression of the global HIV/AIDS epidemic in the 1980s. Typical for the first AIDS legends was the inclusion of two strangers who had consensual sex with each other, one of whom deliberately infected the other one, and then told him or her that he or she has now been infected with AIDS. These have been referred to as the “Welcome to the world of AIDS” legends or “AIDS Mary/Harry” legends (Goldstein 2004, 38). In pin-prick legends collected previously, HIV-infected needles have been struck into fruits, condoms, and into people either directly by the perpetrator or by placing an infected needle, for example, on a bus or movie theatre seat (Goldstein 2004, 141-142; Bennett 2005, 114-116). Goldstein understands the motif of being pierced by something sharp, such as a thorn or a needle as an intrusion and contamination, as pierced skin “can be filled with all manners of evil” (2004, 141).

During a discussion session with two women aged twenty-four and fifty-five years in Masiphumelele, a nineteen-year-old woman who worked as my interpreter told me about a journalist who had been deliberately infected with HIV. According to her report, a primetime news anchor for the state-owned South African Broadcasting Company had been

purposely infected with HIV by a nurse during an HIV test. The two informants added quickly that they had also heard about the nurse who allegedly had been jealous of the news anchor’s beauty and success and had, thus, purposely infected her using a syringe filled with HIV-infected blood. During the fieldwork, different versions of this legend, often involving a distant acquaintance instead of the nurse, were told especially by the residents in Masiphumelele.

In February 2011 while I was conducting interviews at the Male Clinic in Khayelitsha, Mpendulo, a thirty-one-year-old man, approached me. After ensuring his anonymity, he proceeded to share his perceptions of the disease. Like many others, Mpendulo first referred to the rumor that condoms were infected with HIV. But he did not want to pursue talking about the condoms; instead he insisted on telling me about oranges that were infected with HIV.

There was some story here [Khayelitsha], I think four years ago, or three, about oranges. They say they put injections in oranges, and then they give free oranges to everybody. You see, when you eat that orange you become HIV positive, and so on.

When I asked Mpendulo who he thought was responsible for injecting the HI virus into the oranges, he thought it was the private company selling and exporting the oranges. Kaschula notes that reports about blood oranges being infected with HIV had already been widely spread around South Africa already in 1993. In these versions, the infected oranges are mostly related to conspiratorial right-wing plots (2008). Reports of citrus fruits

contaminated with HIV found in Europe have been linked to users of intravenous drugs sticking their used needles into lemons and oranges hoping that the acidity of the fruit would disinfect the needle (Flanagan 2003). Mpendulo was not the only one at the clinic who told me about infected oranges. After talking to him, a discussion started at the clinic waiting area, and also other men told me similar stories. Like many others, these accounts were often characterized by expressions of conspiracy.

Considering how present and tangible the disease is among the clients at the Male Clinic, the non-stop information sessions, the testing, the needles, and the fear of testing HIV positive, I found it surprising that the legend about being infected while having an HIV test never appeared there. As fear, anxiety, and other disturbing sentiments are normally related to reasons behind legends, would not the legend implying that you might be infected while being tested for HIV be the most probable legend to be found there? The men at the male clinic queue sometimes for hours to be tested. The distress and anxiety they feel must be overwhelming; for many, the probability of testing HIV positive is considerable, the possibilities of getting adequate treatment in the townships are poor, and the stigma related to being HIV positive is socially restraining. Consequently, as a result of the distress related to these factors, the threshold of entering the clinic to get tested is very high; many men told me that they had thought about coming there for a long time, even for years, but that they lacked the courage to do it earlier.

Of course, from a pragmatic point of view, the absence of the legend about getting infected while having an HIV test could be explained by the fact that men who believed in it never made it as far as the clinic. But this does not explain why the legend about the infected oranges appeared only at the clinic (I never heard it anywhere else), while the legend about being infected while testing for HIV only appeared outside the clinic. Both legends include a needle and the possible threat of an HIV infection as motifs. The only difference between them is that in the former, the HI virus is injected into a fruit, which is to be eaten by someone, and in the latter, the virus is injected directly into a person.

In psychoanalytics, the term displacement is used when sentiments associated with something that is feared and unacceptable are projected onto something considered safer and, therefore, easier to handle. Interpreting themes from popular culture, such as rhymes and tales, Alan Dundes demonstrates how projection is present in folklore as a psychological defense mechanism to address the cause of anxiety through “a guilt-free means of exploring the problem” (1976, 1532). In other words, a more comfortable object is referred to instead of the original one in order to decrease the anxiety and fear attached to it: “What is attributed is usually some internal impulse or feeling which is painful, unacceptable, or taboo” (Dundes 1976, 1505). Dundes goes as far as proposing that projection is such an inherent feature of folklore that “if folklore did not provide a socially sanctioned outlet for projection, it [folklore] would almost certainly cease

to exist" (1976, 1532).

Drawing from this perspective, could not the legend about the infected oranges be considered a local Male Clinic variant of the legend about getting the infection while tested? Such reasoning would make sense if the orange is understood as a more comfortable surrogate for the body, and the legend about oranges, consequently, a more comfortable variant of the legend about getting infected while having an HIV test. In this sense, the fear related to getting tested is projected onto the orange, as the traditional variant of the legend would be too directly anchored to the activities of the clinic to be able to appear there. Both legends could still be considered to address the same distress related to getting tested for HIV. In a more general sense, I also perceived the same kind of distress outside the Male Clinic when I confronted people about HIV/AIDS.

Legends of Resistance

After starting my fieldwork, it did not take me long to notice that people were often rather reluctant to participate in any kind of activities related to HIV/AIDS. At first, I sensed that this was due to people simply being tired of anything that had to do with the disease. But it was more than just a reluctance to talk; many of my informants also felt clearly distressed when confronted with the disease. Considering the number of infected persons, HIV/AIDS has hit South Africa more severely than any other country. In the townships, people are very aware that they live in the most infected country in the world and are, therefore, also the most infected people in the world. Nearly everybody is in one

way or another touched by HIV/AIDS; if you are not infected yourself, a family member, a relative, or a friend most probably is. Faced with the cold facts of HIV/AIDS in their life, the distress of many of my informants was present not only in the legend-like reports I was told, but also in the more hidden expressions of people, such as tone of voice, the shaking of heads, and other types of body language. Expressions of distress became, however, even more articulate in the conspiratorial reports about the disease.

Many black South Africans carry within them bitterness and anger originating in the injustice of the Apartheid era; the townships are still isolated from the rest of the city, living conditions are poor, and the rate of HIV infections is much higher than outside the township walls. The HIV/AIDS infection rate in South Africa started to rise dramatically in the mid-1990s, which also coincides with the end of the Apartheid era in South Africa, a fact that not only feeds into the bitterness and distress that stem from HIV/AIDS, but also offers a fertile growing ground for conspiratorial perceptions that include the displaced Apartheid regime.

Like many others that I talked to at the Male Clinic in Khayelitsha, the twenty-one-year-old Thabo, had the same pragmatic view on how to prevent the spread of the disease, that is, through responsibility, faithfulness, and condom use. When I asked about his thoughts concerning the origins of the disease in April 2011, he told me about a workshop he had attended in 2001. He quoted a man who had talked at the workshop. At a certain point however, instead of just quoting, the words of the quotee became

Thabo's:

People of America wanted to colonize Africa. And they found out that the population here is too much, and most of us do not want them here. You see, blacks did not want white people at that time. There were wars and all that stuff; apartheid and stuff. So, overseas they thought of what would decrease the number of black people here, so that there can be more white people than black people. What they did is that they took the disease. It is like something they created this disease, you see like medically, I do not know how. Africa is the area that has got the highest rate of HIV. Maybe it could be I am not sure.

Thabo's comprehension about HIV/AIDS was rather typical; on the one hand, he was very well informed about the disease and knew his ABCs well. On the other hand, his account is a characteristic expression of conspiratorial thinking very similar to others I had heard. Like Thabo, many of my informants suggested that the disease is part of a malevolent plan to wipe out the black population in South Africa. The antagonist in these accounts appeared as a white man in general, a hidden fraction of the Apartheid regime or "the Americans." Conspiracy theories were especially articulate when expressing notions about the origin of HIV/AIDS, but they were also present in the legend about the infected condom and the pin-prick legends.

Diane Goldstein has probably undertaken one of the most thorough and methodologically inspiring studies of contemporary AIDS legends in Newfoundland, Canada. Many of the themes and motifs that Goldstein

identifies, such as conspiracy theories about sinister plots by governments or other actors with genocidal plans, are very similar to those that I detected during my fieldwork in Cape Town (2004, 52). Richard Hofstadter suggests that social conflicts, based on fears and hatred, are the fuel for conspiratorial thinking (1964, 39). Considering the complex past of South Africa and especially black South Africans, such socially derived fears and frustrations can easily be seen as underlying reasons behind the conspiratorial nature of the AIDS discourse among my informants.

Besides reacting to frustration and distress, the AIDS legends also carry with them a voice of resistance. Goldstein suggests that legend scholars have been "underreading the resistance voice" in, for example, health legends, and that AIDS legends should be understood through the inherent message of resistance against medical authority they convey (2004, 148-151). Elisa Sobo has examined the link between the low levels of condom use among African-American women by interpreting the women's understandings of heterosexual relationships. Sobo proposes that narrative strategies can be applied in order to enhance one's self-esteem or, for example, that conspiracy theories are used to support group dignity (Sobo 1993). Counter-narratives are conventionally considered as verbal reactions to the increasing downfall of the Great Western meta-narratives, such as foundational stories and other myths (Lyotard 1984). However, they can, as Peters and Lankshire (1996) propose, besides being a postmodern narrative phenomenon, also be understood as verbal counter-reactions to an official or

hegemonic narrative.

HIV/AIDS is present everywhere in the townships; almost anywhere you turn, there is a poster informing citizens about the dangers of HIV/AIDS and the possibilities of guarding oneself from them. Besides distributing practical advice concerning condom use and the nearest testing facility, the mere abundance of these signs conveys the message that the townships and their residents are saturated with HIV/AIDS.

The massive information programs about the advantages of using condoms and getting tested for HIV have made people very aware of how the disease works and about the kind of behavior that is desired. Nevertheless, “flesh-to-flesh” sex is still considered to be much more “real” by many of my informants, both men and women. And the fear of testing positive raises the threshold for getting an HIV test; even if people know that by being aware of their own status they can, if necessary, get treatment, not nearly everybody dares to take an HIV test. Not using condoms and the reluctance to having an HIV test clearly constitute a dissonance between people’s knowledge about how they should act and how many people, in fact, act.

To contest the usability and safety of condoms by claiming that using one infects the user with HIV, instead of protecting from an infection, can be understood as a way to question the negative perception inflicted on oneself by not using condoms. Similarly, if the legend about the infected orange is understood as a more comfortable variant of the legend about getting infected while being tested for HIV, it can also be interpreted as a way to narratively

oppose the HIV tests. Furthermore, by seeing conspiracies behind the disease it is possible to put the blame for HIV/AIDS in general on someone else, rather than seeing the own role and responsibility in the epidemic.

The conspiratorial traits of many of the AIDS legends I encountered in Cape Town also further enforces their function as narrative expressions of resistance towards the hegemonic message promoting condom use and HIV testing, but also the disease in general. By telling legends about infected condoms, pin-pricked oranges, and malevolent conspiracies, the South Africans most affected by the disease are able to question the different hegemonic messages surrounding HIV/AIDS and, as Sobo proposes, enhance their self-esteem and maintain the group’s dignity, in a situation where very few good alternatives exist.

Conclusion

When I commenced my first fieldwork about the “South African AIDS myth,” I expected to meet townships filled to the brim with one belief more extravagant than the other.

Instead, as discussed above, many of my informants showed very detailed knowledge of the disease and its clinical qualities. In many cases, their knowledge was far superior to mine. At first appearance, I had, in fact, a hard time observing any so-called AIDS myths, an observation that does not harmonize with previous studies’ suggestions. However, even if not evident in the beginning, a clear mismatch sometimes surfaced between the information gained from different information campaigns at health

care centers or at schools and people's expressions of the disease. Some of these perceptions, especially the reports about the infected condoms and pin-pricked oranges, I recognized as an unmistakable part of the AIDS legend corpus.

During my fieldwork, I learned that HIV/AIDS is a hard subject to approach in South Africa, not only due to people being rather exhausted of the disease, but also because people feel distressed when having to confront HIV/AIDS. Therefore, conducting fieldwork about HIV/AIDS can be troublesome and frustrating. More profound layers and delicate pieces of information in people's perceptions of HIV/AIDS can only be found when informants feel comfortable enough to share their knowledge with the ethnographer, which is also the reason why the ethnographic fieldwork has played such an important role in my study. Scrutinizing these finer grains of perceptions, the themes and motifs found in the legends, such as the lubricant on the condom as a substance carrying the infection and the orange as a projection of the body, have revealed that they convey inherent messages of resistance. Working on different levels, the AIDS legends in the townships in Cape Town can be interpreted as narrative strategies aiming to maintain the control of one's self-esteem and dignity in the distressful crossfire of risk, fear, denial, and a complex political history.

Notes

1. Whether they should be called urban, contemporary or modern legends, or simply legends has been amply discussed in previous studies. For the sake of clarity and coherence, and as this article is not aimed at discussing

if legends differ from each other and if they, hence, should be labelled differently, I will call them legends or AIDS legends (see subsection entitled, "Fear, Confusion, and Anxiety").

Works Cited

Discussion Forum Posts and Newspaper Articles

- BBC. 2006. "SA's Zuma 'showered to avoid HIV.'" *BBC*, 5 April. <http://news.bbc.co.uk/2/hi/africa/4879822.stm>. (5 March 2008)
- Bevan, Stephen. 2006. "Deputy minister takes on Manto." *Sunday Tribune*, 10 December. <http://www.sundaytribune.co.za/index.php?fArticleId=3586435>. (17 March 2008)
- Flanagan, Pat. 2003. "NEEDLE HORROR; Drug users 'cleaning' syringes in shop fruit." *The Mirror*. 29 September.
- McGreal, Chris. 2001. "AIDS myth drives South African baby-rape crisis 'due to AIDS myth.'" *The Guardian*, 3 November. <http://www.guardian.co.uk/world/2001/nov/03/AIDS.chrismcgreal> (20 February 2013)
- McGreal, Chris. 2007. "HIV-infected condoms sent to kill Africans, claims archbishop." *The Guardian*, 27. <http://www.guardian.co.uk/world/2007/sep/27/AIDS.international>. (18 July 2012)
- Nakash. 2006. "The AIDS in Condoms conspiracy." *Abovetopsecret.com*, 10 February. <http://www.abovetopsecret.com/forum/thread194661/pg1>. (25 August 2012)

- Swarns, Rachel. 2000. "Focus on AIDS Epidemic, Mandela Says." *New York Times*, 15 July. <http://query.nytimes.com/gst/fullpage.html?res=9507E2DB143BF936A25754C0A9669C8B63&n=Top/News/Health/Diseases,%20Conditions,%20and%20Health%20Topics/AIDS>. (17 March 2008)
- Taylor, David Chase. 2012. "Condoms." *Bio Terror Bible.com*. <https://sites.google.com/site/bioterrorbible/causes/condoms>. (3 September 2012)
- UNAIDS Report on the Global AIDS Epidemic 2010. http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/20101123_globalreport_en.pdf. (1 June 2011)
- References**
- Baleta Adele. 2006. "'Beetroot' sidelined in South Africa." *The Lancet Infectious Diseases* no. 6(10): 620.
- Bennett, Gillian. 2005. *Bodies. Sex, Violence, Disease, and Death in Contemporary Legend*. Jackson: University Press of Mississippi.
- Brunvand, Jan Harold. 1981. *The Vanishing Hitchhiker*. London: Pan Books.
- Dégh, Linda. 2001. *Legend and Belief*. Bloomington: Indiana University Press.
- Dundes, Alan. 1976. "Projection in Folklore: A Plea for Psychoanalytic Semiotics." *MLN* no. 91(6): 1500–1533.
- Goldstein, Diane. 2004. *Once Upon a Virus. AIDS Legends and Vernacular Risk Perception*. Logan: Utah State University Press.
- Hofstadter, Richard 1965. *The Paranoid Style of American Politics and Other Essays*. New York: Alfred A. Knopf.
- Iliffe, John. 2006. *The African AIDS Epidemic - A History*. Oxford: James Currey.
- Kaschula, Russel. 2008. "Myth and reality in the New South Africa: Contemporary oralliterature." Available at: <http://www.oulitnet.co.za/seminarroom/myth.asp> (17 May 2012)
- Keele, B. F., et al.. 2006. "Chimpanzee reservoirs of pandemic and nonpandemic HIV-1." *Science* no. 313: 523–526.
- Leclerc-Madlala, Suzanne. 2002. "On The Virgin Cleansing Myth: Gendered Bodies, AIDS and Ethno medicine." *African Journal of AIDS Research* no. 1(2): 87–95.
- Lyotard, Jean-Francois 1984: *The Postmodern Condition: A Report on Knowledge*. Manchester: Manchester University Press.
- Mwale, Marisen. 2008. "Behavioural Change vis-à-vis Hiv/AIDS Knowledge Mismatch among Adolescents: The Case of Some Selected Schools in Zomba." *Nordic Journal of African Studies* 17(4): 288–299.
- Nattrass, Nicoli. 2012. "AIDS Conspiracy Beliefs and Unsafe Sex in Cape Town." *AIDS Behavior* no. 16(3): 761–773.
- Niehaus, Isak. 2005. "Dr. Wouter Basson, Americans, and Wild Beasts: Men's Conspiracy Theories of HIV/AIDS in the South African Lowveld." *Medical Anthropology* no. 24(2): 179–208.
- Parikh, Anokhi and Whiteside, Alan.

2007. "Twenty Five Years of HIV/AIDS: South Africa's Policy Challenges." *The Fletcher Forum of World Affairs* no. 31(1): 61–73.
- Pitcher Graeme and Bowley Douglas. 2002. "Infant rape in South Africa." *The Lancet* no. 359(9303).
- Robins, Steven. 2004. "'Long live Zackie, long live': AIDS activism, science and citizenship after apartheid." *Journal of Southern African Studies* no. 30(3): 651–672.
- Setel, Philip W. 1999. *A Plague of Paradoxes: AIDS, Culture, and Demography in Northern Tanzania*. Chicago : University of Chicago Press.
- Sobo, Elisa J. 1993. Inner-City Women and AIDS: The Psycho-Social Benefits of Unsafe Sex. *Culture, Medicine and Psychiatry* 17(4): 455–485.
- Stadler, Jonathan. 2003. "Rumour, Gossip and Blame: Implications for HIV/AIDS Prevention in the South African Lowveld." *AIDS Education and Prevention* no. 15(4): 357–368.
- Tangherlini, Timothy 1990. "'It Happened Not Too Far from Here...': A Survey of Legend Theory and Characterization." *Western Folklore* no. 49(4): 371–390.
- Turner, Patricia. 1993. *I Heard It Through the Grapevine: Rumor in African-American Culture*. Berkeley: University of California Press.
- Turok, Ivan. 2001. "Persistent Polarisation Post-Apartheid? Progress towards Urban Integration in Cape Town." *Urban Studies* no. 38(13): 2349–2377.
- Western, John. 2002. "A divided city: Cape Town." *Political Geography* 21: 711–716.

Responses

Andrea Kitta

East Carolina University

Sivelä's research demonstrates the importance of fieldwork and public health campaigns which focus on the needs of the community and individual. The sort of informational fatigue that Sivelä points out among his participants when it comes to the HIV/AIDS message clearly demonstrates what happens when a health message is constantly repeated to a population without understanding the particular concerns, beliefs, or fears of the population. As Goldstein has noted, health information has to fit the community's belief systems, not expect the community to adapt to the message (Goldstein 2004: 56). Clearly there is a disconnect between the health message, which is clearly understood, and the actual practices of the community, which scholars are still attempting to understand. We are fortunate to have scholarship from a wide variety of disciplines on HIV/AIDS, but in this situation, fieldwork such as Sivelä's, Anika Wilson's work in Malawi, and Goldstein's scholarship on HIV/AIDS legends may be the most useful. Risk perception is not an easy thing to understand, since it is, as Sobo notes, "multifaceted, culture-bound, personal, and political" (Sobo 1995: 3). This is not an easy problem and there is no easy answer.

Stigmatization complicates our understanding of risk perception as well. In this case, the testing environment, possible of infection, and discussion about HIV/AIDS are all a part of what Goldstein and Shuman refers to as the "stigmatized vernacular", as it expresses "not only the emic experience of stigmatization, but

also the contagion of stigma—the way it spills over beyond the topic into the means of articulation" (2012: 116). Sivelä notes that the fear of stigmatization may be enough to drive people away from places like clinics, especially if one knows that in addition to the testing they will undergo (a fearful enough situation within itself), they will additionally receive further "education" on HIV/AIDS, as if they do not understand the circumstances which put them into this situation. Clearly, the individuals Sivelä observed already understand that they have engaged in behaviors that have put them in a risky situation or else they would not have come to the clinic. Further stigmatizing these people by forcing them to engage with information that they already understand instead of answering questions and acknowledging their real fears and concerns does nothing to improve their likelihood to return to the clinic or change their behavior.

The conversation (and its related stigma) extends outward from there. Sivelä notes that "politicians are a part of the same narrative culture as the majority of the people in South Africa and, hence, affected by the same oral traditions as everybody else" which is important to emphasize since it can be forgotten by the lay public and media. I have noted in past research that those who hold positions of power are often thought to not participate in legends or be somehow above them (Kitta 2012) when in reality, legends are "not the exclusive domain of any single age, race, profession, or socioeconomic group" (deVos 1996: 3). Simply put, everyone believes in these legends to some extent and those legends can complicate the associated stigmas.

While my recent book only contained a small amount of information with a direct link to Sivelä's research, primarily in the area of contaminated vaccines and injections used as a way to spread disease, I would like to discuss a few of the legends associated with this research. I found the legend associated with the infected oranges to be particularly interesting. While I would not consider myself a proponent of the psychoanalytic approach, I find the linkage between oranges as being symbolic for humans interesting, primarily because when one is taught to give an injection, the typical way to practice is with an orange. Perhaps that is why oranges, above all other possible foods which could be contaminated, are the ones found in this legend. Of course, without knowledge of the popularity or propensity of this particular fruit in the region, this is mere speculation.

Additionally, I found the brief mention of the "Virgin Cure" legend interesting, not only because of the information it provides, but also because it serves as yet another case of how our own research and what we see in the media can become a "fixed" text instead of demonstrating the dynamic process of folklore. There is always the danger that when we study a specific group, especially a group which may not be studied again, that our observations become the basis of stereotypes about the beliefs of those people, which is, of course, not our intention.

Sivelä's study demonstrates some of the major concerns amongst vernacular health scholars, including the stigmatized vernacular, the dynamic process of folklore, and the importance of public

health campaigns which focus on the individual and community, meeting them where they are instead of where they want them to be.

Works Cited

- de Vos, Gail. 1996. *Tales, Rumor, and Gossip: Exploring Contemporary Folk Literature in Grades 7-12*. Westport, Connecticut: Libraries Unlimited.
- Goldstein and Shuman. 2012. "The Stigmatized Vernacular: Where Reflexivity Meets Untellability". *Journal of Folklore Research*, 49: 2 (113-126).
- Goldstein, Diane. 2004. *Once Upon A Virus: AIDS Legends and Vernacular Risk Perception*. Logan, Utah: Utah State University Press.
- Kitta, Andrea. 2012. *Vaccines and Public Concern in History: Legend, Rumor, and Risk Perception*. Routledge.
- Sobo, Elisa. 1995. *Choosing Unsafe Sex: AIDS Risk Denial Among Disadvantaged Women*. Philadelphia: University of Pennsylvania Press.
- Wilson, Anika. 2012. "Of Love Potions and Witch Baskets: Domesticity, Mobility, and Occult Rumors in Malawi." *Western Folklore* 71:2. (149-173)
- _____. 2008. " 'There is No Secret Under the Sun': Rumors, AIDS Beliefs, and Prevention Strategies of Wives in Rural Malawi." Doctoral Dissertation, University of Pennsylvania.

**Alan Whiteside &
Given Mutinta**

*University of KwaZulu Natal,
South Africa*

Jonas Sivelä's article, "Infected Condoms and Pin-Pricked Oranges: An Ethnographic Study of AIDS Legends in Two Townships in Cape Town" is a deeply interesting ethnographic study from two townships in Cape Town. Tellingly, Sivelä's study notes, "Contrary to the impression I had gotten from previous studies and media coverage that reported townships filled to the brim with one "myth" more bizarre than the other, I was surprised (and ashamed to say, disappointed) by how well my informants were informed about the disease and its clinical properties."

In his fieldwork, he found "clear variations in how people talked about the disease; they did not always focus on hard, clinical facts. The same person, who had just given me her fresh, and seemingly accurate, insights into the medical dimensions could ... say something that clearly stood out ... [that] government-distributed condoms had purposely been contaminated with HIV." He says "these crumbs started to form identifiable shapes of narratives and striking similarities with the AIDS legend corpus started to appear. The repertoire of these legends was, however, astonishingly narrow." The article focuses on two types of legends that stood out from the discourse surrounding HIV/AIDS: infected condoms and a variety of pin-prick legends that imply people are being purposely infected with HIV-infected needles or unwittingly by infected fruit.

HIV and AIDS myths and legends certainly fuelled the epidemic in South Africa by allowing people to ignore messages on how to protect themselves and their partners or excuse risky behavior. Sivelä's article addresses important issues by exploring what is embodied currently in the HIV and AIDS myths.

He understands the context. In 2011, an estimated 5.6 million South Africans were living with HIV and AIDS. In the same year, 270,190 South Africans died of AIDS-related causes (Statistics South Africa 2012). This statistic makes South Africa the worst affected country in the world. Prior to the roll out of treatment, sickness, death, and funerals had become a huge part of daily life, particularly in the townships. Making sense of this epidemic was difficult for the ordinary people.

South Africa is fortunate to have an exceptionally strong research community and a wealth of writing on the epidemic. Research has ranged from bench science to economics and has included quantitative and qualitative methodologies. This may be why there were few "legends."

Sivelä's conclusion that HIV and AIDS legends are used by people as strategies of maintaining control of their self-esteem and dignity in the crossfire of risk, fear, denial, and a complex political history, is important. It is a worthy addition to the small body of ethnographic research that highlights new areas of HIV prevention to be addressed (see, for example, Leclerc-Madlala 2002; Hunter 2004; Visser 2012, and Chazan 2008).

Sivelä's findings show that HIV and AIDS "myths" are human and social phenomena which need an appropriate

method of analysis. So-called myths, or legends as he classifies them, can be best studied using an ethnographic approach that deals with social interactions, behaviours, and perceptions that occur within groups, teams, organisations, and communities.

As Sivelä discusses, it is the cultural aspects that are most uncomfortable for South Africans. This was seen in the Mbeki lead denial (in which the President argued that HIV did not cause AIDS and poverty was the major issue for Africa) that has been extensively documented (Nattrass 2012; Fourie 2006; Cullinan and Anso 2009).

In 2000 when the Mbeki response first emerged, one of the authors of this contribution (Whiteside) co-wrote a book with Clem Sunter aimed at the South African public, *AIDS: The Challenge for South Africa*. The cover stated "On the issue of HIV / AIDS, the majority of South Africans can be divided into two broad categories: those who bury their heads in the sand and deny that the epidemic exists and those who believe that it exists but they cannot do anything about it." The text of the book included boxes with "Myths" and "Reality." For example:

Myth: Condoms don't work because the virus can pass through the latex, and anyway they fail.

Reality: The virus cannot pass through the latex. If condoms are used properly, consistently, and are South African Bureau of Standards (SABS) approved, they provide close to 100 per cent protection. (Whiteside and Sunter 2000, 34).

Whiteside, an economist, and Sunter, a captain of industry, thought this would bring clarity. These authors believe that

collecting and communicating accurate information is the key to understanding and fighting the HIV and AIDS epidemic. They were wrong. As this article shows, thirty years into the HIV and AIDS epidemic, misconceptions surrounding HIV and AIDS and its transmission are still present.

The lack of a comprehensive understanding of the nature of HIV and AIDS myths is due to researchers' failure to use appropriate methodologies to explore the phenomena of HIV and AIDS myths. The few existing studies on HIV and AIDS myths are predominantly underpinned by quantitative and qualitative methods or both, and neglect participant observation when using qualitative research techniques (Jewkes et al. 2006; Evian 2006; Dickson 2012). This article begins to address the gap.

Increased use of ethnographic research into HIV and AIDS myths can provide rich, holistic insights into South Africans' views and actions, and the location they inhabit. Ethnographic research helps social scientists document the culture, the perspectives, and practices of the people in their settings that sustain and nurture HIV and AIDS myths. These can only be understood when researchers directly engage with the South African communities they are studying. Through ethnography, researchers could 'immerse' themselves in South African communities, and generate a richer understanding of the subtleties of their myths.

Even if Sivelä's article has rich and detailed understanding of the link between human and social behavior with HIV and AIDS myths, it is incomplete if there are no efforts to use

the ethnographic scientific research for practical applications so as to enhance the fight against the HIV and AIDS epidemic. Ethnographic researchers should translate their research into action, helping to further understand and find practical responses to the HIV and AIDS myths and epidemic. And this sadly is where most ethnography falls short.

Sivelä's findings show the importance of investing in ethnographic research within South African academia, government, and civil society: to inform policy and implementation with ethnographic and locally legitimate evidence on HIV and AIDS myths. The capacity for ethnographic research is virtually non-existent in much of South Africa.

It is also important to address research-policy communications gaps. A key to bridging Sivela's research and policy is to increase the accessibility of his findings through rapid and wide dissemination to all stakeholders by means of a variety of media channels. Therefore, a primary question should be, to what extent will Sivelä's findings be disseminated apart from publication in *Cultural Analysis*? Researchers such as Sivelä need to recognize the role of, and join forces with, proven effective linking mechanisms in South Africa such as civil society organizations (CSOs), the private sector, and the media. The implementation gap needs to be addressed, and links must be forged between researchers like Sivela, street-level bureaucrats, and CSOs.

In order to maximize his chances of policy impact, Sivelä and ethnographers in general should recognize how they can be proactive. First, they can develop a detailed understanding of

the policymaking process, the nature of the evidence they have and all the other stakeholders involved in the policy area who can help to get their findings across. They could develop an overall strategy for the work by identifying political supporters and opponents; keep an eye out for and be able to react to policy windows; ensure the HIV and AIDS myths evidence is credible and practically useful; and seek to build coalitions with like-minded groups in South Africa. Secondly, ethnographic researchers should be tactical by getting to know and work with the policymakers; build long-term interventions of his research; communicate effectively; use participatory approaches; and identify key networkers. Being tactical is a basic ethical requirement of anyone who does this type of research, but when it deals with a challenge like AIDS it is morally necessary.

Finally, as Southern Africans, we note with satisfaction that Sivelä found fewer AIDS legends than he expected. We suspect that with treatment being available people's preoccupations are with poverty, unemployment, hunger, and shelter. The interesting project for the future is to make sense of how the epidemic could be leveraged to build social cohesion and a better society.

Works Cited

- Chazan, May. 2008. "Seven 'Deadly' Assumptions: Unraveling the Implications of HIV / AIDS Among Grandmothers in South Africa and Beyond." *Ageing and Society* no. (28): 935-958.

- Cullinan, Kerry and Tom Anso. 2009. *The Virus, Vitamins, and Vegetables: The South African HIV/AIDS Mystery*. Cape Town: Jacana Media.
- Evian, Clive. 2006. *Primary HIV/AIDS Care*. Malaysia: Jacana.
- Fourie, Pieter. 2006. *The Political Management of HIV and AIDS in South Africa: One Burden Too Many*. London: Palgrave Macmillan.
- Hunter, Mark. 2004. *Masculinities, Multiple Sexual Partners, and AIDS: the Making and Unmaking of Isoka in KwaZulu-Natal*. Durban: Natal Archives.
- Jewkes, Rachael et al. 2006. "A Cluster Randomized-Controlled Trial to Determine the Effectiveness of Stepping Stones in Preventing HIV Infections and Promoting Safer Sexual Behaviour Amongst Youth in the Rural Eastern Cape, South Africa: Trial Design, Methods and Baseline Findings." *Tropical Medicine & International Health* no. 11(1): 3–16.
- Joint United Nations Programme on HIV / AIDS (UNAIDS). 2010. *Report on the Global AIDS Epidemic 2010*. Geneva: UNAIDS.
- Leclerc-Madlala, Suzanne. 2002. "Youth, HIV / AIDS and the Importance of Sexual Culture and Context." *Social Dynamics* no. 28 (1): 20-41.
- Nattrass, Nicole. 2012. *The AIDS Conspiracy: Science Fights Back*. Columbia: Columbia University Press.
- Statistics South Africa (SSA). 2012. *Evaluation of HIV and AIDS. Statistics South Africa*. Pretoria: SSA.
- Visser, Paul. 2012. *HIV and AIDS Myths*. Cape Town: South Africa.
- Whiteside, Alan and Clem Sunter. 2000. *AIDS The Challenge for South Africa*. Cape Town: Human and Rousseau Tafelberg.