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Steven Robins^a

^a Department of Sociology and Social Anthropology, University of Stellenbosch, Matieland, South Africa

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Foot Soldiers of Global Health: Teaching and Preaching AIDS Science and Modern Medicine on the Frontline

Steven Robins

This article investigates the ways in which global health messages and forms of health citizenship are mediated by AIDS activists in rural South Africa. It focuses on how these activists and treatment literacy practitioners are not only concerned with changing the lives of people living with AIDS to better manage biological conditions associated with their seropositive status, but also with how they are also committed to recruiting new members into their biopolitical projects and epistemic communities. These mobilization processes involve translating and mediating biomedical ideas and practices into vernacular forms that can be easily understood and acted on by the “targets” of these recruitment strategies. However, these processes of “vernacularization” of biomedical knowledge often occur in settings where even the most basic scientific understandings and framings of medicine cannot be taken for granted. This ethnographic case study shows that global health programs and their local mediators often encounter “friction” from the most powerful national actors as well as the most marginalized local ones.

Key Words: activists; global health; HIV/AIDS; mediators; translation; treatment

STEVEN ROBINS is an Associate Professor in the Department of Sociology and Social Anthropology at the University of Stellenbosch. He has published on a wide range of topics including the politics of land, “development,” and identity in Zimbabwe and South Africa; the Truth & Reconciliation Commission; urban studies; and most recently on citizenship and governance. His recent book titled *From Revolution to Rights in South Africa: Social Movements and Popular Politics* (in press) focuses on globally connected social movements, NGOs, and CBOs that are involved in democratic struggles over access to AIDS treatment, land, and housing. He may be reached at the Department of Sociology & Social Anthropology, Private Bag X1, Matieland 7602, South Africa. E-mail: robins@netactive.co.za

INTRODUCTION

When you drive through Lusikisiki in the Eastern Cape Province of South Africa¹ after the rains you are struck by the green rolling hills, the healthy looking cattle grazing in the village pastures, and the endless fields of maize. For those in the know, the extraordinary biodiversity of the area is as impressive as the rolling hills and the maize fields. This high rainfall and fertile part of the picturesque Wild Coast distinguishes it from so many other communal areas in South Africa that regularly experience drought. But the statistics show that not all is well in the Xhosa-speaking rural villages of Pondoland. The district, like so many parts of South Africa, has an extremely high HIV infection rate of above 25 percent. It also has a severely under-resourced provincial health department.

As we drove past Lusikisiki's provincial hospital, St. Elizabeth's, Herman "Themba"² Reuter, the *Médecins Sans Frontières* (MSF) doctor responsible for Lusikisiki's HIV/AIDS program, pointed out the shacks that served as the accommodation for the hospital's nursing staff. Further on we passed old shipping containers that comprised the main Lusikisiki Village Clinic. Dr. Reuter spoke about the enormous capacity and resource problems facing the Eastern Cape health system and the difficulties of attracting and retaining nursing staff in such contexts. More than 50 percent of the hospital posts were not filled because of these problems. Only dedicated, or lethargic, health professionals were prepared to remain in this deep rural part of the Eastern Cape Province. The lack of HIV policy on antiretrovirals (ARVs) did not deter the 30-something doctor, who immediately set about training nurses, local Treatment Action Campaign (TAC) volunteers, and counselors on HIV/AIDS treatment and voluntary counseling and testing. A few months later, a cohort of well-trained and committed health workers was ready to embark on treatment.

By the time the South African government finally agreed to "rollout" a national antiretroviral program in October 2003, this rural MSF clinic was prepared to embark on ARV treatment. It soon became recognized internationally as one of most successful rural ARV sites in Africa. In 2006, MSF handed over to the Eastern Cape Department of Health an exceptionally successful community and nurse-driven ARV program. This extraordinary experiment in primary health care and community empowerment emerged from a partnership between MSF, a globally connected NGO; TAC, a national social movement; and the provincial department of health. In the course of establishing this program, new forms of health citizenship and AIDS activism emerged. This article tracks how MSF sought to mediate ideas and practices of global medicine in Lusikisiki as well as the obstacles it encountered. It investigates how MSF drew on AIDS

activists and treatment literacy practitioners to translate and mediate the ideas and practices of global medicine in a rural setting where competing cultural and religious understandings of illness and treatment clashed with the universalist discourses of biomedicine. This case study draws attention to some of the limits and obstacles encountered by these activist mediators of biomedical technologies and biomedical citizenship.

The Lusikisiki case study discussed below investigates the work of AIDS activists who mediated global health messages and forms of health citizenship. These activists wanted to change the lives of people living with AIDS so they could better manage biological conditions associated with their seropositive status as well as to recruit new members into their biopolitical projects and epistemic communities. Their mobilization processes involved translating biomedical ideas and practices into vernacular forms that could be easily understood and acted on by the “targets” of these recruitment strategies. However, these processes of translation and “vernacularization” of biomedical knowledge often occurred in settings where even the most basic understandings and framings of medical science could not be taken for granted. The Lusikisiki case study shows that global health programs and their grassroots mediators often encounter stiff opposition from the most powerful political actors as well as the most marginalized.

MSF'S MEDIATORS OF GLOBAL MEDICINE

In recent years, a number of observers have written about the dramatic expansion of antiretroviral therapy in Africa and elsewhere in the Global South. Vihn-Kim Nguyen (2005), for example, described “antiretroviral globalization” in Africa as an intervention on a scale similar to that of colonialism. Similarly, I have written elsewhere about how AIDS activists in South Africa have become part of a global health movement that has introduced new ideas about rights to health care as well as new forms of health citizenship (Robins 2004). This article is concerned with how AIDS activists in a rural village in South Africa mediate these global biomedical interventions. It focuses on how AIDS activists, as “true believers” of AIDS science and medicine, seek to “convert” rural villagers into acceptance of the fundamentals of “AIDS science” through recourse to rhetorical strategies that are not that dissimilar to those deployed by Christian missionaries (see Niezen 1997; Turner 1995). Similar to the missionaries before them, AIDS activists and health professionals all have to resort to persuasive arguments and translations that resonate with local idioms and discourses on illness and healing.

Like most forms of globalization, the processes of embedding and translating biomedical discourses in particular places are anything but

straightforward or stable. Former South African President Thabo Mbeki's dissident science position on AIDS,³ as well as the Gambian president's claims to use "seven herbs named in the Koran" to cure AIDS (Cassidy and Leach 2007), suggests that the global hegemony of "Western" medicine and science is often vulnerable to challenges from political and religious leaders (see Nattrass 2007; Fassin 2007; Robins 2004; Epstein 2007). Similarly, the increasing involvement of international health agencies in health programs in the south has periodically unleashed backlashes from governments claiming that these humanitarian interventions represent "foreign interests" and constitute threats to national sovereignty.

Examples of challenges to global medical hegemony include an extraordinary series of South African government objections to mainstream biomedical and scientific truth (Robins 2004; Fassin 2007; Nattrass 2007). This has tended to take the form of a knowledge politics in which senior officials, primarily the president and his health minister, have contested the findings of the scientific establishment for instance by challenging statistics on AIDS mortality and morbidity, and questioning the efficacy and safety of ARVs. It has also taken the form of the government support for scientific trials and the promotion of "African solutions" for AIDS such as Virodine (an industrial solvent), "traditional medicines" such as *Ubejane*, and an "alternative diet" of garlic, lemons, African potatoes, and olive oil advocated by former Health Minister Manto Tshabala-Msimang. These challenges to scientific orthodoxy have occasionally taken on the form of anti-imperialist and anti-racist rhetoric and arguments about the imposition of Western hegemony and the undermining of the national sovereignty of African countries (Fassin 2007).

These national-level challenges to global biomedicine also often connect in complex ways with local expressions of distrust, skepticism, and opposition to Western medical interventions. These responses are often based on alternative indigenous understandings about the causes of illness; for instance, African beliefs in witchcraft (Ashforth 2001; Rodlach 2006; Epstein 2007). They may also involve consumer preferences for alternative and complementary treatment such as traditional African medicine, New Age treatment, or homeopathy. This rejection of the scientific authority and claims of global biomedicine were also evident in the former South African minister of health's support for Matthias Rath, an AIDS dissident and wealthy multivitamin manufacturer who claimed that ARVs were dangerously toxic and who promoted his own products as cures for HIV/AIDS.

In Africa, there are many examples of both individual government officials and citizens' suspicion of the motivations of practitioners and advocates of Western science and biomedicine (Robins 2004). These responses

include a plethora of conspiracy theories and popular myths about the dangers of modern medicine ranging from resistance by Islamic clerics in West Africa to Western immunization programs to the promotion of “alternative cures” for HIV by political leaders and self-proclaimed healers in South Africa and The Gambia (Nattass 2007; Cassidy and Leach 2007). In South Africa, official challenges to the findings of the mainstream scientific establishment have also involved direct government interference in the architecture and institutional arrangements of key medical bodies. This has included government attempts to influence the composition and positions of the South African National AIDS Council, the Medical Research Council, and the Medical Controls Council.

Some of the most visible clashes between government officials and AIDS activists have been in international forums such as AIDS conferences. These public conflicts have generally occurred between government officials, especially the health minister and TAC and MSF activists. They have also involved UNAIDS’ outspoken representative Stephen Lewis and, to a lesser degree, officials from the Global Fund and other international funding organizations. While much of the attention of the media and scholarly analysis has focused on the global and national stage—for instance, in terms of the controversial AIDS positions of the former President Mbeki and his former health minister—less is understood about the national and local dimensions of global AIDS interventions in South Africa.

There seems to a strong link between national level AIDS politics and the obstacles encountered by activists and health workers at the clinic level (Dr. Herman Reuter, personal communication, Lusikisiki, 2004). There is, for instance, considerable evidence that confusion about the safety of ARVs and the causality of HIV have contributed towards difficulties in convincing South Africans to participate in voluntary counseling and testing and ARV therapy programs. The relatively low uptake of HIV services in certain provinces reflects these ongoing difficulties that health workers, NGOs, and activists encounter on a daily basis. Whereas the African National Congress local government and provisional leadership in the Western Cape Province actively supported MSF and TAC campaigns for the provision of ARVs in the public health sector, the political leadership in most of the other provinces was far more “loyal” to what they perceived to be the president’s position on HIV/AIDS. For example, prior to 2003, Eastern Cape and Mpumalanga provincial political leadership vehemently opposed TAC and MSF activists and health professionals who advocated for ARV programs. These national and provincial political battles were played out at the local clinic level in the Eastern Cape and Limpopo Provinces and elsewhere in the country.

AIDS activists and health professionals operating at the clinic level also encountered numerous social and cultural obstacles. As a result of

the entrenchment of patriarchal cultures, especially in the rural areas of the former homelands, women often do not have autonomy to decide for themselves whether to test for HIV or whether go on ARV therapy should they require treatment. Whereas my earlier research focused on the individual agency and rights-based politics of AIDS activists (Robins 2004), the case study discussed below highlights some of the social and cultural limits on individual agency. These constraints are discussed in relation to attempts by MSF and TAC activists to broker and translate global biomedical messages in local settings where there are deeply entrenched alternative conceptions of illness and agency.

BIOMEDICAL FOOT-SOLDIERS IN LUSIKISIKI

In 1971 a small group of French doctors and journalists established MSF in response to the perceived inadequacies of humanitarian responses to the Biafran war in Nigeria. This new humanitarian organization, unlike the International Committee of the Red Cross, strove to be fully independent and to not limit itself through the conventions of state boundaries. By 2006, MSF had grown into a massive humanitarian organization that had field missions and advocacy positions in 83 countries and over 1,500 expatriate and 13,000 national staff.⁴

Typically, MSF intervenes in contexts defined by the breakdown in state health and welfare services, often precipitated by war, famine, population displacement, disease, drought, and natural disasters. Generally these interventions involve providing emergency health and welfare services to meet physical survival rather than providing more long-term needs. This form of medical intervention is characterized by the “humanitarian kit”—a mobile repository of medical logistics designed for rapid action in the field (see Redfield 2007). Redfield also described MSF’s *modus operandi* as an evolving tradition of *temoignage* (witnessing) in which NGOs “now play a central role in defining secular moral truth for an international audience” (Redfield 2006:3). This form of collective advocacy and “motivated truth” aims to leverage resources and shame states and international agencies into action in settings demanding immediate humanitarian aid. Redfield argued that by integrating medical expertise and public advocacy, MSF participates in producing scientific and technical knowledge that can be used for ethical ends.

MSF’s response to AIDS in South Africa fits in with the overall ideology of the organization. From the start, MSF’s aim was to catalyze, and perhaps shame, the South African state into action by showing that it was indeed possible to provide ARVs to people living with AIDS in Africa. MSF’s

Lusikisiki project, like its partner project in Khayelitsha in Cape Town, was integrated into the country's public health system at the primary health care clinic level. It was specifically designed as a short-term intervention that would be handed over to the Department of Health after three years. However, by establishing ARV programs in South Africa, MSF was committing itself to more long-term involvement than its more typical short-term modes of humanitarian intervention.

In October 2003, the national department of health gave the green light for MSF to provide ARVs in Lusikisiki; on December 10, 2003, ex-President Nelson Mandela officially launched the program. By mid-2006, less than three years later, approximately 2,500 people had been started on ARVs, and 46,039 had been tested (MSF 2006:4). The program's treatment success rates were recorded in medical journals and celebrated at international AIDS conferences, and Lusikisiki received considerable positive attention in the national and international media. This extraordinarily successful community and nurse-driven AIDS program involved voluntary counseling and testing, condom distribution, prevention of Mother-to-Children Transmission of HIV, HIV/TB integration, and ARV therapy. It included doctors, pharmacists, nurses, adherence counselors, pharmacy assistants, community caregivers, support groups, community clinic committees, activists, and people living with HIV/AIDS. The October 2006, the MSF report on Lusikisiki described the workings of this innovative decentralized antiretroviral therapy program and the various roles of the health staff.

The traditional model of community care givers is to do community-based health promotion. In Lusikisiki they work in the clinics, taking on some of the nurses' workload (including voluntary counseling and testing, opening of HIV folders with social history, transferring lab results into folders, conducting support groups). Given the nature and magnitude of the HIV epidemic, it is critical to educate service users to empower them to take responsibility for their own treatment, rather than relying on the community health worker going to the community to enforce directly observed therapy. Defaulter tracing is done by support group members who come from the same rural village as the person who missed their appointment. These support group members are appointed by the adherence counselors and are given training on approaches to ARV adherence. (MSF 2006: 11)

The Lusikisiki program involved a close partnership between the state's public health system and TAC, a social movement. This partnership represented a significant departure from typical humanitarian interventions, which tend to be defined by sudden population displacements or disease outbreaks in which the immediate goal is to arrive on site as rapidly as

possible with sufficient equipment to be effective (Redfield 2007:4). By working closely with both a social movement and the state, MSF was able to redefine its usual mode of operation, and it became increasingly involved in longer-term processes of policy engagement and program implementation. MSF and the TAC were also able to leverage access to state health resources by legally challenging the pricing and patent protocols of the global pharmaceutical industry as well as by deploying the South African Constitution to legally challenge the state for its initial refusal to provide ARVs in the public health sector. These forms of legal activism and social mobilization contributed to the emergence of new forms of health citizenship that have migrated beyond AIDS activism. In addition, the culture of health activism that emerged from MSF's programs has also diffused into the broader society and public health system.

From Brussels to Khayelitsha to Lusikisiki

In an interview a few years ago, Dr. Eric Goemaere from MSF-Belgium told me about his first attempt in 1999 to persuade South African Department of Health officials to establish a national antiretroviral treatment program. His meetings with department of health officials in Pretoria went nowhere. It became clear quite early on that no political commitment for establishing such a program existed. Government's arguments against treatment included the high cost of ARV drugs and assertions by some senior members of the political leadership that these drugs were toxic and ineffective. Given the lack of government interest in such an initiative, Dr. Goemaere decided to visit Cape Town for a few days before returning to Belgium. It seemed to be a clear-cut case of "mission unaccomplished." However, in Cape Town he met Zackie Achmat, a Cape Town-based AIDS activist from the newly emerging social movement, Treatment Action Campaign. After many TAC media campaigns, demonstrations, and court cases, the global pharmaceutical industry was eventually convinced that defending intellectual property rights and brand drugs was not only morally flawed but also detrimental to profit margins. Later, as a result of concerted AIDS activist campaigns, the courts ordered the South African government to provide ARV drugs to pregnant mothers to prevent the transmission of HIV from mothers to children. In October 2003, with the anti-AIDS drugs prices dramatically reduced as a result of successful campaigns spearheaded by MSF and TAC, the South African Government finally agreed to establish a national ARV program.

The success story of South African AIDS activism provides insights into the workings of global health citizenship in the 21st century. However, focusing on this extraordinarily heroic account of a David and Goliath

struggle against the might of “Big Pharma” and the South African government can also obscure the more mundane aspects of the fight against the pandemic. The following account describes the story of how ARVs arrived in Pondoland.

Bringing ARVs and Hope to Pondoland

ARVs were seen as a key aspect of HIV care as it is an extremely effective intervention that can be targeted in a relatively small group of the community, thus creating a sense of optimism in an otherwise depressive atmosphere of the worsening HIV epidemic. ARVs are also medically speaking the best intervention as treatment OIs [opportunistic infections] improves the quality of life; however it is only ARVs that really extend life. (MSF 2004: 3)

Before I was very weak and sick. I was a skeleton. I weighed only 43 kgs. I didn't know what was wrong with me. I went to the [Lusikisiki] clinic and they told me I have HIV. Then, my CD4 count was 24. Today, I am 66 kg and my CD4 is 375. (Nozibele Mditshwa, one of the MSF program's first ARV patients, upon receiving her certificate for treatment adherence; Health-e News Service, 31st October 2005).

When MSF doctors and nurses and TAC activists began their ARV treatment “trial” in 2000 in the Xhosa-speaking working class township of Khayelitsha in Cape Town, they were fully aware that they faced a daunting challenge. Government and public health skeptics seemed to have concluded that the public health system would not be able to implement what was portrayed as an unaffordable, complicated, and inappropriate “First World” AIDS treatment regimen. By implementing an ARV program in an urban African context, MSF doctors and nurses hoped to challenge this claim. As the findings of the studies of the efficacy of the Khayelitsha program began to be released, it became clear that ARVs could work in Africa (Coetzee et al. 2004). Skeptics were still not satisfied. The next problem they posed was whether it would be possible to replicate an urban-based ARV program in a rural site. Influential public health professionals and academics argued that a dysfunctional and under-resourced public health system, along with rural poverty and inadequate sanitation and poor nutrition in most rural areas, meant that the Khayelitsha antiretroviral therapy program could not be reproduced in most parts of the country. Whereas the former health minister's prescriptions of garlic, African potatoes, and olive oil as alternatives to ARVs could be dismissed on strictly scientific grounds, the dire conditions in underdeveloped rural areas had to be taken seriously. It was with this in mind that MSF and TAC identified the Eastern Cape Province health district of Lusikisiki in Pondoland as their first rural ARV site.

MSF's first line of attack at Lusikisiki was opportunistic infections. Prior to the arrival of MSF, nurses knew extremely little about HIV/AIDS, and had no training on treating people with HIV with the drugs already in their clinics. As Dr. Reuter, the MSF doctor at the Lusikisiki clinic explained to me, patients who presented typical HIV symptoms were typically sent back to their home villages and told to prepare themselves for death. With the arrival of MSF, clinic nurses were empowered with knowledge and drugs to treat thrush and a range of other opportunistic infections. This created a new sense of confidence among nurses, volunteers, counselors, and ordinary villagers. Suddenly HIV/AIDS was no longer a death sentence. Treatment of opportunistic infections dramatically altered popular perceptions about AIDS. Even though ARVs were not yet available in the local hospitals and clinics, there was a palpable sense of hope amongst AIDS activists and health professionals. Nurses were learning that it was possible to treat HIV/AIDS, and those diagnosed with HIV were no longer seen as the "walking dead." By the time the national government announced its national ARV treatment program in October 2003, Lusikisiki health workers were trained and ready.

Fast-forward to February 2004 and a group of Lusikisiki HIV counselors discussing their experiences working in the area. Many of these HIV-positive counselors spoke of the initial disbelief among villagers when they began to publicly disclose their status. Villagers claimed that the MSF counselors were paid to say they were HIV-positive. How could they be HIV-positive when they looked so healthy? The treatment of opportunistic infections had created a dilemma for these counselors. As one counselor recalled of her early counseling sessions: "Some of the villagers would say to me, 'You look so fat and beautiful, and your skin looks so smooth, how can we believe that you have this thing?'" Another counselor based at St. Elizabeth Hospital spoke of how a taxi load of HIV-positive Umtata residents who had heard about MSF's treatment program arrived at Lusikisiki demanding to be treated: "Dr. Themba [Reuter] examined them, gave an appropriate prescription for their problems but told them that they should go back to Umtata and demand ARV treatment from Umtata clinics which are designated ARV sites." For MSF the problem was no longer that of challenging the government over AIDS policies, but rather applying pressure on the state's public health services to ensure that treatment policy was implemented properly.

The accounts from the counselors reveal that the treatment of opportunistic infections had contributed significantly toward breaking the silence and stigma surrounding HIV/AIDS. Dr. Reuter, the nurses, and the counselors all spoke of the dramatically increased demand for treatment from Lusikisiki residents. The demand for AIDS testing, too, was up, as was

the treatment of opportunistic infections. TAC treatment support groups were flourishing and HIV-positive T-shirts were visible in the streets of Lusikisiki town. This relative openness was largely the result of MSF's policy of encouraging disclosure in their counseling approach. Before someone was tested they were asked to whom they would disclose their status.

Another catalyst for this open attitude toward HIV/AIDS in Pondoland was the Cape Town "Stand Up For Our Lives" march on Parliament in 2003. A large contingent from the newly formed TAC branches in Lusikisiki came back from the Cape Town march highly motivated and aware that they were part of a national social movement. Many of the key HIV-positive TAC activists realized that their personal experiences were similar to thousands of other South Africans. They were no longer alone. In just over a year, Lusikisiki had been transformed from a place where HIV/AIDS was a taboo topic to a place where hundreds of HIV-positive people were open about their status and flocking to the clinics. Rather than promoting the protection of privacy and confidentiality about HIV, MSF and TAC chose to push the disclosure line. All this took place in a rural setting portrayed by government officials as characterized by conditions of chronic poverty, illiteracy, and ignorance. Government and public health skeptics had assumed that these were insurmountable obstacles to the implementation of ARV programs.

Post-apartheid South Africa provided MSF with an ideal opportunity to challenge mainstream biomedical and public health approaches to HIV/AIDS in the Third World. The emergence of TAC as a grassroots social movement created the conditions for MSF's empowering vision of health citizenship. TAC's massive support base also provided MSF with the necessary political legitimacy and credibility to intervene in addressing HIV in South Africa. This NGO-social movement partnership was extremely effective in rural Lusikisiki and elsewhere in the country. Whereas MSF has often had to appear neutral and non-partisan, the conditions in South Africa, and its partnership with a relatively militant social movement, obliged the NGO to take on a more overtly political stance. Given TAC's civil disobedience campaigns, court cases, and street demonstrations, MSF could not afford to treat its South African mission as "business as usual."

Shortly after starting to provide generic ARVs to patients in the beginning of 2003, successes already emerged. After three months on ARVs, Bomikazi, a young woman who was asked by her stepfather to leave his house because she had become too sick for him to look after her, was healthy and had found employment. She had a partner again after many months of being too ill to even think about sex. Together with Dr. Reuter, we visited Bomikazi at her mother's "RDP" house in Joe Slovo, a new, low-income housing community on the outskirts of Lusikisiki town. Bomikazi

told us how she was extremely ill when she arrived at the clinic. She tested HIV-positive, and after she disclosed her status to her family she was given her own plates and utensils with which to eat. When we met her, she lived with a supportive sister. Bomikazi asked Dr. Reuter whether it would be wise for her to have a baby with her new partner. This triggered a lengthy and lively discussion on whether it made sense to get pregnant with a man she had only known for three months: Would her new boyfriend stick around once he knew she was both pregnant and HIV-positive? Bomikazi responded that she wanted a child even if it meant she would end up raising the child on her own. In any case, most of her female friends raised their children on their own. The conversation covered topics such as men who avoided family responsibilities upon pregnancy, as well as issues such as domestic violence, secrecy and disclosure, trust, and strategies for achieving gender equality in relationships. Dr. Reuter was interested to know whether TAC helped young women navigate their way through this gendered battleground. It appeared that while young women such as Bomikazi were more empowered than their mothers, gender inequality was still deeply entrenched and part of everyday life in Pondoland.

These conversations between Dr. Reuter and his patients revealed an approach to HIV that went well beyond conventional biomedical practice. This approach challenged the aura of expertise, authority, and paternalism that characterizes most public health encounters between doctors and nurses and their patients. Engaging openly with issues of gender relations, sexuality, marriage, and pregnancy helped break down the traditional hierarchies and barriers between the health expert and the passive and docile patient. This seemed to explain the successes of the Lusikisiki program. But could this approach be replicated in more conventional public health settings? Skeptics had reluctantly acknowledged that ARV therapy could work in urban centers such as Cape Town and Johannesburg, but remained doubtful whether these could work in conservative rural communities. MSF's decision to start an ARV program in rural Eastern Cape attempted to challenge this skepticism.

Choosing Pondoland as the second MSF ARV site was bound to be an enormous challenge. Yet the program has been judged a success by a number of program evaluations and studies (Coetzee et al. 2004), even after MSF handed over the project to the Eastern Cape Department of Health in 2006. Similar programs are also succeeding elsewhere in South Africa, including its rural areas. MSF's decision to opt for a nurse and community-driven treatment approach was a key factor in the successes at Lusikisiki and Khayelitsha. This did not prevent treatment skeptics from questioning whether an overstretched and under-resourced public health system could implement nurse-driven antiretroviral therapy programs.

Although it is still too early to know the long-term results of the national antiretroviral therapy program, it would seem that aspects of MSF's decentralized community and nurse-driven approach have indeed been successfully replicated, with adjustments, elsewhere. However, as the case study below indicates, numerous constraints and challenges have been encountered when MSF and TAC activists have sought to mediate and translate the global discourses of medicine and health citizenship in the rural villages of Lusikisiki. Clearly, antiretroviral therapy is not a straightforward traveling technology or magic bullet that can be seamlessly implemented in diverse local settings across the globe.

GROUNDING "ANTIRETROVIRAL GLOBALIZATION": A CASE STUDY OF ANTIRETROVIRAL THERAPY AS A "TRAVELING TECHNOLOGY"

In 2003, together with a small group of TAC and MSF activists from the small rural town of Lusikisiki, I visited a village headman from Mboyti, a Xhosa-speaking rural village in the Pondoland area of the Eastern Cape Province. The purpose of the visit was to convince the Mboyti headman, and through him the local chief, of the urgent need to embark on AIDS awareness campaigns and prevention and treatment programs in his village. Although the headman was not at his homestead when we arrived, we were able to talk to his wife. Following an introduction by one of the MSF activists, the headman's wife responded by claiming that it was completely inconceivable that villagers would take the risk of publicly disclosing their HIV-positive status. She was visibly shocked when the MSF activist pointed out that most of the MSF and TAC activists in front of her were living openly as HIV-positive people. Living openly with HIV was not something that she had ever imagined was possible. While this had become quite common in Khayelitsha Township in Cape Town where MSF and the Western Cape Department of Health had established a community-driven antiretroviral therapy program, for the wife of the Mboyti headman, and many others in rural South Africa, this possibility seemed absurd. It became clear that the standardized public health messages about voluntary counseling and testing, CD4 counts, viral loads, HIV prevention, ARVs, health rights, and disclosure had not yet reached these Pondoland villagers.

During my stay at Mboyti, I learned that none of the villagers I spoke to knew that the internationally acclaimed MSF-run antiretroviral therapy clinic could be found just 15 kilometers from their village. This observation, which I conveyed to the MSF doctor, Dr. Reuter, had prompted the MSF and TAC activists to visit nearby Mboyti. A young man working at the

upmarket holiday resort at Mboyti had told me that his own family members regularly went to Durban to buy traditional medicines (*muti*) to treat illnesses, including AIDS. Although this young man had been exposed to AIDS awareness campaigns at his school, he did not know that an AIDS treatment program was available in nearby Lusikisiki.

The MSF program at Lusikisiki had been established at a time when the South African government was vehemently opposed to AIDS treatment. Like the Khayelitsha program in Cape Town, MSF were able to establish the antiretroviral therapy program in Lusikisiki by presenting it as a "scientific trial." As was mentioned earlier, until 2003, the government had vigorously opposed calls from MSF and TAC activists for a national ARV program. It was within this anti-ARV context that MSF established the first rural based AIDS program in South Africa. However, it was not only government opposition to ARVs that MSF and TAC activists had to contend with. In addition, these rural areas were characterized as places where the widespread use of traditional medicines and alternative conceptions of illness threatened to undermine biomedical approaches to HIV/AIDS. Activists also encountered conservative cultural and religiously based ideas about gender and sexuality that presented obstacles to their AIDS awareness and sex education campaigns in rural Pondoland.⁵

Accounts of the daily practices and experiences of South African AIDS activists in rural Pondoland draw attention to the difficulties of translating the "HIV scientific truths"; i.e., ideas associated with global health programs about HIV transmission, prevention, and treatment. These epistemological and cultural challenges are of course not unique to Pondoland or South Africa. A number of anthropologists have written about the tensions between biomedical and "lay" or indigenous interpretations of illness and healing. However, few have investigated the rhetorical strategies of activists as brokers of biomedicine. There are of course a number of studies that have focused on the role of missionaries as mediators and translators of modern medicine. For example, writing about the Cree of the James Bay region in northern Quebec, Ronald Niezen (1997) compares biomedical interventions among indigenous peoples in Canada with religious conversion and the imposition of Christian beliefs among these colonized peoples. He describes the various ways in which "medical evangelism" undermined indigenous Cree ideas and practices relating to illness and healing. Whereas Christian missionaries and medical evangelists depended on some degree of indigenization in their mediations of modern medicine (Kleinman 1980; Comaroff 1985), the independent medical administrations that followed on their heels resorted to prohibition and more coercive methods of persuasion "to attempt to transform native behavior into a more consistent reflection of biomedical belief" (Niezen 1997:464). In some respects, AIDS activists in

South Africa can also be seen as medical evangelists. In rural Pondoland, AIDS activists drew on rhetorics of persuasion that were similar to those deployed by medical evangelists in Canada and other former colonies.

The AIDS dissident debate, the questioning of the efficacy and safety of ARVs by the president and the health minister, and a range of “AIDS myths,” obliged TAC and MSF activists to acknowledge and respond to lay interpretations of illness. These locally embedded lay explanations included the blaming of AIDS on witchcraft; the discussion of AIDS conspiracies and beliefs, for instance, that AIDS was invented by “whites” who want to limit black population growth; the belief that doctors and nurses inject patients with AIDS when they go for tests; the conviction that free government condoms are laced with HIV-infected “maggots”; the idea that pharmaceutical companies seek to create markets for their drugs in Africa; the suggestion that Africans are used as guinea pigs for scientific experiments with AIDS drugs; the myth that sex with virgins, including infants, can cure AIDS; and the insinuation that antiretrovirals are dangerously toxic (Robins 2004). This plethora of popularly held “AIDS myths,” as well as the stigma, shame, and silence associated with AIDS, has contributed toward widespread AIDS denial. It is within this generalized context of AIDS myths, folk epistemologies, and denialism that MSF and TAC activists attempted to deploy scientific authority and rhetorics of persuasion to promote the objectives of HIV/AIDS programs.

The discussion below is based on fieldwork done during visits to the MSF program in Lusikisiki. It focuses on the role of MSF and TAC lay counselors and treatment literacy practitioners who sought to mediate scientific discourses on HIV in the rural villages of Pondoland. These pedagogical interventions hoped to produce “scientific” ways of understanding the body, disease, sexuality, and treatment. These forms of medical activism, it will be argued, reveal important insights into the globalization and localization of these discourses on science, medicine, and citizenship.

MEDIATORS OF GLOBAL MEDICINE AND CONTESTED “FACTS”

At a TAC Congress in Cape Town a couple of years ago, a veteran AIDS activist told me that the fundamental goal of TAC was to convert members to “a scientific world view.” This would, he believed, shift people away from attributing illness and misfortune to witchcraft and the ancestors. The treatment literacy practitioners and lay counselors that I met in Lusikisiki appeared to share this absolute faith in science and modern medicine. They seemed unquestioning and unwavering in their belief in the importance of disseminating the “scientific facts” about AIDS to “the masses.” They

themselves had acquired these “facts” during the course of numerous TAC and MSF workshops on AIDS awareness, sex education, and treatment literacy. In addition, a significant number of them had acquired their scientific and biomedical literacy as a result of being HIV-positive and being on ARV therapy.

Notwithstanding their deep commitment to the “scientific facts” about HIV and AIDS, activists encountered numerous obstacles and challenges during their daily attempts to implant these “facts” in the hearts and minds of residents in the small towns and rural villages in which they worked. These obstacles included age and gender hierarchies and sexual taboos. For example, local teachers questioned the scientific knowledge and authority of these youthful AIDS activists, especially young women who spoke about sex, condoms, AIDS science, and biology. Older people were particularly offended by “sex talk” from young people. For instance, activist educators found it difficult to identify culturally appropriate words for genitalia and sexual intercourse. Other challenges came from members of the community who questioned the actual existence of HIV and AIDS and who attributed illness and death to sorcery and witchcraft (*umthakati*). Some claimed that what activists and health workers referred to as HIV/AIDS’ opportunistic infections were simply pneumonia, diabetes, or tuberculosis, and that these were therefore “not new diseases.” Similarly, certain opportunistic infections and HIV-related illnesses were identified as *twasa*, which was widely understood as being a sign that the ill person had been chosen by the ancestors to become a *sangoma* (diviner). The following section examines the experiences and rhetorics of conversion deployed by two TAC activists, Anna and Sipho.⁶ Although global health programs can be seen as standardized global assemblages, the responses of the mediators and targets of these programs can contest the truth claims of these biomedical discourses. Like the Christian missionaries before them, in the face of skepticism and alternative conceptions of illness and healing, activist mediators of these biomedical discourses strive to develop convincing, scientifically based arguments and rhetoric.

Latter-Day Livingstones and the Gospel of Global Medicine

These accounts of village workshops, discussions, and arguments about science, medicine, ancestors, and witchcraft resonate with the well-known narrations of Dr. Livingstone’s attempts to convince African chiefs and rainmakers that it was God, rather than the ancestors, that delivered rain, well being, and health. In the cases below, AIDS activists deployed the authority of science and medicine, rather than God, to fight a pandemic widely attributed to ancestors, witchcraft, and other “non-scientific” causes.

Activists such as Anna fought these epistemic battles by drawing on the authority of science and medicine as well as their personal experiences and testimonies of illness, treatment, and the harrowing passage from “near death” to “new life” (see Robins 2006). As Anna told me, “In my work as a treatment literacy practitioner, I preach the gospel of AIDS prevention and treatment based on my own experiences.”

Contrary to the universalistic and decontextualised scientific language of mainstream public health discourses (e.g., family planning, and AIDS education manuals, curricula, and guidelines), the specificities of gender, age, and education influenced the encounters between AIDS activists and community members in Lusikisiki. For example, Anna, an HIV-positive Xhosa-speaking woman in her 20s, spoke of how, during the AIDS awareness workshops at schools, some teachers challenged her about her knowledge of science and biology: “Sometimes they’re kind of confusing you. . . . They’re happy when you don’t understand more biology than them. They only want to prove the point that they know more about biology than you.” These age, gender, and educational barriers were especially visible when it came to “sex talk.”

Anna: Ja, we do have that challenge more especially when you go to the rural areas where you cannot teach old men how to use condoms because they will tell you “You’re not going to teach me how to have sex with my husband or my wife. How can you teach me about sex because you’re so young, it’s really unacceptable?” . . . When I use penis in Xhosa I say *ipipi*. Then elders say “No, you’re not supposed to say that.”

Critics of medicalization in the global South (i.e., developing world) posit the existence of all-powerful and hegemonic Western biomedical discourses that seamlessly colonize the consciousness of Third World people. By contrast, my discussions with activists such as Anna reveal that they experienced concerted challenges “from below” in the course of their treatment literacy and AIDS awareness workshops and discussions with villagers. There appear to be myriad ways in which the power of science and medicine was contested in places like Pondoland. For instance, Anna spoke of how she attempts to convey the “scientific facts,” which include references to HIV transmission, viral loads, CD4 counts, the immune system, drug regimes, and resistance. These “facts” were mediated through accounts of her own experiences as an HIV-positive woman who uses ARVs. She conceded, however, that not everyone was persuaded by these “facts.” Alternative explanations of illness included claims that opportunistic infections such as shingles were either due to stress or *twasa*, a condition believed to be a sign that the ancestors wanted the ill person to become a *sangoma* (diviner).

Anna: Ja, ja, there are people who don't believe in HIV and AIDS. They will tell that you that if you've got shingles it's because you've got stress, and that people who always get shingles are the same people who always have stress and that it's not AIDS.... If you're losing weight, you've got shingles, and you've got peripheral neuropathy and you don't want to wear shoes because your feet are always paining, people will always tend to think that you are *twasa*. We tell them if you've got these opportunistic infections then you can go and become a *sangoma* [diviner] but at least go to the clinic and do HIV tests and see what the results are. Then, if your results are positive it means you've got HIV, you're not a *sangoma* [laughter].

It was also quite common for people to refuse to believe that activists and treatment literacy practitioners such as Anna were themselves HIV-positive. As many AIDS activists explained to me, it was often said that they looked too healthy to have AIDS and that they were being paid by NGOs to make false claims about their status (Phumzile Nwagi, personal correspondence, Cape Town, 2006). In addition, many discussions focused on claims that symptoms of opportunistic infections such as diarrhea and physical wasting were in fact a result of witchcraft and the actions of jealous neighbors. Anna claimed, however, that the increasing availability of AIDS treatment made it easier to persuade ill people to go to the clinics for testing. Yet, if clinics were overcrowded, understaffed, and at some distance from peoples' homes, villagers would tend to seek help from *sangomas* and *iinyanga* (traditional healers) instead.

Anna: People [in Lusikisiki] were denying that there is this virus because they wanted to believe that they have been bewitched and they were saying it was from *ukudlisa*, which is like being poisoned. And they wanted to believe that because when you're being bewitched or poisoned, you're getting thin and you have got a running stomach and then it's really similar to the opportunistic infections of HIV. But now people are starting to go to the clinic to do voluntary counseling and testing.

Sipho, who is in his 20s and is a Xhosa-speaking TAC activist in Lusikisiki, attributed this rejection of the "scientific facts" to elders' beliefs in ancestors, witchcraft, and the efficacy of traditional medicines (*muti*). According to Sipho, they were also extremely suspicious of doctors and modern medicines, and claimed that "whites are the people trying to kill us coming here with their pills."⁷ By contrast, the younger generation, according to Sipho, subscribed to modern science and medicine. Sipho recalled how he grew up exposed to his grandparents' and neighbors' profound skepticism and suspicion of modern medicine and "modern diets." The elders, he claimed,

blamed these modern drugs and foods for making the younger generation weak and susceptible to illness.

Sipho: The grandmothers and grandfathers don't want any person to take the ARVs or any tablets from the hospital. When I was young I wasn't fed eggs and drinking milk, I was eating maize only. The old people told us that eggs and eating the nice food of the whites every day is why we're getting sick.... They tell us that the HIV is coming here because we're eating eggs, eating cheese and everything, that's why we're getting sick. "If you're getting sick, *umtwanam* [my child], I can't take you into hospital. The only thing I can do is go into the forest and dig for roots and make *muti*. This can make you strong, rather than using the tablets."

Both Anna and Sipho concluded that rural villagers in Lusikisiki resorted to traditional healers and *sangomas* because they did not have easy access to clinics and medicines, or because the nurses were rude and disrespectful toward patients. This, they argued, increased the numbers of those who turned to traditional healers for help. Anna thought that better resourced and more accessible clinic services would bring more the patients to the clinics, and ultimately win them over to "scientific medicine."

Sipho and Anna spoke extensively about "AIDS myths" that circulated in Lusikisiki. These included the belief that sex with a virgin could provide a cure for AIDS by allowing the infected person to expel the virus through sex. This belief also mitigated against the use of condoms, which would "block" the expulsion of the virus. Sipho tried to convince people in Lusikisiki that the virus was not confined to the penis. He did this by pointing out that HIV tests were done by taking blood from the finger or some other part of the body.

Sipho: There are other bad stories about youth who think if you have sex with a virgin, if you're HIV positive, the HIV is going out.... Some believe it but we tried to tell them that the virus is in the whole body, it's not in the penis. Because they think the HIV and AIDS is staying in the penis [and] not going anywhere else. Because they think that's why, if you have sex without a condom, you think the virus is not staying in the vagina and the penis. It can go out. But we convince them, no man, if this thing is living in the penis, why if you're going to test your blood, maybe the drop of blood is taken from your finger, then you test positive. If ever this thing was staying in your penis or in the vagina I think the blood test should be done in the vagina or the penis.

Steven Robins (SR): So they have a very different understanding of the disease, where it is located and how it works.... How do you explain what the virus is?

Sipho: We try to tell the people, the virus is like a germ. Then we're living with a germ in the body....

Sipho was convinced that the major obstacle to scientific understanding in Lusikisiki was the backwardness of the traditionalist elders, a theme that he repeated throughout our discussions. It is also quite plausible that Sipho's positing of a generational divide—between modern, scientifically literate youth and traditionalist elders—is also reflective of a sharp rural-urban divide in terms of access to health resources. Rural areas tend to be at a significant disadvantage when it comes to the availability of trained staff and access to medicines and equipment.⁸ This may account for the widespread use of traditional healing in rural areas. Although TAC activists such as Anna and Sipho appear to subscribe to a totalizing scientific worldview that has no place to “things traditional,” it is not inconceivable that, were they to experience difficulties in accessing to modern medicines, they, too, could be driven to seek the services of traditional healers. TAC's stridently scientific worldview could perhaps be described as a form of “techno-fundamentalism.” This could result in TAC activists being reluctant to acknowledge in interviews or at TAC branch meetings that their beliefs and behaviors, like those of “the elders,” may not always conform to a strictly scientific rationality.⁹ In the face of government lethargy in relation to supporting AIDS treatment, as well as AIDS dissident thinking within government and unsubstantiated claims by traditional healers that they can “cure AIDS,” TAC and MSF activists seemed to be driven towards an intransigent techno-fundamentalist position in relation to AIDS science.

The political fallout surrounding HIV/AIDS was a serious obstacle to the spread of the “scientific facts” in Pondoland, as it was in other parts of South Africa. Anna and Sipho blamed former President Mbeki and the former health minister for “confusing people.” Anna mentioned that some people in Lusikisiki interpreted the health minister's “anti-AIDS” nutritional diet of African potatoes, garlic, lemon and olive oil, as an alternative to “dangerous ARVS.” Anna's mother, who was a nurse in Lusikisiki, was sympathetic to the former health minister's “African solutions.” As a result Anna was given this “*muti*” when she became seriously ill as a result of HIV. She was also sent conventional allopathic medicines by her uncle, who at the time was a senior official in the department of health. Anna eventually confronted her mother, and subsequently joined TAC and was selected for the MSF antiretroviral therapy program in Lusikisiki. Her own life experiences as a person living with AIDS infused her approach to AIDS awareness and treatment literacy programs. The excerpt below draws attention to the highly personalized, and at times quite improvised, rhetorics of persuasion and evidence that are deployed by activists in their responses to skepticism toward medical science, ARV treatment, and AIDS messages.

Anna: Yes, some people are saying that they don't believe in HIV and AIDS because it's the president who's saying that [it doesn't exist]. What we always do is to educate them about HIV. . . . But when they ask about the African potato and stuff, obviously I won't have good answers for that because I'm not sure. But the only thing I always say is, "I'm sure what antiretrovirals are doing because I'm using antiretrovirals. So that's the only thing I can tell you about." . . . I cannot just say, "Go and use garlic because it's good." It is not approved [so] I cannot promote that. . . .

SR: . . . How do you deal with people who say nutrition is more important than ARVs?

A: Ja, I tell them that I agree that nutrition is important, but nutrition doesn't lower the viral load in the body. Nutrition can boost your immune system, but when we deal with the virus, then we deal with the viral load as well as the CD4 count. And that's when you need nutrition and you need treatment. And then, let's say you've got esophageal thrush, it's not easy to eat because you are in pain. Then that's where you need treatment to treat esophageal thrush so that you can be able to eat. That is why I strongly believe that they work hand in hand, they work together, you need nutrition and you need treatment, you see.

Sipho also spoke about the widespread skepticism, questioning, suspicion, rumors, and open opposition that he encountered in response to his treatment literacy and "safe sex" messages. He also spoke of popular beliefs that government condoms were contaminated with "maggots"¹⁰ and HIV, a topic that was widely discussed amongst clients at *shebeens* (taverns).¹¹

Sipho: . . . In my location there's a tavern where young girls are drinking beer and brandy and they get into love with older people who are maybe HIV positive. . . . They often say that if you have sex with a condom you're wasting your time. Both the men and the women say they don't want condoms. They will say, "No, I want flesh to flesh." The other one's telling you "You can't eat a sweet with the paper wrapping. I want flesh to flesh." They will tell you it's nice to have sex without a condom. But I tell them the condom is protecting you not from the virus only, but even from pregnancy, because some of the girls are teenagers but they already have two children. . . . People are also saying the free condoms from government have maggots. . . . They say it's better to not use condoms because they are scared of these [government] condoms. My brother was telling me, it's better to use a plastic bag than to use a condom from the government. . . . If you're HIV positive, you have the virus but you may not have AIDS. You are living with the virus. But most people think that if you are HIV positive you already have AIDS and you're going to die immediately. . . .

Sipho also claimed that the churches in Lusikisiki were generally unsupportive of AIDS activists' attempts to make people more aware of HIV

and AIDS and treatment. Like beliefs in witchcraft, Christian religious ideas presented barriers to HIV/AIDS and sex education efforts in Lusikisiki. Far from being part of a biomedical juggernaut, activists seeking to mediate these AIDS messages encountered constant questioning and resistance in their daily encounters with villagers in Pondoland; religious beliefs, witchcraft, AIDS conspiracy theories, and myths all contributed towards this friction to the dissemination of biomedical truth.

Sipho: The churches here also don't understand [HIV and AIDS] easily. . . . I was trying to educate the church elders about HIV and they told me, "This is a church, don't talk like a sinner because here we are praying for each other each and every day. If you're getting sick come in front and pray, God can help you no matter what happens." Last month the reverend died of AIDS. No one from the church wanted to attend the funeral because he died badly, from AIDS. AIDS is a big disgrace in this place. . . . A big reverend [in Lusikisiki] said "I'm not feeling good about going there. If I attend this funeral God can punish me." . . . So we need to destroy this discrimination. . . .

What these interviews do not indicate is that those who are not "true believers" of medical science may indeed experience profound ambivalence and uncertainty toward scientific explanations of HIV and ARV treatment. For instance, given that not all those who undergo ARV treatment survive—one in six people on ARVs in Lusikisiki die—people in places such as rural Lusikisiki watch closely for signs of treatment success or failure (Jonny Steinberg, personal communication). There appears to be an agnostic and experimental attitude toward both modern medicine's "magical drugs" and the claims of traditional healers and diviners. In other words, people in places like Lusikisiki do not necessarily fully buy into either, and instead may demand concrete, observable evidence of their efficacy. For instance, whereas nurses in Lusikisiki diagnose shingles as an HIV-related opportunistic infection, it is widely believed that shingles as the result of witchcraft, i.e., it is believed that a snake sent by a witch has slid across the torso of the afflicted person, and this results in shingles (Steinberg, personal communication). If the nurses are seen to be able to effectively treat shingles, and another person with shingles goes to an *inyanga* (traditional healer) and is not cured or dies, then the popular interpretation could be that nurses and doctors have more powerful *muthi* (traditional medicine) than the traditional healers and diviners. People living in areas of high HIV prevalence often closely observe and follow the progress or regression of those who go onto ARVs. For example, when an HIV-positive person who is asymptomatic becomes visibly ill because of antiretroviral therapy's side effects, this often leads to lay interpretations that the drugs brought there by "the whites" are dangerous and toxic. If a seriously ill person is

seen to go through a Lazarus-like recovery as a result of ARVs, this can dramatically shift the balance of power between modern medicine and traditional healing. Clearly, rhetorics of persuasion deployed by AIDS activists and health workers require the production of both sound arguments and hard evidence. These mediators of global health are also called upon to embed the “scientific facts” within local conceptions of truth, knowledge-power and evidence.

CONCLUSION

While some critiques of biomedicine envisage Third World people as docile subjects of totalizing Western medical and scientific discourses, this article illustrates that that public health interventions and grassroots health activism can, under certain conditions, produce new forms of political agency and active citizenship. These forms of agency may include rejections or reinterpretations of biomedical discourses as well as the embrace of its scientific explanations and technologies. For instance, the expansion of the global reach of biomedical discourses and products in the global south has generated rejections and suspicion of Western medicine as well as the promotion of new desires and expectations amongst the Third World poor who are increasingly demanding that they too deserve access to life-prolonging medical technologies. Similarly, the “conversion” of people living with AIDS into activists and “true believers” of modern science and medicine can be understood as evidence of the potentially empowering consequences of access to biomedical resources. Of course, not all biomedical encounters produce these forms of agency and empowerment.

Although the global expansion of biomedicine in the global south has been taking place for decades, the “antiretroviral therapy revolution” has dramatically extended biomedicine’s reach. This has been facilitated through the massive injections of resources from international agencies such as the Global Fund, PEPFAR, and UNAIDS. In addition to these global health resources, there has been a dramatic expansion of globally connected health social movements such as TAC. These social movements, together with NGO allies such as MSF, mediate these new biotechnologies and forms of health citizenship in ways that can, under certain conditions, contribute toward the promotion of innovative forms of agency, citizenship, and solidarity. But this is clearly not a seamless narrative of scientific and biomedical progress and citizen empowerment. As this article demonstrates, activist mediators of biomedicine regularly encounter small acts of resistance in their daily attempts to disseminate “scientific facts” and “medical solutions.”

The article contends that AIDS activists from MSF and TAC can be seen as part of a modernist vanguard of foot soldiers responsible for mediating global discourses on biomedicine, science, rights, and responsibilities. They can also be seen as cultural translators and catalysts for the creation of globally connected epistemic communities and new forms of solidarity and social belonging among people living with AIDS. Although the long-term outcomes of these activist interventions are far from predictable, this article illustrates the problems with assumptions by some critics who bemoan the “medicalization” of the Third World via an all-powerful AIDS industry that is seen to produce docile and depoliticised biomedical subjects. Instead, the Lusikisiki case study suggests that the scientific authority of the activist “foot soldiers” of modern medicine, sexual education, and public health is often fragile and routinely contested. This contestation, it would seem, is particularly visible in places like Pondoland, situated as they are in the heart of the rural periphery of southern Africa.

These TAC and MSF AIDS activists are of course not the first wave of modernist reformers to embark on sexual education in Pondoland. In *Reaction to Conquest*, a path-breaking ethnography of Pondoland published in 1936, Monica Hunter (1936: 180–86) described the partial successes of attempts by Christian missionaries to outlaw premarital sexual practices of Mpondo youth.¹² Family planning, AIDS prevention, and sex education materials and interventions have become remarkably globalized and standardized since the colonial era interventions of the Christian missionaries that Monica Hunter writes about. Yet, like the first wave of Christian reformers, today’s reproductive health and HIV practitioners also have to take cognizance of the small acts of resistance to these conversion processes. Not surprisingly, the biomedical ideas and practices associated with the forms of health citizenship promoted by MSF and TAC continue to encounter “friction” in the rural hinterlands of South Africa and beyond.

NOTES

1. Lusikisiki, with a population of 150,000, is part of the Qakeni Local Service Area (health district) in the Eastern Cape Province. It is one of the poorest areas of one of the poorest provinces in South Africa. Up to 80 percent of the population live below the poverty line (defined as household expenditure of R800 per month). (MSF 2006: 3). For an excellent account of the 19th and early 20th century history of Pondoland see Monica Hunter’s (1936) *Reaction to Conquest*.
2. Themba, the name given to Dr. Reuter, means “hope” in isiXhosa.
3. It also necessary to bear in mind that most ANC leaders, and those of its trade union and Communist Party alliance partners, do not necessarily share the president’s dissident views on AIDS.

4. See Redfield (2005, 2006) for excellent accounts of the emergence MSF and its evolving ideas and practices.
5. During my visit to Lusikisiki I also attended a MSF and TAC sex education workshop. At the workshop, an openly gay AIDS activist from East London shocked the moral sensibilities of the young, mostly female and heterosexual group of Xhosa-speaking AIDS activists by regaling to them accounts of homosexual practices that most of them never knew existed. As a woman told me afterwards, "I am completely traumatized." A lesbian activist attending the workshop told me that if she were to be open about her lesbianism in Lusikisiki's rural villages she would probably be killed for being *umthakati*, a witch. The East London visitor departed leaving many of the activists dazed and bewildered. There is probably a significant difference between doing AIDS activist work and sex education in rural Lusikisiki and the more cosmopolitan urban townships of Cape Town, Durban, and Johannesburg. Yet, even in "liberal" and cosmopolitan Cape Town, lesbian and gay couples are attacked for being open about their sexual orientation, and a young TAC AIDS activist was killed in 2005 by her rapist after she revealed her HIV-positive status. AIDS activists, it would seem, are mediators of potentially dangerous and empowering knowledge about sexuality and sexual rights.
6. These are not their real names.
7. It is possible that this skepticism of science and modern medicine is connected to forms of neo-traditionalism associated with "Red" and "School" orientations amongst Xhosa-speakers (see Mayer and Mayer 1971). It is also likely that this skepticism and suspicion is being fuelled by the president and his health minister's questioning of mainstream AIDS science and their claims that anti-retroviral drugs are toxic. The turn to "traditional medicine" and "alternative therapies" by the health minister, and her tacit support of Dr. Matthias Rath's vitamin "solution" is probably also fuelling these local responses.
8. Similar disparities in access to health resources exist between provinces, with the Western Cape Province being considerably better resourced than the Eastern Cape (Chris Colvin, personal correspondence).
9. These activists' mastery of the basics of AIDS science and treatment literacy allows them to be modern subjects rather than docile objects or 'targets' of biomedicine. Yet, this access to scientific and biomedical literacy and subjectivity need not necessarily preclude them from appropriating the same "traditionalist" beliefs and practices they attribute to "the elders."
10. During a visit with MSF and TAC activists to a Lusikisiki tavern to demonstrate the femicondom, a number of inebriated clients told us that if you poured hot water into the condom you could see these "maggots." It appears that they were referring to the lubricant in condoms.
11. In September 2007, 20 million government condoms had to be recalled as a result of the nationwide distribution of "reject condoms." The government's decision followed allegations that quality control officials were bribed to pass these flawed contraceptives. This has no doubt heightened fears and suspicions about government condoms.
12. Hunter (1936: 180–86) wrote, "Girls between the ages of 8 and 12, and boys between 9 and 14 begin to go to *izitshotsho* or *amagubura*, gatherings of unmarried girls, boys, and young men, for dancing and sweetheartening (*ukumetsha*). The young people of one small local district... gather in the evening and sing, then pair off to sleep together. The couple lie in each other's arms, but the hymen of the girl must not be ruptured. If it is, the boy responsible is liable to a heavy fine.... Alongside the Pondo law and custom governing the relations of unmarried persons are another set of ideas introduced by Christian missionaries. The churches have condemned *ukumetsha*, and forbid their members to allow their children to attend young people's dances. Children of church members do not normally attend dances, but *ukumetsha* is commonly practiced among them...."

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