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Article (Accepted Version)

Mills, Elizabeth (2017) 'When the skies fight': HIV, violence and pathways of precarity in South Africa. *Reproductive Health Matters*, 24 (47). pp. 85-95. ISSN 0968-8080

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When the skies fight: gender, HIV and pathways of precarity in South Africa¹ Elizabeth Mills

1. Introduction

"It's like when the skies fight, when the clouds are angry and dark. They crash into each other and lightning flies across the sky. You never know where the lightning is going to hit. That's what it's like with HIV." (Zama, 2011)

The rain collected and dropped down the windscreen as Zama and I sat in the car talking outside the office where she worked as an HIV treatment literacy facilitator. We had known each other for eight years, but it was only now that she started to tell me how she acquired HIV. As Zama spoke about her younger self and the men she had had sex with without feeling that she could say no, without knowing how to say no, without believing she had the right to enjoy sex, I was struck by the clanging dissonance between the studies I had read and the lives I had subsequently come to know.

Diagnosed with HIV in 2001, Zama started taking antiretroviral (ARV) therapy in 2002. Following concern about ARVs toxicity, as the former South African President Mbeki had claimed (cf. Gevisser, 2008), Zama's positive embodied experience of ARVs prompted her to join a large-scale social movement calling on the South African government to provide ARVs through the public health sector. This movement was spearheaded by a coalition of organisations in which the Treatment Action Campaign (TAC) featured most prominently, and it was shaped by people like Zama and other women presented in this article.

I conducted the ethnographic research on which this article is based, in 2010 and 2011. The ethnographic findings are rooted in South Africa's historic struggle for ARVs, and grew out of a longstanding political and medical anthropological research focus on the biopolitical antecedents of South African citizens' struggle for life, and health, across the apartheid and anti-apartheid eras in the apartheid and post-apartheid struggle for life (Geffen, 2010). While the findings speak to this longer political and research history, they also represent a departure from ethnographic studies of ARV programmes that were situated in the time lag between the international development of HIV medicines in 1996 and their distribution through national health systems (Geffen, 2010). From a tightly circumscribed focus on the politics of life linked to HIV medicines, the ethnography broadened its focus onto HIV-positive women's everyday lives in post-apartheid South Africa. This article focusses, in particular, on the politics of life that inhere around HIV-positive women's embodiment of and resistance to structural and interpersonal violence.

In writing this article on gender, violence and HIV in South Africa, I recognise that the starting place for ethnographic research matters:

"If you start from the 'negative minimalisms' (Thin 2008: 149) of sheer survival and bare life, of violence, suffering, deprivation, and destitution, then you provide a very different description of lives than if you begin from people's situated concerns... [O]ur tendency to focus on the dystopic has been at the price of forgetting to think about 'other ways of thinking' — supposedly this is what anthropologists do best." (Marsland, 2012: 464) The ethnography in this article takes people as its starting place. While the findings call attention to women's embodied and chronic struggle for life against a background of pernicious structural and interpersonal violence, they also reveal the

¹ Acknowledgement: I wish to acknowledge the academic support of Dr Hayley MacGregor and Prof Melissa Leach. Thank you, Nondumiso Hlwele, for your invaluable insight and research support. I thank all the people I came to know during my fieldwork, for letting me into their worlds, and for coming into mine. The research was funded through a Commonwealth Scholarship and the Oppenheimer Memorial Trust.

nuanced ways that women strategically resist and reconfigure violent structures and relationships. Structured across two sections, the findings in this paper trace the connections between structural and interpersonal violence; they suggest that these forms of violence are interlinked and that women's embodiment of direct forms of interpersonal violence, like gender-violence, cannot be divorced from broader dynamics that fuel structural violence.

Structural violence, a concept originally formulated by Johan Galtung (Geffen, 2010) refers to the harm people experience when social structures or institutions prevent them from meeting their basic needs. Galtung's definition and subsequent analyses (Le Marcis, 2012, Vale and Thabeng, 2016, Cluver et al., 2015) point to the violence generated by social arrangements that put people in harm's way. *'The arrangements are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people.'* (Galtung, 1969) While revealing HIV-positive women's struggle with the political and economic organization of their social world and the way in which they embodied this organization as structural violence (through, for example, the state's refusal to provide essential ARVs), the findings also discuss women's direct experience of violence through interpersonal relationships. In this article, the term 'interpersonal violence' specifically denotes violence against women (VAW) (although it is widely recognised that interpersonal violence affects all sexes and genders, and particularly those people who do not follow normative and socially-constructed gender and sexual codes) (cf. Farmer, 1996). This article follows the United Nations' definition of VAW as 'any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life'.²

The findings articulate two 'pathways' through which HIV becomes embodied. These pathways reflect the intersection of structural and interpersonal violence; this intersection is denoted, in this paper, through the concept of precarity: *"[Precarity designates] that politically induced condition in which certain populations suffer from failing social and economic networks of support ... Such populations are at heightened risk of disease, poverty, starvation, displacement, and of exposure to violence without protection"* (Fassin, 2007, Biehl, 2005). I use the concept of precarity for two reasons: first, it foregrounds the uneven effect of structural violence on different populations; and second, it highlights the relationship between multiple forms of violence and the way they become embodied. In her early writing on precarious life, Butler (1969) argues that the narrative construction, by international media, of 'terrorists' after the 9/11 attacks worked to render people 'less than human' by failing to acknowledge their vulnerability; in her later writing on gender, performance and precarity, Butler suggests that while vulnerability refers to a particular condition, the term precarity speaks to the mechanics that coalesce to create conditions of 'maximised vulnerability' (Farmer et al., 2006: 1686) I use the term precarity, rather than vulnerability, in order to pan out from women's very real embodiment of violence, to draw attention to the broader workings of inequality and (bio)power that come together to reinforce structural and interpersonal violence. In doing so, the findings reveal that women are not only subject to multiple forms of violence but also active agents who strategically navigate their embodied precarity.

2. Methodology

"[E]thnographic engagement can help us chart some of the complex and often contradictory ways in which neoliberalizing health structures, moral economy, and biology are forged in local worlds where biotechnology and structural violence now exist side-by-side" (Biehl, 2004: 125).

² <http://www.un.org/documents/ga/res/48/a48r104.htm>; accessed November 2015.

This article is based on multi-sited ethnographic research in 2010 and 2011 that I conducted in South Africa and Brazil in order to locate South Africa, and the lives of the people with whom I worked, in a regional and global terrain. I used visual and participatory tools in order to move away from privileging what is said and to move closer towards a more layered understanding of the quieter and perhaps less visible spaces of people's lives.

In conducting an ethnography to explore shifting embodied and political subjectivities, I was aware that, as Whyte (2009) cautions, I would run the risk of masking the complexities of lives lived beyond a single identity – as 'HIV-positive', 'woman', 'on ARVs'. Further, I was conscious that I needed to not only look at how people made claims and secured resources by mobilising particular identities, but that their embodied subjectivities may also speak to deeply rooted forms of structural violence. As Whyte argues, "There is a danger that we lose sight of the political and economic bases of health in our concern with identity, recognition, and the formative effects of biomedical and social technology" (Jewkes and Morrell, 2012, Butler, 2004b, Lalor et al., 2016). The findings in this article speak to these broader dynamics, including structural violence, that expand beyond a singular focus on HIV and they draw specifically on ethnographic research with people living in Khayelitsha, a semiformal housing area that lies across 45 kilometers of the Cape Flats in the Cape Town Metropole district of the Western Cape Province. According to a 2011 study, almost 62% of Khayelitsha's residents had migrated from the Eastern Cape, seeking to access better health care, education, employment opportunities, and especially in search of life-saving ARVs for themselves and their sick children.³

In addition to participant observation, informal conversations and life history interviews, I used a set of visual research methods including participatory photography and film, and actor network mapping (Butler, 2009: 2). The participatory photography (2004a) and film (2009) methods entailed providing digital cameras for each of the ten women who formed the core of my ethnography, and working with them to document, for example, where they felt the absence or presence of the state in their lives. All ten women had, at some point in the previous decade, worked with the Treatment Action Campaign (TAC). Their engagement with TAC enabled me to explore their perception of the state linked to their experience of ARVs, and to draw comparisons across the group and with the broader sample (I conducted an additional 40 interviews with people on ARVs, and 20 interviews with policy makers, activists and academics in Brazil and South Africa). All the women in this core group were employed: six women worked with uYaphi, a company that made paper mache bowls; two worked as researchers with an HIV organisation; and two were treatment literacy practitioners with a community media company. In conjunction with participant observation, I used actor network mapping; this entailed working with a set of visual methods, at times, in conjunction with life-history and narrative interviews in order to develop a fuller sense of the women's lives, kinship networks, affective relationships and organisational associations. The ten women in the core group created a set of journey maps (tracing the woman's life from her birth to the present moment), social maps (showing family relationships and the spaces of homes, for example) and digital maps (using Google Earth and layering stories and photographs on to space) (2009). Together, these methods, enabled me to conduct ethnographic research beyond what was said, to understand how meaning is made in and through practices (Dennis Jr et al., 2009, Kolb, 2008, Prins, 2010), senses (Allen, 2012, Poletti, 2011) and space (Kindon, 2009).

³ While it may be located on the periphery of the Western Cape's economic centre – Cape Town's Central Business District – Khayelitsha has played a pivotal role in South Africa's political history. It was the first place where governmental and nongovernmental actors (including the Provincial Department of Health, TAC and MSF) worked together to provide ARVs through the public health sector.

Ethics permission for this study was formally obtained from the University of Sussex. Each of the study participants provided written consent. Through discussions across the research process, the participants expressed how they would like to be represented, which stories should be shared most boldly, and which stories should not be shared at all. While the stories below are accounts that the women were comfortable with me sharing in different public arenas, I have changed everyone's names, and all identifying characteristics have been removed.

3. Pathways of precarity

The principal form of precarity that emerged in my fieldwork relates to women's embodied vulnerability, centring specifically on women's and girls' bodies as corporeal sites of structural and interpersonal violence. This precarity is explored along two interlinked 'pathways' to highlight how HIV moves along social, economic and political fissures, into and between people's bodies and lives. In this respect, I use the term 'pathways' in conjunction with social epidemiological approaches to health in general (Campbell and Gregor, 2004), and to HIV in particular (Cornwall and Gaventa, 2001, Kleinman and Kleinman, 1994). At a broad level, social epidemiological approaches cohere around three areas of focus: psychosocial approaches; the social production of disease and/or political economy of health approach; and ecosocial theory and related multi-level frameworks. The findings reflect the political economy of health approach that 'explicitly address[es] economic and political determinants of health and disease, including structural barriers to people living healthy lives'

The two sections below explore how precarity is borne through the body with HIV entering women's and girls' lives through relational networks that travel both vertical pathways across generations and horizontal pathways between partners. The section on 'vertical pathways' explores the nature of structural violence, and its embodiment in women's lives across generations, while the section on 'horizontal pathways' explores the nature of interpersonal violence, focusing on women's intimate relationships.

3.1. "So my baby gets HIV too": vertical pathways of precarity

Pregnancy followed by the birth, illness and potential death of a child were the metaphorical lightning strikes through which women came to learn of their HIV-status. The women in this study had learnt of their own and their child's HIV status in the late 1990s and early 2000s, before treatment or prevention of vertical HIV transmission (hereafter referred to as PMTCT, prevention of mother-to-child transmission) were available in the public sector. Studies conducted in South Africa prior to the roll-out of PMTCT in 2003, found that up to one-third of all HIV-positive children would likely have died in their first year of life without access to this treatment (Richter et al., 2009).

Despite the government's initial commitment to establish the efficacy of nevirapine, a cornerstone of the PMTCT regimen in resource-poor settings (Galvao, 2005), it refused to make this medicine available in the public health sector (Wemrell et al., 2016, Berkman et al., 2014, Krieger, 2001). An application to remove restrictions on the public provision of nevirapine was brought to the High Court in Pretoria in 2001 by a broad coalition of associations and members of civil society, including the Save our Babies and the Treatment Action Campaign (TAC).⁴ The court case was won, and it was then appealed. Twice. The second appeal was denied and a national PMTCT program was finally initiated in 2003 (Rhodes et al., 2012, Harling et al., 2008). This section illustrates the legacy of the government's failure to roll-out effective PMTCT, and it suggests that this constitutes a form of structural violence that women and their children embody in the present.

⁴ <http://www.saflii.org/za/cases/ZACC/2002/15.html#fn5>

Brenda was born in 1979. In 1999, in the course of her penultimate year at school, Brenda became pregnant. Her partner had told her that he was HIV-positive, but this disclosure held little meaning for Brenda because she did not know about HIV:

“He was the first boyfriend. So we had sex without a condom. At that time I didn’t understand HIV. That was 1999. So my boyfriend [told] me he was HIV positive, but like a joke”.

Brenda’s geographic location in a rural village in the Eastern Cape placed her on the periphery of available HIV information and health services. Without information about the routes that HIV travels, in this case through sex (without condoms) and without treatment to prevent vertical transmission, Brenda was unable to stop the virus from entering her own or her child’s body. Her first child died of HIV.

In 2001 Brenda became pregnant with her second child. During this time she also became seriously ill. Hoping to access life-saving health care for her daughter and her daughter’s unborn child, Brenda’s mother brought her to Cape Town. However, in 2001, PMTCT was not available anywhere in the country and Brenda’s second child, a girl, died in her first year of life.

The pathways that enabled HIV to move into Brenda’s body, and into her first two children’s bodies, illustrate the dynamics of structural violence, linked to social epidemiology and precarity, in two ways. First, in Brenda’s case, she was placed at ‘heightened risk of exposure to disease’ through the failure of the public health system to reach rural areas with essential public health resources (like HIV information, condoms and health care). Second, the state generated ‘politically induced conditions of precarity’ through its failure to provide treatment to prevent vertical transmission from Brenda to her children. Early HIV research in South Africa, among miners for example (Krieger, 2001: n.p.), similarly found that infection was not simply about individual risk but about a broader array of social, political and economic determinants.

Miriam, like Brenda, was born in 1979 and was compelled to stop high school three months before her final examinations in order to take care of her mother. When Miriam returned to her mother’s home, she entered her first sexual relationship and, like Brenda, became pregnant in 1997. Unaware of how HIV is transmitted and unable to access PMTCT, Miriam was also unable to protect herself or prevent her daughter, Nena, from contracting HIV. Nena was born as Miriam’s mother died. Miriam wrote rather than spoke the stories of her younger self in the pages of a diary that moved like an unspoken conversation between her bag into mine. She wrote about shutting down her mother’s home after she gave birth so that she could live in the hospital between the wards that held her mother and her daughter. She wrote of her heartbreak at choosing between her mother’s death and her daughter’s life, and of her decision to take her daughter out of the frail failing clinic in the heart of the Eastern Cape to the medical hub of urban Cape Town, where her daughter received excellent, albeit belated, medical care. Like Brenda, Miriam learnt of her HIV-status when her daughter tested HIV-positive in 1998.

Zama’s nephew, like Nena, was born in the Eastern Cape in 1997. He too was born on the cusp of death, abandoned by his father because the actual cost of his care outweighed, in his father’s mind, the potential of his son’s life. Unlike Nena, he survived because a doctor in the Eastern Cape paid privately for him to access ARVs. His delayed treatment, however, resulted in both physical and cognitive impairments. The ill-health that characterised the beginning of these two children’s lives fundamentally constrains their current and future health and wellbeing. In line with Fassin’s ethnography on embodied memory (Palumbo et al., 2010), these children bear witness to the

persistence of embodied precarity as a result of delayed treatment and the legacy of poor health care in rural South Africa.

3.2. “It’s hard to be a girl in this country”: horizontal pathways of precarity

The proliferation of sexual violence experienced by the women I worked with, and by generations of girls before and after them, moved into sharp relief over the course of my fieldwork. In a cross-sectional study in three South African districts in the Eastern Cape and Kwa-Zulu Natal, researchers interviewed 1738 men aged 18 – 49 years (Nattrass, 2007). This study found that 27.6% of all men had raped a woman or girl; rape of a current or ex-partner was reported by 14.3% of the men; 11.7% had raped an acquaintance or stranger (but not a partner) and 9.7% had raped both strangers and partners. Of all the men interviewed, almost half (42.4%) had been physically violent to an intimate partner (Heywood, 2003). Longitudinal analysis of a cluster-randomised control trial undertaken in the Eastern Cape between 2002 and 2006 with 1099 women aged 15 – 26 years indicated, conclusively, that there was a causal relationship between relationship power inequity and intimate partner violence, and an increased risk of HIV infection among young South African women (Campbell, 1997).

As noted above, in using the concept of precarity, I seek to move away from *describing* women’s ‘risk’ linked to their experiences of violence as vulnerable subjects. I do so in order to make the workings of inequality that shape the kinds of violence that women experience more visible. Therefore, the findings discussed below do not seek to show causality between sexual violence and HIV. Instead, the findings engage in the ‘muddier middle ground’ as women negotiate intimacy and coercion in their sexual partnerships and across generations. Replacing numbers with people, this section also seeks to challenge the hegemonic and ubiquitous discourse that positions poor Black women as ‘vulnerable’ without recognising the nuanced, albeit fraught, strategies that women employ to navigate precarity. This follows de Certeau’s (2007) notion of ‘making do’, as women simultaneously embodied, resisted and performed precarity in complex configurations that challenged linear assumptions of women as either ‘deserving subjects’ or as ‘autonomous agents’ (Jewkes et al., 2009).

3.2.1. An epidemic of rape

When she was pregnant with her third child, Brenda showed me a photograph of her grandmother sitting on a bench outside her home. Her arms were stretched around the small shoulders of her two great-granddaughters. The girls, in frayed dresses with grazed knees, looked blankly at the camera. Brenda touched the screen, tracing the faces of her relatives. Speaking with a tone of urgency, she asked me if I knew of “*that school teacher... the one who’s been in Vukani [a local newspaper] ... who raped 30 children in Khayelitsha? He raped these two girls*”. I put my hand on her hand on the screen still showing her grandmother and nieces, generations that came before and after her; we sat in silence, shoulders touching. Later, she came out of an antenatal check-up saying, “*It’s a boy*”. Travelling back to Khayelitsha, she said, “*I’m glad it’s a boy. It’s hard to be a girl in this country.*”]

As a young girl the same age as Brenda’s nieces, Lilian’s parents left her to live with strangers. Born in Johannesburg in 1972, Lilian spearheaded TAC’s campaign to compel the government to provide PMTCT; she testified on behalf of TAC and her affidavit was used as evidence in the court case. Over time, in 2012, Lilian created a journey map where she documented the journey of her life. Starting forty years earlier, Lilian notes her birth on the top left hand side of the map. Next to this date, she writes of the abuse she endured throughout her childhood, lacking the protection of her parents.

This aspect of Lilian's life generated conditions of embodied precarity that reinforced each other: to combat apartheid's structural economic violence, her parents left her with strangers as they went to find work. Without any protection, Lilian was abused and raped by these strangers and then later, after running away from them, she was raped by relatives. She ran away again, and because she did not have any social or economic resources to draw on, she lived on the streets where she entered an abusive relationship and became pregnant in 1999. Like Brenda's, her baby was very ill and she spent most of the first year of her child's life in and out of hospital until, in June 2000, her baby died. She learnt that she was HIV positive when her child tested positive in 2000.

This story is documented on the right hand side of her journey map, in contrast to and in dialogue with the narrative on the left of the map documenting her embodied vulnerability to rape and abuse in the years leading up to her daughter's birth. On the top right hand side of Lilian's journey map is a photograph of a pregnancy scan, a foetus in profile, pictured in black and white. Next to the image she writes, "Preg[nant] with my daughter". The three photographs below this top image are tiered and mirror the progression of her life into activism. The first photograph is of a waiting room with a woman holding a child. The second photograph is of a grave strewn with flowers, and next to the image Lilian wrote, "Death of my child made me an activist". She drew an arrow connecting this photograph with a third photograph of people lining up in a queue. Next to it she has written "1999. Queing [sic] in cold, to cast my vote, hoping for 'better life'" and along the arrow to the photograph of the grave representing her dead daughter, she has written "only to be disappointed".

This account points to Lilian's belief that the democratic state is intimately entwined with her and her child's capacity to live; the 'politics of life' are iterated by Lilian's conviction that the state should ameliorate precarity by creating conditions for a 'better life', for her child to live without HIV and for herself to live with HIV on ARVs. Her rationale for becoming an activist, therefore, was to challenge the way the democratic state was implicated in her experience of structural violence; the state created conditions of vulnerability through its failure to provide treatment to prevent vertical transmission. Lilian now has a young boy who, she says, is 'living proof' of her work as an activist to challenge the government to end this particular form of structural violence, embodied through her own and her children's vulnerability to HIV, by compelling the government to provide PMTCT.

3.2.2. Eschewing Shweshwe: navigating risk and pleasure

In my sitting room I had a bright red *Shweshwe*-patterned bowl made by Miriam. It held condoms, femidoms and lubricant received from an LGBTQ organisation for free and covered with rainbows and statements like "homophobia is un-African". Knowing about femidoms and condoms, the women in the study were most interested in the lubricant. The women oscillated between wanting the lubricant and not wanting the messages on the packaging. I left it at that, but later realised that all the sachets were gone. An unspoken agreement ensued: I kept the bowl stocked with lubricant and the women kept taking them. Weeks later, Miriam told me that she thought lubricant was an excellent invention.

This vignette speaks to a broader tension that emerged in my fieldwork: women enjoyed intimacy and sex, on the one hand, but found it difficult to negotiate the actual conditions of sex with their partners on the other. Three conditions, in particular, contributed to horizontal pathways of precarity linked to embodied risk through women's sexual relationships with men. First, the majority of the women in the core group felt unable to insist on safe sex with their partner. Second, they found it difficult to negotiate the frequency of sex. Third, they struggled to balance their desire for intimacy and support from their partner with the knowledge that their partners had other sexual relationships. These conditions congealed into pathways of embodied precarity: through unsafe sex

with partners who had unprotected sex with multiple partners, the women risked contracting new strains of HIV and developing viral resistance to their ARVs.

A few months into my fieldwork, Lilian told me that she had found out that her partner was having sex with other women. By the end of my fieldwork, Lilian had become angry. Unwilling to withstand her partner's infidelity any longer, she ended their relationship. Miriam's partner, too, had multiple sexual relationships; she learnt about this by reading the text messages on his phone. When Miriam confronted Samkelo, he said that she was his only partner and that the last time he tested (in 2005) he was HIV negative. Samkelo did not believe that he needed to test again and felt that he, and not Miriam, was at risk when having unprotected sex. Despite this rationale, he refused to wear condoms. Miriam felt compelled to have sex with him in order to keep him in her and her children's lives, but was concerned about contracting other viral strains and developing resistance to her ARVs.

Miriam's son, Khanyo, stays with Samkelo – his father – and attends the school across the road from Samkelo's home. Miriam chose to keep Khanyo in this school as a strategic measure to compel Samkelo to take parental responsibility for their son. These measures also distributed the financial responsibility of Miriam's two children across two households, and enabled Miriam to maintain her economic independence and to negotiate the frequency of her contact with Samkelo.

I first learnt about Samkelo on Miriam's birthday. Like Brenda, and all ten women I worked with, Miriam had a camera that she used to take photographs. That day Miriam took me through the photographs that she had recently taken, showing me the fabric of one of her friend's skirt. It was a fine pattern of white lines on a blue background that is called *Shweshwe*; it indicates that the wearer is married. Miriam told me that she would never get married because, "Men are macho when they get married. If I got married the *xhosa* tradition would kill me. That's why you'll never see me wearing *Shweshwe*". By opting out of marriage, Miriam was able to insist on living in her own home with Nena (her daughter) and by remaining in a sexual relationship with Samkelo, she ensured that her son's father stayed in his child's life and shared responsibility for her children as a co-parent.

Eight of the ten women in the core group lived in a separate home from their partner. Earning their own income and living in their own home, or with their parents, were central strategies for the women to negotiate their desire for intimacy and partnership alongside their concerns about the risks that intimacy entailed for their bodies and their lives. Brenda, however, lived with her partner, and therefore employed different strategies for negotiating the embodied implications of his insistence on unprotected sex.

After her final hospital check-up before her scheduled caesarean, we navigated our way back to the home where Brenda lived. As we drove past the 'Three thousands', the metal shacks the size of a small room that cost R3, 000 (\$205), Brenda said that this would be her last child. Her partner was HIV-positive and he did not want to use condoms. She felt unable to insist on using condoms because she was living in his home and not in her own recently purchased 'Three thousand'. She had not finished paying it off and rented to her cousins to pay the final instalments. Her tactical response to the difficulties entailed in owing money, in negotiating sex, and in preventing pregnancy, was tubal ligation. Brenda's decision to have her tubes tied – just before her son, Mpilo, was born - was one way for her to navigate the pressures placed on her by her partner's insistence on unsafe sex; she was not, however, able to protect herself from contracting other strains of HIV, and this placed her at higher risk for developing resistance to her ARVs.

Discussion

The findings detail the intersection of structural and interpersonal violence in women's lives, and reveal the extent to which women exert a 'constrained agency', on the one hand, to resist structural violence and reconfigure their political relationship with the state (through activism calling for access to AIDS medicines); and, on the other hand, to shift the gender dynamics that fuel interpersonal violence (through a careful navigation of intimacy and independence). In doing so, the article engages with the 'muddier' middle ground between the 'negative minimalisms' of oppressive structures and a politics of home: the women in the study embodied structural and interpersonal violence while strategically and simultaneously navigating and resisting the pathways that this precarity follows into their lives.

The presence of multiple forms of violence suggests that there is a risk that a singular focus on violence experienced through interpersonal relationships can mask the violence that is created and sustained by political, social and economic structures. First, because a focus on gender inequality linked to interpersonal violence can place blame on individuals (largely men) without recognising and addressing the social, economic and political 'ecosystem' in which they are located (Jewkes et al., 2009). Ascribing HIV transmission, in epidemiological terms, solely to interpersonal gender violence does not, in itself, engage with the complex pathways that women navigate between desire and risk in their sexual relationships, and in extremely difficult socio-economic contexts (Jewkes et al., 2010). In this respect, the ethnography found that women are subtly, and sometimes with great difficulty, negotiating their intimate relationships with men by forming separate households and by working and establishing their financial independence. This was not a straightforward matter of asserting agency or submitting to intersecting structures of inequality; here the findings challenge structural theories that position agency in relation to structure (1984) without looking at 'grey space' in between.

For we see that although Brenda enjoyed her sexual relationship with her partner, she felt unable to insist on using a condom when having sex because she was reliant on her partner for her home. If we consider her decision to have her 'tubes tied' in light of this picture, it seems that Brenda's life fits a narrative of the economically dependent woman struggling to negotiate sex in an unequal relationship. This narrative could be understood as transactional: providing sex in exchange for a home. But this would be inaccurate. Brenda's decision to have her 'tubes tied' was a tactical one, just as her decision to stay in her partner's home was a conscious, albeit constrained, choice. By looking at the multiple pathways that HIV travelled into women's bodies in the accounts above, we do not only see the socio-economic structures that "make it hard to be a girl in this country". We also see the myriad tactics that women employ along these pathways to seek medical care for their children, to establish their financial independence, and to negotiate the risks and desires that surface in sexual relationships. In this respect, these findings propose a different reading of 'empowerment': one in which women do not need 'rescuing' by development actors but instead, perhaps, require recognition and support for their careful navigation of precarious life in the face of obdurate inequality and persistent structural violence (Jones, 2011). Women not only exerted their constrained agency in their social and sexual relationships, but also very much in their political relationship with the state through various shifting citizen practices around HIV medicine (Heise, 1998). Lilian, for example, describes how her child's death marked her decision to join TAC and fight for her own and other HIV-positive people's lives.

Second, a singular focus on interpersonal sexual violence might also fuel the problematic construction of a binary in which women are positioned as passive victims of men who are, conversely, held to be active perpetrators. This binary has been increasingly identified as problematic in studies on sexual rights and diversity (cf. Cornwall, 2002, Cornwall, 2014), and also in research on the positive role that

men play through collective action to address SGBV (Cornwall and Brock, 2005) and in studies on the harmful effects of hegemonic masculinities for both men and women (Mills, 2016).

While the presence of gender inequality, and its brutal manifestation as sexual violence in girls' and women's lives was a strong feature of my fieldwork, I was still confronted by the explanatory limitations of epidemiological assertions that stipulated a correlation between gender inequality and higher rates of HIV infection among women compared to men. I do not dispute this correlation; in fact, part of the rationale underpinning my research lay in the multiple and intersecting inequalities that seemed to drive HIV, in epidemiological terms, into women's lives and bodies. This was most striking when, in 2008, young women in South Africa were almost four times as likely to be HIV-positive compared to young men of the same age (20 – 24) (Lalor et al., 2016). Overall prevalence in this age group has subsequently declined, but the characteristics of prevalence according to sex remained the same: young women are still more likely to be HIV-positive than men (Edström et al., 2015).

In trying to make sense of these figures, I came across studies that linked these statistics to sexual violence: articles with titles like "AIDS has a woman's face" (Morrell et al., 2013) or "Troubling the angels" (see Giddens, 1990) proliferated in studies that explored this correlation. Other research suggested that sexual violence and its relationship to HIV occurs against an inflected backdrop of pervasive and entangled inequalities in South Africa, where gender, sexuality, race and class powerfully intersect to reinforce poor Black women's vulnerability (Johnson et al., 2013). The trope of 'transactional sex' perhaps best characterises the accounts of HIV and intersectional inequality. These studies suggest that (particularly young) poor Black women are less able to negotiate sex, or in some cases, that women actively engage in sex with wealthier men in exchange for material goods. This has been observed in South Africa (UNAIDS, 2015), but also further up the continent, in Sierra Leone (Annan, 2003) for example, where life and livelihoods are, like most places in the world, relational and navigated materially through affect and intimacy.

The third reason that a singular focus on interpersonal violence can be problematic lies in its potential to direct our attention towards individuals or 'cultures of inequality' and away from the politics of structural violence in which the state is implicated. Not only does the state enter the body of individuals or populations through disciplining techniques or the provision of HIV medicines that enable bodies to return to health (Lather and Smithies, 1997), but the findings show how the state's absence, too, exerts an effect on the body. For Miriam, the state was absent in the Eastern Cape, as it was in many of the women's lives, in so much as it did not provide essential ARV therapies that would have prevented HIV from moving into her daughter's body, that would have stopped her daughter from starting life on the cusp of death. The absence of the state was visible too, in the responsibility that was conferred on women, implicitly, to provide unpaid care for kin who could not access health care in rural parts of the country, or who could not access essential medicines that would sustain their lives even when health centres were accessible and functional.

The notion of precarity entails holding both individuals and institutions accountable for the intersections between interpersonal and structural violence; and it therefore requires a recognition, too, that relationships between individuals and their communities are guided by social norms. For we see how women's ability to stop HIV from entering their bodies was very much related to their constrained and fluctuating agency in their sexual relationships. This was connected to a broader set of intersecting inequalities, like the gendered expectations around care that forced Miriam to terminate her education and start caring for her brothers and her mother; evinced, too, as Zama entered her first sexual relationships, like Miriam and Brenda, without knowing how to insist on using condoms and, at times, without feeling she could say no. The historic failure of the state to provide treatment to stop HIV from travelling along vertical pathways from mothers into their children's bodies generated further sources of precarity. Lilian describes how, like Miriam, her child's

illness was indecipherable, and that her child's death was directly attributable to the state's refusal to provide treatment to prevent vertical transmission.

Therefore, while the findings centre on women's experiences of two forms of violence - structural and interpersonal - the article argues these forms of violence cannot be separated, and it suggests that successful policy interventions need to recognise the politics and dynamics of violence that inhere in political and social institutions and manifest through interpersonal relationships at an individual level. Finally, the findings indicate the value of looking more closely at how, and where, individuals resist violence, hold agency and negotiate the fraught conditions of their vitality. Therefore, by situating research on gender, violence and HIV in a middle ground, between conceptualisations of structural violence as 'top-down' (Dworkin et al., 2012, Jewkes and Morrell, 2012) or resistance as 'globalisation from below' (Diggins, 2015), it might become more possible to identify the pathways through which women come to embody and also resist precarity.

References

- ALLEN, Q. 2012. Photographs and stories: ethics, benefits and dilemmas of using participant photography with Black middle-class male youth. *Qualitative Research*, 12, 443-458.
- ANNAN, K. 2003. In Africa Aids Has a Woman's Face. *WOMEN AND ENVIRONMENTS INTERNATIONAL*, 49-50.
- BERKMAN, L. F., KAWACHI, I. & GLYMOUR, M. M. 2014. *Social epidemiology*, Oxford University Press.
- BIEHL, J. 2005. *Vita: Life in a Zone of Social Abandonment*, Berkeley, University of California Press.
- BUTLER, J. 2004a. *Precarious life : the powers of mourning and violence*, London ; New York, Verso.
- BUTLER, J. 2004b. *Undoing gender*, New York ; London, Routledge.
- BUTLER, J. 2009. Performativity, Precarity and Sexual Politics. *Antropólogos Iberoamericanos en Red (AIBR)*.
- CAMPBELL, C. 1997. Migrancy, masculine identities and AIDS: The psychosocial context of HIV transmission on the South African gold mines. *Social Science & Medicine*, 45, 273-281.
- CAMPBELL, M. & GREGOR, F. 2004. *Mapping Social Relations: A Primer for Institutional Ethnography*, Walnut Creek, AltaMira Press.
- CLUVER, L. D., HODES, R. J., TOSKA, E., KIDIA, K. K., ORKIN, F. M., SHERR, L. & MEINCK, F. 2015. 'HIV is like a tsotsi. ARVs are your guns': associations between HIV-disclosure and adherence to antiretroviral treatment among adolescents in South Africa. *Aids*, 29, S57-S65.
- CORNWALL, A. 2002. Spending Power: Love, Money, and the Reconfiguration of Gender Relations in Ado-Odo, Southwestern Nigeria. *American Ethnologist*, 29, 963-980.
- CORNWALL, A. 2014. Women's empowerment: What works and why? : WIDER Working Paper.
- CORNWALL, A. & BROCK, K. 2005. What do buzzwords do for development policy? A critical look at 'participation', 'empowerment' and 'poverty reduction'. *Third world quarterly*, 26, 1043-1060.
- CORNWALL, A. & GAVENTA, J. 2001. From users and choosers to makers and shapers: repositioning participation in social policy. *IDS Working Paper 127*.
- DE CERTEAU, M. 1984. *The Practice of Everyday Life*, University of California Press.
- DENNIS JR, S. F., GAULOCHE, S., CARPIANO, R. M. & BROWN, D. 2009. Participatory photo mapping (PPM): Exploring an integrated method for health and place research with young people. *Health & Place*, 15, 466-473.
- DIGGINS, J. 2015. ECONOMIC RUNAWAYS: PATRONAGE, POVERTY AND THE

- PURSUIT OF 'FREEDOM' ON SIERRA LEONE'S MARITIME FRONTIER. *Africa*, 85, 312-332.
- DWORKIN, S. L., COLVIN, C., HATCHER, A. & PEACOCK, D. 2012. Men's Perceptions of Women's Rights and Changing Gender Relations in South Africa Lessons for Working With Men and Boys in HIV and Antiviolence Programs. *Gender & Society*, 26, 97-120.
- EDSTRÖM, J., HASSINK, A., SHAHROKH, T. & STERN, E. 2015. Engendering Men: A Collaborative Review of Evidence on Men and Boys in Social Change and Gender Equality.
- FARMER, P. 1996. On Suffering and Structural Violence: A View from Below. *Daedalus*, 125, 261-283.
- FARMER, P. E., NIZEYE, B., STULAC, S. & KESHAVJEE, S. 2006. Structural violence and clinical medicine. *PLoS Medicine*, 3, e449.
- FASSIN, D. 2007. *When Bodies Remember: Experiences and Politics of AIDS in South Africa*, Los Angeles, University of California Press.
- GALTUNG, J. 1969. Violence, peace, and peace research. *Journal of peace research*, 6, 167-191.
- GALVAO, J. 2005. Brazil and Access to HIV/AIDS Drugs: A Question of Human Rights and Public Health. *American Journal of Public Health*, 7.
- GEFFEN, N. 2010. *Debunking Delusions: The Inside Story of the Treatment Action Campaign*, Jacana Media.
- GEVISSER, M. 2008. *Thabo Mbeki - The Dream Deferred*, Cape Town, Jonathan Ball Publishers.
- GIDDENS, A. 1990. *The Consequences of Modernity*, Cambridge, Cambridge University Press.
- HARLING, G., EHRLICH, R. & MYER, L. 2008. The social epidemiology of tuberculosis in South Africa: a multilevel analysis. *Social science & medicine*, 66, 492-505.
- HEISE, L. L. 1998. Violence against women an integrated, ecological framework. *Violence against women*, 4, 262-290.
- HEYWOOD, M. 2003. Preventing Mother-to-Child HIV Transmission in South Africa: Background Strategies and Outcomes of the Treatment Action Campaign Case against the Minister of Health Current Development. *S. Afr. J. on Hum. Rts*, 19, 278.
- JEWKES, R. & MORRELL, R. 2012. Sexuality and the limits of agency among South African teenage women: Theorising femininities and their connections to HIV risk practises. *Social Science & Medicine*, 74, 1729-1737.
- JEWKES, R. K., DUNKLE, K., NDUNA, M. & SHAI, N. 2010. Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study. *Lancet*, 376, 41-48.
- JEWKES, R. K., SIKWEIYA, Y., MORRELL, R. & DUNKLE, K. 2009. Understanding Men's Health and Use of Violence: Interface of Rape and HIV in South Africa. *MRC Policy Brief*.
- JOHNSON, L. F., MOSSONG, J., DORRINGTON, R. E., SCHOMAKER, M., HOFFMANN, C. J., KEISER, O., FOX, M. P., WOOD, R., PROZESKY, H. & GIDDY, J. 2013. Life Expectancies of South African Adults Starting Antiretroviral Treatment: Collaborative Analysis of Cohort Studies. *PLoS medicine*, 10, e1001418.
- JONES, R. B. 2011. Creating Postcolonial Visual Pedagogy. *Postcolonial Representations of Women*. Springer Netherlands.
- KINDON, S. 2009. Participatory Video. In: EDITORS-IN-CHIEF: ROB, K. & NIGEL, T. (eds.) *International Encyclopedia of Human Geography*. Oxford: Elsevier.
- KLEINMAN, A. & KLEINMAN, J. 1994. How Bodies Remember: Social Memory and Bodily Experience of Criticism, Resistance, and Deligitimation Following China's Cultural Revolution. *New Literary History*, 25, 707 - 723.

- KOLB, B. 2008. Involving, Sharing, Analysing - Potential of the Participatory Photo Interview. *Qualitative Social Research*, 9.
- KRIEGER, N. 2001. Theories for social epidemiology in the 21st century: an ecosocial perspective. *International journal of epidemiology*, 30, 668-677.
- LALOR, K., MILLS, E., SÁNCHEZ GARCÍA, A. & HASTE, P. 2016. Gender, Sexuality and Social Justice: What's Law Got to Do with It?
- LATHER, P. & SMITHIES, C. 1997. *Troubling the angels: Women living with HIV/AIDS*, Westview Press, Inc.
- LE MARCIS, F. 2012. Struggling with AIDS in South Africa: The Space of the Everyday as a Field of Recognition. *Medical Anthropology Quarterly*, 26, 486-502.
- MILLS, E. 2016. 'You Have to Raise a Fist!': Seeing and Speaking to the State in South Africa.
- MORRELL, R., JEWKES, R., LINDEGGER, G. & HAMLALL, V. 2013. Hegemonic masculinity: reviewing the gendered analysis of men's power in South Africa. *South African Review of Sociology*, 44, 3-21.
- NATTRASS, N. 2007. *Mortal Combat: AIDS Denialism and the Struggle for Antiretrovirals in South Africa*, Durban, University of Kwa-Zulu Natal Press.
- PALUMBO, P., LINDSEY, J. C., HUGHES, M. D., COTTON, M. F., BOBAT, R., MEYERS, T., BWAKURA-DANGAREMBIZI, M., CHI, B. H., MUSOKE, P., KAMTHUNZI, P., SCHIMANA, W., PURDUE, L., ESHLEMAN, S. H., ABRAMS, E. J., MILLAR, L., PETZOLD, E., MOFENSON, L. M., JEAN-PHILIPPE, P. & VIOLARI, A. 2010. Antiretroviral Treatment for Children with Peripartum Nevirapine Exposure. *New England Journal of Medicine*, 363, 1510-1520.
- POLETTI, A. 2011. Coaxing an intimate public: Life narrative in digital storytelling. *Continuum*, 25, 73-83.
- PRINS, E. 2010. Participatory photography: A tool for empowerment or surveillance? *Action Research*, 8, 426-443.
- RHODES, T., WAGNER, K., STRATHDEE, S. A., SHANNON, K., DAVIDSON, P. & BOURGOIS, P. 2012. Structural violence and structural vulnerability within the risk environment: theoretical and methodological perspectives for a social epidemiology of HIV risk among injection drug users and sex workers. *Rethinking social epidemiology*. Springer.
- RICHTER, L., STEIN, A., CLUVER, L. & KADT, J. D. 2009. Infants and Young Children Affected by HIV/AIDS. In: ROHLER, P., SWARTZ, L., KALICHMAN, S. & SIMBAYI, L. (eds.) *HIV/AIDS in South Africa 25 Years On: Psychosocial Perspectives*. New York: Springer.
- UNAIDS, A. 2015. Info. South Africa HIV prevalence.
- VALE, B. & THABENG, M. 2016. Redeeming Lost Mothers: Adolescent Antiretroviral Treatment and the Making of Home in South Africa. *Medical anthropology*.
- WEMRELL, M., MERLO, J., MULINARI, S. & HORNBORG, A.-C. 2016. Contemporary Epidemiology: A Review of Critical Discussions Within the Discipline and A Call for Further Dialogue with Social Theory. *Sociology Compass*, 10, 153-171.
- WHYTE, S. R. 2009. Health Identities and Subjectivities. *Medical Anthropology Quarterly*, 23, 6-15.