

9 Managing Recognition in a Time of AIDS

‘And … she’s pregnant.’ Lesedi and I sat in shock for a few moments. It had taken some time to eke this information out of her; she had refused to tell me anything on the phone, other than that her cousin Tumi was in hospital.¹ She had called home, asking to use the Legae’s postal address to access a good hospital that would be less crowded than those in the city, but she would explain no further. Gradually, as we sat on the long benches lining the small courtyard of the maternity ward, the story emerged.

Lesedi had found Tumi in the middle of the night, collapsed in the hallway of the house they shared with two other maternal cousins and Lesedi’s daughter in the capital, Gaborone. Tumi had been weak and sick for some time, and had lost weight. She had had episodes when she talked nonsensically. The signs were straightforward enough and saved articulating the painfully obvious: apparently Tumi herself had known for some time that she was HIV-positive, although it was only the routine test at the hospital that had brought the fact to the attention of her cousin. The pregnancy was an added surprise to everyone, Tumi included.

The last time I had seen Tumi had been at a family wedding some months before. Even then I hadn’t seen her much; she had come home with a new boyfriend and was reluctant to bring him into the yard. A long-term relationship with another man had ended dramatically not long before, upon her discovery of photograph albums stashed under his bed recording his marriage to another woman in his home village. By all accounts Tumi was smitten and enthusiastic, and the new relationship was happy and hopeful.

Now, on the hard hospital benches, Lesedi began to tell a different story. Tumi had met the new man at the clinic where she worked, and where he was a regular client. They had begun seeing each other. He talked of the untimely loss of his first wife and about his desire to remarry. And then the clinic doctor sent Tumi’s workmate a text message, asking her to warn Tumi that she was getting involved with a man

¹ Tumi is Lesedi’s mother’s younger sister’s child – *ngwana a mmangwane*.

who was HIV-positive. But, by that point, Tumi was too much in love to care. ‘Or maybe the workmate didn’t tell her right away?’ I suggested. ‘People can be jealous.’ Lesedi shrugged. ‘*Gareitse*,’ she said. ‘It’s possible. I think she just loved the idea of getting married. You know, what girl doesn’t want that?’

Around us, women in advanced stages of pregnancy lounged about in bathrobes, their hair wrapped in scarves, chatting with visiting family members. Lesedi took in the scene with a flat expression, the usual glint of mischief and knowing irony gone from her eyes. She explained that the doctor had disclosed more than his patient’s status – which Tumi, working at the clinic’s registration desk, would probably have been able to glean from his file in any case. He had explained that the man’s first wife had died of AIDS and that the man himself had nearly died as well. The doctor surmised that the man carried a particularly virulent strain of HIV, and said as much in his text to Tumi’s colleague. It was an astonishing breach of confidentiality, if not unprecedented; from early on in the epidemic, the relative ethical merits of patient privacy versus potential risk to loved ones had been hotly debated. For Lesedi, the question of confidentiality mattered less than the danger her cousin was now in.

Three months later, Tumi had discovered that she, too, was HIV-positive. She mentioned it to no one but her new boyfriend, who quickly began to withdraw. Lesedi felt that the stress of the situation was what had begun to take its toll on Tumi, making it impossible for her to cope with the combined effects of the virus and – as was now apparent – a pregnancy.

‘Where is this guy now?’ I asked. The situation angered me: the man’s apparent capriciousness, Tumi’s willingness to trust him, her illness, the baby, the shockwaves sent through everyone else’s lives, his convenient absence, the impotence of anyone to do anything about any of it. Lesedi shrugged again. She wasn’t sure if Tumi was still in touch with him but suspected she was. He hadn’t shown his face. Besides Lesedi, the only other regular visitor Tumi had was the married man she had been with before. She explained that I couldn’t go in to see Tumi myself – she was being treated for tuberculosis and was limited to two regular visitors.

We sat in silence for a while, punctuated only by the occasional ‘*Mxml!*’, a sharp teeth-sucking sound of annoyance and derision. We watched the round, bath-robed women basking in the sun. Two soldiers walked by in camouflage and high, polished boots, entirely out of place. Our disgruntlement latched onto them as they passed. ‘Ah! Men are useless,’ said Lesedi. ‘Imagine. What kind of person can do that?’ We fell quiet, each thinking of the number of men we knew who had abandoned women to their pregnancies; and the number of women we knew whose pregnancies had helped them secure some relationships and end others.

It didn't always involve life-threatening illness, but we both knew plenty of people, men and women, who could do similar things in similar circumstances. That didn't diminish the ethical imperative of Lesedi's question, though: what kind of person does these things? And what does it mean for them, for those embroiled in the situation, for the networks of their relationships, and for us?

Lesedi and Tumi were both from the far north-east corner of the country, a day's drive away. Their mothers were sisters and they had grown up together. They stayed with Lesedi's seven-year-old daughter and two other maternal cousins in a spacious, three-room house in one of the new neighbourhoods springing up around the capital, spanned by rutted, unpaved roads and convenient to a profusion of shopping malls. They went home infrequently, but always for major holidays and events. The grandmother who had raised them was diabetic and increasingly frail. Lesedi had built a roomy house in their natal yard, but both women felt that there was little left for them there and that the obligations of life at home were too consuming.

With an expression of surprised guilt, Lesedi admitted that she had been thinking about asking Tumi to move out. She felt that Tumi had not been contributing enough at home, and Lesedi was overwhelmed with the demands of her own university schooling and caring for her child. Of course, she could not ask such a thing now, but awareness of her responsibility for the additional care Tumi would require in the coming weeks and months showed in the strain on her face. I asked her whether she planned to tell her grandmother at least – knowing that, in such a situation, the elderly woman would be certain to come down to help. Lesedi hung her head and shook it slowly. 'I don't think so,' she said. '*Kana* she's old, it can kill her. I'll just tell them about the pregnancy – it's bad enough.'

Tumi's tale resonated with many others I heard. Whenever I became naïvely exasperated with friends for putting themselves in danger of contracting HIV, I was met with similar explanations: a shrug and an assertion that love, the promise of marriage, or the desire for a child made sense of the risk (see the description of AIDS as a problem of love in Klaits 2010: 3; see also Hunter 2010). The *dikgang* that surround the goals of pregnancy or marriage in usual circumstances, with far-reaching consequences of their own, put this reaction in context. HIV is rendered *one of many* risks to be borne in the project of making the family and the self, one of many potential crises to be faced in that process. It is a risk people are willing to take in order to build conjugal relationships, which open up opportunities to self-make and to refigure kin relations. In this sense, it is a risk of the same order as others I have described above, many of which also present the threat of illness or death. Indeed, Batswana actively absorb HIV and AIDS into the range of *dikgang* associated with conjugal intimacy as a crucial means of living with the epidemic.

Even practices that seem to offer little more than an egregious danger of infection – like having multiple partners, as Batswana often do – might be understood to *ameliorate* the other risks inherent in intimate relationships. Before antiretroviral (ARV) treatment was made widely available, Klaits notes that men in the Apostolic church he studied kept multiple partners ‘in order to “protect themselves” (*go itshireletsa*), ironically the same phrase used in health campaigns to promote condoms’ (2010: 131). Klaits links this ‘protection’ to a distribution of love that ensures emotional well-being and the improved chance of return on one’s investments in others. Such protection is no less necessary in a time of widespread ARV treatment. Indeed, the imperative to keep a relational self fragmented and concealed, in order to protect oneself and others against witchcraft, predates and outstrips the particularities of the pandemic (see Comaroff and Comaroff 2001). It is a sort of protection decisively linked to managing and containing recognisability, to controlling who can see, speak about, or know a person, on what terms, and to what extent. And it suggests that this protection against relational indeterminacies and risks is as important as – or *more* important than – protection against the virus (Hirsch et al. 2009: 19).

Of course, to say that the risk of contracting HIV or developing AIDS is of the same order as other *dikgang* in intimate relationships is not to say that the stakes remain the same. Public health discourse has actively sought to heighten the stakes of HIV infection, as have behaviour change campaigns run by government, NGOs, and international agencies countrywide. In many ways, these responses to the epidemic explicitly pathologise the *dikgang* I have described, turning the everyday ambiguities associated with intimacy, care, love, sex, marriage, pregnancy, and birth into clearer-cut questions of life and death. These renditions seek to change the terms of engagement with HIV and AIDS by requiring and attempting to refigure their recognition (Henderson 2011: 24; LeMarcis 2012; Nguyen 2010), foregrounding the visibility of the disease over the people and relationships it affects.²

HIV became recognisable in Tumi’s body in many of the same ways her pregnancy eventually did. Its symptoms became visible gradually, over a period of several months. And, as Lesedi’s reflections indicate, it provoked some of the same responses and repercussions that we saw in Chapter 7. It signalled the existence of a relationship without incontrovertibly identifying the man involved, and it fell to the woman’s natal family above all to negotiate the crisis, reasserting her connection to them. I knew young women who returned home to their natal yards to

² Something similar might be said of the COVID-19 pandemic, of course – a possibility to which I return in the Epilogue.

be nursed in advanced stages of illness, much as they might return to give birth and be confined. And nursing – or continuous, intimate care – was a primary means through which the family could address the *kgang* of illness and seek to contain it (Klaits 2010; Livingston 2005). Friends often noted that death after a long illness at home was preferable to sudden death because it offered family the opportunity to discharge responsibilities still owed to their stricken relative by contributing to their care. For women like Tsholo, the recognition of AIDS was much like the recognition of pregnancy and birth: it was primarily oriented towards reproducing relationships to natal kin.

But differences emerge in what is recognised, in the options available for managing the *dikgang* that arise, and in the repercussions of those management strategies. In Tumi's story, it is recognition of the disease itself that threatens to dominate. The relationship through which it was transmitted and the people involved recede from view by comparison. And, in the overdetermined representational context of AIDS interventions, this differential recognition works to change what is made recognisable: that is, mortality and the threat of death, instead of relational personhood and the potential of life. The conceptual distance between recognising AIDS and recognising relationships or persons is underscored by Tumi's willingness to accept and overlook her boyfriend's HIV-positive status, which she had many ways of knowing. At the same time, the dominance of the disease in the way in which the clinic staff perceived not only the boyfriend but also his past marriage and Tumi's relationship with him underscores the violent priority of recognition claimed by the virus in contexts where biomedical knowledge and public health discourse hold sway.

The recognisability of AIDS, in this case, produces *dikgang* that differ markedly from those that emerge when conjugal relationships are recognised. It throws into question the capacity both of the individual to care for herself and of her family to care for her, without themselves falling ill and dying. As Klaits argues convincingly, AIDS is hard to talk about because it enhances scrutiny of and 'frequently amounts to critical commentaries on caregiving relationships' (Klaits 2010: 33). In a similar vein, Livingston notes that the care required for debility renders differences among kin problematically visible, as 'relationships undergo both public and private scrutiny' (Livingston 2005: 3). But the same might be said of marriage and pregnancy. Concern surrounding the Legae pregnancies focused on the family's ability to look after both their own daughters and their daughters' children, as well as the fathers' willingness and ability to do so. And Kagiso's abortive proposal meant that his and his girlfriend's relationship, and the full range of kin relationships in

which they were embedded, came under deeply problematic scrutiny, highlighting and creating differences both among and between their families. *Dikgang* routinely destabilise relationships and call them into question; as we have seen, the *dikgang* associated with marriage and pregnancy destabilise the full range of kin relationships, across generations, among siblings, and between couples. But when that range of *dikgang* is engaged, reflected upon, and addressed – even if they are never fully resolved – they create potential for the full range of those relationships to be reproduced and reconfigured (even if the results may be mixed). And they make it possible for the individuals involved to self-make, to be seen, and to see themselves as ethical persons through the gaze, or recognition, of others (Werbner 2015; 2016). An intransigent problem arises when that process of reflection and recognition is shifted away from those relationships, and the *dikgang* they involve, to AIDS as a terminal disease – adequate responses to which lie exclusively in the hands of biomedicine and public health.

AIDS *qua* AIDS cannot be reported to a partner's kin the way pregnancy can; fines cannot be levied; kin negotiators cannot be informed and sent to make claims. AIDS cannot be demonstrated to extended kin as proof of readiness to marry, nor can it be negotiated between two families; and while it may throw the failings of intergenerational relationships into relief, it cannot help address them. But AIDS as a *kgang* of conjugalit, a crisis in the making of selves and of families, *can* be reflected upon and addressed on those terms. The *kgang* of AIDS overlaps enough with other conjugal *dikgang* that it can be absorbed into them; and, where it can't, Batswana actively recast it in terms of *dikgang* that can be addressed. More than simply 'hiding' the disease, this work involves shifting reflection and recognition from the disease itself back to people and relationships, transferring the stakes from life and death back to kin-making and self-making. Much as Livingston (2005) argues for traditional Tswana diagnostic categories, the key is to embed affliction within social relations that can be engaged constructively. Doing so redirects the moral imagination of HIV and AIDS, refocusing it on the hidden dynamics of selves in relation rather than on the virus, keeping it alive to 'alternatives in flux' (Werbner 2016: 87) and practical possibilities of response. Small wonder, then, that Lesedi would choose to notify her grandmother about Tumi's pregnancy – a *kgang* about which something could be done and around which kin-making and self-making could proceed – but not about her HIV-positive status. She worked not so much to conceal her cousin's diagnosis as to subsume it and the crisis it represented in a way that prioritised and enabled Tumi's self-making and kin-making projects.