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When Life Happens: Theatres of HIV and Complexity in South Africa

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“When Life Happens”: Theatres of HIV and Complexity in South Africa

by

Jessica S. Ruthven

A dissertation presented to the Graduate School of Arts and Sciences of Washington University in partial fulfillment of the requirements for the degree of Doctor of Philosophy

December 2014

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ABSTRACT OF THE DISSERTATION

“When Life Happens”: Theatres of HIV and Complexity in South Africa

by

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Doctor of Philosophy in Anthropology

Washington University in St. Louis, 2014

Professor Carolyn Sargent, Chair

This dissertation examines theatre as part of an artistic movement in South Africa to address the social, structural, and emotional repercussions of HIV, as well as a space in which knowledge about HIV/AIDS is actively created, mediated, reproduced, challenged, and presented for public consumption. Although applied theatre has a long history in the country, I focus on innovation in recent theatrical practices that have occurred as artists and members of broader civil society struggle to understand the trajectory of the country’s AIDS epidemic and question the scope of popular national HIV intervention campaigns. I use emerging forms of cultural production as a lens through which to interrogate knowledge production and representation about HIV/AIDS, illness, and sexuality in the post-apartheid era; the effects of HIV/AIDS within communities and in individual people’s lived experience; and the creative responses front-line health workers develop to mediate between global public health agendas and the particularities of local health needs.

I follow the lives of 81 urban theatre-makers across 20 different artistic groups at mainstream, community, university, and non-governmental organization levels. I focus on the lived experiences of six theatre groups and four independent, experimental theatre-makers as a representative cross-section of the artists with whom I worked. My research extends the domain
of medical anthropology beyond conventional health settings to include analysis of how artistic technologies lend themselves to HIV/AIDS communication and intervention practices. In particular, I identify and explore certain artistic technologies that are engaged by theatre-makers to rework definitions of health, illness, reflexivity, and activism for the contemporary moment.

Principally, I analyze the kinds of language and optics theatre-makers are starting to incorporate into their intervention work on HIV/AIDS and how these changes reflect broader shifts in their ideas about the possibilities for health programming in the second decade after democratization. I argue that theatre-makers are actively challenging the scope and techniques of reflexivity implicit in dominant public health models for HIV intervention. While common global public health attention to HIV/AIDS often privileges focus on biomedical facts or analysis of underlying structural factors that contribute to health inequalities, many artists in the country have recently begun interrogating what they call “life’s complexities”: the hard-to-explain parts of human lives that emerge, not fully rationally understood by the people experiencing them, during times of economic, social, political, environmental, and biological disruption or from contradictions in life. I analyze how, why, and in reaction to what political pressures theatre-makers have begun acknowledging this kind of complexity within interventions related to HIV. In addition, I present ethnographic data for a grounded analysis of what complexity means to the people with whom I worked. I then take those local understandings as a basis for theorizing.

I argue that theatre-makers are using the focus on “complexity” as a point of entry to produce expanded forms of reflexivity meant to handle or engage with the kinds of existential concerns that emerge during lived experience of systemic structural inequality, marginality, violence, illness, and vulnerability. In addition, I suggest theatre-makers are positioning these new ideas about reflexivity as a form of health activism for the post-apartheid era and subtly but
significantly recasting the individual/community dichotomy implicit in many global public health outreach programs by challenging neoliberal conceptions of the responsible health citizen. Through these shifts, I argue that theatre-makers are actively developing and promoting an alternative form of health subjectivity based on critical reflexivity around the relationships between self, society, structure, and agency.

A final goal of this project was to provide an anthropological critique of theatre as an institution within the broader healthcare industry of South Africa. I investigate how power and oppression articulate within the artistic sector and contribute to differences between how theatre-makers talk about the style and content of their work and what kinds of health theatre are implemented in practice. Examining both what is said and what is done illuminates the tensions health workers face on the ground in mediating between ideological convictions and the structural constraints that often heavily influence applied practice. I analyze what kinds of power are involved in the health theatre sector’s interactions with other institutions in the country, as well as what kinds of creativity are enacted when theatre-makers attempt to negotiate the competing interests of involved stakeholders and work at the interstices of disciplinary boundaries.

I explicate the kinds of institutional power and influence that shape the context in which knowledge about HIV/AIDS is produced within the arts, how theatre-makers experience these contexts, and what strategies artists implement when they begin to engage with institutional power structures. In addition, I argue that theatre-makers have begun deploying certain ideologies and discursive topics as a bid to gain cultural capital, structural power, and material resources within the broader HIV/AIDS intervention industry. These topics include narratives about creative economy, interdisciplinarity, and complementarity in programming that work
together to privilege multiple modalities of treatment, prevention, and care rather than narrowly supporting biomedical notions of health. I maintain this perspective provides a way to make the symbolic and social boundaries between intervention models permeable in order to promote certain projects of artists, such as expanding definitions of healing. Finally, I suggest that one of the main ways theatre-makers are creatively speaking back to institutional power and struggles over program resources and sector positioning is by challenging hegemonic metrics of “progress” and “success” within interventions as a way to effect social change.
Part 1:
Setting the Stage: Background and Theory
CHAPTER 1
Introduction

Peering over the roasted chicken we’d just gotten for lunch, Akhona* scowled. Shaking his finger at no one in particular, he said between bites, “See, Jess, this is what you have to deal with as someone who comes here to Nyanga to do theatre work.” Akhona is the Artistic Director of Siyaya Community Theatre, a group of artists whose home base alternated between three townships in Cape Town (Gugulethu, Nyanga, and Langa) during the three years I conducted on-and-off research with them. Akhona and I had just left in the hands of one of Siyaya’s senior actors the rehearsal of their revamped HIV opera. As Akhona took my arm and hauled me toward the door of Nyanga’s Zolani Community Centre, he said, “We have other business. Come.”

That “other business” ended up being a meeting with the principal of a local primary school about a possible contract to perform Siyaya’s production over a number of weeks. Although we spent a couple of hours chatting with the school director, we didn’t hammer out any specific contract details. We did accomplish something, though: we successfully escaped a mugger. After we’d left the primary school, Akhona and I strolled through the local taxi rank as he voiced his frustrations over not being able to secure the performance contract. Then we both noticed a suspicious man tracing our steps. Akhona turned, pulled me into a small barber shop, and said, “Jess, that man is about to mug you.” Deadpan, I replied, “I suspected that might be the case.”

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* Any name with a star following it indicates a pseudonym used to protect the anonymity and confidentiality of the research participant.
The four occupants of the barber shop looked askance at us until Akhona pointed at me and explained, “That guy passing just now—he was going to mug her.” The four shrugged in unison and went back to their business. The potential mugger gave us a steely look as he passed the shop and hesitated for a moment before continuing on his journey. Later, at lunch, Akhona mentioned the incident when talking about the hardships of applied health theatre intervention in South Africa. He noted:

This is what you have to deal with when you come here, as a white woman from the United States. But this—this is not what we have to deal with, those of us who live here day after day. We have to deal with our artists not having money for the transportation. We have to deal with the girls getting pregnant and not being able to play the parts. With the guys starting out wanting to do community theatre to “make a difference” and finally giving up to start singing groups, instead, to make money. Because we can’t get funding for our HIV plays. I try to make this work. We have an opera. An opera! A HIV opera. Who else in the country has an opera about HIV? But no matter how new we are and what we do is different from everyone else, the truth is still there: this country needs new ways of talking about HIV, everyone is bored of the old ways and no one listens, but the government just keeps putting money into the same old programs that don’t work. And us, the artists, we have new things to say, new stories. People will listen! But things keep us down. These things, the unemployment, no food, TB, the bureaucracies, the politics, everyone saying no all the time when we try to make things work, donors saying ‘no—you must talk about condoms, condoms’…it’s hard. It’s hard, Jess. This group [Siyaya], these people have talent and experience, but I don’t know if I can do this anymore. Keep going. It wears you out.

Not only did Akhona treat me like a mix of daughter and confidante, he is also one of the most outspoken of the artists with whom I worked in making implicit connections between South Africa’s arts sector, the broader healthcare industry, and the politics of health communication. In his commentary on the hardships related to producing applied health theatre in the country, he makes clear reference to the value he sees in artistic efforts related to health, as well as the constraints his group faces in their attempts to introduce innovation into HIV programming.

Although there are academics and journalists who have discussed HIV/AIDS as a political issue as well as scholars who question the purpose of theatre in present-day South
Africa, there are not many accounts of the two topics being melded together in one strong social critique outside of the humanities. However, applied health theatre is part of what anthropologists consider a major social institution: art. Theatre related to HIV/AIDS is part of an artistic movement in South Africa to address the social, structural, and emotional repercussions of HIV in the country. By being attentive to these forms of cultural production, I suggest medical anthropologists stand to gain a better understanding of this understudied space in which knowledge about HIV/AIDS is actively created, mediated, reproduced, reinterpreted, challenged, and presented for public consumption and reception.

In this dissertation, I take HIV/AIDS theatre as a unit of analysis, which enables insight into power relations, social inequality, and politics both associated with and reflected by theatre productions. Politics of HIV/AIDS in South Africa are reflected in the content of health-related performances, and examining historical specificity in community-produced narratives in productions reveals ways in which official HIV/AIDS policy influences daily realities of those affected. In addition, another avenue of inquiry I pursue is analyzing to what extent biomedical agendas have coopted the arts community (for what purpose, by whom, how, and what that

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3 While much scholarly work has been conducted on HIV/AIDS in the humanities (and in media/representation studies broadly), in this dissertation I specifically deal with HIV in applied theatre, visual, and the choral arts because those are areas I have found to be studied less robustly by anthropologists and health communication scholars than some other types of media, such as television (often soap operas), radio, and film. Ideas about affective techniques and communication theory differ widely between print and television media versus live, in-person artistic campaigns. This is another reason I privilege analysis of live theatrical HIV/AIDS productions. I think the absence of some of those conceptual links provides provocative terrain for further research into anthropological and historical accounts of the use and impact of HIV/AIDS theatre in the public realm.

4 For brevity, I have chosen to refer in this dissertation to theatre that includes primary content themes related to HIV/AIDS as “HIV/AIDS theatre.” The artists with whom I worked disliked the term “HIV/AIDS theatre” but often used it themselves for lack of a better term. Most considered their work simply “theatre” without the “HIV/AIDS” designation necessary, despite HIV/AIDS being a primary theme.
means for people involved in this kind of health arts initiative).  This kind of possible cooptation brings to mind government-sponsored European cooptation of the arts in the apartheid era; in many instances, the apartheid government put its support and funding behind certain forms of theatre to promote its separatist agenda (Blumberg & Walder 1994). In that instance, black South African theatre forms were repressed in an effort to silence dissident voices in the arts world. Two essential questions that have motivated this research project include: what is the government, in its support of certain forms of HIV/AIDS theatre, trying to accomplish in the contemporary political/health landscape? How are artists speaking back to power and resisting such institutional efforts—and how can they do so more effectively?

1.1 Applied Health Theatre

Roughly 20% of South Africa’s population is HIV positive, and there is widespread recognition among government agencies, media specialists, policy-makers, civic organizations, public health and anthropology scholars, and laypersons that urban health literacy related to HIV is well established. Given that national public health campaigns have underscored the importance of HIV/AIDS education, awareness, and health promotion programs in the past but HIV prevalence remains stable, certain sectors of the healthcare industry have begun questioning past tactics and experimenting with alternative health communication methodologies. Notably, as a response to historically narrow public health foci (based on rational choice or psychological theories of individual behavior change), applied theatre has emerged in the post-apartheid era as a challenge to the educational and health communication paradigms commonly used in global HIV/AIDS interventions. Artistic critiques of past intervention efforts in the country often focus on the scope and techniques of reflexivity implicit in these paradigms.
In my dissertation, I provide an ethnography of contemporary applied health theatre in South Africa as it relates to creative economies, sexuality, and HIV. Drawing on 12 months of fieldwork with Johannesburg and Cape Town theatre participants, including participant-observation, in-depth interviews, and analysis of live HIV/AIDS theatre and scripts, this dissertation examines how the nexus between audiences, knowledge, and agency is challenged within emerging artistic practices in South Africa. At its core, this dissertation is the story of a period of reflection about the place of applied theatre in the country’s health industry and civic activism that occurred in the mid-2000s, as well as the resultant ideological and practical innovation that continues to provide foundations for current debates about health promotion and care practices.

In particular, I follow the lives of 81 theatre-makers across 20 different artistic groups at mainstream, community, university, and non-governmental organization (NGO) levels. I focus on the lived experiences of six theatre groups and four independent, experimental theatre-makers as a representative cross-section of the artists with whom I worked. This dissertation is the story of their struggles to understand, define, and reposition the role of applied theatre within the broader healthcare industry, as well as the country’s burgeoning creative economy. It is the story of their thoughts, critiques, feelings, experiences, hopes, aspirations, failings, disappointments, fears, anger, frustrations, ideas, actions, and beliefs. I draw heavily on their words in this dissertation as data and contextualize what they have to say within historical and sociopolitical considerations. Additionally, I elucidate the ways artistic organizations use theatre practices and representations of HIV/AIDS to explore new health and political subjectivities. More broadly, my research explores questions about the potential of integrating medical anthropology and

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5 Johannesburg is often referred to as “Joburg” by residents, and I will use this convention in the dissertation.
performance studies to provide ongoing opportunities for reflection on dominant concepts of health intervention, as well as interdisciplinary theory on performance and healing. My research extends the domain of medical anthropology beyond conventional health settings to include consideration of how artistic technologies lend themselves to HIV/AIDS communication practices in South Africa.

A large part of my dissertation research involved examining the relationship between artistic technologies and knowledge. I utilize ethnographic vignettes and theatre-maker discourse to argue that certain artistic technologies and concepts are engaged by theatre-makers to rework definitions of health, illness, reflexivity, and activism for the contemporary moment. Principally, I analyze how theatre-makers are re-conceptualizing what kinds of reflection are important to HIV/AIDS intervention programs. A major concern in this dissertation is the development of the concept of “complexity” in an attempt to integrate medical anthropology and the humanistic concerns of performance studies. I analyze the concept of “complexity” as theatre-makers use it in relation to sexuality and health.

While social scientists often use the term “complexity” to index the ways complicated social systems interact, I noticed in the field that theatre-makers used it in a different way. For many theatre-makers, “complexity” was used as an analytical category to index or examine the kinds of existential concerns that emerge during lived experience of systemic structural inequality, marginality, violence, illness, and vulnerability. A main theoretical concern within medical anthropology is producing insight into how people explain and react to health-related issues. However, I suggest anthropology scholars sometimes over-privilege analysis of the known at the expense of interrogating the unknown or the hard-to-explain: the parts of human lives that emerge, not fully rationally understood by the people experiencing them, during times
of economic, social, political, environmental, and biological disruption or from contradictions in life.

Alternatively, for theatre-makers the term “complexity” often means the impact on people’s subjectivities of anxiety, uncertainty, confusion, disquietude, or the simple disturbance produced in people when they experience incoherent, precarious, or volatile events. I argue that theatre-makers are using the focus on “complexity” as a point of entry to produce reflexive health subjectivities meant to handle or engage with this kind of existential incoherence. This kind of expanded reflexivity is intended to mine subjective knowledge in ways different from conventional public health programs and pull intervention participants into consideration of a range of ways to understand or produce knowledge about the worlds in which they live.

In contrast to the kinds of reflexivity premised on Western rationalities implicit in neoliberal ideas of responsible biocitizenship, theatre-makers are starting to privilege the incorporation of knowledge outside of narrow focus on the cognitive and behavioral within public health programming. In particular, artists are centering within intervention optics types of knowledge about health and sexuality that originate in people’s bodies, intuitions, emotions, and lived experience. I also argue that artists are subtly but importantly shifting the individual/community dichotomy rhetoric tacit in many global public health outreach programs and positioning expanded reflexivity premised on experiential knowledge and intuition as a form of health activism in the post-apartheid era.

In my work, I suggest that this push to place expanded forms of reflexivity in conversation with cognitive rationalities is partly about challenging the production and control of knowledge within global public health—from where it originates, who authors it, and how it is used in social spheres. It is also about an effort to more strongly consider underlying
socioeconomic and political factors that contribute to health inequalities and HIV prevalence in the country rather than narrowly conceiving of intervention as a set of communication or health promotion problems. In essence, some theatre-makers are trying to use artistic technologies to prompt intervention participants to think about and engage with health issues at a level different from dominant national HIV awareness campaigns.

Theatre-maker efforts at innovation within the public health sector were premised on certain foundational ideas, theories, and assumptions about the nature of interventions, communication, social change, and healing. While I made progress in analyzing the theoretical paradigms on which theatre interventions rest, I also noted that what happens in practice often differs—sometimes drastically and sometimes subtly. This dissertation is therefore, in part, an analysis of the dual stories told by artists at the forefront of health communication practices in the country: what happens at the level of discourse and ideology compared to what gets implemented on the ground when they try to operationalize those ideas and put them into practice. Finally, it is also a discussion of the mediation that happens between those two stories, including analysis of the factors that shape compromises between artistic vision and practice.

1.2 Research Objectives and Major Findings

Using a mixed methodological approach, this project was driven by three primary concerns. The first was to study how applied theatre acts as a vehicle for health communication, promotion, and knowledge production about HIV/AIDS. The second was to determine the impact, as defined by both theatre-makers and audience members, of the main contemporary HIV/AIDS applied theatre genres in the communities and personal lives of those involved. The third was to investigate how the content and aesthetic forms of community-level applied theatre
have shaped conceptualizations of health inequity, subjective illness experience, and definitions about what constitutes healing in South Africa.

A secondary goal of this project is to address the dearth of anthropological analysis of HIV/AIDS theatre by combining political-economic and interpretive perspectives to examine the production and reception of applied health theatre in contemporary South Africa. Most health communication scholarship on cultural representations of HIV/AIDS emphasizes how health beliefs are constructed and circulated in television, radio, and print media campaigns; however, this project expands on mass media studies to include live theatre interventions as units of analysis.

It includes mainstream and commercial theatre, industrial theatre, university theatre, theatre in education (TIE), community theatre, and emerging programs that integrate methods from a variety of applied theatre genres. In this project, I used qualitative methods to examine how psychosocial and emotional complexities of the epidemic are (and in some cases, are not) connected to broader social contexts through performance, as well as how emotion becomes a privileged affective component of intervention processes.

A final goal of this project was to investigate differences between how theatre-makers talk about the style and content of their work and what kinds of applied health theatre are actually implemented in practice. A major finding of my dissertation research is that two major stories characterizing this sector were simultaneously deployed by involved participants: what was happening in discourse versus what was happening in practice. During fieldwork, I noted that although theatre-makers who produce HIV/AIDS-related material avidly discuss the need for new ways to represent HIV/AIDS, currently little stylistic variation occurs in practice at the community theatre level; however, innovation in style at the mainstream and university-produced
levels of theatre is more robust and experimental. Many theatre-makers also discuss the need to shift content from previous ways of messaging about HIV/AIDS (including themes of death, loss, stigma, and abandonment) to inclusion of messages that discuss various ways to live (positively) with HIV, embrace inclusion, and maintain healthy interpersonal relationships.

In the audience sample, the majority of the respondents expressed the idea that they would not mind watching an HIV/AIDS-related theatre performance provided that its content and style were different from the kinds of art related to HIV they had seen (or heard about) previously. There has been general aversion to theatre that portrays HIV/AIDS as deadly and to productions including rape scenes, which are perceived as characteristic of the kinds of theatre produced about HIV in the past. Most of the participants expressed the idea that they are uncomfortable discussing with family members the plays related to HIV/AIDS they have seen; however, many reported discussing the content of the plays with friends. Not much in-depth discussion of style, other than an aversion to didacticism, was reported.

Analysis of both what is said and what is done illuminates the difficulties/tensions health workers face on the ground in mediating between ideological convictions and the structural constraints that often heavily influence applied practice. Very real questions remain about the scope and impact of applied health theatre related to HIV/AIDS. An important finding of this project is that although the theatre-makers with whom I worked expressed the idea that HIV/AIDS-related theatre is and has been pervasive in the country, this was not unambiguously the case. Of the people interviewed in this project, about 42% of the participants could recall seeing an HIV/AIDS-related performance prior to the one they had just participated in or watched. The rest could not recall personally ever attending a live theatrical performance.
For several reasons, including a shift in presidential administration, changing international health funding priorities, and a perceived “AIDS fatigue” among potential audience members, the number of community theatre groups producing consistent HIV/AIDS-related theatre work has decreased in the past few years (starting 2009, although participant response has stated this began as early as 2004). Many of the community theatre groups with whom I worked during pilot research (2008 and 2009) were no longer producing HIV/AIDS-related work by 2010-2011. Instead, they were focusing on gender violence and abuse of children within family structures. Another contributing factor I noted during research is that publicity/marketing for productions that include HIV/AIDS-related themes has shifted from an explicit statement of relation to HIV/AIDS to a policy of non-statement regarding direct HIV reference. I found that at the National Arts Festival in Grahamstown, fewer productions (than the past 2-3 years) explicitly stated an HIV/AIDS reference in their program synopsis; however, I also found that some productions contained HIV/AIDS-related content despite not explicitly claiming to do so. I suggest this has to do with changing ideas about how best to incorporate and fluidly integrate HIV/AIDS-related topics into health communication practices without alienating audiences or privileging didactic messaging. This topic is addressed in Part Three of the dissertation.

Questions on the real and perceived relevance of HIV/AIDS-related theatre in people’s lives currently garnered a wide variety of responses among artists, audience members, and everyday people ranging from the notion that such theatre is outdated to impassioned arguments that it must continue to be produced and shown to learners in primary and high schools particularly, since the information contained is important to their safety and sexual health. Most participants, audience members as well as theatre-makers, expressed the idea that as a medium, theatre has great potential within HIV/AIDS interventions in South Africa; however, they
thought that potential was not currently being met by the majority of the groups producing live performances on this topic (exceptions were noted). Theatre-makers within the industry often debated these two issues, which led me to more closely examine the practical constraints around theatre-makers’ work, including structural, political, moral, and ideological considerations.

One space in which these considerations intersect was theatre-maker anxiety over funding. Discussion of the politics around funding was a recurring theme in interviews during the year of fieldwork (much more so than during 2008 and 2009 pilot studies). The majority of theatre-makers interviewed felt like the recent economic recession coupled with donor/funder requirements significantly affected the kinds of knowledge they could foster in the public realm (artistically) about HIV/AIDS. In addition, also problematic for artists was donor insistence on quantitative metrics for measuring program impact, which contrasts sharply with theatre-maker ideology about the affective possibilities of artistic health programs.

A significant finding of this project is the uncovering of core disconnects between some theatre-makers and their donor/funders (e.g. government, corporate, private, and international donors) regarding how success is defined within HIV/AIDS-related theatre interventions. A recurring theme in the interviews with theatre-makers was the desire for sustainable funding coupled with strong donor/group relationships based on communication and shared ideals about how to evaluate the HIV/AIDS-related theatre projects. Although not a novel finding, I do think a significant disconnect is occurring between theatre-makers' ideas about the value of their work and how it should be evaluated compared to funder/donors' ideas about the same topic.

My original project goals did not include examining this aspect of the industry in much depth, but the fervor with which most artists discussed this topic necessitated a shift to accommodate archival research around funding and politics. This finding relates to the politics
of HIV/AIDS funding nationally and internationally and is shaped by moralizing discourses and narrow ideologies about what is and is not valued in defining health and wellbeing in post-apartheid South Africa. While this information may prove valuable to public health policy analysts and other stakeholders in mediating differing ideas about goals, expectations, and ways of measuring success in HIV/AIDS interventions that employ artistic components, it may also be of use in evaluating the ongoing ways in which unequal power relations provide scaffolding for the architecture of HIV/AIDS knowledge production within local discourses.

A final major finding of this project was that although political commentary was common in theatre-maker interviews, explicit links between HIV/AIDS content and politics within the performances were rare and limited in form. Content tended to focus on a more individual level engagement with the subject matter (e.g. personal behavior related to health; subjective life experiences, responses, thoughts, and feelings; and consequences of actions). Initially, I thought this indicated a decrease in politically-involved theatre. Through analysis, I realized that what was actually happening was the redefining of what health activism and civic participation mean in the post-apartheid era by theatre-makers.

This phenomenon was also closely related to how theatre-makers were working to expand what healing and health signify generally and in relation to sexuality and infectious disease in particular. For theatre-makers, healing is often portrayed as an active, social, collaborative process in which emotional affect plays a significant role. Health, rather than narrowly describing physiological characteristics, was discussed as a process of personal integration sometimes aided by social interaction, in which individuals connect considerations of their physiological states with their mental, emotional, and interpersonal experiences. In some
respects, health is a form of deep reflexivity in addition to certain forms of physiological states of being. I address these topics in Part Four of the dissertation.

To meet the research objectives of this project, I worked formally with stakeholders in Johannesburg and Cape Town including theatre-makers; audience members; media representatives from arts and health journalism; health and arts NGOs; national and international project funders; government officials; and clinicians. I conducted informal fieldwork with numerous other individuals to inform the context of my project. In addition, I collected data on 55 health-related live theatre productions, obtained video footage of 29 HIV/AIDS-related theatre plays, and procured 10 HIV/AIDS-related theatre scripts for analysis. I also collected filmed footage of 24 other theatre events from a dedicated annual HIV/AIDS and sexuality theatre festival in Johannesburg.

1.3 Research Design: Sampling, Methods, and Geography of Research Sites

In this section, I include a description of the project’s major research sites, sampling procedures, methodology used to gather ethnographic data, what I accomplished while in the field, and how I selected and analyzed the data used in this dissertation. For this project, pilot fieldwork was conducted over 6 months from 2008 to 2009. Primary fieldwork was conducted over 12 months from August 2010 to August 2011. I divided my focus between two urban centers in South Africa: Johannesburg and Cape Town.

The methodological approach included participant-observation, semi-structured in-depth interviews, cultural domain analysis, script analysis, and archival and media research. Before any work commenced, this project was vigorously reviewed and approved by Washington University in Saint Louis’ Institutional Review Board (IRB), hosted by the university’s Human

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6 See Table 1 (Appendix A) for further details on video footage and scripts.
Research Protection Office (HRPO) and conforms to all federal regulations for research protocols involving human participants. In the initial two months of fieldwork, I conducted exploratory research with key informants identified during pilot studies to accomplish the following: document the forms and frequency of HIV/AIDS applied theatre activity in the area during the past decade; identify which groups were currently producing HIV-related theatre; and obtain feedback and theatre-maker suggestions about what kinds of information they considered relevant for assessing audience reaction to and impact of performances. In the remaining fieldwork time, I conducted participant-observation and semi-structured interviews with theatre-makers as they produced, rehearsed, marketed, and performed HIV/AIDS-related productions.

I focused major research efforts on production processes but supplemented this with audience member interviews. I also attended and conducted participant-observation at a variety of theatre festivals as they were announced throughout the year. For each theatre group with whom I worked, I collected scripts for analysis if they were produced. All semi-structured interviews were audio-recorded with the consent of interviewees. The last month of fieldwork included archival research in which I collected public and print media documents from the resource centers of the following organizations: Drama for Life (Johannesburg), AREPP: Theatre for Life (Johannesburg), the National Arts Council (Johannesburg), Sibikwa Community Theatre (Benoni), and the Theatre Arts Admin Collective (Cape Town).

Population Sampling

Production: Theatre-Makers

The population sample for the production context includes directors, actors, and other theatre-makers (n=81) from a total of 20 applied theatre organizations (groups, collectives, and collaborations). Eight organizations were based in Johannesburg, and 12 were based in Cape
Town. Of the individuals interviewed, 56 theatre-makers were in Johannesburg, and 25 were in Cape Town.

During the first two months of fieldwork, I collated a list of everyone in the country who was a known contributor to HIV/AIDS theatre during the fieldwork year. In addition, I collated a list of all theatre-makers in the country who were known to have produced HIV/AIDS work in the past but were not actively involved in the industry that particular year. From these two lists, I worked with key informants to choose which groups to include in this project. I selected and forged research relationships primarily with four community theatre groups (Siyaya, Masibambisane, Isambane, and Hlalanathi), two institutional theatre organizations (Drama for Life and AREPP: Theatre for Life), one independent experimental theatre project (HIV/AIDS: In It Together), and five individual theatre-makers (P.J. Sabbagha, Peter Hayes, Mike van Graan, Kieron Jina, and Pieter-Dirk Uys).

**Reception: Audience**

The population sample for the reception context includes audience members (n=30) of eight different theatre productions\(^7\). I collected basic demographic information for each interview with audience members. For in-depth interviews, I recruited interviewees directly at performances using a sampling design that takes into consideration the following variables: (1) gender (M/F); (2) age; (3) geographic area of residence; and (4) type of theatre attended. This allowed me to compare data across applied theatre genres; communities; and both gender and age categories. Of the 30 audience members interviewed, 17 are adults, and 13 are school students, with twice as many females as males.

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\(^7\) Five of these productions were from five of the main theatre groups studied in this project.
Research Sites

For my dissertation analysis, I primarily draw on data from twelve theatre-maker groups or individuals across three geographic communities in Johannesburg (Braamfontein, Hillbrow, and Soweto/Orlando East) and three communities in Cape Town (City Center, Khayelitsha, and Nyanga). The major, annual national arts festival occurs in Grahamstown, which also comprised a research location.

Johannesburg: Braamfontein, Hillbrow, and Orlando East

(DFL, HIV/AIDS: In It Together, P.J. Sabbagha, Kieron Jina, Hlalanathi, and Isambane):

The primary research site was Johannesburg, a city heavily affected by the AIDS epidemic and one of South Africa’s leading theatre centers. With a population of 3.6 million people, it is the largest city in South Africa. In addition, it is the capital of the most densely populated of South Africa’s nine provinces, Gauteng. Although Gauteng is the country’s smallest province geographically, it comprises the largest share of the nation’s population (approximately 22.39%) and has a 30.3% HIV prevalence rate. Johannesburg is the commercial hub of South Africa and is also characterized by high crime levels, poverty, and unemployment. English and isiZulu are the most commonly spoken languages, and black South Africans make up about 75% of the city’s population (Statistics South Africa 2011).

Braamfontein, a central suburb in Johannesburg, is located north of the city’s center. It is a corporate district, a hub for arts and entertainment, and houses the University of the Witwatersrand (“Wits University”). Drama for Life, the project HIV/AIDS: In It Together, and independent artists P.J. Sabbagha and Kieron Jina were all active in Braamfontein.

Hillbrow, home to community theatre group Hlalanathi, is a low-income inner city residential area characterized by high rates of unemployment, poverty, and population density. In the 1970s, it was an Apartheid-designated “whites only” area. In the post-apartheid era, it has
gone through population shifts and has become home to local migrant and immigrant populations from surrounding African countries. Often called the “melting pot” of Johannesburg, it is one of the city’s most multi-cultural neighborhoods. It is also notorious for crime and commercial sex work. Xenophobia has been a significant problem in Hillbrow since the early 2000s. About 50,000 people live in Hillbrow, and the majority is Black African (Statistics South Africa 2001). It houses the Hillbrow Theatre, a rising arts center.

Orlando is a township of Johannesburg in the urban area Soweto (South Western Townships). Founded in 1931, it was the first township in Soweto and is divided into two main areas: Orlando West and Orlando East. I specifically worked in Orlando East with community theatre group Isambane. Orlando is historically known in South Africa as the site of significant anti-apartheid activism, most notably the 1976 Soweto Uprising in Orlando West, where protests were led by high school students as a foundational component of the liberation struggle. Like many other townships in the country, the denizens of Orlando East struggle with poverty, crime, high unemployment rates, and domestic violence.

**Cape Town: City Center, Khayelitsha, and Nyanga**

*(Masibambisane, Mike van Graan, Pieter-Dirk Uys, Peter Hayes, and Siyaya)*

A second research site was Cape Town, one of South Africa’s leading theatre centers and economic hubs. It is the capital of the Western Cape Province and legislative capital of South Africa. Cape Town is the country’s second most populous city (roughly 3.35 million people), while the Western Cape holds about 10.45% of the country’s total population and has an 18.5% HIV prevalence rate (Statistics South Africa 2001).

Cape Town’s city center includes the central business district (CBD), the harbor, and a variety of tourist attractions, including markets, museums, restaurants, theatres, and bars.
Independent theatre-makers Mike van Graan, Pieter-Dirk Uys, and Peter Hayes were active in this community.

Khayelitsha and Nyanga are both townships on the outskirts of the city. Khayelitsha, home to community theatre group Masibambisane, is a partly informal township located in the Cape Flats area of Cape Town. It sits southeast of Cape Town’s central business district, is the city’s largest township, and has one of the country’s highest HIV prevalence rates. Khayelitsha has an estimated population of 500,000 people, of whom 90.5% are black South Africans with the majority living in informal housing. The predominant spoken language is isiXhosa. The township is known for its high unemployment rate, crime, sexual violence, and young demographic (75% of the population is younger than 35) (Statistics South Africa 2001).

Nyanga, home to community theatre group Siyaya, was established in 1948 and is one of the oldest black townships in Cape Town. Siyaya was based at the Zolani Community Center in Nyanga. The township’s roots are in the migrant labor system, and it holds the overflow population from another neighboring township, Langa. Considered one of the poorest and most dangerous parts of Cape Town, Nyanga is south of Cape Town’s city center, near the Cape Town International Airport, and borders another major township, Gugulethu. Nyanga has a population of about 60,000 people, with 99.54% Black African and a 56% unemployment rate (Statistics South Africa 2001). Both HIV/AIDS and violent crime are significant community issues in Nyanga. As late as 2011, the township reported the highest number of murders in the province and gained a reputation as the “murder capital” of South Africa (Cape Argus 2011).

**Durban, South Africa (AREPP: Theatre for Life)**

The research sites for AREPP: Theatre for Life include several geographic regions of South Africa. Headquarters for AREPP are located in Sydenham, Johannesburg and Mowbray,
Cape Town. Teams of AREPP theatre-makers travel to a variety of primary and secondary schools in different communities in the following provinces: Western Cape, Gauteng, Mpumalanga, Southern Cape, Eastern Cape, and KwaZulu-Natal. Some of the major cities covered in AREPP’s theatre tours include Johannesburg, Durban, Cape Town, East London, and Port Elizabeth. I was primarily involved with one tour group as they performed in Johannesburg and Durban, the largest city in the province of KwaZulu-Natal.

Grahamstown, South Africa (National Arts Festival)

A final research site included Grahamstown, the location of the country’s annual National Arts Festival, which is the largest arts festival in sub-Saharan Africa. Grahamstown is located in the Eastern Cape Province. The city has a population of about 125,000 people, although that number swells during festival season (June/July) (Statistics South Africa 2001). Grahamstown is also known for housing Rhodes University, one of the country’s major academic institutions.

Research Methods

For this project, I broadly utilized participant-observation, semi-structured in-depth interviewing, archival research, and print media collection. This dissertation project had six critical research questions. The questions covered both production and reception of applied HIV/AIDS theatre. For each, I reiterate the research question and explain what kinds of information I collected in order to answer them.

Production: Theatre-Makers

I investigated the following questions and collected associated data:

(a) How do theatre-makers make decisions about production content, aesthetic form, target audiences, and communication practices?
I expanded my understanding of each organization through daily participant-observation in organization activities, training programs, and lectures. I investigated the processes of performance construction through participant-observation in the formative phase of production creation, the workshopping of plays, rehearsals, and performance publicity. This provided data on how productions are formed and who the primary people involved in the formation processes are. I also used semi-structured in-depth interviews to collect information from theatre-makers about how they choose production content, what guides their choices of target audiences, and why they chose the applied theatre genre and associated communication practices through which they conduct their interventions. I used a modified form of cultural domain analysis to collect data on the cultural domain of themes that structure health promotion and knowledge production within applied theatre interventions. My method was to ask theatre-makers to free list major content themes included in their performances and rank order the results by frequency of inclusion.

(b) What theories of communication, social change, and healing do theatre-makers draw on to inform knowledge production about HIV/AIDS?

I used in-depth, person-centered interviewing to collect data on the theoretical foundations of theatre productions. Preliminary fieldwork indicated that Augusto Boal, Paulo Freire, Phil Jones, Jonathan Fox, Barney Simon, Athol Fugard, John Kani, and Gibson Kente are major performance theorists or artists on whom theatre-makers draw to create their work, including aesthetic and political agendas. I asked questions to investigate the perspectives of each theatre group (or individual theatre-maker) as theatre training, producing, and networking organizations, including their opinions about what kind of ideas generally inform applied theatre in South

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8 Here, I use the term “theoretical foundations” loosely to encompass academic formal theory and informal ideas, thoughts, and influences on people’s artistic work.
Africa and which people have influenced their own ideas about performance techniques and goals. I also asked theatre-makers to describe their understanding of the impact of theatre interventions generally and their own in particular to collect data to identify similarities or disconnect between ideas of impact envisioned by those who produce theatre and those who consume or participate in it.

(c) What options for health behaviors and individual and collective social action for change are advocated or produced during theatrical HIV/AIDS interventions?

I used in-depth interviews to ask theatre-makers to give evidence of and explain the types of behavioral, conceptual, and social change advocated in their productions. I attended and videotaped, when possible, all HIV-related performances by theatre groups or individual theatre-makers. I also attended 7 major national festivals, including the National Arts Festival in Grahamstown. At these performances, I collected data on play content, audience demographics, and scripts (when extant). Analysis of this data allows me to assess what levels of social change for health are discussed or promoted in theatre performances (e.g. individual, community, structural) and to investigate how HIV/AIDS and illness are represented by theatre-makers.

Finally, I conducted archival research to collect data from applied theatre NGO reports (when extant) to assess how prior quantitative impact surveys have defined “impact.” In order to collect data on present discussion of the value of applied health theatre in South Africa, I also collected newspaper articles, HIV/AIDS posters, and other forms of public media data.

**Reception: Audience**

I asked the following questions and collected associated data:

(a) How are the impacts of applied health theatre programs given meaning in the everyday lives of those involved?
I used in-depth interviews to ask audience members questions about how they conceptualize the impact of the theatre intervention, the relevance of the content to their daily lives, and the intensity of their subjective/emotional experience during the theatre intervention. Rather than operationalize impact only as factual knowledge gained from the intervention, I asked audience members to share their reflections and emotional responses provoked by the theatre experience. Questions included topics such as the effect of theatre interventions on the ability to cope with social problems caused by the epidemic; how different communication practices and theatre techniques, which vary by genre, influence internalization of content and creation of significance for audience members; and individuals’ thoughts, actions, and emotions during the performance.

In addition to interviews, I conducted participant-observation with audience members during any immediate post-performance discussion forums between theatre-makers, HIV peer educators, and audience members. I gathered data on the opinions and emotional responses of audience members, the types of questions or topics audience members pose in discussion, and the conversations between audience members about the production.

(b) How do audience members interpret and use both individual and collective understandings about HIV/AIDS?

I conducted in-depth interviews to ask audience members to share their ideas and understandings about HIV/AIDS, including its biomedical dimensions and the ways the epidemic influences their daily realities. I also asked interviewees to describe how information about HIV/AIDS affects the building of interpersonal relationships and community ties. By gathering information on how audience members interpret the information presented about HIV/AIDS within applied theatre productions, comparisons may be made between those understandings and production intent as defined by theatre-makers. In this way, I collected ethnographic data on whether and
how information discussed within theatre interventions is translated to conceptual and/or behavioral change in daily community life. Theatre-makers’ motives may be compared to what their interventions actually accomplish (intended or not) among audience members.

(c) Are health issues and solutions to problems related to HIV/AIDS being defined in ways that audience members consider actionable, realistic, and consonant with their needs and interests?

I first conducted in-depth interviews to collect data on how audience members process messages, practices, and methods associated with health theatre. The scope of inquiry broadly included questions on their perceptions about HIV/AIDS, the content and key themes of the theatrical performance, what impact production aesthetics had on their satisfaction with the experience, and their understanding of what actionable knowledge about HIV intervention was created or proposed through the performance process on individual and collective levels. I also used cultural domain analysis to construct a domain of health issues related to HIV/AIDS that are important to audience members. I asked all interviewed audience members to free list and then rank order thematic topics of health related to HIV/AIDS that they consider key areas of relevance for their lives.

Accomplishments In-Field

While the prior section describes the kind of methods I used to complete this project, this section outlines the particular research accomplished during the six months of pilot study (2008-2009) and twelve months of dissertation fieldwork (2010-2011).

Interviews:

I conducted 126 total semi-structured, in-depth interviews. These included 81 theatre-makers (56 in Johannesburg, 25 in Cape Town) who produce HIV/AIDS-related performances.
The theatre-makers span the membership of 20 theatre organizations in South Africa. Of those 20 groups, I focused interviews primarily on the membership of seven theatre groups and five individual theatre-makers (n=67). Contextual interviews were collected with theatre-makers from another 13 theatre organizations in the country who were working on a variety of issue-based theatre topics, all of them health-related but not exclusively about HIV/AIDS (n=14). I also held semi-structured interviews with 30 audience members who had seen HIV/AIDS-related theatre in South Africa. These included audience members of shows performed by five of the theatre groups studied (Masibambisane = 7 students; AREPP = 6 students; HIV/AIDS: In It Together = 6 adults; Siyaya = 2 adults; Drama for Life = 5 adults) (n=26) and audience members of two other performances that were part of two different festivals in the country (Street Revolution = 3 adults; Cleansed at Grahamstown = 1 adult) (n=4).

Finally, I conducted semi-structured interviews with nine journalists, four funders, and two clinicians associated with HIV/AIDS or health-related theatre in South Africa. This was intended to provide contextual information for interviews with theatre-makers and audience members. The funder interviews covered four of the five major national funders for HIV/AIDS-related theatre projects. The journalists worked both in Cape Town and Johannesburg primarily as arts and/or health writers.

**Participant-Observation:**

I conducted primary participant-observation with one HIV/AIDS-related theatre training organization, one institutionalized HIV/AIDS-related theatre group, one HIV/AIDS-related theatre group sponsored by the US Embassy and the University of the Witwatersrand, five individuals working privately on projects in the HIV/AIDS theatre industry (two of whom are well-known in the commercial theatre sector), and four community theatre groups involved in
HIV/AIDS-related work. Fieldnotes were taken during participant-observation with each group, which spanned the theatre-production process, including workshopping of plays, theatre games, improvisational sessions, rehearsals, training, performance feedback note sessions, and external examination feedback sessions.

**Performance Data:**

I attended and took fieldnotes on 58 plays, 55 of which were health-related theatre plays at the community and mainstream theatre levels. Not all of these plays were specifically about HIV/AIDS, but they were all related to health topics that have garnered media and government attention in the past several years. Some of these performances occurred at national and regional theatre festivals, and some occurred in other venues. I attended 7 major theatre festivals (ranging in length from 2 to 10 days) across the country during the 12 months of fieldwork.

**Script Data:**

I collected eight HIV/AIDS-related theatre scripts for analysis (three from community theatre groups and five from mainstream theatre or institutionalized theatre organizations).

**Film Data:**

I collected filmed footage of 28 HIV/AIDS-related theatre productions (25 of which I attended) in Johannesburg and Cape Town for in-depth analysis. In addition, I collected filmed video footage of 27 productions in the Drama for Life Sex Actually Festival of 2010 from DFL staff.

**Print Media Research:**

I performed cursory news print media research and gathered publicly available archived media articles/reviews from major newspapers in the country on HIV/AIDS-related theatre productions over the past five years. In addition, I solicited extant copies of play reviews
directly from the nine health and arts journalists across Cape Town and Johannesburg whom I interviewed. I also collected a host of other print and public media data in the form of funding publications given out at the National Arts Festival; festival and conference official and unofficial programs, participation rules, calls for audition and adjudicators, and presenter biographies; course materials, lesson plans, readings, and handouts for three Drama for Life courses, the AREPP: Theatre for Life program and the Laduma Jungle Theatre program; all group vision statements and information pamphlets when available; and performance playbills and handouts when available.

Archival Work:

I secured access to the National Arts Council (NAC) archives to do archival research on HIV/AIDS-related theatre produced in the last ten years. In this part, I collected NAC Annual Reports from 2006-2010; the NAC Survey on the Public and the Arts; NAC Dance Report; and funding information for Theatre Projects and Theatre Bursaries for the years 2007, 2009, and 2010. My time at the NAC was limited because I only gained access to their archives in the last two weeks of fieldwork. I also collected documents from the Business and Arts South Africa (BASA) archive, including annual reports, flyers, grant guidelines and applications, and research reports.

Data Analysis: Selection

In this section, I describe which data I chose for inclusion in this dissertation and the reasons behind those choices.

Projects:

I chose nine theatrical projects/productions to analyze in-depth as part of the primary data set for this manuscript. I have collected video footage and scripts where available for each of these
projects. I chose these specific projects as representative of the data collected on the other total 80 plays/productions which I viewed. In addition, these nine projects were produced by theatre groups or individuals with whom I worked most closely in my fieldwork.

Because I worked more closely with these artists than others, I have been able to perform more in-depth analysis of the theatrical processes, ideologies, and products of these projects. These nine projects span community theatre, mainstream/commercial theatre, experimental theatre, NGO-level theatre, and theatre produced in dramatic training organizations. For similar reasons, I draw primarily on my interactions with four community theatre groups (Siyaya, Hlalanathi, Masibambisane, and Isambane), two institutional organizations (AREPP: Theatre for Life, Drama for Life), one experimental independent project (*HIV/AIDS: In It Together*), and three individual theatre-makers (P.J. Sabbagha, Peter Hayes, and Pieter-Dirk Uys) as my primary data set for this dissertation.

**Interviews:**

Although I conducted a total of 126 semi-structured interviews during fieldwork, I have selected 52 as representative of the data set to use in my primary analysis. Participants belong to the following categories:

*Theatre-Makers:* Of the total interviews collected with theatre-makers (*n*=81), I chose to transcribe, code, and analyze 48 of them for inclusion in the primary data set for this dissertation. The remaining interviews were excluded for a range of reasons, including lack of direct relevance to the project, problems with language, difficulties in the interviewing process, and strong group cohesion in ideas and interview content within the Drama for Life population.
Audience Members: I collected 30 total interviews with audience members, but the resulting data were neither as high quality nor as representative as that from the theatre-maker interviews and is therefore included in my analysis sparingly and mainly as contextual support.

Others: I collected additional semi-structured interviews for contextual data with nine journalists, four members of national funding organizations, and two HIV/AIDS clinicians. I transcribed four of the nine journalist interviews (the other five were not familiar enough with the interview topics to be of significant use). In analysis for this project, I draw on interviews from the four funders and two clinicians for contextual information, but these interviews were not transcribed.

Data Analysis: Methods
Written field notes from participant-observation, interview transcripts, scripts, and collected archive and public media documents were entered into and organized with the MaxQDA 11 qualitative data analysis software program. I coded the data for themes that address the three research objectives and conducted qualitative inductive comparative analysis of the goals, ideology, communication strategies, performance aesthetics, and impact between the HIV/AIDS applied theatre genres represented.

Script analysis in this project consists of close readings and coding of scripts to identify explicit and implicit messages about HIV/AIDS, symbols and metaphors used to describe HIV/AIDS and illness, relationships between characters (both seropositive and seronegative), and character objectives and tactics within the play context. Analysis of this data contributes to understanding the production of public ideas and moral judgments about the epidemic within

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I did, however, code these interviews using MaxQDA 11, which allows the coding of vocal recordings without needing to transcribe the audio recordings as text.
play content, which are underrepresented in most academic attention to dramatic performance about HIV in South Africa.

Quantitative analysis within this project is largely confined to audience demographics and cultural domain analysis. I conducted basic quantitative analysis on the demographic data collected on audience members to construct a profile of typical audience compositions and to determine if there are any correlations between demographic characteristics of audience members (e.g. age and gender) and perceptions of the impact of theatre as a health intervention. I also recorded the results of cultural domain analysis using MaxQDA and ran basic statistical operations to reveal patterns in domain construction (HIV/AIDS-related health issues identified as relevant by theatre-makers and those identified as relevant by audience members). These methods form the basis of my grounded analytic framework.

1.4 Organization of the Dissertation and Main Arguments

This dissertation is organized into five main parts. The first part includes this introduction and a chapter outlining the theoretical framework I employ. The second part details background information necessary to contextualize the ethnographic data and analytical arguments presented in the rest of the chapters. The third part interrogates the concept of “complexity” as theatre-makers use it in relation to sexuality and health. In the fourth part, I expand on theatre-maker notions of complexity to show how and why artists are using this concept to reimagine the possibilities of theatre as an active health intervention in the post-apartheid context. In the final section, I present an anthropological critique of applied theatre as an institution within the broader healthcare industry in South Africa. This part of the dissertation shows how anthropological considerations of political economy and structural violence ground analysis of theatre in particular historical contexts and illuminate the ways in which institutional
relationships and power shape HIV intervention efforts in the country. In the conclusion, I use this in-depth analysis to propose several ways that anthropology can contribute to theatre studies. I also detail how performance studies ideology and theory can contribute equally to medical anthropology, notably in recent efforts to build more integrated ethnographic and analytical models for research on infectious and chronic disease globally.

**Part One**

The first part of the dissertation includes this introduction and a chapter describing the bodies of literature that comprise the theoretical framework on which I draw to analyze health-related theatre in South Africa. It includes the following two chapters:

**Chapter 1: Introduction**

In this chapter, I introduce applied health theatre as a component of the broader HIV/AIDS industry in South Africa. I describe the major research objectives and findings of my dissertation project, along with the research design used. I also include a summary of the organization of the dissertation and the main arguments I elaborate.

**Chapter 2: Medical Anthropology and Performance Studies (Literature and Theoretical Framework)**

In Chapter 2, I provide an overview of the two bodies of literature on which I draw to create a theoretical background for analysis. This includes critical approaches to medical anthropology and the field of performance studies. I also introduce my suggestions for creating an integrated approach to the global study of HIV/AIDS through combining disciplinary strengths from the two fields.

**Part Two**

In the second part of the dissertation, I discuss the contextual information necessary to understand the ethnographic data and theoretical arguments presented in the remaining parts of the dissertation. Part Two includes the following chapters:
Chapter 3: Epidemiology, History, and Political Economy of HIV/AIDS in South Africa

This chapter elaborates the epidemiological, historical, and political economic context required to understand South Africa’s various national reactions to global public health perspectives on HIV and the country’s particular HIV/AIDS policy. Specifically, I discuss how the intersection of the health and arts sectors is deeply embedded in and shaped by a web of institutional forces that both enable and constrain the efforts of artists who attend to sexual health issues and the audiences who participate in their intervention processes.

Chapter 4: Applied Theatre: A Period of Reflection

In Chapter 4, I move from the discussion of politics, economy, and HIV/AIDS policy to an overview of the history of theatre in South Africa (1948-2010), including its applied dimensions and the emergence of theatre dedicated to HIV/AIDS topics. The impact of HIV/AIDS on theatre is broader than in this dedicated form, as it pervades much of the modern theatrical discourse in the country. This chapter elaborates the relevance of applied health theatre in South Africa as it relates to HIV and the AIDS epidemic and explains the rising importance of narratives of innovation and creative risk within the health arts sector. Combined with the previous chapter, this one sets the stage for understanding more contemporary developments within the health communications sector vis-à-vis live theatre performances and contextualizes all remaining data presentation and analysis in the following chapters.

Part Three

In this part of the dissertation, I attend to a central anthropological concern: complexity in life. One of the major ways theatre practitioners are addressing problems within past public health efforts is through development of and advocacy for new frameworks for approaching HIV/AIDS programming. These frameworks are premised on examining perceived past failures of national health promotion and treatment programs that engage with HIV/AIDS, which are
typically seen as static and didactic, and instead privileging the use of dynamic, mixed approaches to production creation. This includes integrating biomedical and arts theories of healing and change as well as addressing multiple levels of audience engagement. In addition, theatre-makers put forward distinct ideas about complexity in subjective experience and its relationship to sexuality and health.

Although various disciplines have directed scholarly attention to the concept of complexity, there has been a resurgence of interest in the concept of complexity among social science academics since the 1990s. Calls for deeper attention to complexity have been issued from anthropology (Biehl 2009; Bourgois & Schonberg 2009) and tend to define complexity as the complicated interactions that emerge at the interface of various domains in multi-faceted social systems, as well as what is produced through these interactions. In my dissertation research, I found that this term was understood and used differently in specific ways by the artists with whom I worked.

Rather than assuming an a priori definition of complexity, I argue in this section for the need to push the parochialism of common ideas about what the concept “complexity” means. In the chapters that follow, I present ethnographic data for a grounded analysis of what complexity means to the people with whom I worked. I then take those local understandings of complexity as the basis for theorizing.

In this part of the dissertation, I have three primary objectives. First, I discuss more in-depth the sociopolitical context that has led to artistic critiques of biomedical and public health HIV initiatives, including explicating the reasons why theatre-makers consider past HIV health promotion attempts in the country a failure. Second, I introduce the ideology behind theatre-maker demands for the development of new intervention frameworks, including the theories of
healing and performance on which their beliefs about health intervention are based and how those theoretical premises differ from the ideology of former (dominant, global public health) paradigms. Finally, I detail what kinds of framework changes are being developed in and advocated by some members of the arts community. I argue that the theatrical aesthetic is being positioned as providing a unique space for combined bodily, visual, aural, educational, interactive, and creative engagement with HIV-related topics.

Overall, this part of the dissertation is meant to be conceptually generative and is about developing constructs, language, and frameworks for augmenting the ways in which the social sciences attend to lived experience of HIV and the AIDS epidemic through incorporating select conceptual ideas from the humanities (specifically the discipline of performance studies and acting theory). In the first chapter of this part of the dissertation, I analyze the kinds of innovation and creative risk theatre-makers are attempting in relation to aesthetics. In the second, I analyze the kinds of language and optics theatre-makers are starting to incorporate into their intervention work on HIV/AIDS and how these changes reflect broader shifts in their ideas about the possibilities for health programming in the post-apartheid period. Part Three contains the following chapters:

**Chapter 5: Complexity Aesthetics**

For many theatre-makers in the country, the answer to “what have we learned from past failures?” has resoundingly been “increase boundary-crossing in our work—in both form and content.” An overwhelming majority of theatre-makers conceptualize this needed change (in how to create theatre work in relation to HIV) as a shift toward prioritizing and valuing blurred boundaries between content and form and between artistic and biomedical initiatives. This means a shift toward mixing and matching underlying theories of healing, change, and practice
from a variety of theatre genres, as well as integrating biomedical information with emotional and social components of the AIDS epidemic.

This idea rose from the widespread critiques I discuss in Chapter 4 against the kinds of interventions that solely privilege biomedical fact-giving about HIV transmission and risk or are framed in problematic ways. In this chapter, I first describe the initial theatre genres used to communicate health information about HIV in the country. Next, I discuss genres of increasing importance to theatre-makers as artistic critiques of past intervention efforts mount in the public realm. I argue that theatre-makers are moving toward a mixed approach to aesthetics (or “Syncretic Theatre”) in a directed attempt to bolster the ability of HIV intervention efforts to handle both nuance in life and experiences of the unknown in health/care.

In addition to integrating biomedical and artistic concerns within interventions, theatre-makers focused on introducing more fluidity and dynamism into their work by increasing their mastery of a wide variety of theatrical intervention and performance styles/strategies for purposes of experimental theatre work. I suggest this effort is about expanding communication styles and practices to more fluidly react to dynamic changing sociopolitical contexts in the country, as well as the ever-shifting emotional and affective states people experience in daily life. It has much to do with introducing new aesthetics and challenging prior forms of intervention.

Chapter 6: Complexity: Language and Optics

In Chapter 6, I call for greater anthropological engagement with the concept of complexity and how it shapes people’s lives—attention to local definitions of complexity, why complexity becomes important, and how people deal with it in daily life. In addition, I argue for the utility of privileging in broader research agendas the kind of complexity my informants
discussed: complexity as issues of temporality (“moments”) and incoherence (“shadows”). In my fieldwork, I discovered that for theatre-makers, the focus of interventions was often on developing language to talk about and questions to frame incoherence in lived experience and then interrogate how that incoherence affects people’s health actions and outcomes.

I suggest a complexity framing can serve a similar role within anthropology regarding vocabulary development and shifting optics of analysis. In particular, in this chapter I argue for using “complexity” as a framing device to make the incoherent parts of lived experience an explicit focus of anthropological analysis rather than a tacit one. This is about intentionality—making complexity a primary analytic as an intentional strategy to reveal information about how society and human experience are shaped by notions of incoherence. By using complexity as a framing device, new information on a wide range of topics becomes accessible. Three important topics include people’s existential experiences of the not-fully-known in relation to health and sexuality; the links between system and experiential complexity; and subjective understandings of contradiction (within people’s thoughts, actions, feelings, and circumstances) as they relate to defining health and seeking healthcare and treatment for sexually transmitted infections (STIs).

I argue that using a complexity framework is instrumental in creating a more nuanced integration of affective considerations into historical, political, economic, and linguistic ones within the social sciences. This is about capturing how people experience their lives as enmeshed in systems that do not always (or even very often) produce worlds characterized by stability, immutability, or coherence.

**Part Four**

In the fourth part of the dissertation, I expand my analysis of theatre-maker ideas about more deeply incorporating complex aspects of lived experience into national public health programs. I show how artists are putting the aesthetics and constructs of complexity I describe
in Part Three into action within recent intervention efforts. In addition, I use the constructs developed in Chapter 6 to talk about complexity (moments and shadows) to show what kind of anthropological analysis is possible when subjective experience of incoherence is privileged as an analytic category. In particular, I discuss what kinds of HIV program innovation theatre-makers are advocating within global public health attention to HIV and how those innovations challenge some common ideas about topics of anthropological interest—specifically global health agendas and language, stigma, reflexivity, the individual/community and structure/agency dichotomies, health subjectivity, and ideas about social change through health activism. These topics are presented through a two-chapter discussion of examples of health processes within theatre that are critical to the HIV/AIDS work of my project’s informants. In Chapter 7, I analyze the process of “acknowledgment,” and in Chapter 8, I attend to reflexivity as a health theatre process.

**Chapter 7: Complexity in Action: Acknowledging Incoherence**

In Chapter 7, I analyze how, why, and in reaction to what political pressures theatre-makers have begun acknowledging complexity within interventions related to HIV. In addition, I investigate how artists are using the “shadows” construct as a way to acknowledge complexity in life in order to create conceptual space for reconsideration of a host of actions related to sexuality that are often stigmatized or framed as problems within the media and some public health campaigns. Rather than constructing the kinds of actions, perceptions, and categories of being indexed by “shadows” as problems to be fixed, theatre-makers promote acknowledging the existence of people’s shadows in a value-neutral space devoid of moralizing good/bad discourse.
Chapter 8: Complexity in Action: Creating Reflexive Health Subjects

In Chapter 8, I argue that theatre-makers are actively challenging the scope and techniques of reflexivity implicit in dominant public health models for HIV intervention. In particular, I suggest that theatre-makers are re-conceptualizing what kinds of reflection are important within HIV/AIDS intervention programs, positioning these new ideas about reflection as a form of health activism for the post-apartheid era, and subtly but significantly recasting the individual/community dichotomy implicit in many global public health outreach programs by challenging neoliberal conceptions of the responsible health citizen. Through these shifts, I argue that theatre-makers are actively developing and promoting an alternative form of health subjectivity based on critical reflexivity around the relationships between self, society, structure, and agency.

Part Five

The fifth part of the dissertation is an anthropological critique of theatre as an institution within the broader healthcare industry of South Africa. While Parts Three and Four examine the story of what applied health theatre-makers are trying to do within the HIV/AIDS industry, this part of the dissertation tells the story of how power and oppression articulate within the artistic sector and shape what happens in practice. A main goal of this chapter is the generation, presentation, and analysis of ethnographic data on theatre as an institution. Although many performance studies scholars attend to the ways in which applied theatre programs operate socially as part of larger public health practices, similar attention to theatre as an institution within healthcare is not as robust within anthropology broadly and medical anthropology in particular.

In this part of the dissertation, I argue for moving away from the common trope in anthropological scholarship of analyzing theatre as an auxiliary component of biomedical
practices and toward consideration of theatre as a primary institution within the South African public health sector. By doing so, productive avenues are opened for studying (1) the institutional control of experience among theatre-makers who are deeply devoted to exploring sexuality and health in the post-apartheid era and (2) the kinds of public knowledge produced about HIV within artistic work and the aesthetics through which it is communicated.

In particular, I argue that attending to the institutional control of experience and knowledge production within applied health theatre enables analysis of the ways through which organizations choose to convey their ideology, how those choices of form reflect politics, and what theatrical content reveals about NGO support or critique of the status quo. Privileging the study of applied health theatre as an industry in relation to other industries and institutions allows researchers to begin saying things about the following: the kinds of institutional power and influence that shape the context in which knowledge about HIV/AIDS is produced within the arts (critical structural analysis), how theatre-makers experience these contexts (subjective and interpretive analysis), and what strategies artists implement in practice when they begin to engage with and respond to institutional power structures (analysis of creative innovation).

Shifting focus to theatre as an institution allows access to understanding how theatre-makers, as health workers, think and feel about the possibilities and limits of their work in the present political-economic context.

In this part of the dissertation, rather than establishing only that applied health theatre does interact with other institutions and industries in the country, I analyze what kinds of power are involved in these interactions and what kinds of creativity are enacted when theatre-makers attempt to negotiate the competing interests of involved stakeholders and work at the interstices of disciplinary boundaries. This part of the dissertation contains the following two chapters:
Chapter 9: Power: Compromise and Institutional Control of Experience

In this chapter, I assert that analyzing theatre as a social institution and an active industry within South Africa opens up certain information about the applied theatre sector: relationships between theatre stakeholders, its history as embedded in power relations, and the political-economic context in which theatre-makers produce knowledge about HIV. Applied theatre operates in relation to other institutions and industries within the country, and its key players have to negotiate the competing interests of those other industries. However, very little is known about this industry within the social sciences. Few ethnographers have ventured into this area of research or examined applied theatre related to health as a social institution. In this chapter, I describe who the main stakeholders are within this industry and analyze how participants in applied theatre related to health interact with other institutions and industry sectors in the country, as well as how participants negotiate the competing interests of those sectors (primarily health, government, and funding).

I ground this discussion through presentation of a detailed ethnographic analysis of one of the best examples of how applied theatre is intricately embedded in a web of institutional power relations among a variety of sectors: the arts and health funding situation in the country in relation to HIV/AIDS. This is an important example because funding (and access to it) is implicated deeply in what constitutes the web of structural barriers and supports to (effective) intervention programs. In many HIV artistic encounters, theatre-makers have very distinct ideas about how to produce knowledge, create meaning, and affect audiences when it comes to topics about health, sexuality, and illness. However, this integrated focus is often heavily mediated by outside institutional forces with competing priorities. These competing priorities often lead to a
perceived (and sometimes real) disconnect between theatre-maker and funder goals in relation to impact and meaning-making processes.

In this chapter, I argue that the changing relationship between the State and the Arts in South Africa from the early 1990s to the present, including government legislation and policy, has significantly shaped what kind of knowledge is produced about HIV/AIDS, as well as the aesthetics through which that content is communicated. In addition, national and international funding organizations have contributed to constructing HIV/AIDS health communication agendas within the arts. As a result, theatre-makers must work constantly to negotiate competing interests of the various stakeholders involved in their projects, and processes of ideological compromise often occur. I analyze the effects of institutional power on conceptions of artistic integrity and impact within artistic HIV/AIDS endeavors. I also detail how theatre-makers characterize the funding environment as problematic and inattentive to their voices, opinions, frameworks, and experiences. Finally, I incorporate discussion of associated ethical considerations, intended and unintended consequences, and structural problems that arise from these complex practices of negotiation that occur within the applied health theatre funding realm.

**Chapter 10: Speaking Back to Power: Creative Economies and Parallel Contributions**

In this chapter, I analyze a variety of ways theatre-makers have begun speaking back to the forms of institutional power and control I introduce in Chapter 9. In particular, I argue that theatre-makers have begun deploying certain ideologies and discursive topics as a bid to gain cultural capital, structural power, and material resources within the broader HIV/AIDS intervention industry in the country. These topics include narratives about creative economy, interdisciplinarity, complementarity in programming, and program frameworks that privilege the
parallel contributions of multiple modalities of treatment, prevention, and care rather than narrowly supporting biomedical notions of health.

I argue that this perspective is about opening up the possibilities for interventions—what they can do and accomplish—by incorporating more strategies, broader goals, alternative tactics, and rethinking institutional relationship possibilities. In addition, I argue that discursive use of a parallel contributions narrative by theatre-makers is a way to make the symbolic and social boundaries between intervention models permeable in order to promote certain projects of artists, such as expanding definitions of healing. Finally, I suggest that one of the main ways theatre-makers are creatively speaking back to institutional power and struggles over funding and sector positioning is by challenging hegemonic metrics of “progress” and “success” within interventions as a way to effect social change.

**Conclusion**

**Chapter 11: Conclusion to the Dissertation**

In this final chapter, I discuss the applied implications of the various arguments and frameworks I present in prior chapters. In particular, I discuss possibilities for expanding conceptual ways to understand and methodological ways to access information about (1) the effects of HIV/AIDS within communities and in individual people’s lived experience and (2) the creative responses front-line health workers develop to mediate between global public health agendas and the particularities of local health needs.

The conclusion also identifies other avenues of analysis and writing that are important for understanding the full scope of the broader implications of this research but were not included in this dissertation because of page constraints.
CHAPTER 2
Medical Anthropology and Performance Studies (Literature and Theory)

As a method, ethnography is particularly useful for research on how theatre articulates in the public realm with HIV/AIDS. It provides a way to analyze theatre through a framework that highlights, by direct observation, dynamic interactions between politics, economy, health, art, and activism in the lived reality of those involved. However, very little ethnography on HIV/AIDS and live theatre exists within medical anthropology globally, and none exists on this cultural phenomenon in South Africa. This dearth of data is one reason I advocate the analysis of theatre as a primary institution within health intervention projects: we know little about applied health theatre as an industry.

From an anthropological perspective, a body of literature exists that examines HIV/AIDS in South Africa (and elsewhere) broadly and deeply from several different perspectives, including anthropological analysis of the political economy of health, public health strategy and policy analysis, economic impact, and health activism. Similarly, anthropological literature exists on the concept of “performance.” However, in most analyses, everyday life/activity is discussed as performance. Less common outside of the anthropology of art are anthropological analyses of actual performance mediums, artistic products (such as plays), and their effects in a broader social context. In particular, much less literature exists within medical anthropology that analyzes the combination of the concepts and experiences of HIV/AIDS and art, including the resulting production of social impact and meaning.

In contrast, the field of performance studies has a robust history of examining the concept of “performance” in a multitude of ways, including analysis of cultural products and applied
health theatre practices in particular. However, despite this discipline’s stated focus on social and historical context, scholarship on specific applied health theatre projects within this field often lacks the kind of deeply nuanced thick description and political economic analyses that are privileged within the ethnographic tradition.

In this dissertation, I put performance studies perspectives on applied theatre in conversation with attempts in medical anthropology to develop new ways to study HIV/AIDS and experience. Recently, medical anthropologists have begun rethinking how best to frame their work to reflect the increasingly complex and dynamic political, moral, and knowledge economies of global HIV/AIDS. Increasingly, anthropologists are asking what the most relevant questions for contemporary contexts are, as well as what kinds of theoretical frameworks are best suited to intervention development in a world where living with HIV long-term is becoming as common as dying from AIDS-related causes was 30 years ago. Medical anthropologists have been searching for additional ways to attend to the changing nexus of HIV, human experience, meaning, and structural inequality, and I argue throughout the dissertation that analysis of performance components of applied health theatre yield some useful techniques, tools, and conceptual constructs to do this.

I suggest that the integration of performance studies theory with medical anthropology leads to productive interdisciplinary approaches to theorizing the lived experience of HIV/AIDS globally as well as practical solutions to enduring HIV/AIDS intervention programming problems on the ground. While I describe these approaches in more depth throughout the dissertation, I introduce here the two major bodies of theory on which I draw to create a

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10 E.g. One important practical component of artistic health interventions is their role in providing people a way to cope with their own experiences in regards to HIV.
framework for analyzing the connections between theatre, politics, agency, and health in South Africa.

2.1 Medical Anthropology and HIV/AIDS: Shifting Practices in Integrated Ethnography

The political, moral, and knowledge economies of HIV/AIDS in South Africa are complicated and require a variegated approach for which anthropology is well suited. Ethnography on HIV/AIDS in general has led to insights on the structural violence of poverty (Farmer 1992); male perspectives on sex and AIDS (Dumestre & Toure 1998); traditional healers (Ngubane 1977); the fractured movement of HIV/AIDS knowledge (Kane 1998); failures and successes in intervention programs (Campbell 2003); extramarital sexuality (Wardlow et al. 2009); marital HIV risk (Parikh 2007); and the politics of HIV/AIDS in South Africa (Fassin 2007), among many others. Although anthropological contributions to world understanding of HIV/AIDS have been significant, there is still room to push the boundaries of the types of questions we ask about the epidemic.

One way to push these boundaries is to pursue the integration of various bodies of theory to produce dynamic, multi- (and inter-) disciplinary questions. I posit the study of HIV/AIDS theatre provides that kind of important but overlooked site of analytical utility. Because it is situated at the intersection of politics, health, art, social movements, representation, communication, and education, analysis of HIV/AIDS theatre is ideally located to contribute to many different anthropological areas of inquiry. This ties in well with new approaches in medical anthropology that have emerged within the last decade and are dedicated to developing novel ways to study HIV/AIDS and human experience. I situate my research among these new, integrative attempts within anthropology to make continued progress in addressing AIDS globally.
In this section, I first provide a brief overview of trends in how HIV/AIDS has been studied within anthropology historically, which provides context for new developments in the field. Next, I detail an emerging integrative perspective in the anthropology of HIV/AIDS. I then situate my dissertation project within this new literature and assert what contributions can be made to medical anthropology as a field by examining the institutional role of theatre within the broader health industry.

**Past Anthropological Trends in the Study of HIV/AIDS**

Because anthropologists were slow to enter the HIV/AIDS research arena in the 1980s, the dominant paradigm structuring scientific and social science research on HIV/AIDS has been a biomedical, individualistic one (Altman 1999; Parker 2001; Schoepf 2001). This dominance endures, but starting in the early 1990s, anthropological contributions to the study of HIV/AIDS increasingly gained importance. Currently, anthropology provides some of the most creative and important alternative approaches to HIV/AIDS research, and anthropologists provide a much-needed critical voice to the larger discussion (Parker 2001).

Although earlier biomedical research foci included behavioral correlates of HIV infection among individuals, risk groups, and behavior change, anthropologists voiced critiques of those reductionist and individualist approaches (Schoepf 2001; Parker 2001; Altman 1999). Earlier social science research that emerged in response to HIV/AIDS used similar quantifiable data and focused primarily on individual knowledge, attitudes, and practices (the KAP approach) associated with the risk of HIV infection. These studies largely employed psychological theories of behavior change, such as the Theory of Reasoned Action or the Health Belief Model, and the underlying goal included creation of prevention and intervention strategies that would lead to decreased HIV risk through changed individual sexual behavior (Parker 2001). The limits to this
kind of research and its subsequent strategies quickly became apparent, and anthropologists were among the first social scientists to promote the inclusion of both cultural and structural factors in the study of HIV (Parker 2001). However, it was not until the late 1990s that anthropological contributions to HIV/AIDS research gained enough traction to contribute significantly to a larger body of interdisciplinary literature (Altman 1999).

Two major trends in anthropological literature on HIV/AIDS have been (1) the study of cultural meanings that construct sexual experience and shape practices associated with risk of HIV transmission and (2) political economic analyses of structural forces that shape the context for HIV/AIDS epidemics and health inequality (Treichler 1999; Parker 2000). The political economy approach is currently the dominant anthropological paradigm for analysis of HIV/AIDS (Parker 2001; Farmer 1999, 2003). This paradigm acknowledges and highlights the central role of politics, economics, and other structural factors in determining the geography of AIDS epidemics, as well as the barriers and facilitators to successful intervention campaigns (Baer et al. 1997; Feldman 1994; Parker 2000). As Richard Parker notes, this kind of research has emerged in a number of different settings through a number of different voices. He states:

The language that it has used, the conceptual tools that it has employed, and the specific focus of analysis have often varied (e.g. Bond et al 1997; Farmer 1992; Singer 1994, 1998). In spite of the differences in terminology and at times in research emphasis, this work has consistently focused on what can be described as forms of ‘structural violence,’ which determine the social vulnerability of both groups and individuals. In developing these concepts, the work considers the interactive or synergistic effects of social factors such as poverty and economic exploitation, gender power, sexual oppression, racism, and social exclusion (Farmer et al 1996; Singer 1998; Parker et al 2000). And the research has typically linked this vulnerability to a consideration of the ways in which such structural violence is itself situated in historically constituted political and economic systems—systems in which diverse political and economic processes and policies (whether related to economic development, housing, labor, migration or immigration, health, education, and welfare) create the dynamic of the epidemic and must be addressed in order to have any hope of reducing the spread of HIV infection. [Parker 2001:168]
Although the political economy of health model dominates the field, more recent research on community mobilization and activism in relation to HIV/AIDS has gained prominence (e.g. Parker 2011; Parker 1996; Nel et al. 2001; Altman 1999; Robins 2006). These studies increasingly draw on social movement theory in order to investigate the articulation of HIV/AIDS, power, and oppression (Paiva 2000; Parker 2001; Robins 2004). Recent advances in research also include forays into understanding lived experience of the AIDS epidemic, search for and engagement in therapy processes, and community response to mobilization efforts (Parker 2011; Schoepf 2001; Campbell 2007; James 2002; Hirsch et al. 2010; Nguyen 2010). Limits of biomedicine are increasingly noted, and although political economy provides an excellent framework for understanding power dynamics and underlying structures that shape experience of HIV/AIDS, new questions about transformation and subjectivities are being explored.

**Integrative Approaches: The “New HIV/AIDS Ethnographers”**

These new questions and perspectives provide opportunities to explore the HIV/AIDS epidemic in other ways, and some of the most recent developments in the Anthropology of HIV have come from emerging perspectives. One of these shifts is to analyze HIV/AIDS as a process—a social process inscribed on collective and individual bodies as a result of both cultural and material factors. Understanding HIV/AIDS this way enables a reframing of research that pushes boundaries of contemporary anthropological inquiry, reconnects the political economy framework to symbol, meaning, and phenomenology, and creates access to aspects of human experience that have the potential to inspire even more innovative research/connections that shed light on a range of anthropological questions, including those involving power and subjectivity, lived experiences of transformation, and agency. This dynamic nexus is where I
situate my work. As stated, two of the most common approaches to framing the investigation of HIV/AIDS include a biomedical lens and an anthropological political economy framework; however, a third, more subjective, phenomenological approach represented by, among other endeavors, artistic initiatives to address the epidemic, provides analytical space rife with opportunities to transform current anthropological analysis of HIV/AIDS. I see particular potential in integrating these three approaches.

Since the early 2000s, there has been growing recognition of a new methodology and analytic framework within the anthropology of HIV (and HIV/AIDS studies more broadly). This emerging framework eschews the binaries of past discipline separatism and instead works to integrate a variety of methods, techniques, and approaches for studying the epidemic in an inter- or multi-disciplinary way. In my past writing, I have called it the “integrated approach” to studying HIV/AIDS within medical anthropology. Medical humanities scholar Gregory Tomso (2010) has recently recognized the same trend and simply terms it “the new HIV/AIDS ethnographers.”

This approach actively seeks to integrate levels of analysis that range from individual subjects through macro-social determinants of disease and capture attention to language, emotion, and subjective elements in addition to structural violence in more robust ways than has been represented within critical medical anthropology scholarship in the past. The approach is most clearly illustrated in ethnographic work on HIV/AIDS by a handful of scholars. Among the scholars who have emerged in the field to give us the best examples to date of ethnography that combines subjectivity, lived experience, political economy, linguistic, and other approaches in an actively holistic analysis that attends to the very real complexities people experience in everyday life are the following: João Biehl (2005, 2009), Didier Fassin (2007), Mark Padilla (2007),
Hector Carrillo (2002), Shao-hua Liu (2011), and Sandra Theresa Hyde (2007). Within the anthropology of infectious disease more generally, an example may be found within the work of Charles Briggs and Clara Mantini-Briggs (2004). Mark Hunter (2010) has done work in this area specifically focused on HIV in South Africa.

This kind of analysis blurs the lines between history, political economy, phenomenology, discourse analysis, studies of affect, social movements, and ethnography, as well as the distinction between individual and context. It begins with historical analysis at a global level and moves gradually through analysis of the political-economic contexts that shape lived experience and subjective understandings of illness, health, and sexuality. This development in the anthropology of HIV/AIDS combines the kind of meaning-centered, interpretive, and subjective project coming out of the Harvard and Berkeley schools of anthropology (spearheaded by Arthur Kleinman and Paul Farmer, with contributions from other scholars such as Nancy Scheper-Hughes, Veena Das, Margaret Lock, and Anne-Marie Mol) with the driving theoretical paradigm of critical medical anthropology, which advocates applying critical theory in analysis of the political economy of health (and the effects of social inequality on disease in a given population). This emerging approach avoids focus on the individual through a mere behavioral perspective and instead privileges meaning-centered analysis couched in critical political-economic attention to social inequality.

This framework answers disciplinary calls that have long been standard within medical anthropology. As early as the mid-1990s, heavyweight anthropological scholars of HIV/AIDS, such as Douglas Feldman, Richard Parker, Paul Farmer, and Brooke Schoepf, have either been advocating for this kind of integrated approach or have been actively working out how to accomplish it. However, it is only within the past decade that scholars have started to answer
that call in a focused way. Perhaps the most ubiquitous banner call of social scientists in the past 20 years highlighted the necessity of paying attention to local context in HIV/AIDS intervention practices rather than applying blanket prevention, treatment, or care solutions (Schneider & Stein 2001; Campbell 2007; Altman 1999; Schoepf 2001; Parker 2001; James 2002; Randolph & Viswanath 2004).

This call has been joined, among others, by the increasingly common recommendations of anthropologists to privilege analysis of interconnections or the interface between prevention and treatment; applied and theoretical frameworks; structure and agency (Schoepf 2001; Kippax et al. 2013); community mobilization, empowerment, activism, and advocacy (Robins 2004, 2006; Schneider 2002; Parker 1996; Altman 1999; Jennings & Anderson 2003; James 2002; Campbell 2007); and attention to symbol, meaning, discourse, lived reality and subjectivity, representation, and the embodiment of inequality represented by HIV (Biehl 2005; Farmer 1992; Wood et al. 2007; Schoepf 2001, Singer & Erickson 2011; Lisk 2010; Jacobs & Johnson 2007; Wood & Lambert 2008; Campbell 2008).

Some of the more senior scholars in the field have produced publications typologizing the waves of AIDS research within anthropology and are now actively advocating combining the methodologies of these distinct approaches to produce a more integrated framework (e.g. Singer & Erickson 2011; Parker 2001; Parker 1996; Schoepf 2001). For 25 years, articles within social science have reiterated the need to privilege analysis of these topics. It is now important to consider what the next step should be. I suggest an important question for us to consider as a field is how to operationalize these calls for interconnected analysis in practice. This is where I see the potential for analysis of theatre to contribute to the development of medical anthropology.
frameworks by providing some conceptual tools, vocabulary, and methods for engaging in this sort of integrated theoretical project.

2.2 Performance Studies: The Betwixt and Between

In contrast to medical anthropology, broad trends within performance studies are difficult to pin down, explain, or capture with any precision primarily because of the field’s intense disciplinary commitment to interdisciplinarity. The playground of performance studies is the liminal: the betwixt and between. At its core, performance studies synthesizes approaches from a wide variety of disciplines in the social sciences, gender studies, history, psychoanalysis, area studies, and media and popular cultural studies. Theoretically, the field pulls strongly from critical pedagogy, critical theory, phenomenology, existentialism, subjectivity studies, sociology, anthropology, semiotics, acting theory, and poststructuralist thought. Because the field casts such a wide net and draws from so many disparate bodies of theory, scholars within performance studies often have a difficult time defining exactly what objects of study the field privileges, which theoretical frameworks it uses consistently, and what methodology or methodologies to use in gathering and analyzing data. Performance studies scholars are notoriously invigorated by this difficulty: the uncertain, ambiguous, liminal, complex, complicated, and undefined are strong disciplinary interests and what tend to draw people to performance scholarship.

Origin of the Field: Between Theatre and Anthropology

Dell Hymes (1974) states that it is through the study of performance that academics can look forward to an integration of the social sciences and humanities. Forty years later, I agree with heart of this statement with several important caveats. While scholars in the humanities who study performance have drawn heavily from social science theory, the number of contemporary social scientists who actively incorporate performance theory and concepts from
the humanities are not as numerous. The active incorporation and consideration of performance concepts from the humanities was more prominent within 1950s-1980s anthropology and sociology than it is today. In addition, although it is still common to find anthropologists who rely heavily on performance as a metaphor for social life, it is less common to find social scientists who explicitly analyze artistic institutions as such and incorporate theories of healing, social change, performance, and affect that are foundational to the humanities (particularly the fields of performance studies and theatre studies).

Performance studies is a relatively young field. During the 1980s-1990s, the discipline grew out of a response to scholars associated with theatre departments in the United States who recognized a need for curriculum change to reflect wider definitions of what constitutes performance as well as the increasingly global dimensions of theatre work (Bial 2003). The genealogy of the field can be traced back to the establishment of performing arts departments in United States universities in the 1980s and later in Australia, England, Wales, France, and Brazil.\(^{11}\)

Although the field is in its fourth decade among formal institutional structures, its intellectual roots spread to the 1970s with collaborations between anthropologist Victor Turner and theatre scholar Richard Schechner. One of the pioneers of the field, Schechner coined the term “performance studies” through his work with Turner in the late 1970s and early 1980s. The common designation of the field as “between theatre and anthropology” is understandable but

\(^{11}\) The twin origins of Performance Studies are the founding programs at New York University under theatre scholar Richard Schechner and Northwestern University under anthropologist Dwight Conquergood. Other notable programs in the US include performance studies departments at Brown University, University of California—Los Angeles, University of California—Berkeley, University of Wisconsin, Texas A&M University, University of North Carolina—Chapel Hill, University of Maryland, Louisiana State University, and Indiana University—Bloomington. Notable foreign programs include those at the University of Sidney, University of Hamburg, University of Warwick, University of Paris, and the University of Wales. Notable supporting presses include Routledge and the University of California Press (Kirshenblatt-Gimblett 2004).
somewhat misleading: the field draws on a wide intellectual community and contributes to an increasing body of diverse academic traditions.\(^\text{12}\)

**Major Objects of Analysis**

Broadly, performance studies takes “performance” as its object of analysis—in all of its varied social manifestations and definitions. Prominent scholar Barbara Kirshenblatt-Gimblett notes that “performance studies starts with a set of concerns and objects and ranges widely for what it needs by way of theory and method” (2003:43). The field of performance studies takes performance as an organizing gestalt for the study of a wide range of behaviors and actions without limiting the types of approach that may be used to study the intersection of performance and culture. Many of the objects of study within performance studies are coextensive with salient concerns of contemporary anthropology. In particular, shared broad concerns include the following: performance/performing/performativity, mimesis, rhetoric, communitas, liminality, ritual, play, agency, action, embodiment and embodied practices, materiality, sensory experience, affect, personhood and identity, corporeality, the senses, creativity, reflexivity, subjectivity and intersubjectivity, presence, knowledge production, and communication (Kirshenblatt-Gimblett 2004; Bial 2003; Palmer & Jankowiak 1996).

Performance studies scholars also seek to understand knowledge industries, particularly those related to knowledge that is located in the body.\(^\text{13}\) In addition, many scholars in the field

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\(^{12}\) There are a few key scholars who make their home in the field of performance studies (e.g. Henry Bial, Richard Schechner, Jose Munoz, Diana Taylor, Barbara Kirshenblatt-Gimblett, and Peggy Phelan). However, most of the field’s key theorists tend to come from Departments of Drama, Comparative Literature, or Theatre Studies (e.g. Brooks McNamara, W. B. Worthen, Marvin Carlson, Phillip Zarrilli); English, Literary Criticism, and Communication (e.g. Jon McKenzie, Philip Auslander, Eve Kosofsky Sedgwick); Philosophy (e.g. Susanne K. Langer, Judith Butler, J. L. Austin); Anthropology, Linguistics, Folklore, and Sociology (e.g. Richard Bauman, Dwight Conquergood, Johannes Fabian, Clifford Geertz, Victor Turner, Edith Turner, Erving Goffman); Psychology (Brian Sutton-Smith); Cultural and Area Studies (e.g. Raymond Williams, Frances Harding, Isidore Okpewho); and practicing theatre-makers, including actors, directors, playwrights, and performance artists (e.g. Herbert Blau, Bertolt Brecht, Jerzy Grotowski, Antonin Artaud, Lee Strasberg, Eugenio Barba, Konstantin Stanislavski, Vsevolod Meyerhold).
work from the premise that performance is an inherent constituent of all human communication, which echoes common anthropological approaches (Birdwhistell 1970). Another focus of analysis is human artistic expression. Because many global art forms synthesize movement, sound, speech, narrative, objects, and story, collating the study of performance under one academic roof avoids parsing the study of various artistic forms into disparate disciplines medium by medium. Performance studies also widens the range of what can be counted as art-making practice, challenges aesthetic hierarchies, and analyzes how those hierarchies are formed in society (Kirshenblatt-Gimblett 2004). There are a few major approaches to thinking about “performance” as an object of analysis in the field (Carlson 2004, Carlson 1996; Auslander 2007; Schechner 2013; Bial 2007). I focus here on the approach developed within New York University in the 1980s.

The “Broad Spectrum Approach” to performance was pioneered by Richard Schechner and popularized within the Department of Performance Studies at New York University (NYU). According to performance scholar Henry Bial (2004), the term “performance” often refers to a tangible, bounded event that involves the presentation of rehearsed artistic actions; however, this definition may be extended to other cultural events that involve a performer.

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13 For example, performance studies scholars often draw on theoretical concepts ranging from Marcel Mauss’ (1973) techniques of the body, Otto Sibum’s (1995) gestural knowledge, Paul Connerton’s (2011) body memory, to Pierre Bourdieu’s (1977) concept of habitus.

14 A second major intellectual paradigm among performance studies programs includes the “Aesthetic Communication Approach” of Northwestern University. This approach studies the performative nature of human communication in all its varied forms (Kirshenblatt-Gimblett 2004). While NYU shifted definitions of theatrical practice to expand what can be framed as a theatrical event and what counts as performance, the Northwestern Performance Studies Department, mainly through Dwight Conquergood, expanded the notion of performance by locating it within the School of Communication and the primary domains of orality, speech, and communication. The Performance Studies department at Northwestern sprung from historical institutional elocution and literary traditions combined with Conquergood’s anthropological background. This second approach also expands notions of literature to include not only written text but also “cultural texts.”

15 The NYU Department of Performance Studies was established in 1980 as the first of its kind.
(someone doing something) and a spectator (someone observing something). What is key in this shift is that “performance” as a concept is considered more productive when uncoupled from any culturally specific divisions of the arts by medium and genre (e.g. theatre, dance, music, performance art) and opened to include a broad spectrum of additional activities.

In this definition, performance is construed as a continuum of human actions ranging from ritual, play, sports, politics, religion, performing arts, to the enactment of social, professional, gender, race, and class roles, through to healing (from shamanism to surgery) (Schechner 2004). The expansion of the study of performance was the central project of the NYU program from its founding. It was the result of increasing recognition among theatre scholars in the 1980s that while important, the historical focus on European and American theatre traditions in United States academia was marginalizing scholarship on other kinds of performance in other places in the world. This narrow focus on European theatre traditions was out of sync with increasingly international, global, intergeneric, and multicultural systems of professional performing arts (Bial 2003).

This move toward a more interdisciplinary intellectual project for studying an expanded idea of performance originated with Schechner’s convictions that only a small part of the world’s cultures equated theatre with written scripts, so any program in performance studies should start with a foundational intercultural understanding of “performance” (Phelan & Lane 1998). Schechner states, “Performance is a very inclusive notion of action; theatre is only one node on a continuum that reaches from ritualization in animal behavior (including humans) through performances in everyday life—greetings, displays of emotion, family scenes, and so on—to rites, ceremonies, and performances: large-scale theatrical events” (1977:1). Through the initial work of scholars within NYU’s Performance Studies Department, ideas about “performance”
were expanded to include many other types of social action other than bounded, limited notions of “theatre,” including performance in everyday life\textsuperscript{16}. This idea of “performance in everyday life” was initially popularized by Erving Goffman (1960), who was one of the first social scientists to turn toward theatre for a framework through which to interpret non-theatrical behavior (Bial 2004). Through this perspective, performative behavior, not just performing arts, becomes an object for scholarly analysis.

Richard Schechner is one of the most well-known contemporary names within performance studies, and he borrowed heavily from Gregory Bateson and Victor Turner in shaping his conception of formal research approaches to theatricality (Beeman 1993). Schechner’s primary contributions include analysis of the ritual of theatre performance; explication of the “as if” liminal space of theatrical performance and its relation to “real” life/events (i.e., not part of a constructed performance); and the extension of theatre analysis from performance as an isolated event to the entirety of the performance experience as a socially determined structure, including scripting and rehearsal processes, audience/performer interaction, and social context (Beeman 1993).

I have found Schechner’s work particularly helpful in shaping my ideas about performance, but I suggest that his approach, which was partly a backlash against the narrowness of the discipline of theatre studies, has resulted in a significant de-emphasis of the social relevance of theatre as a cultural institution. Instead of employing theatre/acting primarily as a convention and a metaphor for the study of culture as drama, I maintain that further work is needed in the investigation of the intricacies of theatre as an institution—its possibilities for the creation of meaning, how symbols are constructed and manipulated (e.g. symbols of illness), in

\textsuperscript{16} Historically in the United States, “theatre” has indexed European and American text-based drama that is performed in formal structures (e.g. stage theatres or centers of performing arts).
what forms arts organizations choose to convey their ideology, how those choices of form reflect politics, and what theatrical content reveals about NGO/group support or critiques of the status quo.

Theatre provides a space for social reflexivity, and performances have the potential to highlight, reinforce, or question hegemonic ideology. As anthropologist William Beeman states, theatre “does even more than engage participants and spectators in the immediate context of the theatrical event. It evokes and solidifies a network of social and cognitive relationships existing in a triangular relationship between performer, spectator, and the world at large” (1993:386). This kind of performance studies scholarship within anthropology is lacking, and one area in which I see potential for its development is analysis of HIV theatre, which has become an artistic medium of contemporary relevance in South Africa. One major limit to anthropological attention to and theorizing about theatre is simply that little of it exists as published material in major journals and books. Writing two decades ago, William Beeman’s (1993) publication on performance within anthropology is still the major overview dedicated to the topic.

In addition, while Schechner and other performance scholars recognize differences in global performance traditions, I suggest the limits of applying and imposing Western models of theatre to non-Western modes of performance must be more rigorously acknowledged within performance studies. While the performance-as-metaphor approach has been popular within the social sciences and performance studies, this way of thinking about performance has overwhelmingly been located within Western ideas of theatre and drama. This trend mirrors the unfortunately limited historical focus on Western theatre practices within mainstream performance structures.
Problems arise when the only performance metaphors used to think about sociocultural life are Western ones and when scholars attempt to apply Western theatrical models to analysis of non-Western performance practices. There are a multitude of indigenous theories of performance, and it is important to distinguish between Western and local ones (although they are not necessarily diametrically opposed). This is not always done within scholarly attention to performance, theatre, and other art forms (Okpewho 2004). While I incorporate a wide variety of theory in this dissertation (much of it based in Western ideas of performance), I present a primarily local theoretical focus in chapter discussions. In the ideological frameworks explicated by most of the theatre-makers with whom I worked, there are interwoven elements of a host of theoretical traditions—Western, generically non-Western, and ideas of performance that are specific to South Africa.

2.3 Integrated Perspectives: Performance and (Medical) Anthropology

Within anthropology, performance has been studied primarily by sociocultural anthropologists, gender studies scholars, linguists, and folklorists. Other scholars who have made significant theoretical contributions to anthropological study of performance include sociologists (Goffman 1975), philosophers/critics (Langer 1955, 1957; Merleau-Ponty 1962; Bakhtin 1981), and performance studies scholars (Schechner 2013). The anthropology of performance has close ties to performance studies; however, approaches within the two fields

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exhibit some differences. For example, the anthropology of performance has primarily concentrated on ritual, play, religion, and performance in everyday life. Less common has been formal study of art mediums as cultural institutions, industries, and modes of communication and knowledge production.

The majority of anthropologists who are well-known in performance theory focus on the use of performance as a metaphor for social interpretation rather than analyzing performance mediums as full components of social life and ways of meaning-making within societies, although Dwight Conquergood and Johannes Fabian are notable exceptions. For example, both Dell Hymes and Victor Turner are broadly concerned with contingent meaning and indeterminacy within social life. Hymes (1981) treats performance as a form of social action that involves presentation of form and self to audiences in everyday life. In contrast, Turner (1986) views performance as a social drama in which conflict and conflict resolution are enacted.

This use of theatre/acting as a metaphor for social interaction has been applied widely to the study of ritual (Turner 1969; Geertz 1973; Kapferer 1979; Frisbie 1980); gender (Butler 1988, 1990; Jones 2001; hooks 1989); linguistics (Beeman 1982; Briggs 1988; Duranti 1983; Kuipers 1990; Urban 1991; Hymes 1974; Silverstein 1976); folklore (Bauman 1992; Ben-Amos & Goldstein 1975; Hymes 1974); humor (Apte 1985; Willeford 1969; Beeman 1981); liminality (Turner 1969; Beeman 1982; Davis 1982; Schechner 1985); shamanism (Taussig 1987; Laderman 1991; Rouget 1985); poetics (Bauman 1977; Briggs 1988; Blackburn 1981); religion

18 Performance scholar Catherine Bell (2004) supports Carlson’s observation when she states that the performance analogy, through the idea of “cultural performance,” became increasingly common among the social sciences from the 1950s-1980s through the works of certain theorists: particularly Kenneth Burke’s (1969) “dramatism,” Victor Turner’s (1980) “social dramas,” Clifford Geertz’s (1981) “theatre state,” and J.L. Austin (1962) and John R. Searle’s (1969) analysis of “speech acts.” On the other hand, the closely related sub-disciplines of the Anthropology of Art and the Anthropology of the Senses do tend to focus on this latter framing of art and human expression within societies.
Two of the most influential anthropologists on performance studies, Clifford Geertz and Victor Turner, provide generalized theory about the structure of the performance aesthetic that inspired later generations of performance scholars; however, neither conducted extensive ethnographic or structural analysis of specific performance pieces or traditions (Beeman 1993). One of Geertz’s main contributions includes popularizing the interpretive project in anthropological analysis of ritual. He advocates understanding behavior as symbolic action and analyzing play as performance (if public) and as performative (if private) (Geertz 1973).

In contrast, Victor Turner, although he too contributed general theory about performance, is best known in performance studies for his description and popularization of the terms “communitas” and “liminality” in relation to rituals and performance. For Turner, “communitas” describes intense feelings of social togetherness, which are often connected to rituals, while “liminality” is defined as a period of transition between two distinct states that is often characterized by ambiguity (1969). Turner uses communitas and liminality to explain different aspects of ritual, and the concepts have been extended by later scholars to describe some of the mechanisms at work in theatrical performance.

Despite the pervasive performance-as-metaphor trend, Palmer & Jankowiak (1996) note that overall, anthropologists still have not reached any consensus on the meaning or utility of “performance” within anthropology. I do not consider this lack of consensus a negative quality. Since performance incorporates so many disparate aspects of human life, nonconsensus is perhaps a logical conclusion of many people thinking and writing about it. I support fully utilizing performance as a concept in myriad ways within anthropology. However, I advocate
including within scholarly attention a specific focus on theatre as an industry. Although anthropological attention to performance spans a wide variety of topics, geographic areas, and theoretical traditions, there are some limits to the ways anthropologists have historically engaged with performance studies. In an article on the history of studying theatre and spectacle, William Beeman notes:

> Anthropologists have studied performance largely for what it can show about other human institutions such as religion, political life, gender relations, and ethnic identity. Less study has been devoted to performance per se; its structure, its cultural meaning apart from other institutions, the conditions under which it occurs, and its place within broad patterns of community life. This neglect is particularly noticeable with respect to performative activities designed specifically to “entertain:” theatre and spectacle. [1993:370]

Beeman (1993) highlights some holes in anthropological approaches to the study of performance and notes that the lack of anthropological focus on theatre as a cultural institution is surprising since theatre is a practice to which people in most societies devote significant time and energy. From my own readings in this field, I agree with Beeman that there is a dearth of detailed ethnographic material on theatre, especially theatre designed to accomplish or facilitate social change related to health. Like Beeman, I assert that it is important to study the structure and meaning of performance as an independent institution; however, I also consider it critically important to recognize that theatre (as part of a cultural institution) acts in relation to other institutions and industries and must be analyzed in this co-constitutive interaction.  

Within medical anthropology in particular, the primary authors who write about performance (e.g. Michael Taussig 1987, 1993; Margaret Lock 1993; Ronald Frankenberg 1986; Laderman & Roseman 1996; Csordas 1996) tend to lean heavily on the performance-as-metaphor trope and deemphasize analyzing artistic industries for their healing, communicative,

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19 This point is the main argument of Part Five of this dissertation.
and knowledge production potential. In this dissertation, I am concerned with one subset of performance tradition (applied theatre) that can be useful to medical anthropology endeavors, and I also point out how the critical perspectives of medical anthropology may benefit performance scholars.

For instance, the anthropology of performance as a field has been criticized for aestheticizing culture while ignoring the real suffering of daily life and neglecting how power is deployed socially within artistic mediums (Komitee 2011; Bauman 2011). Mixing the political economy of health perspective of medical anthropology with the more subjective, affect-and-embodiment oriented philosophy of performance studies (along with the anthropologies of art and the senses) provides compelling opportunities for rethinking the concept of performance (both its utility and definition) as it relates to public health programming; interpersonal communication about illness, disease, and health; and the role of artistic mediums and industries within a community’s healing repertoire.

In addition, I see theoretical potential in combining critical medical anthropology (with its deeply historical and political economic approaches to the study of health inequalities) with the performance-oriented interest in subjective experience and liminal states of performance studies. While each field separately provides a broad foundation for thinking through the social relevance and impact of applied health theatre in South Africa, combining the two bodies of theory enables a more integrated, nuanced way of thinking about human experience of HIV, the HIV/AIDS epidemic, and sexuality. In this dissertation, I focus on three areas where this kind of integrated scholarship is particularly applicable and provide fruitful possibilities for inquiry. These involve developing new theoretical tools to better capture subjective experience of illness, deal with ambiguity and complexity in life (Part 3), and rethink reflexivity as it relates to health
subjectivity and activism (Part 4). All three areas are topics on which I elaborate in detail as they relate to the particularities of urban arts/health activism in South Africa’s post-apartheid era.
Part 2: History and Context

The primary goal of this second part of the dissertation is to provide all the necessary historical, political economic, social, artistic, and epidemiological information in order to contextualize the remainder of the dissertation. While the third, fourth, and fifth parts of this dissertation present the main arguments, ethnographic data, analysis, and theoretical discussions, this second part is meant to provide readers a roadmap for understanding how applied theatre has become significant within South Africa’s health intervention landscape. I have included here two contextual chapters.

In Chapter 3, I provide an overview of the epidemiology of HIV/AIDS in South Africa, as well as an in-depth historical and political economic analysis of the early years of the country’s epidemic. In Chapter 4, I give an overview of the history of theatre within South Africa as a way to explain the past relevance of theatre in the country, as well as its enduring significance in the post-apartheid era.
CHAPTER 3
Epidemiology, History, and Political Economy of HIV/AIDS in South Africa

Introduction

Seconds before he spoke, sincerity flooded the man’s eyes. It was followed by concern, and you could see the shadows of anger that tightened his face. He was middle-aged, white South African, and an accomplished theatre-maker. A group of 17 students and I were sitting in a black-box theatre listening to the man in front of us. He said, “We live in a country where everyone is affected by HIV, if not infected. Statistically, five of us in this room are HIV positive.”

It was 2008, and that was the first time I heard anyone in South Africa voice the “everyone is infected or affected by HIV” expression. It is a popular one, both in conversational language about the AIDS epidemic and in the ubiquitous HIV/AIDS awareness media campaigns splashed across billboards, fences, and other flat surfaces that make up the everyday corridors of Johannesburg’s urban landscape. The students sitting with me had become friends over the month I spent taking classes and working with them in the theatre program built around HIV/AIDS as content. The man whose sincerity caught me was a senior director I respected, and I knew he was right. Statistically, several of us in that theatre were HIV positive. No one was openly HIV positive, despite the safe environment we had been working to create in the program. I later found out that every person in the room knew someone who was HIV positive, and most of those people were relatives and friends—not strangers.

South Africa is known globally as the country that has the highest number of people living with HIV. That number currently sits at about 5.6 million people (UNAIDS 2012). It is
accepted as common knowledge that everyone is affected by HIV, regardless of class, ethnicity, geographic region, or other indicators. I knew these statistics when I entered the field that season for a pilot study, and when the theatre-maker made his comment, I cringed. Later, after some reflection, I had a host of questions: How can this situation be? Why is it so? What does it mean to live in a country where such a high portion of the population is HIV positive? Who are these 5.6 million people? Where do they live and under what conditions? Who cares for them? Who advocates for them? What national policy governs their lives, their health, and their daily existence? Who is most vulnerable in the country—and why? What has been done to address the AIDS epidemic, and what remains to be done?

In this chapter, I begin to answer some of these questions. In particular, I provide epidemiological, historical, and political economic context for explicating the links between past events and contemporary practices that contributed to the rise of the HIV/AIDS applied theatre industry in South Africa around the late 1990s. Understanding the country’s epidemiological profile and political economic history sets the stage for comprehending more contemporary developments within the HIV/AIDS intervention sector and contextualizing the main data and theoretical arguments presented in the chapters that follow.

3.1 Epidemiology

In order to grasp the magnitude of HIV/AIDS in South Africa, it is first necessary to describe epidemiological statistics and the geography of AIDS in the country. Statistics and geography do not capture the full extent of the epidemic and its subjective components, but they start to contextualize why South Africa is known as a country where the entire population is affected by HIV. There are numerous domestic statistics-reporting organizations, and both South African government officials and media publications are notorious for politicizing and
strategically using published statistics. This is part of what makes it difficult to accurately report epidemiological information on HIV/AIDS in South Africa; however, certain statistics are commonly used in academic literature to outline the scope of the epidemic. The country has between a 16-25% HIV prevalence rate, depending on the statistics source, but 20% is currently popularly accepted as the standard. This section outlines some common areas of public health focus in epidemiological surveys and provides a broad overview of AIDS in South Africa. It presents context for understanding the scale of the epidemic and its potential for impact in the lives of everyday citizens and particularly those who dedicate time and energy to national HIV prevention, treatment, and care efforts.

**Demographics**

The Republic of South Africa is a democratic nation comprised of nine provinces: Northern Cape, Western Cape, Eastern Cape, North West, Free State, Gauteng, Limpopo, Mpumalanga, and KwaZulu-Natal. Pretoria is the administrative capital; Bloemfontein is the judicial capital; Cape Town is the legislative capital; and Johannesburg is the unofficial industrial capital of the country. There are four major demographic categories popularly used to classify the country’s population: Black, White, Indian, and Coloured. These categories are rooted in the Population Registration Act of 1950, which was part of apartheid legislation and required each citizen of the country to register according to racial characteristics. Although the

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20Some of the most common organizations reporting on epidemiological factors related to HIV/AIDS are the United Nations program on HIV/AIDS (UNAIDS); the World Health Organization (WHO); South Africa’s Medical Research Council (MRC); the South African Department of Health; the Human Sciences Research Council (HSRC) of South Africa; and the UK-based international AIDS charity AVERT (Robins 2004).

21“Coloured” is a category used to encompass people of Khoisan, Malaysian, and Chinese origin, as well as people of mixed decent. In recent years, the category “Asian” has also emerged to capture citizens who fall outside of the Black/White dichotomy and is sometimes listed officially as “Indian/Asian.”
act was repealed in 1991, these categories persist and are used pervasively in all levels of
discourse, from government through popular media.

**POPULATION.** According to the country’s most recent census, the current population is
51,770,560 (Statistics South Africa 2011). Gauteng Province houses the majority of the
population with 12,272,262 people and is followed closely by the province of KwaZulu-Natal.
Northern Cape is the least populated province with 1,145,861 individuals. Black Africans
comprise 79.2% of the population, followed by White and Coloured at both 8.9%, Indian at
2.5%, and Other at 0.5%. The gender composition of the country is recorded at 51.4% female
and 48.6% male. The median age of the total population is 25 years (Statistics South Africa
2011).

**EDUCATION.** Only 28.9% of the total population over the age of twenty years has
completed 12th grade (secondary level education). In contrast, 33.9% have completed some high
school, 8.6% have no schooling, and 11.8% have tertiary qualifications. At the time of the
census, 36.5% of the White population had attained a level of education higher than Grade 12
(tertiary level), compared to 8.3% of the Black African population, 7.4% of the Coloured
population, and 21.6% of the Indian population (Statistics South Africa 2011). The rates are
slightly higher for people who have attained (but not completed) some secondary education:
35.5% of Black Africans, 42.0% of Coloured persons, 26.1% of Indian/Asian persons, and
21.4% of White persons (Statistics South Africa 2011).

**HOUSEHOLDS AND ECONOMIC INDICATORS.** As of 2011, South Africa had
14,450,161 recorded households. Among these, 77.6% were formal dwellings, 7.9% were
traditional dwellings, 13.6% were informal dwellings, and 0.9% of the households were counted
as Other. The average annual household income is R103,204 (about $12,900 USD based on
2011 exchange rates); however, the average female-headed household has about half (at R67,330) the annual income of male counterparts (R128,329). The country’s official unemployment rate is 29.8% of the total population (Statistics South Africa 2011).

**HIV Prevalence, Incidence, Mortality, and Trends**

South Africa has a generalized HIV epidemic, and an estimated 5.63 million people were living with HIV in 2009 according to the most recent government data. The most common mode of HIV transmission in South Africa is heterosexual sex, with mother-to-child transmission historically (although decreasing in the past 5 years) comprising another main route of infection. Over the past 5 years, national HIV prevalence in the general population has shown a downward trend in children and a slight upward trend in adults. The current adult\(^{22}\) prevalence rate is about 17%, although depending on statistics sources, it ranges from 16-25% (UNAIDS 2012). According to data from population-based sero-surveys and sentinel surveillance of pregnant women, the epidemic has stabilized over the past four years at a national antenatal prevalence of about 30% (UNAIDS 2012). The country has 380,000 new HIV infections per year and 270,000 annual AIDS deaths (UNAIDS 2011). However, the Actuarial Society of South Africa (ASSA) has estimated the number of annual AIDS deaths at a much lower number, due to increased ARV rollout in the past few years: 194,000 in 2010 (ASSA 2011).

Although HIV prevalence has reached a plateau among the general population, the total number of people living with HIV has increased. Some scholars attribute this to the number of annual new infections exceeding annual AIDS-related deaths, with increasing provision of ARV treatment in the country prolonging the lives of people living with HIV (PLHIV) (UNAIDS

\(^{22}\) In South African government documents, “adult” is considered 25+ years of age.
By 2012, South Africa had achieved a 66% ART coverage rate (UNAIDS 2012). Official government data estimates the ART coverage rate at 75.2% (UNAIDS 2012).

**GOVERNMENT STATISTICS.** In addition to statistics acquired by international organizations or NGOs, the South African government has commissioned its own seroprevalence surveys. One of the most recent is the National HIV and Syphilis Sero-prevalence Survey of 2011. This survey is based on data from 33,446 women attending antenatal clinics across all nine provinces (SA Department of Health 2011). It shows a slight decrease in HIV prevalence rates from 2005 (30.2%) to 2006 (29.4%), an increase in prevalence to 2010 (30.2%), and a slight decrease in 2011 (29.5%). AVERT, an international HIV/AIDS charity, notes that government surveys are not always reliable because of dubious data collection methodology (AVERT 2008). Although the numbers are slightly different, general trends are the same: there is a higher estimated HIV prevalence rate among black South Africans, females, people aged 20-40 years, and those living in informal urban housing (AVERT 2008).

**HIV PREVALENCE BY PROVINCE.** The prevalence of HIV in South Africa shows considerable variance across provinces, as well as across ethnic populations. There are several provinces that have higher rates than the national average when all causes of AIDS-related deaths are taken into consideration: KwaZulu-Natal has a rate of 41.5% of deaths accounted for by AIDS, Mpumalanga has a rate of 40.7%, and Gauteng, the country’s economic center, has a rate of 32.5% (BBC News 2005). Official Department of Health estimates of HIV prevalence by province for 2011 illustrate how the country’s general prevalence rate may mask the very real effects of variable rates across geographic regions: KwaZulu-Natal at 24.7% HIV prevalence, Mpumalanga with 24.11%, and Gauteng with 16.09% (SA Department of Health 2011).
The Human Sciences Research Council of South Africa (HSRC) also analyzes general and provincial prevalence rates, but it provides estimates on differences between rural and urban settings, as well. According to the HSRC, area of residence is associated with HIV prevalence, with urban informal areas having the highest rate at 17.6%, followed by rural informal at 11.6%, rural formal at 9.9%, and urban formal housing the lowest with 9.1% (HSRC 2005). Higher risk for contracting HIV in South Africa is correlated geographically with areas such as KwaZulu-Natal, formerly designated by the apartheid government as a “homeland” for black South Africans. During apartheid, most black South Africans were moved and then confined to designated homelands until the urbanization that came along with gold mining necessitated migration of labor back into cities (Robins 2004). Both homelands and black urban housing were contested areas with increased protest, conflict, and violence during the anti-apartheid struggle, and higher HIV prevalence probably reflects the enduring effects of apartheid in KwaZulu-Natal and regions with a similar history. Historically white areas have much lower HIV prevalence rates. For example, according to the National Department of Health HIV prevalence survey, the Western Cape (arguably a stronghold of Afrikaners) has a prevalence rate of only 4.75% (SA Department of Health 2011). Higher risk in this province is again associated with urban informal housing, which is predominantly populated by black South Africans (UNAIDS 2008; Robins 2004).

**GENDER.** Although HIV prevalence rates among both young adult males and females have decreased over time, it should be noted that prevalence among young adult females is much higher than their young adult male counterparts (UNAIDS 2008; UNAIDS 2012). Estimates show that in youth aged 15-24, about four women are infected for every man (Cooper et al.
While this difference is partly accounted for by biological factors, it also strongly reflects gender inequalities still prominent in South Africa.

**AIDS ORPHANS AND ANTIRETROVIRALS.** The number of AIDS orphans$^{23}$ in South Africa has increased from 400,000 in 2001 to 1,400,000 in 2007 to 2,100,000 in 2010 (UNAIDS 2012). The majority of people in South Africa receiving antiretroviral therapy treatment are women who have access to it through reproductive health clinics. The estimated number of people, male and female, receiving antiretroviral therapy in South Africa increased from 55,000 in 2004 to 460,000 in 2007. However, according to UNAIDS/WHO, the estimated number of people needing antiretroviral therapy in the country was 1.2 million in 2004 and 1.7 million in 2007 (UNAIDS 2008). Although the current estimated antiretroviral coverage rate is between 66-75% of eligible persons, a large portion of the population still needs antiretrovirals that are currently inaccessible (especially in rural areas). It should be noted, though, that significant ART scale-up in 2009 pushed the country forward in its goal to have 15 million people living with HIV on ART by 2015.

**Statistical Limits in South Africa**

HIV/AIDS statistics in South Africa are problematic, at best. The National Department of Health generates its own set of statistics, but many other agencies also produce statistical analysis of South Africa’s AIDS epidemic. Among them are UNAIDS, Human Sciences Research Council, the Actuarial Society of South Africa, the World Health Organization, unofficial media estimates, and various other government departments. Most of the recent statistics produced in the country hail from a variety of reports generated in the mid-2000s (from

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$^{23}$ In government documents, “AIDS orphans” is a category defined as children under 17 who have lost one or both parents to AIDS.
about 2003-2006); however, new government, international, and NGO assessments were initiated from the period 2010-2012. At the time of writing, those reports have either not been made public or are in the process of being made public. The results of some of the studies have been included in national reports, but the primary documents have not yet been made publicly available. This makes it difficult to produce any kind of clear, linear accounting of common epidemiological statistics for the country.

Problems with the accuracy and representativeness of HIV/AIDS prevalence reporting are commonly referenced in popular media and academic research (Heywood & Cornell 1998; Fassin 2007; Schoepf 2001; Campbell 2003). Problems with statistical analysis are influenced by a range of factors, including underreporting due to social stigma (Altman 2006); cause of death misclassification on death certificates; sampling limitations; variance in the location of clinics, which may influence both their accessibility to the general population and their constituent population (AVERT 2008); government corruption (Campbell 2003); concerns about decreasing tourism (Altman 2006); concerns about foreign investor abandonment and the consequent destabilization of the economy (Terreblanche 2002); and the politicization of statistics (Schoepf 2001).

In addition, although averages for HIV prevalence may be reported and analyzed by both national and international organizations, those averages do not provide complete contexts for the

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24 Such as the UN Global AIDS Response Progress Report (UNGAPR), which reports on the National AIDS Spending Assessment).

25 Including the following: Limitations due to (1) problems with extrapolation to general populations from high-risk groups such as pregnant women at antenatal clinics, which are internationally recognized as the most reliable place from which to collect statistics on HIV prevalence, (2) overestimation of HIV prevalence in the young adult women age group as a known bias in antenatal studies due to population self-selection for sexual activity, and (3) demographic and socio-economic selection in data collected from public health facilities due to self-selecting populations of health-care seekers; group exclusion that might lead to over- or underestimation of prevalence through alternate (non-antenatal clinic) surveys because of group inaccessibility (e.g. the homeless, nationals living in foreign military barracks, prisoners, and very young children) (AVERT 2008).
HIV/AIDS situation. In certain areas of the country, notably particular townships, HIV prevalence rates are higher than the national average—especially when compared to predominantly white, upper-middle class areas such as the town of Stellenbosch.

**Key Populations and Risk Groups**

Although South Africa has a generalized epidemic, the Department of Health, as well as other government organizations and NGOs, have identified certain populations that have higher than average HIV prevalence or are at particularly higher risk of HIV transmission than the general population. These populations are alternately called targeted populations, risk groups, key populations, or most-at-risk populations (MARP), depending on the organization (UNAIDS 2012). This increased vulnerability to HIV infection is due to a variety of factors, most of which are linked to either individual behavior or structural inequalities in the country. A few examples include marginalization, lack of resources, inadequate access to health-care services, more frequent exposure to the virus, extreme stigma, and unemployment (UNAIDS 2012). Globally, men who have sex with men (MSM), transgender people (TG), commercial sex workers (CSW), injecting drug users (IDU), prisoners, and migrant populations are shown to be at disproportionate risk for HIV infection (Global Fund 2011). This holds true for the South African context.

According to the National Strategic Plan on HIV, STIs, and TB (SANAC 2012), the current targeted populations in South Africa are mobile and migrant populations, commercial sex workers and their clients, MSM, people with disabilities, young women between the ages of 15-24, people living or working along national roads and highways, people living in informal settlements in urban areas, people with the lowest socio-economic status, uncircumcised men, injecting drug users, transgender persons, orphans and other vulnerable children and youth, and
people who abuse alcohol. In the past, the list also included mine workers and prison populations.

**South Africa’s Epidemic in Context: Comparison to Sub-Saharan Africa**

The magnitude of South Africa’s epidemic may be contextualized by comparing it to the scope of HIV/AIDS globally and to other sub-Saharan African countries in particular. According to the World Health Organization (WHO), there were 34 million people living with HIV/AIDS worldwide in 2011. Of those, 5.6 million reside in South Africa. In the same year, there were 1.7 million AIDS-related deaths globally, which is down from the 2.3 million in 2005 (UNAIDS 2012). However, HIV continues to be a major global public health issue, having claimed over 25 million lives during the past three decades. The epidemic and modes of transmission vary widely from country to country, but sub-Saharan Africa remains the region most affected by the epidemic, with nearly 1 in every 20 adults living with HIV and 69% of all people living with HIV located here (UNAIDS 2012). The region’s adult infection rate hovers around six percent. By comparison, the second most-infected region (the Caribbean) has an adult infection rate of 1.2 percent, and the worldwide adult infection rate stands at one percent (UNAIDS 2006). Women make up an increasing percentage of HIV infections globally and particularly in sub-Saharan Africa. By 2006, women accounted for 57% of the HIV positive adults in sub-Saharan Africa (Youde 2007). Although South Africa does not hold the highest prevalence rate in sub-Saharan Africa (that dubious title belongs to Swaziland, which has the highest adult infection rate in the world at 26% in 2011), it does contain the highest number of people living with HIV in the world (UNAIDS 2012).
In this section, I have provided a brief profile of the AIDS epidemic in South Africa. In the next section, I start to outline some of the factors that have contributed to the epidemiological snapshot just discussed.

3.2 Setting the Scene: Political Economy and Historical Context

The following is a major question that resounds throughout scholarly attention to South African history and its HIV/AIDS policy: What, exactly, is South Africa’s AIDS Policy? This is no easy question to answer in a definitive way. Official national HIV/AIDS policy may be outlined and described, but what is outlined at the national level is rarely implemented wholesale at provincial and local levels. In addition, at times, official national policy is in direct conflict with ideology publicly promoted by South Africa’s leaders (including Heads of State). The policy changes constantly, and a complex number of actors (both domestic and international, government and civil society) contribute to its creation and revision. In addition, the policies of the national and provincial governments have varied widely and are often at odds with each other26 (Youde 2007).

In order to answer the previous seemingly straightforward question, I outline the historical, social, structural, environmental, and political economic factors that have and continue to shape the spread of the AIDS epidemic in South Africa and create barriers and facilitators to HIV intervention efforts at national, international, local, and NGO levels. I discuss how structural factors contribute to the epidemic, which provides the scaffolding necessary for understanding how applied theatre fits into South Africa’s health sector, as well as what current

26In this dissertation, I largely restrict my analysis to national HIV/AIDS policy rather than provincial and local. This is partly for reasons of brevity and partially because a more complete compendium of scholarship is available for national level analysis; provincial and local policy is notoriously difficult (methodologically) on which to collect data.
HIV/AIDS policy in South Africa is, why that policy is in place, and how applied theatre related to HIV has been shaped by it.

I first provide an overview of the historical and political economic context for the AIDS epidemic in South Africa. In it, I limit discussion primarily to politics and the development of HIV/AIDS policy, as well as the structural and economic factors that underpin those two areas (e.g. structural adjustment and health services, neoliberalism, national policy and connection to international policy, controversies, health service delivery and access to care—including ARV scale-up and inequality in access, and the intersection of HIV with TB, gender violence, and poverty). Additional topics, such as the place of civil society and the changing structures of health activism in the country, along with discussion of the domestic and international financial support for intervention efforts (understanding the institutions that govern international flows of resources), will be elaborated in the subsequent chapters during which they are particularly relevant.

History, Structural Violence, and National Responses to HIV/AIDS

It should be noted that most academic writing about South Africa reflects historic divisions within the country, and it has been difficult for scholars to produce solid synthetic studies of apartheid. This is mostly due to difficulty spanning the racial, ethnic, or economic divisions during the apartheid era, which extend even to the archives where records pertaining to each group were separately housed (Clark & Worger 2004). General histories written as texts for students tend to be the best source of integrated accounts of pre-1900 events in the country, as well as their relation to trends in the 20th century27. For ease of analysis, I follow convention and

27 Good examples of historical texts about South Africa include the following: Thompson 2001; Worden 2007; Lodge 2002; MacKinnon 2003; and Foster 2012. These are the texts used in this dissertation for historical foundation.
present discussion of South Africa’s history by historical eras based on political movements and developments. Although the historical roots of the HIV epidemic in South Africa extend back to early colonization, I begin my discussion with the apartheid era.


The years of official apartheid policy run from 1948, with the installation of the National Party (NP) into government office, to 1994, when Nelson Mandela was democratically elected president. Apartheid, a political system characterized by extreme forms of racial separation, resulted in deeply ingrained social and economic inequality. It was supported by an ideology that denigrated black South Africans and produced legitimizing justification for structural inequality (Robins 2004). During years leading up to the apartheid regime, the country experienced the introduction of industrial capitalism (primarily in relation to diamond and gold mines), which led to increased urbanization, worsening rural poverty, undermining of traditional sexual values and controls, dramatic changes in household structure and gender relations, increased gender violence, declines in health standards, and increased urban crime (Wood et al. 2007; Heywood & Cornell 1998; Schoepf 2001). What occurred between 1948 and 1994 was a protracted struggle for human rights denied under apartheid. The effects of apartheid are still apparent in contemporary South Africa and are especially manifest in profound economic and health inequality.

**Key Legislation: Apartheid Legislative Program**

In his ethnography on the HIV/AIDS epidemic in South Africa, Didier Fassin (2007) argues that both the AIDS epidemic and response to the epidemic stem from the brutal and encompassing systems of apartheid and its predecessor of colonial policy, implemented in South Africa for over 300 years. One important but often overlooked aspect of this history is colonial
public health legislation, which was used to legitimize official policies of separate development. In official discourse about apartheid and its roots, many structural factors are examined, but rarely are public health and sanitation laws given adequate treatment in historical and anthropological accounts (Fassin 2007). Without an understanding of some of this legislation, the historical development of public health policy cannot be properly situated.

The Public Health Act of 1897 provides a good example. It is probably the most prominent health act used to legitimize apartheid in South Africa. In this legislation on sanitation, used as the legal foundation for the first steps toward official urban segregation policy, separation was justified based on the logic that urban “slum-dwelling” black South Africans and their unhygienic living conditions were the cause of any contagious disease outbreak. According to this logic, moving all urban-dwelling black South Africans to “native homelands” created for their use in the eastern part of the country would solve urban health problems and allow black South Africans increased space in which to prevent confined, poor living conditions (Fassin 2007). This is an example of early colonial treatment of public health, and more recent attention to health by the apartheid government shows similar lack of consideration.

Regarding official apartheid policy, some of the key legislation that precipitated later resistance and intense civil society activism in South Africa addressed topics such as pass laws, education, and the geographic and ethnic division of population groups into races in the country. “Homelands” were further codified in discrimination policies such as the colonial Native Urban Areas Act of 1923 and the 1945 Natives Urban Areas Consolidation Act, as well as the apartheid era Population Registration Act of 1950, the Group Areas Act of 1950, the Native Abolition of Passes and Coordination of Documents Act of 1952 (the “Pass Laws Act”), and the Bantu
Education Act of 1953 (Clark & Worger 2007). These were designed to establish mechanisms for determining and registering the race of all South Africans, institutionalize segregation, divide the country into geographical regions based on race, and institute inequality in education under apartheid. Although I agree with Fassin that apartheid-era and colonial legislation has not been given much attention, it should be noted that there has been significant scholarly literature analyzing post-apartheid public health policy (e.g. Wouters et al. 2010; Schneider & Stein 2001; Butler 2005; Schneider 2002; Cooper et al. 2004; Goyer & Gow 2002; Sadie 1992; Johnson 2004; Jones 2005).


One legacy of apartheid is deep, racially charged mistrust of government interventions in public health. This becomes clear in early apartheid government response to HIV/AIDS. The first two cases of AIDS in South Africa were reported in 1982. The deputy director general of the Health Department labeled the two instances (white homosexuals) as isolated cases and set the tone for the remainder of the apartheid government’s official policy toward HIV/AIDS: infection is confined to “high risk groups,” and prevention should prevent it from reaching the larger public (Fassin 2007). From 1982-1987, the government focused its meager testing and broader intervention campaigns on risk groups and neglected to pursue a wider campaign among black South Africans or the general Afrikaner population. The first AIDS Advisory Group, composed of physicians and researchers, was established in 1985 by the government. From 1987, official discourse began to change to recognize that risk existed for black African heterosexuals, as well. Health Minister Willie van Niekerk charged promiscuity with being the
greatest danger, and government discourse thereafter leaned heavily toward moralizing sexual activity, including a healthy dose of Afrikaner religious doctrine espousing conjugal fidelity.

The first formalized, national prevention campaign was orchestrated by the McCann advertising agency and launched in 1988, but attention to it was low amidst the increasing anti-apartheid resistance in that decade (Fassin 2007). Toward the end of the 1980s, AIDS had become a highly political issue wielded by both the apartheid government (lashing out against the black African population for licentiousness) and non-white populations (posing the increasing HIV prevalence among the black population as another in a long list of apartheid-based violence against black South Africans and the government’s campaigns as racist propaganda). As noted by scholars, there was little chance the apartheid government could run an effective HIV/AIDS prevention program in the 1980s even if it had been inclined to do so; the government had no credibility or legitimacy with the vast majority of the country’s population (Van der Vliet 1994). Efforts that were made by the government were often viewed with deep suspicion by the general public, a legacy of other apartheid health abuses, such as those committed by Wouter Basson, director of Project Coast, the National Party’s chemical and biological warfare program. Project Coast was suspected of (and at times proven associated with) nefarious health projects ranging from mass infection of Namibian refugee camps by cholera-contaminated water to the search for a sterilization vaccine for black South African women (Fassin 2007).

These and other apartheid government health scandals made it virtually impossible for the broader South African public to trust early HIV/AIDS campaigns. For example, Virginia van der Vliet (1994) discusses state responses to the epidemic and associated criticisms incited by certain official policies. Discussions of early government response in HIV/AIDS literature often
conform to Van der Vliet’s notion that apartheid created a society where prejudice, mistrust, and fear haunted black/white relations. This legacy will affect not only black perceptions of state AIDS campaigns, but also right-wing constructions of the epidemic and, in the final analysis, any alternative campaign devised by the anti-apartheid organizations themselves (van der Vliet 1994). While the apartheid government’s response to the epidemic was certainly cursory and ineffective, the sole responsibility of that failure cannot be attributed to a complete lack of effort. The structural violence caused by apartheid, and the fear/mistrust that was a result of such violence, must also be considered contributing factors to failure of early responses to HIV/AIDS in South Africa.

**Contemporary HIV Policy (1994-2014)**

I now turn to contemporary HIV/AIDS policy and detail the political economic context for ongoing HIV/AIDS intervention, as well as the specifics of policies that have been implemented in the country post-apartheid. Didier Fassin (2007) holds that the HIV/AIDS epidemic is part of the political violence of the apartheid legacy. It is not just the end-product of apartheid structural violence, but rather one more episode of political inequality in a long history of inequality. Politics, economics, and the discourse produced through those two factors are three of the main structures implicated in the current AIDS epidemic. This section outlines some of the policy, structural roadblocks, and civil society responses to these first years of early HIV/AIDS intervention on the part of the post-apartheid, ANC government.


By the 1980s, the apartheid state resorted to retaining control through military power and detention, and the majority of the country’s population was alienated to an unprecedented degree. In addition, mounting international (economic and moral) sanctions against South Africa’s apartheid policies continued unabated. In 1990, under increasing pressure from internal
and international factions, President F.W. de Klerk unbanned the major political forces of the anti-apartheid struggle, the exiled African National Congress (ANC) and Pan-African Congress (PAC), made a commitment to meaningful change, and started a process of shifting the country toward democracy (Worden 2007). With the release of Nelson Mandela from Robben Island prison in 1990, the goal of liberation eclipsed all other activist issues. National attention was focused on the most apparent human rights abuses, those related to blatant racial discrimination, and scant attention remained for serious focus on the increasing HIV prevalence rates (Heywood & Cornell 1998). From 1990-1994, the main concern of the government was negotiations between the ruling National Party and the ANC. These negotiations between the apartheid state and the unbanned political movements were fraught with tension and characterized by suspicion but eventually led to the creation of a new democratic constitution and democratic elections in 1994, which the ANC won.

On 10 May 1994, Nelson Mandela became president of the Government of National Unity in South Africa’s first democratic elections. Although the years 1990-1994 are considered the official “transition” years, I include the first ANC government post-1994 (the Mandela Era) as a time of continued transition. During this period, the new government focused attention on the massive project of restructuring a country formerly based on apartheid ideology (Heywood & Cornell 1998).

This first five years in The New South Africa were years of great optimism and hope among a large majority of the country’s population. This also extended to the issue of HIV/AIDS. At this time, Dr. Nkosazana Clarice Dlamini-Zuma was appointed Minister of Health, and shortly afterward HIV/AIDS was listed as one of the 22 Lead Presidential Projects of the new government’s Reconstruction and Development Programme (RDP). The government
outlined new policy for addressing the burgeoning epidemic in the country and proposed new structures in the RDP for incorporating civil society engagement and ideas about policy into government documents. These included an HIV/AIDS and STD advisory group, a Committee on NGO Funding, and a Committee of HIV/AIDS and Sexually Transmitted Disease Research. Unfortunately, early response to the AIDS epidemic by the democratically elected ANC government fared little better than early NP response. This is another key factor in the ongoing historical contributions to the spread of HIV/AIDS in South Africa. Heywood and Cornell (1998) attribute this to the apartheid legacy of wide-scale militarization, debilitating poverty, and entrenched racism, which prevented an early and unified response on the part of the ANC, the NP, and the broader general public. Health activists in the country initially commended the government for its laudable attention to HIV/AIDS after the miserable failure of the apartheid government to intervene; however, that optimism later turned to deep disillusionment after several public government scandals occurred in relation to HIV/AIDS policy and funding. By 1998, the ambitious policy Mandela’s administration had set out at the beginning of his term had fallen considerably short of the government’s (and civil society’s) expectations. Even though few resources were allocated to campaigns against HIV/AIDS during this time, it should be noted that the ANC did recognize the potential public health risk of an AIDS epidemic.

In June 1990, a National AIDS Task Force was commissioned by the ANC, followed by the creation of the National AIDS Coordinating Committee of South Africa (NACOSA) in 1992. NACOSA deliberations included the perspectives of several different players in the AIDS policy arena, such as healthcare workers, public health officials, the government, and some health activists (Heywood & Cornell 1998). The AIDS Strategy (National AIDS Plan for South Africa) emerged as the product of NACOSA deliberation, and in 1994, that plan was adopted by the new
government. The plan focused on prevention of HIV through public education campaigns, reducing transmission of HIV through care, treatment, and support for those infected, and mobilizing national, provincial, local, and international resources to fight the epidemic.

This initial program advocated a human rights-based approach to treating AIDS and couching AIDS intervention in broader social terms that encompassed medical, legal, and economic needs of the population (Youde 2007). AIDS activists in the country initially applauded Mandela’s administration for its aggressive policy and stated commitment toward addressing the epidemic; however, the plan failed to live up to its promise. Although the strategy included a holistic and multi-sectorial response to the AIDS epidemic, the post-election transformation process prevented implementation of many included principles. In short, the new ANC government had overestimated the capital and social resources it had to devote to HIV/AIDS intervention in the midst of such overarching social, economic, and political transformation (Youde 2007).

In addition to being low priority on the ANC agenda, the epidemic was bolstered by the weakening of many activist and popular organizations after 1994. Many prominent human rights and struggle activists were recruited to public service or elected into government positions at national, provincial, and local levels. With government cooptation of these leading civic figures, AIDS NGOs were further weakened (Heywood & Cornell 1998). Despite these setbacks, President Nelson Mandela managed to characterize the AIDS epidemic in a way that would have enduring resonance for citizens of South Africa: in a speech to the World Economic Forum in 1997, Mandela called the epidemic “The New Struggle” and stated, “The vision which fuelled our struggle for freedom; the deployment of energies and resources; the unity and commitment to common goals—all these are needed if we are to bring AIDS under control” (Cape Argus 1997).
During the same year, the Inter-Ministerial Committee on AIDS (IMC) was established as the first high-level political body on AIDS in the post-apartheid era. It was chaired by then-Deputy President Thabo Mbeki and provided political oversight on HIV/AIDS in the country but failed to integrate civil society organizations to any significant degree.

Despite demobilization in the NGO sector, one of the enduring legacies of anti-apartheid activism was the creation of a strong popular dissenting voice, which would later coalesce into the creation of activist groups, protests, and theatre engaging resistance content. Activism became a central focus for expressing political discontent, and structures such as community organizations, NGOs, and other activist outlets were maintained despite being weakened in government transition. The Treatment Action Campaign (TAC) is such an organization. Established in 1998 in Cape Town, its first campaign called for the provision of antiretrovirals (ARVs) for the prevention of mother-to-child HIV transmission (PMTCT). TAC has played an enduring role in HIV/AIDS activism in the country and will be discussed in more detail in a later chapter.

Although political-economic factors have been fore-grounded in this section, it should be noted that discourse is also potentially an important component of structural violence in the country. Accompanying economic policy changes and administrative reform in public health administration - which tended to foreground markets and individuals and ignore or downplay the significance of structural inequality - increasing ideological value has been placed on biomedical and individualized approaches to illness over other ways of experiencing and understanding illness (and health). This biomedical discursive focus pervades academic, public health, media, and (increasingly) government attention to HIV/AIDS in the country and was a major component of how HIV/AIDS was understood in the Mandela Era.

In September 2008, Thabo Mbeki, South Africa’s president since 1999, was asked by his political party to resign. Although it was months before new presidential elections, Mbeki complied. Parliament elected an interim president, Kgalema Motlanthe, until the April 2009 general elections—which Jacob Zuma of the African National Congress won. This development simultaneously heralds progress and problems: many cabinet resignations followed in Mbeki’s wake, and Motlanthe replaced South Africa’s highly controversial health minister Manto Tshabalala-Msimang with Barbara Hogan. This change has been characterized by South African media as a monumental step of progress for the country’s health department. In order to understand why, it is necessary to look retrospectively on government involvement in the escalation of the HIV/AIDS epidemic in South Africa. Government denialism, continued health funding scandal, and Mbeki and Tshabalala-Msimang’s courting of dissident AIDS science are all implicated in understanding the high HIV prevalence rates South Africa currently exhibits. Although Tshabalala-Msimang’s replacement is a progressive step in addressing the country’s escalating AIDS environment, the recent government changes must be viewed circumspectly.

The second ANC government in the post-apartheid era saw the induction of Thabo Mbeki as President in mid-1999. This era is characterized heavily by public controversies, AIDS denialism within the Mbeki administration, and enduring government and civil society fractures. The context in which the administration was trying to create new HIV/AIDS policy included escalating economic changes, affirmative action, and a host of inequalities despite the government’s stated commitment to focusing on human rights and decreasing inequality (including the areas of unemployment and poverty, gender dynamics, sexual violence, and access to healthcare and medication). Although this era is characterized by dissent and complications,
the government made some moderate progress, including establishing a new organization to oversee overall response to HIV/AIDS in the country that aimed to better include the civil society sector. In the following section, I first describe that development, which impacted policy, and then move to a discussion of the controversies that resulted from government AIDS denialism in this period.

**South African National AIDS Council (SANAC)**

To give context to the controversies that occurred during this time frame, it might be helpful to first outline some of the policy developments. One of the most significant developments during Mbeki’s administration was establishing the South African National AIDS Council (SANAC) in 2000. This replaced the Inter-Ministerial Committee on AIDS and was composed of both government and civil society organizations. SANAC is a multi-sectorial national coordinating body intended to oversee and advise government on HIV/AIDS in South Africa. Representatives from all government departments and 19 civil society sectors are present on the council, including TAC, the National Association of People with AIDS (NAPWA), and the Positives Convention (SANAC 2013). This was an effort by the government to ensure civil society inclusion into national response to HIV/AIDS in the country.

In February 2000, two major programs were launched under SANAC. These included the National Integrated Plan (NIP) for children infected and affected by HIV/AIDS and the HIV/AIDS/STD National Strategic Plan for South Africa 2000-2005. The NIP was a joint venture between the Departments of Health, Education, and Social Development and promoted life skills education for youth, community-based care for people infected with HIV, and support for HIV-positive children through the organization’s funds. The new National Strategic Plan (2000-2005) promoted the primary (and nebulous) goals of reducing new infections and reducing
the impact of HIV/AIDS on individuals, families, and communities. Comprehensive plans for mass provision of ARVs remained absent from these programs, which provided a source of major conflict between government and civil society in the following years.

**Politics, Discourse, and Controversy: Government Denialism and ARV Provision**

The two major controversies of this part of Mbeki’s time as President of South Africa include the Dissident Science Debate and continued struggles over ARV provision in the country.

**DISSIDENT SCIENCE.** One of the most powerful factors in the rapid spread of HIV/AIDS in South Africa may be government denial, and the Dissident Science Debate is an apt example of how HIV/AIDS has become a highly politicized topic in the country. One of the most popular quotations in media and scholarly articles about Mbeki’s treatment of the AIDS epidemic is his notorious comment doubting the etiological link between HIV and AIDS (Altman 2006; Benatar 2001; Butler 2005). In fact, President Mbeki did not formally recognize that link until 2003. The two main claims dissidents have made include questioning the etiology of AIDS and asserting that antiretroviral drugs are toxic and ultimately harmful (Fassin 2002, 2007; Altman 2006; Robins 2006). In both incidents, Mbeki’s government expressed deep distrust of Western, scientific establishments and international consensus about AIDS.

In 2000, the 13th International AIDS Conference was held in Durban, South Africa, and Mbeki organized a President’s Select Advisory Panel of experts equally weighted with internationally renowned HIV/AIDS scientists and so-called AIDS dissidents (Robins 2004). Mbeki’s views were supported by these Western AIDS dissidents, including Peter Duesberg, David Rasnick, and Charles Geshekter (Fassin 2007). In addition to outside support for dissident claims, Mbeki was also supported by ANC health minister Dr. Manto Tshabalala-Msimang, who
has often asserted the toxicity of AZT. She earned the nickname “Dr. Beetroot” for her promotion of olive oil, lemon, and beetroot as part of a healthy diet to treat AIDS symptoms. Although AIDS sufferers should eat a healthy diet as part of their treatment, her advocacy for the use of vitamins as preferable to AZT for HIV/AIDS treatment caused public uproar and controversy (BBC News 2007; Fassin 2007).

Another factor undermining the government’s credibility in the eyes of public health activists and those involved in the greater health system was the appearance in 2002 of the controversial Castro document on the ANC website. This document suggested that Western pharmaceutical companies were responsible for creating the AIDS epidemic in South Africa because of their desire to create drug markets (Robins 2004). After media outrage, the ANC officially attempted to distance itself from the document, but it was popularly held that included views were representative of those espoused by high-ranking ANC officials (Robins 2004).

Mbeki’s defense in response to media criticism often centered around the idea that poverty, poor nutrition, and inequality were the main factors associated with AIDS, and biomedical versions of its etiology promoted racist representations of AIDS as a “black disease” linked to stereotypes of hyper-sexualized Africans (Robins 2004; Fassin 2007). Although many of the disgruntled activists and international health workers would have agreed with Mbeki about the political economic underpinnings to the AIDS epidemic, his questioning of the link between HIV and AIDS was inexcusable. Mbeki’s position was soundly criticized by the South African media and HIV/AIDS activists, but his ideas gave credibility to popular forms of AIDS denialism and alternative etiological explanations, including blaming AIDS on witchcraft, rumors associating AIDS with white conspiracies to contain black population growth, accusations of the use of Africans as guinea pigs for AIDS drug experiments, the idea that sex
with a virgin cures AIDS, and the notion that AIDS is simply a CIA conspiracy (Robins 2004; Fassin 2007; Van der Vliet 1994; Kalichman & Simbayi 2004).

Health professionals and activists argued that Mbeki’s stance undermined efforts of public health institutions, scientists, and NGOs to address the AIDS epidemic in productive and necessary ways. Dissident science involved in the early years of Thabo Mbeki’s presidency has been blamed for the lack of an effective AIDS response and the deaths of thousands. Although Mbeki’s actions in the early 2000s are implicated in current, high HIV prevalence rates, his actions must be situated within a deeper historical context: his views were not antagonistic for the sake of being antagonistic. They were a reflection, or a public voicing, of suspicion associated with biomedicine as a product of decades of institutionalized public health oppression by the apartheid state (Fassin 2007; Van der Vliet 1994; Schneider & Fassin 2002; Terreblanche 2002). Challenges faced in the post-apartheid era (e.g. dissident science, mistrust of official health policy, and denialism) were perhaps comprehensible in the context of enduring apartheid structural violence. Nonetheless, they contributed to the perpetration, if not the exacerbation, of HIV/AIDS in the country (Wouters et al. 2010; Youde 2007; Fassin 2007).

**CONTINUED STRUGGLES OVER ARV Provision.** Although the history of HIV/AIDS in South Africa has always included struggles over ARV provision, matters escalated during the early 2000s. The continued reticence of the government to provide increased ARV treatment for PMTCT (and specifically the use of nevirapine) eventually led to litigation and to the Comprehensive ARV Plan being put into place. Certain civil society organizations, namely TAC, lost patience with the government’s dissembling over ARV provision in official policy and took the government (the health minister) to court over the issue in 2001. In December 2001, the Pretoria High Court ordered the government to implement the prophylaxis of mother-to-child
transmission by using nevirapine (Fassin 2007). This decision went through several appeals, but in April 2002, the health minister finally issued instructions authorizing the distribution of antiretroviral therapy for PMTCT. This led to public policy by litigation, which had not happened in the country until this point.

There were several unintended consequences of this legislation. One included changes in the HIV/AIDS national budget: the share of the total HIV/AIDS funding earmarked for care rose from 6.6% in 2000/1 to 59.3% in 2003/4, and the share for prevention dropped from 93.4% in 2000/1 to 38.6% in 2003/4 (UNAIDS 2012). This change coincides with anecdotal evidence, from the theatre-makers with whom I worked, on the time frame during which a lull in HIV/AIDS-related theatre (and funding for it) began; however, that lull was not in full force in the country until around 2009. The context for this includes a tension around emphasizing prevention or treatment/care in national HIV/AIDS policy. Government and civil society have vacillated on this issue for years, although the first years of Mbeki’s administration were especially mired in debate over which component should be emphasized (and where the money should go). Prevention was considered critical, but treatment and care were thought to offer people hope; the prospect of treatment was considered a way to mobilize society (Berkman 2001). Other consequences include the increased politicization of HIV/AIDS, scale-up of civil society activism, and a boost of international attention to and funding of HIV initiatives in the country (Berkman 2001).


Responding to increasing civil society and international pressure and criticism, the Health Department partnered with representatives from civil society in 2006 to create the HIV & AIDS

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28 This tension between prevention and treatment is elaborated in Part 4 and the conclusion to the dissertation.
and STI National Strategic Plan on AIDS 2007-2011. This means the new 5-year plan was developed under the direction of SANAC but included (and solicited input from) a range of stakeholders: government officials, civil society organizations, academic and research institutions, labor and business organizations, and the United Nations. The plan was launched in March 2007, called for a multi-sectorial response that expanded on the NSP 2000-2005, especially in areas related to ARV provision. The plan claimed to be founded on a holistic, socio-medical paradigm and was yet another attempt by the government to repair its relationship with civil society and promote working cooperatively to address the increasing HIV/AIDS problem in the country. This policy focused on the following key priority areas: (1) Prevention; (2) Treatment, care and support; (3) Human and legal rights; and (4) Monitoring, research and surveillance. The policy was hailed as progressive, but problems with implementation continued to plague the nation. Although South Africa’s central policy making capacity was gaining in strength with increased civil society collaboration, the country continued to have weak provincial implementation due to its problematic healthcare infrastructure (Parkhurst & Lush 2004; Wouters et al. 2010).

Since the introduction of the Comprehensive Plan on ARVs, access to care and treatment for those infected by HIV has increased; however, implementation of this policy has been slow. Universal access to ARV treatment during this time period remained far from realized. By the end of 2004, about 50,000 people received ART. At the end of 2005, the number increased to between 178,000-235,000 people (WHO & UNAIDS 2007). After three years of publicly available ART, an estimated 257,000-363,000 people were receiving ART through the public sector, whereas an estimated 800,000-1,000,000 people were in need of antiretroviral drugs
(Wouters et al. 2010; WHO & UNAIDS 2007). This sluggish rollout of ARVs has fueled continued struggle between civil society and government.

On 25 September 2008, a cabinet reshuffle ended with President Mbeki resigning from office after losing the support of the ANC. Former Health Minister Tshabalala-Msimang was also redeployed. This formally concluded the era of Mbeki’s influence on HIV/AIDS policy in South Africa. AIDS activists hailed this as a monumental point of progress.


Jacob Zuma won the 2009 general elections in South Africa and became the third president of the country in its fourth administration post-apartheid. He was reelected president in the general 2012 elections and continues in this capacity through the present. Zuma’s relationship with HIV/AIDS policy has been a bumpy one: he was involved in lengthy legal disputes in the early-to-mid 2000s on charges of corruption and rape. In addition, Zuma is reputed to have known the HIV positive status of the woman he allegedly raped (but with whom he had admitted unprotected sexual contact) and has been quoted saying showering after sex will minimize the risk of contracting HIV (BBC News 2006). However, Zuma’s administration has been praised in recent years for its attention to HIV/AIDS treatment, especially a scale-up in rollout of ARVs in the country and a massive HIV testing campaign as part of its prevention program. Zuma has initiated several changes to the country’s HIV/AIDS policy and has also faced certain challenges.

One of the first changes Zuma made was to replace interim Health Minister Barbara Hogan with physician Aaron Motsoaledi, which disappointed many in civil society (Wouters et al. 2010). However, in 2010 Zuma introduced a new primary healthcare model with increased focus on health promotion and prevention rather than only curative services. It remains to be
seen, though, what will come out of this shift back to focus on prevention. A component of this shift was the implementation in 2010/2011 of an expanded ART provision program, which resulted in 1.6 million people living with HIV receiving treatment. This increased coverage of ART was primarily accomplished by a reduction in cost of antiretrovirals through a new tender for ART: more antiretrovirals were able to be dispersed for the same budget. In addition, Zuma’s administration shifted from voluntary counseling and testing (VCT) to provider-initiated HIV counseling and testing (HCT) and launched the world’s largest HCT campaign the same year. In the most recent incarnation of the National Strategic Plan on HIV, STIs, and TB (2012-2016), there has been an increased focus on TB as a co-factor of HIV infection; creating nine provincial strategic implementation plans; re-engineering primary healthcare; roll-out of a male medical circumcision program; a reduction of levels of MTCT; increased number of people tested for HIV; and scale-up of TB screening.

As we are among the early years of this new National Strategic Plan, it remains to be seen how it will affect the country’s HIV prevalence. The challenges for the Zuma Administration regarding HIV/AIDS identified in the UN Program Report of 2012 include many of the issues that have plagued HIV/AIDS efforts in the country historically. For instance, health provision is still a significant problem. The majority of South Africans rely on state-provided health services (and of these, most are black South Africans) that are offered by severely over-taxed clinicians: only one out of every three doctors is working in this sector. Communities without any doctors and those with overburdened clinicians both face similar challenges in terms of universal access to ART (Wouters et al. 2010).

In addition, multi-sectorial coordination remains an enduring problem. The work of the Presidency is supported at the provincial level through the nine Offices of Premiers. At the
departmental level, most major government departments have dedicated budgets for sector-specific HIV and TB interventions, including Health, Basic Education, Social Development, Labour, Justice, Police Services, and Correctional Services (UNAIDS 2012). Coordinating and implementing national policy on this variety of levels among the nine provinces remains an unwieldy task, and there is a noted lack of effective implementation in some rural areas (UNAIDS 2012). Service delivery in the health sector has been a persistent problem throughout South Africa’s history and continues to be so. There has been increased focus on improving healthcare service delivery and access to care, but little progress has been made in practice.

There is a need for policies for the growing number of serodiscordant couples in the country; policy which currently does not exist. Finally, the entire realm of monitoring and evaluation of interventions and programs related to HIV/AIDS in the country needs to be addressed and has not been up to the present. The monitoring and evaluation (M&E) programs in place are few, poorly implemented, and have excessive problems. Finally, in the past 3-4 years, South Africa is seeing resurgence in HIV/AIDS activism. The general population was willing to give the new democratic government a number of years to sort out issues in the country, but critiques of government programs are starting to emerge in increasing quantity.

3.3 Conclusion

In this chapter, I illustrated some of the ways historical and political economic factors have contributed to the geography of infection in the country, as well as the development of HIV/AIDS policy intended to constrain the epidemic. This bricolage of factors combines to create part of the context in which applied theatre related to HIV has emerged, and as such, it is important background information.

29 The problems in the monitoring and evaluation programs in place in South Africa will be discussed in depth in Part Five.
CHAPTER 4
Applied Theatre: A Period of Reflection

Introduction
As Linda* moved toward the center of the room in the ramshackle township rehearsal space, he glanced sideways toward the director of the group. The rest of the twelve of us held hands and formed a circle around the 26-year-old Xhosa man and waited, fidgeting, as he took up the teller’s post in the middle of our ring. I had been playing theatre games with the group for about 45 minutes that day as we worked toward transitioning to their rehearsal. The games were about fostering trust, openness, and forthrightness in the group, especially since an outsider (me) had just recently started tagging along for the group’s activities.

Linda made his way to the center, and I wondered what he was going to say. This particular game was about positive reinforcement and nonjudgmental acceptance of whoever was in the center of our circle. The person made a series of statements reflecting his or her feelings, thoughts, moods, or actions in that moment, and the rest of us repeated those back. Most people so far had stuck with relatively benign, general statements like “I am happy, laughing, upbeat, and colorful” or “I am bored, hungry, curious, and tired.” Linda had a reputation for going under the surface of his life to reach the parts of his character not quite so sterile and straightforward. He cocked his head and made eye contact with a few people before saying, “I am sex. I am anger and resentful. I am deep but sometimes shallow. I am an abuser seeking forgiveness. I am also trustworthy and kind. I am a father, a son, a lover, a friend, a worker. I am sick.”

People tensed during some of his statements, but by the time we got around to our group chant that followed his offering, they were visibly letting the tension out of their bodies and replacing it with openness to what Linda had shared. We said together, “You are sex. You are
anger and resentful. You are deep but sometimes shallow. You are an abuser seeking forgiveness. You are also trustworthy and kind. You are a father, a son, a lover, a friend, and a worker. You are sick.” The long statement was followed by the last thing we all said in unison, “You do not have to try to be these things; you ARE these things right now.” In doing so, we collectively acknowledged who Linda felt like he was at that time in his life without disallowing him any of it or turning away from his statements.

This game was one of my first experiences with theatre in the country. It was emotional and based on mining individual subjectivity rather than the highly politically engaged theatre I was expecting to see after reading countless books and articles about South Africa’s world-famous protest/activist theatre tradition that had spanned the 30 years prior to democratization in 1994. The kinds of theatre I saw again and again that first summer of pilot research echoed the style and content of this game, and I repeatedly thought, “Why? Where’s all the activist theatre? Where’s the social critique? Why aren’t we protesting?” Despite people voicing intense sociopolitical critique to me in interviews, the same kinds of sentiments were not being expressed within the art I was seeing.

Why the difference? In this chapter, I start explaining why through detailing the history of applied theatre in the country, as well as the changes the industry has gone through during the move from apartheid to democracy. I describe what the applied theatre sector has been in the past (and why), as well as what characterizes it now. I move from the prior discussion of politics, economy, and HIV/AIDS policy to an overview of the history of theatre in South Africa, including its applied dimensions. Additionally, I detail the emergence of theatre dedicated to topics related to HIV/AIDS.
Combined with the last chapter, this one sets the stage for understanding more contemporary developments within the health communications sector vis-à-vis live theatre performances and contextualizes all remaining data presentation and analysis in the following chapters. This chapter introduces some of the frameworks through which scholarship on struggle theatre and the cultural capital of HIV/AIDS have come to take their current shape. While I focus on applied theatre, I also include short references to commercial and mainstream theatre practices because some of the theatre-makers with whom I worked self-identify as mainstream practitioners.

What is presented in this chapter illuminates the history, significance, and variety of performance modalities within the country’s arts sector. I first detail the rise of applied theatre during the apartheid era and examine activist theatre literature, of which both theory and practice are components. I then move to a short discussion of general trends in applied theatre post-1994 that have shaped how HIV/AIDS has been incorporated into artistic practices in this geographic region. I introduce the rise of HIV/AIDS as a thematic topic within applied theatre. Finally, I assert that the applied health theatre sector in the country is a space in which innovation and creativity in finding new routes to communication about HIV are actively privileged. I introduce the concept of Creative Risk and note that applied theatre provides a space where participants can experiment with models of intervention. Although I am hesitant to suggest theatre-makers have more institutional freedom to experiment with alternatives to current intervention practices, the theatre sector is one in which such exploration is highly supported (ideologically, if not structurally).

I develop the idea of theatre as an experiential canvas on which new approaches to HIV intervention are sketched, assessed, played with, and discarded or accepted before being placed
in the public eye. Because this is a space in which experimentation is enabled in certain circumstances (yet inhibited in others), it is a space in which real possibilities for innovation in approaches to HIV/AIDS intervention may be built—or at least the seeds of change sown and nurtured. Therefore, applied health theatre provides an industry to analyze for what it can contribute to global attempts to develop more nuanced and productive frameworks for understanding human experience of HIV and the AIDS epidemic.

4.1 “Commercial” vs. “Applied” Theatre: The Politics of Space and Language

Jessica: So, what do you call this kind of theatre that’s occurring in South Africa now, in the townships?

Jabu*: Applied theatre. Because in community theatre, you can find people who practice theatre for development, you know. Because within community theatre, it’s a general practice it’s just that there’s practitioners in communities, because…Okay, also you need to take note on this word “community.” How it was used before 1994. The word “community” has been aligned with “black, poor, disadvantaged,” and that’s why today there’s a problem with the use of this name, called “community theatre,” because for me it still says “this is a theatre which is poor, unprofessional, they don’t make money, and it’s underprivileged, they don’t have lights, they don’t have costumes,” you know? And that’s why today for me there’s a big problem with the usage of the word “community theatre.” You can talk of “community theatre” in the 1980s, but now, it’s a problem. Now it’s a problem because what it does at the moment is that it confines theatre to class. Post-colonialism, now, 2008, it’s a label for material conditions.

As Jabu, a 36-year-old black South African theatre-maker from Mpumalanga Province notes, the effects of structural violence are evident in the politics of space and terminology involved in HIV/AIDS theatre in South Africa. In the process of interviewing theatre-makers across the country, a theme that quickly emerged was the distinction—in style, location, and value—between commercial and applied theatre (fieldwork 2008-2011). From the first years of apartheid through the transition to democracy in the early 1990s and up to the present, theatre in South Africa was confined primarily within two overarching categories: commercial and applied. These two terms denote very different types of theatrical activity, but it should be noted that within South Africa,
there is often slippage between these two (although the slippage is more prominent in the post-apartheid era than during apartheid).

The term “commercial theatre” is often used interchangeably with “professional,” “formal,” or “mainstream” theatre and indexes a kind of theatrical activity usually produced as a for-profit venture by theatre companies or independent groups who have formal training in European theatre techniques and production practices. It targets middle-class audiences and caters to people in the country who have the economic means to pay for artistic entertainment. It occurs in formal theatre spaces, often with partial state-subsidized funding, and is confined to urban areas. In addition, it is usually staged primarily for popular entertainment rather than actively focused on examining sociopolitical issues in any critical manner, was often described by theatre-makers as far less political than any other type of theatre occurring in the country, and was thought to receive greater and more stable income.

The professional theatre activity in South Africa under apartheid took place primarily in the four generously state-subsidized Performing Arts Councils (PACs), which were registered in Section 21 of the Companies Act of 1973 as non-profit organizations. The PAC theatres were located in Pretoria, Cape Town, Bloemfontein, and Durban, and they catered exclusively to elite, white, urban audiences. Other professional theatres were located in larger metropolitan areas in civic theatres funded by the city (municipal governments) (Van Heerden 2008).

Although characterization of types (or levels) of theatre are fluid and include commercial, academic, community, religious, industrial, and other forms of theatre, the other major form often contrasted with commercial theatre was applied theatre. In contrast to commercial theatre, applied theatre is a type of theatrical engagement that privileges critically examining topics of political, economic, and psychological importance. Applied theatre is a globally recognized
form of engaged theatre practice, and it encompasses a wide variety of aesthetics, including activist theatre, theatre for development, theatre in education, dramatherapy, and process drama. Within South Africa, this kind of theatre is often equated erroneously with “community” theatre or “township” theatre.  

Although these distinctions do not apply to all forms of theatre in the country, a sense of division between these two types of theatre (commercial and applied) was often expressed. For example, one key informant indicated the introduction of economic reform and increasing capitalist values post-1994 as root causes of the hierarchization of theatre institutions in the country. Value differences between the two types of theatre (commercial and applied) may be seen through differences in state-subsidized funding and the facts that commercial theatre occurs in formal performance areas (usually characterized as safe), community theatre occurs in informal areas (often in townships, which are portrayed as potentially dangerous spaces), and commercial theatre is given higher value than community theatre in the public imaginary as expressed in media discourse.  

In addition to formal/informal performance spaces, another prominent distinction in the kinds of theatre that occur (and how prevalent they are) is the urban versus rural divide. The theatre-makers with whom I worked commonly acknowledged that most theatre related to HIV occurs in urban centers. As for value judgments, discussion of theatre produced by rural community groups was often prefaced by statements doubting the accuracy of biomedical HIV information contained in play content. In regard to funding, both international and national,  

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30The term “community theatre” was characterized by the theatre-makers with whom I worked as either a genre of applied theatre or a geographic place where theatre occurred—primarily in informal theatre spaces (e.g. streets, community centers, schools). It was also considered to subsist without stable funding (and often without ever receiving state funds), include content that was driven by social issues, target township audiences, and confined usually to townships or rural areas.
urban areas are highly privileged over rural areas, which again underscores a politics of space involved in the distribution of (HIV) theatre in the country.

Usage of applied theatre terminology has become more accurate and complex post-1994, but during the apartheid era, the overwhelmingly predominant form of applied theatre practiced was protest theatre (also called activist theatre or struggle theatre). Because this form of theatre was performed primarily in townships and other venues of protest by black South African theatre makers as a form of anti-apartheid cultural activism, it is often also called township theatre. Some township theatre can arguably be classified as professional theatre, especially productions produced by prominent theatre-makers such as Gibson Kente and Mbongeni Ngema (among others); however, since I focus specifically on activist theatre in this section, with its attendant focus on engaged theatrical practice, I include it within the umbrella term “applied theatre.”

As a final point on language and space, it should be noted that several parallel subsystems of theatre are operational in South Africa simultaneously. For analytic purposes, I have divided these into categories based on general trends regarding where the productions are created and showcased. These include the following broad categories: mainstream theatre (professional, formal), school and university theatre, community theatre, and industrial theatre. Other scholars also include categories like “amateur” theatre, but that terminology has considerable pejorative connotations within South African theatre-making, and I do not use it in this dissertation.

In addition, some scholars use genre labels, such as educational theatre or theatre for development, as analytic categories for types of theatre within the country. I do not follow this

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31 It should be noted that the category “township theatre” is not limited to struggle/protest theatre. It also includes other forms of theatre that came out of townships during the 1940s-1990s, such as the widely popular township musical genre.
32 In addition, “applied theatre” occurs at any of the various levels of theatre described in this chapter.
naming convention. Genre categories can be and often are used in a variety of ways by a variety of theatre groups, ranging from mainstream to community theatre. Genres tend to refer to theatrical practices and aesthetics, which can be incorporated by any type of group. For this reason, I separate genres from theatre system category labels.

The primary genre labels I use in this dissertation are based on a grounded analysis of my data and come from the local terminology of the theatre-makers with whom I worked: activist theatre, experimental theatre, theatre in education (TIE), theatre for development (TFD), dramatherapy, playback theatre, physical theatre, realist theatre, puppetry, process drama, and African dance. While people regularly use these category and genre labels in everyday language about theatre making in South Africa, there is considerable slippage in the post-apartheid era between these devised analytic categories.

4.2 Applied Theatre in Apartheid South Africa

I elaborate here some of the characteristics and theoretical foundations of two historically important forms of applied theatre in South Africa: township and protest theatre. Both styles are the foundations on which later forms of HIV/AIDS-related theatre have been built and provide a grounding from which contemporary artists have sculpted their changing ideas about health activism and artistic practice in the country.

Township Theatre

In South Africa, the term “township” has a very specific meaning. Within the context of forced physical segregation of residential areas along racial lines under the Group Areas Act of 1950, the term most often refers to urban areas allocated to non-white populations for residential occupation. Some of the most famous townships within South Africa include Soweto in

33Soweto is actually a group of separate townships, the South Western Townships (Soweto) of Johannesburg.
Johannesburg (Gauteng province) and Khayelitsha, Gugulethu, Langa, and Nyanga in Cape Town (Western Cape province). Urban residential areas populated by white groups are more often called “suburbs” (Van Heerden 2008). Townships, populated mostly by black South Africans, are often areas with high rates of unemployment, crime, and sub-par housing (mostly shacks), and a lack of formal infrastructure or typical urban facilities. The major formal theatres of the country, such as Cape Town’s Baxter Theatre and Johannesburg’s Market Theatre, Windybrow Theatre, and Civic Theatre, are all located in urban areas not easily accessible to the vast majority of the country’s population. The informal performance spaces within townships are ill-equipped and primarily consist of community halls.

Despite a lack of suitable facilities for performance, theatre has nonetheless constituted a large part of township life and cultural expression. During the 1920s-1930s, live theatre was a popular form of working-class entertainment. In the 1930s-1940s, township theatre took a decidedly more political turn. The first South African playwright to challenge apartheid openly was township musician and dramatist Herbert Dhlomo, who staged a series of productions during this time (Van Heerden 2008). In the 1950s-1960s, under the oppressive policies of the Nationalist Party, cultural expression in townships became more difficult; however, artists persevered to create a vibrant theatre movement. From the mid-1960s until the end of apartheid, live theatre surged in popularity as a form of collective expression of resistance against the human rights abuses perpetrated by the government.

Some of the most well-known theatre-makers who produced work in this era include Gibson Kente, Athol Fugard, John Kani, Pieter-Dirk Uys, Zakes Mda, Mbongeni Ngema, Barney

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34 This has somewhat shifted within the past 5 years with the building of Soweto Theatre in 2012 (the venue construction began in 2009).
Simon, and Fatima Dyke. Gibson Kente (1932-2004) was a playwright based in Soweto and has often been called the Father of Black Theatre in South Africa. His career spanned 50 years, and he was one of the first writers to deal with life in black townships. The Township Musical genre grew from the work of pioneers like Kente and became an important form of popular entertainment (Van Heerden 2008). This kind of theatre influenced later theatrical aesthetics in the country and provided the foundation on which activist theatre developed.

Barney Simon and Athol Fugard are also important historical figures in South African theatre. The works of these two opened the country to German Brechtian theatre influences, which allowed for further development of protest theatre practices. Fugard is the most internationally famous anti-apartheid playwright and was most active in the country during the 1970s-1990s. His works defiantly indicted apartheid policy, despite artistic censorship under the apartheid government. Barney Simon was the co-founder of the Market Theatre (1976), which was the birthplace of the country’s contemporary indigenous theatre movement, first multiracial cultural center, and premier theatre focused on engaged political theatre. Simon was known for his theatrical production process, “workshopping,” which created new work through improvisation, research, and collaborative writing. The workshopping of productions has become an integral tradition in township and community theatre since this time.

Another critical historical figure is Pieter-Dirk Uys, the country’s most famous satirist. Under apartheid, he used the comedic genre to critique the government’s racial policies. His work has continued in the post-apartheid era and privileges topics such as HIV. Other notable individuals include Mbongeni Ngema, who was strongly connected to the initial protest theatre movement but later came under popular censure for his involvement in theatre scandals over the misuse of government funds for cultural productions (including those about HIV/AIDS); Fatima
Dyke, who was one of the first female theatre-makers to speak out against apartheid; and John Kani and Zakes Mda, who were both important figures in apartheid-era theatre, but their involvement in cultural politics became more pronounced in the post-apartheid period.

**Protest Theatre**

Within the later decades of apartheid, theatre produced in the country’s townships grew into a powerful social and aesthetic movement, which has been thoroughly documented and analyzed (Gunner 1994; Fuchs & Davis 1996; Kruger 1999; Larlham 1985; Van Heerden 2008). As previously mentioned, one of the main forms of resistance in the anti-apartheid struggle was a type of engaged theatre with subversive content. The apartheid struggle was seen as having both political and cultural dimensions, and resistance theatre provided a way to combine both aspects. While South African activist theatre also has roots in indigenous performance styles, the genre was heavily influenced by global trends in activist theatre, which in turn are founded on the ideas of three main dramatic theorists: German director Bertolt Brecht, French director Antonin Artaud, and Brazilian director Augusto Boal.

This type of theatre often has alternate names, such as guerilla theatre, activist theatre, applied theatre, or theatre for development (van Erven 2001). Indeed, Augusto Boal (1974) even named his approach the Theatre of the Oppressed. Although many of the ideas surrounding theatre for social change had been around for years, Bertolt Brecht (1964) introduced this concept in a Marxist, codified, and popularized manner in the early 20th century. Artaud and Boal later added important components to the concept, which fleshed out activist theatre into the deeply involved, evocative, workshopped, and participatory style it has today. Reacting to the political climate of his time, Brecht emerged as an anti-fascist dissident in 1920s Germany. In a

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35 However, during the first decade after democracy, there was a significant decline in support for township theatre. In particular, protest theatre came to an abrupt halt in 1994 (Van Heerden 2008).
discussion of Brecht, scholar Loren Kruger assesses the polemics surrounding politics and art
during that time. She states:

the culture of international socialism and related debates about the political function of
art, which deeply influenced Brecht and fellow leftists in the 1920s and 1930s...re-
emerged, albeit more ambiguously, in the protestations of third world solidarity by GDR
state *and* dissidents in the 1970s and 1980s. It still continues to inform theatre for
development projects the world over, especially in post-apartheid South Africa, where the
leftist language and practices inherited from the international socialist tradition continue
to resonate more forcefully than metropolitan readers commonly realize.

[Kruger 2004:13]

In discussing the German Democratic Republic and the influence of socialism, Kruger
emphasizes the deeply political and historical roots from which Brecht’s “Epic Theatre”
developed. The focus of Brecht’s Epic Theatre was the integration of Marxist theory into
cultural practices aimed at radical transformation of society (Kruger 2004). He strove to change
the content, forms, and institutions of theatre in the hopes of enacting social change. His theatre
was an experimental one in which actors and audience participated simultaneously in a project of
combined learning, teaching, and unification (Kruger 2004). Probably the most important of
Brecht’s contributions to activist theatre was the concept *Verfremdung*, translated loosely as
“dis-illusion” (Kruger 2004). Brechtian disillusion encourages the audience to see and
acknowledge contradictions between popular social ideology and actual social conflict in
practice in an attempt to encourage social activism.

Antonin Artaud’s (1958) contribution to this type of theatre, one that strengthened the
impact of Brechtian dis-illusion on audiences, was called Theatre of Cruelty. Artaud’s theory of
theatre was bent on shocking audiences out of complacency by incorporating very strong,
realistic, and often disturbing images, symbols, and sounds. Artaud introduced new techniques
to reach audiences in ways that shattered the illusion of the performance, and his theatre was
intended to use highly affective symbolism to disrupt complacency in audiences and force them
to recognize the realities of their everyday lived existence. His techniques, combined with Brecht’s *Verfremdung* and call for social change, provided possibilities for intensely emotionally- and politically-charged theatre.

Lastly, Augusto Boal (1974), in his Theatre of the Oppressed, popularized a final concept that cemented the contemporary vehicle of activist theatre. Mady Schutzman and Jan Cohen-Cruz succinctly describe Boal’s major contribution when they state, “Boal’s vision is embodied in dramatic techniques that activate passive spectators to become spect-actors—engaged participants rehearsing strategies for personal and social change. Although founded in theatrical exploration, the techniques, all based on transitive learning and collective empowerment, are not limited to the stage” (1994:1). Boal normalized a theatre participation in which the audience engaged as much as the actors. This style of active-participation theatre, an alternative to Europeanized traditional theatre, has been embraced in South Africa for its closer ties to traditional oral story-telling and performance (Schutzman & Cohen-Cruz 1994).

The application of struggle theatre in South Africa has taken many forms; however, its most cited use for resistance has been in its attention to apartheid. Anti-apartheid plays formed part of a cultural movement of resistance through art during apartheid (Biko 1978). Historically, struggle theatre produced anti-apartheid plays that addressed various structures of violence, and they constituted an important form of resistance to apartheid, in combination with other types of protests and demonstrations. New forms of theatre became expressions of resistance against the Euro-centric forms imposed on the South African population by the apartheid regime (Blumberg & Walder 1994).

Theatre also contributed to the apartheid struggle with an increasing rise in incorporation of political imagery, including the toyi-toyi dance, freedom songs, and necklacing (Gunner
1994). Struggle theatre in South Africa has a complex chronological history from early Brechtian influence spanning through prominent anti-apartheid playwrights like Athol Fugard and Herbert Dhlomo and culminating in workshopped theatre groups of the 1970s and 1980s, which ultimately led to the intense protest plays performed in the 1980s and early 1990s (Blumberg & Walder 1994). Much of the literature on struggle theatre in South Africa focuses on the political intention behind and impact of dissident theatre, although there are also close textual readings of particular struggle theatre plays.

Representations of apartheid and structural violence during the apartheid era are prominent in struggle theatre scholarship; however, currently that same richness in discussion of both the representations behind and impact of HIV/AIDS plays is not as apparent within academic scholarship. This is unfortunate, since HIV/AIDS is an issue through which some theatre-makes claim theatre gains new meaning in post-apartheid South Africa. The AIDS epidemic is one of the most politicized factors in the country, and discourse often used to characterize it marks it as the “new apartheid” to be met with similar fervor in popular resistance (Whittaker 1992). Given historical uses of theatre in the struggle against apartheid, it does not seem unusual that theatre has been applied in recent years to the country’s struggle against HIV/AIDS.

4.3 New Developments in Post-Apartheid Theatre

The post-apartheid era was a crucial period for the arts; the entire sociopolitical and economic system of the country went through extreme change. Artists had to adapt to this change and work within it, as well as find ways to represent life in the new democracy through performance. With these changes came a host of developments in funding, thematic content, production style, theatrical form/aesthetics, and arts management techniques (Van Heerden
In addition, there was a pronounced changing relationship between the State and the Arts, which was formalized through legislation and funding initiatives.

Theatre-makers in the post-apartheid era have faced challenges in continuing to deal with issues that have shaped the contemporary political context, as well as incorporating a wide variety of new content and producing theatre in a radically transformed socioeconomic environment. In this section, I cover advances within the South African theatre industry in the following areas: trends in commercial theatre; the rise of arts festivals; and trends in applied theatre, including changes in content, practice, and aesthetics.

**Trends in Commercial Theatre**

In the post-apartheid era, there were a number of institutional changes in the theatre sector that had an impact on commercial theatre, which indirectly affected the applied theatre industry and resonated through the country’s broader arts landscape. These primarily had to do with changes in the relationship between the State and the Arts vis-à-vis funding as formalized through legislation in the new Department of Arts and Culture. Particularly, there has been a conspicuous move toward an industry focused more on popular entertainment than socially engaged theatre, an increase in comedy as a popular genre for artistic production, and a rise in independent commercial theatres.

By the end of the first decade of democracy, there were about 90 venues that functioned as full-time theatres around the country, including privately owned commercial theatres, theatres attached to tertiary educational institutions, privately owned non-profit theatres, state-subsidized local theatres, state-subsidized national theatres, and state-subsidized provincial theatres (Van Heerden 2008; Performing Arts Network of South Africa 2005). This estimate only includes formal theatre structures and does not take into consideration the large number of informal
structures in which theatre is produced by community groups (most often community centers), site-specific performances, or street theatre. With the international reconciliation that accompanied South Africa’s turn toward democracy, there was an influx of high-profile international shows (such as Broadway hits *Cats* and *Evita*) run by producers that were once again willing to tour the country. There was also an increase in building of venues, such as casinos, to host those international productions and the growing number of commercial national productions. A primary trend within commercial theatre was the shift from theatre produced as a resource for cultural production and critique to profit-making entertainment endeavors.

Producing dramatically significant national (and indigenous) theatre in the commercial sector was not prioritized by mainstream theatre-makers during the first decade of independence, and this trend continues to a large extent today. Within this sector, pursuing financial stability and profit through catering to a particular class of audience members remains the goal of many professional theatre organizations—often, but not exclusively, at the expense of national cultural development. Some exceptions to this trend exist, and the Market Theatre is a notable one. The Market Theatre is the country’s most famous independent theatre and was founded in Johannesburg in 1976. It is a performance space celebrated for its production of socially engaged, political theatre, and in 2003 became a state-legislated cultural institution, thereby procuring some state funds. However, its productions continue to reflect and comment upon the country’s sociopolitical environment.

**Emergence of Arts Festival Circuit and Festival Culture**

A trend that significantly affected the way theatre is produced within post-apartheid South Africa is the emergence of the arts festival circuit. As Performance Arts Councils were disbanded, changes in state funding for the arts were legislated, and formal theatre spaces
became increasingly commercialized and based on popular entertainment, theatre-makers with alternative agendas were left without formal spaces in which to perform. While the occurrence of arts festivals was common in South Africa prior to 1994, the role and impact of these festivals changed markedly after democratization and played a crucial formative role in the evolution of theatre production in the post-apartheid period (Van Heerden 2008). Particularly, the emergence of arts festivals has shaped theatre-making processes, motivations behind the creation of artwork, and staging practices.

There has been a proliferation of arts festivals post-1994. South Africa has a wide variety and large number of arts festivals each year, ranging from the National Arts Festival (NAF) to smaller regional festivals, such as the Drama for Life Sex Actually Festival of Johannesburg or the Stop Crime Festival, which changes venues annually. Many of these festivals are regional, and the NAF is the country’s premier national festival for theatrical performance. With the collapse of formal structures (PACs) to house artists and provide full-time employment opportunities, the number of artists creating independent work increased, as well as the number of informal structures to accommodate them.

The emergence of the arts festival circuit created a platform where many productions could be staged simultaneously to a dedicated audience. This was particularly appealing for theatre-makers during a time of intense social change, when audience size fluctuated wildly. This kind of festival circuit led to theatre-makers creating productions specifically to premiere at one of these festivals, with the hopes of touring circuits of festivals or formal theatres for the remainder of the year if the initial performance was well-received and obtained positive media attention. Festivals are a space where professional theatre-makers mingle with university and community theatre-makers and provide one of the only venues and opportunities in the country
for significant professional networking, exchange of artistic ideas, and opportunities for creating relationships that may later result in artistic and business collaboration.

Festivals also provide a space to test new work on audiences, as well as solicit feedback from other theatre-makers. This trend has led to the emergence of what Van Heerden (2008) calls the “Festival Play”—plays created specifically for festivals, rather than for performance in a home community or venue. These plays sometimes have a life within the home communities of groups producing them, but sometimes their only showing is on the festival circuit. My fieldwork anecdotally supports Van Heerden’s conclusion that plays are being created specifically for festivals. In my own research, groups working on HIV/AIDS-related issues most often created work for presentation at a festival and tailored the content of their production to the theme of the festival to which they were applying. In this way, the emergence of the festival circuit has significantly influenced the content of artistic productions in the country, as well as the motivation behind producing new artistic work.

**Applied Theatre: Changes in Content, Practice, and Aesthetics**

Accompanying the widespread social, political, and economic changes in the country, along with shifts in the commercial theatre sector, were notable shifts in the content, practices, and aesthetics of applied theatre. The activist theatre aesthetic dominated the applied theatre topography in South Africa until 1994. At that time, theatre-makers began searching for new ways of presenting their art as well as new issues to tackle for content. As Ian Steadman and Temple Hauptfleisch, co-editors of the seminal academic South African Theatre Journal (SATJ), have noted, great change was anticipated during this time and premised on the idea that there would be new issues for a new era (Van Heerden 2008).
Applied theatre in the first years of the post-apartheid era tended to be depoliticized and produced as educational theatre, physical theatre, and, to a lesser extent, theatre for development; however, theatre-makers are starting to branch out to other genres, especially during the last 10 years. Additionally, it was during this time that the number of companies producing industrial theatre increased. Industrial theatre is a kind of information- and issue-based theatre produced for presentation in corporate environments. Overall, however, there was a marked initial decrease in applied theatre activity in the country after democratization, accompanied by a dwindling interest in and support for applied theatre performances.

Post-1994 was a difficult time for theatre-makers in the applied realm. The sector went through a period of heightened uncertainty over its role in the new democracy. Without the clear, unambiguous specter of apartheid to fight, applied theatre-makers struggled to find the relevance of their work amid social upheaval. Scholars have noted that applied theatre in the 1990s fragmented into a multitude of individual social and development issues as theatre-makers tried to forge a new national artistic agenda and address the many social challenges of a new sociopolitical context. In addition, storytelling and personal narrative became primary genres.

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Industrial Theatre grew out of strategies by private South African corporate entities to minimize the impact of HIV/AIDS, promote HIV prevention, and develop comprehensive programs to address HIV infection amongst their workforce. Most of these programs have been based on educational objectives and communication strategies and privilege behavior change as an ultimate goal. These kinds of theatre interventions utilized within the private sector for HIV/AIDS awareness have often been inadequate in scope and contributed relatively insignificantly to any kind of impact within the workplace; however, where these programs have had moderate success is in education on the risk factors associated with HIV infection and health promotion of HIV/AIDS awareness (Durden & Nduhura 2011; Anglo Gold 2003; Van Rheede van Oudshoorn et al. 2003; Becker 2001; Kruger 2000).

This kind of theatre falls into the broader field of Education-Entertainment (EE) or Edutainment, which is defined as “the process of purposely designing and implementing a media message to both entertain and educate, in order to increase audience knowledge about an educational issue, create favorable attitudes and change overt behavior” (Singhal & Rogers 1999:9). EE/Edutainment strategies have been in use within applied theatre (and communication studies) for at least 50 years. The academic study of EE/Edutainment has recently surged due to its heavy incorporation in health promotion projects, which have made use of a wide variety of media to communicate health messages, such as radio, television, storytelling, music, and live theatre (Singhal & Rogers 1999). I chose not to study industrial theatre because its goals and aesthetics often differ from those prioritized at community levels, and community study was the original focus of this project.
through which applied theatre was produced. Memory, remembering, and stories about individual, everyday people, rather than abstract concepts or sociopolitical slogans, became pervasive. Van Heerden (2008) calls these the “Let me tell you my story” plays. Theatre-makers were trying to acknowledge present lived realities while also reflecting on the country’s recent apartheid history.

A range of thematic trends emerged during this period. According to my research, the seven major social issues most commonly incorporated in applied theatre during this time were crime, gender and domestic violence, rape, poverty, unemployment, substance abuse, and HIV/AIDS. While these themes were incorporated to a nominal extent within mainstream theatre after 1994, they were explicit content topics within the applied theatre realm. There was a clear trend to address these particular social challenges in the contemporary sociopolitical context.

Additional prominent thematic content within applied theatre at this time included reconciliation (its challenges, what it means, and xenophobia in a society trying to overcome its racial and ethnic divisions); exploration of black African history, ritual, and culture (specifically through use of indigenous music and dance); identity and identification (creation and confirmation of individual, community, and national identities, the incorporation of strong biographical elements and storytelling within theatrical aesthetic, and catharsis around acknowledging and validating identities); and human rights and liberties under the new constitution (Van Heerden 2008). Day-to-day issues that arise in a new democracy were also fodder for applied theatre work and covered such themes as affirmative action, racial and gender equality, same-sex relationships, corruption and nepotism, conflict between urban and rural cultures, and a host of other lived experiences for a range of people.
The country’s theatre topography changed dramatically during the years immediately following the fall of apartheid and the rise of the ANC administration under Nelson Mandela. Legislation regarding the arts formally changed the relationship between the State and the cultural production sector, and broad sociopolitical and economic changes accompanying the new democracy undergirded significant structural shifts in commercial dynamics, funding mechanisms, sites of theatre production, scale of performances, and the kinds of thematic content addressed within theatre (Van Heerden 2008). Complicating this already complex topography was the emergence of the arts festival circuit, which influenced audience demographics, as well as how and why theatre was produced in the country. These are some of the major factors that have shaped the production of theatre in the post-apartheid era and provide context for more contemporary artistic work, including the rise of HIV/AIDS as a thematic topic.


While struggle theatre addressed direct effects of apartheid laws before 1994, theatre-makers have searched for new sets of issues to highlight in post-apartheid times. A major thematic focus of post-apartheid applied theatre has been HIV/AIDS. The AIDS epidemic in South Africa has trended toward politicization from its inception in the early 1980s, and with the country’s pervasive history of using performance art as a forum for discussing political resistance and social critique, it seems inevitable that HIV/AIDS and theatre would be paired in the contemporary moment. In fact, HIV/AIDS played a growing role among applied theatre efforts in the country in the 1990s and early 2000s after the transition to democracy and through the country’s well-documented problems with HIV/AIDS denialism at the government level (e.g. President Thabo Mbeki’s denialist response to the link between HIV and AIDS).
I suggest that recent HIV/AIDS performances provide productive examples of how political discussion of the continued effects of structural violence in all realms of South African life, from housing issues to access to antiretrovirals, can be understood within a cultural sphere that enables continued mobilization and activism. While the initial types of theatre used to address HIV/AIDS in the country in the years immediately after democratization tended to employ didactic messaging to raise awareness about HIV risk, theatre-makers have recently begun calling for experimentation with content, form, and aesthetics in HIV/AIDS-related art. In large part, the calls recently issued from the arts sector for innovation in HIV/AIDS communication practices and treatment modalities stem from a period of intense reflection among artists that occurred in the mid-to-late 2000s. This period of reflection was in full effect during my primary fieldwork from 2010-2011.

A majority of my collected data with producers of artistic HIV/AIDS programming documents the intense debates and conversations occurring at the level of ideology among different factions of theatre-makers in the country. While some artists were trying to implement their new ideas in practice, efforts were often stymied by structural factors. In the three years after my fieldwork, I have heard from informants that many of the ideas bandied about during my fieldwork period have slowly started to become reality in practice. Much of my data focuses on the industry tensions that inevitably occur when a sector (in this case, health arts) is in a period of contested transition.

4.5 Narratives of Innovation

Jessica: Someone just made the comment to me that they thought really and truly the time of theatre that has to do with HIV/AIDS has passed. What are your thoughts on that?

Warren: I think I would absolutely agree with that statement if they were talking about HIV theatre that was founded in the belief that one has to “fight” the disease. But if it’s theatre about finding humanity and locating the individual journey through that in
relation to HIV, not losing how HIV affects more and more people, the ripple effect, all of those kinds of things, I think we haven’t gotten close to that. We haven’t even started. Really, I mean the poetics of what it means to be HIV positive, and a world where we are gonna be having so many hundreds of thousands of orphans hasn’t even begun to really hit us.

I think we need to find new ways of talking about the work, need to start finding ways in which we feel comfortable about how our work is spoken about and how we report on our work. It requires a language, you know. We need to look towards things like performance ethnography and action research methods that allow for the personal voice to emerge, that allow for deeper critical reflection, that foster self-reflexive modes and try to find ways to incorporate that into monitoring and evaluation. I also think multi-media technology offers us huge scope, and we need to be given more space for documentary film-making and interacting with the audiences. [Emphasis added]

As the director of Drama for Life, the most prominent HIV/AIDS-related artistic university endeavor in the country, Warren notes in one of our discussions as we walked the halls of the university’s program that HIV-related theatre in South Africa is alive and well but moving in different directions than past health communication efforts.

Over the past nine years, critiques of hegemonic public health HIV/AIDS initiatives have increasingly been issued from the applied theatre sector in the face of perceived failures from the wider HIV/AIDS prevention, treatment, and care industry in South Africa. In a country that is no longer steeped in deep denial at the government level over the connection between HIV and AIDS, whose general population has experienced 30 years of explicit health promotion programs and gained much functional awareness of and basic education in HIV/AIDS risk and prevention strategies, and in which increased ARV roll-out and more rigorous HIV testing campaigns have become routinized, what is—or should be—the role of HIV interventions? This is a question that has become increasingly relevant within applied health theatre. In the past decade, this question has shifted the practices of the health theatre industry and shaped the very core of their programs—both in content and form.
In their attention to past health promotion and treatment efforts, theatre-makers have largely concluded that both their own and other intervention strategies have not worked to fully meet the needs of a population where everyone is affected by the epidemic on so many different levels. By and large, there is a hope, indeed an expectation, on the part of everyone interviewed in this project that HIV intervention programs will have some tangible impact in addressing the country’s AIDS epidemic. Whether or not the claim that past programs have failed is true, theatre-makers often expressed the opinion that the public was not engaging in productive ways with the kinds of interventions prominent in the country.

It should also be noted that debates about the efficacy of the country’s past health program efforts related to HIV/AIDS are widespread. There is a copious body of literature discussing the many failures of HIV intervention programs in South Africa: this idea has common public and academic currency. This literature spans the disciplines of public health and anthropology, as well as the media (for examples, see the following: Campbell 2003, Fassin 2007, Dickinson 2004, Niehaus & Jonsson 2005; Schneider 2002; Benatar 2001; Butler 2005; Harrison et al. 2000). Most of the popular and scholarly questions about the efficacy of past HIV/AIDS intervention efforts focus on early government denialism of the link between HIV and AIDS, the relatively stable and high national HIV prevalence rate over the past decade, nationwide problems with health provision and healthcare access, widespread levels of “AIDS fatigue,” and the failure of health promotion and awareness campaigns to significantly change common sexual actions and practices considered “risky” (e.g. multiple concurrent partnerships).

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37 The focus on the national HIV prevalence rate tends to gloss over successes in decreasing HIV prevalence among certain population groups. In particular, the country has had widespread success in decreasing mother-to-child-transmission rates with increased access to free ARVs.
While advances have clearly been made in biomedical treatment and care of physiological bodies and in public health information dissemination, artists note that other questions related to the epidemic are still left unanswered, other components unaddressed (particularly those related to affect, subjective experience, and interpersonal relationships), and other health priorities and definitions of healing unrecognized or valued at institutional levels. So, a major question for theatre-makers has become: how do we start addressing these failures and filling in the gaps in attention to HIV in the country? How do we start meeting the psychosocial, emotional, interpersonal, cognitive, and embodied needs of people infected with or affected by HIV? And why have past efforts been stymied in their attempts to make substantial change?

In answer, theatre-makers have started calling attention to certain things as particularly problematic to past intervention efforts, including rigidity in health communication standards, inattention to interpersonal complexities in life, and deep ideological and resource divisions among various branches of the healthcare industry. As a response to these critiques, narratives of the necessity for innovation within public health programming have increased among some factions of the applied theatre sector. Accompanying these narratives of innovation are robust calls for new aesthetic and communication practices within theatre related to health. Here, I first examine why the push for new frameworks for HIV intervention is happening at all, including what kinds of problems theatre-makers identify with past intervention efforts. Next, I discuss the relevance of the concept of “creative risk” to theatre-maker ideas about future best practices within public health.

To explain why theatre-makers are issuing such stringent calls for innovation in HIV intervention projects, it is necessary to inspect the structural and ideological factors that bolster
theatre-maker reasoning for saying the country needs new ways to think, talk, and act about HIV.

It is important to note that applied health theatre-makers are not the only group of people calling for this kind of change; there is widespread consensus among other sectors of South Africa’s HIV/AIDS intervention landscape. Consider the following announcement issued from the University of Cape Town and emailed through various listservs:

**SCOPING THE NEXT ERA OF HIV SOCIAL SCIENCE IN AFRICA: WHO, WHAT, HOW?**

Though the role of the social sciences in HIV and AIDS is often thought to revolve primarily around “culture” and "community engagement,” their scope is in fact much broader. The social sciences have also been critical in understanding individual experiences of treatment, illness and caring, assessing the design and operation of health systems and services, evaluating the form and impact of civil society mobilization and political activism, and clarifying the ways in which health diplomacy, macroeconomic policies, Northern donor financing, and public health research and policymaking at global levels have shaped local responses to the epidemic.

The goal of this half-day colloquium is to bring a wide range of scholars interested in HIV social science in Africa together to 1) develop relationships and communities of mutual interest and practice (the 'who') and 2) identify some of the key HIV social science questions, concepts, and priorities going forward (the 'what'), and 3) discuss the research projects, methodologies, initiatives, funding, collaborations, and theories needed to do this work (the 'how').

We want to engage a wide range of interdisciplinary scholars working (or simply interested) in the social sciences and HIV. We invite participants, Southern and Northern, junior and senior, for a half day of conversation, debate and agenda-setting for the new era of HIV social science in Africa.

I received this announcement through at least two different listservs. The colloquium to which the ad refers was held in December 2013 and sponsored by the Social and Political Research Advisory Group at the International AIDS Society (IAS) and the Division of Social and Behavioural Sciences (Public Health) at the University of Cape Town (UCT). Although rhetoric about needing “new ways” to address HIV/AIDS or figuring out the “next era of HIV social science” may be utilized to create renewed interest in a waning topic in public opinion and media, I assert these increasing calls for re-thinking the *who, what, and how* of HIV/AIDS intervention by theatre-makers, as well as broader academics of HIV and policy-makers in the
public health arena, signal a widespread recognition that *something has changed* in global experience of HIV generally and within South Africa in particular.

In fact, many things have changed within South Africa. The sociopolitical context in which public health policy was formed 20 years ago is, in many ways, different today. Knowledge about HIV/AIDS has increased through widespread awareness campaigns. Public opinion and attitudes related to HIV have shifted. I assert that the country is in a moment where people involved in the industries related to HIV/AIDS treatment and care are starting to question the current utility of prior models of health intervention, previous questions asked about HIV/AIDS, and past ideas about which groups of people are best positioned to make effective interventions. This makes the contemporary moment within South Africa, related to HIV/AIDS, exciting theoretically and practically. In the section that follows, I attend to these kinds of context changes and the narratives that accompany them. Pertinent questions here are what faults have theatre-makers found with past intervention strategies, and how do they propose to change things for the better?

**Reacting to the Past**

The calls for innovative, creative alternatives to past ways of engaging with HIV/AIDS within South Africa that are being issued from the applied theatre sector tend to be linked to changes in sociopolitical context within the country and ideas about failures in past intervention efforts. In response to perceived past failures, theatre-makers cite certain problems with biomedical, public health, and artistic efforts to address the country’s high HIV rates. In particular, these have to do with rigidity in health communication practices, inattentiveness to nuance and complexity in lived experience, and divisiveness among the various branches of the country’s HIV/AIDS intervention industry.
Rigidity in Intervention Practices

A significant point of contention about past forms of HIV intervention in the country for many of the artists with whom I worked was the rigidity through which health communication has been conducted. The artists cited didactic health promotion practices and a lack of consideration of the ways in which the sociopolitical landscape of South Africa has changed over time as central reasons the broader public in South Africa has experienced HIV/AIDS fatigue over the last decade. These critiques were applied to biomedical and public health initiatives, as well as to past work within the arts sector.

Programs that privileged authoritative messaging of biomedical information over other modalities of intervention or practices that foster the co-production of knowledge were also implicated in the country’s well-documented HIV/AIDS fatigue. Finally, artists spoke negatively about programs that favor the kind of magic bullet quick-fixes I described in the introduction of the dissertation. Instead, they posited process-based interventions as more productive for the contemporary moment. These themes will be developed in Parts Three and Four of the dissertation.

Underestimating Nuance

In addition, for many theatre-makers, a central problem with past intervention efforts has been their prescriptive agenda for producing certain types of health subjects that foreclose opportunities for a wider range of human action. Certain kinds of actions, thoughts, and feelings are framed as problems to be solved instead of issues to be lived, questioned, and mined for deeper understanding. In a way, past intervention efforts tend to be framed through a shutting down of human experience rather than a keeping open of possibilities. Also, some theatre-makers note that the goals of current intervention efforts are no longer limited to past public
health agendas aimed at straightforward education, health promotion, and awareness of biomedical knowledge. For present health theatre practitioners, the goals of their current work exceed health promotion and move into the realm of therapy, psychosocial critique and analysis, emotion work, and in-depth probing of the ways in which people experience their lives as incoherent. These themes will be developed in Parts Three and Four of the dissertation.

**Broader Health Industry Divisions**

Along with both rigidity in programming practices and inattention to nuance in life, theatre-makers indicated the competitive divisiveness among various branches of the HIV/AIDS care industry as part of the reason behind the country’s failure to reduce its HIV prevalence rate. Artistic critique focused on the idea that there is a lack of a unified front among HIV/AIDS treatment, prevention, and care efforts in the country. Artists often pointed to the competitiveness produced through the national and international health funding sectors as an important component to the broader HIV/AIDS intervention industry’s inability to integrate its various branches (with their constituent modalities of healing) and work together for a common goal. This theme will be developed in discussions of the relationships between HIV/AIDS industry sectors in Part Five of the dissertation.

**Creative Risk**

While the issues just mentioned are some of the problems theatre-makers cite with past HIV/AIDS intervention initiatives, the solution presented by a majority of the people with whom I worked was innovation in programming and experimentation with aesthetic styles and health communication strategies. The active experimentation I discuss in this section involves what is colloquially known as “Creative Risk,” which indexes a process through which experimentation is privileged, and the creation of novel ideas or aesthetics is the result. Ideally, these novelties
are useful, productive, and implementable within programs. However, what is most important here is not necessarily the actual outcome (the ideas, methods, aesthetics, modes, and models produced) but the process through which they are generated: a process that allows risk-taking and fosters experimentation with the content and aesthetics of HIV/AIDS theatre as it relates to different kinds of modes of communication, methods of intervention, technologies of affect, and points of entry into engaging health-related issues.

I argue that applied theatre is an industry to which anthropological attention is productive because this realm is one in which active experimentation with new forms of communication and affective technologies related to health intervention are occurring. In South Africa in particular, the arts and related sectors are where a major impetus of creative risk and innovation regarding prevention, health communication, messaging, and non-physiological treatment is taking place within HIV/AIDS interventions. I noted a marked rise in the importance of creative risk as a tool within intervention development among the applied health theatre sector during my fieldwork. This industry is a space where people are starting to actively advocate for experimenting with genres, aesthetics, and content in HIV intervention. The conversation is actively happening, even though it is embedded in tensions around class, race, ethnicity, generational issues, aesthetics, communication styles, and the politics of funding.

While the ability to be creative is not necessarily a limited commodity, the environments in which creative risk-taking is fostered are often limited within broader health intervention frameworks by factors such as the conflicting ideology of institutional partners or collaborators, lack of resources and funding to create a space for experimentation, and even something as simple as valuing creative risk-taking as a worthwhile endeavor. Within applied theatre, experimentation and risk-taking have been historically highly valued and promoted over time,
even if the practical implementation of applied theatre practices appear staid in certain periods of a region’s history (e.g. theatre-in-education during the early post-apartheid years). The historical importance of creative risk-taking with genre, aesthetics, and content in applied theatre is part of what has led to the development of the wide variety of global artistic forms subsumed under the umbrella term “applied theatre.”

In relation to HIV/AIDS programming globally, creativity can be a risky endeavor, because it requires resources, time, and energy to develop novel programs, and resources allocated to global health (and HIV/AIDS in particular) are often earmarked, understandably, for immediate use in physiological testing, biomedical treatment, and palliative care efforts. Therefore, creative risk-taking is not always a priority for national and international public health campaigns. On the other hand, within the theatre sector, the willingness to take risks, play with, and try out new ideas is often valorized ideologically. This comes out of artistic tendencies to privilege flexibility, improvisation, space for reflection, unconventional thinking, disruptive rather than standardizing forces, and collaborative social thought processes (e.g. through workshopping ideas and productions). By and large, this kind of experimentation in communication styles, affective practices, emotional support methods, and techniques of social critique is not privileged to the same extent in the disciplines of public health, biomedicine, or global HIV advocacy.

Experimentation within the arts can also be risky in relation to how it affects audience members. Although experimentation is highly valued historically within applied theatre, some forms have backfired (e.g. Antonin Artaud’s Theatre of Cruelty) and alienated or traumatized its audiences and involved theatre-makers. This is one reason why the risk of burnout among theatre-makers who create art about HIV/AIDS is so high in the country. Overall, creativity and
the risk-taking involved in it are processes valued in some situations, institutions, and programs—but not in others. However, by privileging the study of theatre as a primary institution within broader HIV/AIDS intervention efforts, it becomes possible to open anthropology’s analytical framework to considerations of where and how this risk is occurring, along with why and to what effect. In addition, it becomes possible to view applied theatre as an experiential canvas on which new ideologies and practices are sketched, tried out, and accepted or discarded in the country before being painted in broad strokes for the public to see.

As suggested earlier in this chapter, there is widespread consensus among theatre-makers that health interventions in South Africa have largely failed to make a difference in HIV/AIDS infection rates, popular opinion of the epidemic, and emotional and psychosocial management of being infected or affected by HIV. Objectively, in broader perspective, there may be some foundation for this opinion. This is not to discount the significant progress that has been made in HIV/AIDS biomedical awareness (risk factors, modes of transmission), the scale-up of ARV rollout, higher numbers of people testing for HIV, or the considerable increase in government recognition and support of PLWHA. These points of progress, put in relief against perceived intervention failures in the country, highlight how difficult the terrain of establishing intervention success/failure may be: this is not a clear-cut situation.

Despite advances that have been made, problems with communication about HIV/AIDS in the country persist. There is also widespread consensus among theatre-makers, media representatives, and the biomedical experts I consulted regarding emerging HIV/AIDS fatigue within the country: the common-sense idea expressed was that people no longer want to hear about HIV/AIDS. While the implicit assumption of this claim is the ringing “at all” that could be attached to the end of the sentence, I suggest theatre-makers in the country are actively trying to
contest that assertion through finding new ways to talk about, represent, and engage with HIV/AIDS. They are shifting the “at all” to “in the same ways as before.” This is a much more active framing. Over the past five years, there has been a marked increase in calls for “new ways” of talking about HIV/AIDS, representing the epidemic, and of making HIV/AIDS issues meaningful for the broader population. This is accompanied by calls for new intervention methods.

The arts represent a space where a movement around experimentation and creative risk is being solidified in the present moment and where conceptual and/or practical innovation in HIV/AIDS programming (related to dimensions that exceed but sometimes include the physiological) has a real possibility of occurring because of the freedom some artists have in experimentation with strategies and techniques. While this innovation and its products are interesting theoretically, what is interesting from an anthropological point of view is how and why some artists in the country have access to the resources that enable freedom with experimentation, while others do not. This inequality in resources and ideological support is one additional reason why analysis of the arts is important in global HIV/AIDS scholarship, and I address it in Part Five of the dissertation.

4.6 Conclusion

In this chapter, I assert that by studying theatre as an institution involved in developing HIV/AIDS intervention programming, it becomes possible to analyze theatre as one important space in which innovation in HIV intervention has become an active focus of involved participants. A critical reason I suggest why artistic productions (particularly live theatre) related to HIV/AIDS are useful to foreground within medical anthropology research is that this is a site where creative risk is currently privileged and where imagination is fostered. Globally, we are in
desperate need of creative intercession in and re-evaluation of HIV/AIDS intervention strategies. This particularly holds true for South Africa.

I note a consensus among theatre-makers that past forms of HIV/AIDS intervention and modes of communication in the country have not yielded the results widely anticipated by government and international public health campaigns. In the face of steady HIV infection rates and increasing HIV/AIDS fatigue among the general population, theatre-makers are reassessing how to conduct HIV/AIDS prevention and care programs and how to talk about human experience of health, illness, and sexuality. A major narrative used in these discussions highlights the idea of creative risk. I argue that the kind of creative risk theatre-makers advocate is a main avenue through which social change is enabled. This is a space for developing an anthropology of the possible: ethnographically looking at the things people want, the ways they envision the future, and the alternatives they create for their lives in the present. There are two levels here: innovation in programming (i.e. production) and the creative risk that occurs within programs on the part of the participants (i.e. consumption).

Theatre-makers have begun explicitly privileging the idea of creatively playing with new ways of incorporating HIV/AIDS (forms, aesthetics, communication strategies) within their interventions in an effort to address past and perceived failures in HIV intervention processes in the country through the late 2000s (from sectors including art, public media, biomedicine, and public health). In addition, a key component within theatre interventions is enrolling the audience in the creative process—taking them on a journey of creative risk in a liminal space. This is about Augusto Boal’s notion of metaxis, “the state of belonging completely and simultaneously to two different, autonomous worlds: the image of reality and the reality of the
image” (1995:43). Through the processes of creative risk and metaxis, participants of theatre interventions enter a space for interplay between the actual and the imagined.

Looking at performance processes in which creative risk is implicated allows researchers and policy makers to understand both how people are framing and understanding their lived realities, as well as what their ideas are for alternatives on the ground. Within HIV theatre, a range of topics are addressed, including sexuality, health, healing, illness, gender dynamics, interpersonal relationships, internalized stigma, and sexual morality. This is important anthropologically because theatre is a space within society in which people’s thoughts and feelings are made explicit about (1) how people experience their lived realities, (2) what about their worlds they would like to be different/the kinds of change they would like to see, and (3) whether and how that change may be enacted.

In addition, I assert that attention to the ways creative risk and innovation are deployed within theatre has the potential to revitalize the kinds of questions we ask in the social sciences about health, knowledge, and sexual experience by redirecting attention to alternative modes of communication, expanded technologies of affect, additional points of entry into engaging health-related issues, and the role and possibilities of imagination and play within health intervention. It is through this emphasis on innovation and creative risk that HIV/AIDS applied theatre work becomes important to and within global efforts to rethink both practical HIV/AIDS intervention models, as well as theoretical frameworks through which to approach the study of HIV/AIDS as it relates to human experience. I note in the chapter that breakthroughs and innovation are enabled within the theatre sector because experimentation and flexibility of form are highly privileged within the arts in South Africa during the contemporary moment.
In this chapter, I have discussed the ways creative risk and imagination are important—not just the kinds of social work they perform in this public health context but also on the level of discipline development: the ways creative risk redirects attention to other kinds of questions about health, illness, healing, and experience. In particular, I argue that changing analytical optics within health intervention to privilege the kind of focus theatre-makers urge allows social scientists to start asking questions about how best to capture subjective experience, ambiguity and complexity in life, and reflexivity as they relate to sexuality and HIV. This sets the stage for the discussion in Part Three, which focuses on how the various artistic attempts at creative risk in theory, knowledge production, and impact succeed and fail in practice, including the tensions around what structural factors mitigate the arts industry and its functional context.
Part 3: “We Need a New Way”: Complexity, the Arts, and Health Intervention

“It is the function of creative people to perceive the relations between thoughts, or things, or forms of expression that may seem utterly different, and to be able to combine them into some new forms—the power to connect the seemingly unconnected.” --William Plomer

It was 10:00 am on a Saturday, and 12 Drama for Life Masters students and I blearily filed into a rectangular classroom at Wits University in Johannesburg and settled in for a morning of work. We were gathered for the program’s feedback session on the students’ final practical exams. The 2010-2011 cohort had spent the last two weeks attending each other’s productions, which often included a facilitated discussion in addition to the performance component. Both aspects were considered formal theatrical practices on which students’ skills would be examined and evaluated. For examiners, the university provided two inside faculty members, as well as a faculty member flown in from the University of Cape Town’s theatre department. This session provided the UCT faculty member’s final feedback. She was flying to Cape Town that afternoon, so we’d all dragged ourselves from bed after an exhausting couple of weeks in deference to her reputation and to receive advice.

Her name was Amahle*. In her casual opening comments on the ideas of Henry Giroux, Peter McLaren, and Paulo Freire, her mastery of critical pedagogy was performed for us; we were all impressed. She was highly educated, beautiful, renowned as a talented performance artist, charismatic, and ruthless in her critique of the Masters students’ theatrical prowess. She was also liberal with praise when it was warranted. When she spoke, we listened with full presence and attention. In discussion with some of the students later that week, the value of what she had to say was reiterated to me. Listening to her that day, I could feel the compelling force
of her words and urge to internalize them, even though I was not a performance student. The ever-present anthropological scribe, I scrawled notes off to the side as she candidly critiqued the students’ work and then opened the floor for discussion. What seemed to resonate most strongly with the group of student theatre practitioners were the following notes Amahle had for them.

She said:

HIV/AIDS programming in this country has been notoriously bad at engaging with people in any kind of way they actually want or making a difference. People are no longer listening, and a lot of that has to do with the framing of intervention efforts. Don’t set yourself up to ‘solve problems.’ This is a very problematic framing. You will fail. These issues—so complex. Be careful of not repeating what has been done—and done ineffectively. Work towards making different kinds of work about these issues.

The old kinds are not working. We have to ask: where must our energy be activated better, resources used better? The responsibility to educate is heavy. This work is about changing the way people think about themselves, others, the world, and changing behavior. But it is not a quick fix. So. What buttons do you push and activate to help them consider thinking or acting differently or treating others differently? You must not think broadly about the topics. Think very specifically of what you’re dealing with and addressing. What exactly—go narrower rather than broader because then you can really get to detail, and participants can give you gems. Through this, it becomes easier for you to contain what comes out in facilitation.

Facilitation skills—it’s a craft. We teach you these forms, and they are important but not rigid. Really allow the workshop to be shaped by what the participants give you. Let them share as much as they are comfortable sharing. Sometimes your workshops were restricted by sticking to the form too closely. Sometimes you get a gem from someone that’s not the ‘right’ answer but very telling of where that person is and what knowledge they have. Pay attention to these. Don’t let sticking to the form restrict you here.

Amahle’s words cover much ground and provide an apt ingress into the content of this section of the dissertation. She foreshadows much of what I cover in Part Three, namely the importance of capturing and addressing the complexities of life\textsuperscript{38}. Unpacking this quotation yields insight to

\textsuperscript{38} This interweaving of themes was ubiquitous in theatre-makers’ discussions with me. The artists would often talk about a range of topics, in the same breath, as connected entities, particularly: dynamism, fluidity, complexity, reflexivity, and the “messiness” of life. In this dissertation, I have separated these themes into chapters for analytical ease and to better showcase the particular implications of each component. In real time, however, they were most often discussed together.
ideas held in common by a majority of the theatre-makers with whom I worked, as well as outlines major themes of this part of the dissertation: the historical problematic framing of interventions in the country (artistic and other) and new ideas posed by artists on how to remedy this framing issue, which are underscored by narratives of innovation and creative risk.

**Complexity Ethnography**

In Amahle’s words to the gathered Drama for Life students, she imparts wisdom gained from her time as a professional theatre-maker who comes from a community theatre background. She points to a dire need in the country for new ways to frame HIV intervention efforts, since past forms of intervention have largely failed to make a difference in the lives of the people she has known who are affected by HIV. Rather than framing certain kinds of sexuality or health-related actions as problems, Amahle urges the students to find alternative ways to talk about HIV and the human actions and emotions that provide the topography for the country’s AIDS epidemic. She points out that these kinds of issues are more “complex” than a problem-framing allows, so students must avoid repeating the kinds of HIV communication and intervention efforts that have not worked well in the past. Finally, she notes that while it is important to continue promoting awareness of HIV and educating people about the biomedical aspects of the epidemic, theatre-makers must also move toward opening up their ideas about possibilities for intervention modalities.

For her, new directions in HIV programming should be about challenging people to think about themselves, their health, their relationships, and their worlds in a variety of different ways. In order to do this, Amahle invokes the wide range of theatre techniques and genres available to the students. She tells them to avoid “going broad” (meaning general, generic HIV messaging)

39 Such as “wear condoms,” “avoid sexual relationships with sex workers,” “abstain,” or “minimize risky behavior.”
and rather to go “narrow”—to think very specifically about what kind of detail to put into their work and what topics they are trying to get audiences to engage with. She links this push to mix genres and use specific performance techniques to telling real stories about people’s everyday lives in an effort to be fluidly attentive to audiences: who they are and what they need in the present moments of their lives.

All of these themes Amahle discusses emerge strongly in the ethnographic data presented in this part of the dissertation. They are all intimately bound to the idea that what the arts have to offer public health programming in the country is a kind of exploratory creativity rarely seen in conventional HIV intervention efforts. I suggest in this part of the dissertation that through this risky creativity emerges new possibilities for global HIV intervention practices that may be more nuanced and attentive to people’s lived realities than some of the more common health communication programs supported nationally in the past. In addition, this kind of creativity on the part of applied health theatre-makers is linked strongly to their idea of “complexity.” Through ethnography of what “complexity” means to the artists with whom I worked, much can be said about the underlying politics of health communication and intervention that undergird artistic notions of best public health practices.

In this third part of the dissertation, I introduce the kinds of ideology that underpin theatre-maker demands for the development of new intervention frameworks, including the theories of healing and performance on which their beliefs about health intervention are based and how those theoretical premises differ from the ideology of former (dominant, global public

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40 Such as the well-documented “Abstain-Be Faithful-Condomize” campaign prominent in East and Southern African countries in the 1990s-2000s and the more recent “HIV—I Am Responsible” campaign promoted by the South African National Department of Health in the early 2010s. These types of programs and their relationship to artistic critiques and contemporary health intervention efforts are elaborated in the chapters of this part of the dissertation and Part Four.
health) paradigms. Finally, I detail what kinds of framework changes are being developed in and advocated by some members of the arts community. I present, analyze, and critique the major framework changes proposed by theatre-makers in which I see the highest potential for intervention theory development and productive theoretical integration with the discipline of medical anthropology.

A major framework change advocated by theatre-makers was increased attention to life’s complexities as related to sexuality and HIV. Unlike many social science definitions of “complexity,” the artists with whom I worked defined complexity as the parts of people’s lives experienced as incoherent and messy: the times when actions, cognitive reasoning, feelings, and motivations are unknown or only partially understood. This concern with the notion of complexity was not the only concern of the people with whom I worked; however, it was raised repeatedly by a majority. This focus on turning attention to incoherence and the messiness of life within public health interventions transected ethnicity, class, and age divisions, although the extent to which it was discussed (or the ways it was discussed) often separated along lines based on those categories. For that reason, I have chosen to analyze and develop this notion of “complexity” within the content of this part of the dissertation.

Part Three includes two chapters. The first is “Complexity Aesthetics” (Chapter 5), in which I argue theatre-makers are moving toward mixed-approach (syncretic) aesthetics in an attempt to expand health communication styles and practices in the country to better attend to nuance and the unknown in lived experience. The second chapter is “Complexity: Language and Optics” (Chapter 6), in which I argue theatre-makers are developing certain health intervention terminology to better capture concerns about temporality and existentialism within public health efforts. This part of the dissertation is focused on theoretical development. It is meant to be
conceptually generative and is about developing constructs, language, and frameworks for augmenting the ways in which the social sciences attend to lived experience of HIV and the AIDS epidemic.

Theoretically at stake in this part of the dissertation is developing a way to keep humanistic considerations within biomedical and global public health policy, rhetoric, and advocacy. It is about bolstering interdisciplinarity to develop a vocabulary and theoretical tools that are sensitive to talking about health issues of global importance without abstracting them or erasing their subjective complexity. I advocate accomplishing this through incorporating select conceptual ideas from the humanities (specifically the disciplines of performance studies and acting theory). In particular, I focus in the following two chapters on performance theories of healing, social change, affect and impact, knowledge production, reflexivity (how we think), communication, and health intervention. I analyze the kinds of practices, strategies, techniques, and games theatre-makers use in their work to link their theoretical aims to their practical intervention goals. By attending to how theatre-makers operationalize their ideology in practice, I posit that conceptual tools may be gained to productively expand recent goals within medical anthropology to produce integrated ethnographic frameworks that attend to the lived, embodied, and affective realities of illness while situating these considerations within deeply critical theoretical frameworks.
CHAPTER 5
Complexity Aesthetics

Introduction

Kirsten fiddled with a piece of paper and looked out the little office’s window as she contemplated her answer to my question about the recent aesthetic changes within applied theatre in South Africa. As one of the few certified dramatherapists in the country as of 2008, she was at the forefront of advocating for new theatre practices within the arts sector. As a white woman in her 40s, she was old enough to have experienced the boom in protest theatre that occurred during heightened anti-apartheid activism of the 1970s-1990s. She was currently employed as a dramatherapist conducting private work on HIV/AIDS-related issues with clients, as well as training students in dramatherapy practices at a university in Johannesburg. Glancing back to meet my eyes, she said:

I think protest theatre played a very important role in South Africa: it’s been a pillar. One of the pillars that created change in this country. But I don’t think that’s where we are today. Sometimes now, people have this ‘Ugh! It’s that protest theatre again. We had that in the 80s’ response. And I think it’s a bit sad because it was very powerful, and I think there was a lot taken from [activist theatre]. But at the same time, I suppose people are looking for new, different ways of addressing the same issues. There’s that kind of sense of maybe activist theatre has been a bit stereotyped from a certain time in our history, and we don’t want to use that again, we don’t want to go back there. But in fact, maybe, we should be, you know?? It brings up questions. [Pause]

I think it’s got something to do with the pain of the past and how to process that, how to integrate that, what to do with that, and I think people have been lost over the last 14-15 years and haven’t known how to use theatre or how to tell our stories. I think just as a nation, our psyche has been in a transitional period over the last 15 years. Yeah, I think we’re moving into a space where people are being able to tell stories again, stories of the past and of the present, and how it affects us. We’re getting to a time where we’re able to look at what happened and you feel ready enough to tell the story. So it’s not so close anymore. But, I mean, maybe I’m in denial, you know? I think that’s [denial] also been a part of our society wanting to live in a so-called honeymoon rainbow nation and kind of realizing it’s not as rainbow, it’s not in the end what the dream was, we’ve moved out of the honeymoon, and I think we’re moving into reality now. It seems like people are telling real stories again, with all the nuance life holds, which is nice to see you know? In theatre, through new ways.
Kirsten captures in her answer a prevalent notion I witnessed in the ideology and practice of many theatre-makers involved in social issue-based work in the country: the idea that applied theatre in South Africa must move away from didactic forms of theatre (e.g. activist and theatre in education) that focus narrowly on the way the world “should” be and toward aesthetic forms that deal with what several people called the “really real.” This is the notion that in this second decade of the post-apartheid era, activists and applied health workers must include in their focus not just how they want things to be but how conditions in life are for individuals and groups right now, in the present moment.

To accomplish this attention to the complexities of the “really real,” many artists have begun advocating for expansion of artistic practices within the country to include a broader range of aesthetic genres capable of handling the kind of life nuance Kirsten mentions. This chapter is about elucidating and analyzing the shifts in aesthetics in the country that have accompanied the rise of HIV/AIDS prevalence over the 1990s-2000s, as well as the kinds of changing ideas that Kirsten invokes about the purpose of the applied arts sector in the post-apartheid era.

5.1 Shifts in Genre and Practice

The last 10 years have witnessed a rapid change in the aesthetic landscape of applied theatre in South Africa as artists move away from primary focus on protest theatre and theatre in education and toward expanded notions of genre possibilities. Incorporation of the following genres has increased, all of which were cited by key contacts as important influences on contemporary applied theatre related to health: physical theatre, process drama, dramatherapy, playback theatre, Theatre of the Oppressed (including Forum and Image Theatre), dramatic realism, African dance and storytelling, storytelling and personal narrative, melodrama, site-
specific work, comedy and satire, improvisation\textsuperscript{41}, and experimental or mixed-methods work. Depending on the person interviewed, community theatre, township theatre, and issue-based work were also cited as aesthetic styles.

Because of the integration of additional genres, examining and considering the differences between genres becomes important, rather than lumping them all under the umbrella term “applied theatre.” This style of analysis, which is focused on generalizing and/or unifying disparate concepts, is what most anthropological attention to applied theatre has done in the past, although this is not the case in performance studies scholarship on the same topic. A finding of my fieldwork is that differences between genres of practice very solidly shaped where theatre-makers see their place in the HIV/AIDS industry and how they think about their relationship to other health sectors—this is a conceptual shift in the role, value, and place of applied theatre in the country’s HIV/AIDS efforts and an attempted practical shift in structural power and positioning\textsuperscript{42}. It is also a very recent shift. Writing just ten years ago, South African performance scholar Gerrit Martz states:

HIV and AIDS is not purely a biomedical issue, and it is simply not just a prevention issue anymore…Relying too heavily on its artistic and creative abilities to educate, theatre-in-education in South Africa seems to be content with its position as a vehicle for information dissemination and does not consider its ability to utterly involve itself as a powerful medium for change that political theatre and theatre-for-development achieved in pre-democratic South Africa…We now need to understand how theatre will benefit and survive in a country and in a society living in the epicenter of an epidemic. What is this theatre’s role in such a society?

\cite{2004:3-4}

Ten years ago, artists were still debating this question of role: what is the role of applied theatre in the New South Africa? By the time I reached the field for pilot research in 2008, theatre-

\textsuperscript{41} Including workshopped or devised performances (as opposed to scripted ones).

\textsuperscript{42} I develop this point about a shift in structural power and positioning in Part Five of the dissertation.
makers had begun actively trying to answer that question. By the time I conducted my major fieldwork in 2010, many theatre-makers in the country were ranging widely for alternative theories of performance, healing, and social change that would work more productively for the context they saw when looking at their country and audiences.

Artists are increasingly incorporating additional genres considered more appropriate for the recent post-apartheid era. This move to incorporate new aesthetic genres within applied theatre is the result of widespread reactions to perceived past deficiencies of prior public health communication and knowledge production campaigns related to HIV. In many ways, this is an active and responsive refashioning of ideas about what theatre can do in relation to health intervention. It is an active attempt to address problems, shift practices, and move with dynamic times and new contexts in order to recast the relevance and space for the arts in post-apartheid South Africa.

In the rest of this chapter, I elaborate the reasoning for inclusion of expanded aesthetic practices in applied health theatre and provide examples of added genres and analysis of what they have to offer HIV/AIDS intervention in the country. Finally, I argue that one of the major ways theatre practitioners are attempting to repair problems with past public health efforts to address the AIDS epidemic is through development of and advocacy for a more integrated framework for approaching HIV/AIDS programming than national efforts to date.

This integrated framework is premised on addressing prior ways of engaging with HIV/AIDS seen as static and didactic by instead privileging the use of mixed approaches, fluidity, dynamism, adaptability, and an increased dedication to integrating biomedical and arts theories of healing and change, as well as addressing multiple levels of audience engagement. The theatrical aesthetic is being framed by artists as providing a space for necessary and
combined bodily, visual, aural, cognitive, educational, interactive, experiential, emotional, and creative engagement with issues related to sexuality and illness. I suggest this aesthetic shift toward syncretism becomes particularly important anthropologically because the approach is being used to make the symbolic and social boundaries between intervention models permeable. This allows artists to promote certain projects, such as expanding definitions of healing and refashioning power differentials between producers and consumers of health knowledge.

In addition, I posit that examining differences in genre approaches to HIV/AIDS intervention practices reveals several things about how theatre-makers are trying to carve out a space within the broader healthcare industry. In particular, I suggest examining this locus of intervention tells us about how people on the ground are trying to negotiate disconnects in global health agendas versus local health priorities and needs. This is about how people creatively respond in practice to institutional control. The syncretic theatre component of new intervention framing is about an attempt by theatre-makers to create more fluid intervention processes that are responsive to audience needs instead of solely privileging donor or theatre-group agendas.

Analysis of particular emerging genres also reveals information about where intervention workers find inspiration for alternatives to past dominant theories of intervention, healing, communication, and affect and what those alternatives are. Many of the most recently used genres within applied health theatre come from styles that originated in Brazil, the United States, and the United Kingdom. Theatre-makers in the country are shaping the genres to better fit the specifics of the South African context. I suggest theatre-makers are drawing on process drama and Theatre of the Oppressed in an attempt to change power dynamics within interventions: both genres invoke theories of intervention based in experiential action and privilege negotiated
meaning and equality in intervention power dynamics. In contrast, dramatherapy and playback theatre provide the opportunity for theatre-makers to carve out alternative spaces of healing.

5.2 Health Arts Sector: Stakeholders and Innovators

The applied theatre industry in South Africa related to health has a variety of stakeholders, and the stylistic differences I discuss in this chapter are being introduced at different levels of the industry. Major aesthetic innovation tends to originate within mainstream, experimental, and university level theatre, but genre blending occurs within community theatre, industrial theatre, and artistic NGOs, as well. This section provides some background detail on the key players involved in the HIV/AIDS theatre industry in the country, including from where they are structurally and aesthetically positioned.

Although there is a robust applied health theatre industry in the country, it has not historically been a stable one. Due to the mutable nature of funding, unequal and inconsistent access to resources, variable personal commitment, and other factors, the industry’s key players have fluctuated wildly over time. There have been a few stable, long-term organizations producing consistent theatrical work related to HIV; however, the industry is overwhelmingly characterized by constant fluctuation in stakeholder makeup, even if the number of stakeholders remains relatively steady.

Performance: Key Players Then and Now

One of the ways of thinking about the current state of HIV/AIDS-related theatre in South Africa is through a quantitative perspective: how prevalent is it? This is a question I hear repeatedly from other anthropologists wanting to understand the relevance of this field. Other questions I hear include: “Who’s producing this work? How many people? How many audience
members are there in general, and who are they?” There are two prongs to this quantitative outlook on relevance and prominence of artistic work.

The first question is how many people, or what sectors of the general population, are actually seeing and engaging with productions. This is difficult to measure or quantify; however, there is increasing anecdotal evidence supporting the observation that within this second decade of democracy, audience members for HIV/AIDS-related applied theatre remain high in number but confined to restricted segments of the general population. In particular, these segments include captive audiences such as students at primary, secondary, and tertiary education institutions; prison populations; health clinic attendees; artistic festival audiences; and to a lesser extent, the general public within townships, who sporadically witness street theatre or productions in community halls.

A second quantitative question is how much work of this type is currently being produced and how many people are privileging HIV/AIDS as a topic of interest. The number of people involved in the production side of applied theatre related to HIV has fluctuated drastically over time, especially in recent years. From about 2001-2008, there was a massive boom in the number of theatre groups incorporating the AIDS epidemic as a content topic within performance. With shifts in national and international donor funding patterns, as well as a growing perception of AIDS fatigue among audience members, the number of groups focused on presenting work explicitly about HIV has decreased within the last 5 years. The exact dates for these cycles of ebbs and flows in the number of groups producing this kind of work are debated among theatre-makers. In general, there is consensus that a boom occurred in the early-to-mid 2000s, a marked decrease happened in the late 2000s, and by the time I conducted fieldwork in 2010, theatre-makers noted resurgence of interest in producing HIV/AIDS-related theatre but not
a complementary growth in actual produced work in the country\textsuperscript{43}. Overall, the number and types of groups producing HIV/AIDS-related theatre content has fluctuated over time and continues to do so.

Some of the key players in this sector had a heyday and are now in decline or altogether disbanded, while others continue to trudge along. There have been significant newcomer organizations, as well as independent individual theatre-makers. Overall, the community theatre sector exhibits some of the most drastic ebbs and flows; groups form, disband, and re-form under the same or new names a year or two later (or sometimes not at all). I list the major contemporary key players in the production of HIV theatre below and have divided them into six major categories as depicted in the following pie chart below\textsuperscript{44}.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{pie_chart.png}
\caption{Theatre: Key Players}
\end{figure}

\textsuperscript{43} There are a number of reasons for these fluctuations, which will be explained in later chapters.

\textsuperscript{44} This is not a fully comprehensive list. It is very difficult to compile a comprehensive list of every group and individual involved in this industry over time because of the instability of the industry, problems with sustainability, and the extent of fluctuations in group membership, involvement and presence in the industry.
In general, there are three major mainstream theatre-makers who produce HIV/AIDS-related theatre\textsuperscript{45}. These include noted satirist Pieter-Dirk Uys; politically involved activist, theatre-maker, and scholar Mike van Graan; and activist and HIV positive theatre-maker Peter Hayes from Hearts & Eyes Theatre Company. All three are based in the Western Cape, although they travel and tour with their productions annually (both nationally and internationally). Mike van Graan and Peter Hayes are based in Cape Town, and Pieter-Dirk Uys is based in Darlington, a small town about 75 km from Cape Town. All three identify as activists and produced some of the most politically-based health theatre during the time I was in the field.

There are two major theatre training programs that consistently grapple with HIV/AIDS-related content\textsuperscript{46}. By far, the institution to do this most widely and in a focused manner is the Drama for Life Program at the University of the Witwatersrand. In this program, which emphasizes inclusion of students from across the Southern African Development Community (SADC) region, students may go through training to receive a formal Masters, Honors, or Bachelor’s degree in applied theatre with a heavy emphasis on HIV/AIDS as primary content. This program works closely with a selection of aesthetic genres: activist theatre, process drama, theatre in education, dramatherapy, Theatre of the Oppressed, and playback theatre chief among them.

\textsuperscript{45} There was very little mainstream or commercial attention to HIV/AIDS as a topic within live theatre production in the country (this is slightly different for television and film). Exceptions include Mike van Graan, Pieter-Dirk Uys, and Peter Hayes’ productions, in addition to international Broadway productions like \textit{Rent}. Theatre-makers widely held the idea that audience members would \textit{not} pay to attend a theatre production where HIV/AIDS was a major thematic topic. On the other hand, some theatre-makers stated that HIV as a topic was not the problem; rather, \textit{how} people portrayed HIV/AIDS-related issues artistically was the issue. However, people generally concluded that it would be difficult to produce a critically successful and commercially viable theatre production related to HIV/AIDS without donor funding.

\textsuperscript{46} This was accurate at the time of my research; however, in the interim few years, programs have emerged at both the University of Cape Town and the University of Stellenbosch.
A training organization that has dealt heavily with HIV/AIDS content in the past is the Sibikwa Community Arts Center in Benoni, South Africa (near Johannesburg). This center could also be classified as a community theatre organization. However, because they prioritize skills training and have a formal skills program in place that confers informal accreditation, I include them as a training organization. In recent years, Sibikwa has only intermittently engaged directly with HIV/AIDS-related issues and was not doing so the year of my field research.

In addition to DFL and Sibikwa, there are other transient groups or project-based productions that are affiliated with university or training institutions, such as the *HIV/AIDS: In It Together* project conceived by Wits faculty member Anthea Moys. This project is affiliated with the University of Witwatersrand, although its funding comes from a variety of sources. There are other NGOs that could be classified as training institutions, such as DramAidE, AREPP: Theatre for Life, and Themba Interactive Theatre, but I classify them in a different section because of their official NGO status.

Within the country, there are about ten major NGOs that have tackled HIV/AIDS content in a significant way, although some are currently producing work related to HIV, and others have moved to different subject matter in the last several years. Among these, some of the most well-known (and on which most scholarly work has focused) are AREPP: Theatre for Life, DramAidE, and Themba Interactive Theatre. Programs operational in the past but no longer active include Soundtrack4Life. Phakama and Bonfire Theatre Company are both organizations that are active some years but not others and include HIV/AIDS-focused content intermittently. Newcomer organizations include Ubom!, Dance4Life, and Clowns without Borders. The Flatfoot Dance Company of Durban is a consistently operational organization, but they focus on HIV/AIDS-related content only intermittently.
Community theatre is a sector of the applied theatre industry that is very difficult to discuss in any comprehensive manner. In Johannesburg alone, there were over 160 active community theatre groups during the year I conducted fieldwork. This number fluctuates from year to year, and the sector is highly dependent upon and responsive to funding trends in the country. In Soweto alone, I encountered over 100 community theatre groups, and many have produced plays incorporating HIV/AIDS-related content in the past (since the early 2000s). They continue to do so. The community theatre sector is thriving, in that groups are continuously formed and produce plays, but the sector is tenuous and unstable in regards to sustainability of those groups, continuity of the organizations, and whether the productions are actually showcased in any venue or for any external audience. The thematic content of community theatre plays is also highly variable; however, every single community theatre group with whom I spoke (representatives from roughly 90 groups around the country) noted that they had an “HIV/AIDS play” in their repertoire at one point during their activity. In contrast, very few community theatre groups focused solely on HIV/AIDS-related issues or made that their primary, long-term thematic commitment.

Other Stakeholders

In addition to the production side of applied theatre (comprised of theatre-makers), there are also other groups of people that have a stake in the applied theatre industry and influence on the aesthetics through which productions are presented to the public. These people primarily consist of a variety of investors, such as national and international funders and donor agencies, some of which include national and foreign governments. The audience is another vested stakeholder, and the people who comprise the audience for this type of applied health theatre

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47 This number was taken from a list of active community theatre groups collated by the community theatre representative at Johannesburg’s Civic Theatre.
intervention often come from the country’s prison industrial complex and local health clinics, both of which are common performance venues. Finally, other interested stakeholders include the following: community officials, leaders, and business organizations; a variety of professional organizations, such as PANS (Performing Arts Network of South Africa); media organizations that cover entertainment, such as Artslink (www.artslink.co.za); various corporate and private sector companies who are involved in corporate social investment (CSI) projects and employ industrial theatre groups; and, increasingly, marketing and publicity firms.

Festivals

Festivals can be one indicator of how much work is being produced on a topic. The only two consistent, long-running theatre festivals in the country dedicated primarily to HIV/AIDS were the “When Life Happens Festival” in Johannesburg (held annually from 2003-2008) and the Drama for Life “Sex Actually” Festival, also in Johannesburg (held annually starting in 2008 and continuing in the present). The “When Life Happens Festival” was spearheaded by noted physical theatre choreographer P.J. Sabbagha, but its 6 year span ended in 2008 due to funding budget cuts by the City of Johannesburg.

Around the same time, the Drama for Life program at the University of Witwatersrand held its inaugural arts festival devoted to HIV/AIDS and has put together a strong festival program annually since. DFL is the premier arts festival venue for HIV/AIDS-related work in the country, and when the program has funding to do so, it takes select productions from the festival and tours Cape Town, Durban, and other major urban areas in the country for part of the
year. There have been some one-off arts festivals devoted to HIV/AIDS productions throughout the last decade, but they tend to have a limited lifespan and do not tour the country48.

Additionally, in the past 10 years, HIV/AIDS has often been incorporated within productions at major annual national and regional arts festivals that are not issue-based or HIV-based. Examples of festivals that are not thematically focused on HIV/AIDS but include productions that have HIV content are the National Arts Festivals at Grahamstown and regional festivals such as the annual Sibikwa Arts Center’s Total Community Theatre Festival, the annual Market Theatre Laboratory’s Zwakala Festival, and the Baxter Theatre’s annual Zabalaza Festival.

5.3 Moving Toward Syncretic Theatre: Mixed Approaches

For many theatre-makers in the country, the answer to “what have we learned from past failures?” has resoundingly been “increase boundary-crossing in our work—in both form and content.” An overwhelming majority of theatre-makers conceptualize this needed change (in how to create theatre work in relation to HIV) as a shift toward prioritizing and valuing blurred boundaries between content and form and between artistic and biomedical initiatives. This means a shift towards mixing and matching underlying theories of healing, change, and practice from a variety of theatre genres, as well as integrating biomedical information with emotional and social components of the AIDS epidemic. This idea rose from the widespread critiques I just discussed in Part Two of the dissertation against kinds of interventions that solely privileged

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48 “One-off” festivals occur once rather than annually over several consecutive years. A notable example of a one-off HIV/AIDS-themed festival includes the Masibambisane Youth Festival held at the Baxter Theatre in Cape Town. The festival has been held annually since 2002; however, they cover a different thematic topic each year, ranging from issues such as crime and gender violence to HIV/AIDS. The theme in 2011 was “HIV.”
biomedical fact-giving about HIV transmission and risk or that were framed in problematic ways or through didactic educational or protest genres.

This theme was commonly addressed in almost all of the interviews I conducted. People expressed their opinions that many of the biomedical initiatives engaged people on a cognitive level but that emotional involvement was lacking. Theatre, on the other hand, was described as more affective because a strong emotional component was combined with the cognitive—in an embodied style—to grip audience members. Interventions were meant to emotionally move a person, raise consciousness, promote reflective action through experiential learning, and educate all at once. The strong emotional side was characterized as making the work more personally meaningful to those involved.

In addition to integrating biomedical and artistic concerns within interventions, theatre-makers focused on introducing more fluidity and dynamism into their work by increasing their mastery of a wide variety of performance styles/strategies for purposes of experimental theatre work. Having the knowledge, training, and skills related to particular artistic forms is here a necessary precursor to experimentation with the different genres and practices. This notion of experimentation has gained ground in the way theatre-makers are starting to branch out in their HIV intervention efforts. Rather than sticking to rigid aesthetic practices, which have been privileged in the past, theatre-makers are increasingly acknowledging the need (in the contemporary context) for mixed approaches and fluidity in affective techniques, producing what I call “syncretic theatre”.

49After writing this chapter, I later learned there is precedent for using this term within theatre scholarship. In particular, Christopher Balme (1999) has written a book on post-colonial strategies for integrating indigenous performance styles into Western notions of theatre. Although the artists with whom I worked also invoked ideas of indigenous/Western style incorporation, they were more concerned with pragmatic combination of affective performance strategies and communication techniques in order to bolster health intervention impact.
Consider the following words of the director of Drama for Life. Here, he speaks about what he thinks Drama for Life, as a program, brings to the table of applied theatre in South Africa. It has much to do with introducing new aesthetics and challenging old forms of intervention. He states:

And then of course challenging the notion of development, and I think right along our continuum is that we’re constantly challenging what does therapy mean, what does healing mean, what is dramatherapy in relationship to different traditional forms of cultural healing? I think those are implicit and not necessarily made explicit all the time, but that is happening. And certainly when we engage with ethics, they have to engage with that, well what am I? Am I a healer, am I a facilitator? Am I a teacher? Am I a development worker? Where do I draw a line? I think the relationship is you know education: what is education? And really understanding that there are different kinds of education, different forms, informal and formal education, so hence our drive, they need to engage with schools as much as they need to engage with community settings. Community settings often have children here in South Africa who are not in school—particularly adolescents that dropped out of school. And of course development, which is highly contentious and has been shaped and formed by the donor community, by Western thinking, and Western implementation and models and those issues are really critical.

And activism I think is the last ingredient. I’ve been challenged, and I’ve been told by certain university people that you can’t mix activism and therapy, they require two very different sensibilities, and I absolutely disagree with that. For me it’s about, and I suppose because I come from a constructivist position that meaning is socially made and that language is socially bound and that healing is not about just self-perfection and internal kind of journey, but sometimes very powerful healing takes place in action, in activating, and in finding a voice and speaking out. And sometimes working with others for others and giving service. I mean, that’s a long debate, but I’m very clear about that, and I think for me that’s probably the most exciting part of our program is the unique combination. It seems to me that the feedback that’s starting to come from graduate scholars is that’s one of the things that have really stimulated them. Mostly with the Masters students, because the Master’s program really draws attention to those relationships. But the honors program, we really want to hone in on facilitation and what does it mean in terms of professional training, the skills that are necessary. And then also looking at very specific models, particularly Theatre of the Oppressed, which has been associated with Theatre for Development. And then moving out into more community-based arts approaches. And I think we’re just beginning to get that right in terms of a trajectory. I think we’ve also just realized we just can’t do it all. We can’t.

He goes on to say that the program does two major things: it teaches methodology/skills and challenges the students to rethink what the following concepts mean: teacher, education,
development, therapy, healing, health, illness, and HIV. As mentioned in past chapters, until the past 10 years, three major performance styles dominated South African applied theatre: activist theatre, theatre-in-education, and Theatre for Development. According to the director of DFL, one of the most exciting components of their program is challenging notions of activism, education, and development by uniquely combining a variety of other aesthetic forms, which have their own ideas about what social engagement and healing mean. This idea of combining aesthetic forms was prevalent in the work and words of many of the artists I met during fieldwork, not just the members of training institutions like Drama for Life.

To illustrate what this kind of syncretic theatre looks like, consider the following descriptions of two performances. The first is a production by a non-profit, women’s collective theatre group in Cape Town that describes the kind of intervention that can occur when syncretic theatre is strongly conceptualized and workshoped heavily\textsuperscript{50}. The second is a lively and boisterous production created by a community theatre group from Lesotho for the DFL HIV/AIDS festival in Johannesburg. It illustrates what often happens when artists attempt to produce syncretic theatre without a strong, unifying artistic vision to hold the mixed practices together.

**Uhambo: Pieces of a Dream**

The following example of play content illustrates how boundaries are being creatively woven together in health-related theatre. The play was created by a group of women artists who assert that their work fosters healing and transformation through the integration of practices such

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\textsuperscript{50}This group is a collective of female performing artists, facilitators, and healing practitioners, and it was founded in 2001. As goals, the collective explores “practical processes of healing through the arts. It focuses on enabling participants to discover and recover their own resources of self-healing. Attention is also given to exploring alternative ways of resolving conflicts both personal and interpersonal” (program website 2013, URL not provided to preserve anonymity).
as storytelling, physical theatre, music and sound, creative writing, and expressive arts therapies. In this particular production, which probed the concept of democracy through the eyes of women living in Cape Town, the following topics were addressed: domestic violence, xenophobia, rape, and HIV. The production took place in site-specific locations, such as minibus taxis and an art gallery. It was selected to be part of the Main Festival Programme at the 2004 National Arts Festival in Grahamstown (and captured on video for posterity), but its resonance with the director of the project held strong as I spoke with her six years later.

In *Uhambo*, one of the main actions was to take the audience through one lesbian woman’s deeply emotional process of coming to terms with being gang-raped and contracting HIV as a consequence. The narrative of the play presented the woman as broken, fragmented, and alienated from her community and from her own body. At the end of the production, this state of being was embodied and made manifest through a station provided on stage in which a representation of a torso had been ripped apart into jagged paper pieces. Audience members were given the opportunity to join the performance process by enacting the role of the woman’s community members and actively choosing to help the woman piece her “self” back together. This necessitated people involved in the performance space take a stand and work together through the task of rebuilding the woman’s puzzle-piece body.

In this instance, although the physiological aspects of HIV/AIDS were mentioned, of more importance was a view of healing that addressed the woman’s psychological and emotional fragmentation and involved a community effort to repair that damage by helping the woman reconnect to her body and integrate it with her community and emotional health. In this piece, healing involves a very holistic understanding of health and personhood, including the physiological *and* psychosocial repercussions of HIV. In addition, audience members were
given a chance to experience both the spectator side and actively enter the performance space. In this way, they could become active agents in the creation of an alternative reality—one in which the fragmented body and psyche of the newly HIV positive woman was collectively pieced together by her own actions and those of others occupying the space. Theatre worked to engage the audience in a live interaction moment where mind-body connections were privileged.

This performance is one illustration of how boundaries between forms of knowledge, intervention goals, levels of engagement, topics of concern, and strategies for affect are being played with in applied health theatre interventions in South Africa. This particular play was based on a true story, and its creation process involved weeks of intensive workshopping between the actors and director in an effort to draw out the story, isolate a core emotional component on which to focus (the piecing back together), and prepare those involved to present it in a sculpted, theatrical way in a highly public forum. Music, sound, audience participation, therapy processes of distancing, and education and awareness about HIV and domestic violence were drawn together as constitutive components of the play. In this kind of theatrical aesthetic (experimental, mixed approaches), all genre practices, biomedical and performance studies theories of healing and change, and levels of actor/audience engagement are available and encouraged for inclusion.

This particular example illustrates a very deft use of mixed approaches, in which people who were highly trained and equipped with a wide variety of performance skills across a spectrum of theatre genres performed a focused, well conceptualized and planned artistic intervention with a targeted demographic (women who had experienced sexual or domestic violence and were enrolled in various women’s shelter programs with whom the theatre group partnered). A production of this sort requires advanced mastery of a range of performance
ideology, techniques, and practices from several different styles and the ability to negotiate between them to discern which practices best match the particular intervention’s goals. This deftness is not always the case with shows in practice.

**It’s About Time (Joale Ke Nako)**

On the opposite side of the spectrum are performances of a type in which the group enthusiastically participates in experimental method-mixing, but the result ends up visually spectacular while being incomprehensible or unfocused: the meaning is unclear and is often lost within the jumble of activity onstage. Consider the following example, which is illustrative of a trend I noticed in performances during fieldwork. In this vignette, I describe a performance I attended during the Drama for Life 2010 Sex Actually Festival. The performance is called *It’s About Time*[^1] and was created by a community theatre group from Lesotho. A former DFL scholar from the year I conducted pilot research (2008) directed the production as part of her extensive continuing theatre work within her home country, after obtaining her Master’s degree in applied theatre.

In the playbill, the excerpt for the show proclaims, “The play endeavors to open an intergenerational dialogue on sexuality, gender, and HIV prevention. It employs the use of a Sesotho folktale, music, and dance to address issues of relationships and empathy between boys and girls, men and women. It is interactive and multilingual.” Although the program explicitly notes its HIV-related content, the play itself failed to shed much more clarity on the exact topic to be dealt with than the vague playbill text.

[^1]: An interesting note is that this production was one of only two in the program (out of five days of performances) that fully embraced and clearly stated its community theatre affiliation, despite being among a large number of community theatre groups present.
I walked into a black box theatre and sat in raked seating with 43 other audience members. I saw a lot of faces I recognized and realized this audience was about 60% Drama for Life scholars, alumni, and associated faculty and staff. That made sense, since a DFL alumna was directing the show—it was the main reason I was there, too. The show opened in song and showcased its large cast. There were 16 performers, all Basotho, between the ages of about 17-27 (7 female, 9 male). The production was conducted in a mix of English and Sesotho. Jeans, t-shirts, and tennis shoes dominated the costuming in a range from whites and tans to greens, purples, and blacks. After the initial song, two of the women walked downstage center and addressed the audience—one in English, the other in sign language—and told us the performance was a participatory production and that the audience, as “spect-actors,” would have chances to join onstage. The rest of the cast milled upstage as the woman asked the audience to call out words that had come to mind when we first read about their production in the festival program. “Time of transformation,” “change attitudes toward sex,” and “sex” were thrown out as offerings from the crowd. After that, the show vaulted into an enthusiastic gumboot dance scene that transformed, rapid-fire, into 10 short dialogue scenes interspersed with song and dance.

I had trouble following the production subtleties, since it was primarily conducted in Sesotho. Enough English peppered the dialogue that, with body language, I could mostly gather the basic storylines. The ten scenes appeared to be unconnected clips, short shots in the lives of different people in this fictional community. The scenes each involved between two to five people, although the final scene had eight people onstage participating in dialogue. The scenes

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52 This is a term from Boalian theatre explained in Chapter 4.

53 Gumboot dance is a popular style of dance in contemporary South Africa. It is performed by dancers wearing wellington boots (i.e. “gumboots”). This form of dance was conceived in mining culture in South Africa as an alternative to drumming and as a form of communication when speaking was discouraged. In combination with dancing, performers strike the boots to produce percussive sound.
ranged from couples arguing about the guy being too pushy with his sexual advances to couples going together for HIV testing. There were songs with refrains claiming, “You cannot tell when someone is HIV by looking at him,” and there was even an orgy scene among two couples in which sex was simulated through dancing. There were minimal props (crates and two chairs), and most of the action was mimed. Including the opening, the performance component was about 30 minutes long.

At the end of the production, the woman who introduced the performance transitioned the show into a 30 minute facilitated discussion component. She started by using a classic playback theatre technique of asking the audience how watching the production made us feel. When an audience member answered with “confusion” and elaborated by saying his Sesotho wasn’t very good, so he felt left out, four of the actors strode downstage to reenact their interpretation of “language confusion” through repeated actions (e.g. one scratched his head while shaking it, eyebrows raised and shoulders hunched toward his ears in a classic “I don’t know” gesture). When they finished, the facilitator turned toward the guy and said, “Was the feeling kind of like that?” amid audience laughter.

After this, the group asked the audience to break into small clusters for focus discussions as part of the intervention. My group included two of the performers and five other audience members. For ten minutes, we chatted about the production at the prodding of the performers, although it quickly became apparent that few members of our group understood the play very well. Several people cited language as a confounding variable and another suggested that the mimed sequences included action choices that were not very strong, which made it hard to figure out what the storyline was. What was unanimously agreed was that despite not quite knowing
what the plot was, the performance was visually spectacular, and the performers kept our attention through their sheer energy.

As the focus group discussion waned, the main facilitator told us we were going to do a Forum Theatre technique to further interrogate the intricacies of the characters’ lives: the characters would stand onstage and reenact one of the scenes. When the scene reached a spot where an audience member thought the character should do or say something different from what originally happened, the audience member was supposed to shout “stop,” tap out the original performer, take the performer’s place, and improvise a new scene with different action or dialogue choices. The basic gist was, “tell us what you would have done differently.”

Ayobami*, a female DFL alumna, requested the orgy scene be repeated. The actors returned to the front of the theatre, started the scene, and when the original female actor told her boyfriend he must include her friend in their sexual escapades that evening, Ayobami yelled “stop,” tapped out the boyfriend character, and took his role. The scene resumed, improvised, when Ayobami replied, “No—baby, I won’t sleep with her because my heart belongs to you. Also, you and I don’t condomize, so I can’t do that with her because I don’t want to get or spread HIV.” The audience laughed at Ayobami’s attempt to simulate a gruff, lower male voice, but they applauded her character’s alternate choice and agreed it was a better option than the original scene’s orgy of unprotected sex.

Several other scenes were reenacted, and about four other audience members joined the performance to suggest different plot options than the original. At the end, the sixteen performers grabbed most of the audience members, took us onstage, asked us to form a circle, and we concluded the performance by stomping the ground rhythmically and singing while holding hands. As people filed out of the room, I overheard a female audience member saying,
“Loved the mix of very complex theatre forms—image, forum, playback—but…I still don’t know what the story was.”

*It’s About Time* is a good example of a trend I witnessed in HIV/AIDS-related theatre that is captured by the phrase, “let’s give it all we’ve got” or perhaps “let’s throw everything we have at it.” In this production, it was apparent during the performance (later, I found out from the director this was the case) that the cast had rudimentary knowledge of and training in a variety of theatre exercises and forms, particularly realism, forum and image theatre, and playback theatre. However, what the group lacked was the experience and advanced facilitation training it takes to determine when and how to deploy the variety of techniques from different styles *strategically*.

The result was a performance that included a dynamic mixed format but lacked a certain cohesiveness central to conveying a clear theme. It is the case that some artistic performances seek out that kind of unclear, ambiguous style that leaves audiences wondering about the message or in a state of confusion; however, this production was not one of that style. This particular production had a centrally animating theme that was unfortunately obscured through language comprehension issues, weak acting mime choices, and an aesthetic that garbled the theme through its attempt to incorporate too many different techniques.

**Training in New Styles:**

*“Learn the rules like a pro, so you can break them like an artist.”* – Pablo Picasso

Although *It’s About Time* was an exciting, highly participatory style of HIV/AIDS performance, it is problematic when the audience clearly does not understand the point of the intervention. An overwhelming numbers of theatre-makers talked about the necessity of innovation in HIV/AIDS-related theatre, and the majority of that rhetoric cited mixed genre methods and boundary-crossing (related to artistic versus other kinds of interventions) as a
primary way to accomplish productive innovation. However, there was a noticeable lack of genre diversity on the ground, outside of university or training spaces. I discuss this phenomenon in other parts of the dissertation (particularly Part Five) and correlate it with disconnect that often occurs between funder and artist goals and ideas of success and progress related to HIV/AIDS intervention. Another considerable obstacle to making this conceptual discussion about mixed approaches actionable in practice is simply that most theatre-makers in the country do not have access to rigorous and complete skills training in production or acting styles and techniques.

In South Africa, formal skills-training programs are often confined to universities or passed on through targeted workshops by senior theatre-makers. Indeed, the director of *Uhambo: Pieces of a Dream* is a senior theatre-maker in the country and a faculty member in a leading South African university’s drama department. The director of *It’s About Time* is a graduate of the Drama for Life program at Wits University in Johannesburg. The actors in both productions were comprised of general members of a community (Khayelitsha for *Uhambo* and a small community in Lesotho for *It’s About Time*), whose only formal performance training came from the teachings of their directors over a period of no more than 3 months. Although informal but rigorous performance skills-training programs were more common in some areas of South Africa in the past, current theatre-makers often bemoaned the lack of in-depth training.

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54 Acting style is a different concept from production style.

55 An example would be the performance collective that operated in Khayelitsha, Cape Town through the Baxter Theatre during the early 2000s. By the time I conducted fieldwork in 2010, this collective had disintegrated, but artists between the ages of 18-30 with whom I conducted interviews often referenced it as an integral component of their earlier acquisition of training in performance, although none could cite the program’s formal name.
programs designed to cover a wide breadth of performance styles and the decline in informal training for the younger generation by more senior actors and directors.

The fact that I have been relying heavily in this chapter on quotations and examples from the Drama for Life director and students should be noted and has probably been apparent. This is because they are the theatre-makers who often speak most articulately, precisely, and at length about experimental, mixed-method styles and ranges of aesthetic practices, despite this topic having widespread resonance within many other groups at all different levels of professionalization and training. Artists at other levels would often throw out names of different genres (Theatre of the Oppressed and playback were ones often invoked) but when prompted to give details about what those genres meant or what kinds of practices were included, conversations inevitably petered out into vague references, or the subject was changed entirely.

5.4 What Syncretic Theatre Adds: Power Dynamics, Fluid Aesthetics, and Alternative Healing

So, why the purposeful shift to mixed approaches? I argue this shift has to do with how artists are starting to engage intentionally with the concept of “complexity” as it relates to HIV, the AIDS epidemic, and human sexuality. There were three particularly important themes I noticed in the way theatre-makers were trying to use aesthetics to introduce more complexity into HIV/AIDS interventions. First, artists were actively broadening their ideas about which aesthetic genres were valuable within HIV/AIDS programming in an attempt to enable participants to tell stories of their lives in ways most relevant and meaningful for them. This answered a perceived need for communication and knowledge production styles that exceed didactic health promotion and address power disparities between health workers and audiences. Second, a majority of theatre-makers were advocating for the use of mixed approaches (what I have called a syncretic theatre aesthetic) in applied health theatre productions in an attempt to
better capture fluidity and nuance in life, including dynamism in contemporary contexts. Finally, I argue that artists are starting to marshal arguments about syncretic theatre practices and certain theatre genres as a way to open up dialogue within public health about what healing means in a country where almost a quarter of the population is living with HIV.

**Preachy Styles, Power, and Process over Product**

One primary way theatre-makers conceptualize necessary change in health communication practices within the country is through recognition of a wide range of relationships between people, HIV, and the AIDS epidemic. This is related to another theme in the web that makes up the call for innovation in intervention styles: perceived problematic messaging styles in past interventions. Underscoring this theme is usually a concern by artists with how past educational health promotion programs have been preachy and boring or else didactic and patronizing.

If interventions are perceived as either (boring or patronizing), theatre-makers have noted audiences tend to simply stop listening or paying attention. In the theatre-in-education (TIE) form, dominant with applied health theatre in the 1990s to early 2000s, information about HIV is most often relayed to audience members in a binary performers-as-authoritative-educators and audience-as-passive-receivers format: people are told what to do and not to do. There is little space for negotiating meaning or challenging of knowledge and power structures within TIE. Consider the following words by Warren, the director of Drama for Life. Here, he discusses a move away from TIE and traditional forms of education toward a different genre, process drama. He said:

Drama in education, and particularly the British model, is about using drama as a methodology to draw bridges between the classroom and the real world. The reason for that is that in process drama, there are certain principles, and one is negotiation: the notion of negotiated meaning in a classroom space. And so the reason behind using this
kind of methodology would be, the large majority of our students come from very traditional, conservative forms of education where they have been treated as empty vessels, to use Freirian language, and essentially have come from a sense of right and wrong.

And I think the methodology really challenges students to reconsider how meaning can be made amongst people and how it can grow and how it can be shared. Related to that is the position of the teacher. In process drama, the teacher is required to relinquish certain forms of power, not all power. It’s not so much about relinquishing power but rather the responsibility of being the teacher. It’s about making power explicit and then allowing for that power to be negotiated in imaginative and symbolic terms. Again, it’s the understanding that if the symbolic language is strong enough and if the bridge between the imagined world and the real world are strong enough in metaphor, then children and even adults are more than capable of being able to shape and form and make meaning together. The teacher really plays a specific role of intervening and facilitating and holding.

So it’s about changing, reconstructing the notion of what the teacher is, and for us that’s quite critical. Particularly by the Master’s students, they really need to fundamentally understand that not only in theory but in practice as well, and they really struggle in practice. Every year this is the one thing that they struggle with the most, they find it hard to understand, they find it hard to even begin to imagine what it may mean to relinquish certain traditional forms of power. And again, I think if we go back to HIV and AIDS, it goes back to the heart of relationships and how relationships are negotiated and how gender is negotiated. Many of our students come from worlds where societies and communities are structured in very particular ways. That status system. So now we’re smashing those boundaries in ways that offer alternatives and wholesome alternatives.

This quotation by the DFL director echoes some of the concerns Amahle voiced in the vignette that opened this part of the dissertation. Here, Warren notes the importance of smashing boundaries and power differentials between the producers of interventions or educators and the consumers of that knowledge. Rather than having such a division, Warren talks about the importance of employing process drama, a genre that forefronts the co-creation of knowledge and negotiated meaning among all participants. Amahle also addresses this theme in her notes to the students. She implores them to be attentive to the responsibility of educating about health within their future work while avoiding the pitfall of focusing primarily on educating participants.
about what they “should” know or pushing them in the (behavioral or cognitive) direction

students think they should go.

This concern with paying attention to where participants/audience members are in their present moment—the things they know, feel, are ready to face/deal with—has become increasingly important to the artists with whom I worked. Many consider simple acknowledgment of “where a person is” to be the primary foundational basis from which to work an intervention. In addition, the director of Drama for Life points out the critical need for interventions to deeply reevaluate power structures in interpersonal relationships that mirror larger problems with structural inequality in the country (e.g. positions of authority and gender dynamics). However, he also notes the difficulty people face doing this: even theatre-makers have trouble with it, and they are specifically trained to interact with others in an open, vulnerable, giving, egalitarian way.

Another faculty member of Drama for Life, Alma*, echoed a similar refrain when we discussed her ideas about changing trends in HIV/AIDS-related theatre in the country. She states:

Well, instead of just giving people information, I think the understanding has grown that HIV/AIDS affects every aspect of people’s lives. And therefore, I think methodologies have been used to investigate how groups of people are feeling and coping and to help them empower themselves to find ways of looking after themselves as communities in a sense, making their own lives better in whatever ways are possible to them. So instead of simply carrying information, I think it’s become more of a kind of, it’s using the methodology to look at social, psychological power, all kinds of issues you know that are the fallout from the disease.

Alma’s words call attention to shifts toward a focus on meaning-making and interrogating forms of power implicated in the myriad interpersonal relationships and relationships to institutions that occur in the lives of people who are HIV positive. Theatre-makers are now also looking for

56 This is a major topic developed in Chapter 7.
forms of intervention that allow more equitable knowledge interactions between performers and audience members and that highlight negotiated meaning rather than simple presentation of information. This kind of attention to meaning-making and interpersonal relationships is evident within the syncretic theatre production *Uhambo* by the Cape Town women’s collective.

These concerns with new intervention goals and ways of creating or questioning meaning have to do with being more attentive to the complex ways a variety of people think about HIV and live in relation to AIDS, as well as challenging past knowledge and power dynamics within hegemonic interventions. Creative risk is being employed to branch out from simple health promotion campaigns into more nuanced, subjective terrain.

**Process Drama: “Beautiful Power Play”**

An example of the kind of move away from preachy styles and toward negotiated meaning and power dynamics that is increasingly occurring within applied health theatre may be found within process drama, the genre of theatre Warren mentions above. Process drama is an experiential genre of applied theatre in which the participants and facilitator engage in the co-creation of an imaginary dramatic world and story to explore a particular problem, theme, situation, issue, or concept. In process drama, there is no external audience or culminated final production; the performance work conducted is for the benefit of the participants. It is conducted as an improvised dramatic form without a script, and the goal is the process of thematic exploration rather than predetermined plot outcomes. All participants, including the facilitator, assume a variety of roles in the creation of the story and experience the world from different character vantage points. The form encourages negotiation of meaning, experiential learning, and deep modes of reflection during out-of-role activities. The out-of-role reflective activities are also designed to encourage participants to consider the story, theme, or world from different
Vantage points. Major goals of process drama are expanded self-awareness and understanding of the relationships, conflicts, and dynamics that contribute to the story’s arc; increased capacity for empathy; and critical analysis of the thematic topic (Piazzoli 2012).

The roots of the genre are in dramatic play, and its structural origins date back to the 1970s with the work of educators and pioneers of drama-in-education, Gavin Bolton and Dorothy Heathcote (Bolton 1979). Process drama was popularized and further theorized in the 1990s through the work of artist and drama education professor Cecily O’Neill (1995). My closest encounter with process drama was during participant-observation with the Drama for Life Masters students in one of their classes, over a two-week period. There were nine students in the class, me, and the professor (Tammy). As we began learning about process drama, Tammy told us about her work in primary schools conducting process drama and implored us to understand the fundamentals of the genre. She said:

Process drama is a way of learning that disrupts conventional power relationships between the teacher and learner. There is no ‘performance,’ per se. It’s about enrolling people in the experience, learning through the drama. The point of process drama is to live through the role. This level of engagement is the goal. It takes a captivating situation, not great acting skills. You learn through the doing, through action. Empathy is an enormous learning aim, as is metaxis—the link between Self and Other. The more metaphoric and distanced you make it, the better the imaginative buy-in and learning. This is all about beautiful power play: about showing you value what the students have to give to the learning process, not just what you have to give to them. Using playfulness to transition into role is one of the most difficult parts. If they buy into your role, they buy into their own, so use your acting skills to build belief.

At the beginning of the second week’s class, we were ready to conduct an actual process drama. Tammy had us warm up through playing a common improvisational theatre game called “Yes, Let’s!” and a common children’s game called “Elves, Wizards, and Giants.” All the students in the class were between the ages of 25 and 40, and there were seven females and three males. The premise and goals of “Yes, Let’s!” are simple: the purpose is to prompt the group to start
engaging imaginatively and to accept, without hesitation, the story suggestions of other participants.

This is a critical part of creating a safe space for participants to allow their imagination and creativity to fully engage with the process, and it is often a fundamental premise of improvisation: whatever your partner offers in the performance space, you take and figuratively run with it. It is not rejected or judged. It may be later critiqued during out-of-role reflection time, but *in the performance space*, it is accepted, unquestioned.

In the game, the person who is “it” in “Yes, Let’s!” calls out a suggested activity for all the participants to engage in, and the group yells out “Yes, let’s!” while miming the action. Our group went through a series of hugging lions, walking like giraffes, hugging each other, planting trees, and dancing. “Elves, Wizards, and Giants” is a game that is a little more involved, but its goal is to promote individual spontaneity (so, acting without thinking too much) and strategizing and working together as groups.

After wrapping up the introductory games, we entered the Victorian Era and spent 30 minutes creating a world and story about labor. At the end, we stepped out-of-role and sat in a circle to talk about the recipe for process drama and its difficulties. The first step is to find a relevant theme. We had not created our first process drama about HIV/AIDS, and this was a deliberate tactic of Tammy’s. Rarely do process dramas begin their first story with potentially deep or emotional topics; you work up to those as you go along. The second step is selecting a context and telling your group where and when the story will take place. The third and fourth steps involve creating the roles and frames to establish which viewpoints each person will take in this particular story. The fifth step establishes some object as a sign or symbol of the context to
deepen belief and further the story’s tension. After that, the process drama begins, and the sixth step is active reflection after the story concludes.

During our story, one of the guys in class and I had a very difficult time enrolling in the story. He had trouble connecting to his character, and my problems were more mundane: I was tired, hungry, and my attention kept wandering. We talked about these factors after the story concluded, and Tammy noted each participant is going to have a different experience within the process drama, which is part of what makes it such a great performance tool: all of those experiences and stories are shared in the reflection process that follows. She made a point of noting that my difficulties of the day were ones the students would likely face in the field when they began their own projects because hunger and listlessness are unfortunately common hurdles faced in work with underprivileged children and adults.

As a genre, process drama is connected to critical pedagogy and the quest to restructure power dynamics within relationships. It is also focused on encouraging empathy, acceptance, and a fundamental belief in the power of process over product. These deep concerns with process and critical pedagogy pervade almost all of the applied theatre genres. This concern with process in performance reflects the broader performance studies focus on process. As Henry Bial notes:

One of the basic tenets of performance studies is that a performance is not a static finished product. Performances are always in-process, changing, growing, and moving through time. Through a specific performance event may appear to be fixed and bounded, it is actually part of an ongoing sequence that includes the training of the performers, rehearsals, and other forms of preparation, the presentation of the performance to a specific audience in a specific time and place, and the aftermath, in which the performance lives on in recordings, critical responses, and the memories of performers and spectators. Performance studies scholars consider the entire performance process as their object of inquiry.

[2004:215]
This perspective opens the possibility of examining intervention programs as processes—a perspective that considers things provisionally, as they change over time and are negotiated among involved parties (e.g. funders, participants, producers, spectators). This shift from focus on product to process is critical in theatre-makers’ framework for approaching HIV/AIDS intervention because they consider living in a society where HIV is ubiquitous to be a process, not something a “one-off” program can “fix.” Also, they strongly believe that working processually, experientially, and actively with program participants is the most productive way to help people work through their thoughts and feelings related to health, illness, and sexuality. Effectively, this is a theory of intervention based in experiential action that works over a span of time (preferably a long one) and privileges negotiated meaning and equality in intervention power dynamics.

“Allowing Conversations to Happen” and “Moving with the Times:” From Rigid to Syncretic Aesthetics

In the previous chapter, I noted that part of theatre-makers’ desire for innovation in strategies to address HIV/AIDS is a preoccupation with the perceived static nature of past interventions (as a whole). In the opening vignette for this part of the dissertation, Amahle addresses her students and clearly references a trend she considers problematic: rigidity in past intervention forms. Although she correlates this rigidity with broader HIV intervention efforts in the country (particularly health education campaigns within the media and those that were government-backed), she discusses in the quotation past theatrical genres that have been used to handle the representation of HIV in public. Amahle’s opinions are representative of the kinds of changing ideas I heard during fieldwork about the aesthetics of applied health theatre in the country, and this ideology promoting mixed approaches is present in the syncretic performances I discussed earlier, Uhambo and It’s About Time.
In talking about working with audience members during performance workshops, Amahle notes, “Sometimes you get a gem from someone that’s not the ‘right’ answer but very telling of where that person is and what knowledge they have. Pay attention to these. Don’t let sticking to the form restrict here.” This was an integral point for many theatre-makers who considered activist theatre and TIE to be theatrical forms that limited the ways they could engage with audience members. For Amahle and many other artists, understanding the foundations of form, aesthetics, techniques, and practices that were associated with a variety of theatre genres was considered vitally important. However, equally important to them was the ability to know when to sacrifice form in order to connect meaningfully with the audience.

This notion of allowing workshops to be shaped by what participants give to the performance facilitator rather than rigidly conforming to one style and therefore shutting down possible points of meaningful contact, sharing, information, or questions from the audience was mentioned often during interviews. The director of Drama for Life, Warren, also addressed this point when he voiced concerns over past ways applied health theatre NGO projects have operated. He said:

What I’m aware of both at Themba and at AREPP is how, what’s the word, rigid they’ve become and potentially, you know, that there’s a sense of ‘this is the way you do it,’ and it’s you know, there’s no negotiation and so what begins to happen is even the facilitation is stilted, it’s not about listening, it’s more about ‘this is the way I’m supposed to do it. I’m going to need to ask this question, and I need to move it on.’ And then you can’t go, ‘but hold on, you just missed a major opportunity in this discussion here’! And because I’ve been watching Themba just recently, there’s this one performance they did with teachers, and the need to talk was huge and the issues were critical, but because of this formula, there was a lack of engagement. So for me, there’s a rigid kind of modeling. And theoretically, yes, there may be a reason behind this, and maybe a fairly superficial understanding of what that’s about, but it misses the point because I think all of them bind to the notions of participatory education. But somewhere along the line, the structure, the method, the strategies have become foregrounded over and above, ‘what is this really about?’ [Emphasis added]
The director hits upon a very important point and fine line theatre-makers must balance. Training in a particular theatre intervention style is critical, because each style has its own techniques, games, and strategies for engaging audiences in a particular way, for a particular reason (e.g. this ranges on a spectrum from motivating audiences to think critically about the scene at hand to engaging in an emotional catharsis that is considered healing). However, some theatre-makers have noted that artistic interventions in the country have become, to some extent, slaves to form at the expense of meaningful interaction with intervention participants. In his interview, Warren noted this when he stressed the importance of easing rigidity in form in deference to critically engaging with figuring out what participants are really concerned about—this is related to the idea I mentioned earlier about artists trying to access what is considered the “really real” or “real concerns” over superficial intervention health communication mandates.

Amahle’s attention was on the same topic. She also speaks of the importance of gaining mastery of particular aesthetic and facilitation styles (“forms”) but notes that being restricted by these forms leads to poor art and poor facilitated discussions with participants. What this is a concern about is the difficult ability to be dynamically adaptive in the moment. It points to the necessity of being less static, and therefore more interesting, through being more responsive to what audience members actually want to discuss and allowing those conversations to happen (even if they are not part of official intervention program agendas).

**The Dynamic Post-Apartheid Era**

In addition to allowing fluidity within intervention aesthetics for reasons related to facilitating expanded forms of audience expression and engagement, artists often talked about the need to include other (and new) kinds of health communication practices that better “fit” with the “feel” of the country in the second decade after democratization. This relates back to
Kirsten’s answer in the beginning of this chapter on why she thinks new aesthetic forms should be used in the contemporary moment. For her, new sociopolitical contexts require new ways of telling stories and communicating about health issues.

This notion is a reaction against the ways many artists think about how hegemonic HIV/AIDS programs in the country have been implemented in practice over the last 30 years. It is a critique against imposing intervention styles and methods that were appropriate for past sociohistorical contexts onto the present historical moment, which is considered by most theatre-makers to be categorically different from the early years of the post-apartheid era. Another applied theatre-maker backs up the point Kirsten made in the opening vignette when he notes, “The reality of now doesn’t accommodate message-driven theatre anymore. We need different things. Work in the past was too desperate…it needs to change.” This concern is also a call from theatre-makers for interventions to be attentive to the ways that not only broader historical circumstance but everyday life can change suddenly and with profound implications.

Examples of single days of importance that affected some kind of significant or felt difference in the country regarding HIV/AIDS include the following: the days Thabo Mbeki was named President and Manto Tshabalala-Msimang was named Health Minister; the day the Treatment Action Campaign won its legal suit over the government, which was ordered to provide PMTCT programs in public health clinics; the day the Mbeki/Tshabalala-Msimang reign finally ended and Aaron Motsoaledi took over as Health Minister. On a more individual level, the following are examples of days of importance: the day an AIDS patient receives free ARVs for the first time; the day someone finds out his HIV status; the day a person discloses her HIV positive status to her parents or lover.
Contexts can also take years to change, or change can occur so incrementally that its effects are masked until much later. These changes happen through the everyday and the monumental. For instance, the country has witnessed a gradual increase of ARV provision and government and media promotion of testing. These two initiatives have spanned the effort of years of work by HIV activists and policy makers, but the changes have occurred, and the landscape around HIV in the country looks different today than 20 years ago.

In anthropology, we note that contexts have always been in flux; this is not new. However, in the past, a strong united front on health promotion/prevention and treatment vis-à-vis ARVs were critical points of intervention in South Africa that needed to be addressed (arguably) before any others could be considered. Now, with changes in public attitude toward HIV, increased ARV rollout, increasing numbers of HIV testing and voluntary counseling, space is being created for other points of intervention. Other intervention priorities are emerging as equally important to the people who live HIV as a daily reality, and as the production *Uhambo* makes clear, many of these priorities have to do with interpersonal relationships and subjective experience of sexuality and HIV.

Theatre-makers are struggling to bring attention to two points in particular. First, past methods of HIV intervention (and studying/analyzing HIV) in the country have not always been the most integrated. However, they addressed the needs of their time, for their context, for their goals, and for the questions those scholars were asking. Earlier intervention models and research around HIV provided a strong foundation for HIV scholarship. Second, the context has now changed, and so too must intervention approaches, questions, optics of analysis, and theory. Interventions must fluidly adapt to dynamic changes in context, and this *necessitates* changes in health communication styles, practices, and aesthetics in the country.
Essentially, the kinds of aesthetics that worked well during anti-apartheid struggles and in the early years after democracy (e.g. activist theatre and theatre-in-education) are deemed by contemporary theatre-makers to be no longer solely adequate for present contexts. Cheryl*, a senior DFL faculty member who holds a joint appointment at the University of KwaZulu-Natal noted this trend when she stated:

Well I think once applied drama was developed within university academic departments, people then started working in communities. And I think through that, there’s been some kind of dissemination of those ideas into communities. But that happened only from about the mid-80s onwards; so it’s fairly recent. I was only one of the people who worked in applied drama in our department. There others who focused particularly on community theatre and on involvement in communities in and around Pietermaritzburg. Their initial work was all very Boalian based, but I think as people worked in the field and experienced the realities of the field, obviously methodology adapts itself and new ideas come in as you face problems, and how to deal with those problems, and different things are tried. So I think as the work grew, there’s been a multiplicity of input into the kinds of methodologies that people use and it’s more sort of, it’s wider, it’s more interdisciplinary I suppose than it used to be. When it was initially started up it was kind of a purer form of Boal that was practiced.

Here, Cheryl tells the story of her experience within applied theatre as it has changed over time. Cheryl, a highly educated white woman, was in her 70s at the time of our interview, so she had witnessed changes in the field throughout the anti-apartheid struggle, across democratization, and into the present era. For her, the shift to incorporating a wider range of aesthetic genres and theatrical practices was an organic one necessitated by changing realities on the ground and interaction with new problems in people’s lives and communities over time.

This concern is about having enough tools to shift and fluidly move into other theatre forms when audience members are not responding to or resonating with what performers initially offer them. Theatre-makers noted past artists were getting bogged down in form (one form), so they began advocating moving to mixed-methods or experimental forms in order to have a larger caddy of tools to draw from in any one performance. In this understanding of dynamism, what is
privileged is the ability to fluidly and quickly respond to the needs of the audience in a particular performance.

For instance, in the production *It’s About Time*, the Basotho theatre-makers used the strategy of small focus discussion groups in the performance space to prompt audience dialogue about the production’s content. However, because most of the people in the audience had trouble understanding the content of the play due to language issues, the focus group did not yield the kind of in-depth conversation the theatre-makers had hoped. After about 10 minutes of the focus group, the theatre-makers abandoned that applied theatre strategy and quickly moved to a Forum Theatre technique where scenes were re-enacted, and audience members could go onstage, take over a character’s role, and change the plot line to something more acceptable to that audience member.

In this way, the actors in *It’s About Time* used their knowledge of multiple theatre genres to draw on a variety of tactics in the performance space and respond to the needs of the audience. If the audience could not discuss the intricacies of the performance because of language barriers—fine: the performers would introduce a new tactic to allow the audience to make up their own stories in their native languages. In this way, when one form is not working, strategies from other forms can be trotted out and used. In essence, this model is about being able to “roll with the punches.” Syncretic theatre (the melding of methods, strategies, performance techniques, and theories of intervention and affect) is proposed as a way to remedy the rigidity and unresponsiveness of past HIV/AIDS applied theatre aesthetics.

This understanding of dynamism is related to the opening vignette in this part of the dissertation where Amahle tells the DFL students many of them were losing great opportunities for reaching their audience because they were too mired in one form and were unable to follow
where audience members obviously wanted to go. However, as Amahle noted, despite this use of expanded genres becoming increasingly important within applied HIV/AIDS interventions, it is an incredibly difficult skill to master multiple genres and takes much training. It requires knowledge of a wide variety of forms, as well as the experience and skill to know when to stick to one form and when it is better to cut a loss and switch tactics. As the production *It’s About Time* also illustrates, it is important for a group to grasp which aesthetics and performance strategies are working for the audience and allow them to continue with those rather than flitting between multiple styles for the sake of variety.

**Site-Specificity and People Needing Different Things at Different Times**

An additional component to this second concern with fluidity and dynamism is recognition of the need for and ability to use multiple aesthetic genres to reach a wide variety of people who learn things in different ways at different times in their lives (i.e. a wide net of ways to reach people are needed). This involves a core recognition that HIV/AIDS intervention work is fundamentally site-specific. In fact, “site-specific” is a genre within applied theatre that embodies the spirit of this philosophy: it is a performance conducted outside of formal theatre spaces in a particular public site at a particular time with a particular audience—whoever happens to walk by or show up. It is a performance in that space, with those people, in that time, and then it is over. It changes to suit the space and audience, and it is highly responsive.

Site-specific work has become a buzzword in South Africa over the last two decades and was brought up continuously within the interviews I conducted. Certain experimental artists mentioned earlier, such as Jay Pather, Kieron Jina, and P.J. Sabbagha, tend to produce site-specific theatre related to health issues, and it is a common aesthetic practice among the broader theatre sector. This focus on site-specificity (and specificity of aesthetic strategies) is about
being attentive to and responding to differences between people, audiences, crowds, and tailoring performance work, especially facilitated components or practices from playback, process drama, and dramatherapy, to the needs of the audience, not just the needs of the funder or the agenda of the performance group. By attending to such specificity and cultivating the ability to fluidly move between considerations of physical, emotional, subjective, and sociopolitical components of HIV experience, recent intervention practices are considered more “complex” than many prior HIV programming efforts.

**Alternative Ideas about Healing**

Finally, I argue that the concept of syncretic theatre is being used to make the symbolic and social boundaries between intervention models permeable in order to promote certain projects of artists, such as expanding definitions of healing. This is a use of theatre to reframe HIV intervention at the national level as a political issue related to what kinds of ideas about healing and whose health priorities are given structural and ideological support and which are ignored.

In this framework, the critical importance of physiological health and the biomedical interventions that attend to it are equally important and valid in the HIV intervention landscape as are other types of interventions that focus on psychosocial issues and the importance of meaning, representation, expression, emotions, interpersonal relationships, and reflective thinking in ideas about healing. This use of the syncretic theatre framework is an attempt by artists to merge performance domains of health knowledge with biomedical and public health ones. I present and elaborate two examples of aesthetic forms whose practices are being used to introduce and weave into HIV programming alternative notions of healing that originate in performance theory: dramatherapy and playback theatre.
Dramatherapy: Healing through Integration

Dramatherapy is a theatrical genre gaining ground in South African applied theatre practice. The form refers to using drama as a form of therapy, with the intention of healing through bringing about emotional, political, psychological, and spiritual change in people. At its core are two maxims: First, theatre is a way of actively participating in the world and not merely an imitation of it. Second, within theatre, there is a powerful potential for individual psychological and social healing. Within this form, symbolism, metaphor, and distancing are used to foster connections between conscious and subconscious emotional and mental processes (Jones 1996). The processes involved in dramatherapy include making a connection between the participant’s inner world and some problematic situation or life experience through dramatic activity in which the participant seeks to achieve a new relationship with or perspective on the problem or experience under consideration. The overall goal is to find in this new way of relating to the issue some form of productive change (thought or action), increased understanding, resolution, or emotional or mental catharsis.

Dramatherapy was established in the United Kingdom in the early 1960s through the work of Gordon Wiseman and is often used in therapeutic work with psychiatric patients, elderly populations, prison populations, abused children and adolescents, and other vulnerable populations or people who have experienced traumatic or troubling life events. Robert Landy is the major pioneer of dramatherapy in the United States, and both Phil Jones and Sue Jennings are well-known contemporary scholars of dramatherapy. In Drama as Therapy: Theatre as Living, Phil Jones makes a claim about how the conception of dramatherapy changed within psychological treatment modalities in the 1970s-1990s, and it echoes an argument I make about the shift in applied theatre in South Africa:
Over the past two decades a change has come to be fully acknowledged: that the drama itself is the therapy. This change marks the emergence of Dramatherapy as it is currently practiced. There are two main aspects to this change or development. One is that the Dramatherapy session can deal with primary processes involved in the client’s change rather than being an adjunct to other ways of working, such as psychotherapy. The other is that the root of this process is in the drama. Dramatherapy is not a psychotherapy group or behavioural therapy programme which has some dramatic activities added to it. The drama does not serve the therapy. The drama process contains the therapy.

[1996:4]

In much the same way Jones asserts the place of dramatherapy changed within mental health services in the 1990s, I see the historical role of theatre within HIV interventions (as an adjunct to biomedicine) being actively challenged today: theatre-makers conceptualize their interventions as primary—their interventions do the healing work, as well as the education, awareness, emotional integration, mind-body connection, and critical thought work.

Dramatherapy is an increasingly important form of applied theatre within South Africa. Its growing popularity is often attributed to the need for people within the country to heal from traumatic events that happen in their daily lives, as well as the country’s past struggle with apartheid. Yet, this is the genre of emerging importance with which I had the least amount of contact or experience. I was able to gain interviews with six of the main, formally trained and registered dramatherapists in the country through whose advocacy and work this genre is trickling out into the larger applied theatre industry; however, because the space created within dramatherapy is considered a more heightened form of safe, therapeutic space than other genres of applied theatre, I was rarely afforded the opportunity to participate directly in dramatherapy interventions.

In fact, my requests to be involved in the three or four major dramatherapy projects I encountered were all turned down (with apologies), and the only experience I had with this form was during public, open workshops within the Drama for Life “Sex Actually” Festival of 2010.
Even with Drama for Life, a group with whom I was formally affiliated as a visiting researcher and scholar, I was excluded from the class during which dramatherapy sessions were taught and conducted on matters related to HIV/AIDS. This was the only class or component in the Drama for Life program to which my access was restricted. 

Despite my limited personal interaction with dramatherapy sessions, some of the artists involved in my research often discussed the particularities of the genre and its meaning to their work. Although talk of dramatherapy was more common among the university program (DFL) and mainstream theatre-makers, the ideas behind dramatherapy were referenced occasionally in my work with community theatre groups. Most artists worked with the Five Phase Model of Dramatherapy, in which the therapy session follows a patterned movement through (1) dramatic play; (2) scene work; (3) role play; (4) culminating enactments; and (5) closing dramatic rituals.

Dramatic play is the process of using theatre games to develop group cohesion, trust, and relationships. Scene work involves cultivating performance, acting, and other theatre skills for the heart of the intervention, which consists of role play and the culminating enactments. Role play begins the therapeutic process by engaging the particular theme or problem the group is working through by enacting related fictional stories and scenes. The culminating enactment stage is the process through which very specific, personal issues, events, and problems are broached through theatre—either through highly symbolic and metaphoric modes or hyperrealistic re-enactments of the actual trauma or event (depending on the dramatherapist’s theoretical background and training). The closing dramatic ritual stage serves to provide a space

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57 The reasoning for my exclusion as explained to me was that although I was a valued member of the program that year, I was not a full member of the program. Because there were days I missed program classes and events due to conflicting fieldwork with other theatre groups, I was not considered a fully participatory member. As such, the director of the program deemed it necessary to maintain the “safe space” integrity of the class and only include full participatory members of the formal program.
for reflection, discussion, and emotional distancing from the therapy session as participants move back into non-therapy spaces.

Several key processes are associated with dramatherapy, including distancing, dramatic projection, witnessing, embodiment, and transformation. Distancing is a component of role play that comes from role theory, and it involves changing the degree to which the role being played in the drama is like the participant in actuality (so, moving to more symbolic or distanced versions of the role) in order to allow people to “play” roles similar to themselves without actually invoking their own traumatic experiences directly. Dramatic projection is the ability to take an idea or emotion from the participant and project it into the dramatic space through action, words, or metaphor. Through this, problems deemed “internal” become “external” and can be addressed and acted upon. Witnessing refers to the process of having one’s story be heard and accepted by others. Embodiment is also a key component and is used as a process through acting—ideas or events are acted out through the body, using the senses, in order to engage memories through feeling and sense rather than solely through cognition.

Transformation is also a key process and goal of dramatherapy. For most of the dramatherapists with whom I worked, transformation was linked strongly to the concept of “healing.” When I asked the dramatherapists or the theatre-makers who had some dramatherapy training, answers were often expressed that related change to healing through the integration of fragmented bodies and psyches. For example, when I asked a non-dramatherapist (but someone with some dramatherapy training) within Drama for Life what “healing” meant for her, she responded, “Healing...that’s a transformation within a person from a less integrated state to a more integrated state of behavior, outlook, perception, responsibility.”
Common refrains when I asked other theatre-makers what healing meant to them included comments about wholeness and wellbeing. For them, healing is a movement from a stage of fragmentation (of some sort) into a greater state of integration and wholeness—and “health” connotes the wellness of minds and feelings as well as physical bodies. By attending to these more intangible forms of healing and health, theatre-makers felt like they were actively addressing a gap in broader contemporary HIV/AIDS programming in the country, which primarily focuses in a limited sense on physical bodies.

The play mentioned earlier, *Uhambo: Pieces of a Dream*, relied heavily on dramatherapy techniques in the scene where the HIV positive woman tries to piece the paper representation of her broken torso (self) back together with the help of the audience. Although a part of the woman’s physical body was being stitched back together, the representation was meant to include the woman’s psyche. By involving audience members in the process, the woman’s interpersonal relationships with her “community” (the audience) were linked very closely with her emotional health and physical wholeness.

**Playback Theatre: Healing through Acceptance**

Playback theatre is a final genre I will discuss in this chapter, and its invocation was on the tongues of even more theatre-makers than dramatherapy or process drama. References to playback theatre were made at the university, mainstream, experimental, and community theatre levels, although functional and advanced understanding of playback processes and techniques were most often limited to the university sphere. Playback theatre is related to both Theatre of the Oppressed and dramatherapy. Unlike dramatherapy, it does not position itself in a therapeutic domain, even though constructive change is one of its founding principles.
Unlike the Forum Theatre of Theatre of the Oppressed, playback theatre does not reject the personal and privilege the sociopolitical; however, both can be components. Playback theatre allows its audiences to raise issues of importance to them and shape the tenor and theme of a performance through the medium of their personal stories—good and bad, joy and suffering. The range of human experiences and narratives is up for grabs, unlike the focus of Forum Theatre, which is explicitly about oppression, or dramatherapy, which is often about dealing with traumatic events or problematic situations.

At its core, Playback theatre is a form of improvisational theatre in which a performer called a “conductor” facilitates the sharing of stories by audience members. Audience members share personal stories or moments from their lives, choose actors to play the different roles, and then performers “play it back” to the storyteller and audience using non-naturalistic performance styles. The performers interpret the story and re-create it onstage for all to see. This is a genre that also relies heavily on metaphor in the process of playing stories back to participants, although the stories offered by participants come from their own lives and are often quite specific and detailed (Fox 2000).

Playback theatre was founded in 1975 by Jonathan Fox and Jo Salas as a way to honor ordinary life experiences, offer a space for audiences to celebrate and explore their stories, reveal differences of perspective within a community or audience, and facilitate community or group cohesion, understanding, and empathy. Unlike Theatre of the Oppressed, which is problem-and-

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Footnote: Audience members tend to choose actors based on two criteria: (1) physical similarity, so often a black South African male audience member will choose a black South African male actor to represent him or (2) gut feeling or emotional connection to a particular actor. It was often the case that an audience member who was, for example, a white South African female would choose an actor of different ethnicity and/or gender to represent her based on some feeling of connection to the actor (with whom she had no prior experience before the performance). So, the white South African female may pick a Coloured South African male to play her role in the story because he projects some quality that resonates with how she sees herself.
solution oriented, solutions are not the main focus of the playback form. Narrative, storytelling, and witnessing of stories are foregrounded. In relation to HIV/AIDS, many of the theatre-makers in South Africa talked about using playback theatre as one way to promote normalizing discussion of HIV generally.

To get a picture of what this looks like in practice, I include below my fieldnotes on the first playback performance of the Drama for Life “Sex Actually” Festival in August 2010.

This afternoon, I went to DFL Playback Theatre in the Nunnery. I took paper notes on audience demographics and content. On audience participation. This was my first experience in playback when someone in the room actually made fun of the medium. One of the guys who got up to tell a long story was 100% lying through his teeth as he told it. Just…it was jarring. Playback can be so powerful and meaningful, and people share their lives and stories, and those stories are honored and handled carefully, and people cry and face things they haven’t faced before, or it can be a really funny and fun experience or all of the above. But this guy…just lied. Playback, like so many other of these interventions, is dependent on honesty, truthfulness, and a willingness to be really deeply open. And vulnerable. There’s something important in this—that think about it. Anyway, the second person to tell a long story was a girl, a young girl, in her early 20s maybe, and hers was very moving. It was about how she’d told an AIDS orphan that she’d adopt her for real later in life, but then hadn’t spoken to the orphan in about 2 years and how that made her feel. She promised to adopt this orphan because, in the moment, she’d been so overwhelmed by the plight of this girl. Actually, I should just tell the whole story.

This girl gets up and shares her story, which the group then played back to her (and interpreted very well—I wish I’d had a video of this. I don’t remember if they videotaped this session or not). She cried as it was being played back to her. Usually at the end, the conductor asks the storyteller “And did your story go something like that…?” and the storyteller usually is in some kind of very obvious deep emotional state (usually either crying or laughter) and they usually say, “Yes, very much” or “just like that.”

Anyway, the girl’s story: basically what she told us is that (and I think it takes courage to tell this in public, to strangers). So basically what happened, is that this girl was in 11th grade, and her class sponsored an AIDS orphanage. Each class member “adopted” an AIDS orphan for the year and sent them little gifts, clothes, whatever. There was also a big bake sale and rally to earn money for the orphanage. It was like their class’s good works deed for the year. Anyway, a particular orphan was assigned to her, and she sent her various things, including one of her old, favorite dresses from when she was a child. She and a friend of hers were talking one afternoon as they walked home from school about adopting children, and her friend asked if she’d ever really adopt an AIDS orphan. She said, “Of course not!” and that it’d be too much responsibility and why would you
want to adopt a child that’s definitely going to die?? You’d invest so much love in the child only to have her die a few years later.

The day for them to take the money to the orphanage and meet the AIDS orphans came, and as she entered the orphanage, she KNEW which was her AIDS orphan because she was wearing her old, favorite dress. They spent the day playing with the kids, and at one point, her ‘adopted’ AIDS orphan walked up to her, tugged on her shirt, looked her in the eyes, and plainly asked her if she was ever going to take her home with her. In that moment, she told the little girl yes—that one day she would adopt her for real. She said she was just overwhelmed in the moment by the lost look on the child’s face, the hope, the want, the desire to be loved and cared for. So she promised the little girl she’d come back for her and adopt her for real. She kept in touch with the girl for a few months after that, but then got increasingly stressed about having told this girl she’d adopt her when she didn’t actually want to adopt her, so she eventually just quit calling the orphanage. Their names were Lali* and Thandeka*. The girl telling the story was Lali, and she started crying as it was being told. When asked about it at the end, Lali said the rendition or re-telling had been pretty good and it had actually happened almost exactly like the way they acted it out. She said it made her want to look up the little girl, see if she’s still alive, and call her.

There are several important dynamics at play in this recounting of the playback event. The first is the necessity for vulnerability and generosity within the playback space. Playback as a form is premised on telling stories that are “true” for the story-teller: stories of events as the teller experienced them at the time they occurred or from their distanced personal understanding afterward. Truth here is equated with subjective experience. The first person to tell a story in this intervention made up his story, and the result was an excessively awkward experience for the performers and the rest of the audience. I remember people in the audience catching each other’s glances, shaking their heads, and generally conveying confusion, bemusement, and even anger as the storyteller proceeded; however, as a tenet of the theatre form, playback actors are required to take whatever story is offered by the audience member and treat it as valid and real, to accept it in that space. So, even though the audience expressed discomfort with what was a fabricated, over-the-top, disingenuous story offering, the performers tried to recreate his story.

The second person to tell a story was a female, and her offering appeared to be a genuine story from her life. In it, she tells the story of her encounter with an HIV positive orphan and of
her discomfort with how she handled the experience. By the end of her story, she was struggling
to articulate her feelings, understand and explain her own reasoning for telling the girl she would
adopt her, and publicly express the shame she felt about abandoning the little girl. By the time
the actors finished re-creating her story and playing it back to her, she was openly weeping—but
also laughing. She stated that the experience of the theatre intervention made her want to
reconnect with the little girl. Whether she actually attempted to reconnect with her in the weeks
after is not the point of the intervention (which is not premised on or consumed with the notion
of behavior change).

What the intervention did was provide a space in which Lali could share her experience,
have her story interpreted through other people (the actors) and relayed back to her for reflection,
provide witnesses to an everyday life experience that had affected her, and actively ask the
audience to reflect and speak on their reactions (thoughts, feelings) to her story. Playback
theatre is about change, but it is a much more subtle transformation than that advocated by many
other genres of applied theatre.

The change within playback is about allowing and fostering open communication. It is
about theatre-makers looking at audiences and conveying the following philosophy: “your stories
matter, and we accept them no matter how ugly, or beautiful, they may be. No matter how deep,
dark, shameful, or light, fluffy, and superficial, we accept your stories and through accepting
them, we accept you.” In this intervention modality, personal narrative becomes the vehicle
through which healing occurs.

In playback, healing is a concept strongly correlated with speaking openly about daily life
experiences, fostering generosity, and sharing yourself, through your experiences and stories,
with others (the actors and members of the audience). Speaking openly and generosity in sharing
yourself are parts of the change (in both individuals and as communities) that playback advocates. When I asked Elizabeth*, a 27-year-old white South African who was one of the foremost playback artists in the country, what role she saw playback theatre taking in broader HIV/AIDS interventions, she began by describing past forms of messaging/intervention in the country and moved to how playback is different. She said:

I mean, messaging left, right, and center—use a condom, do this, do that, live a healthy lifestyle. Meanwhile, I mean that’s completely irrelevant if you’re completely poverty stricken, if you’re wrapped in a community of denial, and I’m talking about, you know, rich and poor. That’s very much the situation here I find. Because you’re not actually dealing with the basics of what it means to have the HIV/AIDS prevalence we do in this country, you’re not dealing with the fact that talking about intimacy in this country is a no-go zone for a lot of African cultures and Western culture, also it’s sort of like it’s done in a very sterile way. It’s like, “Yes, we can talk about it!” But we don’t really talk about it.

I mean, I don’t even remember having sex ed or having my parents speak about it. So if you don’t have that kind of environment, how on earth are you going to make people feel comfortable about walking into a shop and getting a box of condoms or kind of open up about the subject and not be labeled as a bunch of, you know, NGO development workers—because of course they talk about that stuff! So it’s about trying to normalize that conversation. And that’s what we try to do. It’s this universal experience, and it’s freaking freaky to be dealing with HIV and AIDS in a way in which it is so, like infected everything we do in terms of our sexual conduct. Just, yeah, start dealing with just that, the overwhelmingness of it.

In her interview, Elizabeth echoes the sentiments of many people I talked with in South Africa, not just theatre-makers: the idea that through HIV/AIDS interventions in South Africa so far, people tend to pat themselves on the back and say the country is making progress in talking about sexuality and HIV, but there has been little progress in “really” talking about it. It is that “really” that makes the all the difference in the kind of intervention theatre-makers are trying to accomplish.

For Elizabeth, talking about HIV and the AIDS epidemic is not about condoms, HIV prevalence rates, healthy lifestyles, messaging, or prescriptive directions on how to live and experience sexuality. Talking about HIV “really” is getting into the nitty-gritty of how people
feel about the epidemic and how that shapes their actions and thoughts—the “overwhelmingness” of it. It is about normalizing speaking about HIV in relation to all aspects of life, what she sees as a universal experience (in South Africa). Playback theatre becomes an intervention modality to normalize talking about HIV and other sensitive topics and to promote generosity with sharing deeply personal stories of experience with HIV.

Lali’s ambivalence about how to relate, emotionally and in actions, to an HIV positive orphan put into her care is a good example. After she watched the performance, she wondered aloud why she had really said yes when the girl asked her to adopt her—Lali was questioning her own life and motives, her own susceptibility to the emotions of others and instinctive response to give the child what she wanted, even when that desire went against Lali’s own life goals. Lali exclaimed, “What is up with that??” Someone else in the audience questioned why people tend to automatically pair the idea of “AIDS orphan” with “death,” as Lali had done in her story.

Those kinds of questionings are what the playback artist I interviewed references. Here, the focus is not on some kind of generic “saving” of AIDS orphans, condomizing, safe sex practices, or other common topics of discussion in HIV intervention. The focus is on being vulnerable, sharing personal experience, questioning the self, motivations for actions, the ways people relate to others and compromise their own values in the face of another human’s emotional pain, and on questioning common media representations that link death with HIV.

In playback, the goal is to help people become comfortable sharing their experiences and having their stories heard and acknowledged. How does this contribute to HIV intervention in the country? According to some theatre-makers, it is only when the larger population is ready to “really” talk about HIV, the “really” real topics, that any kind of substantial change can occur. “Really” talking about HIV paves the way to social and individual transformation in emotions,
actions, and thoughts. Healing, in this conceptualization and in stark contrast to biomedical thought, is about learning how to openly communicate and share your subjective life experiences with other people in a vulnerable and giving way.

5.5 Conclusion: Complexity Aesthetics

There has been an increase in the number and range of aesthetic styles drawn upon by theatre-makers who produce health-related artistic work, and this is partly explained by recent calls by artists for innovation in how HIV/AIDS is represented in public intervention programs. These calls for stylistic innovation originate in artistic critiques of past HIV/AIDS intervention programs in South Africa, both performance-oriented and those located within biomedical or public health initiatives. A primary way theatre-makers are using aesthetic forms to remedy perceived past health intervention failures is by introducing what they consider more “complexity” into their work. This is accomplished through expanding the number and range of genres from which they draw and mixing the underlying practices, affective theories, and stylistic components of multiple genres to produce a form of syncretic theatre that is meant to be more responsive to what audiences need by selectively discerning appropriate techniques for particular performance goals. As I noted, this syncretic approach to health intervention sometimes works well (as in the case of *Uhambho*), but it also often fails to achieve performance objectives, partly due to a lack of easy access to in-depth skills training related to aesthetics in the country (as in the case of *It’s About Time*).

In the chapter, I argue that this artistic move toward “complexity” as it relates to expanding aesthetic genre is about more deeply engaging with notions of truth, interpersonal relationships, emotion, and deeply subjective experience of HIV and sexuality than common biomedical and public health prevention, treatment, and care programs. It is also about
challenging the kinds of power dynamics so common within dominant HIV/AIDS interventions in the country by actively involving participants in the co-creation of knowledge rather than sidelining them as passive recipients of information. The move toward “complexity” is additionally about being fluidly responsive to dynamic individual and sociopolitical contexts; more vociferously promoting the notion of process over product in HIV programming; opening up public dialogue about what healing means in the second decade after democratization; and expanding the techniques of communication on which artists draw to better handle, capture, and represent the ways lived experience is deeply nuanced and, at times, not fully understood.

This move toward complexity aesthetics answers long-held calls from the arts sector for expanded intervention and communication styles that go beyond didacticism to begin engaging with the kinds of confusing life experiences that emerge in situations where people do not fully understand their actions, contexts, feelings, or thoughts. Lali’s experience, as discussed in the playback theatre example, is a good illustration of the kind of engagement theatre-makers are starting to advocate with HIV/AIDS issues outside of didactic messaging.

The move toward syncretic theatre is an attempt by artists to recognize that the individuals who comprise their audiences learn in different ways and are affected by a variety of aesthetics and communication styles. There is often overlap between interpretation of the boundaries of theatre styles. For this chapter, a central point is that artistic forms are important backbones on which programs are based, but allowing the performance and discussion process to be restricted by form has become anathema for applied health theatre-makers in the country. Fluidity and experimentation are increasingly being privileged, and I suggest this has to do with artist attempts to be responsive to audience needs and interests in a way not fully realized within many health communication and prevention programs in the country to date. In particular, artists
are trying to start engaging with the deeply emotional components of lived HIV experience, as well as the existential issues that arise around sexuality, especially in historical contexts where sexuality is always already embedded in popular considerations of physical health and bodily integrity.

The components of complexity that I mention here are themes that run through both chapters in this part of the dissertation. In this chapter, I have covered some of the differences between genres increasingly being used within applied health theatre practices in the country. I argue it is important to analyze genre differences because they often reveal how theatre-makers are playing with possibilities for health communication and healing in the country.

In particular, I suggest theatre-makers are starting to promote additional agendas within public health programming. For theatre-makers, the goal is no longer only or primarily about behavior change or knowledge promotion. The goals include sharing subjective experiences, working through situations that are not fully known or understood, exploring the many ways that people relate to each other under the ever-present specter of HIV, and practicing communicating with vulnerability. Artists are starting to deeply engage with a kind of communication about sexuality and HIV that is less about what is known and more about discussing the not-fully-known, as well as probing the “really real.” These are themes I develop in the next chapter.
CHAPTER 6
Complexity: Language and Optics

Introduction

Artificial lights cast a flat sheen over the room as I entered an HIV/AIDS and TB clinic in Mitchell’s Plain, Cape Town. I walked to the front counter, which was enclosed by metal bars covered in chipped paint. Posted signs proclaimed the dire state of health in the country: international research has shown South Africa has the highest number of HIV infections worldwide, with about 5.5 million people infected (UNAIDS 2005). I glanced from the poster to a pamphlet extolling the virtues of the ABC (Abstain, Be Faithful, Condomise) plan of HIV prevention. Then I looked past the block of metal bars to the nurse beyond and waited for her attention. The air smelled strongly of antiseptic.

It was 2005, and this was my fourth day in Cape Town and my first in the clinic. I was there to volunteer my services as general helper. As an undergraduate with a passion for sub-Saharan African Studies, this was my first time outside of the United States. Without any medical or public health training, I was put to work directing the flow of clinic traffic. For a month, I talked with HIV/AIDS and TB patients as they waited for appointments, and I wandered from clinic wing to wing helping where I could. One day, I was allowed to join an HIV testing counselor during three of his sessions. One in particular shaped the development of my later academic research interests. I was 22 years old at the time, and a 19-year-old woman new to motherhood entered the cramped shipping crate that served as a counseling space. She’d recently tested HIV positive and was back for a follow-up counseling session.

What I remember was the incongruity of their communication. The counselor talked the language of the clinic: antiretrovirals, mother to child transmission, adherence to future treatment
schedules, controversies about breastfeeding, and the importance of disclosure. The woman gazed blankly at the floor for a long time, listening. Then she turned back to us and said, “Why didn’t he tell me? What am I going to do? I have sores so bad I can’t go to work and sometimes I can’t even stand up.” She paused for awhile and looked away from us. When her gaze returned to mine, she said plaintively, “Who will want me like this? And the medication’s too…besides, if he was sleeping with someone else, why did he want me around, anyway?”

Although the clinic provided a necessary and beneficial education program through its counseling services, the woman’s immediate concerns didn’t seem to correspond with those prioritized by the counselor.

The language the counselor spoke was filled with concepts like risk, behavior, choice, decisions, priorities, treatment protocols, cause and effect, prevention strategies for future sexual partners, medication regimes, hospital visits, PMTCT, and clinical care. In contrast, the language of the woman was peppered with references to relationships, family, and unanswered questions about her desirability, work prospects, breakdowns in communication with her sexual partner, and her self-worth. I knew the information imparted by the counselor was important to the woman’s future, but I still wondered who was going to help her resolve the need she expressed for answers to those other questions. This was one of my first experiences with biomedical HIV/AIDS care in South Africa.

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In the introduction to this part of the dissertation, I discussed the philosophy of one theatre-maker (Amahle) regarding the difference between past HIV/AIDS intervention campaigns in South Africa and current theatrical efforts to fill some of the perceived gaps in that programming. One of the holes mentioned most often by the artists with whom I worked was
lack of attention to the kinds of deeply complicated, subjective, and interpersonal questions the 19-year-old mother just asked and widespread preference at a national level for health promotion projects or focus on physiological treatment.

Amahle’s words of advice to expand intervention foci strongly resonated with the students to whom she was speaking, and this is partly because these opinions are becoming very popular among applied theatre-makers in the post-apartheid era. Amahle’s thoughts are reiterated by DFL director Warren. When speaking of his vision of contemporary applied health theatre, he noted:

It’s that somebody needs to go through an experience that will allow them to really reconsider their own behavior but also understand how difficult it is to change behaviors and how difficult it is to begin to deal with HIV and AIDS because it is such a complex issue. It goes to the heart of intimacy and the heart of sexuality, that there’s so many unspoken. Of course the necessity for understanding the medical aspects of it remains, but there’s also the necessity to understand what sex is and what it’s about and then more than that, it’s to understand that there are many things that are unspoken and unsaid and, you know, how do you grapple with cultural beliefs and systems that direct people’s behavior in a very particular way? Or make meaning of behaviors?

In this quotation, while Warren explicitly recognizes the continued importance of understanding what he calls the medical aspects of HIV/AIDS, he points to other considerations as equally important to current practitioners. In particular, of central concern becomes meaning-making around the following: intimacy, sexuality, behaviors/actions, the unspoken, and the unsaid. These “intangibles” have increasingly become a component of lived experience on which theatre-makers focus. They have started advocating for their inclusion into broader ideas about HIV intervention and care.

The need for this is illustrated in the young mother’s plaintive questions as she desperately tries to make sense of the love relationship that resulted in her HIV positive status. This new, intentional focus of theatre-makers is about highlighting the kinds of situations in
people’s lives that are incoherent to individuals and result in an existential experience of not-knowing. This is also about interrogating realms of experience of HIV that often remain unaddressed, unacknowledged, and unspoken within hegemonic public health practices in the country. What theatre-makers are reacting to here is the necessity of better accommodating the shifting needs and goals of their audiences. These ideas about shifting goals have been popularized since the mid-2000s.

In the past, promoting health knowledge, particularly about HIV risk and transmission, was a main theme of artistic interventions. As Amahle noted in her advice to the DFL students, the responsibility to educate (about HIV) has dominated the intervention landscape in South Africa through the 1990s-2000s. It was especially important in the context of Thabo Mbeki’s presidential administration, where misinformation about the link between HIV and AIDS was common and confusion surrounding the epidemic was rife in public opinion. However, theatre-makers have started questioning the role of interventions in the post-apartheid context, as well as their role as interveners.

6.1 Goals of the Present Not Limited to Goals of the Past

What kinds of interventions are relevant when a large part of the population has internalized media messaging and knowledge about HIV risk and transmission and can parrot statistics back to anyone who asks? This was a question raised in discussions among theatre-makers, which was driven home to me with particular force during an interview I conducted with Kefilwe*, a senior journalist at IRIN Plus News59. She is a highly educated black South African about 35 years old and has been reporting on the AIDS epidemic since 2001. I initially

59 IRIN Plus News is a humanitarian analysis and news service branch of the UN Office for the Coordination of Humanitarian Affairs in South Africa
approached her to obtain opinions on HIV/AIDS-related plays she had attended, but she noted that it had been a few years since she had seen any HIV plays. When asked why, Kefilwe stated:

I mean, I think we’ve changed focus now. People don’t need that kind of [awareness] drama. Our priorities have shifted now. People know so much more about HIV/AIDS. We need something more engaging, with plot and storylines, than the usual preachy stuff that we’ve come to know. People talk about AIDS fatigue. So you need to keep telling the story, but how do you find different ways of telling the story? It was important initially to tell a human story about HIV, but that story was often a stereotype about the African woman: poor, dejected, a receiver of HIV. That always upset me because I was a black woman, and I couldn’t relate. These are not the women I know! I always wanted a different story told. There’s more to it now than just “HIV/AIDS is killing millions of people.” Now, people are living with it.

For her, the story of AIDS has changed subtly in the country. The story is still about infection, and education goals must remain, but other (more complicated) themes are emerging after three decades of knowledge about HIV. We fell into a discussion about how HIV had affected her personal life, and she said, “I was in a relationship for four years. I knew my boyfriend was cheating on me, but I’m empowered: I’ve got two degrees. I earn a lot of money. But, I just couldn’t bring myself to do the whole condom-negotiation thing.” She reiterated that at the time, she knew all the facts about HIV; she knew her boyfriend slept with other women; and she knew she had the power to leave the relationship if she wanted. However, with a shrug, she said she didn’t want to leave but was also unwilling to engage the condom negotiation dynamic.

Kefilwe’s story is illustrative of the kinds of stories theatre-makers are now considering. Given the surface details of her story (black South African woman in a sexual relationship with a “cheating” black South African man), many health promotion intervention efforts of the past would stop their interrogation into the situation at one of four fallback narratives: First, that Kefilwe does not actually have all the information she needs to make a safe decision (i.e. education). However, in actuality, she has been studying and reporting on HIV for a decade. Second, that Kefilwe does not have the structural power to ask for safe sex (i.e. structural
dis/advantage). However, she does have education, a stable job, social capital, prestige, adequate wealth, and, as she later assured me, a strong network of supportive female friends in her life.

Third, that Kefilwe does not want to endanger her romantic relationship by introducing distrust through asking for condom use (i.e. trust). However, the typical conception of trust dynamic was not at issue with Kefilwe; she already knew without doubt her partner was having unprotected sex with other women, and she accepted this as a fact. Last, that Kefilwe, as a black South African woman in a society where talking openly about sex is still taboo, is uncomfortable subverting sociocultural norms of proper female behavior in order to secure her sexual safety and health (i.e. cultural behavior/factors). However, while it is true that openly discussing sexual topics in South Africa is still a socially uneasy thing to do, Kefilwe noted that she and her partner openly discussed many other sexual topics, including sexual positioning preferences, the use of sex toys, and issues of hygiene.

So, for some theatre-makers, the question becomes: what is the role of interventions when the social context includes people like Kefilwe--strong, educated, powerful women who engage in multiple concurrent partnerships with eyes open to HIV risk? Theatre-makers were quick to note that education is still important and some contexts have not changed (particularly those related to HIV and gender violence); however, they have begun recognizing a much wider range of ways people experience HIV in their lives and that situations like Kefilwe’s are more “complex” than former public health and even social science models for representing and understanding such situations.

### 6.2 The Turn to the “Complex”

In this chapter, I attend to a central anthropological concern: complexity. Although complexity has historically garnered attention among a variety of disciplines (e.g. anthropology,
physics, mathematics, chemistry, computer science, and the biological sciences), there has been a resurgence of interest in the concept of complexity among academics since the 1990s. Calls for deeper attention to complexity have recently been issued from anthropology (Biehl 2009; Bourgois & Schonberg 2009; Bondarenko 2007). In most of these cases, complexity is defined as both the complicated interactions that emerge at the interface of various domains in a multi-faceted system, as well as what is produced through these interactions. For example, Biehl (2011) identifies the judicialization of healthcare in Brazil as the complex product of interactions between biomedical rationality, normative acts of national health policy, the deployment of human rights discourses by public attorneys, the emergence of new sociomedical forms of support, and the everyday lived experience of juridical subjects. In other cases, appeals to understanding social complexity are positioned as a way to avoid biological reductionism when explaining human behavior and experience (e.g. McKinnon & Silverman 2005).

While these views of complexity are essential for understanding the ways in which macro- and micro-level sociopolitical processes interact to bear on the lives of individuals, I argue they are not the only (productive) ways to think about the concept of complexity. Broadly in this chapter, I call for greater anthropological engagement with complexity as a local construct in addition to complexity as an overarching ideological goal of the discipline. This includes attention to local definitions of complexity, for what reasons people cite complexity as important, and how people deal with their understandings of “complex” worlds in daily life.

In particular, I advocate examining the nexus of complexity and public health in South Africa: how the concept shapes people’s lives and the ways in which artists deploy it to actively challenge hegemonic notions of proper public health intervention goals and tactics. When I was in the field, I found it striking how often this term was invoked by the artists with whom I
worked. Over time, I realized they understood and used the concept of “complexity” in specific ways in relation to public health intervention practices. In the past, health promotion and physiological treatment were primary public health foci in South Africa, but some theatre-makers increasingly advocate for expanding program optics and goals to include other components of HIV/AIDS intervention. One of the most compelling of these additional foci is the concept of complexity, which indexes for many theatre-makers the deeply subjective sides of HIV and sexuality that people experience as incoherent.

As a consequence, rather than assuming an a priori definition of complexity, I argue for the need to push the parochialism of common ideas about what the concept of complexity means. Through vignettes of theatre processes, I present in this chapter ethnographic data for a grounded analysis of what complexity means to the people with whom I worked and take those local understandings of complexity as the basis for theorizing. I discuss complexity not only as dynamic interactions among a variety of variables in a system but also as states of incoherency.60 In particular, I ethnographically analyze two constructs artists have used to engage with states of incoherence: “moments” and “shadows.” I describe the variety of valences “moments” and “shadows” have for theatre-makers and detail the knowledge and cultural resources on which they draw to engage with ideas about complexity. Both of these constructs have played key

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60 By “incoherency,” I mean states of being characterized by a lack of clarity, understanding, knowledge, order, simplicity, direct causal relations, and/or straightforwardness. This is a very broad category, but theatre-makers discussed particular kinds of incoherency in their work, which I describe later and subsume under the label “shadows.”

61 By “construct,” I mean a conceptual idea with various elements intended to aid understanding of some phenomenon. In this particular case, I refer to two conceptual ideas (moments and shadows) which were particularly salient to the artists with whom I worked. They invoked both of these constructs in their ongoing efforts to make sense of how people experience HIV/AIDS in daily life, why past intervention programs have failed to make substantive change in HIV infection rates in South Africa over the last 30 years, and what artist contributions to innovation in HIV programming globally might look like in practice.
roles in recent theatre-maker attempts to understand how people make meaning about illness, health, and sexuality in worlds often characterized by incoherence.

By more closely focusing attention to the ways in which artists understand “complexity” in relation to public health, I suggest that pathways are opened for developing frameworks for HIV intervention that exceed the narrow South African context and may be applicable to global public health efforts to address AIDS epidemics. Using “complexity” as a framing device to make the temporally-relevant and incoherent parts of lived experience an explicit focus of anthropological analysis rather than a tacit one enables certain kinds of questions and topics to be analyzed more intentionally. Two important ones include people’s experience of the unknown and the links between systems and experiential complexity.

### 6.3 Ethnography of Theatre, Health, and Complexity

As noted in previous chapters, some theatre-makers involved in HIV/AIDS-related work have started to strategically manipulate how HIV/AIDS is framed within artistic intervention models. Moving away from didactic, biomedical information dissemination practices, many theatre-makers are starting to use aesthetic and embodied techniques to privilege the convergence of cognition, affect, and the senses in the project of creating meaning amidst the epidemic. I suggest that a major way theatre-makers attempt to accomplish this reframing is through directing attention to the ways in which people experience their lives as “complex.”

This becomes particularly important within public health related to HIV because it starts to ask why people do the things they do, how experience of contradiction affects actions related to sexuality, and what kinds of things people consider to be the “really real” issues around HIV/AIDS. Theatre-makers are starting to try to access and work through the things people do not quite understand about themselves and the worlds in which they live—the range of confusing
topics that hover at the edges of conventional public health foci, such as Kefilwe’s contradictory sexuality and the young mother’s attempts to grapple with and make meaning out of her boyfriend’s silence about multiple partners. To get a sense of what this interrogation looks like in theatrical practice, consider the following two vignettes.

**Jorrell’s Story: Sexually Yours**

The room was a black-box theatre: square with black walls and ceiling, a flat floor, and no stage. As I entered, the twin bed placed center-stage captured most of my attention. It was covered by a red blanket and pillows. A semi-circle of straight-backed chairs framed the bed, and there were already two other girls in the room sitting on the chairs. I figured I was probably supposed to take one, as well. From stage left, a string ran from one side of the room to the other. Pinned to it with laundry clips were pieces of lingerie and twelve torn magazine pages with images that included both males and females, all in states of undress and showcasing a lot of bare skin. Music played from a boom box off to our left: Shaggy’s song “It Wasn’t Me,” about a guy caught cheating on his girlfriend. “Honey came in and she caught me red-handed/ creeping with the girl next door/ Picture this, we were both butt naked/ banging on the bathroom floor/ How could I forget that I’d given her an extra key?/ All this time she was standing there/ she never took her eyes off me.”

This was a workshop called “Sexually Yours.” It was part of Wits University’s Drama for Life “Sex Actually” Festival of 2010. I had arrived in South Africa for fieldwork only two weeks earlier. The festival was held on a university campus, and I remember thinking that was going to significantly shape who the audience (and performers) would be. The neighborhood mentioned in the first monologue, Hillbrow, was about half a mile away walking-distance from the university. It was known for high crime rates, uncontrolled illegal substance use, and
prostitution. Braamfontein, the neighborhood where the university is located, was only nominally better. It had less prostitution and drug use but similar crime rates.

The audience was small, although the room had chairs for 10 people. When the performance started, there were four females in their 20s and me. Four of us were white (three South Africans, and I am from the US), and one woman was black South African. The two performers, who stated their preference for being called “facilitators,” were a 45-year-old white male and a white female in her 50s. The performance began with the man sitting on the bed, directing his monologue to the five audience members; there was no “fourth wall” convention of classic theatrical realism, where an imaginary boundary is erected between performers and audiences. Jorrell*, the performer, spoke to us. He looked us each in our eyes and told his story. His voice was soft and halting, but open. He said:

So I find myself walking down a corridor in a block of flats, in Hillbrow. For a one-night stand. And I’m sort of wondering to myself, why am I doing this? [pause] Anyway, so I’m walking behind a short, quite bold Daddy type guy. And we get to the door, and in we go. The flat smells of old cigarette smoke and a recent fry-up. And he says to me, do you like *The Deer Hunter*? I don’t know if any of you have seen *The Deer Hunter*. Vietnam American film. It’s quite violent. [pause, looks away, looks back] Anyway, so he asks whether he can put *The Deer Hunter* on. I said it’s okay. And so he puts it on. He starts undressing while he’s staring at the television. Says it turns him on. I sort of just sit on the couch facing the television, not taking off my clothes. Anyway, he eventually comes to me and hands me a Black Label (beer), dick sort of dangling in front of me and Robert DeNiro and Christopher Walken shooting deer in the background. [pause] He stays there, and then I think to myself, “Maybe I’ve got to give him a blow-job.”

He’s gone limp, and so I sort of try and arouse him, but nothing happens. And I sort of, yeah, sort of wonder if it’s me. He turns and then watches *The Deer Hunter*. He then asks me to take off my clothes and get into the bath. And for some reason I don’t question that, and I start to get undressed. He leads me to the bathroom, and I ask if he wants me to turn the taps on. He says, “Just lie down,” and then he pisses on me. And then he turns on the taps and [pause] anyway, then I sort of get up out of the bath and get dressed, and I kind of say to him, “I think I’d better go now.” He sort of smiles and says he’d like to have fucked me, but maybe another time. And he kind of, lets me out.

So I walk out the corridor feeling a little bit shaken. I mean, I tend to shake during one-night stands, anyway, I’m feeling relief. I mean, the last time I got fucked was the first time I got
fucked. On a bunk bed in another flat in Hillbrow. Yeah, I was sort of, it was the first time I’d gone to a gay club, and it just felt frightening. All these men. [pause] And I’d come out a year before, so there was this, I suppose, desperate need to lose my virginity. Just get it over and done with. Anyway, my best friend from school took me to a club then disappeared. I felt like this is what I needed to do. [pause] It wasn’t dramatic. It took me a year after that to eventually go and get an AIDS test. Just at the Civic Center, on the other side of Johannesburg theatre. So, yeah. [pause] That year was…filled with fear. And you know, I still shake during one-night stands. [pause] Thank you.

At the point in the monologue when his character starts undressing, Jorrell slowly takes off his clothing, folds it and places it on the bed. He finishes the monologue in only a pair of white briefs, standing almost bare before us—this middle-aged white man whose skin is just beginning to sag. He has bright orange hair. I know him; I’d met him the year before doing pilot research.

This almost naked man before me, with his soft-spoken, hesitant voice, was very much like the real Jorrell I’d met the year before. Throughout the piece, I just kept thinking, “Is this Jorrel’s real story? Whose story is this? Is this fictional? Is this real? Oh, my God. I can’t believe this happened to Jorrell. Did this happen to him? This can’t be his story…right?” I was anxious, felt protective, and wasn’t sure what to do. The female started her monologue next, and it was obvious she was not telling her own story. My dissonance about whether Jorrell’s story was real or not only increased.

After the two monologues concluded, the female facilitator turned to us and asked us what we thought of the scenes. One girl immediately spoke up with a comment that mirrored my own thoughts. She said, “I don’t know, the Jorrell one, just the way he was speaking made me feel like, I don’t know. He was very vulnerable. And I almost wanted to go up there and hug him and tell him it’s going to be okay.” The female facilitator asked her when she first got a sense of that vulnerability. She answered, “I don’t know. It was very methodical, the way he was taking off his clothes. And the way he was speaking, it was almost [pause] childlike.” At the time, the facilitators didn’t reveal whether Jorrell’s monologue was his own story, someone
else’s, or fiction. It was only later that I discovered it was his story, his exceptional vulnerability, his sharing—his life.

In the workshop, I discovered the female’s monologue was pulled from the text of a book called *Smacked*, by South African author Melinda Ferguson. The text described the woman’s real-life experience as a dope addict in Hillbrow who traded sex for drugs. The particular scene recounted a gang-rape at gunpoint she had experienced, including her thoughts while it happened. The entire workshop took one hour and fifty minutes. The first 20 minutes were performance, description of how the rest of the workshop would be conducted and what its goals were, then time for us all to introduce ourselves. The final hour and a half was a conversation about sexuality sparked by discussion of our responses to the scenes, the song playing as we entered the space, and the hanging magazine images, but it transcended those initial prompts. The seven of us chatted about ourselves, our sexual experiences, and our thoughts about sex and sexuality. The facilitators had theatre games ready for us to play if the discussion faltered. It didn’t. Once the conversation got rolling, the seven of us kept it clipping along amidst laughter, embarrassment, hesitancy, and choruses of agreement and understanding.

The discussion kept returning to disconnect between head and body that people sometimes experience in their lives. The female facilitator noted about her monologue:

The reason she was there was to get dope. “I’ll let you fuck me, if you give me drugs.” So it’s one of those unusual kinds of situations that people can get themselves into. It’s that disconnection between the head and the body—and it was something we were starting to question. For me, that was also in Jorrell’s story, there’s an element of “what are we doing this for, and what do we get out of this??” Like in Jorrell’s story, it’s sort of putting himself in an uncomfortable situation with an unknown person. And why do we do that? Why do we do what we do?
She suggested we jump into the topic sideways by talking about something less intense. She asked us how we describe ourselves sexually—a one word description of how we are and how we would like to be.

The main commonality that emerged from all of the experiences shared was that none of us could comfortably complete that task—our sexualities were more complex than a one-word description would allow, and the other audience members were hesitant to even try. Mostly, stories of experiences or ideas about sex were shared. One girl noted that she wasn’t sexually active at the moment, but in general, she kind of thought sex was gross. Another girl shared, “Look, I know what I like, but my current boyfriend doesn’t like the same things. So while I like to be pushed around, bitten, and scratched, he’s very gentle. And sometimes that leads to unexciting sex. And sometimes he wants something, and I don’t, but I just do it anyway. So for me, sex is just, like, okay. I don’t really know what really great sex feels like.” A third audience member expressed anxiety over her own sexuality when it was compared to someone else’s: she noted that her current boyfriend is more experienced than she is, and she knows some of his past partners. They got into a conversation about sex with past partners, and she found out that a girl they both know, “this mousy girl, was an inner sex animal and like having sex with him all over the place, the university, where we live and walk every day. And then it’s like, ‘why are WE not doing that??’”

The rest of the discussion was spent unpacking these various complex, very personal experiences we all had. The following questions were introduced by Jorrell and the other facilitator: “what would make your sexual situation more satisfying? What element would make a difference?”; “how do we verbally engage with a partner?”; “how did you feel about the comparative nature of your discussion with your boyfriend?”; “what are some of the reasons you
choose not to be sexually active right now?”; “when do you feel sexy? How do we think about that for ourselves? What is our element? So, we produce sexiness—when do we do this?” And finally, Jorrell asked the big question again: “why do we do what we do?”

This vignette illustrates a typical applied theatre production in South Africa regarding content, form, practices, and aesthetics. The content focuses on personal narrative and stories related to sex, sexuality, drug use, sexual violence, interpersonal communication, insecurities, trying to understand why people make the choices they make or do the things they do, and related topics. The content privileges concern with individual thoughts, understandings, and feelings about thematic topics while placing them in relation to other participants’ similar sharing of personal experience.

The aesthetics set the tone for creating a safe space to discuss sensitive topics. The black box theatre is small, intimate, and devoid of any reference to the ‘outside world’ other than props that are symbolically linked to the content of the workshop. The magazine images invoke bodies, naked and sexualized. The twin bed, with its slashes of red pillows and mangled sheets, signals the potential weight of the workshop to participants who enter the room. However, the upbeat pop tune juxtaposed with these other production components introduces a sense of levity.

The theatrical form and practices associated with this production are ubiquitous among HIV/AIDS theatre in South Africa. Breaking the “fourth wall” to speak directly with audience members during the monologue is a common convention. The first actor, through the process of stripping his body bare of clothing, makes himself vulnerable in a very tangible sense before asking the same (figuratively) of the workshop participants. Many productions begin with some kind of heightened, formal theatrical performance (in this instance, monologues) and then move into a facilitated discussion that asks participants to share their thoughts and feelings. The next
step is to weave in cognitive reflection on real life experiences or the stories previously offered in the performance space. The next vignette further illustrates this potential of process-oriented applied theatre to elicit discussion of sensitive, confusing topics within the health intervention space.

**Noluvuyo’s Story: Violated**

About 18 people milled around the small black box theatre as I arrived. The director of the HIV/AIDS theatre intervention group had given me free reign to interview anyone who would speak with me, but he stipulated that in turn, I had to join the group’s weekly theatre workshop and theory classes. I’d met the participants only a week before, and all were seasoned actors and directors. That day was the second time I joined their workshop, and I hoped I could conjure old acting talent to avoid being labeled “that anthropologist who had no idea what she was doing.” As I placed my backpack in one of the theatre’s 99 seats, light filtered through the door and highlighted dusty footprints. Judging from their number, the space was well-used.

The director described the game we were playing that day. It was an “energy web game” based on identifying, understanding, and recognizing changing interaction, relational, and emotional patterns within a group of people. In addition, it was meant to encourage group bonding and expression of difficult topics. Being conscious of and responsive to such group energy is considered imperative for the kind of deep emotional and mental work required in many applied theatre exercises. The director marked a line across the room, with one side labeled Number 10 and the other Number 0. He told us that ten represented a positively joyous state of being. Zero was equated with a state of extreme negativity and distress. We were told to reflect on how we were feeling in that moment, state the number corresponding to our disposition, walk to a representative point on the line, and then describe aloud our state of being.
in one word. After all were finished, he would release us from our positions, and we were instructed to approach the person with whom we felt most connected and establish contact through some form of touch—our choice what kind.

We took turns. At first, I was paralyzed with indecision. I’d received bad news from home just 30 minutes prior. If I were honest about my state of being, I would have to allow these people access to parts of myself usually kept private. I heard a succession of statements: From a Zimbabwean who’d been unable to visit his family: “One. Disheartened.” From an HIV-positive woman: “Three. Tired.” From a young actor: “Nine. Sexy.” As people spread over the feeling spectrum and shared their personal moments, I was increasingly moved; their honesty compelled my own. My turn came. I trotted to a space between a woman from Lesotho and a man from South Africa and said, “Two. Damaged.” I felt proud of my openness until a woman I’d befriended took her turn and showed me what vulnerability really means within a theatre space. She was South African, 26 years old, and her name was Noluvuyo*. As she passed on her way to the end of the line, I saw the distinctive glint of tears in her eyes. When she arrived at her point, she said simply: “Zero. Violated.”

In a later interview with Noluvuyo, she recounted her experience of that game to me. She noted it would have been an understatement to say she’d had a bad day. Much like me, she had received very hard news from a loved one earlier. Her news, however, was related to a theatre game she had played the prior Tuesday. In that game, it was revealed that of all the other players (comprised of other HIV/AIDS peer educators), she was the only one who had never had sex without a condom. In other words, she was the only one with a perfect safe sex “record,” which was something about which she felt pride. She told me it was a core part of how she thought about herself and her place in the world (as a public health peer educator). She brought up the
game later that night with her current boyfriend and remarked on her surprise that others in the
group did not consistently practice safe sex. She said he was quiet at the time, and it was only on
the morning of the day we played the energy web game that he admitted there had been times in
the past when he had not worn a condom during sex with her.

Noluvuyo said she was still processing that information—what it meant for her, her self-
conceptions, her identity in relation to her job, her trust for her boyfriend, her trust in her own
judgment, and her health—when we began the energy web game. Until that morning, in her
mind she had been a woman with a perfect safe sex record. Then suddenly, unexpectedly, and
without her consent, that part of how she saw herself was taken away when her boyfriend
admitted not wearing condoms. Worse, in her mind, she became a hypocrite for advocating safe
sex and not practicing it. In our interview, she looked at me and said, “How could I not have
known that, Jess? Really. Don’t you, like, feel it or something? And the [pause] the semen
[pause] doesn’t that fall out? It has to feel different when there’s no condom. How did I not
know? How?”

Within the game, Noluvuyo said she immediately felt exposed when she claimed her
number as zero. Although the group had no knowledge yet of why Noluvuyo used the word
“violated” to describe how she felt in that moment, the response in the room was immediate.
Something I remember vividly was seeing the reactions of compassion emanate from the rest of
the people in the room. I saw empathy in their bodies, in their impulsive steps toward her, and in
their ensuing struggles to stay still, as per game rules. I experienced the same struggle to stay
rooted to my spot instead of crossing those two feet to hold Noluvuyo. When the facilitator
allowed people to move and approach the person with whom they had the greatest connection,
the overwhelming support and care for Noluvuyo was embodied and expressed spatially as 14 of us surged to connect to her through touching her face, shoulders, arms, waist, and back.

Noluvuyo’s verbal communication had been pithy, but the reaction it garnered spoke volumes. That reaction was rooted in people’s bodies, facial expressions, and geography. The map of our group’s energy in that moment centered on one person at the negative end of the spectrum and radiated out, with several people connecting to the homesick Zimbabwean. The facilitator then asked each person to explain why he or she chose the person to whom they were connected and to voice who else they might have chosen, instead.

Through such reflection and discussion, our group got a sense of why the energy web formed as it did and how it could have been different under other circumstances. The facilitator explained that in all theatre work, but especially in work dealing with HIV/AIDS issues, a group has to be cognizant of, open to experiencing, and constantly responsive to the emotional and mental lives of its members. Vulnerability, acceptance, willingness to care, and empathy are privileged and considered strengths in this kind of intervention space. Games like this one require and foster a level of openness and deep thought I have rarely encountered elsewhere.

In the moment when 13 people and I gave Noluvuyo our support and energy because of two words she had spoken, my mind flashed to the HIV/AIDS clinic mentioned at the beginning of this chapter. I couldn’t help but wonder how the young mother would have felt if she were standing in Noluvuyo’s place. What number and word would she have said, and how would those 18 people have aligned themselves in relation to her experience as expressed through voice, embodied demeanor, and spatial placement in the room? Would her questions and her vulnerability have been accommodated differently than they were in the HIV/AIDS counselor’s shipping crate that afternoon in 2005?
6.4 Unpacking Art and Subjective Complexity

These vignettes represent two of the myriad ways applied health interventions manifest in South Africa. When compared as strategies, they personify one of the most prominent debates within AIDS research and generate questions about which intervention paradigms are most appropriate for international and national public health campaigns and what kinds of knowledge construction and communication strategies best address health needs at national and local levels.

The characteristics of both of these productions illustrate commonly acknowledged reasons among South African theatre-makers and performance studies scholars for why artistic approaches to HIV/AIDS interventions are important: the ability of the theatrical form to provide a protected space for exploring sensitive topics and meaning-creation; a venue in which subject matter may be made meaningful to people on a personal, emotional level; the development of imaginative potential; the fostering of empathy and understanding; an experiential ethos; and a place for recognizing and creating alternatives. Additionally, some other significant reasons I heard during fieldwork for the importance of artistic approaches to HIV/AIDS intervention include their ability to revitalize the kinds of questions we ask about health, knowledge, and sexual experience; promote introspection; and push people out of their comfort zones and into deeper modes of reflection about their lives, choices, practices, and actions.

In general, there is an established literature on the importance of art in societies and human life (Morphy & Perkins 2006; Gell 1998; Svasek 2007; Schneider & Wright 2010; Marcus & Meyers 1995; Layton 1991; Langer 1955; Coote & Shelton 1994). A robust literature also exists in relation to ideas about what art, as a form, can do that other forms of public health prevention and health promotion programs cannot do (e.g. Dalrymple 2006; Middelkoop et al. 2006; Evian 1992; Chinyowa 2009; Stuttaford et al. 2006; Maritz 2004; White 2006; Low 2010). These ideas broadly deal with the ability of artistic interventions to encourage discussion and
critical thinking; personalize material; make topics meaningful to participants; empower and entertain people; combine affective, cognitive, and emotional aspects of an issue; and provide a powerful form of immediacy through live forms of performance.

Overall, my fieldwork observations tend to support these various theories on the importance of art in life, developing human relationships and intersubjectivity, communication, and meaning-creation. The theatre-makers with whom I worked, at all socioeconomic levels, ethnicities, and ages, tended to list similar reasons for why they think their work is important. There was also general consensus about what they claimed artistic live theatre practices can do for public health efforts that other forms of intervention (like biomedicine or even mass media campaigns) cannot. However, the theatre-makers also mentioned some ideas about the relevance of art that are not as prevalent in core theoretical texts on the value of artistic practices or that extend common claims.62

Through ethnography, I realized existential experience of HIV was identified by most artists as an important gap in current intervention measures that must be addressed in the future before any “real” kind of progress can be made in the country’s attempts to deal with its AIDS epidemic. In particular, artists were interested in the ways in which people experienced their sexualities and lives in relation to HIV as incoherent, or not fully understood. In fact, I often heard artists struggle to find words to capture what they meant when they talked about this realm of experience, and a ubiquitous sentiment about what constitutes it is echoed through the words of Peter, a 24-year-old black South African theatre-maker from Soweto: “Jess, this is about all those things we, as people and health workers, just don’t really understand.”

62 I elaborate and analyze some of these other ideas in the dissertation chapters that follow.
Both of the vignettes offer prime examples of the kind of gritty, confusing experiences theatre-makers are trying to highlight and work through within artistic interventions. For instance, in the story Jorrell shared in the “Sexually Yours” workshop, he noted that his first experience with a one-night stand instilled so much fear in him that he still shakes every time he has such an encounter—and yet, he continues to pursue one-night stands. The workshop was partly about parsing out that disconnect between his sexual actions and embodied reactions to them.

For Noluvuyo, the issue was less about contradictions between emotions and actions and more about trying to understand the implications for her self-identity of miscommunication about sexuality between her partner and herself. As a result of initial communicative ambiguity with her partner, which was later addressed as a result of direct discussion of her experiences in the theatre space, Noluvuyo realized her partner had failed to use condoms (without her knowledge) during some of their sexual activities. Her struggles to understand the situation and its bearing on her life could be heard in her repeated questions to me: “How could I not have known? How?? And what does this mean for me?” Although the answers to her questions were not revealed during the theatre game, the theatre process provided a space for her to begin acknowledging, voicing, and thinking reflexively about her life, actions, and emotional experience of violation (both sexual and trust).

Despite struggles among theatre-makers to outline the boundaries of this realm of experience, it was often simply called “complexity,” and artists had begun advocating its inclusion in public health programming foci as a response and challenge to hegemonic intervention efforts. This is a messy realm of experience difficult to access but identified by artistic public health workers as the next critical step in developing HIV interventions globally to
be more effective. What theatre-makers are trying to do with their focus on existential complexity leaves the realm of the sterile, straightforward, technological, and product-focused magic bullet approach to healthcare and enters the gritty, confusing, unmanageable, incoherent components of lived experience that contribute heavily to the country’s AIDS epidemic.

In some ways, the kind of work theatre-makers are doing begins to answer João Biehl’s (2011) recent calls for a greater infusion of subjective-oriented analysis into scholarly and policy attention to HIV/AIDS. Instead of normative health promotional lecturing to audiences, theatre-makers are starting to deeply mine the very real subjective experiences of themselves and their audience members. However, it is important to note that “complexity” for theatre-makers does not index the entire range of subjectivity. Rather, this is a particular kind of subjectivity and a specific sub-set of subjective experience: the incoherent “really real.” This is about theatre-makers attempting to communicate, capture, and theorize complicated realities that individuals struggle to face or make sense of on their own: the contingent, ambiguous, and dynamic.

Theatre-makers have begun using “complexity” as an analytic to reveal information about the ways in which people experience their realities as messy, ambiguous, fluid, contradictory, and unknown. I suggest a complexity framing can serve a similar function within anthropology. The complexity framing opens up considerations of how people find their own language to talk about their experiences of incoherence and strategies for handling it rather than simply mining the ways in which people are constituted or confined by categories of expert discourse (as in Foucault’s archaeology of the subject). In the particular case of theatre-makers involved in health initiatives in South Africa, I noticed a pronounced effort to develop language to talk about and methods to access incoherence in lived experience.
Two constructs of complexity that were repeatedly invoked to avoid reductionism, subvert binaries, and attend in more nuanced ways to how people experience their lives in relation to social, economic, and political structures were “moments” and “shadows.” In the rest of this chapter, I provide ethnographic data and analysis on the ways these two constructs are used by theatre-makers to functionally navigate complexity in relation to sexuality and health in HIV intervention programming. This kind of interrogation into how individual actions are shaped by existential experiences of incoherence is not limited to the South African context or even to HIV/AIDS research. It is applicable in a broader way to people who live in unstable environments or have experience with a variety of acute and chronic conditions.

6.5 Theatres of Moments and Shadows

During fieldwork, I realized theatre-makers were attempting to more directly address existential complexity through development of two conceptual constructs designed to engage with, access, and explain the messiness of human experience: “moments” and “shadows.” Theatre-makers used “moments” to talk about issues of temporality associated with lived experience of HIV and “shadows” to index the kind of incoherence I have discussed in this chapter. I argue for the consideration of the local constructs “moments” and “shadows” as both analytics and theoretical concepts that are potentially productive within scholarship about HIV/AIDS. In particular, I suggest that theatre-makers in South Africa use these two concepts as a way to work around some of the limitations of dominant biomedical, public health, and anthropological approaches to HIV intervention research and development globally. At their

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63 Although there are many different ideas theatre-makers use to come to terms with the messiness of human experience, I chose to ethnographically focus on and theoretically develop these two constructs (moments and shadows) because of the exciting potential I see for them in development of future HIV/AIDS interventions and because they were two highlighted, often-discussed ideas among the theatre-makers with whom I worked in the field.
core, these two constructs are conceptual tools theatre-makers use to understand how people make meaning about illness, health, and sexuality in ambiguous worlds.

One of the main ways to examine these notions of “moments” and “shadows” is to look at the range of ways theatre-makers speak about them in relation to their artistic work in South Africa. The following two sections of this chapter present ethnographic data elucidating the various valences of these constructs and their relevance within applied health theatre.

**A Theatre of Moments**

During fieldwork, the idea of “moments” captured my attention. Moments have multivalent meaning within theatre-making in South Africa. This concept was repeatedly invoked during my participant-observation with theatre groups and also in interviews. When talking about how theatre related to HIV/AIDS can impact audience members, artists often referenced moments: being “in the moment,” moments of clarity, the fleetingness of moments, risky moments and moments of excess, life-changing moments, the impact of moments, finding moments of truth. If people were not speaking directly about moments as a concept, they were describing important moments—their own or others: moments that changed the way they thought about things. Moments that made them feel, remember, or consider HIV/AIDS. “Moments” became integral to framing experience in relation to theatre and HIV.

As I continued fieldwork, “moments” became a pervasive part of the discourse theatre-makers used to talk about the relevance of their own work, as well as their ideas on HIV intervention innovation. I suggest that the relevance of “moments” can be extended from theatre practice to broader social science engagement with HIV/AIDS. In particular, in this section of the chapter, I analyze the utility of “moments” as a conceptual tool for anthropologists to engage the more subjective, lived experiences of HIV in our attempts at holistic analysis of AIDS.
epidemics (i.e. integrating the subjective). “Moments” become a way to integrate medical anthropology and performance studies: the goal is to contribute to interdisciplinary theory and practice related to health communication and knowledge production about HIV/AIDS.

To ground this section’s discussion in data, I include quotations of theatre-makers speaking about their conceptualizations of “moments.” One major way moments were invoked in these conversations was in relation to ideas about the impact of theatre as a health intervention. The idea of “moments” was consistently mentioned in close relationship with broader discussions about affect, aesthetics, and meaning-making.

Moments and Impact

In the ways theatre-makers discussed the impact of their work on audience members or the impact of life on them, “moments” came up often in conversation. Primarily, theatre-makers spoke about how to make moments meaningful within an intervention and how to understand or think about moments within plays that people had found meaningful in the past. This first body of discourse on moments deals with intention and ideas about how to produce affect (in an effort to produce impact) within theatre productions—basically, how to make moments meaningful. The second body of discourse on moments and impact focuses instead on thinking about how people have experienced the theatre-space in the past and whether they later remember those

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64 This idea of “making meaningful” was often related to the idea of “resonance.” In a sense, theatre-makers are concerned with producing a deeper than cognitive effect on audience members, which is often called “resonance.” Resonance combines cognition with affect and the senses. Theatre-makers often asked the question: how do we get audiences to resonate with this concept, production, message, or memory? For the artists with whom I worked, impact occurred in moments, and moments were made meaningful within the theatre space through resonance. These ideas about affect, moments, and resonance were also intricately bound to ideas about “intuition.” Unfortunately, the artistic literature on resonance and the anthropological literature on intuition fall outside the scope of this dissertation. The link between affect and intuition within the theatre-space was considered a key component for producing impact in theatre interventions and will be a productive place for future academic interrogation. I will follow-up on both of these topics (resonance and intuition) in later publications.
experiences. This second focus is on recognizing the potential limits of moments of impact within artistic interventions.

Here, I present four examples of how theatre-makers talked about “moments” in relation to impact. The first three are related to ideas about how to make moments meaningful: relinquish interpretive control over moments; take adequate time and care to let moments develop within theatre productions; and make moments personal, specific, and part of a life story versus general educational messaging. The fourth example notes the limits of the impact of moments within theatre.

MOMENTS AND AMBIGUITY: “Why must I control every moment?”

A majority of the theatre-makers with whom I worked talked about the need for taking great care with presenting moments in performance. Part of this care had to do with allowing certain moments to be presented without didactic dialogue acting as a closed interpretive box. In effect, this meant allowing some measure of ambiguity into certain moments onstage and giving up some measure of interpretive control over them in deference to audience interpretation. P.J. Sabbagha, one of the choreographers of Deep Night, said to me:

There are always moments in every piece that remain ambiguous, and that ambiguity is part of its beauty, is that it’s not defined. And sometimes I watch, I’ll be in a rehearsal and watch something that I’ve seen a hundred times and suddenly it could make sense and the next day it just won’t make any sense at all. And I’m prepared to allow something to go onstage that I don’t properly understand because I don’t know what the audience is going to understand. And so I allow that kind of thing to happen and I allow performers to bring something that makes perfect sense to them but absolutely no sense to me because that’s their perspective and an audiences’ perspective is not necessarily the same as my perspective. So why must I control every moment?

In this view of moments, P.J.’s final question rings the loudest: “why must I control every moment?” He reminds us that giving up some amount of narrative and interpretive control within interventions is important for creating room for unexpected types of impact and for
allowing audiences to make meaning out of what is presented onstage in a way that is relevant to their lives. In this perspective, ambiguity or leaving interpretation of the content open are considered strengths of productions in contrast to the more rigid promotional practices of hegemonic public health campaigns.

AESTHETICS AND CARE: “Indulging in the Moment”

In addition to being willing to give up control over every moment and allowing some ambiguity to remain, other theatre-makers noted the importance of highlighting and showing with care personal moments in the lives of characters as entry points to considering lived experience with HIV. This care had to do with presentation of deeply personal life moments (sometimes real, sometimes fictional) in a public space and with shaping the aesthetics of that presentation—taking the time to let the moment develop. Charmaine, an actor from AREPP, discussed this in her description of how the play in which she was cast failed to give that kind of care and development to a moment of importance in her character’s life—the moment when the character read the results of a home HIV test:

In theatre, less is more. Basically that’s what I learned in tertiary (education). Less is more. You don’t need to, for a person to really think you, they don’t need to say “I’m safe”—you can just see their actions. Even signs. Just some sort of action will [pause] You know, I think less is more. It doesn’t need to, it’s like, theatre is not the same as TV. With TV, you know you must show that stuff, I’m going to the cameras, going out, chasing a taxi, or going into the car, going back at home, then looking at the AIDS test kit, testing, you know? With theatre, theatre is there. The now. You know, you just need to read that thing. People don’t even need to know that I’m HIV positive. Like, if you go through the whole process, if you start the story, like the drama from beginning till end, you learn that “Oh, that person’s got the AIDS home test kit now, it’s not the pregnancy test, you know?”

And unfortunately they don’t see that it’s the HIV test kit, but then one actor says, “No, it’s a home AIDS test kit.” Just that—that, it’s enough. That is enough. Her being there, reading this. I think we could have at least had a bit of a moment with her going onstage and reading that thing, maybe just having that moment of ‘what am I going to do?’”, like that one moment when people are alone, that private moment, to see what happens to them when they get tested, you know? Just that private moment, just them by themselves.
and then taking the pill, deciding to take the pill (to commit suicide). Like, hopeless. That hopeless moment. If we could have indulged in that moment. But I guess because of time and you know, it’s limited. This whole thing. So, yeah. But I think that was enough. We didn’t need more than that.

For Charmaine, HIV interventions must try to capture and carefully portray moments of subjective experience in people’s lives. In this particular instance, time within the play was not given to that moment to allow it to fully develop, and Charmaine noted the scene felt rushed, which probably made it harder for audiences to connect. In the play, the character goes from testing for HIV at home to committing suicide in less than a minute. In essence, not allowing moments to develop onstage is a disruption of the process of resonance.

**STORY-TELLING AND THE PERSONAL: “Hidden Moments”**

Another way theatre-makers discussed the impact of their work in relation to moments were the moments within plays that affected viewers. People often mentioned “moments of clarity” or referenced how certain moments within a play had made a life-long memory imprint. Those moments, heightened through performance, were characterized as marking something and making it memorable. In addition, it was very common to hear theatre-makers talk about needing to move away from educational messaging and toward story-telling focused on particular events in the lives of people affected by HIV.

In one interview with an actor (Butholezwe*) from a community theatre group in Nyanga Township, Cape Town, he noted that theatre should be used to tell the stories that have not yet been told—to reveal the hidden moments of the AIDS epidemic, not just old educational messages. For him, this was central to combatting the perceived Culture of Silence around HIV and sexuality in the country. Butholezwe stated:

Yeah, it’s one of the moments that we have to show! Because, take for example, these people they’re going to our homes when it’s times that we are going to vote, and they want to educate us about politics and “why we have to vote, ah, I don’t care about vote.”
And most of the people they don’t vote because they don’t care about it because they don’t know nothing. It’s similar to HIV. HIV knowledge is not that bad. People are accepting very easily now because of why? I will tell you one story, there was a lady who was HIV negative, he cried. I said why? “I wanted to be HIV positive.” Because why? “I’m going to get the drugs. I’m going to get that money,” do you understand? So it’s one of those stories! You understand? I’m serious. And some of them say, “Ngodani, because I’ve got to get that money and stuff like that.” So, some of them are very greedy. Just to get that money. So, it’s one of those things we really really really need to show, not only just making those (educational) speeches and stuff like that, just go to the people, you understand?

For the actor, theatre is not just about making speeches; it is about finding “one of the moments we have to show.” In this case, that is the moment of someone finding out her HIV negative status and being upset rather than relieved because her status then precludes her from receiving government grant money. So, these are moments of personal life that the actor considered not often discussed in South Africa but that need to be shown. For the actor, instead of general educational messaging, making the stories specific and personal is what will enable audience connection to the story and the likelihood that it will be remembered in the future.

TRANSIENCE OF MOMENTS: “I will never have sex again.”

A fourth way “moments” came up in discussions of impact with theatre-makers was in reference to their transience. In this framing, moments of impact within plays could have strong effect on people in the moment, but those moments of affect could also be fleeting and disappear in a moment. In discussion with Chuma*, a 27-year-old Zimbabwean actor from the Drama for Life program, he spoke about the space in which theatre related to HIV takes place, how to measure impact, and also of his own realization that the impact theatre has can be temporary:

I remember, you know the Make Art/Stop AIDS thing? We went to an exhibition in Newtown, so there were these pictures of dead people in coffins, people who had died of HIV, of AIDS, I’m sorry and oh, some scary pictures. So I was just talking to these guys that were doing all that, and eish! They said, “I don’t even want to think about even all these things again,” but then afterwards I was talking to them and they were saying no, just because you’ve seen the pictures now, it hits you, it had an impact on you right now. But the moment you walk out of this space, it’s gone. That thing you were saying, “I will
never have sex again,” but you walk out of the space the next thing you say, the next person passing by you, you’ve forgotten about those images already. So that’s, then one of the guys was talking, saying something interesting, that probably with such issues or so, you don’t really have to get feedback immediately after. Because probably people are still in the moment, so it might affect them then, but after 15 minutes, it’s gone.

So with this, the idea is that audience members can be strongly affected in the moment but lose that emotional or cognitive connection to the play’s material outside of the performance space. Some theatre-makers also related this transience of affect to moments of life—both impact and life can change in a moment. Here, recognition of the possible limits of impact within theatre is made explicit by Chuma through reference to the fleetingness of affect. In this perspective, the idea of moments is tied to how people experience the theatre-space: in moments.

This view corresponds well with a finding in my research. In general, from the audience interviews I conducted, people tended to remember particular moments of plays or their experiences/thoughts/emotions while watching or participating in the theatre intervention. Rarely did audience members remember entire plots of stories, names of productions, where or when they saw the production, who the performance members were (actors, groups), or in what context they saw plays. Rather, affective moments stood out and were recounted in their stories to me.

“Moments” as a Construct

Ethnographic examination of “moments” within theatre reveals how some artists are attempting to introduce additional foci to public health agendas. In particular, I suggest artists were using the concept of moments to advocate shifting the temporal optics of interventions. For theatre-makers, “moments” is a multivalent concept that indexes a range of ideas all related to the notion of pulling policy and intervention gazes from the distant, unknown future to the now: the present moment. The construct “moments” provides a way for artists to look at the
experience of incoherence in a temporal frame that is manageable. It is a unit of analysis of lived experience.

What does engaging with this unit of analysis reveal in relation to HIV? As an analytic frame, the idea of “moments” calls attention to temporality and performs the work of addressing temporal disjuncture common within public health interventions. Instead of narrowly limiting questions about what kinds of impact interventions can have to future “behavior change,” theatre-makers advocate opening up consideration of impact to include thinking about how HIV programs intervene meaningfully in the present. Using the construct as an analytic sometimes reveals what is important to the person who experiences the moment—how they feel about that moment and what (if any) enduring relevance it has in their lives. So, for the population with whom I worked, this construct is about thinking through whether, how, and what kinds of impact moments of lived experience have in people’s worlds.

This is potentially important in situations when anthropologists are trying to understand how and why the quotidian becomes meaningful to people. This construct provides a way (for both theatre-makers and anthropologists) to talk about and tell the stories of how the everyday can become particularly relevant in lives. Regarding HIV, the “moments” construct tells us things about the way people experience time in relation to illness, gives us a way to talk about important temporal dimensions to people in their lives, and reveals information about processes of meaning-making that surround health and sexuality. In addition, it provides a vehicle for more explicitly bringing in and talking about emotions, affect, feeling, embodiment, subjectivity, individualism, and particularity within intervention practices and research. A common question among theatre-makers was “how do you feel in this moment of your life?” and was asked as a
way to pull in affective consideration of people’s relationship and reactions to their environmental and structural contexts.

For example, the energy game mentioned earlier is a strategy (or method) used by theatre-makers to prompt participants to focus on their thoughts, feelings, and concerns in the exact moment their turn comes to choose a position on the line. The energy web formed near the end of the game is a snapshot of how that group of people connects and interacts at that time; it may change in the future (indeed, the after-game reflection is designed to get participants to think about how the web could have been different and why). So, the game is about shifting the optics of intervention to examining what is occurring in people’s lives in that moment. The game calls for deep vulnerability and honesty. In doing so, it urges participants to speak up about concerns in their lives they might otherwise sublimate or avoid mentioning to others.

Noluvuyo’s story illustrates this. The game is designed to allow someone like Noluvuyo to be as vulnerable and honest as her comfort level dictates. The game does not require her to divulge all of the details behind her story or her choice of adjective and number. If she chooses to share that information with the group during reflection time, that is encouraged. The game itself simply makes room for expression and consideration of the complicated, messy, contradictory, or not fully understood aspects of what is going on in someone’s life at that time. Noluvuyo did not even know how she felt about what happened with her boyfriend; however, she intuitively felt like her boyfriend’s admission about the lapse in condom use held great significance for her and would probably change the way she thought about herself and her work as an HIV peer educator. Theatre-makers, much like other HIV intervention workers, struggle with finding a language to talk about these messy, not fully understood parts of lived experience.
In this chapter, I suggest “moments” is a potentially useful conceptual construct for social theory. In particular, I posit the broader anthropological relevance of using the “moments” construct is deploying it as a framing device to talk about and analyze critical moments in people’s lives as they relate to ideas about the future and the past. This is a framing device for integrating levels of temporality within anthropological analysis. It is a concept that calls to us as researchers to retrain our optics on both the present as-is and the relationship of the present to other temporal domains (e.g. the past and the future). In a way, the construct “moments” is an intentional way of thinking through lived experience—it is a framing device for looking at event-driven phenomena and integrating temporalities in that analysis. This is not a revolutionary idea, but it is an intentional, directed one. In this way, it bolsters our ability to avoid potentially disruptive temporal dichotomies in research and writing.

As a theoretical concept, the idea of “moments” is an attempt by theatre-makers to engage with people through a temporal framework that reflects how many theatre-makers believe people experience their lives: through moments. This is not a prescriptive framework suggesting that people only experience life through moments; however, use of this language and framing is an explicit and ever-present recognition of the possibility of mutability in people’s lives. The construct is used by theatre-makers as a way to keep dynamism and fluidity at the forefront of intervention worker’s minds when they think about the goals of their programs and the processes they put in practice to accomplish those goals. Intentional use of this term is an active way of framing experience: it does not allow people to forget the mutable components of lived experience or of the sociopolitical contexts in which people’s experience is located and shaped.
A Theatre of Shadows

The second complexity construct I present in this chapter is “shadows.” For theatre-makers, the construct “shadows” is a conceptual label for demarcating the boundaries of the kinds of incoherence in lived experience to which they privilege attention within their artistic HIV interventions. In this way, “shadows” are simply the collection of actions, thoughts, and feelings theatre-makers index as incoherent (which is a component of complexity). In their attempts to define and set parameters for the parts of complexity indexed by “shadows,” theatre-makers gave examples that fell into four main categories: (a) the contradictory; (b) the hard-to-face, handle, confront, or say; (c) the unknown, the unsaid, and the unacknowledged; and (d) the confusing, not-fully-understood, or ambiguous. The “shadows” construct provides a linguistic starting point for talking about the incoherent parts of human experience—establishing what

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65 This is a designation I have given to a local concept many theatre-makers discussed during my fieldwork. Multiple artists used the idea of shadows, gray areas, contrasts of light/dark and acknowledged/unacknowledged in a variety of ways, either through language, metaphor, or actual use of shadows within their productions, to invoke a kind of existential incoherence people feel in their lives. There was even one theatre-maker who explicitly referred to the range of ideas artists used to express the kinds of actions, thoughts, and feelings that hover at the edge of the visible and understandable as “shadows.” I use this evocative description as the concept name.

Also notable is the difference between the way theatre-makers talked about “shadows” and references by Carl Jung (2011) to “shadows.” For Jung, shadows were linked to ideas of the unconscious, repressed desires, and intentions in people’s psyches that are often indexed in some way as negative or that should be “integrated.” In contrast, theatre-makers talk about shadows in relation to a much wider range of actions, thoughts, and feelings but explicitly without a negative connotation. For the artists with whom I worked, “shadows” was more about interrogating gray areas of understanding or metaphors about bringing topics from darkness into light than it was about repression or negativity. In addition, while Jung advocates in some ways integrating shadow parts of people’s psyches into their conscious reflections, artists sometimes encourage but do not privilege that kind of integration.

Although I have chosen to highlight and analyze this concept of “shadows” in this dissertation, I have some reservations about its utility as an analytic or theoretical concept because it is so inclusive. Also, what is considered shadowy practices or emotion in one locale may not be considered shadowy in another. However, theatre-makers returned again and again in their work to addressing parts of human experience they considered shadowy and therefore problematic in their hiddenness or their incomprehensibility. Therefore, I think it is important to pursue a critical analysis of how theatre-makers think about this category of actions, emotion, and thought and its relationship to public health interventions, despite the concept’s possible limitations. I see it as a starting point for “dealing with” what is hard to deal with.
those incoherent parts of experience are and why they are important to understanding people’s sexualities and ideas about health.

Theatre-makers use this concept to shift intervention optics to incoherent realms of lived experience in order to figure out their effects on HIV prevalence rates and people’s emotional everyday states. For many theatre-makers, the “shadows” concept was considered a critical point of potential public health intervention that not many other kinds of interventions privilege or review. In this section of the chapter, I describe how theatre-makers define shadows and what impact intervention focus on shadows can have.

**A Language of Shadows**

During my fieldwork, I witnessed theatre-makers actively struggling to develop a vocabulary for talking about complexity and messiness in lived experience. For the artists with whom I worked, “shadows” in relation to complexity was an inclusive term that spanned a wide range of human action, thought (or disruption of thought), emotion, and intuition. Shadows were considered implicated in the failure of public health interventions based on theories of rational choice, logic, risk assessment, and decision.

When theatre-makers touched on this idea (if not the term itself) in interviews and daily discussion, their discourse was initially amorphous: “all those things we don’t understand.” They were attempting to figure out what kinds of things have proven difficult to address within HIV/AIDS intervention efforts in the past and identify possible points of failure or break-down. Theatre-makers were asking the following questions: where are our efforts being stymied, and why are they not working? This was often expressed in the ubiquitous cry by theatre-makers of “why do people do the things they do?”
An example of this was when P.J. Sabbagha talked about how his theatre collaborative came up with the concept for their HIV/AIDS-themed production *Deep Night*. When I asked him what the piece was about, he stated:

With *Deep Night*, for me it was just about a lamp post in the middle of the night. And what happens underneath the lamp post. And that was the starting point. And then I kind of looked back at my own life and looked at the city and then it kind of, the look and feel and the direction of the piece grew. Very—yeah? Look, I mean, *Deep Night* comes for me from just having lived in the kind of seedy belly of the city, and I know how this city operates and how people, young people behave and carry on. And in a way for me what always amazed me is that it was easier for people to have anonymous, unprotected sex than talk to someone about HIV. The one, just mentioning HIV was far more threatening than screwing somebody in the dark, nilly willy. You know? So the level of risky behavior for me, it just, the balance, it all has to do with drug culture and it has to do with clubbing, and it’s the same all over the world. So for me that was, that’s very interesting. And we all know that moment of excess, whatever it is, whether it’s an orgasm or whether it’s too much to drink or whether it’s four nights partying non-stop, of trying to retrieve yourself. Recover yourself, hang on to your sense of self in some way. So for me *Deep Night* is a lot about that. Oh, it’s just kind of ‘oh my god what’s just happened?’ and not in a judgmental way, but in a feeling like you’re falling through yourself and you need to just hang on in some way.

The performance piece focuses on trying to capture grand themes like lust, loneliness, rejection, and the desire to belong and to be loved. Sabbagha states, “This tiny, sophisticated virus permeates our minds; bodies; and hearts, revealing the bleakest and most beautiful layers of our humanity” (Van der Merwe 2010). For Sabbagha, the impetus for creating *Deep Night* was to interrogate aspects of lived experience that people find difficult to fully comprehend, acknowledge, or understand within their usual frames of reference.

For example, he mentions how difficult it is to reconcile the idea that some people find it easier or less threatening to have sex with strangers in the dark somewhere than to simply ask their partners in one sentence whether or not they have been tested for HIV. This component deals with the aspect of shadows indexed as the “silenced,” the “unsaid,” or the confusing. He also mentions an example of times in people’s lives where they feel cognitive disconnect borne
of intense emotionality or circumstances: when people are so intoxicated by substances, by desire for companionship and intimacy, seduction, sexual desperation, or by fear of being alone that a solid grip on consequence is lost—those moments when protection against HIV is not on a person’s mind or simply holds equal value with other considerations. This links back to the part of shadows theatre-makers cite as the “hard to confront” or “ambiguous.” Finally, Sabbagha invokes a more existential component of shadows when he references the struggle some people experience after “moments of excess,” in which they have to recover and stitch back together their senses of self. This connects to theatre-maker ideas of shadows as the parts of people’s experiences that are disjointed and not-fully-understood.

“Shadows” as a Construct

The “shadows” construct operates in a less theoretical and more practical realm than “moments”: it is less about creating a conceptual construct to avoid dichotomy in analysis and rather more about creating conceptual space to define complexity. It indexes the parts of human experience that are hard to understand, categorize, parse out, admit, or address—the contradictory, the little understood, the hard-to-face, and the uncomfortable.

As an analytic, the concept of “shadows” is used by theatre-makers to call attention within interventions to all of the gray, messy, difficult, and complicated parts of human experience that conventional HIV/AIDS programs tend to either minimize or have trouble addressing in a substantive way. For theatre-makers, the analytic gaze of “shadows” is not necessarily a bid to move practical intervention focus away from prevention and education about the biomedical aspects of HIV and the AIDS epidemic, but it is a challenge to insert or start privileging equal attention to the unknown and the messy.
In addition, this complexity construct is often put to work within HIV theatre in South Africa as a way to disturb the simplistic and moralizing language commonly used within media and global health programming depictions of HIV and sexuality. It is used as a conceptual place-holder to talk about incoherence related to sexuality and health without falling into reductionist, moralizing language. Although what counts as a shadow varied depending on the artist being interviewed, one goal often explicitly linked to investigation and discussion of shadows was contesting stigma, shame, internalized social judgment, and the culture of silence around HIV/AIDS that is still pervasive in South Africa. I analyze this function of “shadows” in further detail in the next chapter.

As a theoretical concept, the idea of “shadows” is simply an effort by theatre-makers to produce language for talking about difficult parts of human experience. It is a kind of category place-holder for existentially complex experiences that are not fully understood even by the person experiencing them. The concept is a challenge to conventional public health wisdom that everything can be known, broken down into parts, figured out, and dealt with in a logical manner. “Shadows” operates as a challenge to received ideas about intervention programming that operate on the basis that humans are always or primarily logical (in any definition of “logic,” not just Western logic) and consciously calculate risks—or even think about them. It is an acknowledgment that there are parts of people’s lives that interventions have trouble accessing, dealing with, and addressing partly because the people who experience them do not fully understand, recognize, or even want to acknowledge them. It is also a call to action to develop methodologies within intervention practices that better grapple with aspects of people that are considered shadowy. This use of “shadows” is also developed further in the next chapter.
6.6 Discussion: Complexity and New Agendas in Post-Apartheid HIV/AIDS Intervention

For decades, anthropologists and public health scholars have been trying to parse out the complexities around risky sexual practices, sexual behavior (and the logics surrounding it), decision-making processes in relation to interpersonal relationships, and generally—why people do the things they do. Ethnography on HIV/AIDS has led to insights about how macro-processes and institutional structures enable and constrain the lives, choices, possibilities, and actions of individuals (e.g. Farmer 1992; Vidal 1996; Campbell 2003; Fassin 2007; Lurie et al. 2003; Fourie 2006; Kerrigan et al. 2013). Medical anthropologists have made inroads into theory about structure, agency, and the concepts of choice and risk (Parikh 2004; Parikh 2008; Mol 2008; Beckman 2013; Susser & Stein 2000). They have also made progress in examining how people’s social networks and peer groups influence their actions, thoughts, and perspectives on sexuality, loss, gendered vulnerability, poverty, decision-making, traditional healing, and bodily/mental health (e.g. Setel 1999; Dumestre & Toure 1998; Parikh 2008; Parikh 2007; Ngubani 1977; Campbell 2003; Schoepf 2003; Falola & Heaton 2007; Van Hollen 2007; Buffington et al. 2014; Simmons 2012; Van den Borne 2005).

However, medical anthropologists have begun rethinking how best to frame their work to reflect increasingly complex and dynamic political, moral, and knowledge economies of global HIV/AIDS. At the AAA 2013 Conference, I attended all of the major AIDS and Anthropology Research Group (AARG) meetings, and a theme that quickly emerged was the idea that medical anthropology is experiencing a crisis in its HIV/AIDS scholarship. Although some HIV scholars consider the field to be thriving, many others are beginning to express concerns about future directions. Overall, recent discussion within AARG has focused on identifying patterns and trends in anthropological work related to HIV/AIDS.
A key component in this process is exploring the role anthropology can play in future efforts to stem the effects of HIV globally, including reducing transmission rates, mitigating impacts, and revitalizing the kinds of questions asked about HIV within broader global health literature\(^6\). Although anthropological contributions to world understanding of AIDS epidemics have been significant, scholarship is needed that continues to push the boundaries of the types of questions we ask about the epidemic. This includes asking the following: what are the most relevant questions for contemporary contexts, and what kinds of theoretical frameworks are best suited to intervention development in a world where living with HIV long-term is becoming as common as dying from AIDS-related causes was 30 years ago?

As I discussed previously, one framing particularly important to the artists with whom I conducted fieldwork focused on the idea of complexity. Anthropologists have long characterized human experience as complex and advocated for research and intervention paradigms that reflect this premise; however, in the spirit of revitalizing social science approaches to HIV/AIDS, I think anthropology’s engagement with “the complex” can be productively pushed further. Particularly within medical anthropology, the issue is not whether scholars address complexity. Medical anthropologists recognize complexity, dynamism, and the messiness of life and describe particular cases of complexity in vivid detail through ethnography and life histories\(^7\). At issue is how medical anthropologists talk about complexity. Within the

\(^6\) This discussion was also part of another recent conference: http://www.sil.org/about/news/role-anthropologists-hiv-aids-crisis-conference-discussion. Although it is impossible to gauge whether this group of people speaks for a large constituency, it is noteworthy that several conferences over the past 10 years have been dedicated directly to this topic, panels within larger conferences have focused on the issues just mentioned, and these questions have been raised within anthropological scholarship on HIV/AIDS over the past decade. An in-depth discussion of that scholarship is located earlier in the dissertation (Chapter 2).

\(^7\) For examples of detailed ethnography and life histories that engage with social, psychological, structural, and affective complexities that surround HIV/AIDS, see the following: (Biehl 2009) on the political-economy of pharmaceuticals in Brazil and the personal lives of those affected by treatment programs; (Lepani 2012) on sexual
anthropology of HIV in particular, there is widespread tendency to acknowledge complexity, but
ethnographies that move beyond its recognition to engage in a deeper, more systematic way with
the concept itself are not as common.

While it is exceedingly important to acknowledge the basic premise that life is complex
(as are sexuality, health, and illness), there are further questions to ask: what do we do about that
complexity? How do we access it, talk about it, and analyze it? Can it be studied
systematically? What do we mean when we use this term—what does it index or define? How
can complexity be studied and for what ends—who is studying complexity and under what
agendas? Ethnography of applied health theatre in South Africa allows us to gain
anthropological insight on how artists think about complexity in life and its relationship to
health, healing, illness, and sexuality. These insights illuminate some of the stakes of complexity
research and how disparate academic fields can creatively contribute to new frameworks for
understanding and intervening in global epidemics.

For the artists involved in this project, talking about complexity was an instrumental way
to change the optics of interventions from imparting biomedical knowledge about known
HIV/AIDS risk to topics they considered left out of conventional programming: existential
incoherence, the unknown, and the deeply subjective components of lived experience of HIV.
This was an active attempt to add new components to HIV/AIDS intervention agendas in the
second decade after democracy. However, they were struggling to find vocabulary to discuss,
capture, and portray these topics. For them, “complexity” as a concept provided an entry point for analyzing subjective experience. “Complexity” was variously defined as mutability in experience; the unknown or confusing; and the complicated ways cognition and affect intertwine in the parts of human lives often discursively constructed as interior and difficult rather than outwardly known and easily expressed.

Overall, I argue in this chapter for the importance of attention to local understandings of complexity and the language people use to talk about it. From this, I advocate developing an analytic complexity framing for medical anthropology as a potentially productive tool in social science research. This framing is distinguished by its push to place complexity-as-such at the center of analytical attention. The framing expounds the attributes of complexity, the implications of it in human lives, and directs attention to the variety of ways groups of people think about complexity and for what reasons this term is invoked. The goal here is not simply to recognize that complexity and messiness exist; that interventions must do something about them; or to stop at description of particular cases. What a complexity framing contributes to HIV/AIDS research is an intentional focus on complexity as a primary analytic instead of an incidental contextualizing factor in the persistence of HIV globally. Additional goals are the development of vocabularies for talking about complexity and exploring the possibilities of its use to bridge humanistic and scientific approaches to research and intervention.

In this chapter, I have analyzed how theatre-makers engage with the messiness of life in relation to HIV in South Africa. I have also presented ethnographic data on two different constructs theatre-makers in South Africa use to engage with complexity in lived human experience\textsuperscript{68}: moments and shadows. Through the constructs “moments” and “shadows,” artists

\textsuperscript{68} In particular, how it relates to thinking about sexuality and illness within public health interventions.
make explicit their theoretical concerns with issues of temporality and incoherence in lived experience. From how theatre-makers think about impact to how they structure the aesthetics through which they frame HIV/AIDS, these two constructs are integral to the goals of applied health theatre in the country. Both are implicated in theoretical and practical stakes associated with the HIV/AIDS-related healthcare industry in South Africa.

Two areas of study I consider particularly relevant to ongoing public health and anthropological engagement with HIV/AIDS are subjective experience of the unknown and the links between systems and experiential complexity. Discussion of these two topics reveals how thinking through the “moments” and “shadows” constructs may be useful in the cross-disciplinary growth potential between the fields of medical anthropology, performance studies, and public health. I argue that focusing on complexity as an analytic is useful for creating a language for talking about the grey zones (Bourgois 2009) in social systems and subjective experience that replaces dominant, reductive vocabularies. This becomes critically important at policy levels: vocabularies are needed to talk about the global HIV/AIDS pandemic in ways that keep open considerations of uncertainty, incoherence, and the messiness of life instead of shutting them down because they are difficult to address, quantify, or examine.

The Not-Fully-Known
First, I argue that ethnography of applied health theatre can provide insight into expanding vocabularies to talk about the not-fully-known realms of subjective experience. In part, the use of complexity as a framing device is about deeply subverting prescriptive, Western emphasis on the logical and the known; it is about conceptually engaging with the unknown, the contradictory, and the not fully understood.
In their book *Killer Commodities: Public Health and the Corporate Production of Harm*, Merrill Singer and Hans Baer (2008) put forward the concept of “hidden harm” and call for deeper anthropological examination of the things that are often hidden from public knowing within societies. They argue this engagement with the hidden and unknown is particularly important in capitalist societies where corporations aggressively market potentially harmful, or “killer,” commodities. They call for greater examination of how knowledge about commodities is presented to (or withheld from) the public by corporations and what effects these hidden realms of knowledge have on the public’s burden of injuries and death.

I agree with the importance outlined by Singer and Baer (2008) of more deeply investigating public and social forms of knowing. However, I suggest there is equal value in looking at the level of subjective and intersubjective knowing. Using complexity as a framing device allows anthropologists to see how people’s experience of the unknown, the hidden, and other forms of incoherence shape their actions, perceptions, and feelings about the worlds in which they live, as well as their intersubjective relationships. This framework is about attending to how incoherence as an existential state of being shapes people’s actions and relationships in daily life—not just about how institutional agendas of knowledge misdirection or omission shape the epidemiology of a population.

One way forward in revitalizing medical anthropology attention to HIV is through integrating the strengths of other disciplines with areas of scholarship that have historically given the fields of public health and medical anthropology epistemological trouble. Some global public health scholars and medical anthropologists continue to struggle with creating frameworks attentive to the parts of people’s lives considered ambiguous, contradictory (either explicit or implicit), and unknown. Within public health programming and anthropological theory, there is
a need for developing additional language to access, understand, and analyze people’s experience with the *unsaid*, the hard-to-utter, and the difficult-to-admit. These are the things people do not want to face, are not ready to handle, or hesitate to acknowledge: the difficult. These areas of life are important to anthropologists and, I argue, for analyzing the state of the current AIDS epidemic in South Africa; however, the language of biomedicine, public health, and, to a lesser extent, the social sciences rarely captures those intangible areas of life, no matter how researchers grasp.\(^6^9\).

In contrast, for theatre-makers, these are the topics to which a great deal of their attention is turned—theoretically, conceptually, and methodologically. As theatre-makers look back on the last 30 years of artistic HIV intervention in the country and ruminate on why past programs have not produced the effects originally envisioned, they are increasingly devoting attention to difficult-to-engage topics. They are working to reinvigorate attention to the messiness of life and create frameworks to capture, portray, talk about, and deal with incoherence. This involves developing language to talk about these topics and shifting attention to analysis of what is often colloquially framed as deep emotional levels of complexity and interiority of the self. The “shadows” construct is an active attempt by theatre-makers to start thinking through incoherent experiences.

There are policy and theoretical stakes in developing a vocabulary to talk about complexity and incoherence. Doing so helps stakeholders in interventions understand and frame

\(^{69}\) In fact, it should be noted that these parts of life considered “difficult” are important to understand in a variety of contexts, not just within HIV/AIDS research. Talking about, understanding, and developing methods to study these difficult components of life could be helpful in other kinds of research (e.g. those related to other life-threatening diseases or situations, such as times of violent xenophobic conflict, patients confronting diagnosis of a terminal medical condition, or the lives and experiences of Alzheimer’s patients).
these difficult, elusive components of lived experience. Theatre-makers are trying to find a language (in this case, “moments” and “shadows”) to capture and represent complexity in a way that keeps open considerations of the messy, the mutable, the contradictory, and the complicated within individual thought, feelings, and reactions, as well as within potential policy recommendations for intervention initiatives.

At an experimental medical anthropology conference I attended in 2013\textsuperscript{70}, this exact topic was the subject of several papers. A central concern of the conference that emerged during discussion was the inadequacy of current international public health policy in capturing, thinking about, and expressing the complexities of lived experience\textsuperscript{71}. In particular, anthropologist Emily Yates-Doerr noted that the language of global public health policy is often characterized by a “shutting down” of uncertainty and complexity rather than a “keeping open.” For her, there are stakes of certainty within language in policy discussions: when a language of certainty about how things are or should be becomes reified, status quo authority and power structures tend to solidify. That concretization may not always be in the best interest of people on the consumer side of HIV intervention policy.

I tend to agree with Doerr but consider the stakes wider than certainty or ambiguity. The stakes are also related to language about other facets of complexity, including contradiction, messiness, and conflict. The stakes implicated are about developing vocabularies to study health-related situations that are able to stay with the ways people experience their worlds as incoherent instead of moving away from or reducing them in simplistic ways. Uncertainty and

\textsuperscript{70} Cascadia Seminar 2013: Ethnographic Adventures in Medical Anthropology (Vancouver, BC, Canada).

\textsuperscript{71} This concern spanned the interests of many medical anthropologists and included the language of policy as it relates to hunger, HIV/AIDS, and Alzheimer’s research.
mess are part of human life, at times. In some ways, artists are making a plea for HIV/AIDS interventions to avoid erasing these times of complexity. The stakes of language implicit within the concepts of “moments” and “shadows” are about living with questions and finding the right questions rather than narrowly focusing on problem-solving and answer-finding in mechanistic ways. This is a topic developed in the next chapter (Chapter 7).

The Links between System and Experiential Complexity: Fomenting Interdisciplinary Dialogues

Second, I argue that ethnography of applied theatre provides insight into the link between systems and experiential complexity, which is implicated in integrating materialist and interpretivist approaches to analysis of HIV/AIDS. There is potential for “complexity” as a construct to bridge the historic humanistic/scientific divide within anthropology. I suggest the concept of “complexity” provides one possible way to connect symbolic-interpretive, political economic, affective, temporal, and semiotic approaches and agendas within medical anthropology.

Scholars within medical anthropology have been calling for such an integrated framework to study health, illness, and healing. The development of a nuanced framework that connects subjective and affective experience with consideration of larger institutional inequalities, structural violence, and the place of semiotics and representation is an ongoing theoretical goal of the discipline. This framework development agenda has been a focus for the anthropology of HIV in particular for the last 15 years. I do not posit the concept of

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72 This topic (integrated frameworks) is first introduced in Chapter 5, and an in-depth discussion of the related literature is included there. As a brief recap, these “new HIV/AIDS ethnographers,” with their focus on integrated frameworks for studying HIV/AIDS, attempt to answer one of the most relevant, primary questions of HIV/AIDS ethnography today (and HIV/AIDS studies more broadly): how do we attend to complexity and avoid the binaries of past analytical frameworks in order to better capture lived human experience and the structures that shape it?
“complexity” as the only way to bridge several of the main theoretical approaches within medical anthropology; however, I consider the concept a possible productive tool for integrating interpretivist, materialist, affective, and semiotic approaches to the study of HIV/AIDS.

In addition to exploring language to capture existential incoherence related to HIV/AIDS, the complexity framework is also about attending to experiential complexity in relation to systems complexity. In João Biehl’s writing (2009, 2013), he calls for deeper anthropological critical analysis of the complexities of the global health field without eliding the messiness of experience. By doing so, he asserts, scholars and practitioners involved in global health will avoid what he calls “magic bullet” approaches: the delivery of health technologies that target one specific disease regardless of the complex systems of social, political, and economic factors that influence health. Biehl (2009) calls for more deeply people-centered initiatives, research, analytic frameworks, and methods that go beyond technical and theoretical quick-fixes within global health. He states:

We need analytic frameworks and institutional capacities that move beyond the repetition of history and that focus on people: on-the-ground involvements that address the politics of both control and non-intervention, the fragmentation of efforts, the presence of heterogeneity, the personal and the interpersonal, people’s inventiveness. It is time to attribute to the people we study and describe the kinds of complexities we acknowledge in ourselves, and to bring these complexities into the picture of global health. Policy and popular accounts tend to cast people as helpless victims, over-determined by the environment, history, and power, or as miraculous survivors who bear witness to the success of external aid. Details are suspended…people are put into pre-conceived molds….Anthropology’s task in the field of global health is to produce different kinds of evidence, approaching bold challenges such as the pharmaceuticalization of health care delivery and crucial questions such as what happens to citizenship when politics is reduced to survival—with a deep and dynamic sense of local worlds….In the field, the unexpected happens every day and new causalities come into play. An openness to the surprising and the deployment of categories that are important in human experience can make our science more realistic and hopefully better.

[Biehl 2009:108]
For Biehl, thinking through complexity is unambiguously about furthering the anthropological commitment to avoiding reductionism. However, his characterization of complexity sometimes wavers in his writing between experiential and systems levels without clearly delineating the former. At times, Biehl writes about complexity narrowly as the complicated interactions that emerge from connections between multiple facets of a system. This echoes forms of analysis common within critical medical anthropology’s political economy of health framework that privilege examining the institutional production of inequality and structural violence.

However, Biehl also notes that the need for subjective texture raises broad anthropological questions about ethnography’s potential to bring the private life of the mind (of individuals) into conversations about public health and politics. In his work, Biehl issues a particular call to anthropologists, global health policy makers, and people involved in intervention work: “A more complex model of this flux of people-disease-policy and market dynamics is required—and this calls for innovative partnerships and methods” (2009:121).

In some ways, I read Biehl’s work as a call to bolster the ways anthropologists integrate the “people” component of the people-disease-policy-market dynamics complexity interaction. This involves finding nuanced ways to tease apart and talk about those issues of the “private life of the mind” that shape people’s actions in and experiences of the world. This is an exercise in developing ways of analysis and writing that avoid reductionism and augment integration of attention to deeply personal, individual, subjective experiences of the particular with detailed historical analyses of political economies, inequality, institutional power, semiotics, and discourse.

For Biehl, one possibility for moving toward more complex models to capture the ubiquitous social science interest in the individual/system nexus is the following: stronger
anthropological attention to the experiential knowledge and epistemological breakthroughs of people on the ground who daily navigate contemporary entanglements of power and expert knowledge (2009). I agree with Biehl and directed this kind of attention toward grounded analysis of the issues identified as most important by my informants.

In my research, the population with whom I worked had a protracted and focused interest in exploring the ways people navigate incoherence in their daily experiences of sexuality, illness, and health. I argue that using complexity as a framing device can allow anthropologists to more deeply mine the ordinary dynamics of human interaction in worlds in which incoherence is a daily reality. This is particularly relevant to anthropologists doing research on sensitive topics and vulnerable populations. This framework is about thinking through how institutions and structural violence shape people’s lives, as well as how people’s experience of structural factors shapes their actions and possibilities for agency. This framework is not just about structures, politics, and economics—another component of this story is how people’s understandings of the instability, contradictions, mutability, and unknowns that are created through those political economic factors also shape actions, relationships, and possibilities.

Using a complexity framework is partly about a more nuanced integration of affective considerations into historical, political economic, and linguistic ones. This is about how people experience their lives as enmeshed in systems that do not always (or even very often) produce worlds characterized by stability, immutability, or coherence. I argue that a complexity framing also more clearly directs anthropological attention to questions about how people react to the systems in which they live. This is about seeing what forms of inventiveness are borne out of people’s experiences of incoherency in the world: the complexity framing directs our attention to and tells us things about whether, how, and why people are managing complexity in their lives,
including what strategies they employ for managing incoherence and the ontological assumptions behind what they identify as complex. This framework is about the integration of considerations of experiential complexity (people’s experience of incoherence) with considerations of system complexity (analysis of the complicated relationships that emerge as multiple parts of a system interact).

Finally, from a disciplinary stance, my analytical focus on the constructs in this chapter works to foment a dialogue between intervention perspectives that span the hard sciences, epidemiology and global public health, clinical approaches, social sciences, and the humanities by integrating inter/subjective, semiotic, and political economic components of the AIDS epidemic in South Africa. The constructs “moments” and “shadows” offer the possibility of integrating subjective and political-economic perspectives for a more holistic approach to HIV/AIDS work. The goal in fomenting interdisciplinary dialogues is to develop mutually beneficial ways forward for both theatre-makers and social scientists in their engagement with global public health crises. The two constructs offer ways to acknowledge and privilege complex, confusing, contradictory, messy, ambiguous lived experience in research while also locating that lived experience within broader sociopolitical and economic contexts.

For me, the “moments” construct is a tool for integrating some of the holistic tendencies between performance studies and medical anthropology in their attention to HIV/AIDS. It offers a way to think about the impact of interventions vis-à-vis theories of affect and meaning-making. Thinking about affect and moments involves a consideration of where, when, and how meaning-

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73 This is a possibility I think we should harness; however an important note is that within theatre, this possibility is not always realized. Even though theatre-makers talk about the importance of privileging lived experience, a deeper-than-cognitive form of affect, and the integration of mixed methods in their work to respond to the dynamism of life, a lot of the artistic work I saw in practice, on the ground, was still produced within the educational messaging model. I discuss this more in-depth in Chapter 9.
making takes place (in specific instances in time). The “moments” construct is also strongly tied to the notion of validating people’s subjective experiences. This is similar to what anthropologists call “giving a voice” to people and also to the often-referenced South African philosophy of Ubuntu: “I am because we are.” It is an acknowledging of the humanity of another person and his or her reality while holding that and living with that recognition.

The concept “shadows” provides a focusing analytical lens through which to examine and reflect upon the parts of people’s lives they consider confusing, contradictory, messy, or difficult to handle. “Shadows” as a construct is used as an attempt to facilitate the engagement of intervention participants in consideration of the parts of their lives that may be affecting their health, relationships with others, and their own agency in relation to healthcare. A premise of the push to examine shadows within theatre processes is the idea that only by confronting, thinking about, and dealing with shadows can something then be done about them—even if what is done is simply acknowledging they exist as part of the context that shapes a person’s relationship to formal and informal healthcare infrastructure in the country.

I posit theatre-making related to HIV/AIDS within South Africa is currently in a period of transition, where the recent debates and conceptualizations of theatre-makers on things such as “moments” and “shadows” are only just starting to be implemented in practice. However, I also suggest that ideas privileged by theatre-makers—subjective experience, moments of life, reflexivity, affect, meaning-making, and fluidity—can be useful and more strongly integrated into where medical anthropologists excel: critical political economic and historical analysis. Interpretive anthropology is also useful in this endeavor, and I think “moments” and “shadows” provide a potential bridge between performance studies, interpretive medical anthropology, and critical medical anthropology.
A notable and valid critique of the theatre processes I have described in this chapter is that very little consideration of the political economic context was present within them, and attention to it was also noticeably absent during the post-game reflection. While the two constructs discussed in this chapter are potentially useful for accessing and framing subjective experience, theatre-makers currently rarely situate such subjective experience accessed by their processes within larger sociopolitical contexts or critiques of broader structural power relations within the country. This is somewhat counterintuitive, since highly critical protest theatre has been a historically important form of activism within the country.

A finding of my dissertation fieldwork was that many theatre-makers speak openly about the importance of politicizing their HIV/AIDS-related theatre interventions, but few have begun the process of integrating subjective and political economic critique in their actual day-to-day theatre work. This is a point of legitimate critique of the kinds of applied health theatre currently being produced in South Africa, but it is one many theatre-makers recognize and are slowly attempting to address. What theatre does well, however, is access messy subjective experience. I suggest that weaving together some of the theoretical concerns and methods of theatre with the political economy of health approach of critical medical anthropology has the potential to produce a more complete framework for understanding the intricacies of HIV in human experience than either field’s common approaches used separately. Integrating these models of analysis can advance our applied contributions to HIV/AIDS policy and intervention efforts on a broad scale. The overall stakes implicated in this point are about elucidating disciplinary articulations and continuing to push at the borders of how medical anthropology

74 Theatre-makers note the fine line of balancing integration of critical analysis into their more subjective artistic work. The hesitancy to re-engage with politicized theatre is often expressed as a function of activism fatigue in the country and audience hesitancy to watch theatre considered heavy-handed regarding political messaging.
thinks about sexually transmitted illnesses and what sustained role anthropologists have in the development of global public health policy.

6.7 Conclusion
In summary, I have discussed in this part of the dissertation how some health theatre-makers in South Africa are currently deeply engrossed in the project of looking at perceived past failures in national HIV/AIDS intervention strategies and trying to figure out how to address them, which includes casting about for alternatives to past dominant theories of intervention, healing, communication, and affect. This project of theirs is about a push for innovation in HIV/AIDS programming that involves responding to dynamic, changing sociopolitical and historical contexts for which older intervention frameworks may no longer be the most appropriate. It asks what are the driving questions, intervention goals, objects of analysis, and theoretical frameworks through which HIV/AIDS researchers and policy makers understand the epidemiology and implications of HIV in human lives in what is widely considered a “new era” of intervention (across the board of the AIDS industry).

For theatre-makers in particular, these new agendas tend to highlight the idea of “complexity.” In this chapter, I have outlined how theatre-makers define, access, and set the parameters for “complexity” as it relates to sexuality and public health in South Africa. Rather than assuming an a priori definition of complexity, I have argued for the need to push the parochialism of common ideas about what the concept of “complexity” means within anthropology. In particular, I call for greater anthropological engagement with the concept of complexity and how it shapes people’s lives—attention to local definitions of complexity, why complexity is important, and how people deal with it in daily life.
I also outlined the utility of privileging in broader research agendas the kind of complexity my informants discussed: complexity as issues of temporality and incoherence. I provided and analyzed ethnographic data about two conceptual constructs theatre-makers use to address complexity and messiness in lived experience: moments and shadows. For theatre-makers, the focus was on developing language to talk about and questions to frame incoherence in lived experience. I argued in this chapter for using “complexity” as a framing device to make the incoherent parts of lived experience an explicit focus of anthropological analysis rather than a tacit one.

Finally, I suggest that using a complexity framework is partly about creating a more nuanced integration of affective considerations into historical, political, economic, and linguistic ones within the social sciences. This is about capturing how people experience their lives as enmeshed in systems that do not always (or even very often) produce worlds characterized by stability, immutability, or coherence. By using complexity as a framing device, information on a range of topics is revealed. Three important ones I outlined include people’s existential experience of the unknown in relation to health and sexuality, the links between system and experiential complexity, and subjective understandings of contradiction (thoughts, actions, feelings, circumstances) as they relate to defining health and seeking healthcare and treatment for STIs.

While this chapter has analyzed the “moments” and “shadows” constructs and discussed their relevance for artistic HIV/AIDS interventions in South Africa, the next part of the dissertation pushes analysis of the constructs further. In Chapters 7 and 8, I build on this discussion of complexity within healthcare by evaluating the ways in which theatre-makers put into practice what they access through the constructs “moments” and “shadows” in order to
accomplish particular intervention work. In the chapters, I answer certain questions: how do theatre-makers use these two constructs to create and put into practice the innovation in HIV/AIDS programming they advocate so strongly? How do theatre-makers use the constructs in creating alternative forms of HIV/AIDS intervention practice, and what are some of those major efforts?
Part 4: Putting Complexity in Action: Theatre as a Health Intervention

Introduction

As I approached, I waved to the guard at the University of Cape Town entrance gates. He scowled but let me pass when I flashed the visitor’s card assigned to me by the Department of Drama. Most of my university-level theatre research was conducted in Johannesburg, but several important artists with prodigious bodies of work made their home in Cape Town. In January 2010, I’d made a solo drive from one side of the country to the other in order to meet some of the movers and shakers of South Africa’s art world. That day, I was on the way to my first formal interview with Denvon*, a 48-year-old nationally acclaimed choreographer who has directed over 100 productions since breaking onto the country’s art scene in 1984. Born in Durban, Denvon is Coloured South African and obtained a degree in performing arts from a prestigious university in the United States before returning to make his home in Cape Town’s central business district. He was heavily involved in the anti-apartheid protest theatre of the 1980s-1990s and has continued artistic engagement with social issues in the post-apartheid era.

Denvon’s multifaceted work in the sector has included developing arts legislation, teaching at formal and informal arts organizations, producing arts workshops across the country, and choreographing highly experimental theatre and dance at mainstream, university, and community levels. Denvon and I had run into each other several times at artistic events over the past few years, but I was looking forward to speaking with him at length about his experiences with and thoughts on HIV-related theatre. Over a cup of tea in one of the classrooms, I asked him what he was trying to accomplish with his artistic work. Denvon was not currently producing an HIV-related show but had worked on health-related theatre in the past. He noted
that despite the topic of his work, there are often common threads in what he tries to accomplish.

Smirking, he spoke of his productions over the last 10 years:

We were hard-assed artists. We did a piece about trauma, and we traumatized the audience [laughing]. ‘Cause it was just this horribly violent--I mean I raped somebody, and it was just like, hard-core work! People would walk out and shout. So I mean, we weren’t a bunch of hand-holding, humming hippies. When we went to a place, we created rupture. In terms of an impact, I want people to walk out or away from the performance shattered. [laughing] I guess that probably accounts for the strong choices I do. I see performance very much as affective. It’s meant to get underneath somebody’s skin, you know. It really is about trying to find a way in which there is an involvement that you can’t just spin in and out of. I mean you can, but I try to stop you. It’s about facing the truth. And I think for me, that’s about the best form of feeling. It’s not just about making you feel nice, but what is the truth of the matter? How do you meet that truth? I think we were constantly wanting to keep our feet firmly on the ground as to what we could do and what we wanted to do. And this kind of trying to meet with the reality became imperative. That’s what we attempted to do with audiences, as well. And you know, critics hated and loved it. We opened “Unclenching the Fist” in Grahamstown, and people walked out! There was always great stuff around it. It’s the same thing with “Body of Evidence,” it’s trying to meet the reality of it. In meeting the reality, I feel that’s all I can do [as an artist].

I can’t make you feel nice. I can’t make you feel nice for coming to terms with those dark spaces that you didn’t want to. And if that’s healing, then maybe I’m doing a tiny bit of it. If that’s not, then I’m not doing that. But I certainly want in the works to really get to some kind of a truth. For the dancers in performance as well as in terms of their relationship with the audience. Site-specificity allows for a kind of fairly intimate relationship with the audience, which really takes one to a space where you can experiment with notions of the truth. And what it (truth) should be.

The two chapters that follow explore several of the themes Denvon mentions in his musings on what theatre accomplishes in people’s lives and what it has the potential to offer public health programming. As detailed in the last chapter, many theatre-makers consider certain common HIV intervention foci\textsuperscript{75} necessary but insufficient for fully capturing the lived experience of HIV

\textsuperscript{75} Particularly the following: knowledge promotion for prevention, biomedical technologies for treatment, and attention to underlying structural contributors to the AIDS epidemic.
and creating successful intervention programs. For theatre-makers, the realms of knowledge, structure, political economy, and biomedical technologies comprise critically important components of the story of AIDS epidemics but an incomplete picture: individual experience of life’s complexities also shapes people’s health outcomes and actions in the world in important ways. In particular, theatre-makers are concerned centrally with the parts of people’s lived experience often categorized as incoherent or hard to understand.

In his interview, Denvon discussed this component of lived experience as “those dark spaces” people sometimes have difficulty confronting or coming to terms with in their lives. Those “dark spaces” of incoherence are often exactly the points at which theatre-makers involved in health-related work attempt to intervene in people’s lives, actions, thoughts, and feelings. In our interview, Denvon echoed an increasingly common idea among the artists with whom I worked. For Denvon, what theatre offers to the world of public health programming is a willingness to engage with and embrace the “hard-core work” from which other types of programs shy away: theatre is about a voluntariness to eschew comfort, get under people’s skin, and go to the hard places—places of messy emotion, ambiguity, contingency, indecipherability, and subjective fragmentation.

In contrast to the early years of the epidemic, theatre-makers increasingly note that artistic interventions are no longer only about parroting biomedical information to audience members through health promotion and education on how to wear condoms or reduce HIV risk. As Denvon mentioned, theatre is now also about shattering people and encouraging them to face

Definitions of a “successful” program are multiple, varied, and contested. By “successful,” I do not simply mean programs that reach certain numbers of people or are able to engage citizens with biomedical health systems. Another argument of my dissertation is that theatre-makers are actively involved in re-thinking definitions of “success” and “progress” within HIV intervention programming globally, and this is one main topic elaborated in Chapter 10.
the “hard truths” of their lives and the incoherencies in their worlds. This is about a shift away from theatre as a venue for simply imparting expert biomedical knowledge and toward the idea of theatre as a space for exploring the limits of knowledge, certainty, and coherence as they relate to sexuality and health (and how those limits affect people’s actions, thoughts, and feelings).

In many ways, what theatre-makers are doing is emphasizing a radical break with common biomedical rationalities that underscore many HIV intervention programs in the country. While artists recognize the value of biomedical programs and health promotion campaigns, they are heavily advocating inclusion of another, complementary realm of consideration: subjective, lived experience of existential incoherence. For theatre-makers, the world of logic and the “known” (so common within biomedical rationalities) is no longer the only or primary focus of HIV programming. Considered equally important by artists are the parts of people’s worlds that are not-fully-understood.

Although Denvon chuckled when he talked about the intensity of his work and the ruptures it sometimes creates among audiences, his green eyes held gravitas as he discussed the necessity of encouraging people to think very deeply about the difficult and sometimes hard-to-understand realities of their lives. For him, theatre makes a critical intervention into public health practices by urging theatre participants to find out the “truths” of their realities and meet that truth by acknowledging its existence. Other theatre-makers spoke about the same goal in different ways. For instance, a 47-year-old white South African mainstream theatre-maker referred to it as “embracing your shadows,” and a 24-year-old black South African community theatre-maker discussed it as simply “coming to terms with your reality.” For some theatre-makers in the country, an increasingly important agenda of applied health theatre is urging
audience members to experiment with notions of truth and reality—establishing what those contextual health realities are, meeting them head-on, and experimenting with what they could or should be in the future (alternatives) and how to accomplish that change. This agenda is fundamentally (but sometimes implicitly) about encouraging audience members to think through possibilities for social change and health activism in the post-apartheid era.

In the two chapters that follow, I analyze productions and theatre-maker ideas about the importance of acknowledging people’s existing subjectivity fragmentation, as well as intentionally engaging in the project of shattering and rupturing people’s self-identities in order to create social change. Part of this includes interrogating the assumptions that undergird the types of subjectivities theatre-makers are trying to produce, as well as the ones that characterize the kinds of neoliberal-based health citizenship projects to which artists are reacting. Within South Africa, HIV/AIDS intervention programs (including those prioritized by the government, international organizations, and domestic NGOs) have largely employed biomedical and public health perspectives underwritten with concerns that reflect the interests of neoliberalism. These perspectives include practices that privilege principles of biology, physiology, clinical medicine, individual bodies, universalizing logics of rationality, curative practices, etiological agents, and moralizing discourses of personal responsibility. In common intervention efforts in the country, the object of focus is the rational subject of classic HIV prevention—the person who seeks out biomedical information about HIV transmission and risk, listens to aid workers in rapt attention, and dutifully adheres to safe-sex practices for all time after being educated by biomedical institutions.

A question I often heard asked by informants during fieldwork was —where is this subject? Who is this subject? Does this particular health subjectivity actually exist in the world
in any significant way? The imagined (or rather, presumed) rational, individualist actor of biomedicine has not appeared en masse globally. Nevertheless, national programs in South Africa continue to model their prevention, treatment, and care initiatives around biomedical and public health ideologies that focus on concepts such as risk, behavior, and vulnerability (Kippax et al. 2013; Parker 1996).

In this part of the dissertation, I go through two detailed examples of how the complexity constructs described in Chapter 6 (moments and shadows) are put into practice within HIV/AIDS-related theatre. I show what kind of analysis is possible when subjective experience of incoherence is privileged as an analytic category. In particular, I discuss what kinds of HIV program innovation theatre-makers are advocating within global public health attention to HIV and how those innovations challenge some common ideas about topics of anthropological interest—specifically global health agendas and language, stigma, reflexivity, the individual/community and structure/agency dichotomies, health subjectivity, and ideas about social change through health activism.

I argue that applied theatre related to health is being repositioned in the country as a route through which new forms of health subjectivity and activism may be created in the post-apartheid era. A main finding of my research is that this repositioning of theatre is being accomplished through two main processes presented by artists as important points of health intervention: the process of acknowledging that incoherence77 is a key contributing component of the country’s continuing AIDS crisis and the process of promoting critical reflexivity as a form of

77 This term and its use by theatre-makers was described extensively in Chapter 6 and indexes states of being characterized by a lack of clarity, understanding, knowledge, order, simplicity, direct causal relations, and/or straightforwardness. This is a very broad category, but theatre-makers often discussed particular kinds of incoherency in their work. The framework described in Chapter 6 analyzes how artists use the term “complexity” to talk about incoherence as an existential state of being that shapes people’s actions, relationships in daily life, and ideas about sexual health.
of healing and activism. Both of these processes are premised on the coproduction of knowledge (between performers and audience members) about health and sexuality.

I show in the two chapters how theatre-maker ideas about complexity (as incoherence) can be used to engage with and complicate anthropological notions of reflexivity, subjectivity, and citizenship. I begin by explicating in this introduction several concepts used within anthropology over the last decade to characterize and explain the influence of neoliberal ideology on national citizenship projects, including “biological citizenship” (Petryna 2002; Rose & Novas 2005), “therapeutic citizenship” (Nguyen 2005), and “responsibilized citizenship” (Robins 2006). All three concepts facilitate insight into the kinds of health subjectivity and neoliberal bio-governance projects that theatre-makers are actively trying to challenge in this most recent decade of the post-apartheid era.

Between the two chapters, I elaborate exactly what this kind of South African biocitizenship looks like, the rationalities on which it is based, what kinds of national health campaigns have promoted it, and how artists are challenging it through contemporary applied health theatre interventions. I use ethnographic data to explain the importance of the processes of acknowledgment (Chapter 7) and reflexivity (Chapter 8) to theatre-maker ideas about best practices within public health work. I conclude with an analysis of how theatre-makers are marshaling the ideas of incoherence and fragmentation as the basis for producing a kind of critical health subjectivity that provides an alternative to neoliberal biocitizenship, which tends to dominate current HIV/AIDS intervention practices in the country.

Neoliberal Ideology, Subjectivity, and Citizenship Projects

Despite valiant critiques by anthropologists and members of related disciplines, the idea that sexually transmitted infections can be combatted mostly (or entirely) through education
remains pervasive among global public health interventions, policy, and practice. It is also a widely held popular opinion circulated through media and other public avenues. Like anthropologists, some theatre-makers in South Africa have jumped on the bandwagon to challenge the idea that substantive change related to HIV statistics and experience of AIDS may be enacted primarily through either health education or biomedical technologies (e.g. pharmaceuticals or increasing access to condoms).

Over the last decade, anthropological literature has expanded on the ways in which neoliberal ideology has shaped global health subjectivities and forms of bio-governmentality. This body of scholarship often starts with Foucault’s (1976) notion of “biopower” as the extension of state power over the physical bodies and health of a population and the processes and techniques of regulation used within modern nation-states to control those bodies and produce docile subjects. Scholars have established several related concepts to characterize the influence of biopower within societies and explain the constitutive practices through which it operates to control populations and produce particular types of health subjectivity based on neoliberal ideology.

While the concepts within anthropology used to describe forms of sociopolitical belonging mediated by biomedical categories and technology are numerous, certain scholars have set the tone for thinking about the relationship between biology, health systems, and citizenship. These concepts include “biological citizenship” (Petryna 2002; Rose & Novas 2005), “biomedical citizenship” (Biehl 2007), “therapeutic citizenship” (Nguyen 2005), and “responsibilized citizenship” (Robins 2006). All four concepts are used to explore the ways in which neoliberalism contributes to normative citizenship projects related to health and how members of a population respond to the biopoliticization of their bodies. Broadly, all of these
terms draw attention to practices in which conceptions about biology interact with political classifications, forms of activism, and types of subjectivity (Andrejic 2011). They are used to discuss the ways in which people are constituted as citizens or make claims about citizenship and participation in national polities based on some type of shared biological identity. The terms provide a way to talk about the biotechnologies and neoliberal ideologies that shape individual subjectivities related to health (Charles 2013).

Central concerns for scholars who examine issues related to biopolitics are the ways in which advances in the biomedical sciences are implicated in how societies are organized and populations controlled (Greenhough 2014). Extending Foucault’s theory of biopower, new conceptualizations of the relationships between the state and citizens’ biology have been formulated in recent years (Andrejic 2011). These began with Paul Rabinow’s (1992) use of the term “biosocialities” to describe the formation of social relationships and production of identities based on genetic or biological conditions. More recently, Adriana Petryna (2002) has used the idea of “biological citizenship,” which emerged out of her research on post-Chernobyl Ukraine, to describe the processes through which citizens mobilized around injuries caused by radiation and used their damaged biological bodies and status as biological sufferers as resources to make social support and benefit claims on the new Ukrainian state. For Petryna, the term describes “a massive demand for but selective access to a form of social welfare based on medical, scientific, and legal criteria that both acknowledge biological injury and compensate for it” (2002:6). She argues that the social movement that emerged out of citizens’ exposure to radiation constituted a new kind of citizenship defined in biological terms rather than one based on shared belief systems, ideas of culture, or national geography.
In Petryna’s wake, Nikolas Rose and Carlos Novas (2005) build on the idea of biological citizenship but attempt to widen its scope. They use biological citizenship as a descriptive and encompassing term to discuss a wide variety of citizenship projects. For them, biological citizenship is meant to serve as a framework for analyzing how “specific biological presuppositions [have] shaped conceptions of what it means to be a citizen, and underpinned distinctions between actual, potential, troublesome, and impossible citizens” (Rose & Novas 2005: 440). Related to Rose and Novas’ understanding of biological citizenship is Vinh-Kim Nguyen’s (2005) notion of “therapeutic citizenship,” which was developed through ethnographic work in several African countries on the identities and health practices adopted by ART patients as necessary precursors to accessing limited supplies of HIV services. Nguyen’s “therapeutic citizenship” is defined as “a biopolitical citizenship, a system of claims and ethical projects that arise out of the conjugation of techniques used to govern populations and manage individual bodies” (2005:126). Nguyen and colleagues (2007) have argued that certain biomedical practices related to negotiation of access to ART are implicated in the production of therapeutic citizens who (of necessity) conform to biomedical notions of “appropriate” and “healthy” behavior within a context of rights and responsibilities.

Susan Reynolds Whyte (2009) and Steve Robins (2006) also examine the ways in which biomedical rationalities produce self-responsible patients and disciplined bodies, but they shift attention to the realm of health identity politics and the processes through which citizens can claim health rights rather than being “mere beneficiaries, clients, or customers” of biomedical practices (Whyte 2009:9). Robins (2006) in particular examines the way in which the moral politics of HIV/AIDS activism in South Africa contributes to new forms of citizenship (“responsibilized citizenship”) that combine liberal individualist ideas of modern subjects with
health activism, the idea of rights-bearing citizens, and the importance of biosocial identities that emerge from traumatic illness experiences.

**Biocitizenship in South Africa**

Although there are many ways to discuss biological citizenship, the scholars outlined above have largely set the tone for thinking about issues related to biology, health systems, and citizenship projects. While anthropological invocations of the term “biocitizen” are disparate, I see common threads that run throughout the various scholars’ analyses. I consider these common threads a productive starting point for thinking about biocitizenship, and the way that I use the term “biocitizen” in this dissertation issues from these commonalities.

Many scholars analyze the ways in which modern neoliberal governmentality has been heavily involved in projects to promote the individualization of responsibility for managing citizens’ biological existence, the withdrawal of social responsibility for citizens’ health, and the use of biomedical technologies as tools of population surveillance. This kind of bioregulation by nation-states aims to produce docile bodies treated primarily by biomedical technologies, “good” patients who conform to responsibilization agendas, and individual health subjects who seek out knowledge and use it as the basis for assuming responsibility for their own health through logics of rationality, choice, and decision-making (Skovdal et al. 2011; Rose & Novas 2005; Nguyen et al. 2007). Biocitizenship is also used by multiple scholars as a device for describing the ethical demands that biologically-based forms of identification enable (so, the ways in which everyday people use this identity label to make claims on governments as citizens); the ways that empowered, informed individuals can engage with biosciences in general; and finally, the ways that governments attempt to produce normative accounts of biological citizens as a controlling mechanism for citizen-subjectivity (Rose & Novas 2004; Plows & Boddington 2006; Robins
2006). In my dissertation, I am mainly concerned with this latter component of the way scholars think about biocitizenship.

I will be explicit about how I use “biocitizen”: at a fundamental level, I consider biocitizenship a useful term for indexing a way of being a citizen that is tied to the relations between politics, identity, and biology. Analyzing biocitizenship involves understanding the particular ways these relations are created, structured, maintained, and resisted in particular places at particular times. The possibilities for what “biocitizen” can mean are multiple and contingent. I do not consider biocitizenship a prescriptive term to describe how a population interacts with biotechnologies or the healthcare industry; use of this term does not assume one homogenous way of interacting with biotechnologies. Nor should either constituent component of the term (“bio” and “citizen”) be reductively glossed, as some scholars have noted is being done in literature on biocitizenship (Plows & Boddington 2006). I consider biocitizenship a set of practices rather than a static identity or status. These practices shape in some way individual interactions with health systems in nation-states.

While some scholars (e.g. Petryna 2002; Rose & Novas 2004) are centrally concerned with how various populations mobilize through health movements and understand themselves as “biological citizens,” I focus more on analysis of how people in positions of authority (e.g. national health campaigns, government discourse, and international aid organizations) strategically use biological categories and discourse about certain health topics to produce specific kinds of citizenship-subjects. Both perspectives examine the ways in which health is a core mobilizing frame for engagement with state-sponsored healthcare systems. However, in the way I use the term, analysis of biocitizenship examines the way certain kinds of biological

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78 In this case, HIV.
subjectivities are produced and imposed on sectors of a country’s population when healthcare
eight rights and responsibilities are defined by those in positions of power. This is in contrast to other
ways of thinking about biocitizenship within anthropology, such as an examination of the way
civil society members mobilize biological notions of identity to petition states for resources
(Petryna 2002; Biehl 2007).

For me, part of examining biocitizenship is looking at what kinds of citizenship practices
are produced at national levels in relation to biology. This is related to analyzing how economic
ideologies—in the case of South Africa, neoliberalism—have affected social citizenship and
subjectivity projects related to health and healthcare. This involves discussing the kinds of
ideological discourse promoted by neoliberalism that affects multiple levels of healthcare in
South Africa, as well as looking at how members of civil society take up the mantle of
neoliberal-based health citizenship or resist it. The job of anthropologists is to tease apart the
ways in which the concept of “biocitizenship” is being constructed and used by multiple publics
on the ground, who are contesting power relations in multiple ways. Of primary importance is
analysis of under what circumstances and for what reasons notions of biocitizenship are being
invoked or challenged.

Assumptions of “Neoliberal Biocitizenship”:
Known, Coherent, and Controllable Worlds Mitigated by Logics of Risk, Choice, and
Responsibility

On a national level in post-apartheid South Africa, certain kinds of citizenship related to
health are often promoted by the government and international organizations that support health
development work in the country (e.g. World Bank and IMF). In particular, over the last twenty
years, citizenship projects based on neoliberal notions of responsible individualism and
embedded in a rights-and-responsibilities approach to healthcare have become the dominant
model of health subjectivity backed by the Department of Health and other national institutions. These kinds of health-related citizenship projects include normative elements which presuppose while also seek to constitute a certain type of health subject: responsible, logical individuals able to understand and engage with biomedical technologies (such as ARVs). For this reason, I refer in the two chapters that follow to this governmentally-defined conceptualization of health subjectivity as “neoliberal biocitizenship.”

Much like anthropologists, theatre-makers have noted that the types of common HIV initiatives based on public health knowledge promotion and biomedical technologies are often premised on certain basic assumptions about people, knowledge, and the worlds in which they live. Within South Africa, both biomedical and public health programs tend to rely heavily on underlying biomedical logics of responsible, coherent, knowledgeable, adherent health citizens. These logics are based on popular health belief models and theories of reasoned action, rational choice, and more general ideas about the effects of knowledge and education on people’s health-related practices. The models of health subjectivity assumed and produced in these programs presuppose a self-managing, self-reliant, autonomous, prudent personhood that conforms to norms of neoliberal individual responsibility in relation to health. These subjects are the type of people who make choices and decisions about their actions based on biomedical knowledge and straightforward, coherent understandings of themselves and the worlds in which they live.

79 The majority of the theatre-makers with whom I worked described a similar view of the kind of subjectivity and citizenship projects in relation to health their government (and associated media) promoted. They variously talked about it as a kind of individual who is “responsible,” “adherent,” “logical,” “straightforward,” “engaged with the system,” “takes their medication,” “shows up for appointments on time,” “can make choices and decisions,” “has enough food to eat,” “is able to make it to the clinic,” and other designations that conform to the idea of coherent, responsible, knowledgeable citizens who have the structural power to interact successfully with healthcare systems. One theatre-maker even directly referred to the kind of health subjectivity he was reacting against as “neoliberal biocitizenship.”
These models are based on concepts of health subjects as individuals who actively govern their own lives, seek out information and knowledge that will influence their health, are able (structurally positioned) to make their own choices, and then actively participate in managing their health risks through logics of responsible decision-making. In addition, a strong foundational assumption of these models is that individual citizen-subjects know themselves, know their desires in life, and live in worlds that can be known, understood, and controlled. The models also assume a personhood that is perhaps not always stable but is usually coherent (i.e., logical and consistent). By this, I mean the subjectivity models make some kind of room for recognizing that people may change over time, but they tend to assume that individuals have a handle on who they are at the moment, what they want in the world, what they should be doing, and why they do the things they do. For neoliberal biocitizenship projects, the world is a place that can be known, understood, and navigated by responsible, autonomous subjects who have the power to do so.

Most biomedical programs in the country conform to these characterizations and tend to depoliticize illness with their attention to individual physiological, somatic bodies. The goals of national biocitizenship projects are often knowledge- or technology-based and include empowerment through education and reducing socioeconomic barriers so that people have a better chance of exercising individual choice in attaining biocitizen status (e.g. programs for free transportation to clinics and access to ARVs). Scholars in other parts of the world have noted that the production of this type of subject is in part accomplished through governmentality projects and the limiting of resources based on demonstration of biomedical knowledge and willingness to conform to biomedical rationalities and technologies of treatment and care (e.g. Nguyen 2005). Other scholars who have conducted anthropological research in South Africa
have documented similar forms of health-based subjectivity and citizenship projects in the country (Robins 2006).

Many public health programs follow suit and devote little attention to political bodies but shift their attention to social bodies: communities, populations, and the formation of risk groups. Epidemiology underscores these programs and drives public health concern with the concept of risk—and the attendant notion of reducing risky behavior at all costs. Steve Robins calls this “risk factor” epidemiology, which operates through a “technicist discourse that involves ever-finer calibration and endless attempts to control risk in every aspect of our lives” (2006:315). The subject produced through common global public health initiatives is similar to the one produced through biomedical programming but looks slightly different: they are still responsible, knowledgeable individuals but add a concern with reducing health-associated risks in their lives at all costs through processes of cognitive reasoning, benefit analysis, and weighing options before making decisions about their actions in the world. Rose and Novas (2005) note that part of what anthropologists examine through the idea of biological citizenship are the practices that take place within healthcare through a “regime of the self” (perpetrated by neoliberalism): practices aimed at producing sensible individuals with a vested interest in shaping their lives through acts of choice and logic.

The perspectives of artists on past HIV programming intersect with this anthropological body of literature on biocitizenship. Theatre-makers vociferously critique the most common national and international HIV/AIDS development and intervention projects in South Africa. Artists have noted that past intervention efforts in the country largely privileged prevention and treatment modalities that rely on the kinds of biomedical technologies, health promotion and education campaigns, and logics just mentioned. They also tend to heavily implicate this
privileging of rationality-based biological citizenship in the failure of many AIDS-related programs in the country.

In the two chapters that follow, I examine how theatre-makers attempt to provide an alternative to neoliberal citizenship projects in relation to health that are being produced at national governmental and media levels in South Africa. I assert artists are doing this by complicating ideas of “individual” health subjects and expanding ideas about the reflexive processes used to produce such subjects. In addition, they are contributing an additional component to interdisciplinary discussions on the ways in which biomedical rationalities produce self-responsible patients, disciplined bodies, and possibilities for addressing lived experience within public health programming. In particular, I suggest artists augment this area of scholarship by wrenching the focus of analysis away from rationality and toward a concerted focus on and interrogation of subjective experiences of existential incoherence that are caused by various forms of structural violence and personal difference. Artists recognize common barriers to neoliberal biocitizenship but contribute consideration of additional dimensions, as well.

**Barriers to Responsible Biocitizenship**

Along with anthropologists, theatre-makers in South Africa have noted that there are many structural barriers to engaging in the country’s health system as a responsible biocitizen— not everyone has the power or structural positioning to accomplish this goal. Several health activism movements framed through health rights discourse have gained ground in addressing this issue in the country both legally and within popular media (Robins 2006; Fassin 2007; Heywood & Cornell 1998). These movements have promoted finding ways to reduce the structural inequality and socioeconomic barriers that prevent citizens from accessing life-saving anti-retroviral treatment and other forms of biomedical care.
However, rather than attributing program failures solely to a lack of knowledge or awareness about HIV risk factors, irresponsible behavior, or socioeconomic barriers to gaining the structural power and positioning necessary to make informed decisions related to health, theatre-makers are positing the experience of HIV/AIDS in South Africa is also mitigated by “other things.” While I was in the field, the artists with whom I worked were actively involved in trying to figure out and work through what those “other things” might be and how to address them within HIV intervention spaces. This interrogation of intervention possibilities stemmed from theatre-makers’ increasing reflections on why programs in the country have failed to reduce HIV prevalence rates or address problems of stigma. Artists were in a noted period of reflection during my fieldwork year on what might be done differently in the future to change that outcome.80

In particular, theatre-makers have begun observing that while people sometimes do act as knowledgeable, logical, responsible neoliberal health subjects, this is not always (or even primarily) the way people experience their lives. That type of health subjectivity is premised on a coherency of self that is often assumed about people within biomedical and public health perspectives, but it rarely presents a complete, accurate picture of lived reality. Much like many medical anthropologists, theatre-makers assert that knowledge, structure, biomedical technologies, and coherent health subjectivities are part of the story but not the whole story.

80 I discussed at length theatre-maker ideas about the failures of past HIV intervention programs within South Africa—what those ideas are and where that reasoning comes from—in Chapters 4-5 of this dissertation. Also, I suspect this period of reflection and critique about past HIV intervention programming on the part of artists was prompted partly by the substantial decrease in HIV/AIDS-related funding for artistic programs during the year I was in the field. As funding waned, artists began to reflect critically on why their (and others’) programs had not worked in the past and what could be done differently in the future. I address this component of the issue in Chapter 9.
For theatre-makers, the neoliberal biocitizen model leaves out important considerations of the ways in which people often experience their lives as incoherent—unstable, unpredictable, unknown, contradictory, and hard to understand. Rarely do people know and understand everything going on in their lives. Nor is this a matter of simply gaining more knowledge; theatre-makers state that not everything in life is inherently or necessarily knowable and understandable—or known and understood easily. During my fieldwork, questions that preoccupied many of the people who participated in my project were the following: what about the unruly world of the unknown, the indecipherable, or the not-fully-understood? What happens in our lives, sexualities, and to our health outcomes when processes of cognitive rationality and choice break down?

The central ethnographic vignette of Chapter 6 about Jorrell and the “Sexually Yours” workshop is a prime example. Although Jorrell is a white, middle-class, male South African well educated in HIV terminology and risk assessment, he found himself in a stranger’s bathtub being urinated upon as a precursor to anonymous sex with another man whose HIV status was unknown. In his narration of the experience, he says, “I’m sort of wondering to myself, why am I doing this?” After the encounter was over, he noted the relief he felt while simultaneously highlighting his embodied experience of shaking as he left the man’s apartment and wondering about his risk for contracting HIV. Although the experience was traumatic at the time, he continued having one-night stands with strangers without really knowing why he was doing so. His monologue ended, “That year was…filled with fear. And you know, I still shake during one-night stands.” Despite the very conflicted feelings he describes in relation to his experience with one-night stands, he continued engaging this part of his sexuality.
According to theatre-makers, accounts of neoliberal biocitizenship obscure from view experiences of the unknown and not-fully-understood in people’s lives. What is unknown cannot be consistently regulated, surveilled, and disciplined. What is unknown, they assert, makes up a large part of some people’s lived experience—especially those affected by HIV or other infectious illnesses, vulnerable populations, or people in crisis situations. By assuming and attempting to produce certain kinds of subjects that are coherent and rational, hegemonic public health and biomedical prevention, treatment, and care programs in the country both discount and neglect to address the ways in which people often experience their lives as fragmented and confusing.

Production of Alternative Health Subjectivities: Other Rationalities Besides Autonomy and Coherence

As a result, theatre-makers consider a productive new goal of HIV intervention programs is to get people to engage with and recognize their incoherent selves—and how that kind of incoherency influences their health outcomes. Instead of assuming people are always fixed, fully knowable, unified, autonomous subjects who live in controllable worlds, theatre-makers are pushing for HIV interventions to consider the ways in which people’s subjectivities are sometimes disjointed, fragmented, and not fully or easily decipherable. A major finding of my research is that theatre-makers are mobilizing around the idea of incoherence as a way to challenge ideas of neoliberal biocitizenship and produce an alternative kind of health subjectivity and activism in the face of past intervention program failures and limited programming resources.

In addition to challenging neoliberal biocitizenship projects, theatre-makers also participate in the project of actively developing new forms of health subjectivity that are more attentive to the influence of incoherency and interpersonal relationships on people’s health.
They accomplish this by advocating active production of a more consociated individual health subject through theatre processes. By “consociated,” I mean a type of subjectivity that connects or brings into relation with equal consideration the place of existential incoherence in life along with the structural factors and knowledge about HIV that shape people’s health-seeking actions.

This type of consociated health subject is created primarily through two important processes, and both are related to the project of getting people to recognize and engage with their incoherent selves. The first is acknowledgment of the existence of people’s states of incoherence and the influence those states of being may have on a person’s health. The second is promotion of critical reflexivity within theatre processes as a form of healing that encourages participants to better understand themselves and their relationships to other people and structures in their lives. These two processes are not about how subjects are constituted through expert discourse but rather about how subjects constitute and position themselves as they mine their own understandings of their lives, thoughts, feelings, and the worlds in which they live. These processes facilitate Denvon’s call from earlier for people to engage in “hard-core” intervention work to face the realities of the worlds in which they find themselves and meet their own truths in life.
CHAPTER 7
Complexity in Action: Acknowledging Incoherence

Introduction

When I asked famous satirist Pieter-Dirk Uys why his HIV/AIDS-related theatre productions were so much more popular than other performances I had seen that year, he told me that he likes to work with kids young enough to still be scandalized in a titillating manner when talking openly about sex. He also noted that part of what his performances are about is simply allowing people to realize common HIV prevention messaging in the country has not worked because it fails to acknowledge both the complexities of the AIDS epidemic and the fact that HIV is already a significant part of many South Africans’ daily lives. He said:

I tell them a lot of personal things. Look, when I was their age, nobody told me about sex at all. They told me about the birds and the bees. How does a bird fuck a bee?? If you say ‘fuck’ in a school hall, the kids will listen to every single word you say for the rest of the hour. And they’ll remember for the rest of their lives. The teachers have a heart attack, but tough news. And one has to be extremely aware of the fact that many of the kids are HIV positive, that many of them actually have got physical contact with AIDS through parents or people die, so you can’t just sort of come to the point of saying, ‘well, you mustn’t get AIDS because AIDS, you know, it’s terrible.’ It’s got to be life on both sides of the line, you know what I mean? You’ve got to acknowledge AIDS is here.

For Uys, the first step in dealing with the AIDS epidemic is acknowledging its existence. The word “acknowledgment” in colloquial English usage often connotes acceptance of something. For many theatre-makers, “acknowledgment” was a fundamental premise upon which they based their artistic public health initiatives. Although the term sometimes signified acceptance of something, it was more often linked to the notion of “non-judgmental recognition” and lacked overtones of approval. For many theatre-makers involved in HIV/AIDS work in South Africa,
“acknowledgment” was the essential process of nonjudgmentally engaging, in an intentional and reflective way, with any topic considered real\textsuperscript{81} and relevant to public health.

7.1 Fragmented Selves in Non-Judgmental Spaces

Similarly, the first step in dealing with incoherency in life is simple open recognition of its existence. Beyond acknowledging the presence of HIV in the country, acknowledgement of two major things in relation to public health initiatives was broached by theatre-makers in discussion: First, the worlds in which we live are often not stable, coherent, or subject to control. Second, people’s subjectivities are often more fragmented and incoherent than they perceive or would like to believe. This is where the concept of shadows reenters theatre-maker discourse about public health. Part of the push to investigate people’s shadowy incoherence is about making a point in interventions to facilitate discovery and understanding of the confusing parts of lived experience, even though it may feel uncomfortable or awkward for participants to pursue those lines of thought. One goal in this is simply recognition: it is saying that these complex parts\textsuperscript{82} of human experience exist in life and so must be considered within public health interventions rather than avoided, downplayed, or sidelined.

This kind of recognition shifts intervention attention from didactically imparting known biomedical facts to examining confusing and difficult parts of life as primary optics of analysis and important potential points of intercession. Another part of the goal is challenging hegemonic expert discourse presented through other kinds of public health initiatives as “the truth.” In such

\textsuperscript{81} Theatre-makers often spoke of the “real” in terms of internal and external: internal realities tended to be subjective, dynamic, and associated with cognition and affect. External realities were characterized more as objective contextual conditions people experience in their lives, such as high crime rates, high levels of unemployment, political corruption, and pervasive xenophobia within South Africa.

\textsuperscript{82} For example: subjective thoughts, actions, reactions, feelings.
initiatives, discourse about individual responsibility, strategies of risk avoidance, and ideas about proper social and sexual behavior are presented as authoritative and construct normative accounts of how people should be or should act. In contrast, theatre-makers support explicitly recognizing the ways in which people’s lives are often not coherent or stable.

Acknowledging people as fragmented (or sometimes fragmented) opens possibilities and paves the way for recognizing that people’s perspectives about the world are variable, multiple, and subject to constant revision based on changing contexts and additional life experience\(^83\). For theatre-makers, acknowledgement of life’s complex incoherence is an active process within and critically necessary starting point of public health intervention. Rather than trying to simply impart health promotional information on one authoritative account of reality, theatre-makers are trying to open possibilities for allowing people to non-judgmentally acknowledge their subjective multiplicity. Acknowledgement as a public health intervention process is also often discussed as “embracing” or “meeting” these parts of ourselves.

### 7.2 Acknowledgment as Recognition: Embracing Shadows and Meeting Truths

Part of the relevance of thinking through complexity for theatre-makers was an attempt to shift more common public health intervention optics from the known and understood\(^84\) to those parts of people’s lives that are incoherent (or “shadowy”): confusing, contradictory, not fully understood, uncomfortable, or are considered hard to confront or “deal with” because of some

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\(^83\) It is important to note here that this perspective is nuanced: theatre-makers are not saying people’s lives constantly change. Rather, they are saying that the possibility of change is ever-present. An equally important component of this perspective is recognizing the ways in which people’s lives often stay the same due to a variety of factors from structural constraints to simple emotional inability to engage intentionally and productively with life’s difficulties at that moment in time.

\(^84\) For example: biomedical facts and risk reduction strategies.
form of societal or internalized judgment. Theatre-makers intentionally interrogate with care the parts of people’s lives, thoughts, emotions, and actions often construed by audience members and broader society as difficult, mutable, messy, and disjointed (rather than coherent and stable). For my informants, “incoherence” indexed a range of things, including the contradictory; the complicated and hard to face, handle, confront, or say; the uncertain, confusing, not fully understood, and ambiguous; the unknown, unsaid, and unacknowledged; and the fluid and dynamic in both personal lives and sociopolitical contexts. A good example of this is found within the production Deep Night by the Forgotten Angle Theatre Collaborative of Johannesburg.

The Forgotten Angle Theatre Collaborative (FATC) is a physical theatre and dance company in Johannesburg that normally operates on a project basis but runs as a full-time company when they have the funding to do so. It was founded in January 1995 by P.J. Sabbagha and Tracey Human and is committed to creating contemporary South African dance theatre that investigates critical personal and social issues. Sabbagha is a 45-year-old white South African man who is openly HIV positive. He draws heavily on his own and his dancers’ life experiences and emotions to create artistic works. During the year I was in the field, FATC had just received a 3-year funding commitment from the National Arts Council and was, for the first time since its inception, able to operate as a full-time performance company. As a result of the company’s commitment to critical social art and P.J.’s personal experience with HIV, FATC is popularly

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85 Another category of experience indexed within “shadows” is the unknown, unsaid, uncertain, and unacknowledged; however, I address this category in the next framework (Reflexivity), so I am bracketing it in this chapter.

86 The company is currently supported by the National Arts Council of South Africa, the National Lotteries Board, the University of Johannesburg, Prohelvetia (Swiss Arts Council), and Rand Merchant Bank.
regarded as South Africa’s leading contemporary dance company in addressing the presence of HIV/AIDS in South African society. It is also often described as a leading voice in the emergence of new South African protest theatre and issue-based dance theatre.

The company cites as its main mission “the facilitation, development, and advancement of a progressive and dynamic socially responsible contemporary theater, dance, and arts culture in both the South African professional and community-based arts industry as well as the formal and informal education and training sectors” (FATC 2014). In addition, the company identifies its core values as individuality, respect, personal empowerment, accountability, finding your own creative voice, human beings come first, personal and social healing, speaking the unspeakable, learning to listen closely, and sustainability (FATC 2014). It operates through a variety of projects, including supporting artistic residencies; producing an annual arts activism festival; creating individual dance productions for national and international touring; offering open dance classes to the broader Johannesburg community; local outreach and inner city youth projects; extended rural community-based outreach projects; and running intensive one-to-two week summer and winter schools on contemporary dance and physical theatre for learners in Grades 10-12, as well as young artists and emerging professionals.

The company currently has six full-time dance members, and Sabbagha operates as the Artistic Director and choreographer. At the time of my fieldwork, the company supported four members and was showcasing two major productions (both HIV/AIDS-related): *Deep Night* and *I Think It’s Hamlet*. *Deep Night* is a full-length production (60 minutes) inspired by young, urban clubbing culture in Johannesburg, and it uses dance and physical theatre to follow the relationships and interactions between four characters. Sabbagha describes the piece as being

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87 Four black South African males, one Coloured South African male, and one black South African female.
about the fine line that people walk in the early morning hours between reality and fantasy—the
time after clubbing when anything can happen and inhibitions are loosened. He says the show is
about promiscuity and the loss of a sense of self that happens to people when they are intoxicated
on anything from alcohol to desire, which potentially contributes to actions that lead to
contracting HIV.

DEEP NIGHT: Forgotten Angle Theatre Collaborative

The floor reverberated with the characteristic sounds of P.J. Sabbagha’s productions as I
approached the theatre doors and stole inside. I was a few minutes late to the performance, and I
could feel the deep, sustained bass notes humming through the seat and into my chest as I sat
down. The space was dark, but sepia images of a club front were projected on large screens
upstage. As the lights rose to dark blue and green, two dancers were revealed huddled upstage
center. Both male, the dancers embraced before pushing each other away. They walked barefoot
across the stage, and the background sound was a steady, heavy thrum as the men eschewed
words and used their bodies to alternately caress then fight. The tension of contradictory feeling
was projected as one man held his body rigid and aloof from the other but reached tenderly
across the space to slide his fingers down the other’s face. The second man cupped his hands
around the first man’s fingers and took a tentative step forward, leading with his pelvis, to breach
the distance before violently ripping the first man’s fingers away from his face and batting the
arm away.

As the men continued their incongruous dance of desire and refusal across the stage, their
shadows loomed large in projection against the back screens. About four minutes into the
production, a woman strutted onstage through the shadows clad only in a gold dress that
skimmed her knees. Before emerging into a spotlight, the lit end of her cigarette flashed in the
darkness. As she walked out of the shadows, she dragged one of the men behind her and held a Styrofoam cup in the other. The two shared a smoke and drink, and their movements grew increasingly sensuous. They disappeared behind a screened panel, and seconds later larger-than-life shadows of two women were illuminated as light pierced the screen. Light flashed on the panel in short bursts, and shadow images of action behind the screen revealed two women posing suggestively and beckoning toward passers-by.

Abruptly, the shadow-lit images disappear as club music starts to play. Three figures in gold, green, and pink lamé dresses saunter center-stage and dance club-style, hiking their skirts up their thighs as they gyrate their hips lasciviously. The lights brighten, and one of the figures is revealed as male, cross-dressing in a wig. Their intoxicated state is depicted through their wild, loose movements as they stumble into each other and call to figures off-stage. Soon, a man enters from stage left as the dress-clad figures playfully mime having sex. After all three taunt him for a few minutes, the girl in gold lamé stays for a duet as the other two dress-clad figures walk offstage. The production continues through solo, duet, and ensemble scenes between the four characters as the relationships between them evolve and partners change.

Lighting plays a key role in the production. At times, the dancers’ actions are brightly illuminated, but they are shrouded in darkness at others. In one scene between all four characters, the stage is primarily dark, but each character has small LED lights attached to their hands. Opera music pipes in while flashes of light bounce across the stage and illuminate glimpses of naked flesh as the dancers frantically interact, clad only in underwear. In a key scene, two women in dresses walk onstage and preen until a man enters with a huge red leaf blower. He repeatedly blows away their wigs and aims the large, phallic blower between their legs and up their skirts as they yelp protestation and attempt to right their appearances. As the
women leave, a man in bright white briefs walks onstage staring intently at an orange dress hanging from his arm. The man with the leaf-blower circles the newcomer as if unsure what to do with this man so clearly consumed with his dress. Finally, the first man uses the leaf-blower to blow the dress away from the second man, who is left alone onstage as his discarded dress tumbles to the floor. His long solo ends as he retrieves the rumpled dress from the floor and retires behind a screen to don it once again.

The next solo begins under bright light with the dancer in the gold dress, and her movements are frantic as she walks in from upstage center. For a full three minutes, her solitary confusion and anguish are displayed through the intensity of her motions. She repeatedly grasps her head and torso and then flings her arms out from her body toward the audience as if she is tearing parts of herself away. As she does so, one strap of her dress is violently torn, and the dress flaps down revealing her naked torso. She alternates between clasping her hands over her heart and then violently gripping her head. She jerks to one side before staggering to the other. Eventually, she tries repeatedly to catch her breath but cannot. She grabs both of her bare breasts and abruptly ceases motion. As she stares out above the audience, the lights dim.

When the lights return, the same dancer is flipping through a newspaper and stands nude except for a pair of black briefs, and she is onstage with two of the others. A male dancer rips the newspaper from her hands and plasters torn fragments of it across her torso, while the other male dancer aims the leaf-blower at the woman’s chest. The wind from the blower rips the fragments of newspaper away from the woman as she begins to alternately grasp for them and spread her arms wide to let them go. The male dancer gathers up the paper fragments and continues to cover the woman’s torso with newspaper pieces until the woman starts to violently rip them away from her body and throw them to the ground.
As I watch, it seems as though the woman rejects having her body covered by the fragments of media, but she cannot strip away the paper fast enough. The man continues to cover her with paper under the wind onslaught of the leaf-blower until the woman collapses to the ground, covered. Both men stop and stare at the nearly-naked, prone figure on the ground blanketed in ripped fragments of news and curled in a fetal position. She slowly picks herself up and makes her way offstage as the other female dancer enters and begins a tender, sensual duet with one of the men that reprises the theme of contradictory feeling from the opening scene. Of all the music in the production, this piercing song affects me most. A woman’s background vocals provide a haunting soundtrack of both pain and love. I can feel the couple’s confusion, desire, and loss as they alternately dote on and push each other away. At times, it appears as if they are doing both at once. The couples’ movements are hesitant at points but decisive at others.

Fifty minutes into the production, the shadows return in force. A panel is abruptly back-lit to show a solitary woman. A man enters the frame, clasps her waist from behind, and bends to kiss her neck. She throws his hands off her body, he grasps her again, and she rears up to kick through the screen panel. The couple breaks out of the shadows, and the lights blaze to full illumination as the two stand off against each other. The couple simulates sex in between bouts of fighting until the woman forcefully pushes the man away three times before walking offstage and leaving him lying on the floor. Dejected, the man flounders on the ground and rolls into a nest of torn newspaper. The other male dancer makes a return with the leaf-blower and buries the man in fragmented, shredded newspaper, then blows the man and paper across the stage.

The lights dim as the first man is blown against the back wall. He rises from the shredded paper and is pinned against the back wall by the leaf-blower’s power. When the
second man turns the blower off and walks away, the first man falls back onto the ground in the newspaper fragments. As he lies discarded in the pile of fragments, he tries to raise himself. He cannot. The silhouettes of the three women are seen off to the right in the background as the lighting changes. The lights fade to black on the discarded man and then fade to black as the three women beckon offshore to another passerby.
As a production, *Deep Night* is a multimedia piece incorporating video art, sound, and movement to explore the lives of and relationships between four characters embedded in the urban nightscape of Johannesburg. Presented are some of the contexts in which possibilities for visceral contact with HIV are, at times, heightened. These are the everyday socializing experiences of a large part of the urban youth population, and HIV is part of the ever-present shadow cast over the relationships forged and lost in these contexts. The production showcases themes indexed by theatre-makers as part of the incoherence people within contemporary South Africa face daily in their attempts to navigate sexuality in a country where almost a quarter of the population is HIV positive: love, lust, longing, loneliness, disjointed selves, conflicted feelings, multiple partners, and dynamic relationships. Actual shadows created through light on screened panels are used in the production as a play between light and dark—the acknowledged and unacknowledged. The shadows are used to invoke the kinds of actions, thoughts, feelings, and perceptions people experience in life but have difficulty facing, describing, or explicitly acknowledging in open verbal dialogue about their sexualities and health.

The characters struggle with their contradictory feelings about each other and their desires to stay in relationships or leave. The confusion the characters feel about their sexualities and interpersonal relationships are externalized through constant embodied action: hesitant movements clash with decisive ones, a step toward one person is immediately morphed into pushing the person away in violent rejection. Individual experience of existential incoherence is most clearly noted through the scenes involving the woman in the gold dress. She begins the piece whole, clothed, and laughing with other women while dancing. In a later scene, she is alone and fights with herself—clothing ripped, she tears pieces of herself away, throws them
toward the audience, and struggles with reconciling her head and her heart. She is no longer presented as whole, coherent, or even fully clothed: her subjective fragmentation and internal struggles are made manifest through embodied action.

By the end of the production, she no longer wears a dress at all. Clad in only a pair of black briefs, she has shredded fragments of society’s expectations (symbolically represented through torn newspaper pieces) thrust onto her body by other characters, and she is buried in them. No longer is her subjective fragmentation only internal—now the onslaught of society’s multiple expectations, roles, and norms are held to her body by force through the leaf-blower’s wind. In the production, her struggles to reconcile the multiple, conflicting parts of her subjectivity with society’s multiple expectations are put on display under bright lights. This is a representation of the disjuncture that can occur between the way in which society urges its citizens to think and act rationally and the parts of people’s selves that crave other things, are simply not fully understood, or hold equal weight with a desire to be responsible. The production presents some of the kinds of contradictions people must work through or deal with in interpersonal relationships, sexuality, and life in a country where ever-present reminders of HIV dot the landscape on billboards, in commercials, in public service announcements, and as part of people’s bodies.

For Sabbagha and the performers, this production is all about acknowledging the ways in which people experience their lives as incoherent and how that in turn affects their actions and feelings about the world. The piece is about embracing shadows—the things that are real for people but which they have a hard time acknowledging openly in their lives—the things that stand in the background of a person’s life not fully understood or recognized. It is about finding and dealing with the “hard truths” of life.
In our interview, Sabbagha huffed in exasperation at one point and noted that in his experience, people are more comfortable having sex with a stranger than they are having a conversation about HIV. While he noted there has been a lot of education within South Africa about HIV, most of it is fear- and shame-based. It avoids actually dealing with the fundamental reality that up to a quarter of the population is already HIV positive—and the rest of the population is already affected by the virus through their relationships with HIV positive people as well as the pervasive discourses that circulate in the media about the AIDS epidemic. He noted that before any kind of public health initiative could have real effect, people must acknowledge that (1) HIV is here already and (2) human lives and emotions are complex and often not straightforward or subject to programming premised solely on cognitive reasoning. Unlike many medical anthropologists who primarily frame these two points as realistic components of the context in which intervention programs are created, Sabbagha and his collaborators maintain that delving into and acknowledging the existence of those complexities of human thought/emotion present a primary starting point for dealing with HIV in the country. Rather than being part of the context in which programs are created, theatre-makers are moving toward making these complexities the main focus of intervention programming.

For example, when talking about the creation of Deep Night, Sabbagha and one of his long-time collaborative dancers discussed the place of incoherence in their creative process and what accessing that incoherence can feel like:

P.J.: I love traumatic moments. We have different things that turn us on. I’m like “Woo!” and the performers are like, “Bahhhh!” I think they’re beautiful moments. You know, I was a wild, wild, wild party animal beyond what you could imagine. I know what the Deep Night is about. Teetering between realities—in that moment of teetering is where we lose our inhibitions. We all know what goes on in Joburg—the party starts at 11 pm and stops when you go to work the next morning.
Bafekile*: When you work with P.J., you have to go to your Pit of Hell all the time. Constantly. It’s emotionally exhausting. Always. You don’t want to face it, things from your past, and he pushes you to go there.

In the discussion, Sabbagha spoke about his love of delving into the dark recesses of people’s souls and pulling up all the beautiful hidden emotions people tend to bury. As an artist, one of his favorite topics to explore is the shadows of human experience, and he asks of his collaborators the same willingness to delve into the difficult parts of their lives and pull to light everything found within. Often, these topics are the kinds of things not explicitly recognized or dealt with inside conventional public health programming.

In a media interview with Esther Baker-Tarpaga (2010), another collaborator on the Deep Night project stated, “I like talking about issues in South Africa that we tend to sweep under the carpet. Those are the things I like to talk about because they’re so like in your face, and people will pretend they’re not there! I like challenging society and myself—just to see what fresh new vocabulary we can come up with.” For Sabbagha, the point of his artistic work related to HIV/AIDS is to focus attention on the real-life sides of his performer’s lives, those issues his collaborator says society commonly sweeps under the carpet, as well as to put existential shadows on display for audience consideration. In a review of Sabbagha’s production Deep Night in South Africa’s premier arts news source, Robyn Sassen had the following to say:

“Deep Night” engages with many darknesses, presenting the demon of HIV/Aids [sic] in a potent allegory. This piece of ostensibly innocuous garden equipment (leaf blower) is central to Deep Night's unpredictable narrative. Here, the leaf-blower becomes a tool of male clout, aggression, and sexual threat, but the plot writhes with explicit references to cross-dressing and violent sexual hunger that doesn't discriminate by gender. The dancers' facial expressions remain almost noncommittal in this brutal, bewildering piece which explores notions of physical vulnerability shatteringly; rather they rely on how their bodies are blown, contorted, and thrown by the context, the choreography and the piece's narrative. Each character in the piece develops his or her persona, while "Deep Night" presses on issues of ugliness, interruption, and horror with boldness, not cringing where costumes fail or fall.
[Sassen 2010: Artslink]
Sassen, as a media representative, repeats some of the same ideas about shadows that Sabbagha promotes: the darknesses of human experience are suitable subject matter for artistic interventions, and those shadows can be beautiful in their starkness. She notes that the production takes on issues of “ugliness, interruption, and horror” with boldness and refuses to back down or cringe away from handling and thinking about them.

For many theatre-makers, this idea of “cringing away” is central to where they find fault in past health intervention efforts and prevention programs. Instead of embracing with strength and austerity the difficult, confusing, or even traumatic emotional or behavioral components of life, intervention frameworks based on neoliberal biocitizenship models often try to reduce or explain away incoherence; it does not fit with their idealization of stable, coherent, autonomous, individual, and responsible subject-citizens. As a field, performance studies is far more comfortable acknowledging and living with these kinds of complexities, and theatre-makers make it a point to turn their attention to this arena of existential incoherence and its effects on people’s sexualities and health.

Although the other production FATC showcased in 2010, I Think It’s Hamlet, was not marketed or publicized as an HIV/AIDS-related production, the director’s note from Sabbagha in the playbill for the show also links that production to ideas about HIV/AIDS and acknowledging the shadows of human experience:

The work is a bit of “madness” inspired by William Shakespeare’s Hamlet. A philosophically physical tangle on the mystery of our human experience. The impossibility of certainty, the complexity of action, the disease of inaction, the mystery of love, life and death and our relentless search for some kind of "truth." The work is not a retelling of the original narrative or a linear exploration of its characters. Instead, it is an essay on our personal responses and interaction with the text, its themes, motifs, and symbols through the lens of our contemporary experience as individuals and artists. As

88 Commonly, biomedical and public health programs.
contemporary artists I believe it is essential and unavoidable to look deeply and constantly at pressing social and personal issues. Hamlet’s preoccupation with death and suicide, his desperation trying to forge his future, his need to change his world, and his endless existential probing speaks directly to very contemporary personal, social, and political issues. As always, I find it impossible to avoid thinking around HIV and AIDS, and Hamlet provides an opportunity to interrogate the psychological impacts of the disease on our experience.

Here, the company’s interpretation of the classic Shakespeare production is framed within broad terms related to the human experience of incoherence. Toward the end, Sabbagha links the existential parts of human experience to the idea of complexity as it relates to HIV in South Africa and notes the importance of thinking about the psychological impacts of disease on human experience within artistic projects. In contrast, *Deep Night* was explicitly linked thematically to HIV/AIDS and experience of incoherence within production content, marketing around the production, and within interviews conducted with the involved theatre-makers.

**Bongani**

An applied example of this philosophy of acknowledging incoherence (or struggling to do this) arose in an interview with one of the Drama for Life students, Bongani*89*. It is a good example of theatre-makers pushing the boundaries of examining things people have difficulty facing or coming to terms with in their own lives: the places where people experience contradiction between their own actions and ideals. Instead of detailing characters in a production (such as the incoherence of the characters in *Deep Night*), this example foregrounds the same kind of lived experience in the work processes and relationships of an actual person. In the interview, Bongani and I were talking about the difficulties he faces eliciting discussion from theatre participants about their own sex lives. He said he understood how hard it was at times to

89 He is a 26-year-old Cameroonian male.
really engage with the parts of yourself that you do not fully understand or even ideologically support.

Bongani paused for a bit and then asked me to turn off the microphone because he had a story to tell that he did not want recorded. After that, he spoke of the last time he had sex. It had been 21 months, and he noted that as a responsible man, he usually wore condoms. However, that particular night, he did not. He was unsure why. He said, “Man, it was stupid, and I hated myself for it afterwards. But in the moment, I just [pause] didn’t.” Later that week, as he was conducting a theatre intervention with some youths, he discussed with them abstinence and condom use (in the failure of abstinence). In our interview, he said:

Ah, I was being dishonest with myself when I was talking about my project with some people, and I suddenly paused. Like, ‘Ah, c’mon man don’t say that, why are you saying that about condoms?? Didn’t you just (not use one) [pause] you see?? That idea, it broke me for real. And it’s true. I wouldn’t tell my participants in my project that that happened to me. In my project, I talk about honesty, and I don’t know if I’d be honest.

He did not understand his own actions, but he later went on to say that he considered it important to have those contradictory experiences, because a lot of the people with whom he will be working have similar experiences. The point here is that Bongani felt a significant disconnect between how he saw himself as a responsible person and the reality of his actions. He struggled with facing that fact (“meeting that truth,” as Denvon would say) and being honest with himself and with the participants of his theatre workshop. Although he was open enough to tell the story, he was so uncomfortable with his actions that he did not want the story to be recorded. The act of recording his story was a level of acknowledgment of his actions he could not face.

Contrary to conventional public health programs that demand a certain kind of responsible engagement, differences in levels of engagement with intervention processes is

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90 However, he did give consent for the story to be used in my writing.
allowed and even encouraged by theatre-makers. Acknowledgment as a health intervention process makes room for different levels of ability or readiness to recognize incoherence in life and the ways it affects actions, thoughts, and feelings. Part of acknowledging incoherence in life is also acknowledging that people can only engage with interventions to the best of their ability—at the level of their current comfort in that moment of their lives. This idea of “to the best of someone’s ability” is an important part of theatre-makers’ understanding of acknowledgment as a process. For instance, Sabbagha’s ability and willingness to acknowledge his shadows is highly developed; however, as some of his dancers noted above, they have trouble meeting him at the same level of vulnerability. Bongani is a good example. In our interview, he was able to engage with his shadows enough to discuss them with me, but he was not yet ready to have those shadows immortalized through a voice recording that might be made public to people at a later date.

Bongani’s story and the reaction of Sabbagha’s collaborator both illustrate how theatre-makers are struggling with the idea of acknowledgment (as a process of recognition of incoherence) within their work. Although FATC is just one company and Deep Night one production, the ideology of the group members and the content of the show reflect the widely held belief of other theatre-makers that acknowledging incoherence in human experience is an important starting point for HIV intervention programs and an important process offered within theatre related to public health in particular. It is related to Peter Hayes’ idea of “embracing shadows” and Denvon’s concept of “meeting truths.” Here, Bongani frames it simply as an intense and aware level of self-interrogation and honesty.
Recognition of Incoherence and Fragmentation

For theatre-makers, acknowledgment as a health intervention process is fundamentally about recognizing the limits of cognitive knowledge. Acknowledgement is a way to recognize the existence of incoherence in life along with fragmented subjectivities without attaching or imposing a moral valence to them. The second part of this process is creation of a non-judgmental space in which the parts of people’s subjectivities they do not fully understand may be interrogated. Acknowledgment is about allowing people to be who they are without judgment, and it is premised on the idea that removing judgment allows the fragmented, shadowy sides of people’s subjectivities to come to the fore for examination.

Within some recent applied health theatre work, this process of acknowledging incoherence has become a central starting point for intervention processes. This process of acknowledgement is as much an ideological commitment to engaging with incoherence as it is a call for recognizing that health subjectivity is rarely experienced by the general population as the stable, autonomous, knowledge-based, responsibility-oriented biocitizen model of common intervention programming. The kind of acknowledgment theatre-makers discuss is about allowing incoherence to become a part of the mainstream conversation within public health and the broader healthcare industry. It is about allowing people’s shadows (instances of incoherence) to come under intervention optics, as well as participants’ personal gazes. It is about encouraging participants to acknowledge, give voice to, and then start working toward mediating or balancing their shadows in a way that is personally productive.

7.3 Acknowledgment as Challenging Intervention Language and Reassessing Health Activism

Once complexities have been acknowledged, theatre-makers posed the next question: what do we do about these parts of lived experience? Should anything be done at all? Theatre-
makers were quick to assert that not only does incoherence in life exist, but the kinds of thoughts, actions, and feelings that comprise incoherence are often framed within conventional health interventions as “problems.”

In the online health section of TIME magazine, an article was recently (2013) published called “No Condom Culture: Why Teens Aren’t Practicing Safe Sex.” Although the article explored the decline of safe-sex practices in the United States, its overall tone mirrors a perspective found globally in media related to sexually transmitted infections: the idea that complacency in safe sex practices is linked directly to a worldwide absence of fear among teenagers about the consequences of obtaining STIs. The article directly positions “fear of death from sex” as a good thing: in the article’s perspective, fearing death through sex (from obtaining potentially life-ending sexually transmitted infections) leads directly to more responsible, less risky sexual behavior among teenagers. Unfortunately, this is a common perspective within intervention programs on the ground, and the theatre-makers with whom I worked find it problematic. They often mentioned this perspective and reacted strongly against it.

Pieter-Dirk Uys spoke of this in our interview about his work on HIV/AIDS. He spoke of the critical need to acknowledge that HIV is a part of the experience of most people’s lives in South Africa, as well as a need to recognize the simple fact that sex happens, will continue to happen, and that many people enjoy it. Here, he notes the necessity of finding ways around normativity claims, fear-mongering among STI intervention practices, judgment, problem-framings, moralizing discourses, and the ever-present “should/should not” rhetoric of past HIV

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91 Anthropologists have also noted a similar outcome within HIV intervention programming. Literature on the stigmatizing effect of moralizing discourse and framing certain sexual actions as “problems” exists within anthropology and public health broadly. For examples, see Brown et al. 2003; Castro & Farmer 2005; Ehiri et al. 2005; Tsai et al. 2013; Mbonu et al. 2009; Skinner & Mfecane 2004; Herdt 2001; Fortenberry et al. 2002.
programming in the country. In particular, he notes the common link between religion, faith, and sexuality that gets invoked within South African HIV programming:

I look at my little audience, and they’re Muslim kids and Christian kids, and it’s a hugely frightening thing: this thing of sex and religion. I said to them, “you know, I’m going to talk with you about things you might feel uncomfortable about, but when I talk about sex here, it’s not about morality; it’s about hygiene. It’s hygiene. If you don’t brush your teeth, what happens?” They say, ‘we lose our teeth.’ I said yes! If you don’t look after your health, through sex, what happens? They say, ‘we get AIDS.’ And you can see the kids’ relief: it’s not about morality. It’s not about what God said you can’t do.

So one has to, sort of, talk without being judgmental, without having a moral high ground. It’s a hell of a challenge, I must say. And you know, things should be better, and they are better on the one hand, at least we’re away from square one to square two. And that’s why it’s important to, you know, when I say the safer sex is no sex, it’s old news that the sex happens. And I say to the kids, you know, it’s going to happen. And I want to tell you it’s very nice. Don’t let anybody tell you it’s not nice! Why do you think we’re all doing it? It is nice. Rolling in the grass is also nice, but if there’s a snake in the grass, it might change your mind. Know what you’re doing.

In our conversation, Uys positions theatre interventions as a way out of moralizing discourse about HIV/AIDS and sexuality. Within many popular HIV intervention programs in the country, sex is represented in much the same way as in the TIME magazine article: something to be feared or avoided. HIV/AIDS programs funded by United States’ PEPFAR have, until Barack Obama’s administration, precluded disbursing funds to any initiative that did not explicitly support abstinence as a primary HIV prevention modality. Similar to the religious subjectivity Uys discusses, biocitizenship also promotes set ideas about what is “right” or “wrong” behavior when it comes to sexuality.

Under both religious and biocitizen subjectivities that are premised on morality and personal responsibility, there is no room to consider or discuss the kind of actions, thoughts, and feelings exhibited by Bongani, the dancers in Deep Night, or Sabbagha’s characterization of himself as a “wild wild wild party animal” in the past. Within neoliberal biocitizenship, Bongani’s actions would be stigmatized—especially since he neglected to use a condom during
sex when he had full knowledge and awareness of the reasons why he “should” use one. Even though the kind of actions, thoughts, and feelings discussed by theatre-makers as “incoherent” or “complex” are very real parts of those people’s lives, they are often constructed a priori as “problems” within common HIV intervention paradigms.

While even Uys does not fully disengage from placing negative connotations on certain sexual actions (here, unprotected sex is likened to a snake in the grass), he does recognize the need to talk about certain kinds of often-stigmatized behavior in non-stigmatizing ways. Johannes*, a 23-year-old white male Afrikaans actor, raised similar points in discussion with me about his HIV/AIDS-related theatre work. He noted:

"Look, we’re not there to tell them listen you can do this, you can’t do that. No, we tell them: listen you can have sex, you’re human, we tell it—a spade is a spade. We put it there for them, and they see it’s okay. And their thought process will then be, “It’s okay. We can talk about these things.” These things do happen. We’re all individuals, we’re all human. And basically just putting it out there as it is, saying here’s the mirror; we reflect your society.

For Johannes, an important impact of health-related theatre is mirroring the realities of society and putting on display the kinds of complicated actions, thoughts, and feelings erased under neoliberal biocitizenship. Rather than stigmatizing sexual expression, for Johannes the point of artistic health interventions is to open a non-judgmental space to speak about difficult topics.

Acknowledgment of incoherence as a process is, in part, about tensions around social change and activism within health interventions. Theatre-makers debate heatedly about this. For some, a main intervention goal is to mirror society and simply recognize and show complexity in lived experience through performance art. Johannes’ and Uys’ ideas about the importance of moving discussion of sexuality and illness into non-moralizing spaces reflect the practical side of this common viewpoint. However, for other artists, the point of health-related
theatre is to actively challenge the status quo and encourage critical reflection on social and personal topics while urging social action.

Acknowledging incoherence allows both recognition of incoherence and challenge of the status quo simultaneously. Rather than simple recognition of the existence of complexity in life, acknowledgment as a process is a way theatre-makers try to open space for considering individual and social change without necessitating it in moralist terms or falling back on reductionist framings of individuals as socially determined by the contexts in which they live. This concern parallels well-documented anthropological attention to the nexus of agency and social structure (Bourdieu 1977; Giddens 1979; Mahmood 2005; Ortner 2006; Gell 1998; Singer 1995; Farmer 2004).

One finding of my dissertation research is that in a practical, applied sense, theatre-makers’ focus on the process of “acknowledging” incoherence (also: “meeting truths” or “embracing shadows”) is about their struggle to find or build a vocabulary that challenges the language of “problems” within dominant health interventions. This is interesting anthropologically because ideas about how best to frame interventions for productive audience consumption have become fraught with tension in contemporary theatre-making about health, as well as the broader realm of global health communication. This intervention push on the part of artists is about acknowledging certain actions, thoughts, and feelings people experience are often framed as problems within common intervention discourse, which creates a judgmental environment that forecloses the possibility of really interrogating the relevance of those parts of people’s lives. I witnessed artists struggling daily with this topic in their attempts to re-think how best to address HIV.
For many theatre-makers, part of the acknowledgment process within theatre is questioning how and why (for what reasons or ends) the things indexed by incoherence come to be constituted as problems and whose agendas regulate this problem framing within popular interventions. While acknowledgement as a health intervention process in some ways closely resembles the types of therapeutic goals within psychology (talk therapy, cognitive-behavioral therapy, psychoanalysis), this process in theatre extends its reach into a tacitly political realm of social critique. Acknowledgment within theatre intervention modalities is about “coming to terms with reality,” but it is also about creating space to challenge regulatory, normative discourses about health, sexuality, and illness created in spaces of institutional power and circulated by national and popular regulatory bodies and their representatives (e.g. Departments of Health, the media, international funding organizations, the World Health Organization, clinicians, and journalists). For artists, the theatre space is one of interrogation (into power and control at institutional levels) and creativity (venues for alternative meaning-creation).

I maintain theatre-makers have begun actively challenging the problem framework for public health intervention and are suggesting subtle changes. Many theatre-makers note that the problem framing is unhelpful because it suggests primary intervention goals are to “fix” these problems over any other form of intervention engagement, modality, or agenda. This need to fix problems becomes particularly dubitable because it is both judgmental and often ignores disconnect between funder/artist intervention agendas and audience needs or interests. In essence, they note the problem framing can (and often does) shut down people’s engagement with public health intervention practices. Problem-framing sets up an issue as something that must necessarily be changed—and usually changed in certain, limited ways. Through acknowledging incoherence in life, theatre-makers try to balance a very fine line within
interventions by creating a space to interrogate issues that allows for change without
prescriptively demanding it. It allows people to interrogate an issue nonjudgmentally with the
premise that change is possible but not required. This in turn makes space for audiences to
listen, react, think, feel, and consider whether (and if so, how) they want to change their actions
or contexts.

Overall, the important result that accompanies theatre-maker attention to ideas about
problems, framings, and agendas is an active attempt to find nonjudgmental forms of
intervention that move away from moralizing discourses about illness, health, and sexuality. For
theatre-makers, the focus on complexity as incoherence is important because it shifts framing
issues within interventions from “problems” to simply “realities to be acknowledged and
addressed.” The change in language from “problems” to “acknowledgment” is a subtle but
important part of artists’ goal to shift interventions from their judgmental past in the country to
practices deemed non-stigmatizing.

In addition, the use of the shadow construct provides a starting point for talking about
often-stigmatized actions in non-stigmatizing ways, and it shows how engaging with
considerations of complexity can have applied, practical relevance within public health
programming. Although “shadow” sometimes has a negative connotation or undertone in
colloquial use, theatre-makers use the term to refer more to the liminal space theatre offers to
consider human action and feelings that are not quite fully understood by the people
experiencing them. In this way, the use of shadows as a construct shows how theatre-makers are
engaging with issues of incoherence to disturb the kinds of dichotomous public health
intervention framings so often put into practice at national levels.
For instance, Jorrell, a 45-year-old white South African, homosexual man talked about how in his youth, the sexuality with which he identified was discussed within society as a “problem.” In speaking of his goals within his own theatre work, he went on to say:

Well, I really hope that it allows, it encourages children and youth to question, to be able to acknowledge who they are. I’m just speaking from my own bitter journey in life! [melodramatic tones] You know, my own ability to acknowledge who I was, and there was no place that was secure enough to start asking those questions and getting help. Yeah. So that’s my, yeah, wish fulfillment. That the plays allow a safe space to both question, investigate, and reflect on issues, on identity.

According to Jorrell, theatre provides a way for people to “acknowledge” who they are and explore their identities rather than automatically problematizing certain components of people’s identification processes (e.g. homosexuality).

Despite the critical importance for most contemporary artists of this shift away from “problems” and toward “acknowledgement” in reimagining HIV intervention possibilities, many discussed the topic in a number of ways that are often contradictory. Sometimes, problem-solving was discussed as valuable and important. Other times, artists would say that the language of “solving problems” is very troubling because it sets up interventions for failure. For example, consider the following quotations taken from interviews and focus-group discussions after performances:

Ownership of Problems
It’s like in that moment, you’re not saying ‘we are the theatre company and we’ve come in to fix your problems.’ We’re saying—‘this is the problem; you as a community own this problem. What are you going to do?’ And then there’s a process where we facilitate and process of making action plans or taking action. It’s about ownership. Ownership of the problems or the issues. There’s a strong culture of donors coming in to fix the problem. And we’re saying—no! The community has these issues, we don’t even really want to call them problems because we’re trying to move now to a more Appreciative Inquiry philosophy, so it’s about ownership. If the community can own and acknowledge that the problem is here. But we also, depending on the issue, obviously you can’t fix everything then and there. It varies from issue to issue. Some things are obviously more complex. We did for example a litter play and that resulted in an action-plan. Task groups were set up and certain people elected to monitor the situation to look after the
bins, to follow-up. So depending on how complex the problem is, yeah. You just have to own what’s going on.

Abandoning “Problem” Framings

There’s too much pressure to problem-solve and fix, and it comes out of your agenda. This is too big a challenge for the time you have with your audience. Also, this language of “solving” problems—it’s troublesome. You assume it can be solved and solved in particular ways. Don’t set up an impossible task. These are not topics that can be treated in those ways—with a “fix.” These are dynamic issues. These are not to be solved. These issues are to be investigated—they are too complex to sort out in a day. This isn’t about “solving” and “right.” This is about living, exploring, and grappling with questions and complexity. Think about how to set up your intervention so you explore sexual discrimination and violence without being frustrated that you don’t solve it.

The first quotation comes from an interview I conducted with a Zambian theatre-maker who currently resides and works in South Africa. It echoes a common perspective I encountered in the field: the idea that people must “own” their problems. Other theatre-makers often noted the importance of “owning” your shadows and “owning” your stories. Playback theatre was considered a particularly important genre for helping people own their stories, shadows, and problems, and the increasing use of this genre within South Africa over the last 5-7 years is often linked to the “ownership” intervention goal.

This perspective is proprietary, has to do with taking responsibility for your life, and echoes the tenets of neoliberal biocitizenship. In the first passage above, the director clearly notes the importance of theatre-makers enabling the agency of community members through HIV intervention processes. However, she places equal importance on avoiding over-reliance on donors or outside sources for quick fixes to community struggles. The perspective is largely a reaction to donor-driven aid and years of broken government promises. It closely parallels calls within HIV intervention literature for community empowerment and community-based participatory action research.
The second quotation is an example of an equally common perspective I heard during fieldwork: the idea that “problem” framings must be abandoned wholesale within intervention practices. This perspective represented a push to reframe issues constructed as “problems” within past intervention practices to simply “issues to be acknowledged” (nonjudgmentally). This second quotation is much more closely aligned with Devon’s concept of “meeting your truth” or the kind of acknowledgment covered through Deep Night. For example, Bafana*, a 27-year-old black South African theatre-maker, stated a plea related to this topic in a Facebook post (5 November 2013):

First we must simply realise that we are violent, before creating “nonviolence” and “fighting crime” campaigns! [Those campaigns] result in more conflict. Let us first look at the Fact without prejudice, without being too hard on ourselves but looking with honesty and compassion at the fact of what we are! Once we have clarity of that perception, we can move from there.

For Bafana, intervention and development work often miss the first and crucial step of simply acknowledging, nonjudgmentally, the existence of an issue in society, in its rush to move toward something else (the “fixing” of the problem). Like many other artists, Bafana implicates this as part of why HIV prevention and health promotion programs are failing in the country. When theatre-makers were more explicit, they sometimes shifted the language from “problems” to “problematic.”

Regardless, this second perspective represents an intentional and active move to challenge how things are constructed as “problems” within official national discourse and reframe issues related to HIV in an effort to avoid judgmental valences. This perspective is about clearing a path ideologically for promoting non-judgmental interventions and finding practical ways to create less judgmental intervention practices (so, ways to deal with stigma, internalized social pressure, judgmental media representations, and common-sense dogma).
Even though this became a stated intervention development goal for many theatre-makers, it was often difficult to implement in practice. A significant finding of my dissertation research, in fact, is that theatre-makers often fail to uphold this framework commitment in practice. For example, consider the following vignette about a student theatre-maker and her Masters project. The story of the student’s project and the feedback she received from the performance’s observers is a very good illustration of the major tensions at play within theatre-maker focus on acknowledging incoherence versus framing people’s shadows as “problems.”

**Naomi, Problems, and Image Theatre**

During one of the Drama for Life Masters Final Exams, a female black South African graduate student (Naomi*) was working with 23 primary students from Hillbrow, a local previously disadvantaged community within Johannesburg. Although I did not actively participate in the group’s former theatre processes, I was invited by the director of DFL to accompany the examiners as they observed Naomi’s project in action. It was early November 2010, and Naomi had been working with these students for about 5 weeks. Her project interrogated power differentials related to sexuality (specifically homosexuality), physical violence, and discrimination within South African school systems. Although HIV/AIDS was not an explicit thematic topic in the performance processes on the day of the exam, discussions about HIV at the nexus of schools, power, and sexuality had been integrated into the workshops Naomi ran with the students over the past month.

After some warm-up games, Naomi directed the students through adapted theatre processes from Augusto Boal’s Image Theatre\(^{92}\). Image Theatre is a type of performance in

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\(^{92}\) Augusto Boal’s Image Theatre is based on Paulo Freire’s philosophy of critical pedagogy. The techniques involved are fully explained in Boal’s book *The Rainbow of Desire*. The purpose of Image Theatre is to interrogate social oppression within an environment that is conducive to critical reflection, equality, and dialogue. It
which participants create representations of abstract concepts (their thoughts, feelings, experiences, and opinions) and realistic situations through a series of exercises using their physical bodies in a technique that produces still images (“human sculptures”). The goal of Image Theatre is to critically engage in reflection on oppression (internal and external), unconscious thoughts, and feelings using both verbal and nonverbal modes of communication in an attempt to identify alternatives to existing social realities (Schutzman & Cohen-Cruz 1994).

Next, Naomi divided the students into three groups. Each group then performed a skit using techniques from Boal’s Theatre of the Oppressed. For instance, one group’s skit was set within a classroom and highlighted interaction between a male student, Thabo, and his female teacher. Thabo approached the teacher and “performed” homosexuality through several stereotyped mannerisms, such as walking in a sashaying manner and speaking with a lisp. The teacher repeatedly hit Thabo after his supposedly homosexual behavior. Later in the scene, other students from the classroom also beat up Thabo.

After the skit concluded, Naomi questioned the rest of the students (who comprised the audience). She asked whether the kind of behavior they witnessed in the scene was right or

constantly moves back and forth between considerations of individual accountability and social responsibility, but it tends to link oppression to underlying social structural forces rather than placing responsibility on individual oppressors. This form of theatre grew out of Boal’s work with oppressed groups within Brazil, wherein he attempted to work with people to help them recognize the forms of social oppression operational in their lives and rehearse ways of overcoming those oppressions in the “real world” through employing creative risk and practice in the fictitious liminal space of the theatre (Boal 1979).

In many ways, Boal’s Image Theatre is a set of aesthetic and artistic exercises (methods) for rehearsing liberation and revolutionary action against oppression. Image Theatre, as part of the broader Theatre of the Oppressed agenda, advocates that participants be Spect-actors rather than Spectators. Through this coined term, Boal means that participants should take an active role in the social construction of new possibilities and new worlds within the theatre space and practice enacting social change in the real world rather than simply passively observing as other people (actors) put on a show. Within Image Theatre, Spect-actors critically reflect on the dramatic action, discuss possible plans for change, and actively engage in said change through physical embodied action. Boal considers the theatre space a metaphorical container in which participants rely on both verbal and non-verbal means to physically embody and experience what their own and others’ oppressions feel like, as well as create alternatives to those oppressions. It involves a collaborative construction of meaning.
wrong. As one, the entire group of students answered “Wrong!” Naomi then asked the students what the “right” or “ideal” thing would be to do in that situation. The audience volunteered a few answers, and Naomi had the student group redo the classroom scene. She noted that the goal of the skit/exercise was to convince the teacher character to change her actions and feelings toward homosexual students. Naomi directed the audience to yell “freeze” when they identified a problem (something they considered wrong) within the scene. At that point, the actors would freeze, and Naomi would ask the audience what the problem is and what the characters should do instead of the actions in the scene. She noted, “We start correcting it from here.” The audience identified “the beating” as the problem and offered a few options for what Thabo could do instead of “taking the beating.” For instance, some students suggested that he should run away or use litigation to sue the teacher.

The students replayed the scene and tried the run-away solution to see if it solved Thabo’s problem; however, the teacher and a bully ran after Thabo and continued to beat him. The audience yelled “freeze!” again, and several people started shouting, “But she wasn’t supposed to run after him!” The audience demanded Naomi tell them why the teacher ran after Thabo. Naomi told them to ask the teacher, so the audience questioned the student playing the teacher about why she continued to persecute Thabo even after he ran away. She explained her reasoning, and Naomi again questioned the audience—“now we know what the teacher thinks, so do you think we can give Thabo better advice for how to deal with the teacher?” The audience was silent for a long time, and then one girl piped up in a frustrated voice, “But [pause] this is who Thabo is. They must just accept him as he is.”

Naomi asked the students to redo the scene one more time to solicit additional options from the audience for how Thabo could deal with the discrimination he was experiencing from
the teacher, as well as the power differential that existed between him and the adult. The audience continued to struggle with finding resolution to the scene. They directly questioned Thabo (in character) to understand why he was doing what he was doing (“acting gay”) and suggested Thabo confront the teacher, explain to the teacher why he is gay, and defend himself.

The teacher responded to these attempts by escalating the shouting and violence. In this scene, the character identified as Oppressor (the teacher) was unwilling to change her actions in any way toward the Oppressed (Thabo). The students in the audience grew increasingly frustrated and discontent with the scene. Finally, several suggested Thabo either (physically) fight the teacher, leave school forever, or listen to the teacher and conform (in this case, conforming meant hiding Thabo’s homosexuality). Naomi eventually stopped the first group because of time constraints and initiated the scenes of the second and third groups. A few students continued to participate in a lackluster manner, but it was hardly at the level of engagement of the first scene about power, discrimination, and sexuality within schools.

In Naomi’s project, she was drawing heavily on Forum and Image Theatre. Within Image Theatre, the group of participants first chooses a topic they agree is an oppression. In this particular case, Naomi and the workshop participants chose sexual discrimination within secondary school settings as the oppression to critically investigate. Next, three or more participants work together using their bodies (no language) to create a particular still image of a scene or experience of oppression that represents social reality as they experience it (Real Image). The goal is to encourage the audience to think about how that image (the representation

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93 This particular workshop was not about HIV, but issues related to HIV had been covered extensively in past workshopping exercises with Naomi’s group. I present discussion of this workshop because it is the one I observed. At issue is less which topic participants choose as an oppression to discuss and more how the topic is framed through theatrical techniques.
of social reality) could be changed to alleviate or fully abolish the oppression. Once suggestions are made, participants from the audience physically change the human sculpture to ease the oppression. This is then called the Ideal Image. Sometimes, participants are encouraged by the facilitator to reflect on how people involved in the scene could transition from the Real Image to the Ideal Image, and a Transitional Image is created. A lot of this discussion often has to do with reflecting on the kinds of power involved in the relationships among people in the scene and linking their ability to change their situation to broader social structures, institutions, and contexts.

In this philosophy, visual images are considered a powerful part of communication and equally important to the workshop as reflection through language and dialogue (Boal 1979). Image Theatre uses the idea of metaxis as the basis for social change. As a heightened state of consciousness that holds two worlds (the real and the fictional) in the mind at the same time, metaxis within the theatre space allows participants to actively critique their “real world” experiences, reflect on possible changes, and enact those changes. Within Image Theatre, real-world scenarios related to oppression are interrogated, and new possibilities for action are practiced within the consciously constructed Ideal Image (the real versus imagined world). This involves an active, collaborative construction of meaning on the part of all participants, not just those onstage⁹⁴. The basis of this philosophy is that Image Theatre allows workshop participants to collectively process (cognitively, emotionally, sensorially) an event through various perspectives and propose alternatives.

⁹⁴ See Boal (2002, 2006) on the efficacy of images within theatre. For Boal, words and language are often intimately tied to reason and cognition. Working in embodied images with human form allows participants to use alternative forms of communication and understanding that decenter the cognitive and add the sensory and emotional as equally important components of meaning-creation. For Boal, keeping cognition coupled to the senses, form, and emotions is an important endeavor: it allows people expanded expressive and perceptive possibilities.
In Naomi’s workshop, she was trying to adapt Image Theatre for a South African context in which homosexuality is often stigmatized. Because of that, she was trying to use Image Theatre without invoking its basis in “problems.” This philosophy of avoiding problem framings is becoming more common within her program (Drama for Life), and indeed much of the critique she garnered from her examiners related to that topic. Although using theatre has potential to change the way people view certain situations and events, Naomi’s particular case illustrates a theatre-maker struggling with how to talk about stigmatizing topics and social change without dichotomizing the issue as either a “problem” or something socially “acceptable.”

In this example, Naomi falls into several common mistakes of interventions as a whole. For instance, instead of asking participants what the “oppression” is, Naomi asks them what the “problem” is. Similarly, instead of asking the students what “alternatives” to the actions in the scene could be used, she asks the students what the “right” or “ideal” solution to the problem would be. After students suggest other possibilities for the actors in the scene, Naomi adds, “Yes! We start correcting it from here.” All three of Naomi’s statements use strong language that frame the scene as a problem to be solved or fixed instead of an issue to be explored and interrogated. In this case, the language used to frame the intervention becomes critical to whether the issues being discussed are framed judgmentally or not. One of Naomi’s examiners remarked at the end of the workshop:

Be careful of how you talk about the issues and oppressions you discuss in the workshop. Sometimes, these are challenges—not problems. They can lead us to new ways of thinking and being. Turn “problems” into opportunities. Don’t dwell on them as “problems.” And be very careful with how you represent gayness. Stereotypes were being presented, and there was no space to explore that or unpack other ways of being gay because you set yourself for a big challenge here—sexuality and discrimination. The real issue was the out-of-control teacher, but sometimes the exercises fell back on gayness being the problem to be fixed—be careful of this framing.
Other examiners agreed and noted that within the intervention, Thabo was sometimes left to defend with logic his reasons for being homosexual—to justify who he is. This positions homosexuality as both a problem and as something that can be cognitively explained. Within the intervention, even though Naomi had been taught to avoid framing topics as problems and she believed strongly in this restructuring of techniques, she continued to pose the issues to be explored as problems to be fixed or solved—problems with “right” or “correct” answers versus “wrong” solutions. In doing so, she reinforced judgmental language.

Naomi’s example is so apt because it illustrates a struggle I saw commonly on the ground: theatre-makers recognizing the need for shifting intervention practices away from judgment, condemnation, and moralizing discourse and toward something else. However, that “something else” was sometimes difficult to articulate. Theatre-makers struggled daily to find language outside of the “problem” narrative that incorporates “owning” what is going on in a person or community’s reality without being judgmental or implying it was the individual’s responsibility to “fix” the issue. The goal was to figure out non-judgmental language capable of reflecting the complicated reality that issues people face in life are partly a result of their own actions and partly out of their control.

This was especially true for artists working with Theatre of the Oppressed. While dramatherapy and playback theatre are two genres that are built on highly nonjudgmental methods, Theatre of the Oppressed is based on identifying certain situations, activities, events, actions, and perspectives as oppressive and therefore problematic. The goal of Image Theatre is to identify and practice alternatives to oppressions in real life. This has an almost inherent censoring component. That struggle is re-articulated within the examiner’s comment that Naomi should reframe the issues/oppression as “challenges” or “opportunities” rather than “problems”:
this is the part where active re-framing within and for the South African context can be seen—

theatre-makers are struggling to use highly influential applied theatre methods to interrogate
social issues, but they are also trying to adapt those forms for use with highly stigmatizing
subject matter in a way that does not reinforce stigma or stereotypes (e.g. HIV/AIDS-related
issues, certain components of sexuality, gender violence, substance abuse). In this particular
case, Naomi’s intervention failed to “solve” the issue of sexual discrimination within secondary
classrooms, and it led to showcasing stereotyped homosexual behavior/actions, as well as many
of the participant students being frustrated by the end of the exercises.

Building a Vocabulary Outside of “Problems” and Implications for Social Change

Theatre-makers are advocating using the process of acknowledgment as a way to create
nonjudgmental spaces for consideration of alternative subjectivities while challenging
stigmatizing “problem” framings so common within HIV intervention paradigms and ideas about
neoliberal biocitizenship. Theatre-makers use the language of shadows and acknowledgment as
a way to recognize and bring to intervention attention two important things: incoherence in life
and fragmented subjectivities. I argue that theatre-makers use the “shadow” construct as a way
to make conceptual space to reconsider a host of actions (e.g. those related to “unsafe” sexuality)
that are often stigmatized or framed as problems within the media and some national public
health campaigns in the country.

Rather than constructing the kinds of actions, perceptions, and categories of being
indexed by “incoherence” or “shadows” as problems to be fixed, theatre-makers encourage
acknowledging the existence of shadows in a value-neutral space devoid of moralizing good/bad
discourse. Acknowledging shadows dovetails with anthropological attempts to find
nonjudgmental ways to talk about stigmatizing topics and critiques about morality discourses

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A major question for theatre-makers has become: if the issues discussed within interventions are not to be framed as “problems,” what are they? How do we talk about and frame them? Although I provided two quotations earlier that make the issue appear black and white (owning problems versus abandoning problem framings), the issue is more complicated. Consider the following quotation from Liesl*, a 30-year-old white South African woman who was an internal examiner of the DFL honors student exams:

Don’t see these as “problems” without connecting them to larger structures and what’s going on and why. If you do, you feel disempowered and put-upon. Link the problems to understanding structure—why all this is happening. Things happen for a reason, and your audience is struggling for a reason—you have to try to understand this. What are factors contributing to system problems? Place yourself and your audience in that bigger picture.

Motlotlehe*, a 27-year-old black woman from Lesotho who was partnered with Liesl as an internal examiner nodded her agreement with the statement. Liesl’s thoughts come from a critique she had of two DFL honors students’ exams. While it echoes the critique a different DFL examiner gave to Naomi during her Masters exam, Liesl’s comment subtly shifts the suggestion from abandoning the problem-framing to actively challenging the problem-framing. In the perspective of the two DFL honors examiners, challenging the problem-framing is about avoiding feelings of disempowerment on the part of intervention participants, but it is equally about linking the issues people face to the social structures and institutions that shape those lived experiences.
For many theatre-makers, the language of “acknowledgment” provides the kind of framing for which they have been calling: it allows a linking between complexity in both social structure and lived experience to critical analysis of particular issues. Rather than necessarily construing incoherence as a problem or even problematic, “acknowledgment” avoids a moralizing valence and allows people to talk about issues of interest in a way that is not deterministically judgmental. It allows theatre-makers a way to examine and talk about social or personal issues that may be construed as problematic while leaving open the conversation about whether those actions, activities, thoughts, and feelings are problematic or not. As a process, acknowledgment is about recognizing the possibility of alternate subjectivities, making room to consider them, and recognizing that people do not always experience their lives as coherent or stable.

I have also suggested in this chapter that theatre-maker construction of acknowledgement as a health intervention process is partly about reassessing health activism in the post-apartheid era. For many artists, acknowledging complexity as incoherence provides a route through which to push an agenda of social critique of health efforts in the country. Acknowledgement as a process also opens the possibility for individual and social change without necessitating it. When change is implicated through acknowledging incoherence, it is about allowing people to change as they can rather than demanding prescribed paths for behavior. As illustrated through Sabbagha’s Deep Night production, Bongani’s thoughts on artistic HIV intervention, and Naomi’s Image Theatre workshop, radical honesty and non-judgment are core components of acknowledging incoherence. Also core is the ability to recognize that an intervention program’s goals may not fully map onto a particular audience’s
interests or needs. This is about allowing people to be who they are without necessitating change but also keeping that door open.

7.4 Conclusion

Through the process of acknowledgement in theatre spaces, the existence of incoherence in life, along with its effects on people, are recognized as social realities that must be addressed within interventions. I maintain theatre-makers are redefining the central starting point for interventions through this process; analyzing complexity in lived experience becomes a point of departure for intervention efforts rather than simply a contextualizing factor in the production of health outcomes. Additionally, I suggest theatre-makers are positioning this process as a way to challenge hegemonic public health intervention framings and language that have limited the ways affected publics have been able to engage with HIV intervention in the country to date.

As a final point, I suggest theatre-makers are using the process of acknowledgement to focus on interrogating people’s “realities” or “truths,” which is about starting to reflexively think through an individual’s subjective experience as it relates to other people and to structures/institutions. This process involves a back-and-forth movement between imagination and perceived reality. Earlier in the chapter, I mentioned Augusto Boal’s notion of metaxis, or the state of living in two worlds simultaneously (the imagined and the actual). Theatre-makers promote experiencing the dialectical relationship between imagination and reality as a route through which social transformation can be accomplished.

Acknowledgment is about recognizing and dealing with the “reality” of the present moment (i.e. the subjective experience) while also imagining alternatives for the present and the future. In the chapter that follows and concludes Part Four of the dissertation, I discuss the ways in which artists are starting to engage with reflexivity as a companion process to
acknowledgement in the challenging of hegemonic intervention language, reassessing of health activism possibilities, and production of alternative health subjectivities in the post-apartheid era.
CHAPTER 8
Complexity in Action: Creating Reflexive Health Subjects

Introduction
Grasping my arm, Peter Hayes leaned across his kitchen table and stared directly into my eyes. We had been chatting for a couple of hours in his home in Observatory, Cape Town. Topics spanned from his life, his past productions, and his feelings about being HIV positive to restaurant recommendations and wine tastings. Gaze direct, he spoke earnestly about finding an audience for his mainstream play *I Am Here*:

Marketing around [social] issues is really, really difficult. What you’ll find very often with *I Am Here* is that it [publicity] doesn’t mention HIV. I think there’s a problem in that, ’cause I think sometimes really aggressive, really truthful marketing will tap into an audience that would go because of the issues. But it is really difficult in terms of the general audience. I know from experience that the white gay population, which would be the majority of the gay theatre-going audience in this country, they do not want to be challenged, they don’t want to think, they don’t want to have their consciousness raised. They go to the theatre and want ass and entertainment. Probably ass before entertainment. But you know, those are the things that they want. A serious play that’s going to make them reflect on their life and challenge some of their shadows? And that’s what I’ve noticed with *I Am Here*. Radically, I mean I’ve never performed a play where I’ve dealt so strongly with shadow stuff, and my own shadow behavior. In doing that was this extraordinary, the shadows that it pulls up in people, you know? The line in the play, ‘we always meet ourselves,’ could not be more true with this play! It really can seriously get under people’s skin in the wrong way. [laughter] You know, in a really really reactionary way it can do that.

He went on to say that after one production, an older, straight, white man approached him and thanked him for telling his story. The man was a recovering alcoholic, and he saw echoes of his own story within Peter’s. He said that watching Peter’s story made him think about some of his own past actions that have been hard to face. Through telling the raw, difficult story of the liaison that led to his HIV positive diagnosis and the emotional fallout it caused in the lives of his
friends and family, Peter’s production had prompted this audience member to start “meeting” some of his own life shadows.

Peter noted, “There’s gotta be that point where the absolute specificity of the story becomes universal, and I get that. I get the heterosexual male alcoholic coming to me afterwards and saying, ‘I’m an alcoholic, and I have been there.’ You know, he hasn’t been there in the details, he’s been there in the emotional content.” As he finished the story, Peter smiled and squeezed my arm. “That’s the reason we do this [theatre], yeah? To get people to think, deeply, about difficult stuff. To live the questions instead of running from them.”

8.1 Living the Questions, Living the Consciousness

In this second chapter of Part Four, I explore how and why some theatre-makers are shifting their focus within interventions from public health education to developing a kind of deeply reflexive health subjectivity among audience members that provides an alternative to neoliberal ideas of responsible health citizenship. In their attempts to make room outside of neoliberal biocitizenship for other types of health subjectivity, I argue that theatre-makers use reflexivity in conjunction with the process of acknowledgment to develop a kind of health subjectivity deeply attentive to the influence of incoherency and interpersonal relationships on people’s health. They accomplish this by advocating active production of a more socially contextualized individual health subject through theatre and then positioning this kind of subjectivity as a form of health activism relevant in the post-apartheid era.

This type of health subject is created primarily through two important processes related to the project of getting people to recognize and engage with their incoherent selves. In the previous chapter, I discussed the first one: acknowledgment of the existence of people’s states of incoherence and the influence those states of being may have on a person’s health. In this
chapter, I discuss the second process: promotion of critical reflexivity within theatre as a form of healing that encourages participants to better understand themselves and their relationships to other people and structures in their lives.

When I use the term “reflexivity” in this chapter, I refer to deep, reflexive thought processes. Historically within anthropology, “reflexivity” has most often referred to a theoretical perspective in the postmodernism movement. In this perspective, reflexivity refers to processes by which the ethnographer—as interpreter of data—reflects upon how personal biases impact understanding of fieldwork (Barnard 2000; McGee & Warms 2004). However, anthropologists have long theorized reflexivity in additional ways (e.g. Scholte 1974; Ruby 1982; Holland 1999; Salzman 2002; Davies 2008; Turner 1979; Pillow 2003; Robertson 2002; Turner & Bruner 1986). For this chapter, the term “reflexivity” will be applied to health and used in a performance studies theoretical tradition indicating self-referencing and reflective modes of performance common in applied theatre; the self-awareness of the audience as an active production participant and co-constructor of meaning; and rehearsal and performance processes that encourage social and self-reflection through theatre conventions (Conquergood 2002; Schechner 2013).

My focus in considering reflexivity in this dissertation is to expand on the ways the concept has been addressed within anthropological literature by discussing new forms of reflexivity related to public health, subjectivity, citizenship, and social change that some theatre-makers in South Africa are starting to advocate. These alternative reflexivity forms are underscored by performance and theatre theories, and I think public health, biomedicine, and social science considerations of health knowledge production can benefit from analysis and consideration of the kinds of reflexivity being promoted by up-and-coming South African artists.
For some theatre-makers, the contemporary goal of their artistic HIV intervention work is to encourage theatre participants to reflect on multiple levels and in various ways on their lives, actions, emotions, and experiences related to health and to “live the questions” that come from that process instead of ignoring, sublimating, or simply turning away from them. I argue that theatre-makers are re-conceptualizing what kinds of reflection are important within HIV/AIDS intervention programs. In particular, I follow theatre-makers stories to show how theatre-makers weave together considerations of complexity (through moments and shadows) in one integrated critique of the scope and techniques of reflexivity implicit in educational and health communication paradigms and what the results of these challenges are. While theatre-makers are involved in critiquing the ways reflexivity is conceptualized within common public health programming, it should be noted that artists are not placing their ideas about innovation in health programming in oppositional contrast to the intervention modalities of biomedicine and public health. Rather, artists are promoting expanding the repertoire of modalities used within HIV interventions to better address the range of ways people experience HIV/AIDS and interact with the country’s healthcare system.

In this chapter, I illustrate and analyze some of the ways theatre-makers are actively developing and promoting a new form of health subjectivity based on critical reflexivity around the relationships between self, society, structure, and agency. This alternative health subjectivity is an attempt by theatre-makers to produce a more socially contextualized health subject than the individual constructed within health programs based on classic neoliberal ideas about responsibility. In this chapter, I follow stories of theatre-makers who are using emerging artistic practices to challenge the particular nexus that occurs so often within common intervention paradigms between audiences, knowledge, and agency.
8.2 Challenging the Scope and Techniques of Reflexivity

Increasingly, theatre-makers have focused on probing the spaces related to health and human experience where cognition and Western ideas of logic break down or are disturbed. This is the realm between the known and unknown—the realm of the not fully known or the partially understood. Theatre-makers have been engaging recently with a level of reflection rarely found within conventional public health programming—this middle space of confusion, partial understanding, partial knowledge, and partial awareness. Theatre-makers have been asking: what do we do with those spaces and states of being? In answer, artists are advocating finding ways to live comfortably within ambiguity or finding ways to push awareness and reflection farther: finding more productive ways to mine human experience. This is about pushing reflexivity past conventional boundaries and into expanded modes. This expanded understanding of what health communication and reflexivity mean and can accomplish is directly opposed to more static models of health communication dominant during the anti-apartheid struggle and in the years directly following democratization.

The kind of reflexivity supported by theatre-makers does not replace a non-reflexive style within former modes of health communication and intervention; however, it does challenge and complicate notions of reflexivity within public health intervention\(^{95}\). Many theatre-makers consider reliance on the kind of cognitive reasoning privileged within common interventions limiting for their intervention purposes. What does this kind of reflexivity look like in practice? Consider the following vignette:

\(^{95}\)It should be noted that not all forms of theatre challenge the scope and techniques of reflexivity implicit in common health communication paradigms. Some forms, particularly theatre-in-education, at times reinforce the kinds of information-driven messaging often found in national public health programs. While these forms of theatre continue to be practiced on the ground, most of the artists with whom I worked focused on the need for innovation in practices to move away from messaging and toward critical reflexivity. Disconnect between this ideology and on-the-ground practice is the explicit focus of Part Five of the dissertation and will be analyzed in Chapter 9.
Theatre Game: 1 to 10

During the first two weeks of my dissertation fieldwork in late August 2010, I was in Johannesburg at a conference hosted by university theatre-makers. The Drama for Life Africa Research Conference was a three day event couched within a larger 14-day arts festival. The conference was devoted to the practice and theorizing of the application of arts to activism, education, and therapy related to health crises in sub-Saharan Africa. Participants spent a lot of time discussing the potential for the arts to be mainstreamed into government and education policies on how community fragmentation and devastation due to HIV/AIDS is handled in African countries. This may sound like a weighty topic—and it is—but the exciting thing about performance studies conferences and performance gatherings more generally is that you get to play theatre games. Even in the most important, weighty, star-studded panel of the day, you get to harness your inner child and participate in the games or sit back and enjoy the show.

One afternoon, a large group of us gathered inside the university’s 409-seat theatre. We were a motley crew of students, professors, visiting academics, resident artists, national and international applied theatre practitioners, university administrators, government officials, and a handful of other interested parties. This particular panel was well attended because global health artist-extraordinaire David Gere was in attendance. I listened as wafts of conversation wrapped around me and was impressed by the number of people talking about their love of Gere’s global health artwork; it outweighed the number of people giggling furtively and whispering about their love of Gere’s brother, Hollywood heartthrob Richard. The panel began, and soon one of the practitioners rose from her chair and walked center stage. Her smile was sly as she called out, “So, we’re going to play a game.” Predictably, because we were in a group of artists, the chorus of cheers far outweighed the smattering of nervous laughter. It was not difficult for her to recruit volunteers, and soon about seven people were onstage and ready to participate.
In the game, the left side of the stage was designated number “1,” and the right side was designated “10.” The panelist gave a value or meaning to each number by making statements, and the volunteers were instructed to stand at the number that reflected their opinions. Elaborating, the panelist swept her arms wide and said, “You can move back and forth between numbers, lie down across two numbers, or use your bodies in any way that best represents your opinions, because I’ll ask you about them.”

The volunteers shifted on their feet and glanced at one another. Some smiled, and their readiness emanated through their laughter and clapping. A few others glanced askance toward the audience with raised eyebrows. One volunteer started shuffling off toward the edge of the stage as if to rejoin the audience but chuckled and tossed out a “Yoh! Just kidding” before jogging back to the main group. The panelist continued. She looked toward the audience and said, “The basic principle here is that every opinion is legitimate.” She turned to the volunteers and clarified, “The only thing you have to know is what number you’re at and why.”

She began with easy statements before transitioning into much harder ones. The first statement garnered laughs from the audience as she assigned to number 1 the sentence, “I’m a fantastic dancer!” while number 10 got the sentence, “I’m a horrible dancer!” One volunteer, obviously trained in dance, pirouetted beautifully to the left side of the stage, while another slunk off to the far right side of the stage and sat down at number 10. A few others wavered hesitantly before heading to a number on the spectrum. I heard people in the audience guffaw in empathy as a girl in her early 20s walked decisively to number 8, thought for a minute, shrugged then took a step to number 7, hopped to number 5, glanced back at number 8, frowned, then finally trudged stolidly to 7. After a few minutes, the panelist asked each volunteer why they chose their number and what their reasoning was.
By the third iteration of the game, the statements became obviously more difficult for volunteers to navigate. They were taking more time with all three parts of the game task—choosing a place on the spectrum line, figuring out their reasoning for being there, and describing that reasoning to the panelist leading the game and the audience. One of the later statements assigned to number 1 the sentence, “HIV/AIDS interventions should attempt to change cultural values and practices.” To number 10 was assigned, “HIV/AIDS interventions should NOT attempt to change cultural values and practices.” There was a lot of running back and forth by the participants, expressions of deep thought and consternation, and people who changed their minds. The participants exhibited admirable ingenuity in representing opinions, feelings, or ideas riddled with contradiction and conflict, as well as the times they were unsure of their answers or simply didn’t know how they felt about the issue being discussed. One person even settled on jumping back and forth between two numbers as her final answer.

After laughter from the audience dwindled, the panelist running the game addressed the participants, “So, explain what numbers you’re at and why.” The first person to answer was a student. She was standing on number 10 with her hands on her hips, and she said, “I don’t know.” She placed her right hand over the center of her chest and continued, “I just feel it. It feels wrong to try to change people’s values. I can’t really explain why. Maybe because I wouldn’t want someone telling me I was wrong. But there has to be a better way, I know it. I feel it.” The panelist moved to question another female student participant at that point. The student was running back and forth between 1 and 10, and she stopped long enough to catch her breath and say, “Well, I think I am both 1 and 10. Because cultural practices are very difficult to change. [pause] But we if we’re going in to change, we need to find what practices are valuable there, what can be worked with there in that place and then accommodate that.”
At this point, a man who appeared to be in his early 40s jumped into the discussion to respond to both students. The man was standing between the numbers 8 and 9. He turned to face the second student and said, “Look, when we think about changing a culture, we’re not talking about changing entire cultures.” Abruptly, he shifted his focus to the audience and appealed, “You can’t go in as an HIV intervention and say ‘your entire culture is wrong.’ We come in with a very specific problem in mind in a culture that is exacerbating things, yeah? And just that needs to change.” He finished with his gaze on the panelist who was facilitating and ruminated, “And you know, I have questions about this question. I mean, what presumptions are you coming in with the idea of ‘culture’ and ‘a culture’ and ‘cultural values’? Does that presume everyone in that society feels that way or does those things? What if some people there want to change? What if others don’t?” In the process of talking through his reasoning, he inched slowly from his position at 8.5 closer to the middle point on the spectrum. By the time he finished talking, he had changed his mind and joined the student in her “both 1 and 10” answer.

This vignette illustrates a typical applied HIV/AIDS theatre process in South Africa regarding content, form, practices, and aesthetics. It also illustrates commonly recognized reasons for why artistic approaches to HIV interventions are important: the ability of the theatrical form to foster empathy, introspection, and understanding; an experiential ethos; and the ability to push people out of their comfort zones and into deeper modes of reflection about their lives, actions, and relationships with others. In addition, the game is a salient example of the actor/audience interaction privileged in theatre-related approaches to HIV/AIDS in post-apartheid South Africa. It involves crossing boundaries of engagement that have historically been set and dominated by more biomedical approaches to interventions.
Rather than a distanced, knowledge-given, fact-based approach to HIV interventions, the game highlights artistic impulses to co-create knowledge with participants about how to approach HIV/AIDS in the country. This game is a productive illustration of the two major components of challenging the scope and techniques of reflexivity that theatre-makers are starting to advocate within public health intervention processes: creating nonjudgmental spaces for reflection and experimenting with other types of reflexivity to produce socially contextualized health subjects.

Creating Space for Cognitive Reflexivity

Part of the importance of theatre games and participatory performance processes is simply creating a nonjudgmental space for reflection on difficult topics. This is related to the process of acknowledging incoherence discussed in the last chapter, but it extends the intervention goals from recognition of incoherence to actively creating an environment in which there is space to think, explore feelings, and discuss ideas. For some theatre-makers, simply “making people think” deeply, in non-superficial ways, is a productive goal and a worthy form of health intervention impact. Most theatre games or facilitation processes, like the one described above, are designed to allow participants multiple opportunities for reflection at different levels, including individual internal reflection during theatre processes and active, voiced group reflection at the end of games. For theatre-makers, an important performance process is opening space to reflect and value people’s stories, thoughts, ideas, opinions, and feelings.

Producing Reflexive Health Subjects: Increasing Levels of Commitment and Integrating Multiple Domains of Experience

While opening spaces for reflexivity is important to theatre-makers, the challenge artists pose to the scope and techniques of reflexivity common within dominant public health
intervention models is about more than creating safe spaces for reflection and discussion: it is about creating reflexive health subjects. In contrast to the early use of theatre primarily for its education and health promotion possibilities, emerging theatre groups often employ a more critical perspective. For many theatre-makers, reflexivity within public health interventions is about increasing the level of commitment to the reflexive process among participants and integrating multiple domains of experience. The “1 to 10” game mentioned earlier provides a good example of the kind of expanded, integrated reflexivity theatre-makers discussed, as well as the shift in content. Rather than promoting certain kinds of biomedical discourse, such as the importance of engagement with biomedical technologies or adherence to avoiding risky behavior, this game asks both participants and the audience to consider critically whether or not HIV interventions should attempt to change the societies in which they are implemented.

In this game, participants are urged to think very hard about their answers, since they represent not just verbal remarks but also embodied physicality: they are required to literally “take a stand.” As the panelist pointed out after everyone had regained their seats, this game requires different levels of commitment in engagement with the statements. The game requires people to think about why they think as they do, not just identify what it is they think. The game also asks participants to embody their ideas and perform them in front of others. Finally, emotion and feelings are often an important part of the process, as well. Not only are participants asked what they thought about during or after the games but also how they feel/felt.

Part of integrating multiple domains of experience is cultivating emotional intelligence, or the ability to be aware of and sensitive to your own and others’ emotional states. For theatre-makers, emotional intelligence is an important component to cultivating self- and social-awareness, and the use of emotional experience to inform understanding of a situation or as a
guide for action is encouraged. Together, these subtle differences in the level of commitment to the process of thinking about an issue and integrating multiple domains of experience is an important element of what theatre-makers say the arts have to offer public health interventions.

Theories of acting, or the theory and practice of performing in theatrical contexts, play a large role in motivating theatre-makers’ focus on increasing levels of commitment and integrating multiple domains of experience within reflexivity processes. In addition, certain characteristics are commonly cited as required for the kinds of reflexivity theatre-makers advocate within their health intervention processes: a focus on personal stories, mining intuitive knowledge, privileging mindfulness, and encouraging vulnerability and uncomfortableness. These characteristics are often present in common acting theory.

Jerzy Grotowski, Bertolt Brecht, Constantin Stanislavski, and Lee Strasberg are four influential acting theorists whose ideas permeate modern actor training, even informal training programs. The theatre-makers with whom I worked were broadly influenced by the acting practices and theories of all four of these theatre practitioners. While not all theatre-makers in South Africa had been formally trained in Brechtian, Grotowskian, Stanislavskian, or Strasbergian theatre, most knew of Brecht and Grotowski, actively practiced Brechtian techniques, and incorporated some of the classic emotion-work of Stanislavski and Strasberg. These four theorists are important for anthropological analysis of theatre as an institution within public health because they have their own ideas about what healing means, what constitutes social change, and how to create palpable affect among audiences. These ideas inform theatre-

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96 Even if actors were not familiar with “formal” acting theory, many of the theories and techniques espoused by these European and South American practitioners were used in early South African theatre by nationally acclaimed artists Gibson Kente (known as the Father of Township Theatre) and Barney Simon (who co-founded the Market Theatre in 1976, one of the country’s most famous arts institutions).
maker intervention techniques and often differ distinctly from other, more dominant intervention modalities. I suggest it is through these differences that theatre-makers are articulating their particular contributions to the healthcare industry and re-fashioning ideas about possibilities for broader health activism in the post-apartheid era.

**Personal Stories and Method Acting**

Pieter-Dirk Uys slapped his hand on the table outside of his theatre in Darling where we were interviewing and exclaimed:

Jessica, it all comes down to being personal! It all comes down to not speaking on your behalf or on the behalf of other people, but on my own. My experience, my fear, my shortcomings, my everything. Me, me. My life. Not your life. I don’t know your life, but I know my life. And if I can really open up my fears to you, as a person, then you can share them with me, and then we are already on the same page. And that’s what I think when I look at all those little faces peering at me.

Pieter was speaking about the HIV/AIDS-related theatre work he has conducted with over 1.5 million school children in South Africa since 2000. His production *For Fact’s Sake!* has also been produced within prisons and reformatories, and he has released a corporate AIDS-information video (*Having Sex with Pieter-Dirk Uys*), a family-friendly video (*Survival Aids*), and a video addressing the fears surrounding HIV testing (*Just a Small Prick!*). For many theatre-makers working in South Africa in the post-apartheid period, personal narrative has become an important vehicle through which to make meaning of their own and their audiences’ experiences.

Historically, within HIV/AIDS intervention efforts, the impact of many media projects has been measured from a biomedical focus on the number of people it reaches and how much or what kind of information is relayed. It is strongly based in educational messaging and hope for subsequent behavior modification in relation to HIV risk (Harrison et al. 2000; Campbell 2008; 97

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97 Darling is a small town in a farming area in the Western Cape. It is located about 75 km north of Cape Town.
Campbell et al. 2007; James 2002; Jacobs & Johnson 2007). In contrast, there has been a subtle but important recent shift within HIV/AIDS-related applied theatre in South Africa to a focus on *stories* and story-telling, especially ones highlighting particular critical moments of lived experience within the lives of characters. This focus by theatre-makers on storytelling coincides with early medical anthropological interest in illness narratives (Garro 1994; Bury 2001; Good 1994; Good et al. 1994; Saris 1995; Kleinman 1988; Stern & Kirmayer 2004) and more recent turns within the field to focus on stories, narrative theory, and the relationship between narrative and healing (e.g. Mattingly 1998; Hurwitz et al. 2004; Mattingly & Garro 2000; Hunter 1991; Good et al. 1994; Cain 1991; Werner et al. 2004; Sharf & Vanderford 2008; Seligman & Kirmayer 2008).

Theatre-maker focus on storytelling parallels anthropological interest in stories as meaning-making endeavors. Both artists and anthropologists often focus on the idea of critical moments of narrative. Cheryl Mattingly’s (1998) ideas about narrative are useful for understanding what is going on within theatre-maker attention to personal stories. According to Mattingly (1998), people often use narratives to accomplish things in their worlds. While anthropologists tend to look at the specificity and context of particular moments of storytelling, the theatre-makers with whom I worked rather employed a discourse of common humanity in their attention to personal narrative in order to bolster empathy among participants and connect performers and audiences. What theatre-makers “do” with their storytelling is an attempt to get participants to recognize common points of “humanity.” In addition, for theatre-makers, this focus on storytelling is based on the foundational premise that affect can happen in a moment—that is all it takes; the right moment. Life happens in connected moments, and some of these can define some of our most enduring, meaning-filled times. In this framework, “moments” assume
a level of importance than can be life-changing. The focus on storytelling is also then subsequently about capturing and crafting those moments in people’s lives and showing them onstage. This differs significantly from common types of generalized didactic messaging within health communication and public health programs.

From my fieldwork with theatre-makers across the country, I have come to think that theatre-makers’ engagement with incoherence through the concepts of “moments” and “shadows” is partly about reflexivity and its relationship to impact. Thinking about impact was very important to the artists with whom I worked, and it was linked to theories of affect. I suggest that for many contemporary theatre-makers, theatre related to HIV/AIDS is not just about the production of knowledge or health promotion; it is also about how that knowledge and those representations are made meaningful to and for people. For theatre-makers, meaning is made through storytelling about moments: critical moments in people’s lives are often described by theatre-makers as “human moments,” or moments many people have some basis for relating to. Using personal narrative and storytelling is related to the idea of “finding the universal in the specific,” which is a mantra for some theatre-makers. It was perhaps expressed best by Peter Hayes in his discussion of what he hopes his artistic work accomplishes in audience member’s lives:

My deepest wish is that people will reflect on their lives with a new window. I have a belief in and around personal narrative, both in that the more specific I can be and ruthlessly honest in telling this story, not trying to tell a general story about a man living with HIV in South Africa, I’m telling this one, that dense, details, places. I do believe that in the specific, it becomes universal.

The idea of “finding the universal in the specific” encapsulates the belief of theatre-makers that through being ruthlessly specific with details of personal lives, universal human experiences may be discovered or invoked. Through these experiences, audiences will be better able to empathize
with what is being presented onstage. These moments are made meaningful not only by
cognitive engagement with the “lesson” or “message” behind them but also through the holistic
linking of that cognitive, reflective realm to specific emotions, stories, memories, and lived
subjective experiences. Therefore, this is about the potentiality of live theatre interventions not
only as a site of health information dissemination but as part of a social process involving active
attempts at meaning-making in relation to lived experience of HIV/AIDS.

Laura, a 24-year-old black South African female, noted that the increasing importance of
personal stories to South Africans in the post-apartheid era is a reaction against didactic protest
theatre in the anti-apartheid era. She said, “We haven’t been listening to each other, you know?
Audiences have been bored with the way they’ve been approached. We now want the stories to
be more personal and real. Not protest theatre anymore. This is about people’s experiences.”

Keely*, a 20-year-old Coloured South African student voiced a similar opinion when we spoke
about what kinds of topics she would like to see within theatre related to HIV. Keely elaborated:

How to live and lead a healthy life if you have AIDS. Then also how to be in an intimate,
sexual relationship if you have AIDS. And then I think for me, the thing that really
became important to me was not the statistics of AIDS in Africa and AIDS in South
Africa, it was more about the personal stories concerning AIDS and HIV and how it
affects individuals in a very personal and intimate way. Because it came closer to home.
I’ve had people who were sort of close to me through other people, who have died of
AIDS. So I know about it, it’s come quite close to home. But what was fascinating for
me was, on a simple level, how do people conduct relationships who have AIDS and
HIV? You know, stuff like that.

[Emphasis added]

Keely’s mind was on HIV, because she had just begun a romantic relationship with a black
South African man 25 years older than she was. She noted that he had vastly more sexual
experience than she had, and that realization prompted her to ask if he would get tested for HIV.
They went for testing together about two weeks before our interview. Although both tested
negative for HIV, the experience made her think about what she would have done if her partner
had tested positive. Keely wanted to see within theatre personal stories of navigating interpersonal relationships when one or more of the people involved are HIV positive. For all four theatre-makers just discussed, the notion of exploring people’s relationships and the particulars of their lives, actions in the world, and emotional landscapes was an important component of health intervention often left out of biomedical and public health approaches.

This kind of moment-work is strongly related to classical Method acting, which is an acting style and group of techniques developed by Russian director Konstantin Stanislavski in the late 1890s to early 1930s. It was later popularized in the United States by director Lee Strasberg and continues to be a pervasive theoretical force in the acting world. Stanislavski’s original work was psychophysical and explored character personalities and actions from internal and external perspectives. In contrast, Strasberg’s interpretation of Method acting uses more psychological techniques to access the “truth” of a character.

Method acting uses the practice of having actors draw on their personal memories, emotions, and sense memories to connect to a character and portray the character onstage in a realistic way. It involves participants mining their own self-understanding, pasts, and internalized emotions and thoughts as a route through which to recreate character feelings and sensations onstage. Rather than core focus on developing external talents such as physical mimicry or voice projection, Method acting draws on developing memory and abilities considered internal—sensory, emotional, and psychological.

This kind of reflexive interrogation has become an important part of health-related theatrical intervention processes, and it combines deep emotional reflection with personal memory and present cognitive thought. Another senior theatre-maker, Warren, brings up this point, and he notes that rather than didactically teaching things to audiences, HIV intervention
workers should be developing with audiences ways to “identify, express, and manage emotions and emotional language” in an attempt to help people understand how they relate to each other in the context of an AIDS epidemic. Warren further goes on to state that the importance in understanding this component of HIV intervention is not just in the “how” but in the “why”—what motivations and impulses drive people to treat others the way they do. This kind of focus on deeply internalized psychosocial and emotional reflection has become increasingly important to theatre-makers as a process of HIV intervention, and it has recently manifested through an intense focus on personal narrative as a genre choice.

**Mining Intuitive Knowledge and Grotowski**

Another important characteristic cited by theatre-makers as necessary for deepened forms of reflexivity within health interventions includes mining intuitive forms of knowledge, which are often delegitimized within hegemonic HIV programming. Both anthropologists and performance studies scholars have discussed the ways in which authoritative knowledge is created and other forms of knowledge marginalized within health communication efforts (e.g. Conquergood 2002; Conquergood 2013; Briggs 2003; Pigg 2001; Treichler 1991, 1999). Intuitive knowledge is a form of knowledge theatre-makers are trying to re-center and privilege within HIV programming instead of allowing it to remain on the periphery. For example, while the “1 to 10” game operates within a cognitive reflection frame, it also makes space for inclusion of other kinds of knowledge or reasoning, particularly intuitive knowledge. The first student to answer did not really know why she had chosen number 10, but she noted that she “felt” it. If this exercise had been a full one instead of a demonstration within a conference, the facilitator would have pushed the student to think about what made her feel that way. In that sense, the game continually asks participants to process their thoughts, actions, and feelings cognitively if
they can, but the game parameters accept intuitive feeling as a perfectly valid form of knowledge and a productive starting point for conversations.

In speaking on this topic, P.J. Sabbagha mentioned that intuition and “gut instinct” are a big part of his set of references for creating and understanding theatrical work. He had the following to say about the difficulties behind incorporating intuitive knowledge and processes:

For me, it’s intensely easy. For my performers, it’s intensely difficult. And therein is the difficulty. To convince people to trust themselves and the process they’re engaged in. It’s about sitting and watching something happen and recognizing a moment and being able to remember it, articulate it, discuss it, and return to it. So very often for what we do for the first week is say okay, there’s an empty space here—I’ll play the music, you do whatever you want. And I just make notes. And then we go, okay, did you remember the way you looked at so-and-so at that moment, or the way you touched that person, or what you were thinking when you walked across the space? Let’s try and start there, so start with that thought, what happens next? So it’s just you know, it’s for me it’s a very intuitive process. It’s about allowing anything to happen and connecting with certain things and then using those certain things as a starting point to then allow other things to grow.

And it’s quite traumatic in a way, because why should anybody else be interested in your intuitive response to anything? But in a way, it just comes to that notion of sincerity and honesty and truth that I was speaking about earlier. When I was constantly trashed, it was easier to be intuitive, in inverted commas, although maybe I wasn’t being intuitive because I couldn’t actually see what was going on, but there were less inhibitions. So I could just go, yes, let’s go blah blah blah. Being sober and working in that way is a lot more difficult because you are far more aware of how you are censoring yourself, how you are judging, how you are predetermining, so you are far more aware of all that information and you need to know okay, this is a sincere moment, or a genuine moment. Yeah.

For Sabbagha, intuition is positioned as critical to his artistic process. It is also a skill he cultivates in his performers and hopes for in his audiences. He considers the ability to recognize moments of significance important for helping people find their “truth.” For many theatre-makers, intuitive knowledge is a space from which it is possible to make sense out of lived experience of incoherence. By looking at moments and shadows and using them as a framing device for feelings, thoughts, and memories, artists push reflexive interrogation of those not-fully-coherent parts of existence under a microscope lens. In addition, in this quotation,
Sabbagha makes clear reference to the viewpoint that moments provide a starting point for intervention engagement. This privileges attention to experience within the frame of moments and the idea that finding moments of emotional honesty can be a productive point of intervention engagement. This idea of emotional honesty is linked by Sabbagha to the idea of allowing people to be present in “honest” moments of their lives without judgment or necessitating linking those moments to cognitive reasoning or future action.

Polish experimental theatre director Jerzy Grotowski was another leading theorist of 20th century theatre, and his work highlights the necessity of thinking through notions of truth and intuitive feeling. Grotowski developed an intensely physical approach to acting that contrasted with the more internalized “method” acting just discussed. Instead of focusing primarily on recreating the internal, emotional states of characters for audience consumption, Grotowski’s style popularized in the 1950s-1990s a rigorous interrogation of the place of physicality, physical discipline, and use of the body in theatre. In addition, for Grotowski, theatre-makers should avoid competing with other contemporary spectacle and media modalities, such as film, and focus instead on what theatre does best—co-creating experiences with spectators.

His style of theatre was called “Poor Theatre” and privileged viscerality in theatre (among actors and within the actor/audience relationship) over spectacle, sound, or use of extensive costuming, sets, or props. In his book *Toward a Poor Theatre*, Grotowski states:

>We do not attempt to answer questions such as: “How does one show irritation? How should one walk?” For these are the sort of questions usually asked. Instead, one must ask the actor: “What are the obstacles blocking you on your way towards the total act which must engage all your psycho-physical resources, from the most instinctive to the most rational?” We must find out what it is that hinders him in the way of respiration, movement, and —most important of all—human contact. What resistances are there? How can they be eliminated? I want to take away, steal from the actor all that disturbs him. That which is creative will remain within him. It is a liberation…I believe there can be no true creative process within the actor if he lacks discipline or spontaneity. Meyerhold based his work on discipline, exterior formation; Stanislavsky on the
spontaneity of daily life. These are, in fact, the two complementary aspects of the creative process.

Grotowski developed a set of intensely physical exercises designed to force theatre participants to abandon their preconceived, clichéd, socialized ideas about what “realistic” and “proper” behaviors, actions, thoughts, and feelings are in order to tap into more “authentic” emotions and actions. This idea of “authenticity” is similar to the kinds of “sincere” or “genuine” moments Sabbagha says are produced through mining intuitive knowledge. Grotowski’s ideas about stealing from the actor (or audience member) all that disturbs him are related to the notion of “finding your truth” that several artists I have mentioned in this chapter have invoked. This push is about moving out of a place of social judgment, stigma, and internalized guilt, shame, or censorship and rather having theatre participants be deeply in tune with what they actually think and feel in the moment. This kind of deeply honest, intuitive ability to acknowledge how a person thinks and feels in the moment is necessary, according to theatre-makers, before any kind of interrogation of those components of subjectivity can occur.

For Grotowski, Poor Theatre and physicality provide a route to greater self-knowledge through stripping away internalized social restrictions, conceits, and other unnecessary constraints. His style of acting attempts to encourage participants to engage all parts of their being from the most instinctive to the most rational. This kind of focus on the integration of multiple domains of experience was present within many of the HIV-related theatre interventions I saw, even if the actors had not been formally trained in Grotowski’s methods. Indeed, in the “1 to 10” game mentioned earlier, part of the process was allowing participants to move to a numbered place on the spectrum without fully knowing why they were going there (intuition or

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98 This also applies when audience participants had not been trained in such methods. The methods were still employed by the actors, who worked to enroll audience participants in the same kinds of processes.
feeling) and then encouraging them later in the game to think through why they had chosen that number (cognitive, rational processing).

**Uncomfortableness and Vulnerability**

Related to intuition is the capacity for vulnerability. Both are critical to the process of overcoming self-censoring in discussion of deeply personal topics related to HIV/AIDS within intervention processes. For theatre-makers, the acts of making people uncomfortable and fostering vulnerability are both important. It is through the process of making people uncomfortable followed by building a safe space to express vulnerability and interrogate shadows that theatre-makers see potential for individual and social change. This process is about asking people for deep vulnerability and fostering people’s willingness to “go to those places” of incoherence and shadows—about pushing people to confront the parts of their lives that are hard or difficult to face. Examples of the importance of uncomfortableness and vulnerability follow.

**DISRUPTING COMFORT: “It was pain made beautiful”**

Although talking about shadows was often framed by theatre-makers (and audience members) as difficult, hard, weird, awkward, and uncomfortable, that uncomfortableness was a core component of the impact theatre-makers thought talking about shadows had. Becoming uncomfortable and facing the uncomfortable unknown were key ways theatre-makers attempted to incite audience members to think about their own shadows. For example, I was able to obtain an interview with a particularly talkative audience member who had just seen P.J. Sabbagha’s production *Zebra* at the 2009 National Arts Festival in Grahamstown. Her thoughts on the difficult topics the production brought up and their links to her own life are illustrative of the kinds of impact theatre-makers often look for when delving into these “deep, dark” emotional places.
Zebra was a physical theatre collaboration between black South African and white Russian dancers that used the black/white dyad as an entry point to discuss the very real and gray (shadow) issues related to contemporary South African masculinity and masculine relationships, including sexuality, rejection, love, bravado, loneliness, comradeship, and aggression. In her reaction, the audience member related components of what was presented onstage to her own life, despite noting how uncomfortable it was to face or think about those topics. She said:

So, yes. Zebra was amazing. The dancers were brilliant, and the piece itself had moments of brilliance. Anyway, I had this huge breakthrough mentally while watching the piece, too. It’s all guys, and it’s about masculinity, love, rejection, relationships, those kinds of things. At one point, two of the dancers, one was really pretty and the other had long hair, have a duet and establish a really strong relationship. Like, they keep trying to come together, and other dancers keep trying to break them apart, but they always immediately reconnect bodies. And then it’s revealed that another dancer and the pretty one used to have a thing together. So, this other dancer and the pretty one then have a duet dance where the other one, okay, so this other one’s got orange hair. Let’s call him Orange Hair. So, Orange Hair attempts over and over again to get Pretty Boy to acknowledge him—recognize him, see him, acknowledge his existence at all. Pretty Boy refuses, and there’s this point where Orange Hair is, he’s, overcome by emotions created from that kind of rejection and that kind of intense love.

It was as if Orange Hair was saying, “Take me. Have me. Accept me” and Pretty Boy was either saying no or, worse, like not even acknowledging him. Ignoring him! As I watched it, my immediate thought was, ‘What Roger and I had was beautiful if it could make me understand this.’ Roger’s a guy I dated, and it ended so, just bad. Bad bad bad. But if it could allow me to share what was happening with this man, this beautiful, expressive, amazing dancer onstage, then the torture of my two year long experience with Rog was beautiful and worthwhile. How crazy is that, you know? But good, I think. I’ve not felt anything positive about what happened with Rog in [pause] what? A year, now. To be able to look back on all of that mess and [pause] just to [pause] the experiences I had with Roger allowed me to connect with what was happening on that stage between Orange Hair and Pretty Boy. It allowed me access into the inner experience of Orange Hair, what he was going through. I had a point of entry for shared emotion and life. I would not have experienced that moment in the dance as strongly as I did if I hadn’t been through all those horrible experiences with Rog. Cheating Rog.

And even though those experiences were ugly and horrible, and even though what Orange Hair was going through in the dance was painful, me being able to connect with the dancer so deeply, in that moment, was beautiful. I have never felt positive about what
happened with Rog, but in that instance, I almost, not really but almost, felt thankful for what happened because it allowed me to understand something I wouldn’t have had before. It wasn’t that I wanted to feel those emotions, but being able to connect with the artist in such a profound manner was [pause] I was just thankful for it. I was thankful to be connected to that particular person, also. Well, “thankful” is not the right word. But it felt like a beautiful moment, though. It was beautiful.

I had access to this beautiful, tragic, dark, hurtful, painful moment. It was like crystallized emotion—it was pain made beautiful. What happened in that dance was what can come from those painful life experiences. It’s horror and trauma lifted from the gutters and transformed. It’s months of pain, anger, resentment, frustration, hatred, self-pity, embarrassment made into one perfect moment of expression. Or movement of expression, maybe. Movement in that it was dance, and movement in that it was like music, a movement in music—it wasn’t a single minute but a collection of moments in time and space with a unifying theme to create a whole. A powerful, emotional, connected whole. Anyway, it was a moment of peace for me.

In this passage, the audience member makes direct and clear connections between the concepts of moments, shadows, and impact. For her, the moment of extreme connection and empathy she felt with one of the dancers in the production resulted in a kind of transformation in the way she viewed her own past experiences with a romantic partner who had been sexually unfaithful. The “shadows” she mentions from her life include the cheating of her sexual partner and the horror, trauma, pain, anger, resentment, frustration, hatred, self-pity, and embarrassment it triggered in her.

Later in the interview, she noted that going through the experience of watching Zebra strained her: it was a painful experience. However, through the experience of witnessing someone else’s (the dancer’s) similar emotional journey, her thoughts on her own difficult, uncomfortable life experience changed in a way she considered positive and beautiful. In the theatre space, the dancers worked to disrupt the audiences’ comfort level and urged them to examine their own shadows or the ones being shown onstage. In this space of disrupted comfort,

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99 This audience member was also a performance artist. That partly explains her eloquence in discussing her reaction to the production.
at least for this audience member, the negative thought patterns she held in relation to a past romantic relationship and sexual experience were transformed: they were “pain made beautiful.”

This embracing of “becoming uncomfortable” or “making uncomfortable” is a part of performance studies ideology, as well as theatre practice. It is a tactic of affect. In this philosophy, when people are made to feel disruptions in comfort, a space is created for some kind of transformation, reflection, and/or healing. For theatre-makers, all of those hard, difficult emotions and actions that happen in life are not the product of moments that should be hidden, closed away, or forgotten. Sometimes, making people uncomfortable through moments of performance is a way to initiate meaningful impact. This philosophy reflects a move away from the tyranny of positive thinking\textsuperscript{100} that characterizes some forms of public health engagement. This philosophy instead privileges inclusion of negative affect in addition to positive. Sometimes, theatre-makers consider simply making someone uncomfortable a valid point of intervention\textsuperscript{101}, because that discomfort potentially prompts reflection in audience members.

**VULNERABILITY AND SPACE:**

“Becoming aware of who I am in this space here and now in relationship to you”

Safe spaces within theatre intervention processes are also considered necessary for the kinds of reflexivity theatre-makers advocate. Vulnerability from participants is an explicit request made by applied theatre-makers in most of their health intervention processes, and artists

\textsuperscript{100} On the “tyranny of positive thinking,” see the following: Held 2002, 2004; Ehrenreich 2009; Fineman 2006; Holland & Lewis 2001.

\textsuperscript{101} This is the case within reason. Theatre-makers recognized that completely traumatizing audiences through extreme discomfort would be inimical to their overall intervention goals. They often referenced Antonin Artaud’s “Theatre of Cruelty” as an example of slightly too extreme discomfort.
attempt to create spaces safe for such kinds of giving on the part of participants\textsuperscript{102}. They also try to make explicit their willingness and ability to hold, respect, and value whatever subject matter is offered by audience members\textsuperscript{103}. Theatre-makers constantly spoke about the need for creating safe spaces to talk about, admit, and work through shadows. The kind of intervention work performed by many applied theatre productions asks for great vulnerability from its participants and great willingness to watch vulnerability from its audiences. For example, one of the theatre-makers within Drama for Life had the following to say about the connections between shadows, moments, vulnerability, and embodiment. He was answering a question I asked about what he thinks theatre in particular brings to the table of HIV intervention efforts. He said:

I think there’s something about embodiment, if we’re really talking about the sense of engaging emotion, spiritually and intellectually. Even for the audience, there’s truly some evidence of when people are watching dance or something, there is some chemical shift that happens in observing, and the body shifts and changes in relationship to other people. When we’re talking about interactive theatre, we’re talking about just bringing it that much closer in terms of embodiment. And if we’re talking about process drama, we’re talking about being embodied right from the beginning to the end, the sense of being aware of who I am in this space here and now in relationship to you. In that embodied environment, there’s a transformation that takes place. That’s something that I’m interested in, that space where transformation takes place.

I have a performance course that I lead around transformations, and I’m heavily influenced by Grotowski, my work with Schechner, my experience of dramatherapy at different levels, but I’m also interested in it from the point of view of the director. What kind of setting can I create that will allow the audience to engage? It’s like finding the entry point, so if I’m trying to speak to an issue that is current and if I’m trying to speak to something that is transpiring within a culture here and now and I want to try and open that space in order for the audience and the performance to engage on a deeper level, it’s about how that space is constructed, it’s about how the performers work with themselves

\textsuperscript{102} Sometimes they accomplish this, and sometimes they do not.

\textsuperscript{103} Most of the 81 artists with whom I worked accomplished this goal with aplomb. I witnessed audience members offer stories of great distress and trauma, as well stories of their actions many people in South Africa would consider reprehensible (e.g. admitting to intentional attempts to infect others with HIV), in some of the artistic interventions. However, the majority of the artists with whom I worked did not stumble in their acceptance of the story offers made by audiences: they did not cringe away from or openly judge in word or body language the stories shared by audience members.
In this passage, the theatre-maker hits on several important connections. He notes that part of how theatre is different from other common HIV intervention efforts (particularly health promotion campaigns) is in its creation of a safe space in which to interrogate actions, feelings, and thoughts in an embodied, immediate way. This is a use of theatre and embodiment to examine relationships between people in the here-and-now. Through creating that space, he notes that the possibility for transformation is enabled; however, what is critical to that transformation actually happening is the performer’s ability to work with openness, transparency, and vulnerability. This view is central to many theories of acting. Grotowski summarizes the importance of fostering vulnerability and positioning acting as the act of laying oneself bare not as a way to show off but as a serious, solemn act of revelation. He states, “The actor must be prepared to be absolutely sincere. It is like a step toward the summit of the actor’s organism in which consciousness and instinct are united” (Grotowski 2002:210). In this perspective, the willingness to openly engage with shadows becomes critical for intervention success.

Other theatre-makers have argued that the opposite is just as critical: the willingness of the audience to meet performers in that space of vulnerability. The key to this view about impact is the foundational premise that only through being vulnerable (and feeling safe enough to allow vulnerability) do people connect with others and create the possibility of self-transformation. For theatre-makers, vulnerability is linked to creative risk; it is risky to make oneself vulnerable (especially in such a public way), but it is through collective, public vulnerability that

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104 And, it could be argued, “performed” vulnerability.
creativity and change are enabled. Here, “making vulnerable” is a productive intervention goal, and vulnerability is positioned as a great strength and a way to make progress within intervention spaces. For some theatre-makers, vulnerability and safe spaces in which to foster it were linked to intervention goals about enabling different forms of communication and ways of engaging with the world—vulnerable ones that privilege openness, forthrightness, and honesty.

**Mindfulness and Brecht**

Finally, I first mentioned Bertolt Brecht, a German director and playwright popular from the 1920s to the 1940s, in Part Two of the dissertation. Brecht became dissatisfied with conventional Western acting, which is often confined to theatrical realism and seeks to recreate characters’ emotions and convey them to the audience. Rather than “disappear” into a role and recreate the internal subjective aspects of a character for audiences in the style of Stanislavski, Strasberg, and to a lesser extent Grotowski, Brecht wanted actors to engage in their character roles critically and show a separation between the character and actor onstage. For Brecht, having actors distance themselves from their characters would encourage audience members to reflect more deeply on the entirety of a character in relation to society rather than becoming “lost” in emotions and story.

This technique is called “Verfremdungseffekt,” (sometimes called distancing or alienation effect) and is used to make the familiar appear strange or the strange appear familiar. Examples of the technique include actors turning to address the audience directly in speech, harsh stage lighting, explanatory placards, or abrupt interruptions of the plot/action (freezing). The breaking of the “fourth wall” in theatre occurs when actors directly turn to

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105 This concept has close parallels to anthropological interest in the same topic. For example, there is noted scholarship on making the familiar strange and the strange familiar within ritual anthropology in general (e.g. Miner 1956) and Victor Turner’s thoughts on liminality in particular (Turner & Bruner 1986; Turner 1969).
address the audience, and this was a common technique within various styles of South African theatre, particularly community theatre. In the “1 to 10” game, the man who turned to speak directly to the audience at one point during his in-game answer is an example of breaking the fourth wall. Breaking the fourth wall is a way to keep audience members in a critical reflexive state rather than allowing them to experience emotional catharsis, which is a goal often considered antithetical to critical reflexivity and is popular within much Greek and Western drama.

It is in this focus on deep reflection that I see possibilities for alternative pathways to activism and health subjectivity in the post-apartheid era. The theatre-makers with whom I worked tended to define reflexivity as intentional, intense reflection on some topic.

“Reflexivity” was often coupled with the concept of Mindfulness as a practice: an attentive, non-judgmental awareness of current experience, including a person’s thoughts, feelings, and beliefs. Combining these two, you get “Reflexive Mindfulness,” or the deep, intentional reflection on a person’s holistic experience at that particular moment. In a discussion about the place of mindfulness in her dramatherapy work, 28-year-old Tammy had the following to say:

[Mindfulness] is like a sense, it’s very human, it’s like having a sense and I’m tempted to say of what’s right and wrong. But it’s not about right and wrong, it’s just a presence and an acknowledgment of things. So when I’m in a space, I’m aware of who and what and how I am in that space. I’m not just unaware. It’s related to the dramatic idea of being ‘in the moment.’ Because you could be in the moment and be completely unmindful and how you are in that moment. So it’s more connected to a self-reflective practice.

Reflexive Mindfulness is related to the process of acknowledgment discussed in the last chapter, but it pushes acknowledgment from recognition of who you are in a particular moment (or what you are experiencing) to actively reflecting deeply about the realities of your life in that moment, in that space.

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106 This is related to the idea of being “in the moment.”
I argue that what theatre-makers are doing is positioning reflexivity as an intentionally productive way of intervening in health matters, a different way to engage purposefully; it is about mindfulness and intentional awareness of one’s self, thoughts, memories, and conceptions about the world. What is revealed or discovered through this process is then contextualized within the person’s broader life across temporal frames ranging from past to future. This concept is an important cornerstone on which some emerging theatrical practices are being based. It provides a way for theatre-makers to access, and a language to talk about, life’s incoherence: these are components of lived experience theatre-makers consider missing from dominant global health communication paradigms.

Theatre academic Henry Bial states, “If we recognize that virtually all human behavior involves performing, then we can think of the theater as a kind of laboratory where actors and directors stage experiments to help us better understand ourselves” (2004:183). For all four acting theorists mentioned here, acting is not mere imitation of life or impersonation of people; it is much, much more. The same holds true for the theatre-makers with whom I worked. For them, using theatre as a health intervention process is a form of healing and a way to both explore the limits of and create knowledge about self and society through attending to combined physical, emotional, sensory, and cognitive forms of knowing.

8.3 Discussion: Producing Consociated Subjects and Reassessing Health Activism

In this chapter, I have presented ethnographic data to support the argument that reflexivity is being positioned by some theatre-makers as a health intervention process. In the rest of this chapter, I discuss the relevance of the reflexivity process (as theatre-makers conceive it) to contemporary research on HIV/AIDS and public health initiatives. Combining a critical medical anthropology framework with a performance studies perspective enables analysis of
reflexivity not simply as a potentially productive intervention process that addresses some components of lived experience often elided in more dominant biomedical and public health campaigns. It also enables insight into what kinds of social implications this reflexivity process has and how theatre-maker emphasis on reflexivity relates to the politics of health in the country. I suggest that some theatre-makers are leveraging the types of reflexivity I have discussed through ethnographic data in this chapter\textsuperscript{107} to produce a kind of health subjectivity that challenges common notions of biocitizenship. In addition, I argue artists are positioning these ideas about expanded reflexivity as a form of health activism that is particularly relevant for the post-apartheid era.

I call the kind of subjectivity theatre-makers are producing “consociated subjectivity.” I develop this term throughout the rest of the chapter, but by “consociated,” I broadly mean a type of subjectivity that uses expanded forms of reflexivity to connect or bring into relation with equal consideration the place of existential incoherence in people’s subjective experiences of health and illness along with realms of the known: particularly, political economic factors that shape people’s access to care and possibilities for health-seeking actions, as well as their cognitive understandings of the biomedical aspects of HIV transmission, risk, and treatment. This kind of subjectivity challenges neoliberal conceptions of biocitizenship by repositioning the individual in relation to broader society and community in more contextualized ways. Additionally, it is used to challenge some of the language within conventional public health campaigns that position individual health-seeking subjects as responsible citizens who live in

\textsuperscript{107} The forms of expanded reflexivity discussed include the following: integrating multiple domains of experience (cognitive, emotional, visceral, spatial, aural), meaning-making through personal narrative, mining intuitive knowledge, promoting vulnerability and uncomfortableness, and encouraging mindfulness.
coherent, stable worlds and have the structural power to make calculated decisions about their health outcomes.

As I noted in Chapter 7, the process of acknowledgment makes space within interventions to start formally interrogating, nonjudgmentally, the ways in which people experience their sexualities and health as incoherent or fragmented (shadowy). Expanded reflexivity, covered in this chapter, is a companion process that provides a route through which the production of alternative subjectivities is accomplished. Both of these processes are concerned centrally with finding ways to deal with the spaces in public health intervention where cognitive knowledge breaks down or is disrupted. Acknowledgement is about recognizing and dealing with the boundaries of knowledge (in the moment), while the expanded forms of reflexivity theatre-makers advocate provide ways to push the limits of current knowledge. These two processes combine to help theatre participants figure out how to live within spaces of disrupted knowledge in a productive way or figure out how to push their reflexivity further. Overall, these two processes are used to define the limits of knowledge within incoherence, probe the spaces where reflexivity breaks down, and produce knowledge out of incoherence.

Common themes between anthropology and performance studies that are implicated in analysis of consociated subjectivity include the following: individuation and socialization, reflexivity, health activism, and forms of citizenship based on biology and health. I elaborate on these in the following discussion.

Re-thinking the Individual: From Neoliberal Biocitizen to Consociated Subjectivity

Theatre-makers position the process of reflexivity as a challenge to certain kinds of public health and biomedical language that make what are construed by artists as erroneous assumptions about the coherence of individuals’ lives and their relationships to the health sector.
For most of the people involved in this project, the notion of the responsible individual of biomedicine is considered inattentive to the realities they see in the lives of their audience members. Nor do artists consider the community-level, risk-based subjectivity produced through common public health programs sufficient to capture individual lived experience in nuanced ways. For the people with whom I worked, both neoliberal biocitizen subjectivity and epidemiologically produced risk-based subjectivities seem like decontextualized representations of how people experience and understand their lives.

As a result, through their work on reflexivity, some theatre-makers are subtly but importantly shifting the individual/community dichotomy implicit in many global public health outreach programs by challenging neoliberal conceptions of the responsible health citizen. Through these shifts, theatre-makers are actively developing and promoting an alternative form of health subjectivity based on critical reflexivity around the relationships between self, society, structure, and agency. The type of subjectivity produced through this process of expanded reflexivity is related to rethinking possibilities for the individual health subject within public health and rethinking what health activism means in the post-apartheid era.

I argue that theatre-makers are interrogating the individual/community dichotomy of global health rhetoric and reframing it to produce a more socially contextualized health-seeking subject. In essence, some theatre-makers are struggling with figuring out what types of health subjectivity are productive within the post-apartheid context: who the health subjects are and what capacity for action they have. I suggest interrogating this kind of performance-produced subjectivity provides the possibility for complicating anthropological understandings of “individual” health subjects within global public health. It also provides an applied opportunity to rethink the possibilities for health campaigns focused on individuals.
The following vignette illustrates this tension between individuals, communities, and social context within on-the-ground theatre practices. In the explication that follows the vignette, I situate the ways theatre-makers understand individual health subjectivity in relation to anthropological considerations of the relationship between individuals, sociality, citizenship, and subjectivity.

“Our Story: Nhlanhla’s Journey”

A 16-year-old boy grabbed my rear end, proffered a grin, and followed it with a somewhat sheepish look when I turned to glare at him. He placed his hands on my waist, and we resumed our train journey around the large, open community center room. I was with two friends who were facilitating theatre processes with a group of 12-18 year-olds without permanent homes. The group currently resided in a nearby children’s shelter in Hillbrow, Johannesburg. Leleti* and Zama* were both black South African theatre-makers in their early 20s, and they were working primarily with a group of 10 male “street children” who were residents at the children’s center. The production that day was called Our Story: Nhlanhla’s Journey and was the culmination of four weeks of theatre workshops. Using adaptations of Augusto Boal’s Games for Actors and Non-Actors, Leleti and Zama led the group of boys in processes of improvisational acting to create an installation performance telling the stories of their lives.

The story centers on one boy, Nhlanhla, and the audience is invited to join the journey of his life. As audience members entered the community center that day, Leleti and Zama acted as facilitators of the performance by playing roles of the train attendants. They asked us to join them on the “Train of Thought.” We were each handed a green paper ticket upon entry, and the

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108 This is the term both the children and Leleti and Zama used to talk about this group of people.
journey of Nhlanhla’s life commenced. The audience lined up single file, hands on the waist of the person ahead, and we started moving through the room as Leleti mimed pulling a conductor’s whistle and shouted “Toot toot!” Throughout the production, we made four stops at pre-designated ‘stations’ where we were asked to disembark the train to witness scenes from Nhlanhla’s personal journey.

The conductor whipped a noisemaker around to signal the first stop. As the mechanical buzzing ceased, we filed into a school room scene and fanned into a semi-circle to watch the action. Four dark blue plastic chairs were placed in two rows, and pencils and pads of paper were strewn on the floor. Nhlanhla appeared as a kid on his first day in Grade 4. He wore white tennis shoes, jeans, and a dark hoodie and playfully goofed around with other kids in his class. People made fun of him when he brought out a lunch his parents had packed, but he just smiled and seemed grateful for it.

The noisemaker buzzed again, and we boarded the train for the next stop. As we disembarked, we saw a white sheet folded on the ground to represent a grave. A makeshift cross covered in tan linen rested at the head of the grave-marker, and Nhlanhla stared at it, subdued. Leleti and Zama informed us that this is the turning point in Nhlanhla’s life—his mother has died. They invited us to join in a song in isiZulu to bid her farewell, and we were given paper cut-outs of flower petals to place on her grave. As they passed Nhlanhla, some of the audience members clasped his shoulders, gave him hugs, or expressed their condolences. I stood watching, purple flower petals in hand, and one of the girls from the audience tugged my arm as the noisemaker signaled it was time to return to the train. I sprinkled my handful of paper petals at the foot of the cross and followed the little girl back to the train. She put my hands around her waist, and we set off for the next scene.
As we traveled around the room, I thought about how dynamic, highly participatory, and whimsical this show had been so far. I thought to myself, “This feels like a children’s pop-up book” as our train came to a halt at the third stop. Here, we learn that Nhlanhla’s father abandoned him as a young child, so he’s been forced to cohabitate with his abusive uncle following the death of his mother. There are a group of guys gathered around a television drinking, and Nhlanhla slinks around the background as if trying to move unnoticed. We watched as his uncle grabbed him by the back of the shirt and threw him to the ground, yelling invectives. Eventually, Nhlanhla broke free of his uncle’s grasp and ran out of the house. His uncle threw a beer bottle at his retreating back and told him not to bother returning.

The fourth was the culminating scene, and there were cigarettes, alcohol, newspaper, and guns strewn about the room as we arrived. The room’s backdrop was a large white sheet littered with graffiti. We disembarked from the Train of Thought as a guy holding a gun entered the space. Two more guys followed on his heels, and all three took seats on boxes that formed a circle around beer bottles and trash. They started badgering Nhlanhla when he entered, and it quickly became apparent he has been living with them on the streets for awhile. The conversation drifted toward Nhlanhla’s future, and the three guys started talking about life circumstances. They eventually told Nhlanhla that he must make a choice about whether to join their gang or not. The scene ends.

Leleti, acting as facilitator, turns to the audience and says, “So, Nhlanhla has been out on the streets fending for himself and has fallen prey to a group of gangsters who invite him to join their gang. The question is will Nhlanhla join them, or will he choose to seek other options?” Six actors from past scenes all crowd into the room to circle Nhlanhla, acting as voices in his head and shouting their opinions about what he should do. After a few moments of this,
Nhlanhla looks thoroughly confused. He sits down, grabs his head, and rests his elbows on his knees. He gazes off into the distance, obviously unclear about his future. Zama then turns to the audience and asks us what we think Nhlanhla’s journey was about. Zama and Leleti facilitate a discussion after the performance and ask us to describe the journey we have taken, whether we think this is the end of the journey, what we think the various destinations at the end of this journey could be, and whether we think Nhlanhla has a choice to make or if his journey is in the hands of fate or structure.

One of the boys in the audience piped up and said, “It’s fate. Life can easily turn. He was a good schoolboy, then in the end he was thinking about being a gangster. Bad things happen. His parents died…he had no choice. He needs someone to take care of him.” A girl quickly jumped in to say she thinks Nhlanhla has limited choice—he has a choice, but he is constrained by his life circumstances. Another girl broke in to say she thinks Nhlanhla has a choice in what he does, and a boy standing next to her agreed and added that Nhlanhla must accept responsibility for his actions. Another guy voiced his opinion that circumstances shape people’s lives—it has a little to do with fate because, in some circumstances, you have no real choice, even though it may seem like you do.

The discussion continued for another 20 minutes, and the audience members (both male and female) spoke up in a lively way. At the end, for closure, Leleti and Zama asked the participants to think about whether Nhlanhla has a choice to make about joining the gang and to deposit their train tickets in the shoe boxes at the edge of the room marked “fate” and “choice” according to how they felt after the discussion. The majority of the audience complied, and I watched as several participants stood in front of the boxes, pondering their opinions of Nhlanhla’s journey. A few started talking about the possibility of tearing their tickets in half and
placing a part in each box to signal the place of both agency and structural constraint in people’s lives. One audience member tore his ticket in half, and several more followed suit.

After the performance, Leleti and Zama told me the point of the discussion was to prompt audience members to think about what options Nhlanhla has—or whether he has any options at all. The point is to think about how Nhlanhla is embedded in his life and what role his interpersonal relationships play in his actions. Zama noted that the theatre processes were partially about proving to the boys they have the ability to perform (theatrically). The rest of it was about collectively telling the story of how this group of boys ended up on the streets and to interrogate what keeps them on the streets.

While the original intention had been to run a workshop based on HIV as a thematic topic, Leleti and Zama realized during the processes that the boys were more interested in and needed to talk about their lives on the streets. Leleti and Zama allowed this change and did not consider it a failure of their process—rather, their flexibility in responding to the needs of their participants was positioned as a strength of theatre as an intervention form. During the discussion, Zama noted the boys’ energy fluctuated constantly, and she was reminded of flows in trains of thought. That was the genesis of the idea for the embodied Train of Thought process. She noted that through the theatre games they played, she could see constant, underlying subconscious considerations among the boys about whether they actually, really had a choice or not in the way their lives have played out. Their thoughts never stopped—it was a continuous thing, like a train, fleeting from one stop (or idea) to another.

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Much like Naomi’s theatre processes with students in the previous chapter (struggling with problem framings), Our Story: Nhlanhla’s Journey is a good example of tensions within
artistic interventions because it shows the struggle theatre-makers have with moving past conventional choice/decision rhetoric despite their intentions to do something different. This struggle in many ways reflects the pervasive influence of national biocitizenship projects within public health programming in the country. In addition, it illustrates the power of internalized dogma in constructing how people think and speak about their relationships to health, structure, and agency.

Both Leleti and Zama have been trained through a rigorous new university program in HIV/AIDS-related applied theatre to think of the dialectical relationship between people’s actions in the world, the structural factors that shape those actions, and individual and collective possibilities for social change mobilization. However, the two still frame their attempts at discussing that dialectic through dichotomist rhetoric of “choice/fate.” Even as theatre-makers attempt to challenge the ubiquitous narratives of neoliberal biocitizenship and personal responsibility that structure knowledge production about HIV and how best to intervene in the country’s AIDS epidemic, they struggle with finding alternatives to such narratives. Indeed, they are working against a history of this kind of neoliberal health-based discourse in the country that increased markedly through national public health campaigns in the late 2000s.

Biocitizenship and Health Policy Discourse: Embracing Neoliberalism in Post-Apartheid South Africa

Neoliberalism refers generally to a philosophy of free markets, privileging the individual, which highlights the ability of the market to solve redistributive problems rather than the state. It is implemented through economic reform that often leads to situations of inequality. Although neoliberalism was introduced to South Africa before democratization, the country’s current neoliberal policies were finalized during the transition from an apartheid-oriented government to a democratic system. The introduction of neoliberal policy followed from international pressure
on the newly elected government, the outside introduction of structural adjustment programs/policy (SAPs), and as part of cementing newly reinstituted international ties, interaction, and allies. The two key economic policies of the post-apartheid government were the 1994 Reconstruction and Development Programme (RDP) and the 1996 Growth, Employment, and Redistribution Plan (GEAR). Broadly, the RDP was an economic policy designed to improve service delivery to the impoverished and support human rights, justice, and development\textsuperscript{109}. The subsequent GEAR policy changed direction and privileged neoliberal economic stabilization.

In 1996, decentralization of the healthcare system accompanied official structural economic change, which led to the implementation of the orthodox economic reform program, GEAR\textsuperscript{110} (Carmody 2002). The two main actors within South Africa pushing for globalization were the state and major conglomerates. Although the new plan was intended to provide economic growth and increase jobs by 600,000, the majority of the South African population has not seen such positive outcomes. Neoliberal policy has deeply affected the areas of employment, crime, gender relations, and healthcare structure in the country (Carmody 2002). One particularly hard-hit area that has been affected by neoliberalism includes the administrative transformation of the public health sector.

\textsuperscript{109} The RDP emphasized two main points: the alleviation of poverty and the reconstruction of the economy. In its contents, the RDP outlined the major role government would play in integrating economic growth in the country with economic reconstruction and social development and the accompanying role the private sector would play in fulfilling basic needs of the population. It was a policy meant to iron out structural inequality within the country; however, there were significant shortcomings in the implementation of the RDP, and the state’s commitment to “people-driven development” appears to have been ambivalent and fluctuating during the time that the redistributive RDP was operational and before the GEAR programme replaced it (Lodge 2002).

\textsuperscript{110} GEAR, in contrast to the RDP, emphasized deficit reduction, tariff reduction, and privatization in all levels and sectors of the economy. It was notorious as an economic framework structured in favor of capital (foreign and local) (Lodge 2002).
With the introduction of neoliberal reform, South Africa experienced rapid health sector restructuring. In 1994, the healthcare system went through a process of decentralization, “the transfer of responsibility for planning, management, and financing from central government to peripheral levels of government” (McIntyre & Klugman 2003:109). Two forms of decentralization, devolution and deconcentration, were implemented. In the devolution process, sub-national levels of government, often provincial or local, were given considerable decision-making authority in politics, including the health sector. This process was finished in 2000, and in the South African Constitution, all three levels of government—national, provincial, and local—have responsibilities in the provision of healthcare. The national level is concerned with policy development, provincial governments are responsible primarily for service provision in hospitals and curative primary care services, and local levels bear the burden of provision of preventive primary care services (McIntyre & Klugman 2003).

Following the devolution process was deconcentration, in which health districts within provinces were created and granted limited authority in administrative decision-making. A problem associated with this process is that health district boundaries are not frequently co-terminous with local government boundaries because lines were not finalized simultaneously. Two outcomes of this process include ubiquitous lack of clarity in responsibilities at local and provincial levels and blurred lines of accountability, which lead to confusion in policy implementation, budgetary problems, and high rates of demoralization among front-line managers and care givers (McIntyre & Klugman 2003). In addition, all of this structural decentralization was followed by fiscal decentralization, and many regions have seen conflicts in allocation of resources at the local level (McIntyre & Klugman 2003). This is especially tragic in light of the fact that there has been little growth in health sector budgets in most provinces,
even though national dictates about policy are handed down and fall on the shoulders of local facility managers who often lack funds to properly implement them (McIntyre & Klugman 2003).

Fiscal problems, unclear outlines of responsibility for policy implementation, and provincial decision autonomy about which healthcare programs to support can lead to a strict limiting of resources solely to biomedical, treatment-oriented HIV/AIDS care. Since 1994, the South African national health policy has been based on the primary health care approach with goals of universal access to basic health services in an integrated health facility setting (McIntyre & Klugman 2003). Although the goal has been integrated healthcare rather than the former vertical organization, the policy has been implemented fully in only a very limited number of facilities.

Most healthcare providers still employ a mix of integrated and vertical program managers, and specialized clinics (e.g. those associated only with HIV/STI prevention and treatment) still exist (McIntyre & Klugman 2003). Counseling, therapy, and community wellness projects are often neglected in favor of provision of ART or HIV testing. Although both of those programs are necessary to community mobilization in response to the AIDS epidemic, other services, such as those providing physical and emotional support to AIDS sufferers, are lacking (McIntyre & Klugman 2003; Kobasa 1990; Schoepf 2001).

Central to the goals of South Africa’s most recent national public health policy interests is the mainstreaming of a cultural model of health seeking subjects as rational, responsible, neoliberal individuals. This kind of subjectivity also supports the goals of the National Strategic Plan on HIV, STIs, and TB (2012-2016) and the government’s agenda of distancing itself from responsibility for the plateauing of high HIV prevalence rates in the country. Many of the
country’s recent major advertising and public relations campaigns regarding HIV/AIDS are centered on the government’s 2009 clarion call for buttressed voluntary HIV testing and counseling nationwide.

The official National HIV Counselling and Testing Campaign Strategy was unveiled in 2010 under the campaign theme “I AM RESPONSIBLE: I am responsible...We are responsible... South Africa is taking responsibility” (Anthony 2010). It followed on the heels of President Jacob Zuma’s call on 1 December 2009 (World AIDS Day) for all South Africans to take individual and collective responsibility for reducing the HIV prevalence rate in the country. In his official speech for World AIDS Day, Zuma stated:

Unlike many others, HIV and AIDS cannot be overcome simply by improving the quality of drinking water, or eradicating mosquitoes, or mass immunisation. It can only be overcome by individuals taking responsibility for their own lives and the lives of those around them…All South Africans should take steps to ensure that they do not become infected, that they do not infect others and that they know their status. Each individual must take responsibility for protection against HIV. To the youth, the future belongs to you. Be responsible and do not expose yourself to risks. Parents and heads of households, let us be open with our children and educate them about HIV and how to prevent it… We can eliminate the scourge of HIV if all South Africans take responsibility for their actions. I need to re-emphasise at this point that we must intensify our prevention efforts if we are to turn off the tap of new HIV and TB infections. Prevention is our most powerful and effective weapon. We have to overcome HIV the same way that it spreads - one individual at a time. We have to really show that all of us are responsible… Let there be no more shame, no more blame, no more discrimination and no more stigma. Let the politicisation and endless debates about HIV and AIDS stop. Let this be the start of an era of openness, of taking personal responsibility, and of working together in unity to prevent HIV infections and to deal with its impact. [Zuma 2009\textsuperscript{111}]

The official “HIV—your responsibility” campaign is based on the principles of the neoliberal subject. Although President Zuma’s speech mentioned the role of government in addressing structural factors that exacerbate the country’s AIDS epidemic, the theme of personal responsibility played a significant role in the majority of his address to the nation. The campaign

positions HIV testing as an entry point to responsible health behavior related to sexually transmitted infections. According to literature issued by the SANAC Secretariat, there are three interpretations to the campaign theme of responsibility:

I must take responsibility for my own health and HIV Status i.e. if I am HIV negative, to stay negative, if I am HIV positive, to seek support and services to ensure I am healthy and don’t spread the virus to others, be they partners or children. I must take responsibility for enabling those in my sphere of influence to make healthy choices (be they my children, my sexual partners, my employees etc). Government is taking responsibility to ensure quality services are available when people present to test.

[Anthony 2010]

Several provinces, including KwaZulu-Natal, have implemented the “I am Responsible” theme as the official Department of Health mandate, and they encourage every citizen of the province to be responsible in their health and health-seeking behaviors112. Keeping in line with the theme of responsibility, the South African Department of Health has developed and promoted a Patient’s Rights Charter that clearly defines the rights and responsibilities of health seeking subjects in South Africa.

In addition to national governmental campaigns, other recent HIV/AIDS NGO and media efforts implore people to take responsibility primarily through testing and male circumcision. Campaigns declare things like “First things first: HCT113!”, “Play Your Part for a Better South

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112 Source: (http://www.kznhealth.gov.za/simama/hct.htm)

113 “First Things First HCT Campaign” is the most recent campaign of the Higher Education and Training HIV/AIDS Programme of South Africa (HEAIDS). It is a voluntary HIV testing, counseling, and education campaign aimed at public higher education institutions and aligns itself with the 2012-2016 National Strategic Plan for HIV, STIs, and TB to maximize opportunities for mass HIV testing. It represents a public-private partnership and includes stakeholders such as Innovative Medicines South Africa (IMSA) and the Foundation for Professional Development (FPD), with support from the United States Agency for International Development (USAID); the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR); the Department of Higher Education and Training; the Department of Health; and the South African National Aids Council (SANAC). According to website literature, “‘First Things First’ aims to help South African tertiary students in particular to fulfill their destinies by encouraging them to be responsible, get tested for HIV and empower themselves by knowing their status and committing to behavior that will protect them and their peers. To know one’s HIV status is the basis for caring for oneself, one’s loved ones, and the broader community from HIV and AIDS. To test HIV negative calls for behavior to stay HIV negative.
Africa\(^{114}\), “Get wise. Get tested. Get circumcised\(^{115}\),” and “I am responsible!\(^{116}\)” All four campaigns are designed to foster a culture of responsibility among South African ideas of health citizenship.

[Photo Credit: UNAIDS 2011]

through responsibility against HIV risk. To test HIV positive calls for precautions to protect oneself and others further, and to be enrolled in wellness and treatment, care and support programmes.”

\(^{114}\) “Play Your Part!” is a national campaign to encourage civic participation and is driven by Brand South Africa to “inspire, empower, and celebrate active citizenship in South Africa” (http://www.southafrica.info/playyourpart/faq.htm#.U26dvlWSo#ixzz31Ls42aOL). Its HIV/AIDS branch encourages all citizens of South Africa to contribute to positive change in the country through recognizing the power of individual responsibility in testing and that “neither government nor business can solve South Africa’s challenges alone. Play Your Part” (Play Your Part 2014).

\(^{115}\) The 2014 World AIDS Day theme is “Get Wise. Get Tested. Get Circumcised.” In addition to the well-established HCT revitalization campaign, World AIDS Day 2013 and 2014 have been dedicated to launching a drive to encourage South Africans to embrace medical male circumcision as a prevention measure (SANAC Bodibe 2013).

\(^{116}\) The “I am Responsible” campaign has also made its way into the business sector. Led by the South African Business Coalition on HIV and AIDS (SABCOHA), companies have worked together to develop a strategy to mobilize the resources within the business sector to support the government in its National Strategic Plan objectives, including a focus on personal responsibility and testing (http://www.sabcoha.org/htc-campaign/).
Although artists recognize the importance of individual action, agency, and responsibility within health outcomes, many theatre-makers consider neoliberal biocitizenship a woefully inadequate model of health subjectivity that too narrowly focuses on individualism and personal responsibility to the exclusion of other factors. This kind of biocitizenship is known for decontextualizing people and producing subjectivities disconnected from other people and sociopolitical considerations (Robins 2006; Rose & Novas 2005). In contrast, artists were promoting development of a kind of reflexive health subject able to incorporate diverse strategies and considerations into their thoughts about healthcare, not just personal responsibility.

Important to note is that few theatre-makers pointed explicitly to neoliberalism as the culprit in the production of responsible biocitizens in South Africa. However, most of the artists with whom I worked talked about the desperate need to reconnect individual health subjects to considerations of interpersonal relationships, structure, economics, politics, agency, existential incoherence (discussed as “complexity”), and motivation.

Relationality and Consociation: Complicating Understandings of “The Individual” Health Subject

Theatre-makers, through their focus on evocative immediacy, are reacting against neoliberal biocitizenship projects and claiming that such projects have little appeal or relevance in the everyday lives of South Africans. While such interventions try to couch human action in the language of individual freedom, choice, risk management, priority assessment, and decision-making, theatre-makers claim that more often than not, people experience their lives in a very different way. Very rarely do people experience their lives as a series of clear, evident choices.

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117 These are all words used by artists to talk about restructuring health subjectivity in the country. Most of this vocabulary was adopted by the people with whom I worked through a range of sources, including academic training (biology, anthropology, theatre), workshops on HIV/AIDS sponsored by the Treatment Action Campaign, widespread consumption of media writing on the politics of HIV in South Africa, and colloquial dialogue between theatre-makers during meetings, conferences, workshops, and collaborations.
and decisions. In moments of experience, particularly in relation to sexuality, people do not spend a majority of their time filtering their lives through prioritizing choices, assessing risks, or making conscious, calculated decisions. Health programs that seek to intervene through logic and teach people how to manage risk or make/prioritize between choices do not fully capture how people are experiencing their lives as incoherent. For theatre-makers, public health programs that try to make an intervention (often through education) only at these points are likely to fail: other strategies, tactics, and modalities must be added to the intervention arsenal. According to many artists, intervention questions about risk, choice, and decisions are not the right questions. The recent attempts by artists to re-think the role of the individual within health-related interventions is fundamentally a problematization of the assumptions of stability and coherency implicit in biocitizenship rationalities.

This is an area of cross-over interest for medical anthropologists and performance practitioners involved in health interventions. Anthropologists have also widely critiqued similar models of public health intervention and underlying rational choice theories of health behavior for not taking into consideration other factors that constrain or enable people’s health prospects, including sociopolitical and historical contexts, endemic structural inequality, family network ties, and underlying moral economies that often conflict with the values of biomedical rationality. Additional factors anthropologists consider important are rampant stigma against HIV, local social expectations and identity roles, and power dynamics influenced by gender, socioeconomic status, or ethnicity. Artists in the country tend to agree with many social science critiques of such magic bullet approaches as inattentive to the underlying structural causes of the country’s high HIV prevalence rate and therefore consider such efforts necessary but insufficient to deal with the realities of lived experience of HIV.
As a result, theatre-makers are advocating for the production of what I have called in this chapter a “consociated” individual: a particularly reflexive form of health subjectivity that links individual subjective experience to broader facets of individuals’ relationships and context (including political, social, and economic positioning). This type of subjectivity constructs individuals as agents enmeshed in webs of interpersonal relationships, knowledge economies, and structural factors that interact to shape the individual subject’s health at any particular moment. Consociated individuality is an understanding of the “individual” that is similar in some ways to neoliberal biocitizenship but differs in certain critical respects.

Through theatrical practices, artists are subtly but importantly trying to shift the idea of the “individual” health subject from a biocitizen solely responsible for the actions, thoughts, feelings, and choices that shape his or her health to an idea of the individual as a more politicized and relationally positioned person. Consociated individuals are those who are more socially contextualized than the neoliberal biocitizen: they are constituted in specific geographic and historical contexts and produced through specific relationships of power, notions of citizenship, interpersonal interactions, structural forces, access to health knowledge, and subjective experiences of the unknown.

Medical anthropologists have pioneered critiques of biocitizenship projects and their underlying knowledge-based rationalities by skillfully and exhaustively documenting ethnographic evidence of the political, economic, and structural constraints on health equality around the globe. Artists agree with those critiques but have pointed out that just as there is a limit to what can be explained about people’s health-related actions through health belief models and cognitive reasoning, there is a limit to the extent to which people’s health understandings can be explained by structural constraints or inequalities. For theatre-makers, one of those limits is
the realm of existential incoherence. What the people with whom I worked are trying to add to policy discussions about HIV is a deep consideration of how subjective experiences of existential incoherence can also shape people’s ideas about health, their access to treatment and care, and their sexual actions. What is contributed is a focus on incoherence—acknowledging it, allowing it to become part of the official conversation, and pushing at its boundaries through expanded forms of reflexivity.

A goal of this type of subjectivity is the pursuit of additional individual knowledge about the world and a concern with the knowable and its limits (so, pushing reflexivity about individuals and a drive to ‘know yourself’). This is similar to the rationality projects of the neoliberal model of responsible biocitizenship. However, while theatre-maker frameworks parallel biocitizenship projects to a certain extent, they diverge in motivations, agendas, and goals. Theatre-makers use processes of expanded reflexivity and mining individual knowledge to challenge neoliberal subjectivity by trying to produce more socially contextualized individual health subjects. They use reflexivity to bridge the disconnected individual biocitizen, re-contextualize people, and mine motivations, agency, and ideas about consequences for health.

The production of consociated individual health subjectivity involves a process of reconsoication\(^{118}\). examining through forms of deep, expanded reflexivity how individual subjectivity is produced through interactions with other people and contexts. This is an active process to re-contextualize individual subjectivity by bringing individuals back into association

\(^{118}\) This concept of reconsoication is very similar to the idea of entextualization by Bauman and Briggs (1990). Entextualization is a process that originates at the nexus of anthropology and discourse studies and is identified by Bauman and Briggs (1990) as a key resource for identity work and thinking through how identity is dynamic and produced through processes of identification and disidentification. The idea of entextualization highlights how language and textual materials are decontextualized or recontextualized and for what social reasons—including analyzing how people use text and semiotic material to perform identity within social media activities (Bauman & Briggs 1990).
with interpersonal relationships, structural forces, their own subjective experience of existential incoherence, and active considerations of agency. This process is a way of asking: how much of my health outcomes are my responsibility, and how much is structured by my context? What agency do I have? What are my motivations? How do my relationships influence my life? How do my actions affect others?

Reconsociation is a very humanistic goal premised on building connections and studying interactions. This is about finding ways to evoke empathy, prompt audience members to recognize they are not alone, and foster connection with others. The process of reconsociation invokes the kind of complexity I introduced in Chapter 6: it examines the kind of subjectivity that emerges from the interactions between people, structure, the known, and the not-fully-known. Rather than a decontextualized individual health subject, consociated health subjectivity seeks to produce deeply reflexive health subjects who consider their interpersonal relationships and socioeconomic and political positionings. This is not about how subjects are constituted through expert discourse but rather about how subjects constitute and position themselves as they mine their own understandings of their thoughts, feelings, and the worlds in which they live.

For example, the beginnings of this way of producing subjectivity through theatrical work are illustrated within Our Story: Nhlanhla’s Journey. The play attempts to shift the story narrative from a cautionary tale against an action judged “right” or “wrong” to an exploration with the audience of understanding an individual in long-term context. Some theatre-makers are moving from past message-driven artistic campaigns toward interrogation of individual life

While this sounds much like the concept of intersubjectivity, it is different. Reconsociation includes considerations of people’s intersubjective relationships, but it also includes consideration of individuals’ relationships to political economic structures, knowledge economies, and individual subjective experience of incoherence, as well. In addition, while this process also sounds like simply studying the ways people are socially contextualized, it is slightly different. Reconsociation is about studying social contextualization, but it is also about studying subjective experience of incoherence, which is not always necessarily directly related to social context.
experience as it relates to context. The play style asks the audience to think about Nhlanhla’s intersubjective relationships over time, his motivations, the amount and kind of agency he has, and what the consequences of his actions may be. The play tries to shift the conversation from a “make the right decision” directive to a critical interrogation of whether Nhlanhla has a choice at all in this particular instance in his life. It also asks audience members to cogitate on the structural factors that have shaped Nhlanhla’s journey in life.

Theatre-makers are challenging the dichotomous language of “choice/decision” by adding in consideration of layers of limited agency. Reflexive processes are meant to foster recognition that people often live their lives in contexts of limited agency. This kind of pushed reflexivity is meant to deeply interrogate what factors constrain people’s options and opportunities in life and what forms of agency people have. Rather than the autonomous neoliberal biocitizen, the consociated subjectivity produced within theatrical interventions recognizes that individuals do not always have clear options or unambiguous power to make clear choices. For instance, in Nhlanhla’s case, he was limited in his younger years by his parents’ control and in his later years by the death of his mother and abandonment by his family. His family (uncle) is represented as abusive, and the gangsters with whom he lives on the streets treat him better. However, Nhlanhla recognizes the potential problems that may arise through joining a gang, which is represented in the scene through copious graffiti, alcohol and drugs strewn about the space, and guns resting on the hips of all the older boys. Nhlanhla’s “choice” is not a clear, resolved, simple, or unambiguous one. The play points out that the idea of choice is actually complicated and contextual.

Theatre-makers are also interested in the “why” behind actions and advocate interrogating motivations to examine how meaning is socially constructed. This is about asking
theatre participants to reflect on themselves, their understandings of their relationships to other people, and their place in relation to structural forces. Theatre-makers are trying to interrogate nonjudgmentally these parts of people’s lives using the immediacy, emotionality, and evocative performance of the artistic medium.

In essence, consociated subjectivity is about understanding individual health subjectivity in context. It is also about interrogating individual responsibility related to health in particular moments, times, places, and in relation to particular people and structural constraints. Theatre-makers are moving toward engaging with long-standing structure versus agency debates and trying to tease apart with their audiences what kinds of power and ability to take action people have (or lack) in their everyday lives.

In many ways, consociated individuality is about holding onto neoliberal ideas of responsible subjectivity but complicating them in particular ways. For theatre-makers, this is about attempting not to reject the responsibility edict of neoliberalism in entirety (accepting responsibility for actions is an important and primary component of the kind of health subjectivity theatre-makers promote). However, it is also considered important to simultaneously recognize a person’s deep interconnection to other people and contextual circumstances. Instead of an individual solely responsible for his or her health, the kind of consociated individual theatre-makers work to produce maintains consideration of personal responsibility while recognizing his or her relationships to and with other people and other socioeconomic considerations.

Consociated individuality provides a way to try to mediate between typical representations of people as rational, responsible health subjects within biomedical and public health campaigns and popular media representations of South Africans as irrational, licentious,
hypersexual people enmeshed in webs of multiple concurrent partnerships and polyamorous relationships operating in chaotic worlds (Fassin 2007; Jacobs & Johnson 2007; Campbell 2008). Theatre-makers are trying to find a way to hold, incorporate, consider, and portray the realities of incoherence (e.g. uncertainty and mutability) in people’s lives while still recognizing the rationalities through which people act in relation to healthcare. They also add considerations of the structures that shape people’s lives, options, and opportunities; thinking about what forms of agency people have; and weaving in recognition of people’s individual values, concerns, and desires.

**Relationality and Anthropology**

A common anthropological topic of interest is the relationship between individuals and society. Theorizing of the individual and personhood is myriad in Western social theory, as is literature on subjectivity and its relationship to agency (Biehl, Good, & Kleinman 2007). The focus by theatre-makers on relationality that I have just outlined brings to mind several anthropological notions of relational subjectivity. Anthropologists have written extensively on relational subjectivity in various ways. In particular, the idea of consociated individuals I have presented in this chapter relates strongly to three anthropological concepts: Marilyn Strathern’s “dividual” (1988), Margaret Lock’s “embedded bodies” (2013), and Arthur Kleinman’s “divided selves” (2011).

Most theories of agency and individual subjectivity tend to assume individual actors as the origination of desire and action (Wardlow 2006). The individual of Western thought is bounded, self-authoring, and acts independently in the world. Within practice theory, common theorizations of agency do not assume that individuals are fully autonomous and dis-embedded from social contexts; however, they tend to fall back conceptually on ideas of people
characterized by individual capacity to act (Wardlow 2006; Ahearn 2001). In contrast, out of her work on Melanesian subjectivity, Marilyn Strathern introduced the concept “dividual” in 1988 to connote a form of relationally constituted personhood as an alternative to Western notions of “individual.” In Strathern’s writing, Melanesian personhood is constructed as a composite: plural, multiply authored, interdependent rather than autonomous, and fundamentally positioned within a network of others (Wardlow 2006). Rather than existing prior to the social worlds in which they live, “dividuals” are constantly constructed through lived experiences and evolving relationships.

In her ethnography on female agency, sexuality, and subjectivity among “passenger women” of Papua New Guinea, anthropologist Holly Wardlow engages with Strathern’s concept of “dividual” but attempts to expand it. She notes:

> Representations of personhood as “individual” “dividual” “relational” “sociocentric” or “egocentric” have been complicated by findings that dominant notions of personhood are often cross-cut by other, often more muted or devalued, dimensions. Indeed, it is possible to witness moments of confusion or contestation, when actors are unsure of, or in disagreement about, whether one should be acting relationally or individually. [Wardlow 2006:19]

Wardlow and other critics of the individual/dividual debate note that this line is often a false dichotomy, and people experience their lives in different contexts as both individual agents and as relationally constituted persons (Wardlow 2006). Additionally, Wardlow draws on Foucault’s ideas on the history of sexuality but points out that what remains undeveloped in Foucault’s thoughts is a theorization of sexual subjectivity and its relationship to agency. In particular, what Foucault misses is an idea of the subject in relation to affective or emotional responses and a subject’s inner life.

I tend to agree with Wardlow and other critics and suggest that consociated subjectivity provides a possible bridge in the individual/dividual debate by focusing analytical attention on
the process of reconsociation: the ways in which socially contextualized personhood is created and how individuals feel, express, and experience their lives as both autonomous and interrelated. Theatre-makers actively advocate for the mining of individual subjective architecture as it relates to emotional lives, lived experience, incoherence, structural constraints, and interpersonal relationships.

Another anthropological concept often invoked in conversations about relational identity is Margaret Lock’s re-working of Jorg Niewohner’s “embedded bodies.” Lock’s work on embedded bodies and local biologies was recently included as part of a special journal series in “Medical Anthropology” on revisiting the concept of local biology in an era of global health. Spearheaded by P. Sean Brotherton and Vinh-Kim Nguyen (2013), the series attempts to move anthropologists beyond considerations of the Western “body proper” (the view of personhood as discrete, individual bodies reduced to isolated biological characteristics) toward emerging forms of post-Foucaultian biopolitics.

In the series, Lock draws on her latest research on Alzheimer’s disease and implores anthropologists to re-engage with “local biology” and “embedded bodies” as conceptual tools. She states:

*Whereas the concept of local biologies argues for an interiority that cannot readily be reduced to the universal body of biomedicine because the body is inseparable from evolutionary, historical, cultural, and sociopolitical contexts, the embedded body provides a vehicle by means of which the molecularized, flexible, biology of epigenetics can retroactively be situated in contexts external to the body—evolutionary, environmental, historical, and sociopolitical.*

[Lock 2013:302]

For Lock, both concepts foreground the ways human lives are always already contingent, and people are inseparably embedded in a history-environment-sociopolitical-culture-biology framework. She notes the urgency for anthropologists to attend to biosocial differentiation
among populations, which is to be understood as the product of individual lived experience in specific historical, sociopolitical, and environmental contexts (Lock 2013). Where Lock and Niewohner’s concepts ask anthropologists to be more attentive to the ways in which biology and sociality are interwoven, the idea of consociated subjectivity asks anthropologists to more deeply consider the ways in which subjective, existential forms of incoherence and sociality are interwoven.

Theatre-maker interest in fragmented subjectivities and incoherence additionally dovetails with recent anthropological attention to similar topics. In particular, Arthur Kleinman (2011) has written on moral sensibilities, the idea of “divided selves” in medicine, and how clinical patients often experience their lives as fractured and full of hidden values. In his writing, Kleinman (2011) notes that the idea of modernity has long been associated with the idea of a divided self, or a global cultural picture of the individual as split, internally discordant, and contradictory. This metaphor of a divided self is often used within the humanities to make sense of “a chaotically complex world and equally complex personhood that is portrayed as fractured and at odds with itself” (2011:1). Kleinman discusses the disconnect between how physicians, decision analysts, and policy makers talk about clinical care and public health and the way individuals experience their lives in relation to health.

According to Kleinman, the dominant metaphor of the self for health policy experts and health services researchers is a simplistic, one-dimensional caricature that reacts in predictable ways to local worlds construed as reductionistically straightforward and homogenized. He goes on to state:

This biomedical and bioethical structure of cases and treatment algorithms isn't just an inadequate presentation of disconnections of human conditions; it is a core distortion of what it means in real life clinical and home settings for individuals to work out responses to serious illnesses and demanding treatments. Not least of these distortions is the way
lived values—the actual practices and engagement over what really matters in a particular place and time among vexed patients, families, and clinicians—are represented as clear-cut choices over admittedly fraught, yet simplistic, unidimensional value questions such as the ethical framing of the messiness and unclarity of end-of-life decisions as straightforward questions of futility versus heroic interventions. What gets lost in this construction of the classic medical scenario are divided emotions and hidden, conflicted values. ….People are better prepared by our culture and our health-care systems to express and respond to lists of stereotypes and clear-cut rules than they are ready to deal with divided emotions and hidden values.

[Kleinman 2011:2-3]

Here, the sentiments Kleinman expresses resonate strongly with theatre-maker insistence that incoherence in life be acknowledged within health intervention spaces. This is considered a primary starting point for engaging pragmatically with the ways people experience their lives as confusing and contradictory and their selves as divided and not fully (or always) apparent and coherent. Kleinman names this disconnect between biomedical understandings of the world and those of the people who live it as a major problem within the healthcare sector and in training of biomedical professionals.

Rarely within medical training or medical literature is the idea acknowledged that people’s values and the positions from which they act in the world are tied strongly to emotions and thus require sensibilities that recognize the hidden and divided components of individual subjectivity. According to Kleinman, very few medical practitioners are trained to articulate and deal with the reality of fragmented subjectivities, hidden values, and contradictions in life. He notes, “Hidden and divided values when unaddressed clinically can come to undermine personal lives and clinical interactions, creating inauthentic and false scenarios for teaching and for working out policies for caregiving. This may be the more subtle yet more fundamental conflict of interest in medicine” (Kleinman 2011:5). It is this subtle yet fundamental conflict of interest within medicine that theatre-makers have begun recently taking on within their intervention work.
Kleinman’s solution for resolving or lessening the consequences of this problem is very similar to the one put forward by theatre-makers: the cultivation among healthcare workers of a moral sensibility of critical self-reflection that recognizes the pressure of conflicted feelings and values within lived experience and on caregiving and health in particular. For Kleinman, the cultivation of this moral sensibility will be accomplished through educating healthcare students on the value of understanding their own “hidden and divided values,” as well as those of their patients (2011). He sees this education coming primarily from serious attention to medical humanities and bolstering attention with medical research to concepts, ideas, and ways of thinking about individuality that originate within the arts.

Kleinman’s view closely parallels the one I have advanced in this dissertation. I tend to agree with Kleinman that further attention to how the humanities and arts approach medical issues would be beneficial within clinical training, continuing medical education, health-care systems in practice, and more specifically HIV/AIDS research. The subjectivity theatre-makers are trying to cultivate among intervention participants provides an alternative to straightforward neoliberal biocitizenship: a sensibility borne of the arts’ intense focus on critical reflexivity that encourages people to recognize and deeply consider the ways in which their lives are contradictory and mired in existential complexity. A sensibility that is premised on being receptive and responsive to the very real and complicated ways people’s emotional lives interact with their cognitive rationalities and embodied selves to produce lived experiences that are not always one-dimensional or straightforward. A subjectivity that embraces considering and working through people’s hidden values and divided selves instead of erasing away the jagged edges that comprise a picture of a person’s life in-the-moment.
The idea I have presented in this part of the chapter (consociated subjectivity) is similar to Strathern’s “dividual,” Lock’s “embedded bodies,” and Kleinman’s “divided selves.” However, what consociated subjectivity adds in particular to conversations about relational subjectivity is recognition of the important influence subjective experience of existential incoherence can have on individual health and action. In this view, individual health subjectivity emerges from multiple and varied interactions between people, knowledge, the structures that shape their lives, and subjective experience of the myriad forms of incoherence often produced at the nexus of health, sexuality, and political economy. This is fundamentally about relationality and the idea that the deeper we go into the self, the more we find connections to others (finding the universal in the specific).

Points of connection between people are emphasized in this perspective, which highlights the importance of what Kleinman calls “cultivated reflection” (2011) or deep reflexive processes to mine the ways individuals connect to others and to institutional forces. In an interview with Clara, a staff member at Drama for Life, she states this opinion clearly in her discussion of how theatre impacts people’s lives:

I don’t know of any statistics, I don’t know of any figures, and I don’t have any proof, but I think doing drama generally for youth, even that is not HIV related excessively, I think doing drama generally in a thoughtful, and I mean by that participating in drama workshops that explore themes through various techniques, I think generally makes people more empathetic and more thoughtful and more aware of their actions and more aware of the consequences of their actions and more aware of their relationships with other people and the implications of those.

This was a very common opinion among the theatre-makers with whom I worked. In another interview, Tonderai, a 34-year-old black South African theatre-maker, simply said, “Theatre is important: it changes the way people relate to each other.” In a dramatherapy workshop I attended, this view was voiced in a slightly different way. The two dramatherapists, Sarah* and
Leah*, said that using arts therapies is a process and practice of relating to other people. Sarah piped up, “It influences, shifts, and improves people’s capacity for relating Self to Other—that’s what art therapies do. It teaches, allows you to practice, and expands on how people relate to each other. It introduces more ways of relating, better ways of relating, and it gets people to practice relating to each other.”

In much of the conversation I had with theatre-makers about levels of impact, the consensus was that contemporary HIV/AIDS-related theatre impacts people at an individual level. This surprised me because artists were not invoking politics as much as past traditions of activist theatre. However, what I noticed theatre-makers doing was trying to subtly bring individuals back into conversation with structure, affect, and interpersonal relationships in an effort to avoid the didacticism of protest theatre and past heavy-handed media campaigns on HIV in the country. For theatre-makers, it was not a matter of dichotomous individual-versus-community thinking (addressing one OR the other). Instead, what seemed so revolutionary about what they were doing is that they were trying to find ways to talk about and produce types of individuals who were more socially contextualized in a very layered way (weaving together considerations of structure, agency, intersubjectivity, political economy, affect, subjective experience, knowledge, and the realm of the incoherent).

**Reflexivity, Consociated Subjectivity, and Links to Health Activism**

Where all of these concerns on the part of theatre-makers with reflexivity and consociated subjectivity become particularly relevant is in their relationship to health activism and possibilities for social change. When I first arrived in South Africa for fieldwork in 2008, I expected to see a country teeming with protest theatre. According to literature on South Africa’s applied theatre sector, artists wielded protest theatre as a cultural weapon during the anti-
apartheid period, and it was described as a permanent fixture of the artistic landscape. However, trying to locate activist theatre upon arrival was like walking through a ghost town. Initially, I thought activist theatre had altogether disappeared. What I saw instead was ubiquitous use of personal narrative theatre or genres that privileged personal storytelling (such as playback theatre or dramatherapy).

Over the three years I conducted fieldwork off and on, I realized activist theatre was not gone; it had simply started to shift forms in the post-apartheid era as a response to changing ideas about activism, messaging and communication styles, and civic participation in the country post-democracy. In a conversation with the director of Drama for Life, I asked him about the recent abundance of personal narrative theatre. He thought for a minute and finally said, “Certainly the personal voice has emerged, there’s no doubt about that. But I think the really great pieces, like Peter Hayes’ work in terms of HIV and AIDS specifically, they’re all firmly located in the politic and culture. That’s part of the sense of going, ‘become aware of, understand this construct, you know, I understand my history.’”

I glanced at Warren and skeptically responded, “Okay. How many theatre makers, how many shows, are engaging that politic, that sociopolitic?” He smiled, shrugged, and admitted, “Not a lot.” We bantered about activism and personal narrative, and I noted that people like Peter Hayes and Mike van Graan, both mainstream theatre-makers, appear to weave the personal with the sociopolitical; however, in most of my everyday experiences with theatre groups at the community and NGO level, the focus was more narrowly confined to individual lives, thoughts, feelings, reactions, and responsibilities. Warren nodded and jumped in to add:

You definitely capture it, and I think you’ve seen more (plays) than I have recently, by the way, but I would say that your view correlates completely with our view as teachers, of the new generation of university students and at high schools. That everyone is saying, ‘oh my goodness, this is a new generation, it’s so self-obsessed and so deeply
involved in their own needs and wants and hows and quite materialistic, too.’ And not even interested in engaging with Other, which poses various questions for all of us [laughing]. But my experience of like working with 1st years is that within a day of really grappling with issues around rights and histories and personal history and then looking at constitutional rights and that artwork and that history, very visual, by the end of the day, people are really, you know, the sense of, an awakening to ‘I am part of something much bigger, I’m part of a history.’ But there is a dislocation (between individuals and broader sociopolitical consideration), I would say a huge dislocation at the moment, particularly from the younger generation to the older generation.

Warren mentions a central shift of concern within contemporary theatre-making in South Africa: the shift from politically engaged theatre toward a theatre of personal stories. Personal narrative has become an important genre for many theatre-makers because it is considered more attentive to subjective lived experience and personal voice, but this style of applied theatre can be problematic for public health intervention work because it runs the risk of separating individual experience from broader social critique, conversations about sociopolitical structure, and health activism.

As a result, I noticed during fieldwork that some theatre-makers are trying to position acknowledgment and expanded notions of reflexivity as forms of health activism for the post-apartheid era. I argue this is a calculated move on their part to overhaul public health intervention techniques as they relate to HIV; however, it is also the result of (and reflects) broader social changes in ideas about civic participation in the post-apartheid era. Theatre-makers debated often about how to define activism post-democracy. I have argued in this chapter that one important outcome of the push toward reflexive processes within theatre interventions is the production of more consociated forms of health subjectivity that provide an alternative to neoliberal biocitizenship. I also suggest that theatre-makers are starting to position this kind of subjectivity, underscored as it is by expanded reflexivity, as a form of health activism. In particular, I posit that artists are focusing on expanded forms of reflexivity to subtly
alter what “awareness” means within public health and health activism to capture contemporary contexts in a more nuanced way.

**Expanded Reflexivity as a New Type of Health Activism: Alternative Pathways to Raising Awareness**

Acknowledgement as a process is about recognizing incoherence in people and making room to consider the ways in which people are already fragmented in their subjectivities. In contrast, reflexivity as a process is about intentionally shattering people (or encouraging them to shatter themselves) in order to break apart myths of coherent selves, mine knowledge, facilitate change, and promote later integration (healing). The idea of “figuring out” a person’s shadows is important to theatre-makers and involves questioning selves, desires, motivations, and the limits of knowledge and agency. For instance, Peter Hayes talks about what he hopes he accomplishes in his own work:

> I want you to ask questions. I want you to go into the emotion, but at the same time, I don’t want you to have a catharsis. I’m not interested in catharsis. I’m interested in action! And I think catharsis is the enemy of action because if you cathart, you’ll leave and go oh! [sigh] ‘Okay, well, I’ve purged that.’ And that’s fabulous, not knocking it, but that’s not what I want to happen in this kind of play. I want you to go into the feeling, and while you’re in that feeling, I want--so something like the strip, you go into the feeling and then the strip comes in, and you’re like, ‘what the fuck?’ you know? And you certainly are in your head, and I launch into possibly the most serious part of the play, and you’re in your head: you’re not feeing it. I don’t want you to feel it. I want you to stay with those questions! You know, as adults, adults at a certain age where men, women, gay, straight, if they’re truly honest, they’ve done something risky. It might not be unprotected sex, but they’ve gone home when they were drunk when they shouldn’t have, you know? We’ve all done something.

Peter discusses the impact of theatre, the importance of activism, and the links between the two. Artistic engagement with activism has a long history in South Africa. As I noted in Chapter 4, protest theatre played a central role in the anti-apartheid political resistance of the 1970s to mid-1990s. With the election of a democratic government in 1994, theatre-makers began critically...
reflecting on the role of the arts in the New South Africa. Themes diversified to include a variety of current social issues, of which HIV/AIDS has become one of the most publicized.

Since the mid-2000s, theatre-makers have begun moving away from privileging global educational and health communication paradigms, and some have re-engaged with questions about the role of the arts in health intervention and activism. A related question is: what kinds of activism are relevant in the post-apartheid context? The theatrical practices, techniques, and strategies of activism used in the apartheid era are considered inappropriate for the current political-economic climate. Some theatre-makers have begun conceptualizing alternative activism practices through actively complicating the concept of “awareness.” This concept has been invoked repeatedly in public health discourse, and most health communication programs include “raising awareness of HIV” as a major goal. The term has also been an important part of activist theatre traditions in South Africa since the 1970s, but it is currently being conceptualized, expanded, and operationalized in different ways for post-apartheid use. In particular, it is being linked explicitly to ideas about healing, reflexivity, and activism.

Using reflexivity to complicate what “awareness” means was a ubiquitous perspective throughout the work I conducted with theatre-makers in South Africa. In Chapter 6, I talked about the production “Sexually Yours” where Jorrell repeatedly asked the workshop participants to think about why people do the things they do. In the production Our Story: Nhlanhla’s Journey, the facilitators asked the participants to consider Nhlanhla’s life path and whether his actions were agentive choices he made or whether they were constrained by structural forces and dynamic relationships. Peter Hayes wants participants to think always about how to stay with questions about self, other, and society and center them as motivational points for activism.
These ideas about activism, reflexivity, and awareness extend to how theatre-makers envision the impact of their work. In general, when I asked theatre-makers what they were trying to accomplish, most replied that it is very difficult to measure impact for artistic work; however, they often had concrete examples about what they hoped would happen. Rather than a focus limited to goals about “knowledge, awareness, education, and entertainment,” they talked about the importance of theatre in a variety of ways, including encouraging critical thinking about Self and Society; finding commonalities between people and humanizing HIV; providing a safe space for audiences to question, problem-solve, create dialogue, build community, and tell their stories. Theatre initiatives were considered places to heal, to face “truth” or “reality,” to emotionalize social issues, acknowledge people’s grief, to make people uncomfortable—to be shattered. It is a space of “showing you’re not alone,” of “making it personal,” of catching attention and “making them think,” and of encouraging activism.

The Drama for Life program is a good example of a group with emerging ideas about how to engage with HIV. In a conversation with the director about the role of Drama for Life in broader health intervention efforts, he said:

I think it’s complex. But briefly I would say that it is about mindfulness and that goes to the heart of an ability to be self-reflexive, to identify, express, and manage emotions and emotional language, an ability to communicate effectively, and an ability to work with others. It’s not just, you know, I think outcomes based education has tended towards framing it as measurable skills in terms of communication or whatsoever. But really, it’s about developing the person in a way that allows them to find their own identity in relationship to culture, politics, to this, the issues of HIV and AIDS….If the work is about HIV and AIDS, then there has to be a deep understanding of how people choose to relate to one another, and not only how, but what motivates and what impulses drive people to do the things that they do, you know, all the evidence clearly suggests that the basic skill teaching has not worked and the basic education has not worked. It’s certainly raised awareness and consciousness, but it hasn’t changed the people….The cognitive/behavioral may touch on effective, but it’s not process. And there’s not enough, there’s a kind of experiential learning that’s required…if it’s a consciousness-raising tool that’s great, that’s 50% of the work, but the rest of the work is what you do with that consciousness, how do you live the consciousness? What changes are required
in order to ensure that that awareness is made effective?...It goes to the heart of intimacy and the heart of sexuality. Of course the necessity for understanding the medical aspects of it remains but there’s also the necessity to understand what sex is and what it’s about and then more than that, it’s to understand that there are many things that are unspoken and unsaid and that you know, how do you grapple with cultural beliefs and systems that direct people’s behavior in a very particular way? Or make meaning of behaviors.

In this, Warren brings up a host of issues: for him, past ways of dealing with HIV have focused on education, raising awareness and consciousness, and understanding the medical aspects of the epidemic. While he notes the critical nature of these components of interventions, he also points out that these approaches don’t get at the heart of intimacy and sexuality or allow people to develop their identity. He underscores the necessity of interrogating how people relate to one another. Importantly, he notes that at its core, theatre should be asking “how do you live the consciousness”? It is not just about awareness-raising and education—it is about figuring out how to live at the intersection of biomedical knowledge about HIV and the complex, dynamic subjective realities people face every day.

Many theatrical interventions have been framed through rhetoric about “raising awareness.” In the past, this usually meant simply “recognition of a problem.” However, what current theatre-makers are doing is complicating and expanding this idea of “awareness.” As noted earlier in the chapter, reflexivity was often coupled with the concept of mindfulness as a practice—an attentive, non-judgmental awareness of current experience, including a person’s thoughts, feelings, and beliefs. Combining these two, you get “Reflexive Mindfulness,” or the deep, intentional reflection on a person’s holistic experience at that particular moment. Artists have begun using Reflexive Mindfulness to mine the depths of people’s shadows. This involves pushing the boundaries of what we are aware of and how we know it (so: reflecting very deeply on self in relationship to others and society). This is also about acknowledging and accepting the unknown (so: delineating the boundaries of present knowledge). This involves fully
incorporating the place of more complex, ambiguous, lived experience of the AIDS epidemic in intervention efforts and actively enrolling audience members in the project of creating meaning around HIV and sexuality.

I suggest that some artists are complicating the common activist and public health concept of “awareness” and positioning reflexive mindfulness as a form of health activism. No longer does the term *only* mean recognition of a social issue or problem. It is being expanded to include a way of thinking and a positionality for activism. Rather than promoting simple “awareness” *of* issues related to health, artists are asking participants to reflexively interrogate their knowledge, the limits of their knowledge, their motivations, and their possibilities for agency in relation to health outcomes. This is about deeply interrogating people’s *capacity for change* and the positionalities from which people act (or not) in the world.

This is a subtle but important shift. Rather than using theatre as an institution designed to bring about behavior change, theatre-makers are starting to reconceptualize the possibilities of theatre as part of a larger process for readying people to make change in their lives. Within theatre, the capacity for change is addressed more directly than instigating definite behavior change (which is a major focus of more dominant public health campaigns). The liminal space of theatre allows participants to play with their individual and collective capacities for change—to think about, test, and reflect on those capacities. A major difference between neoliberal biocitizen approaches to subjectivity and the more consociated form of subjectivity theatre-makers try to produce is the latitude involved in necessitating change on individual levels.

For theatre-makers, reflexive health subjectivity is not about pressuring people to change. Rather, it is about acknowledging where people are in life, how they interact with others, whether or not they are ready to change, and allowing people to *be* who they are in the moment.
For participants, this is a form of “living the consciousness,” which is the idea of understanding what is going on in your world, whether you change anything or not. Simply acknowledging and holding incoherent selves is important in this framework. Theatre-makers say it is from this vantage point, this positionality, that people are best equipped to commence efforts toward social change. It is through this process of deep thought that healing occurs.

In some ways, the push to produce consociated individuals and reflexive health subjects is about fostering a certain positionality for health activism. This is about finding mechanisms to better account for individuality within culture change and encouraging individuals to position themselves--it is about encouraging people to think of themselves as socially, politically, economically, subjectively, and intersubjectively embedded individuals. This is a way to maintain an idea of individuality while linking it strongly to ideas about how people are produced through sociality and relationships with others. It is also an attempt at a grassroots bottom-up development of health subjectivity based in how people think about themselves and their lives, relationships, contextual constraints, opportunities, and ability to act in the world. Reflexivity is positioned in this framework as a mechanism of social change. In essence, this mindfulness is presented as a form of emotional agency.

### 8.4 Conclusion

In this part of the dissertation, I outlined how theatre-makers are trying to make spaces for alternative forms of health subjectivity in the post-apartheid era as a response to the hegemony of neoliberal biocitizenship projects within the broader healthcare industry in the

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120 This notion is very closely linked to Paulo Freire’s (1970, 1973) concept of “critical consciousness,” which focuses on action for social change based on critical reflection. The applications of this concept have been linked explicitly to the healthcare setting by some scholars (e.g. Minkler & Cox 1980). However, the way theatre-makers talk about critical reflexivity and social change expands on Freire’s notion to include the dimensions of existential incoherence, interpersonal relationality, and intersubjectivity in their conceptualizations of what kind of thought must go into creating possibilities for social change related to health.
country. These projects tend to narrowly conceive of citizens as independently acting agents living in rational, coherent, and controllable worlds. For theatre-makers, these kinds of health projects and intervention modalities rarely take into consideration the ways in which people often experience their lives as *incoherent* (or “complex”).

Theatre-makers note that a weak point in dominant styles of HIV intervention is a lack of attention to the ways in which people experience their lives as fragmented, incoherent, unpredictable, confusing, contradictory, and unstable. Although sometimes people act rationally in ways neoliberal biocitizenship projects predict, this is not always the case. Theatre-makers have made a point of intervening in the interstices of global public health practice: the spaces where knowledge and understanding are often disturbed. The push I discussed in this and the prior chapter is toward considering acknowledgment and reflexivity as active health intervention processes, which is about prompting a different level of engagement within global public health with incoherence, existential complexity, and lived experience.

Overall, I argue that the use of expanded notions of reflexivity in theatre to produce consociated individual subjectivity is about a *way of intervening* rather than a particular health outcome. This is important because, for theatre-makers, the way people think about the world, their interpersonal relationships, and structural forces is as important (if not more) than the answers they discover through this process. In many ways, theatre interventions are about introducing alternative ways to have conversations about public health issues. For instance, acknowledgement as a process within health theatre interventions is about introducing a *way of* having a conversation rather than determining what the conversation should be about or with how issues should be dealt. It provides an intervention process that allows and recognizes the existence of complex components of lived experience rather than shuts them down through
judgmental language or calls for particular pre-determined answers based on responsible neoliberal biocitizenship. Rather than finding solutions, the focus within the process of “acknowledgment” is on creating space for discussion and working on questioning strategies that are open-ended rather than leading (which is very similar to the anthropological approach).

Reflexivity as a process within health theatre interventions is about shattering people to explore what new forms of personhood can be created through artistic technologies. I discussed how theatre-makers are challenging the scope and techniques of reflexivity implicit in dominant biomedical and public health HIV/AIDS campaigns, as well as how theatre-makers are trying to challenge neoliberal ideas of individual health subjects by shifting the conversation from biocitizenship to consociated individuality. The process of reflexivity in theatre is not just about recognizing incoherence in people’s lives: it is also about performing incoherence. In some ways, this is a significantly different level of engagement with incoherence than other forms of intervention. This is a socially performative sharing of people’s existential complexity. This involves publicly talking about incoherence, listening to other people’s stories of incoherence, and actively performing it with others. It is an evocative recreation and questioning of incoherence. It is not just recognizing that people have shadows in their lives; it is asking participants to live in their shadows, question their shadows, and create knowledge from that liminal space. This is about mining people’s incoherence in an intentional, direct way.

I suggest this kind of reflexivity is used by artists as the basis for producing consociated subjectivity, which in turn is being positioned by theatre-makers as a pathway to activism, a mode of resistance, and a route to challenge the epistemic authority of the neoliberal biocitizen moral responsibility concept. In this perspective, deep and expanded forms of reflexivity enable individuals to be agents of change through sorting out their positioning in relation to themselves,
other people in their lives, and the sociopolitical contexts in which they live. For theatre-makers, fostering this consociated subjectivity (the emergent interactive relationships between self, others, and structure) is a type of health activism and possible route through which to enact cultural change. Theatre-makers are interrogating the link between systems and individual complexity in order to bring together awareness of both simultaneously. This is an active attempt to raise experiential, agency, and system awareness through which consociated, reflexive health subjects may be produced.

Finally, I suggest that these two processes together are also implicitly linking “healing” to “reflexivity.” Theatre-makers are using the concept of complexity to expand definitions of health and healing. In this framework, health is positioned as a way of thinking about complexity rather than a state of being. For some theatre-makers, acknowledging incoherence and the limits of cognitive knowledge is positioned as a form of healing. For example, in the introduction to the two chapters, Denvon ruminated on his past artistic work and questioned whether encouraging people to face the dark parts of their lives and meet their truths was healing. While he was unsure, other theatre-makers explicitly linked the idea of acknowledging incoherence in life (a person’s shadows) to the idea of healing.

Another example comes from a chat I had with Linda*, a 33-year-old white South African applied theatre teacher, who mentioned that she considers theatre a very healing space. After she had spoken about the healing properties of theatre for awhile, I interrupted to ask her what “healing” actually meant for her. She laughed and said, “Healing, I think off the top of my head, healing is about acknowledging, cleaning, and recovering from wounds, whether those wounds are physical or emotional or mental.” She went on to say that simple acknowledgment of something “off” in one’s life is a type of healing, even if you don’t quite know what it is that’s
off: allowing yourself to feel and recognize that something is not quite right for you is part of what healing means for her. This vague sense of something being “off” is part of what’s included under the banner of incoherence.

For many of the artists presented in these two chapters, embracing shadows and meeting truths are positioned as forms of healing (so, acknowledging “who you are” or “what your reality is” in a particular moment, even if the truth of both of those things can change from moment-to-moment). For the artists, encouraging people to “meet themselves” is a healing process of allowing a person’s shadows, incoherence, difficult truths, and fragmented subjectivity to be and exist in the world. In addition, critical reflection is positioned as part of healing processes. Health is constructed as a particularly reflective form of experiencing the world. Rather than discussing particular health-related actions as “good” or “bad,” theatre-makers advocate positioning health as a form of relational reflexivity. Overall, I have suggested that theatre-makers are trying to subtly shift ideas about HIV intervention processes, goals, and impact.
Part 5: The Story in Practice: Artistic Integrity Contested

Introduction
In the previous four parts of the dissertation, I presented and analyzed some of the ways theatre-makers are starting to talk about what they are actively trying to do within new intervention efforts. However, a significant finding of my dissertation research is that there were sometimes core disconnects between the ideological story theatre-makers tell and the story evident on the ground in practice. Despite the number of people who talk about new ideas of “best practices” within artistic HIV/AIDS efforts, educational theatre persists. The kinds of experimental aesthetics I described in Parts Three and Four, which combine health communication with affective techniques from multiple theatre styles and have that “deeper” focus on lived realities, are not as prevalent on the ground as they are in discourse.

An important question is—why are these new aesthetics, practices, and content themes not as prevalent despite their ubiquitous popularity among emerging and established theatre-makers in the country? This part of the dissertation tells the story of disconnects that often happen between ideology, discourse, and practice among the applied theatre sector in its attention to HIV/AIDS health communication and therapy. In Part Five, I analyze why disconnect happens, how it affects theatre-makers and their work, and what they are starting to do in response to outside institutional pressures to shape their work in particular ways. In short, this part of the dissertation is about ethnographically exploring how power and oppression articulate within the applied health theatre industry, how people experience and feel about it, how it affects their work, and what they do in reaction (the actions they take).
In this dissertation, I advocate examining theatre as a primary institution within the healthcare sector rather than an auxiliary component of other healthcare and communication efforts. Although there are many reasons that justify medical anthropological attention to theatre as a primary institution within broader HIV/AIDS intervention practices, I contend there is an especially relevant one for theorists attempting to develop new, integrated ways of doing HIV/AIDS ethnography. Privileging the study of applied health theatre as an industry in relation to other industries and institutions allows researchers to begin analyzing what kinds of institutional power and influence shape the context in which knowledge about HIV/AIDS is produced within the arts (critical structural analysis), as well as how theatre-makers experience this context (subjective and interpretive analysis) and what they do in response to it. This approach allows access to understanding how theatre-makers think and feel about the possibilities and limits of their work in the present political economic climate. In addition, this approach allows anthropologists to see what happens when theatre-makers engage with and speak back to institutional power structures.

Rather than establishing only that applied health theatre does interact with other institutions and industries in the country, in this part of the dissertation, I analyze how it interacts, what kinds of power are involved in these interactions, and what kinds of creativity are enacted when theatre-makers attempt to negotiate the competing interests of all involved stakeholders and work in the interstices of disciplinary boundaries. Through shifting the lens of analysis from theatre as an auxiliary component of other health practices to theatre as a primary institution within the broader HIV/AIDS intervention complex, it becomes possible to analyze how institutional relationships shape artistic attention to HIV/AIDS in South Africa, how these interactions affect the lived experience of people involved in the applied health theatre industry,
and what kinds of knowledge about HIV/AIDS are produced and promoted in the public artistic sector.

This part of the dissertation is divided into two chapters. In Chapter 9, I detail how the integrated focus some theatre-makers are trying to grapple with often conflicts with the priorities of outside institutional forces. In particular, theatre-makers discussed the idea of artistic integrity and constantly pointed to funding as one of the major factors that shapes the context in which they produce work. Funders were thought to exercise considerable influence over what kinds of information could be produced in the public realm about HIV and sexuality (content), as well as how this information was conveyed (aesthetics). The funding realm was a major area in which artistic integrity and vision were contested. In Chapter 10, I analyze the ways in which theatre-makers are speaking back to the structures of power that shape their work and lived realities.

In both chapters, I present ethnographic data to illustrate the complex web of institutional relationships in which the applied health theatre industry operates and how anthropological attention to this field may be beneficial, theoretically and practically, for medical anthropology and performance studies. The data on which I draw to make these arguments primarily include theatre-maker and funder interviews. This fifth part of the dissertation highlights how ethnography and anthropological analysis can contribute to theatre and performance studies by bolstering historical and political economic analysis of the types of structural relationships and institutional power that shape theatre practices.

121 Although in this dissertation I focus on the relevance of applied theatre to HIV/AIDS interventions, applied theatre is often used within other types of public health programs or in relation to other illnesses. For example, the use of applied theatre to educate audiences about risks related to tuberculosis and fetal alcohol syndrome are common in certain parts of South Africa. In many other sub-Saharan African countries, theatre is used as an intervention within broader campaigns to address sanitation and clean water issues. Increasingly, theatre is being used within environmental activism and even as a way to help people diagnosed with cancer deal with the emotions that result from the diagnosis.
CHAPTER 9
Power: Compromise and Institutional Control of Experience

“If it’s a good play, I’ll go to see it. I mean, *Angels in America* is not about AIDS, although that’s a huge aspect of it. What I do is not about AIDS either: mine is entertainment, mainly humor. When I did my *Foreign AIDS* show, which traveled everywhere, it was at first a very very difficult sell. People said ‘what was it called?’ I said ‘*Foreign AIDS.*’ They said, ‘AIDS? No!’ It was a very hard sell. But it was stories about children, survival, stories about courage, about hope, stories about life.

This is the challenge of theatre: to reinvent oneself with such guile and extraordinary talent that people don’t realize that you are telling them the same story: the story about, you know, ‘we are in charge of our lives and we must survive.’ But you must find a different way of telling me! Because I don’t want to hear it again. And that’s why I love theatre—because it’s live. From my mouth to your ears.”

--Pieter-Dirck Uys

Introduction

In the opening quotation, famous South African satirist Pieter-Dirck Uys notes what a hard “sell” it is to get the general population to engage with commentary on HIV/AIDS, whether national public health programming or artistic campaigns. He locates part of the problem in the staleness of the stories and rhetoric used to frame discussions of HIV/AIDS at national media and health program levels. The ideology of innovation, of finding new ways to tell people’s stories of common experience over time, peppers his words. The difficulties artists face encouraging audiences to engage with HIV also shows through his assertion that even *he* will only go see “good” plays.

This chapter is about the dialectical relationship between ideologies of innovation within artistic health programming and the social realities that shape its actual implementation on the ground. In it, I discuss how theatre-makers are trying to create “good” plays by putting into practice the kinds of health program innovation that I discussed in Parts Three and Four. I also
analyze the deep struggles they have in implementing these creative practices in a sociopolitical context rife with competing institutional forces.

In Chapters 5-8, I analyzed how and why theatre-makers are creatively experimenting with aesthetic forms and modes of knowledge production within their recent HIV/AIDS work. While this push for innovation has become an important trope through which theatre-makers conceptualize best practices, a major finding of my dissertation research is that this focus on creative risk operates most often at the level of ideology and discourse. Analysis of this discourse is important because it is currently shaping developing health arts practices in strong ways. However, during fieldwork I noted a strong disconnect between ideology and practice in theatre-maker attention to HIV. That disconnect is the subject of this chapter.

In this chapter, I present ethnographic data illustrating how applied theatre operates within a web of institutional relationships in the broader healthcare sector in South Africa. A finding of my fieldwork is that artists are actively struggling in South Africa’s contemporary moment to define their role within broader governance, economic, and institutional practices. This is especially true of HIV/AIDS-related theatre because it sits at a complicated intersection between the following national industry sectors: arts and culture, healthcare, charities, and education. Because of its complicated institutional positioning, applied theatre related to HIV is often subject to simultaneous and competing forms of institutional control over the kinds of knowledge that are produced about sexuality and health within interventions, as well as the aesthetics through which those ideas are communicated to audiences.

Attention to the disconnect between ideology and practice is important anthropologically because it enables detailed political economic analysis of the contextualizing factors that undergird the production of applied health theatre. It also illuminates the relevance of the
concept of artistic integrity in the health arts sector, the ways in which this concept is produced, and the contexts in which the artistic integrity of applied health theatre programs becomes highly contested. Additionally, I elaborate the social effects of the processes of compromise that theatre-makers regularly undergo in their interactions with other facets of the country’s HIV/AIDS sector. Examining this disconnect shows how people navigate bureaucracies (or struggle to do so) and makes explicit the kinds of institutional power relations involved in contemporary efforts to produce health-related artistic work.

Finally, this chapter is also about artists’ lived experience of compromise and the practical realities that shape ideological aspirations. I explicate how the lives of the artists involved in these initiatives are affected by the political economic forces that underscore institutional relationships in the healthcare industry and how artists feel about the processes of compromise that often become necessary in their intervention attempts. This component is related to larger debates within HIV/AIDS scholarship on how local community health workers interpellate their role within international discourse production about HIV and the appropriate programs through which to address AIDS epidemics.

In addition, I provide a portrait of actual artistic practice in the country, discuss the contextualizing factors that produce disconnects between ideology and practice, and analyze how applied health theatre is shaped by political economic forces that, at times, structure how health and illness are represented in the arts sector. Through analysis of theatre as primary institution in healthcare, I discuss (1) by what means people working within marginalized intervention efforts and NGOs navigate ideological disconnects in practice, (2) how they feel about the structural inequality and institutional relationships that shape their lives, (3) in what ways theatre-maker lives are impacted by these institutional forces and disconnects (e.g. relationships, quality of life,
sex lives, senses of fulfillment), and (4) what kinds of creative innovations in programming result from this problematized space of ideological disconnect and structural funding inequality.

To do this, I first present a portrait of innovation-in-practice within the health arts sector. Next, I analyze the creative economy of a play produced by a community theatre group from Hillbrow, Johannesburg. I describe the group’s artistic vision, the compromises they make along their rehearsal process, and detail their final product: this is the story of a play from conception to execution. Finally, I analyze the practices and policies that create the contexts of compromise that structure artists’ engagement with the healthcare industry.

9.1 Innovation in Practice

Over the course of a 12 month period I spent in the field, I worked in-depth with 12 theatrical entities: one HIV/AIDS-related theatre training organization based in a university, one institutionalized HIV/AIDS-related theatre group (NGO), one HIV/AIDS-related theatre project sponsored by the US Embassy and Wits University, five individuals working privately on projects in the country’s HIV/AIDS theatre industry (two of whom are well-renowned in the commercial theatre sector), and four community theatre groups known for producing issue-based art with HIV themes.

Out of the 12 total entities with which I conducted in-depth fieldwork, half produced new performance art pieces in the yearlong span. Four of the six new works occurred in university-sponsored spaces, and two were plays created by community theatre groups. Three of the new performances, all produced in university-sponsored spaces, were experimental theatre; two were issue-based, educational community theatre; and Drama for Life produced several new works in a range of styles that spanned educational theatre, process drama, playback theatre, activist theatre, experimental theatre, and dramatherapy.
The two community theatre groups that produced new work were Hlalanathi Community Theatre of Hillbrow in Johannesburg (What is in the Box?) and Isambane Community Theatre of Orlando East, Soweto, Johannesburg (HIV Play). The other two community theatre groups with whom I worked extensively (Masibambisane and Siyaya, both in Cape Town) showcased HIV/AIDS-related plays at prominent community theatre festivals that year, but they were both productions that had been created in the mid-2000s and updated for current times.

Of the five individuals with whom I conducted extensive research, only two produced new work that year: P.J. Sabbagha (I Think It’s Hamlet) and Kieron Jina (Rampage). Both of their new pieces were experimental theatre. However, Sabbagha also showcased two older HIV/AIDS-related productions in several venues: Deep Night, which was conceived in 2009 and Sexscape, which was conceived in conjunction with Drama for Life scholars earlier in 2010. Kieron Jina also showcased an older HIV/AIDS-related work of his created in early 2010 at a festival venue in 2011 (Infectious). Although Jina’s work Facing Shadows was not performed anywhere in 2011, it was created in early 2010 and included HIV/AIDS thematic content. The other three private individuals who performed pieces related to HIV/AIDS in 2011 were showcasing work that had been created within the last decade: Peter Hayes (I Am Here, 2009), Mike van Graan (Iago’s Last Dance, 2010), and Pieter-Dirk Uys (For Fact’s Sake!, 2000).

In addition, I collected eight HIV/AIDS-related theatre scripts for analysis. Five scripts were from mainstream or institutionalized theatre organizations and were productions created within the past decade. Two scripts were productions from community theatre groups that had been created in the past five years, and one was a new script created by a community theatre group in Johannesburg that year (2010-2011).
Institutional Control, Integrity, and Compromise

One of the strongest ways theatre-makers talked about their work in relation to negotiating the competing interests of powerful outside institutional structures that shaped their practices was through the language of “artistic integrity” and “compromise.” The concept of artistic integrity was considered integral by many artists to the affective success of their health theatre programs. They often put forward the idea that when their artistic vision (or “integrity”) was compromised, the innovative goals of their interventions were made impossible to achieve. Because most artists considered their strategies for knowledge production and affect to be significantly different from dominant biomedical and public health initiatives, they located the influential power of their work on audience members in those innovative practices. When outside institutional forces required them to conform to more conventional means of public health promotion, many of the artists involved in this project felt as though their productions lost the creative edginess and potential they originally had for affecting change in the country (at both individual and community levels).

Of the six new productions among the theatre-makers with whom I worked from 2010-2011, four were funded. Of those four, the theatre-makers involved in three of the productions said they did not feel like they had to compromise on their content or aesthetic form. Those three included an individual theatre-maker based out of a university (P.J. Sabbagha), a university-supported independent HIV/AIDS theatre project (*HIV/AIDS: In It Together*), and the artists at university-based training program Drama for Life. When examined more closely through ethnography, the realities of compromise in their artistic work are somewhat more complicated than they originally expressed to me.

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122 These strategies are detailed in-depth in Part Three of the dissertation.
Sabbagha created his production under company funding for his group Forgotten Angle Theatre Collaborative. He noted that he did not have to compromise on the content or form of his work, but this was partly because the funding used to create this particular project was not designated directly for that project. Through institutional shuffling of company funding, Sabbagha was able to produce a piece of HIV/AIDS-related theatre that appealed to and reflected his artistic integrity. His educational training and business acumen facilitated the sleight of hand required to support his artistic vision.

The faculty and staff of the Drama for Life program at Wits University have campaigned strongly and tirelessly for the last seven years to raise funding in support of their innovative efforts at artistic HIV/AIDS-related programming. Central to their stated goals is an effort to revolutionize and revitalize HIV/AIDS communication in the country, and they sponsor an annual HIV/AIDS-related festival to promote the production of new art. Because of their institutional positioning at a prominent university, the voices of the program’s faculty and students have become some of the most outspoken in calling for change in the way HIV/AIDS is framed (and what related issues are discussed) within public health programming, the media, and the arts in South Africa.

From my work with the Drama for Life program, few people involved felt like they had to compromise their artistic vision or integrity in the work they produced. In fact, most considered the program a space for strong experimentation and active creative risk in trying to find new inroads to speaking about public health issues with the country’s general population. This freedom from compromise issues partly from the ability of the program to have a dedicated staff position for project fundraising. I am not aware of any other arts organization in the country that works with public health-related topics that has a similar capacity for such a
position. This program sponsored most of the new HIV artistic work produced from 2010-2011, including 27 original works produced by students in their program, broader university community members, and neighboring community theatre groups for their “HIV/AIDS: Sex Actually Festival” of 2010.\(^{123}\)

The third funded group with members who felt as though they did not have to compromise their artistic integrity was an independent experimental project based out of Wits University called *HIV/AIDS: In It Together*. The members of this group framed their discussions of the project as though they had complete freedom with content and aesthetic choices. Upon further discussion with the director, I learned that the group had almost unprecedented levels of artistic freedom in their aesthetic choices (among funded HIV/AIDS plays), but the content of the workshop, performance art, and documentary produced through this project was heavily influenced by their funder. A stipulation for funding ($15,000 USD), which was provided by the US Embassy through PEPFAR and facilitated by the private arts foundation NIROX, was focus of major thematic content on “AIDS stigma.”\(^{124}\)

The director of the *HIV/AIDS: In It Together* project also recognized that her program received funding from the US Embassy partly because of her and the participants’ affiliation

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\(^{123}\) I have filmed footage of these 27 events, plus filmed footage of 25 other HIV/AIDS-related theatre productions from Johannesburg and Cape Town that I attended during fieldwork. Most of the latter were productions that had been created over the last seven years.

\(^{124}\) This was mentioned by the director and reaffirmed during my interview with the US Embassy Public Affairs Officer who was responsible for liaising with the HIV/AIDS: *In It Together* artists. The money for this particular project was taken from a “public diplomacy” fund within the embassy’s broader HIV/AIDS monetary provision. The PA Officer noted in particular that it was not taken from the prevention or treatment categories of funding. Within the “public diplomacy” division, a major goal of the US Embassy was promoting the reduction of social stigma attached to HIV/AIDS. For her, the *HIV/AIDS: In It Together* project provided a “fresh way to look at stigma.”
with Wits University and Drama for Life\textsuperscript{125}. Although the director of the project was surprised they received funding so easily, she considered the project a resounding success because of the freedom the group had to produce highly experimental, site-specific performance art. Although she recognized the content of their production was predetermined by their funders and expressed mild frustration about the individual-responsibility rhetoric they were required to promote, the director placed more emphasis on the freedom the group had with stylistic creative risk and experimentation.

In contrast to these three examples located within organized spaces of some power (the university setting), the one community theatre group (Hlalanathi) which was funded to produce new HIV/AIDS-related performance art\textsuperscript{126} had a very different institutional experience negotiating terms with their funding organization. All of the theatre-makers in Hlalanathi routinely spoke with me about their dismay over having to compromise on both the content and aesthetics of their production. The experience of Hlalanathi more accurately captures the kind of negotiation and compromise many other theatre-makers (at community, university, NGO, and mainstream levels) discussed at abstract levels and through past examples.

The artists who did not have to compromise (those institutionally well positioned and with more power) often noted the plight of groups who must resort to undermining their artistic integrity to please funding agencies, sponsoring organizations, or local government officials.

\textsuperscript{125}This, too, was backed up by the Public Affairs Officer at the US Embassy. She noted, “Yeah, they got money because of their co-sponsors. DFL and Wits University. Because they had established co-sponsors who already had their own funding. It made the project look like a safer investment, more established and responsible.” However, she also noted that provision of that amount of funding ($15,000 USD) to an arts program for promotion of public diplomacy related to HIV/AIDS was not unprecedented but unusual for PEPFAR-funded programs in South Africa. The other grant given in the same fiscal year for public diplomacy related to HIV/AIDS by the US Embassy went to the Zanendaba Storytellers for HIV education about symptoms, signs of infection, risk factors, and how to protect against HIV.

\textsuperscript{126}Among the artists with whom I worked.
The majority of the artists with whom I worked indicated this kind of compromising of artistic vision as extremely problematic: they considered the undermining of a group’s content and aesthetic choices by outside institutional forces a main factor in the production of poor art, ineffective health promotion and care programs, and the squandering of public health funds on interventions that have little to no impact.\

Even though artists in the country have deployed this major narrative of innovation to reclaim the place of the arts within the broader healthcare industry, disconnect exists between that ideology and the realities of program implementation. The fact remains that only half of the groups with whom I conducted in-depth research produced new work over a 12 month period. Of that half, two artists were not funded and so gained artistic freedom to produce experimental theatre related to HIV without restriction. Of the four funded artists, one found creative ways to avoid compromising his artistic vision by shuffling funds, and one project was given freedom aesthetically but bounded in content, reifying some of the national public health campaign “HIV responsibility” messages. One organization (Drama for Life) appeared to truly have some amount of freedom in artistic vision to change the way HIV/AIDS is approached in health communication programs. Finally, there was the case of Hlalanathi Community Theatre, where compromise of content and aesthetics is starkly visible.

The actual story of innovation and compromise processes on the ground is much more complicated than the narratives often employed by artists to discuss institutional influence on their work. In addition, the ideology of innovation that many artists have begun voicing plays out rather unevenly in daily practice. To get an idea of what this kind of negotiation of competing interests among involved institutions looks like, as well as what the implications,...

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127 The members of AREPP: Theatre for Life were particularly vocal about this topic.
unintended consequences, and ethics of it are, I ground this discussion in a particular example in
the following section. I elaborate what the actual processes of institutional control over
knowledge production within HIV/AIDS-related art look like through the case of Hlalanathi
Community Theatre.

Hlalanathi’s Experience

I breathed a small sigh of relief as Sipho*, the Artistic Director of Hlalanathi Community
Theatre, closed the gates to Hillbrow Theatre behind me. I had been warned in the past week by
no less than twenty people of the imminent danger into which I was placing myself when I
entered Hillbrow, a community in Johannesburg known for its rates of violent crime and sex
work. The reception I received from the members of the community theatre was a warm one,
though. Hlalanathi has a fluctuating membership, but there were about 15 artists associated with
the project I followed (6 females, 9 males). It is housed in the Hillbrow Theatre, although not
officially associated with or sponsored by that organization at the time of my research. The
majority of the members come from a Zulu background, and most were raised in Johannesburg’s
various townships. The age of members ranged from 17 to 31, with most in their early 20s.

After cursory introductions to the members I had not yet met, Sipho started explaining
their most recent project to me. In early November, the group had been commissioned by
Gauteng’s Department of Trade and Industry (DTI) to produce a play for an event during the
annual Sixteen Days of Activism¹²⁸, a national campaign backed by the government to promote
awareness of violence against women and children. World AIDS Day also falls during this
period of time, as well as the International Day of Persons Living with Disabilities. There is
usually a flurry of government and NGO-sponsored awareness campaigns, entertainment, plays,

¹²⁸ Held annually from 25 November—10 December.
and rallies held during this time annually. As the rest of the group milled around the small basement rehearsal space, Sipho elaborated, “We take what the government wrote on a pamphlet about HIV and woman-abuse and say it in an entertaining way. People understand when they laugh, you know? Not when they feel pain.”

A group of six employees of the DTI consulted with the group during the project, and Hlanathi’s initial instructions were simply to produce a piece of theatre incorporating the issues of physical disability, gender violence, and HIV/AIDS responsibility. The group was given a small amount of funding to facilitate creation and rehearsal of the production, as well as travel costs to Pretoria from Johannesburg to perform it. Official rehearsal for the production started the first week of November, and the dress rehearsal occurred three weeks later. The final performance was held during the first week of December, after consultation with the DTI employees on the dress rehearsal.

I joined the group in their second week of rehearsal and spent the following three weeks watching their production creation process, negotiations with their funder (DTI), and providing feedback when it was solicited from Sipho. The cast for the production included four of the female actors, while three of the men contributed in a directing capacity. During the first rehearsal, Sipho and the others outlined for me some of their ideas about the play and their vision for its direction. As the actors warmed up with improvisation games in the background, Sipho talked about the style of performance he was thinking of using for this play. He and another director, Tebogo*, decided it would be 25 minutes long and consist of four scenes that spanned the settings of school, home, public place, and work place. For them, a small cast of four actors
was important because it minimized production costs, hassle over transportation for the artists, and the unruliness that can come from having a larger cast on site\textsuperscript{129}.

At first, Sipho reiterated the narrative of innovation that was circulating among more mainstream or institutionalized theatre groups and solemnly proclaimed, “We must not address the audience; we must \textit{entertain} them.” He and Tebogo talked about the style of the production and bandied about some genres and techniques that have become popular over the last decade. Tebogo suggested, “We need to do some physical theatre and then Forum it.” Sipho jumped in to say, “Yebo, we should have them do some Forum Theatre, that’s the way the audience is going to be interested.” When I asked them to explain what they meant by physical and Forum theatre, Sipho noted, “Physical theatre, it’s sounds, movements, miming. And Forum is getting some audience participation.”

When I nudged him to explain further, Sipho was hard-pressed to describe those two stylistic choices in more specific detail. He shifted the conversation to the importance of story and smiled at the other actors as they nodded in response to his proclamation, “You have to get to the heart of the story first, and \textit{then} start putting HIV issues into it.” This concept echoed the increasingly popular idea floated by more mainstream artists, such as Pieter-Dirk Uys, that HIV messaging within public media should be subsumed and stories of people’s life experiences highlighted. The actors of Hlalanathi initially placed much emphasis on “real” life stories instead of stereotyped public health messages.

However, Hlalanathi’s members commented on the difficulty of this as they talked about what kinds of stories to tell and what themes to incorporate. Although they seemed committed to

\textsuperscript{129}In contrast, the group’s funder requested a larger cast with one actor dedicated to each character rather than having each actor play multiple characters. The members of the funder group thought the production was more understandable with a larger cast.
the idea of starting with stories, the conversation repeatedly devolved into group members asking what themes and messages the funder wanted included. The group struggled to find a balance between story-telling and messaging. Eventually, messaging won out. With only three weeks to create and rehearse the production, the group expressed concern over the time it was taking to explore in-depth ideas about new stories to tell related to HIV and gender violence. The group started with a new spin on the classic “step-father sexually abuses step-daughter” cautionary tale by talking about stories they’d heard from friends relaying situations where underage girls initiated sexual advances toward older men in their families rather than the opposite. These initial conversations involved the actors trying to puzzle through what the emotional motivations might be for that kind of action on the part of underage females or whether those stories might be instances of “blaming the victim”; however, concerns over limited time eventually halted these exploratory sessions.

I watched as the group, under pressure of time constraints, resorted to weaving tired tropes into their play and using stylized over-acting rather than taking the time to probe the emotional depths of the themes covered. The conversation slipped into scenes and messages that have been over-used in past theatrical attention to HIV nationally but were easy for the group to put together, since they had performed similar scenes in past plays: prostitution, schoolchildren and sugar daddies, and trite abuse and rape scenes between a stepfather and daughter.

At one point, Tebogo sat on the floor beside me as I leaned against a wall and took notes. He said, “New stories are important, stories of life, those moments we live that make us who we are. But, see, DTI wants us to talk about condoms, testing, sex within relationships and partners—the decisions we make personally in a relationship. For them, it should be about decisions and informed choices.” He shrugged and continued, “So we have to show that.” One
of the female actors wandered up as Tebogo was talking. She mimicked a peer educator, pointing her finger at us and adding imperiously, “Yeah. Sex is nice but dangerous.” She rolled her eyes as she added the final part of the ubiquitous national HIV message: “So use a condom.”

This slide over the span of several rehearsals from a focus on stories to messaging mirrored Sipho’s framing of the purpose of their play. He began by telling me entertainment and novelty in style were the most important components. However, the group resorted to freezing the performance and speaking in asides directly to the audience, both of which are common stylistic techniques in community theatre and have been used for years in issue-based productions. Sipho explained his use of asides by saying, “The most important people are the audience, so speak directly to them and explain things.” This contradicted his earlier focus on innovation and novelty but underscored the group’s struggle with balancing the ways they were comfortable producing theatre with the new drives to experiment that filtered down from more mainstream theatre spaces.

I drove the group to Pretoria on the dress rehearsal day to help them cut transportation costs. As they set up props in a well-appointed conference room of the Department of Trade and Industry building, I noted how out of place we seemed in our scruffy jeans and t-shirts compared to the young suited professionals walking the halls. Six of those professionals sauntered into the room and sat in a row of chairs at the back. One of them asked Hlalanathi to begin its performance, and the artists moved into place. I started videotaping as the first actor walked to the center of the room, which had been designated the stage. The reaction of the audience to the performance was mixed, with one man smiling the entire time, one woman scowling and yawning, and the rest on the spectrum between.
The DTI employees began their feedback on the show with variations of “This is not quite what we hired you to do.” Although the audience applauded the enthusiasm and raw talent of Hlalanathi’s actors, they took issue with the production’s content, style, and language. One woman piped up and said, “I can’t understand the different scenes. And get rid of the miming. It’s not clear. Also, steer away from speeches. This must just be a play. Don’t have actors looking at the audience.” Another added, “But you need to follow more clearly the ‘we are responsible’ government HIV theme for 2010. Last year it was ‘I am responsible’ for testing, and this year it’s about community responsibility. Make that come out more. As for storyline and approach, just think Soul City.” One of the men commented that the play was good, but there seemed to be some stereotyping going on that should be mitigated because “we don’t encourage that kind of talk.” Another man jumped on that idea and contributed, “Beware of how you term things. Say ‘gender-based violence’ instead of ‘woman abuse.’ Don’t say ‘disabled people.’ Say ‘people with disabilities,’ instead.”

The final blow came from a well-dressed woman who had erstwhile been silent. She commented on the group’s scene in a local tavern. She simply said, “I’m not sure our employees can identify with the scene in the shebeen. Our employees are more sophisticated than that. You need to rework this for the demographic. Grassroots people can relate to this show, but for people like assistant directors they’re completely different and will not be able to identify at all. We have a lot of young people, but they go to bars, not shebeens. Up and coming

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130 Soul City is a popular television melodrama that includes HIV/AIDS-related content.

131 Effectively, a shebeen is a bar in a township. The term was originally used to refer to illegal establishments that sold alcohol without a liquor license, but the term is now used more colloquially to refer to any bar in a township (although particularly to bars that may not have the upscale amenities of clubs or pubs in more affluent parts of the city).
professionals work for us” (emphasis from original). The upwardly mobile middle-class funders wanted one kind of production, while the members of Hlalanathi had framed their play in the styles and language common to Hillbrow and the townships from which they issued: characters were located in shebeens rather than “hip bars.” The disconnect between what the DTI employees wanted and what Hlalanathi had produced was enough to make me wonder why these middle-class professionals had hired a community theatre group from Hillbrow to perform in the first place.\footnote{Sipho clarified this point for me later. While there are industrial theatre companies that often create issue-based work for this kind of employer (DTI), these groups are more expensive to hire than a community theatre group like Hlalanathi. Sipho was aware his group was hired because they charged less than other competing theatre groups.}

Although I was affronted by the end of the session, the members of Hlalanathi took the feedback well. They were professional and said they would make the changes the DTI employees had requested. When we packed up and reached the car, I asked the artists how they felt about the feedback in light of the fact that DTI had given them no initial direction or performance criteria beyond asking them to include content on HIV, physical disability, and gender violence. In my exasperated state, I followed that rapidly with a leading question on how they felt about essentially being told they were unsophisticated, low-class workers (“grassroots people” in the woman’s words) not capturing the essence of professional, middle-class urban life in Johannesburg. Most of the group simply looked resigned. Sipho answered practically, “Jess, this is the way it is. And they’re the funders. We must do what they tell us. We want this job, we want the work, and maybe they can give us more in the future. We’ll just change the play.”

In the final version of the production, there was no evidence of Forum Theatre, stylistic innovation, or novel stories. The group performed what was effectively a health promotion piece related to HIV risk and awareness of gender violence. While the members of Hlalanathi had
discussed the importance of mixing aesthetic genres and moving away from simple health promotion messaging, the group fell back on common tropes of health education. As a result of a lack of formal theatre training, lack of time, limited funding, and funder preferences, the final product looked very different from the ideas that had been bandied about the first few days I joined the group for rehearsal.

The style moved from its experimental roots in the early days of rehearsal toward clear but didactic messaging about condom use, respecting women, and treating people with disabilities as full members of society. However, the members of Hlalanathi did change some of their phrasing to more carefully depict the characters in less stereotyped ways. They also tried to “class up” their play by changing the location of some of the scenes to reflect professional urban lifestyles and middle-class values, despite having little personal access to those values or experience living them.

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When Sipho was approached with the performance commission, he did not ask for an elaboration on what the DTI employees wanted in their show beyond the three themes given. In conversation, he told me he was just grateful for the job and did not want to lose it by asking too many questions or bothering the DTI liaison. Also, he was pretty sure how to put together a production on the three themes, since Hlalanathi had created similar artistic projects in the past. In addition, during the production creation process, Sipho and the other group members all tried hard to keep in mind (or guess) what their funder might want or need regarding the production.

However, the interaction of Hlalanathi with the DTI employees during the dress rehearsal of the play underscores the very real disconnect between what the funder (DTI) wanted and what the theatre group (Hlalanathi) had produced and thought best. This kind of disconnect between
what is communicated or made clear between the various stakeholders in artistic HIV interventions is particularly germane when considering what kinds of knowledge about illness, healing, and sexuality are produced in public media related to HIV. For example, while the members of Hlalanathi were more inspired by the idea of creating theatre that explored the emotional complexities of victim-blaming and motivations behind familial relationships of sexual violence, DTI pushed the group to move toward more conventional public health promotion rhetoric about taking responsibility for individual health and actions.

Also relevant are differences in ideas about the goals and impact of HIV intervention processes among the various stakeholders. While artists often have particular (and alternative) intervention goals in mind when compared to hegemonic public health programs, their ability to operationalize those goals in practice are mitigated heavily by outside institutional forces. As a result of their structural power and positioning, some artists are forced to compromise on both production content and style, leading to interventions that look (on the ground) very different from the kinds of program ideals I discussed in Parts Three and Four of the dissertation.

Illustrated in this story and elaborated in the rest of this chapter are themes related to the impact of the following on the content and style of artistic HIV/AIDS interventions in the country: class differences, structural power, institutional positioning and control, and disconnect between funders and artists. There are significant power differentials between different factions of the applied theatre industry in the country, and the kinds of productions created by institutionally-aligned theatre groups (such as university groups or NGOs) look very different from those produced at the community theatre level. In this chapter, I parse out who has the structural power to practice uncompromised ideology and who does not—which groups are
forced to compromise their artistic integrity, even if they are trying to innovate health communication possibilities for HIV/AIDS at local and national levels.

This chapter is about how everyday people involved in public health programming try to make do in worlds where their ideals and livelihoods are falling through institutional cracks. This is the lived experience side of trying to put interventions into practice: the fear, the frustration, the anger, the turmoil, the apathy, the burn-out, and the fight. In this chapter, I analyze how political economic factors mitigate between the stated ideologies of intervention practices and the actual programs that are implemented on the ground. This is the story of a group of people who feel as though their artistic integrity is being compromised, so they are starting to voice critiques of the systems in which they work and speak back to institutional control of experience and knowledge. I assert that kind of institutional control of experience is limiting the options and possibilities for HIV intervention in the country in potentially problematic ways. I attend to how artists are speaking back to this power in the next chapter.

9.2 Bridging the Gap: Putting Ideology into Practice

So why do disconnects between ideology and practice exist, and what can explain it? What effect does this disconnect have on knowledge production practices and the aesthetics of artistic health programs? How are lived experiences of health theatre workers affected as they try to navigate the competing interests of institutional stakeholders in the processes and products of their contributions to the country’s intervention industry? The artists with whom I worked stressed the importance of creative risk and health programming innovation, but they consistently noted that experimentation is hard to implement in practice. Two narratives were often employed in artist discussions of the institutional web in which their programs rested: Artistic Integrity and a Theatre of Compromise.
Three explanations offered by theatre-makers for the disconnect between ideology and practice were tied closely to political economic factors: the changing relationship between the State and the arts industry over the last 20 years, deep division in national and international funding for the healthcare sector, and structural devaluing of the arts in the post-apartheid era. In this section, I assert that analyzing theatre as a primary institution within the healthcare industry allows for detailed analysis of the contextualizing factors that undergird the production of applied health theatre. Doing so then makes explicit the kinds of institutional power relations involved in contemporary artistic intervention efforts.

**The Changing Relationship between the State and the Arts**

Some artists in the country have asserted that the changing relationship of the state to the arts in the post-apartheid era has led to what they call a Theatre of Compromise: a politically neutered genre of cultural production that lacks the intense activist spirit of the country’s anti-apartheid era plays. In the years immediately after democratization, the burgeoning relationship between the performing arts sector and the new government began taking shape and was formalized in a more codified manner through the 1996 White Paper on Arts, Culture, and Heritage; the 2003 Cultural Institutions Act; and the establishment of the National Arts Council (NAC). These policies and accompanying legislation primarily centered on funding and the arts. Here, I analyze the way government institutions interact with the arts sector and assert that those interactions have shaped contemporary working conditions for theatre-makers in general and those entering the health sector in particular. I discuss important nodes of impact in the state’s relationship to the arts sector, including relevant legislation, state funding of the arts, the development of unions, and the transformation of PACs into playhouses.
The White Papers provided a policy framework for cultural development in the country, including the theatre sector, and outlined new state policy toward governing and subsidizing the performing arts. It was formally adopted by the Cabinet in August 1996 and channeled through the Department of Arts, Culture, Science, and Technology (DACST). State funding for the arts was channeled through DACST from 1994 through 2003. During 2003, this department was split into two entities, and the Department of Arts and Culture (DAC) (minus Science and Technology) was established in fiscal year 2003/2004. At this time, the DAC received its own annual budget (Van Heerden 2008). The established Performing Arts Councils were addressed within the White Papers, which noted, “The activities of these institutions, their continued access to State monies, and their putative transformation, has created more controversy than any other issue facing the Ministry” (DACST 1996:15). In this, the problematic role of theatre sector institutional organization during the early 1990s is clearly stated in relation to the Ministry of the DACST.

At around the same time, the provincial Performing Arts Councils (PACs) were disbanded, and the National Arts Council was established to more equitably handle arts funding in the country. The NAC has been functional from the end of 1997 and is governed by the National Arts Council Act 56 (1997). Its officially stated purpose was to assist in the funding of projects of national significance (NAC 2013). It was to accomplish this by acting as a statutory body receiving parliamentary grants, which were assessed through representation by all nine provinces. This functioned to provide a means through which the federal government could reduce its investment in the arts sector while provincial and local governments increased their role in disbursement of funding (Van Heerden 2008). Funding through the NAC is made
available by application and on an ad hoc basis for theatre-makers; however, clear, official, and transparent procedures for this process remain absent to date.

During my fieldwork, the NAC was one of the most bitterly discussed organizations among applied theatre-makers, and a large gulf in understanding of the purpose, assessment procedures of applications, and fund disbursement agreements continues to exist between NAC administrators and the theatre practitioners who apply for funding. At around the same time as the NAC was being created, the four PACs in the country were being disbanded (a process that took until 2000), thereby significantly restructuring state funding of the arts. However, by a decade into democracy, this new arts policy was still not practically implemented. The Performing Arts Network of South Africa (PANSA) published a detailed critical analysis in 2005 of actual state funding channeled to the former PACs before 1996 and concluded that the White Paper Guidelines had not been followed and the set 22 objectives not achieved after ten years of implementation (Van Heerden 2008; PANSA 2005).

Because of this restructuring and change in official state policy toward the arts sector, it became increasingly difficult for artists working on experimental projects (including those at the intersection of health and art) to secure any kind of state funding. As the funding shifted from PACs to disbursement through the provincial and local advisory panels of the NAC, it became clear that funding was being prioritized for theatre-makers and organizations operating through a neoliberal business paradigm closely related to the kind followed in the commercial theatre sector. Sound business principles, auditing of finances, and the ability to generate detailed financial and impact reports became prerequisites for obtaining state funding for arts projects.

This contributed significantly to how the theatre industry was shaped in the years after apartheid, including who had access to state resources and what kinds of projects did not. Most
of the legislation around the arts was enacted with the goal of more equitable resource support and opportunities for historically disadvantaged and marginalized communities to produce and enjoy arts and culture work. However, the government has fallen noticeably short of this goal. With only a few exceptions, resources, facilities, and other forms of opportunity and support for theatre work within historically disadvantaged communities have not been forthcoming on the scale anticipated by the arts community in the early years of the post-apartheid era. It became increasingly clear that arts and culture in the new democracy were considered a lower priority than most other areas and issues of consideration in the early years of reconstruction, development, and reconciliation (Van Heerden 2008). This has significantly influenced the institutional positioning of health theatre-makers and placed them firmly in the margins of funding and power.

The funding environment for the arts in South Africa, as well as the relationship of the State to the Arts, is widely considered fraught with tension, strife, and frustration on the part of theatre-makers. As scholars Bain and Hauptfleisch note:

Today, state funding for the arts has dwindled significantly and much of the little money that there is finds itself administered by politicians and bureaucrats who are apparently out of touch with the cultural and artistic aspirations of both theatre practitioners and theatre-goers. ...Today, there is an urgent need to balance the interests of what is an essentially elitist social activity with the need to contribute to the cultural development of the nation as a whole [2001:11]

This sentiment is echoed by famous contemporary playwright and theatre scholar Mike van Graan. He states, “If anything has happened over the past decade, it is that there has been a shift from ‘struggle theatre’ to the struggle to make and disseminate theatre, with the latter often being waged with policy, funding and governance institutions that - ironically - were intended to advance theatre” (Van Graan 2004). Although state funding for the arts is no longer formally
tied to apartheid-supported state theatres, a legacy remains of problematic disbursement and disproportionate access to state resources. Additionally, Van Graan notes a trend within commercial theatre toward self-censorship in content and attributes this directly to government support of mainstream theatres. He states:

> The dependence on public funding by the country’s major theatres - with boards that owe their positions to a politician - and managements that were appointed by these boards, have resulted in politically conservative theatres. Principles that were celebrated after the demise of apartheid - such as arm's-length governance, transparency and participatory democracy to promote and defend freedom of creative expression - have all but been replaced (at least in publicly-funded theatres) by self-censorship, political compromise and accommodation with the status quo, which, in turn, has led to politically safe ‘condom theatre.’
> [Van Graan 2004]

Van Graan implicates the changing relationship between the state and the arts, along with the resulting self-censorship, in the lack of production of high quality original work in democratic South Africa (Van Heerden 2008). Van Graan has noted this particularly occurs within the health arts sector (personal communication 2011). With state support and resources came unwillingness on the part of professional theatre-makers to criticize the new government and its broader policy framework in the neoliberal era.

While I agree that this trend toward self-censorship in the arts holds true for the first decade after democracy, I maintain it is shifting in the second decade. Close to 20 years after democracy, theatre-makers are increasingly willing to re-embrace politically motivated and critical artistic work at both mainstream and applied levels. This holds true in the applied health theatre realm, as well. It is from this willingness to experiment that much of the ideology of innovation originates in recent artistic attention to HIV; however, it is within this contextual relationship of the state to the arts that such experimental forms of health communication are often silenced through a lack of institutional support.
Tracing Divisive State Influence: Following Money between the Health and Arts Sectors

One area in which the institutional control of theatre-makers’ experience is especially clear is the funding environment. Because funding was a central concern for the artists with whom I worked, I present here an analysis of the funding environment as it relates to applied health theatre programs. Analysis of institutional relationships within the funding environment related to HIV/AIDS and the arts reveals the politics of artistic and health funding in the country. Particularly germane for this project is the flow of knowledge and resources across the country’s health communication industry.

Through my research, I found that funding trends for applied health theatre often fragment along lines of class and ethnicity and produce considerable funding inequality among the applied theatre industry. This is not a novel finding; fragmentation due to funding trends is documented within public health programs globally (e.g. Pfeiffer & Nichter 2008; Mugavero et al. 2011; Chopra et al. 2009; Tragard & Shrestha 2010; Biesma et al. 2009). Anthropologists have long documented the impact of structural inequality endemic in the global funding environment for HIV/AIDS programs on knowledge production and discourse circulation in a variety of geographic regions (e.g. Pigg 2001). This interest in knowledge production as it relates to funding fragmentation becomes important in the South African context because it reveals the intertextual gaps in official government narratives about the democratized Rainbow Nation, in which unification has erased structural inequality at institutional levels. The institutional relationships that define the contours of the funding sector directly shape artistic health practices: the kinds of knowledge that get produced (what is said), the aesthetics through which that knowledge is communicated (how it is said), and which groups of people have access to the resources that enable production of artistic health programs.
One important indirect consequence of this institutionalized structural inequality is the necessity for theatre-makers to constantly negotiate the competing interests of various stakeholders in their attempts to intervene in the country’s AIDS epidemic (including biomedical, public health, government, and funding institutions). By analyzing theatre as an institution along with the funding environment that shapes it, I detail the lived experience of people trying to navigate a very common phenomenon within global health program implementation: disconnects between the agendas and structural power of involved groups. Examples include disconnects between how funders and artists define impact within interventions, disconnects between international health agendas and local public health priorities, and disconnects between theatre-maker goals and audience needs. Here, I detail some of the deep divisions in funding for the health sector and trace the pathways of national and international resources for HIV/AIDS-related projects.

**Dominant Models of HIV/AIDS Intervention in South Africa: Past and Present**

Do theatre-makers’ claim of institutional marginalization regarding funding have merit? What kinds of HIV programs have been privileged in the past and why? To what public health efforts and sectors have national funds been allocated? In general, although there are exceptions, artistic intervention programs related to HIV have not historically had much access to the funding that comes out of the government’s departments of health or the National Strategic HIV/AIDS Plans. In this section, I examine domestic and international financial support for intervention efforts and look at who finances HIV responses, where the money has gone, and where it is going presently—to which programs and in support of which public health goals, services, and theories of health intervention.
Because their goals and form of impact tend to fall outside the priorities of the Department of Health, the arts have been marginalized in the country in relation to formal HIV intervention practices. This constitutes one of the indirect consequences of artistic devaluing in the country in the post-apartheid era. As a result of this devaluing of the arts at a structural level, which is institutionalized through funding trends in national health spending plans, many artists have extremely limited access to government funds earmarked for HIV/AIDS initiatives. The funding sector is deeply divided with biomedical programs on one side and “other” prevention and treatment modalities on the other.

Most of the health arts programs obtain funding from international sources or from national “charities” or “education” designations rather than “public health” or “HIV/AIDS” designations. The ideologies on which artistic HIV interventions are premised are often not valued or fall outside of the ideological parameters of hegemonic HIV intervention practices (which privilege the individual, physiology, neoliberal focus, and biomedical treatment). This difference in practices influences where the money for health programs comes from and how much gets there.

It is important to understand the institutions that govern international and national flows of resources earmarked for public health efforts, because these constitute a major source of structural support for programs. I construe the local and global dimensions of public health as a continuum—two poles that dialectically interact to produce a lived landscape. The various actors within this continuum have elastic relationships with each other. As João Biehl (2007) notes, international actors often set goals and new norms for institutional action and fill voids in places where national systems and markets fail to address public health needs or have been absent altogether. He states:
In practice, the interests and concerns of donors, not recipients, tend to predominate, and the operations of international organizations tend to reinforce existing and unequal power relations between countries (Bannerjee 2005, 2007; Epstein 2007; Ferguson 2006). Moreover, initiatives are increasingly dominated by scientifically based measures of evaluation, revolving around natural experiments, randomized controlled trials, statistical significance, and cost-effectiveness (Duflo et al 2008; Todd and Wolpin 2006)—a technical rhetoric aligned with the demand of funding organizations for technical solutions. [Biehl 2010:106]

The kind of international influence on domestic HIV/AIDS policy Biehl notes may be seen in South Africa over the last three decades. While some alternative health-making agendas may be privileged ideologically or discussed in public forums like the media, examining where the money goes reveals the actual structural flow of resources across the public health landscape. International goals for global public health can powerfully influence national public health agendas. In Part Four of the dissertation, I discussed how US global policy through neoliberalism and influence from the World Bank led to a reshaping of the healthcare industry in South Africa in the post-apartheid era. This included the privatization of healthcare and a shift toward neoliberal “personal responsibility” ideologies for public health. Global intervention ideology has also shaped funding trends for HIV services in South Africa. This is indicated through domestic and international AIDS expenditures when examined by category and funding source.

In South Africa, the three critical fronts to which financial resources are funneled include prevention, treatment, and care. HIV/AIDS prevention programs in South Africa include two

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133 Some primary stakeholders in allocating and assessing HIV/AIDS funding in the country include the National Department of Health, Statistics South Africa, SANAC, NACOSA, Human Sciences Research Council, PLWHA, TAC, the Medical Research Council, and COSATU. From the private sector, interested parties include mining, automotive, textile, and other labor sectors.
major categories: behavior change education and health communication\textsuperscript{134} (designated as a key element of the national prevention pillar by UNAIDS 2012) and treatment-as-prevention programs\textsuperscript{135}. These two categories make up what the government calls a Combination Prevention Program, which has been a priority in recent years. This kind of program recognizes that no single intervention will address HIV infection at the population level, so a variety of approaches is necessary (UNAIDS 2012). According to the UN Global AIDS Response Progress Report (2012), the Department of Health considers this combination prevention program to be a mix of biomedical, behavioral, and structural interventions that is rights-based, evidence-informed, and community-owned. The extent to which the programs put in practice actually are such a mixture of approaches is highly debated among various health workers.

In addition to its prevention efforts, other programs such as HIV Testing and Voluntary Counseling (VCT), along with care and support for people living with HIV/AIDS and orphans and vulnerable children (OVC) have been in place for years. VCT increased substantially from 2005 to 2010. In 2010, South Africa launched the largest national VCT campaign in the country’s history, with a target of testing 15 million people. By the end of June 2011, 13.3 million people were tested for HIV nationwide. In the last 2 years, VCT has partially given way to the government-driven Provider Initiated Counseling and Testing model, which extends access to HIV counseling and testing at health facilities (UNAIDS 2012). The Program for Care and

\textsuperscript{134}This first category includes health communication that is ultimately intended to change sexual behavior to reduce risk. Examples include youth-oriented life-skills programs, mass and targeted education/awareness/messaging strategies, condom promotion, risk reduction education, promotion of delayed sexual debut and reducing the number of sexual partners, and other communication programs designed to change a population’s knowledge, attitude, and practices (KAP) related to HIV/AIDS and sexuality (Parkhurst & Lush 2004).

\textsuperscript{135}This second category of prevention programs includes initiatives such as male circumcision, treatment of co-infections (such as TB), TB and STI screening, monitoring adherence to medication, the use of ARVs to prevent mother-to-child transmission, the treatment of sexually transmitted infections to reduce risk of HIV transmission, Post Exposure Prophylaxis (PEP), medical male circumcision for men on demand, provision of microbicides, and other clinic-based care (Parkhurst & Lush 2004; UNAIDS 2012).
Support for PLWHA and OVC is considered a central tenet of comprehensive response to HIV in the country by the National Department of Health, but it is primarily run by NGOs and community-based organizations, with the Department of Health providing stipends to organizations for said service (UNAIDS 2012).

Three of the primary source areas for funding for these kinds of programs are public (national), external (international), and private. The majority of national HIV funds in South Africa from 2007-2011 were spent on treatment activities (UNAIDS 2012). According to the National AIDS Spending Assessment Report (SANAC 2012), people living with HIV/AIDS were the primary beneficiaries of HIV/AIDS and TB expenditure in South Africa. This is a result of the significant spending on antiretroviral therapy and other treatment and care activities. A typical example year (2009/2010) includes the following: 63.4% of total national funds went to treatment\(^\text{136}\), followed by social protection, which included a proportion of the Child Support Grant (12.6%), prevention interventions (10.1%), research (4.8%), and program management and co-ordination (4.2%) (UNAIDS 2012).

The remaining categories of national funding include care for orphans and vulnerable children (OVC) receiving only 1.8%, enabling environment (e.g. human rights protection and advocacy) receiving 0.3%, and human resource capacity-building (training) receiving only 2.8% of the total HIV/AIDS and TB spending in 2009/10 in South Africa (UNAIDS 2012). The largest HIV/AIDS service providers were the provincial Departments of Health, mainly the HIV and AIDS/STI/TB (HAST) Units at 23.5%, hospitals at 22.1%, with NGOs, CBOs (community-based organizations) and CSOs (civil society organizations) at 15.9%, followed by the Department of Social Development and the South African Social Security Agency lumped

\(^{136}\)“Treatment” includes antiretroviral treatment, home-based care, palliative care, treatment for sexually transmitted illnesses, and TB medication.
together at 13% of the total in 2009/10 (UNAIDS 2012). Exact monetary figures for each
category may be seen in Table 2 (Appendix B).

The recent trend toward funding treatment services is in direct contrast to the initial trend
in the country to privilege prevention during the first decade of the AIDS epidemic. A key
recommendation of South Africa’s most recent National AIDS Spending Assessment (NASA) is
for the country to increase the priority it gives to prevention. Prevention spending decreased by
8% in fiscal year 2009/2010. However, NASA’s recommendation extends primarily to
increasing budgets for what it deems “key prevention interventions” with demonstrated impact:
medical male circumcision, expanding access to ART, the development of microbicides,
prevention of mother-to-child transmission, dispersal of condoms, and post-exposure prophylaxis
are named as interventions to be expanded.

The report does note the critical enabling role that social mobilization, advocacy, and
behavior change campaigns play in supporting biomedical interventions, despite the difficulty in
proving their effectiveness (UNAIDS 2012; SANAC 2012). The devaluing of, or at least
ambiguity towards, non-biomedical prevention agendas is clear within the report’s framing of
other kinds of intervention as mere enablers of biomedicine rather than legitimate programs in
their own right, with their own goals and measures of impact and success.

Regarding bilateral aid (aid given from a single donor country to a single recipient
country) for HIV/AIDS and TB funding, a range of donors contribute funds to South Africa,
which are often tied to the political self-interest of the donor country. Bilateral support is
responsible for the largest portion of externally sourced HIV/AIDS and TB funding, for example
totaling R1.5 billion (71% of total external funds) in fiscal year 2009/2010. From 2008-2010,
the government of the United States was the largest single contributor through the President’s
Emergency Plan for AIDS Relief (PEPFAR) and comprised 67.2% of total bilateral aid (R2.5 billion) and 8% of the total HIV/AIDS and TB spending in the country.

Other significant contributing governments include the Netherlands and the United Kingdom. Other countries contributed aid, but it was recorded at less than 2% (UNAIDS 2012). Although PEPFAR funding comprised the largest external source of funding, the NASA Report of 2012 indicates that PEPFAR agencies in South Africa were unable to provide actual expenditure broken down by province or activities; the data is simply not available. There was a significant decrease in PEPFAR funding in fiscal year 2009/2010 from the previous year, which may have affected some theatre programs (largely lumped into the “prevention” category, despite their goals, aims, or methods) (UNAIDS 2012). Among the seven theatre groups with whom I worked most closely, only two had received PEPFAR funding, and they only had access to it after reforms to PEPFAR made by Barack Obama’s administration.

Multilateral support also stems from a range of agencies, including UNAIDS, the European Union, World Bank, World Health Organization, the Bill and Melinda Gates Foundation, and the Global Fund. For the year 2009/2010, multilateral support contributed about 20% of the total external funding for HIV/AIDS and TB programs in the country through many small contributions from different agencies (SANAC 2012). The recent cancellation of the Global Fund Round 11 has added uncertainty to prevention program funding in the country, which is not heavily supported currently by domestic national funds. Although it is speculation, since concrete funding data is rarely available from theatre organizations, I suspect that contributions to applied health theatre programs come from international funds far more than domestic ones. This seemed to be the case from anecdotal evidence shared by informants.
Overall, a real concern with examining funding sources is problematic transparency. The Draft NASA Report (SANAC 2012) argues that development partners are rarely transparent about what kinds of programs they fund in the country or what they intend to commit long-term, which leads to hampering integrated responses guided by South Africa’s official stated HIV/AIDS national priorities (UNAIDS 2012). In addition, survey challenges result in the loss of some data, and NASA estimates it captures only about 85% of the country’s total HIV/AIDS expenditure annually. There are difficulties determining differences between projected budgets/allocations and actual expenditures, which contributes to difficulties figuring out where money related to HIV/AIDS is actually being channeled in the country.

The fact that South Africa lacks a central database for donor funds also contributes to these challenges. Of the seven major theatre groups with whom I worked, only the two institutional organizations (Drama for Life and AREPP: Theatre for Life) kept any form of rigorous record-keeping regarding the funding history of their organizations. The four community theatre groups kept no official records of funding and supplied this information from memory when possible, and the experimental theatre group kept some records, but only the founder of the project had access to or knowledge of these.

On the financial front, South Africa has felt the effects of the global economic recession since 2009 and is struggling to maintain its government budget for many things, not just HIV/AIDS funding. What has been determined by a range of agencies investigating funding is that funding from the national public sector is significantly lower for prevention programs than for treatment and care components, while funds provided by international organizations are the opposite (SANAC 2012; UNAIDS 2012). To my knowledge, theatrical HIV/AIDS intervention
programs have *never* been counted among or given funding out of treatment and care
designations, despite the therapeutic claims of their work by many artists and audience members.

**Health Arts Funding Environment**

The broader funding environment for the arts in South Africa is widely considered by
theatre-makers to be fraught with frustration, poor administration, and fragmentation along class
and ethnicity lines. Funding is a tension-filled domain for many artists that enables, constrains,
and shapes theatre-maker lives and artistic works, including the production of knowledge and
impact on aesthetics. A brief summary of the general funding environment for the groups with
whom I worked provides insight into how and why artists characterize the funding environment
as problematic.

In particular, artists spoke about difficulties in determining how much funding is actually
going into the industry, problematic relationships with donors and other institutions, and heavily
unequal distribution of funding within the sector. I also noticed structural problems with reliance
on funding by artistic groups, accompanied by a generalized lack of understanding of the funding
environment. In this section, I weave in discussion of some of the problems and consequences
that occur from the recent funding crisis in the country, the implications of funding inequality,
and factors that mitigate the production of theatre related to health issues.

The four major national sources of funding for theatre work related to HIV/AIDS in
South Africa are the National Lotteries Board, the National Arts Council (NAC), the Arts &
Culture Trust (ACT), and Business and Arts South Africa (BASA). The National Lottery
Distribution Trust Fund (NLDTF) only funds non-profit organizations, including registered
NPOs, NGOs, section 21 companies, public benefit trusts and foundations, and public entities
such as municipalities, schools, and colleges (National Lotteries 2013). The National Lotteries
Board explicitly excludes funding for individuals or non-formally registered nonprofit groups.
In contrast, the National Arts Council funds a broader range of organizations and individuals. The NAC is a national agency mandated by the Department of Arts and Culture. Its main responsibilities and operations include:

Developing South Africa’s creative industry by awarding grants to individuals and organisations in the arts. This is embedded in our mission which is to develop and promote excellence in the arts. The NAC operates by inviting applicants to submit their project proposals and applications for bursaries once per annum, in which an independent panel of experts in each of the seven arts disciplines adjudicates on each application and makes recommendations to the council. (NAC 2013)

The National Arts Council is one of the most notoriously opaque and poorly operating funding institutions for the arts within South Africa, despite its status. The theatre-makers in this project often denigrated the NAC in the same conversations where they expressed desire for NAC funds, commitment to annual project application procedures, and gratitude for NAC grants received in the past.

The Arts & Culture Trust (ACT) is slightly different and operates as a self-sustaining perpetual fund for the development of arts, culture, and heritage in South Africa. It is billed as the oldest funding agency in democratic South Africa and was established to secure financial and other resources for arts, culture, and heritage, as well as to publicize the needs and role of the arts sector in the public domain (ACT 2013). Rather than funding for particular projects, organization, or theatre groups, ACT prioritizes arts scholarships for learners in the country, building the infrastructure of the arts sector, and supporting beneficial partnerships between corporate, public, and cultural sectors.

Business and Arts South Africa (BASA) is very similar to ACT, in that it prioritizes developing business-arts partnerships with the goal of building sustainability for the arts in South Africa rather than focusing on funding particular projects or productions. This often involves
mediating between corporate institutions and arts groups or helping particular art NGOs develop capitalist business models rather than strict dependence on donor funding and relationships (BASA 2013).

Smaller grants are intermittently (and inconsistently) dispersed on an ad hoc basis from the following government departments at national, provincial, and local levels depending on the fiscal year’s budget, social funding priorities, and social responsibility intervention agendas: Department of Arts and Culture, Department of Education, Department of Trade and Industry, Department of Health, Department of Sport and Recreation, and Department of Social Development. The funds from government bodies tend to be disbursed on a short-term project basis or for particular one-off festivals rather than sustained funding of any particular group and their range of efforts over the long term. In effect, projects are funded; groups are not. This is one reason established long-term theatre companies, collectives, or collaboratives are not standard within the theatre sector more broadly, and it contributes heavily to the instability of the funding and project environment in the country. Major international funding support for health theatre projects comes from USAID, PEPFAR, small university collaborative efforts and grants (primarily from Norway, Sweden, Germany, and the United States), the Goethe-Institut, and GIZ (Gesellschaft für Internationale Zusammenarbeit).

The groups and individuals with whom I worked and whose experiences I draw from were funded by the organizations listed here (when they were funded at all). Most often, the funding was intermittent, mixed, and the larger theatre organizations relied on multiple sources of funding each fiscal year. For these institutions, such as DFL and AREPP, grant writing and fundraising were year-long, full-time responsibilities. Other groups and individuals, such as
Isambane Community Theatre in Soweto and Hlananathi Community Theatre of Hillbrow, had little or no access to these funding opportunities because of structural constraints.

**Where Does the Money Go?**

One major difficulty regarding the funding environment, for both theatre-makers and outside researchers, is that it is extremely difficult to determine how much funding is actually flowing into this sector (including from where and at what time). This difficulty stems from a lack of transparency and poor record-keeping on both the sides of funding organizations and theatre groups. The theatre-makers in this project expressed difficulty operating within this constraint. As a researcher, I also found it difficult to sort out with any degree of clarity the ebbs and flows of funding from particular agencies and to particular groups or individuals. Overall, I was mostly unable to do this. A host of reasons are involved.

First and foremost, most theatre organizations, groups, and individuals with whom I worked kept poor records of their funding histories, including incomplete or misplaced records. The extent and completeness of record keeping (written, digital, or oral) varied and generally was higher among groups with some amount of stability from year to year and a consistent, dedicated, safe place of gathering or business (e.g. an office or home devoted to this purpose). The community groups with whom I worked were often unable to recount where funding for their projects came from farther back than one or two years. When they were able to provide a longer funding history, the records recounted often consisted of a list of agencies that had supported them in some way in the past, rather than complete or accurate accounts of the amounts of funding or support received or the dates of granting, disbursement, and use of the funds. Some of the larger organizations, such as Drama for Life, AREPP, and even individuals
(or individuals related to theatre collaboratives) such as P.J. Sabbagha, were able to offer more complete accounting of their funding histories.

On the other side of the equation, the representatives of the funding agencies with whom I interviewed hedged heavily in their accounting of where, to whom, how much, and why their funds were disbursed. I experienced very little transparency in accounts from funding agencies when I tried to pursue a clearer picture of the arts funding environment in the country by directly contacting the major national funding organizations. Only one organization (the National Arts Council) consented to let me access their funding records. Of the four individuals I interviewed from four different funding organizations, only one person (representing the National Arts Council) frankly discussed the funding process and how decisions about funding are made within the majority of organizations that fund the arts sector in South Africa. That individual was a friend I had made during pilot research, and I believe that factored heavily in her candor about funding decision processes.

Every single theatre-maker with whom I worked expressed the opinion that arts funding in the country, across the board, is poorly administered. Theatre-makers were hesitant to name the particular funding agencies they considered to have committed the worst blunders in administration. After numerous interviews with people recounting similar (or the same) stories, a few people finally admitted that the National Arts Council is most often the organization to which people refer when they speak of troubles with funding agencies. It is admittedly understandable that theatre-makers would be hesitant to malign or whistle-blow on the practices of the organization that offers them the most (and most consistent) financial support nationally.

My own experiences within the NAC archives support theatre-maker contentions that funding from this organization is highly disorganized, poorly administered, and not very
transparent. After the staff at the National Arts Council archives spent several hours chatting with and vetting me for credentials, they eventually granted me access to their archives during the last month of my fieldwork. As my contact led me through a maze of boxes holding hard copy records of previous years’ funding applications, statistics, and reports, I became excited about the possibilities of analyzing all that data. This excitement dwindled over the following weeks as I spent hours alone poring through disorganized, incomplete files and trying to make sense of patchy record-keeping. After three weeks of reading pages of funding evaluations, the only real generalized conclusion I could draw is that the funding criteria and process seemed without a consistent trend or formalized conventions. When I expressed this idea to a few key contacts, they heartily agreed with my conclusion.

**Problems with Donor Funding**

Two other major issues that complicate the topography of the funding environment for applied health theatre include rudimentary understanding of funding policy and requirements and increasingly standardized over-reliance on donor funding. There is deep, conflicting information about and opinions on funding policy among theatre-makers. This contributes to the difficulty in compiling any sort of objective picture of the arts funding environment available to applied health theatre-makers for the support of their artistic visions. The patchiness of understanding related to the funding environment is reflected in one of the most common debates about funding in the country—whether there is “enough” of it for the arts sector or not.

This debate has two main sides. Some theatre-makers assert there is plenty of funding for the vast variety of arts projects within South Africa, including all of those related to HIV/AIDS; however, this contingent maintains that groups and individuals do not receive this funding because it is not administered correctly or efficiently within the country or because it is cloaked
in layers of bureaucracy, paper-work, official regulations, and red tape that many of the people who most need the funding cannot bypass. The other contingent states that the reason HIV/AIDS theatre-makers have an increasingly difficult time finding and obtaining funding for their projects or initiatives is that there is no longer much funding at all for HIV/AIDS artistic work. This second contingent often points to the years 2000-2007 as the height of HIV/AIDS related funding within the arts sector and provides anecdotal evidence for a shift from government interest in HIV/AIDS to rising government and corporate interest in other social issues, such as gender-based violence.

These are widely shared ideas about why the funding environment is so problematic; however, establishing what kind of structural validity either argument has is difficult for the reasons presented in the previous section: there is very little generalized transparency or stable consistency in record-keeping when it comes to arts funding in the country among both funding organizations and theatre-makers.

**Patchy Comprehension of Theatre’s Institutional Positioning**

Regardless of debates about whether there is or is not ample funding for applied theatre health initiatives, there is strong consensus among theatre-makers that obtaining funding for HIV/AIDS-related artistic projects has become increasingly difficult. There is also a plethora of anecdotal evidence relaying these difficulties and suggesting ways that this difficulty contributes significantly to shaping the applied health theatre sector. Theatre-makers are acutely aware of the gaps in their understanding of funding procedure and of locating sources for funding outside of the major four national bodies discussed in this chapter. My fieldwork revealed that a large component of this confusion and opacity about funding on the part of artists is produced and
highly influenced by a lack of standardized funding procedures and conventions related to health arts interventions in particular.

The following story is typical of what many artists at university, community theatre group, and NGO levels recounted to me. It concerns P.J. Sabbagha’s attempt to secure funding for an HIV/AIDS-themed festival in Johannesburg (“When Life Happens”). Although I classify Sabbagha’s work as experimental, the funding agencies (particularly the National Lotteries Board) had a much harder time sorting out how to categorize his work. Sabbagha states:

Our National Lottery, six years ago when I applied for money, I had thought of a program called ART, anti-retroviral theatre, which is pretty much what Drama for Life has picked up but ours was more on a grassroots level. We got initial funding to start up and then I approached the Lottery for kind of big money to keep it going and I was declined by Charities. And Charities said, “No no no this is an Arts and Culture project.” And Arts and Culture said “No no no, because it’s HIV, it’s a Charities issue.” Many many foundations I approached gave me the same response—it’s either Charities or Arts and Culture. If it’s HIV, it’s a charity issue. But (they would say) HIV can’t be an Arts and Culture issue. So, because you were doing an HIV and arts-focused project, no one was prepared to fund it.

Jessica: What about, did you ever approach the Health Department?

P.J.: Yeah. A lot of what was happening at that time in terms of Department of Health, corporate social responsibility, private sector is that things were generated internally. So it was very difficult for outside projects to access funding. So, somebody in Department of Health had an idea about how to address this issue, creatively, and the project grew from inside Department of Health. And the same for many big corporates, they were internally developed programs that then went out. We did, you know, when we were running our When Life Happens Festival, which kind of has died sadly. It primarily died because the city ended up in financial problems because of the World Cup. So all, they were our major funder and they were the major attraction for other funders. And by the time the city’s funding died, we’d also been through our previous cycle with Royal Netherlands Embassy and US, so those cycles, everything kind of came to an end at the same time.

Sabbagha struggles with reconciling the interdisciplinary nature of health arts initiatives: they span both health and arts sectors. As a result, funding agencies have a difficult time determining who is responsible for funding such projects. If funding agencies themselves have difficulty figuring this out, imagine how much more difficult it is for the artists to engage with these
departments, plead for consideration of their projects, and be bounced from one organization or public department to another. In addition, Sabbagha notes that often, in order to secure funding, a group must already have previous funding. This limits the ability of some groups to access funding, if they do not have strong relationships with civic organizations or government contacts.

He also notes that although funding may sometimes be obtained from arts and culture sectors, the Department of Health is notorious for funding in-house projects developed by people with inside connections rather than giving full and due consideration to the applications or proposals of independent theatre groups or individuals. This significantly limits the number of groups who have access to Department of Health funding for arts initiatives. As a result, the When Life Happens Festival, which was widely recognized by media and attendees to be an innovative artistic environment for developing new ways to engage with HIV/AIDS-related issues, came to an end in 2008 after several years of production.

These same observations were noted by Jabu*, a 39-year-old black South African man and prominent leader in Johannesburg’s community theatre sector. He often operates out of Uncle Tom’s Hall Community Centre in Orlando West, Soweto, but he has also acquired renown touring nationally with productions that capitalize on sex as a theme. He states:

For example, if I apply to the Gauteng Department of Arts and Culture and say I want to do a production about HIV/AIDS and take it on a national tour, they won’t give me money. They will say to me, ‘go to the Department of Health.’ You see? Because that one falls under health. That’s the problem. And the health department, they already have their people every year which they give to. So that has discouraged a lot of people to continue doing productions about HIV and AIDS because they don’t get funds, and they cannot get funds from Arts and Culture because Arts and Culture says, ‘Nope, this is not our section, you’re supposed to go to Health Department, they’re the ones who fund this kind of a program, as it’s about HIV and AIDS.” And the health department, they have their own people that they fund every year, they continue, they keep on renewing their contracts every year, it’s an obvious thing. And they will open [application tenders] and say ‘Apply! Closing dates and such,’ but that’s just a formality. They know their people, that every year they give the same people money. Every year. I don’t apply for that anymore. I know that I’m wasting my time. I’ve stopped.
Jabu clearly echoes Sabbagha’s sentiments about the confusion in application processes for funding, despite the two theatre-makers operating at different levels of theatre (NGO versus community) and being of different ethnicities and socio-economic classes. Both recognize that health arts initiatives fall through the cracks in funding situations because they straddle both arts and health categories of intervention. Theatre-makers are routinely being bounced back and forth repeatedly by government and other funding organizations who all claim: “this is not our domain.”

**Over-Reliance on Funding**

The second point at issue here is systemic reliance on donor funding, as well as the structural problems this creates within the theatre sector. Another common assertion I heard during interviews and in more informal discussion about funding practices is that in addition to there being little funding available for current HIV/AIDS artistic projects, there is widespread reliance on donor funding for the production of plays or performances throughout the applied health theatre sector. From my fieldwork observations, I would have to agree with this claim.

The majority of the HIV/AIDS-related plays I saw were pieces either commissioned directly by a funding organization/government department or productions created by groups after they had applied to and received funding from a donor agency. These productions often conformed to educational theatre and related practices and were associated with particular events and holidays during the year, such as World AIDS Day, 16 Days of Activism, Youth Day, and Women’s Day. However, it should be noted that some experimental work was created in a funded environment and usually occurred in organizations with explicit integrative and mixed-approach agendas, such as Drama for Life. An exception to this reliance on funding includes
plays produced for showcase at particular festivals and some of the experimental productions created by individual theatre-makers.

This kind of heavy reliance on funding and institutionalized practice of creating commissioned theatre pieces leads to intense competition among groups and individuals for available funding and results in fragmentation of the applied health theatre industry in the country. It also leads to intense instability among the theatre sector: groups form, go out of business when funding runs out, re-form later with different member composition, or simply work on a project-to-project basis without any consistent production of artistic work throughout the year. This was a major reason for an important discrepancy I learned about during my fieldwork between what theatre-makers say and what actually happens in practice. During pre-dissertation fieldwork, every single theatre-maker with whom I spoke stated that HIV/AIDS-related theatre is widespread and ubiquitous throughout the country. This, in some ways, significantly over-represents the amount and consistency of applied theatre related to health that actually occurs on a daily basis in urban areas.

What I found during fieldwork is that a majority of applied theatre groups, especially community theatre groups, have been contracted at one point in time to produce an “HIV/AIDS play.” Therefore, most groups have such a play in their repertoire; however, these productions are not performed with any consistency throughout the year. Rather, they are performed on a funded basis for particular holidays or events, such as the ones referenced earlier. Effectively, while hundreds of community theatre groups across the country have HIV/AIDS-related projects in their overall bodies of work, these plays are only showcased consistently perhaps 20 days out of the year—and those performances are dependent on funding, which by all accounts is a divisive force for many people involved in artistic production related to health. In a discussion
on funding in the arts sector, Ana*, a 32-year-old white South African woman working as a staff
member at Drama for Life had the following to say:

Okay. Sho. It’s looking a bit abysmal because it’s almost as though the funding crisis
has taken a year or two to kind of really filter into our CSI, our international
organizations, even our government organizations, so we’re sitting with the situation
where the National Arts Council, who is one of the primary funders for artists from South
Africa, has now cut their funding by half. And whereas in the past, there were always
two calls for applications and two funding sessions a year, we are now sitting with one
funding session a year, with half of the amount. So, we’ve still got the same amount of
artists, possibly even more, as there always has been, but now everyone’s scrambling for
a piece of the pot. And as we know, creating work is a relatively expensive situation.
And so the NAC grants are getting smaller and smaller, but not just the NAC—everyone
has cut their budgets, and then they say—okay, we can give you R5,000 or R10,000 for a
project; you need to go and find the rest of the funding. And that puts artists and festivals
and whatever kind of creative work under so much pressure, the focus of attention moves
to fund-raising as opposed to creation of work. And so the creation of work suffers. And
that makes it incredibly challenging because artists in this country are not arts managers,
and arts managers are very few and far between. And it is only in the last I would say 5
years that official training of arts managers has really filtered into the systems, but it’s
still very new and it’s still very young, and it’s still an industry that if you look at the pool
of money that exists, you now have an additional person to supplement. But without that
person, you’re not going to get the funds.

Pre-democracy, the way the arts was set up was the government funded and supported
multiple artistic ventures, and each province had their own state theatre, which was
funded by the government and each state theatre, the main ones, not state but provincial
theatres, had a company. It was very Eurocentric and had multiple problems. However,
what it did do was that it actually supported the arts in a way in which we don’t have
anymore.

The government, when you have basic human rights not being met, the discrepancy of
putting on a show and somebody being able to have access to medication or just clean
water, it becomes a difficult argument. So it is a huge challenge. And because funding,
the first place that funding goes from is the arts. That makes it very hard. It’s so
fractured. There’s no standardization, there’s no union. Artists are still like: “fend for
yourself, do what it takes.” And because there’s no solidarity, it makes it very difficult
because no one’s on the same page. So yes within areas, so within community theatre,
people know each other and all of that, and then of course everyone’s fighting for the
same funding, so the competition’s absolutely enormous. Huge and hard and difficult.
And I’m sure in many instances quite cutthroat.

Ana’s comments provide a typical example of how people spoke about the divisiveness of
funding and its fracturing of the industry. She brings up several important points, discusses
where she sees the fractures in the theatre community originating, and relates this to how funds for artistic health interventions are often mismanaged in South Africa or are not valued in the same way as biomedical interventions. She points out that funding incites intense competition among theatre groups and between theatre sectors (e.g. community theatre versus university projects or experimental theatre). She also notes that the recent funding crisis in the country and subsequent increase in competitiveness in funding has led to a shift from focus on creating art to a focus on creating funding proposals—which may or may not come to fruition. A last important aspect of the issue she discusses is her explicit reference to inequality in access to funding; without an arts manager or someone skilled in producing funding proposals, certain theatre-makers will not be funded.

**Shifting Role of the Arts in the Post-Apartheid Era: “Our Voices Are Not Being Heard”**

Many of the issues invoked in the discussion of the relationship between the arts sector and the state, as well as those mentioned in the previous section on institutional influence and power in the funding sector, have been heavily echoed by my informants in regards to the applied HIV/AIDS theatre sector. In particular, they note that the structural devaluing of the arts in the post-apartheid era has inhibited the growth possibilities for the health arts movement. For my informants, the tensions in the country’s funding sector both lead to and reflect a devaluing of the arts in general and issue-based theatrical work in particular.

Disconnect between funders and theatre-makers is symptomatic of a larger disconnect within the arts and health sectors in the country. This is reflected in the numerous attempts by theatre-makers to engage with politicians, various departments of state, the biomedical sector, and other industries involved in healthcare. There are examples of successful attempts to engage
with other institutions\textsuperscript{137}, but there are also many failed attempts. Overall, a major theme that emerged from my interviews with theatre-makers on this topic is that failed attempts to engage with other HIV/AIDS intervention sectors led to theatre-makers feeling like their voices are not being heard by other stakeholders in South Africa’s AIDS policy-making and programming.

This was directly linked by theatre-makers to ideas about how the arts sector is (or is not) valued in post-apartheid South Africa and particularly in many HIV prevention, treatment, and care practices and policies, which tend to be dominated by biomedical ideology. This idea is supported through the work of some academics, who have noted that critical social science and humanities approaches to public health are often ignored by policy makers (Schoepf 2001).

When I explicitly asked the director of Drama for Life if he or his organization had ever felt included as part of public policy related to health issues, he stated:

I think my first answer both as Drama for Life [director] and as an individual, my answer is no. I come from a generation of South Africans who very much are part of the negotiation era, where great amount of care and attention is given to negotiating policy, procedure, transition, you know rights, all of those kinds of things, and my experience has been over the last decade of being less and less involved, so even when I’m invited to consult or conference like the Department of Health and Social Development, I did feel to a large degree that the template had already been set, the agenda was set, and really it was more information giving than ‘let’s really listen to what’s happening and maybe understand what needs to change.’

So I think it speaks again to a structuring of our society. I think it’s a serious question, I think it’s a very serious issue, and I don’t think my experience is in the minority. But that’s just my hunch. I wasn’t at the national [AIDS] conference this year, but the report is, and thank goodness for the Department of Health and Social Development, at least in

\begin{footnotesize}
\textsuperscript{137} For instance, AREPP: Theatre for Life regularly liaises with and receives funding from the Department of Education. In return, a strong focus of their edutainment is based on and supports the national Life Skills Orientation Programming for primary and secondary public education. In addition, several theatre groups with whom I worked had received funding money in the past from various government departments for their projects. When I was in the field, Masibambisane in Khayelitsha, Cape Town, had just received a tender from the local Department of Health for an HIV/AIDS theatre intervention within primary schools in Khayelitsha. The intervention spanned about three months and culminated in the production of seven HIV/AIDS plays by involved primary school groups that were showcased at the annual Masibambisane Youth Festival at the Baxter Theatre (Cape Town).
\end{footnotesize}
Gauteng, are making a very strong stand to work in an integrated fashion, so they you know, the notions that can’t just work within the medical model, you have to work in the social model, as well. Sociobehavioral change. So what’s happened at the national conference apparently is that there was a lot of contention and argument that the medical model is far more important and that social behavioral change is not really part of, shouldn’t be part of the agenda, money shouldn’t be pumped into that area.

So because of the economics and what’s going on in this country, there’s a shift beginning to happen again and the Department of Health and Social Development in Gauteng is going—‘we’re not going to follow that trend.’ We feel that the work that we’ve done in terms of social behavior change, school interventions through theatre, prison work, all of that kind of stuff, is just as important as the medical work that has been done in terms of clinics and laboratories and testing and all of those kinds of interventions. But there is an intolerance, and I suppose I’m just thinking out loud now, but I suppose the testament is that there’s a growing intolerance among the medical field for sociologists and psychologists and health care workers and drama people and all of that. So that stems from the National AIDS Conference. Yeah.

Here, the director speaks clearly to both issues: not feeling like his voice is heard within policy considerations and efforts of other health institutions in the country and also feeling as though the arts in South Africa are not valued as strongly as other types of interventions.

This theme of feeling as though the arts were placed in competitive dichotomy with biomedical health initiatives was a prominent one in interviews with theatre-makers at a more institutional level (universities and NGOs). In a discussion one day with Lefa*, a 29-year-old white South African woman, she brought up how the arts, especially in relation to funding, are often put into this kind of dichotomized comparison relationship with biomedicine and evaluated against basic health care criteria. Lefa described her organization’s constant struggle to justify the importance of their work and the way the situation makes her feel. She also highlights the need to remember the value of meaning-making in people’s lives. She said:

Also again you’ve got to look at the situation. We’re in a 3rd world country. The health, the state of the health of the nation is so not where it needs to be, that money needs to be placed in areas that are critical. So, hospital, basic health that people deserve. Social welfare. A program like Drama for Life would be a complete luxury in terms of their thinking. And quite an alternative way of interacting. I mean, I think the work that we
do is *highly* critical, because I think it works with aspects of the human being individually and the collective as in a community. It’s critical because we deal holistically. The full package. You cannot separate what’s going on physically in your body from your emotional, mental, or psychological state of being.

Arts organizations are able to cross-section those situations, those circumstances within society, and that’s something the arts has always been able to do. It’s the age-old argument—we are able to work with that aspect of people. And if we are able to psychologically, emotionally shift people’s state of being from a less integrated state into an integrated state, that ripple effect of that is so paramount. [laughs] But to try and tell someone who has no concept of how this works to give us money in order to do this critical work, it’s very time consuming because you literally have to, they have to experience it for themselves in order to really understand it. So we try and do that. That’s why the documentary’s become so important, so that they can actually see and be witness to it. It’s not selling a product. It’s selling how important this work is. For the healing of the community or an individual or a country, essentially.

And it’s, sho, it’s just…sho—when I talk about it, it’s so overwhelming [laughs] it’s just a drop in the ocean and you know that you have the potential as this drop to really infuse and disperse and yeah. Melt. Into endless possibilities of really integrated ways of behavior, belief systems, how we treat each other, what we do, how we treat ourselves. It’s a challenge, but we persevere as we always do. The people that work in this organization are definitely here because we believe in what we do. I suppose sometimes it’s just challenging to remind ourselves when you keep knocking on the doors and having them closed in your face and you know much work it is. It’s the same anywhere in the world, and it could be for a number of projects and a number of situations. Sorry, I’m getting a little depressive here [laughs].

The health and government funding, the priorities are different. If you think about it, just basic health, if you don’t have that down, how can you start to even engage with other aspects of health? People don’t have access to ARVs or to testing, even! And we’re still *there* and it’s like 30 years later, and we’re still there! If we’re just looking at HIV and AIDS. But what has happened is a cumulative effect of this like psychology of an impact that HIV and AIDS has had on communities, on families, on schools, on yeah. I mean I know in Botswana, there are towns and villages that just don’t exist anymore because everyone’s dead. Those impacts are really only being felt in the last couple of years, or the last 10 years, but because it’s such a long slow challenging disease, it’s playing out further down the line, and we are not equipped as a country to deal with all of those things. Because of the systems and the bureaucracies, and the red tape and all of those things that are in place, I mean like it’s going to take another 5-10 years for the government to catch up to the notion of how important it is that we do this work. The arts can serve this function in such a meaningful way. I feel like I’m saying the same thing that I’m sure you would hear overseas, you would hear in a number of organizations, not just within the arts but the health sector as well. In other countries. It’s like, we’re all talking the same talk, but what I’m more interested in is what are we going to do about it? South Africa. Because here is our reality, this is the circumstance, so
what can we do with the tools and the skills and the infrastructure right now? Because we can’t just stop. Artists just can’t go, ‘well there’s no money,’ and turn around and go and get jobs in accounting or something else.

J: How does that make you feel?

L: It’s insane! [laughs] It’s exhausting! It’s so, so exhausting. And I personally have been needing to find ways within myself to negotiate disappointment. Negotiate fear. Inadequacies. Just letting people down, letting teams down, letting artists down and then knowing I have to pick myself up in order to re-negotiate. Whew, you’re down, the door’s been slammed again, you can’t do that dream. Okay, let’s re-frame. Let’s re-establish, let’s improvise. Okay, new tap dance; learn the steps. Go. Make it happen.

And then something else happens, and you’ve got to renegotiate again, so you’ve got to be a tough cookie [laughs]. It’s hard and there’s a level of almost separation that I have to do. So that I don’t keep falling into that disappointment and that space of ‘I don’t know how we’re going to do this, I don’t know how I can do the best I can do on this or with these resources. How do I still implement the same kind of impact with nothing?’ How do I still create a safe space for people? So, yes, I personally I feel like I have an enormous responsibility for creating space and giving opportunity to artists, giving work, and of course this is not like me personally, but within the role I play, creating opportunity for people to explore, to heal, to practice. It’s hardcore. Because it becomes very fractured because of the frustration and the challenges and the expectations that are placed on us to just keep, you know, find another way. Make it happen, make it happen, make it happen. And kind of—to what end?

In this block of Lefa’s interview, she covers a lot of ground in her discussion of funding and how the arts are valued. She brings up structural constraints on producing artistic work and also makes the point that basic health care is vital, but what is life without meaning? Art’s ability to make meaningful (and make sense of) the myriad emotional and psychosocial intricacies associated with the AIDS epidemic is part of what gives it power and critical importance. This echoes the ideologies of innovation and affect I covered in Part Three. However, Lefa also notes how deeply difficult it is to get people outside of the theatre industry (other than audiences and people who have experienced the work) to understand the value of artistic health productions, particularly funders.
Lefa’s daily struggle to secure funding for the artists with whom she works invades her personal life and shapes the context of her everyday experience. Later in the interview, she discussed with me how the stress from her job, and from her recent string of failed attempts to network with and engage a variety of other institutions, funders, and stakeholders, had negatively affected her romantic relationship, her health, and severely stressed the friendships she had with her work colleagues. This kind of struggle is a small contributing component of the widely recognized high rates of burnout among artists who work with HIV/AIDS-related issues and projects. Lefa said:

I feel like I give all of myself to this work and maybe that’s a part of the problem. Because if you give all of yourself, then when things do end like last Wednesday, when there are challenges, it affects all of my being. And then you do this work for those incredible moments that happen, when it happens. Because that’s actually what it’s all about. It’s just, it’s astounding. When it happens, woo, you can like, you just fly! You fly, and you just go, “Fuck, I was a part of that!” And I am so grateful that I’m able to do this work. And then you take a deep breath and dive back into the abyss of unknown possibilities.

Warren and Lefa’s words reflect the idea I have suggested in this chapter that health theatre workers’ life experiences are heavily shaped by institutional forms of control and power. The experiences Lefa describes producing health-related theatre, along with the hardships she encounters doing so, reflect the ways her subjective reality is influenced by outside institutions that structure her ability to work and find a sense of fulfillment. Both Warren and Lefa note how difficult it is to continue mobilizing the arts for inclusion as part of the healthcare industry when they feel like their efforts are devalued. However, as Lefa notes, the sense of awe and achievement that comes from an artistic health intervention effort accomplishing its intended goal is what keeps her going despite an uphill struggle to redefine the value of the arts in relation to healthcare in the post-apartheid era.
9.3 Industry Interactions and Negotiating Competing Interests

The wide variety of stakeholders involved in the health theatre sector interact while having knowledge production agendas that sometimes overlap but are often disparate. Because of this, it is important to critically investigate applied health theatre as an educational and power apparatus, including what kinds of information are conveyed within the productions and for what reasons. This becomes especially important when theatre is analyzed as a public venue for the production and negotiation of knowledge about HIV/AIDS, illness, and sexuality; a component of health interventions in the country to which national and international monetary funding is channeled; and an industry with a long history of politically embedded relationships to other institutions, including the state. The theatre sector interacts with other industries, and its participants have to negotiate the competing interests of those industries.

The major institutions and industries with which the applied theatre sector interacts include the following: media and marketing, the biomedical and public health sectors, national and international funding organizations (which can be associated with governments, NGOs, or private investors, such as the Nelson Mandela Foundation of South Africa), the national public education and prison systems, private corporate entities, and grassroots level community structures. A last one includes national and international governments, which tend to be involved in a funding capacity but can also be implicated in other ways, such as through regulation of performance venues (or access to venues).

Within South Africa, the main involved government bodies include the national Department of Arts and Culture, Department of Education, Department of Trade and Industry, Department of Health, and to a lesser extent, Department of Sport and Recreation and Department of Social Development. Provincial and local government bodies are also implicated in the dispensing of funding related to these departments at the local level. Other countries
involved in the health theatre industry in South Africa include Germany, the United States, and the Netherlands. In addition, the strategies and decisions of people involved in the theatre industry are shaped by the following: neoliberalism (policy and ideology); global HIV/AIDS humanitarianism and advocacy rhetoric; the global politics of HIV/AIDS; and the expectations and agendas of partner organizations, such as international universities, activists, arts projects, and NGOs.

Individuals and groups involved in the health theatre industry have to understand, acknowledge, and negotiate the competing interests of any and all of these other entities, as they are related to the particular applied theatre project. This requires complex mediation, both practically and politically. In addition, as outlined in Chapter 4, the health theatre sector is itself embedded in a long history of power relations and interaction with the national government and economy. It is also enmeshed within South Africa’s broader HIV/AIDS intervention landscape and the broader mainstream and applied theatre sectors. Applied health theatre has additionally been implicated as a component of popular health rights social movements that are closely linked to rhetoric about HIV/AIDS and human rights.

There are both indirect and direct consequences of the kinds of interest-negotiation that occur in the applied theatre sector. The indirect consequences relate to knowledge production and resources: who in the country has the resources and institutional access necessary to put on productions (so, who gets to say things and who does not). The direct consequences relate to institutional control of experience and the politics of health communication: what (content) and how (aesthetics) HIV/AIDS-related issues are portrayed within artistic interventions and what

138 Germany: Through the non-profit German cultural association founded by the German government, Goethe-Institut, as well as the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ).

139 United States: Through PEPFAR, various university institution grants, and USAID.
role the compromising of artistic integrity plays in the success or failure of productions. Important to both sets of consequences is consideration of how theatre-makers feel (individually and as a group) about the influence of negotiating competing interests on their work and lived realities.

**Knowledge Production and Inequality**

The opening vignette about Hlalanathi Community Theatre’s production for the Gauteng Department of Trade and Industry illustrates some of what the politics of artistic and health funding in the country reveal about the flow of knowledge and resources across the country’s health communication industry. Structural inequalities have led to a fragmentation of funding along lines of ethnicity and class within the health arts sector. In addition, similar divisions in the theatre sector’s attempts to address the country’s AIDS epidemic are a result of the consequences of groups having to negotiate the competing interests of various stakeholders (including biomedical, public health, government, and funding institutions).

Important questions that arise from analysis of this funding and health arts nexus include: who has access to the resources and power necessary to uphold artistic visions of creative risk, and for whom is compromise necessitated? Who is given the space and resources to push the boundaries of HIV/AIDS artistic intervention efforts and why? What are the consequences of differential access to support resources among health theatre groups? Interrogation of this issue reveals that much of the health arts sector in South Africa is shaped by class-based forms of knowledge production.

**Resources and Skills Training**

The story of the relationship between innovation in health arts practices and the economy in South Africa is very different at various levels of theatre-making. A significant influence of
funding trends on knowledge production within artistic HIV/AIDS performances is differential
group access to resources. Anthropologists have noted that the available funding and personnel
possibilities in a given social setting must be taken into consideration, and attention should be
granted to whom, under what circumstances, and for what purposes those resources are made
available (e.g. Bauman & Briggs 1990). A glaringly obvious point regarding the distribution of
funding is that it was not uniform across the applied theatre landscape.

This is not a novel observation among health-related programming, but the uneven
distribution of resources in South Africa becomes important when it affects what kinds of
discourse about HIV/AIDS and sexuality are produced within health communication and which
are silenced. This immediately invokes questions about social structures, ethnicity, and class in
the country. The majority of community theatre occurs in urban townships on the outskirts of
cities and involves primarily black South African theatre-makers of lower socioeconomic status.
Mainstream, experimental, and university theatre occurs primarily in city centers and involves a
much more privileged socioeconomic class that is often white or colored South African. There
are of course exceptions to this, but it presents a pronounced trend. This topic is a place where
class and ethnicity tensions are revealed clearly and in no uncertain terms: people who have
access to resources and skills such as higher education, training in navigating obtuse bureaucratic
funding environments, and dependable modes of transportation are much better positioned to
obtain funding than those who do not.

This is directly related to which artists in the country have the space and resources to
experiment with new theatrical aesthetics, forms, and content and those whose voices and ideas
are silenced. While norms of innovation and rhetoric about artistic integrity are common at the
mainstream, independent, and university levels of theatre-making, practices at the community
theatre and NGO level are more structured and constrained regarding both content and aesthetics. NGOs like AREPP: Theatre for Life have institutional positioning to access funding, but that government funding comes with restrictions that shape the content of AREPP’s performances. AREPP’s performances are written to complement the Department of Education’s “Life Orientation” lesson programming, which is part of all secondary education in the country\textsuperscript{140}.

In contrast, community theatre groups are heavily dependent on funding but have very little power or institutional positioning from which to negotiate freedom in content or form. While many community theatre groups, such as Hlalanathi Community Theatre, expressed a desire to experiment with new ways of addressing HIV/AIDS artistically, most were unable to follow through on those desires because of factors often associated with township life, such as a lack of a consistent, safe rehearsal space protected from the environment; erratic schedules due to members’ inconsistent employment; unstable group membership; and, notably, lack of formal training in both theatre skills and theory.

The kind of involved discourse about funding I have discussed in this chapter, in addition to actual access to funding resources, were far more prevalent among groups located in experimental, mainstream, or training-institution level theatre. It is much less common a topic of explicit discourse among community theatre-makers, except for the notion (or observation) that they simply cannot get any funding. As a consequence, much of the artistic health communication innovation occurs at levels other than the community. However, the debate over innovation in health communication practices is as common at the community theatre level as others.

\textsuperscript{140} For more on the national Life Orientation program, see: Jacobs 2011.
Of the four community theatre groups with whom I conducted in-depth research, two staunchly advocated for moving away from older styles of health communication and toward innovative, creative techniques. Neither of those two groups (Siyaya and Isambane) was funded during the time I spent with them, although one group (Siyaya) had an HIV/AIDS-related production that was accepted into a prestigious community theatre festival in Cape Town. On the other hand, the two community theatre groups who conformed to older, didactic messaging styles of educational health theatre (Hlalanathi and Masibambisane) were both funded to conduct health arts projects during my fieldwork. While this could be a coincidence, I maintain it is not. Structurally, innovation in health communication techniques and genres was supported far more readily through funding at mainstream, independent, and university levels than within community theatre.

One reason for minimal form and content experimentation at the community level is a lack of space in which to experiment—both literally (rehearsal space) and figuratively (financial and other resources/support). I saw so many groups struggling with this during my fieldwork. Although I discussed the case of Hlalanathi Community Theatre in the beginning of the chapter, many other artists faced similar hardships. For instance, consider the following quotation by Tebogo*, a 31-year-old black South African theatre-maker from Tembisa Township, Johannesburg. He was directing and attempting to develop through the workshop process a production that was accepted in the annual Zwakala Festival (community theatre festival) at the

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141 However, it should be noted that the members of Hlalanathi, as discussed in the beginning of the chapter, were bandying about the idea of innovation in the beginning stages of their work, despite eventually reverting to common HIV messaging styles.

142 Tebogo was mentioned earlier as the artistic consultant with Hlalanathi. He was recruited by Hlalanathi because of his strong training in African dance and his willingness to experiment artistically. After concluding the commissioned production for Hlalanathi, Tebogo returned to his home theatre group and their projects.
Market Theatre Lab, a renowned sister institution of Johannesburg’s famous Market Theatre.

Being accepted into the festival meant that a professional theatre-maker would work with involved groups over a number of weeks to develop their production quality and content before showcasing at the festival. Tebogo, artistic director of Tholul’wazi Theatre Project, said with a shrug:

We were so unlucky, so unfortunate. We just got bad news yesterday that we cannot carry on with the Zwakala Festival, we cannot be part of the festival anymore for one reason. They came to our rehearsals, they sent a fieldworker, he came several times since the beginning of the year. But the people (actors) I chose, it was people who were actually committed in other things, and besides that, they are from different areas (townships), and we didn’t have enough budget for their transportation. And in most cases, you find that every time the fieldworker is there and they are not all in the rehearsals, we’re always short of one or two people, and it was for valid reasons, and they’ve been very patient with us, I must admit, and I cannot blame them for the position they’ve made because obviously I think we had people who were very good on the production, but the organization (Market Theatre Lab) couldn’t meet them halfway in terms of transportation, which caused the problem that we cannot be part of the festival anymore because they (Market Theatre Lab) have a fear that even if they take us, we will not be able to attend the shows or we’ll always have one person missing or all that, you see? I don’t blame them, but up until, if they were on our side and understand that it is the only problem that we have, the transportation. I still would say they were going to say, ‘no, let’s wait until the group gets funding,’ but to wait until we get the funding, it will also, like, not help them, you know?

Here, Tebogo voices some common structural constraints that prevent community theatre groups from developing professional-level productions. In this particular instance, the inability of one or two members of the theatre group to arrive at rehearsals on time resulted in Market Theatre Lab rescinding their invitation to the group for participation in the festival. While the fieldworker noted the group’s talent potential, he was unable to continue working with them after several botched rehearsals.

As someone following the progress of Tholul’wazi, I can empathize with the Market fieldworker. I had allotted a week of fieldwork to attending rehearsals for and development of this particular production; however, I was never able to see a single rehearsal. I would show up
at the designated time and place, wait around for hours with a few of the theatre-makers and Tebogo only to have the day’s work cancelled because other members either had to work other jobs suddenly or were unable to scrounge together minibus taxi fare into the city’s center for the meetings. Although group dynamics are never straightforward or simple, in this instance, something as little as R7 ($1.25 USD) a day for transportation was implicated in the collection of factors that led to an important opportunity (in production development, networking opportunities, and showcasing the play in a famous venue) being lost for the community theatre group. Also lost were skills training hours with the Market Theatre representative, which would have been invaluable to the members of Tholul’wazi: most, other than the artistic director, had never had formal theatrical training.

Hlalanathi’s case also illustrates structural differences in access to training at community levels. While the group mentioned a desire to workshop Forum Theatre processes as a way to revitalize their engagement with HIV/AIDS as a thematic topic, they were largely unable to do so as a result of their rudimentary training in and understanding of Forum Theatre theory and practices. On the other hand, groups such as Drama for Life Playback Theatre were well-positioned to receive intense theoretical and technical training in genres such as playback as a result of their affiliation with a university.

I suggest a second important reason for disconnect between ideology and practice regarding form and content experimentation at the community theatre level was simply a difference in group goals for producing theatre. Groups like Hlalanathi are often primarily driven to create new pieces of HIV/AIDS theatre as a practical result of commissions or funding tenders. In contrast, groups at other levels of theatre production in the country (e.g. independent, mainstream, and university-sponsored) are more prone to producing HIV/AIDS art as a response
to perceived past intervention failures and the de-valuing of the arts in the post-apartheid era. The latter group of artists tended to more explicitly connect their production of new work to ideological reasons related to artistic vision for alternative healing practices.

Whereas artists like P.J. Sabbagha, Kieron Jina, and Peter Hayes produce HIV/AIDS-related work whether funded or not\textsuperscript{143}, most community theatre groups with whom I worked only produced new plays as a result of commissions or for inclusion in festivals. While few community theatre makers have the institutional positioning or independence from funding to resist compromise and actively advocate for new agendas within applied health theatre, artists at mainstream, independent, and NGO levels are more strongly positioned to advocate for innovation and change in health communication practices. For some community theatre makers, although they support the production of health-related theatre, the maintenance of the group itself as an operational entity is more important than the theme of their work or stylistic innovation.

Industry Bureaucracy

A related constraint on who has and does not have access to resources and power is the increasingly obtuse bureaucratic practices bound up with issues of funding, festivals, and any other topic related to professionalization in the theatre industry. There is a very clear need for unionizing among lower socio-economic level theatre-makers and for workshops or other training programs for navigating bureaucracy and writing funding proposals. In general, there is a need in the country for training on conventions of neoliberal bureaucracy. I watched so many community theatre groups struggle with this issue (including struggling with English, which tends to be the primary language of funding, festivals, and large-scale performance venues).

\textsuperscript{143} Independent and mainstream artists are also much more likely to directly petition funding organizations for money to support projects they conceptualize, whereas community theatre groups more passively respond to funding tenders put out by organizations looking for particular kinds of HIV-related art.
Funding requirements severely limit who has access to resources, and they contribute to systemic inequality. For instance, funder requirements for annual audits, formal funding reports, record-keeping that spans a certain number of years, and established bank accounts provide structural barriers to many community theatre-makers who are struggling to enter the applied health theatre industry. P.J. Sabbagha discussed his ideas on the funding economy and the struggles other artists go through trying to secure it. He states:

It is dismal, but we were very, you know, Jill Waterman advised me in ’95 ‘register your company now,’ so I registered in ’98 and because of that, we have 15 years of audits, of record of good governance and all of that which is actually what they’re looking for at the end of the day. If you don’t have that, you can’t do anything. All the funding bodies require at least a 3 year track record, a trail. We’ve always had support from the National Arts Council, either on a project funding or company funding. It’s never been huge, we’ve always had support in some way from the Lottery and now we’ve got a nice big amount. I wish I’d asked for more because I got every penny I asked for, but I kind of have a feeling I could have asked for double and then everybody would be on decent salaries but we’re in a stable place for the next few years, which puts us in the position to find other funding sources. And also, you know, I know that with these funding bodies that if you deliver properly, if you report properly, if you’re accountable, if you demonstrate everything correctly, there’s no reason you won’t get again and you won’t get more. So, you know, the money’s there. But it is about having the right infrastructure in place, the right period, for a long period. To start is very very hard.

For community theatre groups, it’s extremely difficult. You know the only way for those people to go is to do individual applications to NAC or to Department of Arts and Culture, but then they get, like, R20,000 or 10,000 ($1725-$862 USD)--so tiny, tiny bits of money. And somehow [pause] or to partner with larger organizations, which the funding bodies do allow. They allow smaller organizations to partner for a period in order for them to build the required bonafides.

In this interview excerpt, Sabbagha, who had recently secured an amount of funding from a national body that allowed his company to operate fully for 3 years, comments on what it takes structurally to arrive at a certain level of professionalization. He states clearly his opinion that it is incredibly difficult for community theatre groups to establish the necessary credentials for securing formal funding for health arts projects. He also notes his opinion that funding is available for such projects in the country, but it is dispersed only to those groups or individuals.
with the proper training, credentials, and “bonafides” to satisfy large organizational bureaucratic requirements. The bureaucratic red tape described by Sabbagha is not only about a group’s ability to have “correct” auditing infrastructure in place; it is also about the ability of members of a theatre group to be the “right” kind of accountable, neoliberal citizens.

I cannot help but contrast Sabbagha’s experience, as a formally trained theatre-maker and university-educated, white, middle-aged man whose life partner’s income allows them to live at a middle-class level, to the experience of the director of Isambane, the community theatre group I worked with in Soweto, Johannesburg. The director, Ayanda*, is a 26-year-old black South African woman with two children. She is a single mother. Her group’s source of rehearsal space was her mother’s traditional healing house about 20 minutes’ walk from the complex in which her family lived. The group had access to this space only about half of the time I spent with them, because she and her mother periodically fought about a host of personal issues. During these times, her mother would prohibit her from using the traditional healing house on penalty of ejection from their home complex. One of the first things Ayanda asked of me after joining their group was to write funding proposals for her, because she was unable to “speak the language.”

This reference to “speaking the language” refers to both formal funding applications and bureaucratic practices, as well as speaking English comfortably, which is the language in which most funding business is conducted. I watched her struggle that year with securing enough money for even the most minimal of performance requirements: sheltered rehearsal space for the times her mother prohibited the use of the house. Ayanda had little formal education and no formal income. She relied on a monthly government subsistence grant given to her because of her children. Although some of the other group members were her age, most were young females still in school through Grade 9. Four of the males were old enough not to attend school,
but they also had no formal employment or income. A close friend of mine (Lefa), a theatre-maker at a university organization, had the following to say about funding practices, which is appropriate in relation to Ayanda’s struggles:

No one just gives you money. So the funding world in the arts is challenging, it’s difficult, and it’s no wonder that artists, being artists, don’t know how to traverse this. Because it’s complex. I mean, I studied this and I’m still, everyday, there’s something new to learn about how to do it and how to do it properly. So it’s a huge challenge, and there’s policy, there’s structures, there’s—and if you don’t know them, how do you negotiate them? Yeah. It’s quite a thing.

That is a major question most community theatre group members (and especially directors) had when we talked about their ability to sustain their groups: how do you negotiate structures related to funding? Most had very little idea how to even begin engaging with formal funding structures. Ayanda questioned me about, and we discussed at length, strategies of professionalism that she could use during a first meeting (or to secure an initial meeting) with possible funders or collaborators. She fully recognized that the world of funding, organizations, publicity campaigns, and sponsors was a very different world than the one she inhabited everyday.

Despite all of our conversations and my attempts to help her develop a funding proposal for the group to submit to official organizations, during the year I spent with her, Ayanda never finalized the proposal or submitted it anywhere for consideration. We would meet to discuss professionalization in the theatre industry and her entry into the “bigger” ranks of community theatre, but the conversations would often devolve into topics of immediate concern, including how she could find money for food that week and either asking me for financial contribution or to help her brainstorm ways to obtain money for personal (rather than theatre group) use in the immediate future. Because of her socioeconomic positioning, which is very different from
Sabbagha’s positioning, she did not have the space to work out a funding proposal, much less engage directly with the entire system of the funding economy.

I bring up the contrasts between Sabbagha’s and Ayanda’s cases not to downplay in any way the struggles Sabbagha has experienced in his career—which have been many—or the quality of his work—which is impressive. However, his experience of the health theatre industry in South Africa is a very different experience from Ayanda’s. Leleti*, a 23-year-old female black South African member of a community theatre group (Masibambisane) in Khayelitsha Township, Cape Town, expressed her ideas on the instability of the health theatre industry in general and the community theatre sector in particular when she noted:

It goes back to the funding thing because we try, by all means, to create our own funding, like our small things that we want to do, like mini-festivals in community halls and create and have an income and whatever. But at the same time, it’s so little that there’s nothing you can do about it. Community groups want banners, you know? When they will have their festivals. They want to hang their banners. But banners are expensive; they are so expensive! They can’t afford them. So sometimes they get discouraged, and they just go away. And boom, it’s over.

At this level, it is simply a matter of whose health communication agendas are structurally enabled and whose are not. Ayanda’s group produced a particularly creative, unique dance-based performance about the interpersonal relationships infection with HIV facilitates. However, her group’s production was never shown to anyone but me during the year I was in residence. In contrast, Sabbagha’s performance about the relationship between HIV, sexuality, desperation, and Johannesburg nightlife was given several showings in a large theatre space over the same year.

It must be kept in mind that there are shades of gray in this entire funding economy issue and that there are no clear, distinct class and ethnicity lines when it comes to the stability of artistic production in the country. Several “big shot” community theatre leaders in Johannesburg
live a style of fast-paced, high-income life that some white, middle-class NGO theatre-workers I know will never achieve. However, there are definitely general class and ethnicity tensions at play when thinking about who has access to health arts funding in South Africa and who does not. Leleti in the quotation above succinctly captures the specter that haunts so many of the artists I met and characterizes an ever-present possibility of this industry: “Boom. It’s over.”

**Relying on Industry Connections**

In contrast to failed attempts to liaise with other institutions or secure funding, there are some successful attempts. When these attempts by theatre-makers to establish working relationships with other members of the health sector are successful, theatre-makers overwhelmingly attribute this not to any institutional valuing of or concern with artistic practices, health priorities, or impact goals but rather with the force and nature of particular individual personalities within the departments and organizations approached. Theatre-makers noted that relying on connections and personal relationships with individuals within other institutions is the primary way artistic interventions are foregrounded in the country, when they are actually considered. A common example given was the idea that if you (as a group or theatre-maker) can find someone in an organization who has been personally affected by either HIV/AIDS or the power of art, that person will be far more likely to value the kind of artistic intervention practices theatre-makers promoted and support the programs (ideologically or with other resources, such as funding).

However, a major problem with this form of networking is its tenuous nature. Establishing relationships with individuals rather than institutionalizing relationships between organizations and theatre groups becomes problematic when those individuals leave an organization, are retrenched, pass away, or are otherwise removed from their positions. The
connection is then lost, and the process must begin anew. This makes for a highly unstable environment for relationships that bridge various parts of the health sector.

Although this topic was mentioned by many theatre-makers, it was a particular focus for Akhona, the community theatre director of Siyaya mentioned earlier. He recalled an experience where he had spent weeks securing a sponsor from inside the African National Congress (ANC) offices to support his most recent HIV/AIDS-related play. He returned to the office one day and found out that his contact was no longer employed there. When he spoke with the person who had taken over the position, he was told in no uncertain terms, “we don’t deal with that person’s business.” Akhona’s project was not given consideration in this particular instance, and he felt a significant part of that was because of his affiliation with the previous worker. In this case, political competition and personal affiliation worked against his group’s health project, which Akhona classified as politically neutral. After several similar attempts to establish connections with other organizations and government departments, Akhona noted:

I registered my NGO, but I never even try to get funding from our government [anymore] because I know connections, friendships, political organization is a factor. I think our government has much corruption when it comes to terms of monies. If you are not connected, you don’t have an ‘in.’ It’s hard luck for you. You must be close to the right people, because it’s them running things around the country. It’s about who you know and having personal relationships.

Akhona’s experience highlights some of the problems of relying on individual connections within organizations rather than establishing formal recognition within the health sector of what the theatre-makers are trying to do in relation to health arts projects and the value they have generally. This kind of subjective and arbitrary nature of the relationships with donors and other institutions is deeply mirrored in the subjective nature of arts funding in the country.

These types of donor relationships are not unique to South Africa but indicative of a broader trend within arts sectors globally. While theatre-makers were forthcoming in asserting
that the granting of arts funding within South Africa is deeply subjective, arbitrary, and sometimes personally or politically motivated, representatives of the funding agencies with whom I interviewed painted a much more equitable, fair, and just picture of the process behind which funding applications were awarded. Only one funding representative spoke candidly with me about the arts funding granting process, and her thoughts mirrored theatre-maker ideas of the intensely subjective funding application evaluation process.

**Institutional Control of Experience: The Politics of Health Communication and Compromise**

In addition to the relationship between knowledge production and inequality, another major consideration for theatre-makers had to do with how the factors that govern disconnects between ideology and practice often lead to certain information and agendas being privileged over others. Disconnect between funder and theatre-maker ideas about impact and meaning-making reveals certain things about the institutional control of experience in this context, including how ideas are shaped in particular ways about the content of productions, the aesthetics through which HIV is represented, and who proper target audiences should be.

**Production Content**

Through constraints on content, the relationship between artistic integrity and compromise necessitated by negotiating with institutional outsiders is implicated in the politics of health communication. Many theatre-makers considered themselves (and others) increasingly at odds with funders over the content of their work and discussed this with fervor. Akashinga*, a 43-year-old male Zimbabwean theatre-maker now based in South Africa, had years of experience working with applied theatre related to health and other artistic development projects. One day, when I asked him about the impact of theatre, he heaved a sigh and said:
My immediate response is, you know, drama is addressed to the emotions, to the emotional intelligence, it has to do with empathy, it has to do with feelings, and it is difficult to measure attitudes, it’s difficult to measure behavior. However, for purposes of donor funding, people have resorted to statistics--how many people have attended a performance. Which to me is, because it doesn’t necessarily mean that attending a performance means it’s equal to impact. It’s only to be able to get more funding by you know pleasing the donor to indicate how many people have been reached.

This is a typical example of theatre-maker discourse about funder influence. Here, Akashinga notes part of the core disconnect theatre-makers identify between their goals and ideas of impact versus those of funders: theatre-makers privilege emotional engagement, and funders are considered focused on behavior change and reaching large numbers of people. Another common sentiment expressed by theatre-makers was the notion of reaching “just one person.” In this framing, numbers have little meaning; affecting individual people on a personal, emotional level is what is valued.

Some artists discussed the imperative of incorporating affective techniques that privilege emotion, the senses, and embodiment in creating effect on audiences. However, they felt that funders considered this kind of work too “touchy-feely” and not sufficiently grounded in educational messaging—so the theatre-makers noted they had to accommodate this priority difference. This creates what one prominent theatre-maker in the country aptly labels a “Theatre of Compromise.” The implication here is that some artists have to compromise their artistic integrity and vision for HIV communication, which they overwhelmingly indicate as a reason theatre has been ineffectual in making any sort of significant impact among the general population. The compromise is thought to cripple the effect of the work by minimizing affect (emotions).

For example, while Tebogo, the visiting director for Hlalanathi, discussed with me his interest in exploring through the medium of theatre the relationship between the physiological
aspects of HIV’s journey in human bodies and people’s emotional reactions to the changes HIV causes in their lives (which would certainly be innovative), in practice he deferred to funder preferences. In particular, his funder wanted him to structure the content of his production to focus on minimizing HIV risk among key populations—an important but staid message that has been raised again and again within health promotion programs in South Africa. While many theatre-makers privileged thinking about exploratory questions, emotion, and topics that have not been addressed fully in past national health promotion practices, donors more often tend to focus on the importance of public health approaches to messaging within the arts.

**Production Aesthetics**

In addition to institutional control in the realm of content, negotiations between artistic vision and outsider goals are implicated in the kinds of compromise that arise stylistically. Theatre-makers are actively struggling to reconcile the reality of their situation (funding environment) with their ideals, aspirations, and attempts to shift HIV intervention paradigms. Artists spoke at length about this struggle in relation to both the genre through which productions are created (style) and the temporal length of intervention efforts (process).

Many of the theatre-makers with whom I worked discussed compromising on their form in order to placate donors and other outside organizations that exercised some form of control over the artistic vision of their processes. In Hlanathi’s case, the group moved away from initial intent to use certain theatre techniques (like Forum Theatre) in their production out of deference to funder preference for an aesthetic that was simultaneously more clear about its message while being less didactic in its approach. This involved restructuring some of the dialogue to be explicit in its risk-avoidance messaging but also moving away from the kind of theatrical asides often used by community theatre-makers to directly address their audiences.
The length of intervention efforts was also a major point of contention for theatre-makers in relation to their ideas about artistic integrity, form, and compromise. I first mentioned artistic focus on process-oriented work in Chapter 5 when I discussed shifts in health intervention aesthetics. This attention to processual work was tied by artists to considerations of funding and impact, as well. Most of the theatre-makers with whom I worked considered lack of sustainable, long-term funding for artistic HIV/AIDS programs a factor that lead to poorly conceived and hastily produced “one-off” performances that have very little effect on audience members in any way. Theatre-makers tie this to increasing appeals for more process-oriented work, which necessitates significant amounts of time in and involvement with the community in which they intend to perform. Calls for process-oriented work mean longer (and more stable) funding cycles/commitments by donor organizations that span years rather than weeks. This also requires the development of much stronger, long-term relationships between theatre-makers and funding organizations.

This kind of discourse about process, funding, and impact was especially prominent within the more institutionalized NGOs (such as AREPP) and university program Drama for Life (and the ways their students spoke about future work in this industry). The issue of process-oriented work is particularly germane right now in the theatre industry ideologically because theatre-makers are moving from producing one-off educational theatre shows to heavily advocating for process drama, which is a very different type of theatre with different affective techniques, theoretical underpinnings, and ideas about impact. However, from my experience in South Africa, the process-oriented model of intervention funding rarely happens. This is another

144Other scholars have discussed this issue in depth in relation to the theatre industry in particular and any industry that relies on donor funding more generally (Campbell 2003; Heap & Simpson 2004; Chinyowa 2006; Ngufor-Samba 2006; O’Toole 1992), but it is an enduring issue that theatre-makers still support and for which they advocate heavily.
area where outside organizations have the potential to constrain theatre-maker intentions and artistic vision, as well as their ideology about healing and how social change occurs or can occur.

I knew a few projects (four) that received 3+ years of funding at a time, but all were at the NGO or independent theatre level rather than grassroots community theatre efforts. What is far, far more common is the funding pattern described in the following excerpt where Ana, another staff member from Drama for Life, discusses common government funding practices related to HIV/AIDS artistic work:

What happened was you got ridiculous amounts of money being pumped into a festival or project or play or a director or somebody specific who normally has some sort of political allegiance, maybe I shouldn’t be saying that on record, or sway or relationship with existing government. And for example, the end of last year there was a youth festival. They spent some completely obscene amount, like you want to vomit, like R100 million ($8.6 million USD) on this festival. The festival didn’t really happen. It wasn’t really orchestrated properly. It wasn’t coordinated properly, and the case is still pending. The Lotto had to bail them out R14 million ($1.2 million USD), which they did in 3 days. And there’s no accountability, so even though they’re still trying to figure out what happened to the money and where the money all went and all that, the deliverables were so obscene because there really weren’t any deliverables, and there was like advertising (only) two days before the festival—“oh, there’s a youth festival.” And they were playing, like, kissing games or something, like I think the games were supposed to make things more sexy. And then you’ve got somebody like Mbongeni Ngema who got an enormous amount of money to put on Sarafina and you’re like—I don’t think there is no money. I just, the allocation of that is maybe not considered adequately. So it’s a very interesting thing because I think it’s still highly politicized.

The situation described by Ana here is a very commonly referenced one among all levels of theatre-makers in urban South Africa: politically connected individual theatre-makers receive obscene amounts of money from the government to produce an issue-based festival that runs for only one day. Rather than the kind of intensive, workshop-based process theatre advocated by most artists, Ana notes money often goes to poorly conceived government-funded artistic interventions that have little to no effect in the lives of people involved.
Akhona, the director of Siyaya in Nyanga Township, Cape Town, told a similar story of his own experience with receiving government money. The last time he produced artistic work for Cape Town’s Department of Health (beginning of 2010), Akhona was asked to produce a play about sexually transmitted infections. Although his group was not monetarily compensated at a very high rate, he later found out from a government friend that the Department of Health had spent R250,000 ($21,571 USD) on that one day’s event—including publicity, catering, and printed t-shirts. Akhona characterized the government as irresponsible in their management of money for STI-related theatre in this instance and noted:

Is it really wise to spend that kind of money for one day? So is it really possible to spend R250,000 to just tell people for one day to condomize?? Because at JL Zwane Center, I go out every day without spending anymore than R200 ($17 USD) to go out to a space and say to people: condomize. But you government, you say you don’t have funding for arts, but those banners are very expensive quality, good material, but the date is the 12th of March printed on it, so you can’t use it again. After today, that expensive banner is worthless.

Akhona reiterates the concerns of the staff member at Drama for Life related to the mismanagement of funding for health arts initiatives and the government’s irresponsible focus on one-off events rather than supporting the kind of long-term, weekly intervention efforts his community group does day in and day out.

**Target Audiences**

Finally, another important way theatre-makers discussed outside influence on their work included how funders and sponsor organizations direct what kinds of industry relationships the theatre-groups maintain. Some theatre-makers gave examples of funders directly determining who their audiences will be by specifying this as part of the funding contract (for instance, prison populations or primary school students). Others talked about funder influence on potential collaborative partners through more informal suggestion or encouragement. This included
funders backing particular groups of people with whom the theatre group was expected to run workshops.

Drama for Life is a good example of this. Although the various members of DFL had interest in a wide ranging group of people with whom to conduct theatre interventions, their primary funder supported (and strongly encouraged) institutional partnerships with a theatre in Hillbrow, a particular community arts center in Soweto, and an AIDS orphanage on the outskirts of Johannesburg. Although the students of DFL conducted arts intervention work with other organizations, the main official relationships between Drama for Life and other organizations (targeted as participants and audiences) during the year I spent with them were confined to those three partnerships.

9.4 Conclusion

In this chapter, I have included and analyzed ethnographic data that explores a variety of institutional and industry relationships, interactions, and influence on the applied health theatre sector in South Africa. I have also detailed, through examples, how those interactions affect theatre-makers’ lived experience, feelings about their work and its value, and their understandings of the structural factors that enable or constrain their artistic visions. Institutional relationships provide a context for the web of barriers and supports to (effective) intervention programs and are heavily implicated in the disconnect in South African applied health theatre between official discourse about the goals, impact, and value of artistic health interventions and what actually (or unofficially) happens on the ground.

In many HIV artistic encounters in the country, emphasis is placed on using aesthetic and embodied techniques to privilege the convergence of cognition, affect, and the senses in the project of creating meaning. However, this integrated focus is often heavily mediated by outside
institutional forces with competing priorities, such as funding organizations. These competing priorities often lead to a perceived (and sometimes real) disconnect between theatre-maker and funder goals in relation to impact and meaning-making processes. There is an urgent need in the country for stronger analysis of inequalities in access to arts and health funding and how this shapes the content and aesthetics within HIV/AIDS theatre over time. In the latter half of this chapter, I briefly discussed how theatre-makers conceptualize the value, goals, and impact of their work, along with what they consider funder ideas to be about these topics. The relationships between these two perspectives are implicated in shaping (and sometimes limiting) the kinds of knowledge produced about HIV and how it is communicated to and experienced by audiences. It is important to note that not all theatre-groups felt this kind of funder control; however, this topic was one that almost everyone brought up in conversation.

In some ways, I think medical anthropology offers a productive framework for both analyzing the practical implications of these disconnects, as well as for offering a language to talk about these issues in a more nuanced way—one that weaves considerations of emotion and subjective experience into broader political-economic, biomedical, and public health perspectives. Theatre-maker discourse about this topic fluctuated between a holistic framing and a more straw-man approach of “emotion versus the cognitive.” Ethnography can contribute significantly to more performance-oriented approaches to applied health theatre through providing political economic analysis of the contextualizing factors for the production of applied health theatre and making explicit the kinds of institutional power relations involved in contemporary efforts to produce HIV/AIDS artistic work. In the chapter that follows, I detail the particular ways people are starting to speak back to the kinds of control and power I have discussed in this chapter.
CHAPTER 10
Speaking Back to Power: Creative Economies and Parallel Contributions

Introduction

Elizabeth swirled the last dregs of the coffee in the bottom of her cup as we sat outside on a café patio enjoying the sunny, windy summer afternoon. Her dark curls flopped over her blue eyes as she thought hard about the question I had just asked. Looking up, she launched into an answer about why she had wanted to start a playback theatre company in Johannesburg, especially when that particular theatrical style was not yet well-known, widely practiced, or its tenets even understood in a popular sense. She said:

There wasn’t a lot of reflective space for ourselves, just as people here in this country (within common HIV intervention practices). I felt like we hadn’t explored our stories. In that we were just flung into the situation where we were having to learn about HIV and AIDS but not what it actually meant to us. So I thought playback would be an amazing way to do that. It’s not didactic, which really appealed to me. I think there’s a lot of messaging about HIV in the country, but clearly messaging is not really working. So I felt that (playback) was a good way to connect with the fundamentals of people just relating to each other as people. I think you love it or hate it. [laughs] Yeah, but that’s what’s so interesting about playback—it can be a very unsettling experience. It doesn’t promise catharsis; it’s not about that. It can be sometimes quite unnerving. Sometimes you’re going to get it, and sometimes you’re not. I think a lot of people who’ve had a playback workshop are very sold on it because of what it does to you internally and the way you have to listen and the way you have to be. It’s very special.

But then there are those people who come to a performance, and they won’t get it because every night is different. People can sometimes go to very deep emotional places, and if you came into playback and that’s not what you were wanting, you can completely shut off from it. We do our thing the best way we can, and there will be those who are moved or that awaken something in them. It often happens that somebody’s like, ‘I never knew, I never thought about it that way, or it made me think about this,’ and for us that’s enough. That’s important in itself. Somebody will see somebody else’s story, they won’t necessarily tell a story, but they’ll be like—“Wow, you know? I thought I was the only person who had that sort of experience, but now I see that other people have it.” So it’s for that kind of feedback that we do the work. We can’t reach everybody, but I guess we can reach a few.
Elizabeth’s ruminations invoke strongly the kind of ideologies of innovation and reflexivity, as well as the importance of storytelling and meaning-making, that I discussed in Parts Three and Four of the dissertation. She also references the relationship of the arts to other forms of health intervention and outlines the gaps she thinks theatre interventions fill in health communication, prevention, and care efforts. For Elizabeth, having people simply think about what HIV means to them, as well as how they relate to each other as people (which includes recognizing their commonalities with others) are important forms of program impact. She notes that impact is not only about reaching a large number of people but reaching some people in deeply affective ways. The value of theatre-making within healthcare is positioned in her answer as being about a particular way of listening to others and encouraging empathy.

In Elizabeth’s answer, you can see her active struggle to carve out a place for the arts within health intervention and articulate the sector’s importance within considerations of HIV. In the previous chapter, I presented ethnographic data illustrating how applied theatre operates within a web of institutional relationships in the broader healthcare sector in South Africa. In addition, I outlined the ways in which artists are starting to tease apart the effects of those relationships on the kinds of knowledge that are produced about sexuality and health within interventions, as well as the aesthetics through which those ideas are communicated to audiences. This final ethnographic chapter of the dissertation is about how theatre-makers are speaking back to the forms of institutional power that shape their health intervention practices: the particular ways this resistance manifests and why it is framed through certain kinds of discourse.
10.1 Creative Economies

Elizabeth’s attempts to work through the value of playback theatre within health intervention efforts mirrors the way other theatre-makers discussed similar topics. During fieldwork, one of the recurring themes people discussed was how to think about applied health theatre in relation to other organizations, health promotion efforts, and industries. Artists struggled with defining their role in the HIV/AIDS intervention sector in particular and in relation to other industries and ideas about health more broadly. In a recent Facebook conversation thread with Lefa, a key informant, she asked her readers the following question: “I’m searching for a definition….what is your meaning of ‘Creative Economy’?” (October 2013).

This Facebook post is a continuation of her attempts, first mentioned to me during fieldwork, to define what theatre contributes to the world. After several exchanges, Lefa makes the following comment, in which she attempts to develop a working definition of “Creative Economy”:

ok, so let's look at this: I liked this definition of the word 'Economy: The wealth and resources of a country or region....'. So economy is about a collective, and about wealth. Wealth is about a quality of life, which extends beyond the confines of money. So, I say economy looks at the enrichment of a collective, be it a country, community, business etc. Creativity allows us to fully reach the potential of the words Enrichment; Wealth; Economy. It creates the opportunity for experience, aesthetic, beauty, expression, emotional economy, humanity, understanding, imagination, deep communication, transformation, diversity, fun and change. It's about people, and it's about who we are. The enormous challenge that I think we are grappling with towards a definition of Creative Economy, is how to value the above, particularly when it has gone, for the most part, as the things that happen in spite of the economy. The things that are byproducts of what artists do.  

\[145\] An interesting side note is the answer someone else in the thread gave to the artist’s question about what “creative economy” means: “When creativity is co-opted by capitalism.” The concern that their work was being coopted by capitalist ideology was voiced by several artists with whom I worked. This is an interesting topic and relates to the present discussion in that it becomes clear people fear the intrusion of capitalist and neoliberal ideologies (and related institutions that operate under such ideologies) on their artistic integrity.
In this comment, Lefa is actively trying to define the place and value of the arts within contemporary South Africa. She uses the term “Creative Economies” to index how the arts fit into the country’s economic sector and points to “creativity” as a critical concept. Indeed, she states that creativity is what allows people to fully reach the potential of the words “enrichment” and “economy” in a way that exceeds narrow focus on monetary wealth and capitalist ideology and instead moves into the realm of quality of life. This concern with outlining the role of the arts in relation to other economies, institutions, ideologies, and industries was a prevalent component of theatre-maker debates in the country at the time of my fieldwork.

In this chapter, I assert that theatre-makers are involved in an active repositioning of artistic health interventions in the country as a direct result of their increasing recognition that applied theatre is situated at a complicated intersection of competing institutional interests and agendas. I argue that this reassessment is both a reaction to the institutional control of experience described in the previous chapter, as well as a strategic move on the part of artists to reposition the arts sector in relation to the country’s healthcare industry. While the artists with whom I worked genuinely conceptualized applied theatre as a different form of intervention modality than other programs common in the country (with its own health goals and impact possibilities), they were also marshaling discourse about creative economies, interdisciplinarity, and the inclusion of considerations of incoherence within public health as a way to proactively redress their marginalization within broader healthcare efforts (in relation to funding, resources, institutional positioning, and ideological value).

In the rest of this chapter, I discuss a framework theatre-makers were starting to build in reaction to the perceived failures of past HIV intervention models within South Africa. I call the framework “Parallel Contributions,” because this term succinctly captures how artists were
starting to talk about their work in relation to other types of intervention modalities. I describe the tenets of the Parallel Contributions framework and analyze theatre-maker ideology behind the impetus for it, which mirrors some of the larger concerns of performance studies as a discipline (particularly a privileging of fluidity and dynamism and a rejection of binary thinking). Unpacking this ideology reveals much about why performance theories of healing, intervention, and social change are being proffered by artists as necessary components of future HIV/AIDS work in the country.

I elaborate and support two major arguments. First, I argue that the focus on the Parallel Contributions framing by theatre-makers is a bid to increase their cultural capital\textsuperscript{146} and, with it, their structural power and position within the country’s AIDS industry. Second, I argue that one of the main ways theatre-makers are creatively speaking back to institutional power and struggles over funding is by actively challenging hegemonic conceptions of “progress” and “success” within interventions as a way to effect social change. In the remainder of this chapter, I explain this framework by analyzing theatre-maker discourse about it and participant-observation in the tactics, techniques, and practices theatre-makers use to accomplish their goals.

\textbf{10.2 Parallel Contributions}

A majority of the artists with whom I worked talked about the importance of building intervention programs based on the following very simple but often overlooked (at structural levels) ideas: there are a range of intervention and treatment modalities that all have their own strengths and problems, and this is a good thing because people need different services at different times in their lives. The Parallel Contributions framework is fundamentally about recognizing that a range of intervention modalities should be encouraged and embraced within

\textsuperscript{146} Pierre Bourdieus’s concept of “cultural capital.”
global HIV programming, because the people for whom the programs are created have a wide variety of healthcare needs (broadly defined). The kind of program (e.g. education, prevention, treatment, care) that speaks to a person one day may not be the kind of program that person needs most or responds most productively to in 10 months’ time. People’s lives are dynamic; the health programming designed for intervention into those lives should be similarly dynamic and varied.

Effectively, this intervention ideology is being used to develop and promote a strong philosophy of interdisciplinarity by theatre-makers. Theatre-makers were promoting the use of arts methodologies as a critical complement to biomedical, public health, and anthropological approaches to HIV research and program development. This was part of a larger project they advanced for advocating increased interdisciplinary research and policy efforts related to global HIV efforts that more attentively take into consideration the kinds of existential incoherence I outlined in Part Three.

I argue that for theatre-makers, working through the Parallel Contributions framework (1) makes space for recognizing and attending to new goals, contexts, objects of study, and questions that have appeared in the last decade of AIDS work—not just in South Africa, but globally, (2) provides a route through which adaptable, fluid, dynamic programs may be conceptualized and made actionable, and (3) pushes people implicated in HIV program creation (e.g. policy makers, funders, NGOs) to pursue (finding is more difficult) balance between the competing priorities and interests of the various stakeholders in the AIDS industry. This perspective is about opening up the possibilities for interventions—what they can do and accomplish—by incorporating more strategies, broader goals, alternative tactics, and rethinking institutional relationship possibilities.
10.3 Cultural Capital and Interdisciplinarity: The Importance of Complementarity and Boundary-Crossing

Given theatre-maker critiques about past intervention framing, the incommensurability of present intervention goals with those of the past, and concerns about dynamic changing contexts, what are some of the ideas theatre-makers have about how to create new work that circumvents these past pitfalls? For many, the primary way rhetoric about intervention improvement was expressed was through the notion of interdisciplinarity. This included advocating for a complementary intervention paradigm based on multi-modal forms of prevention, treatment, and care, as well as blurring stylistic and disciplinary boundaries in attention to HIV/AIDS.

I suggest in this chapter that the focus on the Parallel Contributions framing by theatre-makers is a bid to increase their cultural capital and, with it, their structural power and position within the country’s AIDS industry. Theatre-makers are deploying narratives of static and rigid past programming and the failure of approaches to the epidemic that privilege only one or two intervention paradigms (e.g. biomedicine and public health) as a strategy to challenge the epistemic authority of biomedicine and make space for increased interdisciplinary work at institutional levels. I suggest that this shift in how theatre-makers conceptualize their place and role within the country’s broader HIV industry has largely come about in response to the devaluing of the arts sector in the post-apartheid era described in Chapter 9. Another contributing factor has been recent forays by some theatre-makers into new performance genres that privilege their own ideas about how healing and social change occur instead of relying on the underlying ideology of biomedicine.

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147 These narratives of failure were discussed in detail in Chapters 4 and 5.

148 These ideas about healing and social change were discussed in detail in Chapter 5.
This challenge is accomplished primarily through marshaling ideologies about complementarity within intervention programming and employing the idea of boundary crossing to conceptualize disciplinary boundaries as places for producing new kinds of knowledge about and possibilities for HIV interventions. In this positioning, divisions between theories and approaches simply become spaces for the creative interrogation of similarities, relationality, complementarity, productive tension, and communication between disciplines rather than points of contention or antagonism.

**Complementary Approaches**

Artists at all levels of theatre began staunchly advocating a complementary approach to HIV intervention programming while I was in the field. This intervention framework echoes the refrains of alternative/complementary healing literature by advocating shifting from the antagonistic division between intervention programs in the country (e.g. clinics, biomedical, psychosocial, arts) to an active recognition of the need for and interconnectedness of a multitude of intervention modalities. It is a subtle ideological nudge in the direction of general public health programming to recognize the value of a range of intervention types and shift rhetoric away from straw-man “us-versus-them” mentalities (which often manifest as biomedical-versus-alternative prevention and treatment programs).

It is a move toward a foundational premise that balance can and must be found between competing institutional, individual human, and program priorities and interests for any significant change to take place in the country regarding HIV prevalence rates and overall subjective reactions to the AIDS epidemic. It is also a push to re-frame and reorganize institutional relationships to recognize an approach that values different treatment modalities that work in tandem. Implicit in this framework is the recognition by artists of a limited range of
definitions of healing in the country and a move on their part to open up what “healing” means and what types of healing are supported through official institutional and unofficial channels.\textsuperscript{149}

This move toward a complementary framework comes out of recent theatre-maker thoughts on the relationships between HIV/AIDS institutions that I introduced in Chapter 9. Overall, theatre-maker discourse on complementarity is about determining what theatre does well, acknowledging what other forms of intervention do well, and recognizing the productive tension that results from their integration into a dynamic, connected, dialectic system. The rest of this section is dedicated to detailing the particular ways theatre-makers envision their place within the broader HIV/AIDS intervention industry in the country.

“By Your Bootstraps”: Ideological Shifts to Complementarity

Despite widespread recognition that applied theatre has been somewhat devalued in the country post-apartheid and strong feelings about dominant interventions and national entities not paying attention to their ideas, theatre-makers had remarkably little “us versus them” mentality during my time in the field. The most commonly voiced viewpoint strongly supported the idea of artistic interventions complementing, not replacing, biomedical and public health campaigns. The parallel contributions framework largely developed out of a reaction to the fact that HIV funding and structural support in South Africa tends to privilege two sets of intervention modalities (biomedical and public health promotion/education) over any others and also from past stymied efforts by theatre-makers to collaborate with representatives of other institutions, such as clinicians, Departments of Health, or government public health policy makers. These obstructed collaboration and funding efforts culminated in a sense of inevitability expressed by many theatre-makers: the notion that applied health artists should be able to count on the

\textsuperscript{149} This idea about opening up what “healing” means was first introduced in Chapter 5 and is elaborated in this chapter.
government for structural, resource, and ideological support of their intervention efforts but cannot do so in actuality.

This notion has led many theatre-makers into a bootstrap mentality best expressed through the idiom “if they won’t do it, then we must.” At its core, the complementary component of the Parallel Contributions framework is a movement in which theatre-makers advocate grassroots organizing and, to a lesser degree, activism around the simple idea that there are a range of modalities of intervention, and taken together, they all have points of connection and productive tension. Therefore, according to artists, institutional relationships within the HIV/AIDS intervention industry should be restructured to reflect that—including the funding in the country.

**Range of Service Modalities and Moving Beyond Antagonistic Division**

In a recent article on activism and civil society mobilization in the face of HIV/AIDS globally, Richard Parker (2011) delineates three major phases in ways HIV/AIDS-related NGOs and other civil society members have approached public engagement of HIV. In the first, there is initial intense activist mobilization in a country to combat social stigma, denial, and inaction on the part of governments and health officials. Second, he notes that from roughly the mid-1990s to mid-2000s, there was a growth in transnational activist movements that focused on issues of treatment access and health equity. This phase played a critical role in shaping global commitments to HIV treatment and service scale-up. The third phase Parker describes ranges from the mid-2000s to the present and is characterized by a fragmented global activist movement, in which some civil society sectors focus attention on implementation of treatment access and scale-up, while others attend to specifics of local struggles related to particular populations and policy concerns.
South Africa fits this model well. The country has a long history of human rights activism, and because of the high levels of mobilization during the anti-apartheid struggle, civic organizations are stronger than in some neighboring sub-Saharan countries. Although the cohesion, strength, and power of NGOs and the broader health activism movement weakened after election of the new democratic government, HIV/AIDS organizations still contribute significantly to HIV/AIDS dialogue on national and local levels (Schoepf 2001). With increasing HIV prevalence rates and international focus on South Africa’s AIDS epidemic, certain NGOs and AIDS campaigns have been identified as major players in the construction of AIDS discourse, the politicization of HIV, and national HIV/AIDS policy-making.

In South Africa, some of those key HIV/AIDS NGOs include activist grouping, such as the Treatment Action Campaign (TAC), the National AIDS Committee of South Africa (NACOSA), The AIDS Consortium, and The National Association of People Living with AIDS (NAPWA), as well as medical and public health scientists based in academic institutions or in NGOs dedicated to biomedical research into vaccines and mother-to-child-transmission of HIV/AIDS, including the Medical Research Council and major universities in Johannesburg, Cape Town, and Durban (Schneider 2002). Noticeably absent from this group of major players are representatives from the arts and culture sector.

As noted in prior chapters, biomedicine emerged in the early 1980s as the dominant paradigm through which to approach global HIV/AIDS problems, and biomedical interventions still command the majority of funding and prestige internationally (Parker 2001). This trend may clearly be seen when viewing activities of prominent HIV/AIDS NGOs in South Africa. Three of the most well-known (TAC, the AIDS Consortium, and Doctors without Borders) focus on providing or lobbying for biomedical care and creating education/awareness campaigns.
HIV/AIDS information campaigns, like those initiated by TAC, have certainly accomplished increased awareness in South Africa; my pilot research was filled with people discussing the ubiquity of biomedical HIV/AIDS knowledge and information on risk reduction. Those campaigns are laudable and necessary, but they forefront individual change instead of other kinds of intervention (e.g. structural or community). They also privilege access to biomedical information rather than any other aspect of HIV/AIDS that could be addressed, such as the more subjective, lived day-to-day experiences AIDS sufferers must navigate (and their associated emotional impacts). Richard Parker states it best:

It has become increasingly apparent that the idea of a behavioral intervention may in fact be a misnomer, since HIV/AIDS prevention interventions almost never function at the level of behavior but rather at the level of social or collective representations (Parker 1996). New knowledge and information about perceived sexual risk will always be interpreted within the context of pre-existing systems of meaning—systems of meaning that necessarily mediate the ways in which such information must always be incorporated into action. [2001:167]

Parker goes on to note that behavioral intervention programs have had limited success and mostly not had widespread impact. As theories of HIV intervention have matured over the decades, action has increasingly become seen as socially constructed and collective, and older behavior interventions have given way to ethnographically grounded AIDS programs that reconstitute collective meanings in ways that will promote safer sexual practice and therefore reduce HIV infection risk (Parker 2001; Altman 1994; Bolton & Singer 1992; Paiva 2000).

A major project theatre-makers are currently involved in, however, is reconsidering these foundational premises of what interventions should be doing. Instead of a focus on behavior change or even the shift to reconstituting collective meanings to promote safer sex, theatre-makers are widening the boundaries of what interventions interrogate and promote. Although advocating safer sexual practices in behavior and meaning remains important, they are starting to
move in very different directions. For instance, the idea of “dealing with” HIV/AIDS has become pervasive among theatre interventions. Instead of placing the majority of their energy into prevention agendas (although prevention remains important), theatre-makers are advocating acknowledging that a large percentage of the population is already infected, and the remaining population is affected by this epidemic. The idea is that something must be done not just to treat physical symptoms of illness or prevent new infections but to handle the psychosocial and emotional effects of HIV in lived experience\textsuperscript{150}.

According to theatre-makers, this widening of intervention modalities relates to paying attention to things like how HIV influences the way people think about their sexualities, sexual possibilities, and sex lives; trust within relationships; their ability and desire to communicate (or not) with others in the ways they want (versus how gender and social norms dictate); what their long and short term priorities are (and how sexuality, reproduction, and relationships with others fit into this); and whether or not people have the physical and emotional fortitude to be adequate caretakers of infected people in their lives. Other topics indicated as important by artists were how people cope with loss and grief; what people think about the kinds of programs and care made available to HIV positive persons; whether, how, and to whom people disclose HIV status; the kinds of anger, shame, trauma, or shutting-down people experience with rape in the country; the effects of everyday tension in the lives of Johannesburg residents as they simply wait for violent crime to happen in their lives or for HIV to make its way into their personal network; and a host of other subjective experiences, emotions, thoughts, and reactions to the epidemic. In addition, as noted in Chapter 8, theatre-makers are moving toward engaging with long-standing

\textsuperscript{150} This idea was first introduced in Chapter 6 on Acknowledging Incoherence.
debates about structure and agency by teasing apart with their audiences what kinds of power and ability to take action people have (or do not have) in their everyday lives.

How civil society engagement with HIV/AIDS will evolve in the future is an ongoing question in the field of global HIV/AIDS response. Parker (2011) notes that activist energy has increasingly been incorporated into the formal structures and institutions of the growing global AIDS industry, and this trend is likely to continue in the wake of the global financial crisis of the late 2000s. Key results of the financial crisis in South Africa have included increasing difficulty for NGOs to maintain independent political positions and voice political critique, changing donor priorities, and funding cutbacks. Parker notes:

As development cooperation agencies have reorganized their programmatic priorities, support for civil society efforts, and, in particular, for more politicized approaches to the epidemic, have been the first thing to go. Donors with a more technical (and sometimes technocratic) approach, such as the Gates Foundation, have increasingly come to dominate the field...a growing shift away from policy monitoring and critical dialogue and towards more technical implementation support appears to be a key tendency at the beginning of the fourth decade of the epidemic.

[2011:35]

My research findings anecdotally support Parker’s projections, and I would include artistic approaches in the group of politicized epidemic efforts that have seen decreased funding in the last decade. Mirroring global trends, South Africa’s AIDS industry has witnessed a protracted back-and-forth struggle over what kinds of programs, which methods, and what types of intervention are most appropriate for the country and should be funded. These practical and ideological struggles are played out within the media, at the levels of national and international governmental policy, in the private sector, and, through competition for funding, are implicated in stakes at the community and individual level.
Recognizing Difference and Connecting Disciplines

Most theatre-makers recognize the value of biomedical treatment programs and public health promotion campaigns, even if they disagree with how those programs are implemented in practice or the theories that undergird them (e.g. theories of rational choice and risk management). What they tend to argue is that artistic HIV/AIDS interventions provide valuable services that are not already a part of (or a valued part of) dominant health frameworks in the country. In essence, the general claim goes: what HIV/AIDS-related theatre offers is unambiguously different from current mainstream HIV programming and caters to or fulfills alternate needs in society. These “other needs” are often related to understanding subjective experience; fostering productive interpersonal relationships and communication; understanding and critiquing representations of illness, sexuality, health, and relationships in the media; and the complex under-layers of lived experience, thought, and action.

For many theatre-makers, the realms their programs address are different from biomedical and public health programs and include the inner world of the self, interpersonal relationships, and alternate ideas about what healing means. To a somewhat lesser extent, the focus is also a political one incorporating socioeconomic critique. By attending to these components of life, theatre-makers seek to fill a hole (deemed critical) they have identified within current national HIV/AIDS programming. The way they talk about their interventions is not as a replacement for other treatment, prevention, and care modalities but a complement to valued programs already in place.

This is not to say theatre-makers do not critique past and current prevention programming; they commonly do. However, the focus of this complementary framework is the simple recognition that arts-based programs have their own methods, theories of healing and
affect, and objects of intervention that are meant to complement other modalities. In some ways, the framework is a bid for both ideological and structural power on the part of representatives from the arts sector. They are saying theatrical interventions should be treated, valued, and structurally supported within the larger HIV/AIDS industry as a primary form of programming instead of relegated to the margins precisely because they have alternate program foci to which current programs are not well attending and because they make room for a broader range of ideas about what healing means.

Although this kind of reasoning was pervasive among my informants, very few of the groups with whom I worked had experience implementing these ideas in practice, which I noted in Chapter 9. Many had attempted to engage with formal structures for more long-term partnerships outside of one-off awareness performances, particularly local and provincial Departments of Health, but their efforts met with indifferent or disinterested reception. Two exceptions were Drama for Life and the women’s collective that performed the previously-mentioned production *Uhambo: Pieces of a Dream*.

The director of *Uhambo* made a concerted effort to work through community centers in Khayelitsha with the help of the Treatment Action Campaign and two other HIV/AIDS NGOs, WolaNani and Simbalela. In the UNIFEM-funded project, the collective identified and visited all the organizations that either worked with women or HIV in Khayelitsha, spoke with them about their project on HIV and violence against women, held meetings with presentations of

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151 This is not the case when it comes to educational institutions. Many of the groups in this project had formed partnerships with specific primary schools and regularly showcased productions at those institutions. Several community theatre groups also forged relationships with particular public health clinics in which they performed awareness skits. Where the groups often failed, however, was in trying to forge collaborations that were not premised on the arts component being used solely for education or awareness. When theatre-makers tried to highlight their other intervention possibilities and healing modalities, they were often met with resistance, skepticism, dismissal, or indifference by various governmental and international organizations.
project proposals, and out of that process, collaborations with three community organizations were begun. Volunteers from the organization were trained in participatory theatre methods and performed in taxis, schools, and clinics over a three month period and used the mobilization techniques they had learned from the performance collective to talk with people they met during and after performances about the production and its content.

The director of the group was adamant in reiterating, “We need to work with existing organizations so that it complements their work. We’re not, we don’t set out to replace what they’re doing, but rather complement what they’re doing.” She posed this complementary framework as an ideological commitment (to integrated collaboration with groups doing related kinds of work but with distinctly different points of intervention and intervention goals), as well as a practical one: it was easier to follow the impact of the project when participants were part of another formal organization and could be tracked through it.

Drama for Life is another example of an organization that made concerted efforts to align their program collaboratively with HIV interventions of non-artistic focus. Near the end of my fieldwork, faculty and staff members at Drama for Life were in active negotiations with a clinic and a set of medical doctors in the Limpopo Province to integrate their artistic methodology and psychosocial/emotional focus with the clinic’s more biomedical, physiological focus. Unlike the women’s collective who produced *Uhamb*o, the impetus behind Drama for Life’s project was more ideological than practical. The director cultivated a relationship with Ndlovu Care Group, which is based in the Ndlovu Medical Center in Elandsdoorn, South Africa. The center was founded in 1994 by Dr. Hugo Templeton as a medical practice to treat HIV/AIDS patients, but it has expanded into a multi-armed organization that tries to integrate with the local community at various levels. In this project, over the course of 8 months, DFL partnered with Ndlovu to
conduct community dialogues with small pockets of people using theatrical methods for both education of the general community and support of PLWHA. In our discussions, the DFL director mentioned that it was a switch to re-engage with clinicians and move away from theatrical theories of healing and change and back toward social behavioral communication models. When I asked how he envisioned that partnership, he stated:

It’s a re-engagement. I don’t fear [pause] I feel, I think you know, certainly for me, my own experience, and I feel like for my colleagues as well is that we’re secure in what it is that we’re doing. I think it’s about the engagement and I think if we, the work will only sustain if there’s collaboration and partnerships. And for me, then it’s about training our students and ourselves, reimagining how we tell the story of our work. How we explain, how we can partner and work effectively together. We don’t have to you know go, “this is my turf and that’s your turf,” kind of thing. So absolutely unnecessary.

And what’s interesting, like with Ndlovu Care Group, is that they do understand that and I think the joy and the discussions, the fact that they play the mavericks on behalf of the funders and the biomedical field and you know, in terms of language and sensibility and all of those things. But there’s an inherent understanding that culture and the processes of art can play a very critical role in healing people’s souls, and the reason why I say that is because you know, for instance Hugo Templeton will talk about how for him HIV and AIDS is not just about, not just driven by poverty, the material reality of poverty, but a poverty of the soul. It kind of goes back to what I was talking about earlier on in terms of self-resilience and well-being and all of that. You know. And that’s a medical doctor and someone who’s worked in that area for 20 years!

Warren articulates two points that are central to the complementary component of the parallel contributions framework. First, he notes that the artists are secure in what they are doing, and this connects back to the point I made about artist carving out their own turf in the growing AIDS industry in South Africa: although theatre-makers value biomedical attention to physiological aspects of human bodies, a large part of their concern rests with attending to more intangible responses to the epidemic. As the director notes, HIV and AIDS are not just about materiality; they are about the soul. Part of what theatre-makers attempt to do is attend to the soul while keeping it connected to the body and avoiding mind/body dichotomies in their actual
practices. Indeed, part of the recent goal of theatre-makers has been to better integrate embodied subjectivity with materiality within HIV/AIDS intervention frameworks.

Second, the director notes that the successful future of HIV/AIDS work in the country is only possible and sustainable through collaboration and program integration across treatment modalities. This is part of what he calls “reimagining how we tell the story of our work”: the complementary component to the framework moves beyond antagonistic turf divisions between public health, biomedicine, alternative, and artistic intervention efforts, and the end result is a narrative of maverick doctors and artists embracing each other’s work. The anathema is not about having a turf or doing one thing particularly well, it is rather about antagonistic and territorial interactions among different sectors. This is almost a directive from artists claiming—you (clinicians and biomedicine) heal their bodies, and we will (theatre-makers) work on their minds, thoughts, relationships, souls, interiority, emotions, feelings, and mind/body connection. Through this rhetorical move, no longer is theatre relegated to health promotion and education activities; it has become part of the country’s healing network in relation to HIV.

This shift in how theatre-makers conceptualize their place and role within the country’s broader HIV industry has largely come about because of recent forays by some theatre-makers into performance genres that privilege their own ideas about how healing and social change occur instead of relying on the underlying ideology of biomedicine. I assert this shift is occurring because of a change in the types of performance genres being used in the country, which include moving from more education-based forms of performance toward deeply reflexive, non-stigmatizing, and critical forms of performance (e.g. Theatre of the Oppressed, playback theatre, and dramatherapy).\textsuperscript{152} Those differences have very solidly shaped where

\textsuperscript{152} The difference between genres was discussed in-depth in Chapter 5.
theatre-makers see their place in the HIV/AIDS industry and how they see their relationship to other health sectors. This is a conceptual shift in the role, value, and place of applied theatre in the country’s HIV/AIDS efforts and an attempted practical shift in power.

This section has covered the complementarity component of the parallel contributions framework. In it, I have argued that theatre-makers are currently advocating a shift from more division-oriented HIV programming in the country (supported by historical trends in funding at a structural level) to a complementary model that recognizes and values multiple intervention modalities and their possibilities for productive interaction. Theatre-makers note that the range of healthcare needs related to HIV must be addressed simultaneously, through the use of a host of intervention techniques, approaches, theories, and methods, rather than in the piecemeal fashion privileging biomedicine offered under the current National HIV/AIDS Strategy.

This concept is not a novel or ground-breaking one; however, it is a way of approaching interventions that is often overlooked or dismissed by policy-makers, governments, and funders on the assumed pragmatic basis of limited funding and program resources. It is also often dismissed on the grounds that interventions such as applied theatre are peripheral support programs for biomedically-based initiatives instead of primary modes of healing and social change in their own right. In their book Righteous Dopefiend, Phillippe Bourgois and Jeff Schonberg make a similar observation in relation to the treatment of heroin addiction when they note:

Different modalities of treatment and services are effective for different people at different times in their careers of drug use and homelessness…A wide diversity of treatment and social support models needs to be made available to drug users, ranging from one-strike-you’re-out abstinence to harm reduction, methadone maintenance, buprenorphine detox, heroin prescription, and subsidized employment initiatives. [2009:302]
Theatre-makers have begun actively voicing a similar opinion. This is about recognizing and foregrounding the idea that different intervention modalities and concepts of healing exist, reach people in different ways at different times in their lives, and should be integrated into a complementary network of strategies for attending to the dynamic span of needs that result in people’s lives from experience with HIV.

In order to create more successful HIV programming in the country, theatre-makers are beginning to advocate working collaboratively with other institutions within the broader AIDS industry in the country, even if they do not fully agree with the tactics and strategies of those other organizations. Part of this vision involves re-thinking institutional relationships in order to shift the divisive, territorial, dismissive, or just plain indifferent attitudes among various practical and theoretical approaches to HIV intervention toward a complementary model that recognizes multiple modalities of healing and change, values diversity in practices, and supports the productive tension that can be found in places of contradiction and ideological difference between approaches.

**Boundary-Crossing**

“Drama has the power to enlarge our frames of reference and to emancipate us from rigid ways of thinking and perceiving.” – Cecily O’Neill (1996)

A second major discourse employed by theatre-makers to shift their institutional positioning is related to the notion of crossing boundaries. Theatre-maker ideology behind recognition of multiple modalities of intervention and healing reflects some of the larger concerns of the following fields and extends some of their constructs and models: performance studies, interdisciplinary studies, and boundary studies. In particular, one overlapping sphere of theoretical interest between theatre-makers and scholars within these bodies of literature is the dynamic structure of life.
The fluidity and dynamism of life are noted areas of concentration for performance studies scholars (Schechner 2013; Bial 2004). I first discussed theatre-maker attention to fluidity and dynamism in relation to the shifts in aesthetics covered in Chapter 5. While changing the aesthetics of productions is a practical way to accommodate the kind of dynamism theatre-makers privilege, attention to dynamism also becomes important at the level of discourse. Theatre-makers explicitly focused attention on the idea that sociohistorical and political economic contexts change over time, as do individual lives. This focus on dynamic contexts is not limited to considerations of larger structures and forces at work in a society; artists are also preoccupied with how community dynamics or individual lives can change instantaneously through life experiences—expected or unexpected.

Theatre-makers recognize that there has been considerable political economic movement in South Africa since democratization and claim that national levels of HIV intervention programming are not keeping up with these contextual changes. In addition, they note that while treatment of physical bodies and prevention programs through education and awareness were critical during the first decade after democratization, these narrow past approaches to ideas about treatment, care, and prevention programs should to be opened to accommodate consideration of new health needs related to HIV that have developed over the last decade.

Interdisciplinarity is posited by theatre-makers as one major answer for introducing dynamic responsiveness to interventions at the national level. A finding of my research was that many current theatre-makers accept mutability as a fundamental premise of lived experience and

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153 As a side note on the relevance of fluidity and dynamism within emerging applied theatre practices, I would like to suggest that consciously or not, this emphasis by theatre-makers on valuing diversity in methods, techniques, and genres reflects the commitment to valuing diversity exhibited in the country’s post-apartheid Constitution. Coupled with the pervasive media narrative of the Rainbow Nation, this framing inevitably invokes the specter of Multiculturalism, the value of which is a commonly debated topic in South African media and among theatre-makers.
practice. For theatre-makers, interdisciplinarity is envisioned as a combination of ranging broadly to draw on a range of theoretical and methodological tools to create fluid, responsive programs and a philosophy of complementarity that values the integration of diverse intervention modalities. For instance, an emeritus professor based formerly at the University of KwaZulu-Natal and still affiliated with the Drama for Life program at Wits University states:

I think the program is open to a variety of theoretical input. I think drama by its very nature is interdisciplinary. I mean, we’re dealing with people, so we draw ideas from all over the place. We draw ideas from gender studies, we draw ideas from sociology, we draw ideas from politics, we draw ideas from philosophy, we draw ideas, we’re now concerned with health. You know, so I think for theatre academics there’s always been a sense that we need to be alert to what the thinking is in a variety of disciplines, and to steal and use and appropriate what is useful to us.

This idea of being comfortable with easily appropriating theory and methods from a variety of disciplines comes, in part, out of her performance studies background, and most other artists felt similarly. In essence, for theatre-makers, this is an ideological commitment to interdisciplinarity borne of and answering a practical need for national HIV programming to better respond to its population’s increasingly diverse health requirements.

In some ways, this philosophy of interdisciplinarity is an epistemological project. It is a commitment to exploring any and all forms of knowledge about intervention strategies that may be able to reach different people at different times in their lives. In addition to coming from performance studies, this commitment to interdisciplinarity is related to the projects of interdisciplinary studies and recent developments in the study of boundaries in the social sciences (boundary theory).

The growing field of interdisciplinary studies prioritizes the breaking down or interrogation of institutionalized disciplinary boundaries, how crossing these borders may be accomplished, and what kinds of new, productive knowledge or approaches are created by
thinking across and through the interstices of disciplines. The focus is on synthesis of
disciplinary theory, perspectives, research methodologies, and affective strategies in order to
create approaches to academic and practical problems that are more complex and multi-faceted
than those produced from single disciplinary perspectives. Theatre-makers (and others) have
argued that the intersections of HIV, AIDS, sexuality, subjective experience, love, care, and
illness are areas in which such inter- or multi-disciplinary approaches are necessary, since the
objects of study span a number of fields.

In addition, boundary theory plays a role in theatre-maker ideology behind the parallel
contributions framework, which is a style of intervention that promotes and tries to develop a
relational perspective. Boundary theorists have also expressed interest in relationality as a
fundamental social process and a perspective that can be constructive in subtly changing the way
we think about difference, sameness, and hybridity. Some of the theatre-makers with whom I
worked explicitly linked their practical and ideological projects to the growing interest in the
study of boundaries within social sciences and performance studies over the last 20 years.

The concepts “boundaries” and “borders” have gained increasing salience within the
social sciences. They have been associated with research on social and collective identity,
cultural membership, cognition, racial and ethnic group positioning and rights, gender inequality
studies, and professionalization and knowledge production, among other themes (Lamont &
Molnar 2002). I attend to boundary research within the latter topic, professionalization and
knowledge production, because it provides several analytics through which to understand how
and why the parallel contributions framework has become so important to theatre-makers in
South Africa. I also reference this field, since one of the primary ways theatre-makers frame
their ongoing contributions to the HIV/AIDS industry is through rhetoric about “boundary crossing.”

The interest within the social sciences on boundaries has a long history, and recent attention to borders has been a renewal of this interest. Scholars within boundary studies tend to distinguish between symbolic and social boundaries, which can provide a useful distinction for thinking about the ways theatre-makers talk about the importance of disciplinary boundaries and of traversing them. Symbolic boundaries are those conceptual distinctions made by people to categorize objects, people, practices, kinds of knowledge, and other areas of social life. Symbolic boundaries are mediums through which people struggle over and come to agree upon definitions of reality, acquire status, monopolize resources, separate others into groups, and compete over the production and institutionalization of different systems of classifications (Lamont & Molnar 2002). In contrast, as sociologists Michele Lamont and Virag Molnar note, social boundaries are “objectified forms of social difference manifested in unequal access to and unequal distribution of resources (material and nonmaterial) and social opportunities…only when symbolic boundaries are widely agreed upon can they take on a constraining character and pattern social interaction in important ways” (2002:168-169). According to Lamont & Molnar (2002), symbolic boundaries exist at an intersubjective level and are necessary but not sufficient for the existence of social boundaries, which tend to manifest in material inequalities.

One of the findings of my research is that theatre-makers are involved in an interesting back-and-forth between constructing symbolic boundaries\(^1\) to delineate what kinds of healing and intervention work their programs do in relation to other AIDS industries and intervention institutions and transgressing boundaries or using play/drama as mediums through which to test

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\(^1\) Regarding epistemologies; groups of people; types of affect; and ideas about the kinds of questions they ask and variation in objects of study of their work as differentiated from other disciplines.
boundaries between disciplines as part of their philosophical commitment to interdisciplinarity. This back-and-forth was about interrogating difference and sameness between types of HIV programming and theories of intervention and playfully testing out or experimenting with what points of commonality or complementarity might be found between them. In other words, it was about finding out how they relate to each other and what productive practices for intervention could come out of those relationships.

Another finding of my research was that this interrogation by theatre-makers of the articulation between symbolic and social boundaries in HIV programming was about reframing HIV intervention at the national level as a political issue related to what kinds of ideas about healing and what/whose health priorities were given structural and ideological support and which frameworks were ignored. This is related to boundary literature on professions, work, and scientific knowledge. In this literature, the term “boundary work” was coined by sociologist Thomas Gieryn (1983) to describe discursive practices through which scientists attempt to distinguish themselves from other perspectives and erect authoritative boundaries around their own work, methodologies, and claims to monopolize epistemic credibility (Lamont & Molnar 2002).

In effect, boundary work can be seen as a credibility contest through which disciplines compete for jurisdictional monopolies over some topic or, in the case of HIV interventions, over a growing industry related to healthcare. Through boundary work, some points of view are valorized, some silenced, and difference becomes institutionalized through political decision-making. In their ubiquitous talk of overcoming “turf wars” and “us-versus-them” thinking, theatre-makers express their frustration and experiences with being on the “losing” side of such credibility and authority struggles over the past 30 years of HIV programming in the country.
I maintain that certain narratives are being deployed as a strategy by theatre-makers to challenge the epistemic authority of biomedicine, including discourse characterizing past HIV programming in the country as static and rigid and discourse pointing to the failure of approaches to the epidemic that privilege only one or two intervention paradigms (e.g. biomedicine and public health). However, what is useful to note within theatre-makers’ response to their past marginalization within HIV programming and healthcare, is that they do not sanction discrediting past modes of intervention but promote the focus on parallel contributions that I have discussed in this chapter. Their programs are not meant to replace biomedical or health promotion ones but to broaden the possibilities for and ways interventions are understood in global programming. Rather than an either/or framework, theatre-makers are advocating a turn away from binary thinking towards a both/and perspective that embraces multiple modalities of intervention and healing at once.

The kind of epistemic boundary work Gieryn (1983) discusses is important at a structural level because it often dictates who and what kinds of programs or perspectives receive important material and non-material resources to support their goals, values, priorities, and projects. In effect, theatre-makers are involved in a bid to increase their cultural capital and, with it, their structural power and position within the country’s AIDS industry. This is about making the symbolic and social boundaries between disciplines permeable in order to enact social change in the power status of the applied theatre industry—to garner more resources, ideological power, and value, as well as to promote certain projects of artists, such as expanding definitions of healing. Rather than using the concept of boundaries to solely explore or enforce the notion of difference, theatre-makers are employing the idea of boundary crossing to conceptualize disciplinary boundaries as productive places for producing new kinds of relational knowledge.
about and possibilities for HIV interventions. Divisions between theories and approaches simply become spaces for the creative interrogation of similarities, productive tension, and communication between disciplines.

10.4 Challenging Dominant Notions of “Progress” and “Success”

A second important way theatre-makers are speaking back to institutional forms of control over their experiences producing health-related art is by actively challenging dominant metrics for defining and measuring “progress” and “success” within HIV/AIDS-related interventions. The struggles I outlined in Chapter 9 over funding and determining what kinds of interventions are most appropriate for South Africa’s present context also extend across the board to considerations about what constitutes valuable impact within HIV programming and what success and healing within interventions mean in the present. The previous chapter was premised on the idea that applied health theatre is an industry into which national and international monetary funding is being channeled for HIV prevention, treatment, and care programs. While there is established evidence for this premise, a corollary idea is that applied health theatre should be a funded intervention. This second notion is still heavily debated among people who hold the resources and power to determine HIV policy and is often couched in a quantitative way: how many people hear the message, and how many people’s behavior does it change? This was noted in Chapter 9 through one theatre-maker’s account of discussions at the most recent National AIDS Conference in South Africa.

Rather than asking questions about how much theatre is produced in the country, how many people see HIV/AIDS plays, or whether artistic health interventions accomplish the goals of biomedical agendas, I consider a more productive research question to be what does applied theatre do or accomplish at all? This question avoids preconceived expectations, and I used it in
my fieldwork. Theatre-makers in the country have begun asking similar questions and moving away from offering ideas about progress that reify notions of success within biomedical and public health paradigms. Instead, I argue that they are starting to contribute a wider array of ideas about possibilities for metrics of success than has been dominant within global health intervention efforts and literature to date\textsuperscript{155}.

I consider this a major practical and theoretical implication of the shift towards a parallel contributions framework. One of the significant findings of my research is that theatre-makers are currently actively engaged in speaking back to funders and policy-makers about the priorities, goals, and value of their work in the HIV/AIDS field. There was widespread recognition among the theatre-makers that current monitoring and evaluation procedures were slanted toward capturing data on behavior change to the exclusion of any other kind of outcome or impact, and their attempts to placate funders on monitoring and evaluation were compromising their ultimate artistic integrity and crippling the possibilities for real, substantial impact the programs could have.

This general trend was captured in the words of one NGO artist. She said one day, “Look, we’re not okay with this anymore. These M&E criteria don’t capture the reality of what we do, and it’s time to re-think what’s possible within HIV work and what the overall goals for

\textsuperscript{155} Despite my description of what success means within programs in this section, these issue mostly from my own observations and analysis. The terms “success,” “progress,” and “impact” were rarely well-described within theatre interventions, which is one considerable problem with trying to determine impact of these kinds of interventions. While artists actively recognized the need to redefine these terms/concepts, they do not often operationalize them in any codified, explicit way. This leads to problems. One in particular is that when I asked theatre-makers to define impact and success, they often simply resorted to vague terms to describe what productions do, such as “engage” the audience. It was only when I pushed much harder for them to define those vague terms (i.e. “engage”) that they started to operationalize what impact and success mean. Most people struggled with defining these terms, even though they appeared to have a very strong sense that theatre did \textit{something} of critical importance.
impact should be. Or can be. This became an especially important point of contention for theatre-makers, since they acknowledged the strong difficulties in measuring behavior change. This conceptual shifting is one of the main ways applied theatre is contributing to broader HIV/AIDS efforts in the country and one of the ways I consider it possible for applied theatre to contribute to global HIV/AIDS efforts. Theoretically, this is exciting because the move toward integrated, boundary-blurred practices within health theatre leads to an attendant change in metrics for what constitutes meaningful progress and success in HIV/AIDS interventions.

**Moving Toward Different Metrics of Success**

In one of several formal interviews with the Director of Drama for Life during the year I spent affiliated with that organization, I asked him about the relationship between health-related theatre, their funders, and notions of impact in the country. Before I could even finish my question, he jumped in to say:

"I think we’ve been battered and mutilated in some respects by funders. The funders have a very dry, scripted mode of reporting that often does not reflect the quality of the human interaction [arts programs have]. I think we need to find new ways of talking about the work, we need to start finding ways in which we feel comfortable about how our work is spoken about and how we report on our work. It requires a language, you know. For me, I think there’s a kind of quality of research that needs to be incorporated. We need to look towards things like performance ethnography and action research methods that allow for the personal voice to emerge, that allow for deeper critical reflection, that have self-reflexive modes and try to find ways to incorporate that into monitoring and evaluation. I also think multi-media technology offers us huge scope and we need to be given more space for documentary film-making and incorporating that into interacting with the audiences."

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156 Although this was the commonly expressed idea in relation to monitoring and evaluation, it was not unanimous. Some theatre-makers were still very interested in figuring out strategies to develop current monitoring and evaluation criteria to better capture affect, emotion, cognition, and behavior. This perspective was more about finding ways to make monitoring and evaluation of existing ideas of impact (behavior change) more accurate rather than moving into the framework of redefining what success and impact within theatre interventions means.
Here, the director mentions the need to find new language to talk about the kind of work theatre accomplishes in people’s lives, particularly vocabularies that reflect the quality of human interaction arts programs promote. For the director, personal voices are important, as well as fostering the capacity for deep, critical reflection within interventions. Finding ways to incorporate these aspects of artistic health efforts into monitoring and evaluation of program impact are described as challenging but necessary.

A ubiquitous theme I heard during fieldwork about the impact of health theatre programs is that they promote introspection and spreading thoughtfulness. Warren’s words reflect this idea, and the ideas of two members of the NGO AREP: Theatre for Life reiterate his focus. In part of her interview, one of the co-artistic directors of AREPP (Brigid) talked about her opinions of how the South African government engages with healthcare in general and HIV in particular. She said:

The thing with this government, see, is the need to have tick boxes and to be able to show impact and numbers. It’s much easier for them to be able to say we’ve set up 14 clinics and fixed up so many hospitals and distributed so many ARVs. I find in many cases, people in government can’t see the bigger picture at all. It’s more than just education, more than how many people we taught about condoms. But they don’t seem to see the value of developing thinking individuals. We come out of a system with far older people within the government structures who think they can tell people what to do and people will listen. Ha! So if you’ve done however many abstinence programs and seen X number of people, you can tick that and it’s done and it works. They don’t buy into the more airy fairy concept of developing people’s self esteem and self efficacy and abilities around finding information. But it’s so important. Theatre does that. We do that.

For Brigid, the “bigger picture” of impact is about developing thinking, critical individuals who are able to assess their lives, opportunities, and constraints. This strongly echoes the focus on critical reflexivity I outlined in Part Four of the dissertation, and other theatre-makers invoked the same or similar ideas. In speaking of the impact of AREPP in the lives of the primary and
secondary students for which he performed every day, Martin*, a 20-year-old Coloured South African, stated:

Look, from what I’ve seen, AREPP does seem to have quite an impact. I mean I suppose the only impact you can really hope for is to get these young people to think about the things that we say to them, and I suppose if in the debate afterwards, any of the issues are raised by them, then that is a lot. That’s a big achievement—just to get them to actually think about these things. If they are actually thinking about these things, and if we can spark debate amongst them, and they go home and talk to their friends or family about it, then that’s definitely a good, recognizable impact. And I think over the years, AREPP has done a lot as far as spreading thoughtfulness on some of the issues.

In all three discourse excerpts, there is a clear, direct link between the idea that it is as important to engage people’s minds, bodies, and emotions in critically reflecting on HIV/AIDS as it is to treat their physiological symptoms. This focus reiterates Elizabeth’s concerns from the chapter’s opening vignette.

For theatre-makers, reaching vast numbers of people with biomedical fact-based information is not the only important consideration; equally important in the contemporary moment is prompting audience members simply to think deeply about their lives, material situations, and emotional states. In addition, I found that change in public meaning, discourse, and social imaginaries are more important to some theatre practitioners than behavior change.

Despite strong cohesion in theatre-maker ideas about changing the definitions of success within program monitoring and evaluation, artists did recognize the difficulties in producing such metrics. In an interview with Valerie*, a 35-year-old Zambian woman who currently produces theatre in South Africa, I asked her what she thought the impact of her own work was. She had the following to say about the limitations of theatre in thinking about impact:

Okay, alright. [laughs] I wish I knew. So, talking in the development field again, I think there is increasingly an understanding, an acceptance that theatre is powerful, that it can convey information in a way that other media can’t. Emotionally, and so on a variety of levels—it’s visual, it’s emotional, so you have that empathy link. It’s also in Africa very, well not specifically in Africa, it’s closely allied with indigenous forms of ritual or
whatever you, you know song and dance etcetera. I think along with that realization is a growing danger for the medium to be abused. And I think there’s a need for practitioners to be discerning about the kind of work they take on and also to be more active in, I hate this phrase, but educating the donor. [laughs] As to what, you know, too often they’re like—right, we need a play, and this is what we want you to do, and this is the script we want you to put on. And it’s like, no no no no, we need to do it our way! [laughs]

I don’t actually think it is that difficult to measure the impact of theatre, but I think people don’t do it. I think we’re lazy about actually assessing. Well, obviously it’s hard to assess behavior change and things like that, but I think we don’t do enough to assess what the longer term impact is. If it could be followed-up with other more practical things, I think that could be really powerful. And it really is about that collaboration, so when I say “educating the donor,” the reason I hate that phrase is because people use it very flippantly, but I think that if there was a strong understanding of what theatre can do and what its limitations are, and to couple it with actual, practical assistance—simple stuff like transport, I mean transport is a big deal in some areas, in urban areas it’s costly, or to say okay here’s a performance, and then just practical, usable information, like sign-posting for where the nearest VCT center is or whatever it might be. If it’s coupled with simple, obvious strategies, that would be powerful.

In this interview passage, the theatre-maker echoes several points I have made in this chapter.

First, she talks about the need for changing the relationship between artists and donors in order to create better artistic health interventions, and this change has to do with recognizing what theatre does well, in addition to its limitations—so, delineating boundaries for what theatre can accomplish. Second, she notes that once those boundaries for theatre have been delineated and the relationship between artists and donors restructured to allow theatre to do what it does “well,” she notes that coupling the artistic intervention with other kinds of programming (such as providing logistical help and transport for people in need and linking to neighboring voluntary testing and counseling centers) in a complementary way would increase the power of this kind of HIV programming effort. Finally, she discusses how outside structural influences (in this case, a donor) often attempt to sculpt the content and aesthetics of applied health theatre, which she considers an encroachment upon her artistic integrity. Laughingly, she states, “No no no no, we need to do it our way!” This idea of doing it “our way” was common among theatre-makers, and
it had to do with rethinking the possibilities of theatre interventions outside of behavior change models.

Practically speaking, the people who make applied health theatre in the country are moving toward the view that biomedical initiatives are necessary but not sufficient to address the various ways in which HIV/AIDS affects physical, mental, and emotional health. Many theatre-makers are starting to characterize their work as a complementary approach of integrating biomedical and arts industries. A variety of performance theories of health, healing, and change are becoming established in current artistic practices. This contrasts with the first decade of post-apartheid applied health theatre interventions, in which art was primarily coopted for biological theories of healing and change.

For theatre-makers, “impact” has become not only health information dissemination but also a social process involving critical reflection on the psychosocial, emotional, and structural factors associated with lived experience of HIV/AIDS. “Success” and “progress” for HIV programming have come to mean different things within the theatre programs I studied. For many theatre-makers, a successful intervention was one built from a foundation of interdisciplinarity, and its success was measured through (1) how well it could adapt to the needs of its audience in real-time, (2) how well it integrated in a complementary fashion with other types of interventions, (3) whether it took into consideration dynamism on structural levels and within the day-to-day lives of individuals, (4) how open it was to accommodating a wide range of ideas about what healing means\textsuperscript{157}, and (5) whether it allowed its audience to engage with the intervention in \textit{the way they want and can} rather than being prescriptive about \textit{how to engage}.

\textsuperscript{157} In general, theatre-makers were consumed with the idea of expanding definitions of healing, recognizing and allowing for different modalities of healing, and creating the space for that multiplicity to exist. As I noted in Chapter 5, the different definitions of healing and health were expanded in various perspectives to include the idea
Something else I noticed in the field is that often theatre-makers talked about what they considered successful HIV plays in the same breath they discussed the importance of putting considerable thought and planning into the content, goals, aesthetics, and associated theatrical affect techniques of the production during its creation. However, theatre-makers rarely made the explicit link between defining as successful a program that had been well-conceptualized and that exhibited a strong aesthetic. In my experience, from both a theatre-maker standpoint and from what I heard among audience members, some of the most “successful” productions were exactly the ones that made very strong aesthetic choices. Despite whether audience members liked those artistic choices or not, the productions with the strongest aesthetics were the ones to which people paid attention, talked about with me and their friends, and remembered over time.

Where I see the real application potential of this underlying ideology of rethinking what progress, success, and impact mean is in the simple idea that progress is linked to shifting away from binary thinking. This movement away from binaries becomes a valuable goal in itself within theatre interventions and their associated practices. With this shift away from binary thinking comes a form of reflection, intervention, and framing that is more capable of dealing with life’s complexities than polarized forms of thought. I develop this idea on the relationship between binary thought, complexity, and health theatre in the dissertation conclusion.

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of healing and health as a social process; health as quality of life and well-being; and healing as integrating fragmented bodies, minds, and emotions into a whole person. This reflects preoccupations within the broader Parallel Contributions framework with ideas of not separating things out or being divisive—healing is seen as a deep kind of “keeping together.” This is also related to the Greek concept of Eudaimonia, which is the linking of the idea of health to “human flourishing” and well-being rather than health solely as a physiological state of being. In all of these ideas discussed by theatre-makers, health is not a state of being. Both health and healing are processes.
10.5 Conclusion

By reframing applied theatre as a main category of analysis and a primary institution involved in the HIV/AIDS intervention sector instead of an ancillary component of other programs, I have suggested it becomes possible to delve into the ways applied theatre and its participants intersect with other parts of the healthcare industry. In its relationship with other institutions in the country, the arts sector’s animating ideology, goals, impact, possibilities for knowledge production, and the experiences of its participants (both theatre-makers and audience) are alternately regulated, controlled, enabled, constrained, shaped, inhibited, and molded in a variety of ways. Theatre-makers respond to outside institutional forces and influence by creatively engaging with the structures that shape their work.

Rigorous and systematic analysis of the effects of structural violence (or even structural influence) on the theatre sector is not a strength of performance studies scholarship in contemporary South Africa. Medical anthropology, with its focus on political economic analysis and ethnographic methods, is particularly useful in interrogating HIV/AIDS performance. It uses a framework that highlights, by direct observation, the dynamic interactions between politics, economy, health, art, and activism in the lived reality of those involved in the applied health theatre sector.

The methods and theory of medical anthropology allow a framework that enables analysis of four important components of the health theatre industry. First, it is possible to

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158 This assertion may be legitimately questioned when considering the theoretical underpinnings of writing by Brazilian theatre director Augusto Boal, German playwright Bertolt Brecht, and performance practices that draw heavily on Paulo Freire’s critical pedagogy. These theorists focus on creating critical aesthetics for use within theatre practices, and activist theatre more broadly is often highly critical of social structures and politics. However, few performance studies scholars in contemporary South Africa focus on systematically and critically evaluating the context in which art is produced. Exceptions include playwright and activist Mike van Graan, who contributes to academic writing on how neoliberal ideology, changing political structures, and the economy affect the production of theatre in South Africa.
examine what kinds of relationships and interactions participants in the applied theatre sector have with broader institutions and industries implicated in HIV/AIDS programming and policy-making in the country. Second, information is revealed about how these interactions shape the possibilities for and context in which art related to HIV/AIDS is produced. Third, ethnography enables understanding of what relevance applied health theatre has in the lives and experiences of involved participants. Last, anthropological analysis facilitates understanding what happens when theatre-makers begin to engage with and speak back to the powerful influences other institutional forces have on their artistic work, vision, and integrity.

It is in the creative negotiation that comes from working at the interstices of disciplinary boundaries and from this speaking-back to power by theatre-makers that I find the most opportunity for elucidating the other side of the equation: what performance studies has to contribute to medical anthropology. In this chapter, I analyzed a variety of ways theatre-makers have begun speaking back to the forms of institutional power and control that I introduced in Chapter 9. In particular, I argue that theatre-makers have begun deploying certain ideologies and discursive topics as a bid to gain cultural capital, structural power, and material resources within the broader HIV/AIDS intervention industry in the country. These topics include narratives about creative economy, interdisciplinarity, complementarity in programming, and program frameworks that privilege the parallel contributions of multiple modalities of treatment, prevention, and care rather than narrowly supporting biomedical notions of health.

The parallel contributions framework is a response by theatre-makers to the kinds of institutional marginalization they often experience within the broader healthcare industry in South Africa. It is an ideological commitment to avoiding antagonistic, divisive, and territorial disputes between different intervention agendas and an active encouragement of recognizing and
structurally supporting the ways disparate programs fit together productively. I argue that this perspective is about opening up the possibilities for interventions—what they can do and accomplish—by incorporating more strategies, broader goals, alternative tactics, and rethinking institutional relationship possibilities. In addition, I argue that discursive use of a parallel contributions narrative by theatre-makers is a way to make the symbolic and social boundaries between intervention models permeable in order to promote certain projects of artists, such as expanding definitions of healing. This framework, ultimately, is an argument for deep interdisciplinarity in HIV/AIDS intervention programming globally, and this argument is a practical one based on a few foundational premises related to theories of health intervention.

For many current theatre-makers who look at the landscape of HIV intervention efforts in South Africa, they see antagonistic programming often fragmented along disciplinary lines and mired in funding competition. The parallel contributions framework leads to restructuring ideas about how a variety of intervention sectors relate to each other, and it comes out of theatre-maker assertions that theatre is not (or is no longer) simply the use of meaning, symbol, and the arts to heighten the efficacy of biomedical programs but is a primary site of valuable intervention, healing, and treatment modalities in its own right. Artistic approaches to HIV are considered complementary to biomedicine and public health efforts rather than secondary or peripheral.

Practically, this framework is an attempt by theatre-makers to link with some of the agendas of interdisciplinary studies, harm reduction models, and alternative/complementary healing to develop a fluid, responsive theory of intervention—one that is experimental and uses creative risk to integrate a wide variety of available ideas, tools, theories, and resources. It is a movement to learn from past failures and fix them—through blurring disciplinary boundaries, mixing strategic approaches, and attempting to better accommodate dynamism and fluidity in
life. The parallel contributions framing is premised on a philosophical shift away from and
dissolving of binary either/or thinking and an attendant shift toward inclusive both/and thinking
based on a fundamental premise that recognizes different healing modalities and privileges their
active incorporation.

In this framework, the critical importance of physiological health and the biomedical
interventions that attend to it are equally important and valid in the HIV intervention landscape
as are other types of interventions that focus on psychosocial issues and the importance of
meaning, representation, expression, emotions, interpersonal relationships, and reflective
thinking in ideas about healing. This framework also proposes an intervention style that is less
concerned with resolving absolutely tensions between conflicting ideas, programs, and methods
and rather concerned with a dialectical examination of the points where those components/fields
intersect and complement each other: the focus is on locating and heightening points of
complementarity rather than wrestling with and fully abating tension. This is a space for
exploring creative possibility, not limitation.

Examining these underlying philosophies of multi-modal approaches and
complementary forms of intervention help in conceptualizing what this new framework looks
like on the ground. I posit that the way theatre-makers are thinking about trending in their HIV
efforts provides a model of intervention that is not restricted to South Africa but may have
application and relevance in other affected regions globally. In addition, the ways theatre-
makers are trying to incorporate multiple approaches in their work in some ways mirrors (or
answers) anthropological calls for more integrated health interventions. This is a space where
people are actively and creatively trying to experiment with alternatives to decades of past
intervention practices (the notion of Creative Risk reappears here). This is also a space where
theatre-makers are trying to play with the boundaries between institutional relationships within the HIV intervention sector and advocate thinking of them as a branching network of equally integral forms of prevention, treatment, and care. Finally, I suggest that one of the main ways theatre-makers are creatively speaking back to institutional power and struggles over funding and sector positioning is by challenging hegemonic metrics of “progress” and “success” within interventions as a way to effect social change.
I entered fieldwork with grand expectations of a nonstop year of ethnographic research into artistic health practices in the country. I thought I would be documenting a wide variety of theatre styles related to health. I was going to tell the world the story of how genre differences in theories of healing and social change affected audience members’ and theatre-makers’ ideas about HIV, health, sexuality, and everyday experience of illness. I expected to attend plays every weekend and rehearsals daily because my pilot research led me to believe applied theatre-making was a ubiquitous practice across urban areas of South Africa. After all, there were more than 100 community theatre groups in Soweto alone and numerous others at mainstream and institutional levels. During pilot research, many artists talked about the pervasiveness of health-related theatre in the country and how issues related to the AIDS epidemic had dominated issue-based art for the last decade.

When I landed in Johannesburg for my first day of fieldwork, I was unprepared for what I actually witnessed in practice. What I saw on the ground looked very different from the picture painted during pilot studies. Looking around, I saw a fragmented arts sector. Many of the applied health theatre-makers I met seemed frustrated with national health promotion campaigns, and they characterized past styles of intervention as ultimately unsuccessful. They pointed to the country’s continued high HIV prevalence rate and widespread levels of “AIDS fatigue” as signs that past efforts had failed the general population somewhere along the line.

In a period of deep reflection on past HIV programming, the artists were figuratively scratching their heads in bemusement, not quite sure what to do, and trying to figure out what had gone wrong. A majority of the artists with whom I worked began heavily advocating for
creative innovation in HIV intervention strategies. Conversations about what that innovation might look like increased, along with experimentations putting it into practice. I held tightly onto the goals of my original project for longer than I should have. After much prodding by artist friends, I finally let those goals go and realized there was a different story to tell about the applied theatre industry as it relates to health in South Africa.

In the opening vignette of this manuscript, a community theatre director described his experiences within the health-related applied theatre industry. Akhona said, “This country needs new ways of talking about HIV. Everyone is bored of the old ways, and no one listens, but the government just keeps putting money into the same old programs that don’t work. And us, the artists, we have new things to say, new stories! People will listen! But things keep us down.” His words capture the trajectory of what I have covered in the preceding chapters. In this dissertation, I have told the story of a group of theatre-makers spread across the country who are trying to revitalize the way HIV/AIDS interventions are conducted at national and local levels in the face of perceived past failures of health communication, promotion, and intervention campaigns.

In Parts One and Two of the dissertation, I discussed the historical, political, economic, and ideological factors that led to artistic critiques of past biomedical and public health HIV initiatives in South Africa and prompted a period of reflection on the place of the arts in healthcare. I explicated the reasons why theatre-makers consider past HIV health promotion attempts a failure and outlined the kinds of past public health policy and programming to which artists react so strongly.

In Parts Three and Four, I introduced and analyzed the kinds of innovation and creative risk theatre-makers are attempting within HIV programming. I focused on the aesthetics and
ideology behind theatre-maker demands for the development of new intervention frameworks. This included discussing the theories of healing and performance on which artistic beliefs about health intervention are based and how those theoretical premises differ from the ideology of former (dominant, global public health) paradigms. In addition, I detailed what kinds of framework changes are being developed in and advocated by some members of the arts community. I analyzed the language, optics, and processes theatre-makers are starting to incorporate into their intervention work on HIV/AIDS and how these changes reflect broader shifts in their ideas about the possibilities for health programming in the post-apartheid period.

In Part Five, I provided an anthropological critique of theatre as an institution within the broader healthcare industry of South Africa. This part of the dissertation told the story of how power and oppression articulate within the artistic sector and shape the uneven ways in which ideology is operationalized in practice. In particular, I argued that attending to the institutional control of experience and knowledge production within applied health theatre enables analysis of the ways through which organizations choose to convey their ideology, how those choices of form reflect politics, and what theatrical content reveals about NGO support or critique of the status quo. I also analyzed the ways in which artists are starting to speak back to institutional forms of power that shape their work. I argued that theatre-makers are marshaling discourses of interdisciplinarity, complementarity, and parallel contributions as a bid to gain cultural capital, structural power, and material resources within the broader HIV/AIDS intervention industry in the country. I also argued that theater-maker focus on parallel contributions as an intervention framework provides a route for introducing new possibilities for what “success” and “progress” mean within global HIV efforts.
11.1 Dissertation Contributions

A primary goal of mine is the development of productive theoretical and methodological frameworks for coping with HIV/AIDS globally through the integration of performance studies and medical anthropology. Key questions that have structured my thoughts on the contributions of this dissertation are what would consideration of the applied theatre industry contribute to medical anthropology, and what would anthropological analysis contribute to the field of performance studies or theatre-making in South Africa? How can ethnographic analysis of artistic institutions revitalize the kinds of questions asked within the social sciences about health, illness, sexuality, and HIV?

A major contribution I make in this dissertation to the fields of anthropology and performance studies is the generation of ethnographic data on an understudied component of global public health programming: the arts sector. Another contribution I make is the development of constructs, language, and frameworks for augmenting the ways in which the social sciences attend to lived experience of HIV and the AIDS epidemic through incorporating select conceptual ideas used by the theatre-makers with whom I worked.

Scholarship and Ethnographic Data

Academic scholarship related to the global use of applied theatre in HIV/AIDS interventions has increased over the last 10 years. However, published works are written primarily by performance studies scholars and practitioners. In relation to South Africa in particular, a large number of peer-reviewed journal articles exist that cover the topic of health-related theatre. However, these are primarily located within journals of public health, (health) communication studies, and performance studies. No other ethnographic work on this topic exists for South Africa, although there are a limited number of anthropological publications on
health-related theatre for other parts of sub-Saharan Africa (e.g. Frank 1996 and Barz 2006 for Uganda; Heap & Simpson 2005 for Zambia; Poehlman 2008 for Malawi).

In addition, although studies have been published that address the increasing importance of HIV/AIDS plays in the spread of public health knowledge, there is not a complementary body of literature analyzing how such productions act as a space to forge continued political reflexivity on structural violence in democratic South Africa. This is particularly unusual, since South Africa arguably has the most developed theatre industry on the continent, including the most developed infrastructure devoted to the arts of any country in sub-Saharan Africa.

Because little systematic focus within the social sciences has been directed to applied health theatre, scholarship is needed that expands on the ways artistic institutions intersect with healthcare systems. A contribution of my project is the production of ethnographic data on applied theatre as it relates to health intervention projects. This is particularly important considering the dearth of data on this topic within medical anthropology.

**Interdisciplinary Engagement: Integrating Medical Anthropology and Performance Studies**

A broad argument I make in this dissertation is for greater interdisciplinary engagement between the fields of medical anthropology and performance studies. In addition, I argue for an active reframing of the way “performance” is conceived and theatre studied within anthropology in general and medical anthropology in particular. Within anthropological attention to “drama” and “performance” in the past, these two concepts have been employed primarily as metaphors for the study of everyday life. Within the few extant anthropological analyses of applied artistic HIV intervention campaigns, theatre is often relegated to secondary status and analyzed as a variable intended to increase efficacy of biomedical prevention programs (Conquergood 1988; Glik et al. 2002; Rossiter et al. 2008).
In this dissertation, I have argued that applied health theatre is an important component of art as a social institution in South Africa as well as part of the healthcare industry. Instead of employing theatre as a metaphor or analyzing it as an auxiliary support to biomedical programs, I argue in this dissertation for the analysis of applied theatre as a primary institution in relation to other institutions involved in HIV/AIDS intervention efforts. I suggest this intentional reframing of applied health theatre as an institution in its own right provides a route through which the fields of medical anthropology and performance studies may be productively bridged.

**Elaborating “Context”**

One way I argue medical anthropology can contribute to performance studies is through bolstering attention to considerations of political economy and structural violence in relation to arts industries. Despite the claims of performance studies scholars that the field is already attentive to the social contextualization of the arts (e.g. Conquergood 2013), most of the writing I have encountered in the discipline falls short of the kind of rigorous political economic analysis that forms the basis of theoretical approaches within critical medical anthropology. I suggest anthropological considerations of political economy and structural violence provide an opportunity to ground analysis of theatre in particular historical contexts and highlight the ways in which institutional relationships and power shape the efforts of applied theatre-makers to engage with social issues. In South Africa in particular, artistic health programs on the ground have been severely mitigated by structural constraints, despite myriad conceptual breakthroughs in possibilities for intervention innovation. Ethnographic methods offer the potential to illuminate the structural factors that limit possibilities for implementing in practice the kinds of conceptual innovation occurring at the level of discourse.
Tools for Integrative Ethnography

In addition to providing opportunities for more grounded political economic analysis of performance mediums, I argue that integrating medical anthropology and performance studies leads to new questions within the social sciences about health and social change and an expansion of ways to understand the interaction of micro- and macro-processes at work in AIDS epidemics. In particular, insight is enabled into the effects of HIV/AIDS within communities and in individual people’s lived experience, as well as the creative responses front-line health workers develop to mediate between global public health agendas and the particularities of local health needs. This intersects well with emerging agendas in medical anthropology.

Recent advances in the anthropology of HIV/AIDS recognize the power of the political economy framework for understanding the structural and historical factors that shape experience, but a growing number of studies pose new questions about understanding social suffering and lived experience of the epidemic, engagement in therapy processes, and community response to mobilization efforts. Since the early 2000s, there has been growing recognition of an integrative analytic framework within the anthropology of HIV. This framework is championed by scholars such as João Biehl (2009) and Philippe Bourgois (2009) and eschews the binaries of past discipline separatism.

The goal is to actively produce frameworks for research and analysis that are more deeply inter- or multi-disciplinary and integrate a broad spectrum of methods, techniques, and approaches for studying public health topics. This framework tries to sidestep common past methodological tendencies within medical anthropology (intentional or not) to dichotomize analysis of individual subjects versus macro-social determinants of disease. Instead, advocates of the framework suggest finding ways to bolster ethnography’s ability to combine subjectivity, intersubjectivity, lived experience, political economy, historical analysis, considerations of
semiotics and discourse, and attention to embodiment and affect in an actively holistic analysis that attends to the very real complexities people experience in everyday life.

Work on the development of this framework answers long-standing disciplinary calls within medical anthropology for the integration of materialist and interpretivist approaches to research on health (and HIV in particular). However, questions remain about how to operationalize these calls for interconnected research and analysis in practice. João Biehl and Adriana Petryna (2013) extend this call and suggest a need to focus on people in everyday practice in order to answer the “how”—by privileging their complexity and their knowledge.

I situate my work within recent integrative ethnography and contribute to this framework by suggesting some possibilities for answering that “how.” I argue that analysis of applied health theatre and the performance ideologies that underpin its grounded practice is a productive site for answering this call for operationalization. Because HIV/AIDS theatre is situated at the nexus of politics, art and performance, education, health, and social movements, it provides a space in which structure, discourse, biomedicine, and subjective experience may be probed.

My research builds on these advances in the study of HIV/AIDS by offering some tools, frameworks, and theoretical concepts to augment integrative attempts within medical anthropology. In particular, I suggest consideration of applied theatre and the performance theories of healing, social change, and affect that buttress it provide constructs and language for attending to experiential, deeply personal, subjective, embodied, and emotional aspects of lived experience in a country where a majority of the population is already affected by HIV.

**Complexity Ethnography**

In this dissertation, I push one step further Biehl and Petryna’s (2013) call to focus on people in everyday practice and privilege their complexity and knowledge in our efforts to build
integrative ethnography. I actively engage with the concept of “complexity” in this project. A main argument of mine is for the need to push the parochialism of common social science ideas about what “complexity” means and center the concept as an analytic in relation to health. In my dissertation research, I found that this term was understood and deployed in specific ways by the artists with whom I worked. I have presented ethnographic data for a grounded analysis of what complexity means to artists and taken those local understandings of complexity as the basis for theorizing.

Within global attention to HIV, biomedical and public health approaches to programming have dominated the intervention landscape. Anthropological considerations of the political economy of health and structural violence have provided an important counterpoint to these two intervention models. While the artists with whom I worked recognized the important contributions of biomedicine, public health, and anthropology to the study of HIV/AIDS, many also put forward the idea that something additional has been missing from scholarly framing of HIV and creation of programs for prevention, treatment, and care. In their ruminations on what could be missing, theatre-makers tended to posit two major points as important to consider in future attention to HIV in South Africa.

First, they note that focusing intervention efforts primarily on prevention and biomedical treatment programs misses the point that HIV is already a significant component of lived experience for almost a quarter of the population who are HIV positive. They suggest that what is needed in the country in tandem with biomedical care are programs that help people deal with the kinds of subjective chaos that come from being infected or having loved ones who are affected. Second, many artists note that provision of pharmaceuticals for physiological treatment, bolstering knowledge about HIV risk and transmission, and recognizing political
economic structures that constrain or enable health outcomes are very important components of HIV programming. However, artists often situate these three approaches within the realm of "the known." They assert these approaches make certain assumptions about people as coherent, logical subjects and the worlds in which they live as relatively stable, or they focus on structural levels of analysis that sometimes elide subjective and emotional components of lived experience.

In contrast, theatre-makers have become concerned with a realm of human experience they index as the “complexities” of life. In relation to HIV in particular, this term invokes the ways in which people experience their lives as incoherent and how this realm of experience affects health outcomes. The artists with whom I worked consider this realm an important but missing component of most global public health attention to HIV.

As a result, some theatre-makers in the country have begun advocating for intentional public health consideration of existential incoherence within HIV programming efforts. Artists are advocating for the addition of considerations of existential incoherence to intervention modalities that have historically privileged physiological treatment of individual bodies, biomedical health promotion and communication agendas, and structural remedies to widespread health inequality. I argue this is a subtle but important shift in thinking about HIV intervention possibilities.

Artists are not simply advocating for the addition of common psychosocial components to HIV programming. Instead, they are calling for addressing the ways in which people experience their everyday lives as not-fully-understood. Rather than being primarily about the "known," this perspective is also about engaging the not-fully-known. Theatre-makers are trying to create language, frameworks, processes, and programs that allow people to freely talk about
parts of their lives that are confusing and often stigmatized within dominant intervention paradigms.

I argue that analyzing how theatre-makers are engaging with the not-fully-known offers some conceptual tools and vocabulary for adding this component of lived experience into the equation when scholars discuss HIV programming and the effects of AIDS epidemics globally. In particular, in this dissertation I have focused on seven such constructs that were privileged within artistic attention to HIV/AIDS during my fieldwork: complexity, incoherence, moments, shadows, acknowledgement, reflexivity, and consociated subjectivity.

At their core, all seven constructs are associated with finding productive ways to accommodate, consider, access, frame, and talk about within HIV intervention models people’s everyday lived experiences of incoherence that either can or do affect their sexualities and health. These constructs are used by artists in an attempt to either probe this realm of experience for greater understanding or provide people ways to be comfortable within incoherence if they are not ready to engage with it. This intentional, directed, systematic engagement with analyzing lived experience of incoherence is rarely as robust in many other disciplines because there are few options within the social sciences for vocabularies to talk about it, methods to access it, or theoretical frameworks to understand it. In some ways, it is an inherently troublesome area of inquiry: how do you talk about or get someone else to talk about the things in their lives even they do not understand (or sometimes, even want to understand)?

Although it is a difficult thing to study, some theatre-makers are positioning it as the next critical step in developing more effective HIV intervention programs globally. Adding intentional consideration of incoherence will not solve HIV/AIDS intervention problems
worldwide, but I agree with the artists with whom I worked that it is a necessary step in the right direction. I go through the contributions of each construct in the discussion below.

**Constructs of Complexity**

“Complexity” was a local term used by theatre-makers to index the parts of people’s lived experiences that affect their health outcomes, are not fully understood by the people who experience them, and have not been defined or codified in academic discussion of public health in any systematic way. This local term was used by theatre-makers to gloss a wide range of actions, thoughts, and feelings that are not “dealt with” in conventional public health programs but often affect the outcomes of such programs. I argue that this concept is valuable for its intentional framing of this influential realm of daily lived experience, which is often elided within dominant forms of HIV programming. It positions experiences of incoherence as an explicit focus of intervention interrogation.

“Incoherence” is a word I have used in this dissertation to describe the range of things theatre-makers called “complex” in life. While the term “complexity” is evocative, it is not very descriptive. There were five major categories of “complexities” in life that artists discussed regularly in relation to health, sexuality, and HIV. The common denominator of this wide range is that they were all about some form of existential incoherence (something that is not clear or easily understood). I find this construct particularly appealing because it captures the nuances theatre-makers try to introduce in considerations of complexity.

Colleagues of mine have suggested that other terms like “self-awareness disconnect” may be more useful. However, such a term implies that people should mine themselves for awareness and be connected inherently as a whole. Theatre-makers are trying to move away from such prescriptive assumptions. While they, too, consider self-awareness a valuable and important
intervention goal, they recognize it is not always a realistic one. In addition, they sometimes find incoherence and subjective fragmentation productive within health processes and ideologically support allowing people to live their incoherence if that is what an individual needs at the time.

“Shadows” is a construct of complexity that has strong relevance within theatre-making. It introduces a starting-point for talking about possibly-stigmatizing-things in non-stigmatizing ways. Shadows are the things people do, feel, and think that hover at the edge of understanding. Artists note that these things may or may not be problematic. Regardless, they affect people's health outcomes and therefore should be part of public health conversations. In essence, discussion of shadows brings these issues “to light” (i.e. into the theatre space for examination). This construct provides a vocabulary word and framing device for talking about existential incoherence within public health without moralizing overtones.

“Moments” is another important construct of complexity used by theatre-makers as a vocabulary word and analytic framing device for thinking through the temporal aspects of existential incoherence. Theatre-makers note that most people experience moments of incoherence in their lives. Artists recognize that “moments” become integral in conversations about sexuality and health because single moments have the ability to change meaning and lives. I argue that using this term intentionally and explicitly is a way to insert into public health discussions considerations of temporality. It provides a way to talk about people as health subjects without assuming they are always rational or always irrational: people experience moments of both coherence and incoherence in their lives, both of which can affect their health. The construct is important because it foregrounds the idea that people's lives, experiences, and identities are fluid.
In addition, I argue that the “moments” construct provides a way to problematize the prevention/treatment dichotomy common in global public health rhetoric and practice. Theatre-makers use “moments” as one possible way to subvert this pervasive dichotomy and as a basis for stronger considerations of harm reduction practices. While the “moments” construct is closely related to the concept of harm reduction, it pushes the limits of the harm reduction model. Whereas harm reduction is related to mitigating problematic issues in the now, the “moments” construct is used by theatre-makers to more deeply integrate the present with considerations of the past and the future. In essence, theatre-maker focus on moments is part of an effort to bridge the prevention/treatment divide by refashioning temporal focus within intervention practices.

“Acknowledgement” is put forward by theatre-makers as a health intervention process. Acknowledgement as a process is about three things. First, it involves actively recognizing that shadows exist in people’s lives. Second, it allows these shadows to become part of public health practice and dialogues in non-judgmental ways. Third, it provides a way to accommodate the fact that some people are not ready or able structurally to engage with common intervention agendas when programs are implemented in communities.

The term "acknowledgement" is also used intentionally by artists as a non-stigmatizing way to deal with a host of actions related to sexuality that are often framed as problems within the media and some national public health campaigns in the country. Rather than constructing the kinds of actions, perceptions, and categories of being indexed by “shadows” as problems to be fixed, theatre-makers promote acknowledging the existence of shadows in a value-neutral space devoid of moralizing good/bad discourse. Acknowledging shadows is a way theatre-makers try to open space for consideration of individual and social change without necessitating it in moralist terms or falling back on reductionist framings of individuals as socially determined
by the contexts in which they live. In this way, acknowledgement as a health process disturbs
the kinds of dichotomous intervention framings that are so often put into practice at national
levels.

“Reflexivity” is a second health process important to theatre-makers. During my
fieldwork, many artists were engaged in a practical critique of the scope and techniques of
reflexivity implicit in common educational and health communication paradigms. They drew on
the notion of reflexivity to re-conceptualize what kinds of reflection are important within
HIV/AIDS intervention programs. In addition, they positioned these new ideas about reflection
as a form of health activism for the post-apartheid era. Rather than operating through an
“awareness” model based narrowly on gaining cognitive knowledge of HIV risk factors and
modes of transmission, artists were moving toward a more critically engaged way of thinking
about the articulation between HIV and an individual's life, interpersonal relationships, actions,
thoughts, feelings, and political economic context. A critical component added by artists is
consideration of existential incoherence: reflexivity becomes a process of asking people to start
thinking about their shadows in order to see if anything can or should be done about them. Last,
artists use the concept of reflexivity to expand definitions of health. In this framework, health is
positioned as a way of thinking and form of reflection rather than a static state of being.

Finally, “consociated subjectivity” is a concept that reflects the theoretical and practical
utility of reflexivity as a process elaborated by artists. Through shifts in the way artists
incorporate considerations of incoherence in their health interventions, they are actively
developing and promoting a form of health subjectivity based on critical reflexivity around the
relationships between self, society, structure, and agency. In the way it is conceptualized by
artists, reflexivity provides a route to subtly but importantly shift the individual/community
dichotomy tacit in many global public health outreach programs by challenging neoliberal conceptions of the responsible health citizen.

This kind of health subjectivity is an attempt by theatre-makers to produce a more socially contextualized health-seeking subject than the individual constructed within health programs based on classic neoliberal ideas about personal responsibility. It is based on a foundational sensibility within the arts that encourages people to recognize and deeply consider the very real and complicated ways in which people’s emotional lives interact with their cognitive rationalities and embodied selves to produce lived experiences that are not always coherent or straightforward.

To "consociate" means to connect or bring something into relation. I suggest artists are trying to bring into relation equal consideration of structural constraints, social relationships between people, cognitive knowledge of biomedical systems and risk factors, and everyday lived experience of existential incoherence on individuals as health subjects. This kind of subjectivity adds to social science scholarship on “individual” health subjects and attempts to add practical consideration of people’s shadows to health intervention efforts.

In summary, theatre-makers in South Africa actively workshop and experiment with ways to capture and deal with the complexities of HIV/AIDS in lived experience, as well as the political economic contexts that shape such experience. In some instances, they make progress. I argue that a very important point of progress theatre-makers contribute to HIV programming is a focus on providing more nuanced alternatives to historically problematic dichotomies that have long held sway within HIV/AIDS studies, such as prevention/treatment, individual/community, structure/agency, known/unknown, and right/wrong. In particular, I find valuable the seven
constructs I have discussed in this dissertation. They work together to contribute five major things to both scholarship about HIV/AIDS and practical intervention efforts on the ground.

First, they answer interdisciplinary calls for expanded health communication styles and intervention goals. Second, they provide an intervention space that is attentive to nuance and can handle incoherence, a language to talk about it, and strategies for dealing with it. Third, they offer a way to move away from problem-framing within programming and toward non-stigmatizing intervention practices. Fourth, they work together to introduce an alternative health subjectivity to neoliberal biocitizenship in South Africa. Finally, they offer possibilities for moving away from binary forms of thinking. They emphasize the synergy between often polarized concepts (e.g. prevention and treatment practices) and provide routes for rethinking or displacing other conceptual binaries that have defined first-wave responses to the AIDS pandemic in the last 30 years.

11.2 Future Lines of Inquiry

I made the decision in this dissertation to foreground analysis of the ideology, theory, aesthetics, language, styles of communication, affective technologies, and intervention practices on which recent theatre-maker attempts at innovation in HIV programming in South Africa are based. I also focused on a political economic analysis of theatre as a primary component of the broader healthcare industry in the country and included considerations of knowledge production and meaning-making. However, I consider other avenues of analysis and writing equally important for understanding the full scope of the broader implications of research into the intersection of artistic practices and healthcare systems.

In particular, I intend to develop in future writing more robust considerations of the articulation between gender, ethnicity, and class within the applied health theatre industry. In
addition, I have a large body of data on representations of illness, sexuality, and health within theatre productions. I intend to use this material for articles that analyze constructions of HIV within the arts as well as how theatre participants respond to those representations and what effect they have on broader HIV/AIDS activism. The ethics that surround applied theatre practices provide an additional route of inquiry. Ethical components are critically important to consider, especially when they are combined with the kinds of deep vulnerability in talking about health-related issues artists ask of their audience members.

Finally, there are important real-world impacts and high stakes involved in public health funding at national and international levels. The impact of programs on targeted audiences is a major concern to potential donors. As such, further research on audience reception of artistic practices would prove particularly useful in analysis of the applied theatre industry and health communication programs more broadly. Although I have provided ethnographic data on the production side of applied health theatre, there were intractable problems with the audience component of my original project. Because of the way many performances were structured, there were significant logistical obstructions to accessing this population. While this does not preclude academic focus on audience reception, it necessitates attention to developing methods for research with this population. This is a component of media and performance research that has stymied artists, health communication scholars, and public health practitioners for years. It also stymied me during fieldwork for this project, but I have every intention of reengaging the reception component of various technologies of communication when I return to South Africa for postdoctoral research.
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Dumestre, Gérard, and Seydou Touré

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Fox, Hannah


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Freire, Paulo


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National Lotteries Board of South Africa  

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Van Heerden, J.  

Van Hollen, Cecilia  

Van Vuuren, Petro Janse  
Wardlow, Holly  

Werner, Anne, Lise Widding Isaksen, and Kirsti Malterud  

White, Mike  

Whittaker, Andrea M.  

Wilson, Anika  

Whyte, Susan Reynolds  

Wood, Kate and Helen Lambert  

Wood, Kate, Helen Lambert, and Rachel Jewkes  

Worden, Nigel  

World Health Organization  

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Wouters, Edwin, HCJ van Rensburg, and H. Meulmans

Youde, Jeremy

Zheng, Tiantian
Appendix A

TABLE 1: Video Footage Collected (29 HIV/AIDS-related theatre productions):

<table>
<thead>
<tr>
<th>Name of Production</th>
<th>Geographic Region</th>
<th>Type of Theatre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iago’s Last Dance</td>
<td>Grahamstown</td>
<td>Commercial</td>
</tr>
<tr>
<td>Bafana, Bafana</td>
<td>Cape Town</td>
<td>Commercial</td>
</tr>
<tr>
<td>Foreign AIDS</td>
<td>Western Cape</td>
<td>Commercial</td>
</tr>
<tr>
<td>I Am Here</td>
<td>Cape Town, Johannesburg</td>
<td>Commercial</td>
</tr>
<tr>
<td>Rampage</td>
<td>Johannesburg</td>
<td>Independent</td>
</tr>
<tr>
<td>Infectious</td>
<td>Johannesburg</td>
<td>Independent</td>
</tr>
<tr>
<td>Paulina</td>
<td>Cape Town (Nyanga)</td>
<td>Community</td>
</tr>
<tr>
<td>HIV/AIDS Play</td>
<td>Johannesburg (Soweto)</td>
<td>Community</td>
</tr>
<tr>
<td>Look Before You Leap:</td>
<td>Johannesburg</td>
<td>NGO</td>
</tr>
<tr>
<td>Hanging</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Look Before You Leap:</td>
<td>Johannesburg</td>
<td>NGO</td>
</tr>
<tr>
<td>No Way</td>
<td></td>
<td></td>
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<tr>
<td>What is in the Box?</td>
<td>Johannesburg (Hillbrow)</td>
<td>Community</td>
</tr>
<tr>
<td>HIV/AIDS Play</td>
<td>Cape Town (Khayelitsha)</td>
<td>Community</td>
</tr>
<tr>
<td>Late Lunch</td>
<td>Johannesburg</td>
<td>University</td>
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<tr>
<td>Traditional Healing Ceremony</td>
<td>Johannesburg (Soweto)</td>
<td>Community</td>
</tr>
<tr>
<td>The New Struggle</td>
<td>Cape Town</td>
<td>Community</td>
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<tr>
<td>HIV Choral Skit</td>
<td>Johannesburg (Soweto)</td>
<td>Community</td>
</tr>
<tr>
<td>HIV/AIDS: In It Together</td>
<td>Johannesburg (Braamfontein)</td>
<td>University</td>
</tr>
<tr>
<td>Deep Night</td>
<td>Johannesburg (Braamfontein)</td>
<td>Independent</td>
</tr>
<tr>
<td>I Think It’s Hamlet</td>
<td>Johannesburg (Braamfontein)</td>
<td>Independent</td>
</tr>
<tr>
<td>Masibambisane Youth</td>
<td>Cape Town</td>
<td>Primary School and Community</td>
</tr>
<tr>
<td>Festival: HIV/AIDS (10 productions)</td>
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</tbody>
</table>

Additional Filmed Footage: DFL Sex Actually Festival 2010 (University, Community, NGO, and Independent Theatre)

<table>
<thead>
<tr>
<th>Name of Production</th>
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<tbody>
<tr>
<td>In the Tearoom</td>
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<tr>
<td>Deep Night</td>
</tr>
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<td>Lover &amp; Another</td>
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<tr>
<td>Fear of Stigma</td>
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<tr>
<td>Dramatherapy</td>
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<td>Ncamisa! The Women</td>
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<tr>
<td>Festival Interviews</td>
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<td>No Go Area</td>
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<tr>
<td>Stories of Transformation</td>
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<td>-----------------------------------</td>
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<tr>
<td>Clowns without Borders</td>
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<tr>
<td>Missing</td>
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<tr>
<td>Hopes and Dreams</td>
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<tr>
<td>Sexy Comedy at Goethe</td>
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<tr>
<td>I Am Here</td>
</tr>
<tr>
<td>Pillow Talk</td>
</tr>
<tr>
<td>Ungasabi</td>
</tr>
<tr>
<td>Happy Period</td>
</tr>
<tr>
<td>Blankets of Shame</td>
</tr>
<tr>
<td>Hi, I’m Gay</td>
</tr>
<tr>
<td>It’s about Time</td>
</tr>
<tr>
<td>Not Enough to be Arrested</td>
</tr>
<tr>
<td>Wedding Day</td>
</tr>
<tr>
<td>Blow</td>
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</table>

**Scripts Collected:**

<table>
<thead>
<tr>
<th>Name of Script</th>
<th>Type of Theatre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Look Before You Leap: No Way</td>
<td>NGO</td>
</tr>
<tr>
<td>Look Before You Leap: Hanging</td>
<td>NGO</td>
</tr>
<tr>
<td>Iago’s Last Dance</td>
<td>Commercial</td>
</tr>
<tr>
<td>Is It Because I’m Jack?</td>
<td>Commercial</td>
</tr>
<tr>
<td>HIV/AIDS Play</td>
<td>Community</td>
</tr>
<tr>
<td>HIV/AIDS and Rape Production</td>
<td>Community</td>
</tr>
<tr>
<td>Skrop Laap</td>
<td>Community</td>
</tr>
<tr>
<td>For Fact’s Sake!</td>
<td>Commercial</td>
</tr>
<tr>
<td>Auditioning Angels</td>
<td>Commercial</td>
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<tr>
<td>Foreign AIDS</td>
<td>Commercial</td>
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</tbody>
</table>
### TABLE 2:
Total SA HIV/AIDS & TB Spending Activities—All Sources (2007/08-2009/10)

![Figure 13: Total SA HIV/AIDS & TB Spending Activities - All Sources (2007/08-2009/10)](image)

Source: Draft NASA Report 2012 (UNGAPR 2012)