Exclusionary inclusion and the normalization of biomedical culture

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Abstract This article offers a postcolonial critique of the Foucaultian literature on neoliberal governmentality. Although the Foucaultian approach to neoliberalism moves beyond market fundamentalism to indicate how governance operates through knowledge regimes, relations of force and technologies of the self, it nonetheless serves to normalize a culturally Western paradigm of the body. Drawing on extensive ethnographic research conducted with people living with HIV/AIDS in two squatter camps in contemporary South Africa, this article argues that the public provision of antiretrovirals constitutes a shift from roll-back to roll-out neoliberalism, instigating a new regime of biomedical citizenship. Structural obstacles often impede marginalized populations from embodying the biological technologies of the self required of them to access citizenship rights. As such, biopolitics blurs into thanatopolitics at the threshold of citizenship, constituting a new form of exclusionary inclusion. But this contractual citizenship is *also* a tool of empire – a means of normalizing biomedical hegemony at the cost of indigenous conceptualizations of the body and health. This article argues, then, that there are both structural and cultural constraints to the imposition of neoliberal rationalities of rule, which have significant implications for the possibilities of resistance.

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Introduction

Pheello Limapo¹ moved to Johannesburg in 2001 in search of work. In 2003, he found out he was HIV-infected when his wife, Elizabeth, tested positive

¹ The data in this article draws from a larger project for which I conducted 30 months of ethnographic research in one formal township (Soweto) and two informal settlements (Lawley

while she was pregnant with their first child. Pheello never did find work, but he was able to access a disability grant because of his HIV-positive status. The disability grant is one of several social welfare grants provided to South African citizens who cannot work to support themselves (Seekings and Nattrass, 2006).² Different assessment criteria are used in different provinces, but ‘a general rule that applies in most hospitals and clinics throughout the country is that an individual with a CD4 count of ≤ 200 , which is roughly associated with clinical Stage 4 AIDS, meets the clinical criteria for receiving a disability grant’ (de Paoli *et al.*, 2010, p. 7). When I first met Pheello in 2005, this grant (which at the time equaled approximately US\$100) had to support his entire family for the month – it was the only ‘income’ on which they could rely.

Pheello was an activist with the Treatment Action Campaign (TAC), a social movement that mobilized on behalf of people living with HIV and AIDS to fight for the public provision of antiretrovirals (ARVs), the biomedical treatment for HIV/AIDS.³ Pheello was a part of this struggle and was one of the first people to get into the treatment program in 2005. When Pheello began taking ARVs, his immune system was strengthened and his CD4 count rose above 200. At this point, he was no longer eligible to receive the disability grant, and the government canceled it. It has become *de facto* policy, that poor, HIV-infected South Africans must ‘choose’ *either* social subsistence *or* life-saving medication.⁴

The TAC and the AIDS Law Project (ALP)⁵ have recently asked the Department of Social Development to consider replacing the disability grant with a chronic illness grant, which would no longer punish AIDS sufferers (by refusing them state support) for being on ARVs, but rather *require* them to be on ARVs in order to receive state support.⁶ In other words, HIV-infected South Africans would have to be enrolled in the state’s ARV program to become eligible for a chronic illness grant. I argue that this change in policy is illustrative of a broader shift in the global governance of health.

and Sol Plaatjie) outside of Johannesburg. I conducted focus group discussions with 250 people, including community stakeholders in each community, people living with HIV/AIDS, indigenous healers and home-based care workers. I conducted multiple in-depth interviews with 165 people in my different research sites, including people living with HIV/AIDS, home-based care givers, NGO staff, nurses and doctors, indigenous healers, spiritual healers, activists and government officials. Those subjects whose names are used in this study have consented to the use of their names. All other participants’ identities remain confidential.

² There is no social welfare provided on the basis of income or indigency in South Africa; there are only social welfare programs for the elderly, vulnerable children and people with chronic illnesses.

³ In popular parlance, antiretrovirals are referred to as ARVs or ART (antiretroviral treatment).

⁴ A CD4 count of 200 is also an eligibility requirement for the government ARV roll-out programme (see Nattrass, 2006; Hardy and Richter, 2006 for a discussion of these policies).

⁵ This organization is now referred to as Section 27.

⁶ Interview, male ALP lawyer, 30 June 2009, Johannesburg (see also ALP, 2010).

Political economy theorists have noted a significant transformation in neoliberal governance over the past 30 years. The 'roll-back' neoliberalism (Peck and Tickell, 2002), which was characteristic in the 1980s, was defined by an active destruction of Keynesian-welfarist interventions and the deregulation of the market. This form of neoliberalism led to growing inequality, a series of recessions throughout the world and widespread public protest – from Seattle, to Chiapas, to Johannesburg. In response, neoliberalism was reconstituted. The 'roll-out' neoliberalism of the so-called 'post'-Washington Consensus era retains its economic bottom line, but buttresses it with attention toward institution building, civil society participation, good governance, social safety nets and poverty eradication (*ibid.*). 'Roll-out' neoliberalism ushers in a new means of governing populations, which emphasizes self-determination, self-responsibility and an entrepreneurial spirit (Rose, 1999). In order to encourage and even teach civility and self-reliance, citizenship rights are often contractualized – requiring the adoption of disciplinary behavioral norms (*ibid.*).

In this article, by bringing this analysis of neoliberal governmentality to bear on considerations of health governance in the global South, I argue that there has been a significant shift in post-apartheid health policy from the necropolitics (Mbembe, 2003; Foucault, 1990; 1997) of 'AIDS denialism' to the biopolitics of ARV provision. Due to this shift, marginalized populations have been thrown life lines, which allow them a very tenuous hold on the body politic and its rights to citizenship; however, they are constantly at risk of losing their hold because of a series of structural obstacles they must overcome and a whole host of disciplinary cultural norms to which they must adhere. As such, I argue that citizenship rights, in the neoliberal era, are not only contractualized but contingent on the embodiment of behavioral norms, which serve to normalize biomedicine and instigate disciplinary cultural constraints on the practice of indigenous healing. Drawing on extensive ethnographic research conducted with people living with HIV or AIDS in two squatter camps outside of Johannesburg, I show how people in informal settlements often cannot or will not assume the biomedical technologies of the self required to take ARVs either because of structural obstacles associated with squatter conditions or because the regimen includes a rejection of indigenous healing. What this case makes clear is that there has been a shift in the technologies of exclusion in the neoliberal era. As populations are governed through freedom and self-responsibility, exclusion no longer needs to be managed through institutionalization. Now, inclusive mechanisms (like the provision of social welfare) coupled with the privatization of blame constitute a new politics of death 'under the very sign of the administration of life' (Butler, 1996, p. 73). I argue this constitutes a form of 'exclusionary inclusion' (Agamben, 1998). This shift in exclusionary processes also conceals an underlying cultural imperialism at work as the biomedical body becomes the means through which postcolonial subjects can access the rights of citizenship. My argument thereby unveils the intricate links between neoliberal and biomedical

expansionism, the effects of the political economy of peoples' subjectivities, and the importance of considering both the structural and cultural implications of power.

I begin by reviewing the scholarship on neoliberal governmentality, explaining how it must be augmented from a postcolonial perspective. The article then traces the shift from roll-back to roll-out neoliberalism in the South African context, arguing that it served to biomedicalize citizenship rights. This was accomplished in part through international intervention but also through a series of crises in state legitimacy. My ethnographic data illustrates the corporeal disciplinary requirements associated with ARV provision and how this institutionalization of biomedical citizenship has served to privatize welfare responsibility and provisionalize rights. I then show how the subjects of these new forms of exclusion challenge the erasure of their cultural identities by pushing back against biomedicalization which has interesting implications for our conceptualization of both embodiment and resistance.

Neoliberal Governmentality and the Normalization of Biomedical Culture

This article develops a postcolonial critique of Foucaultian approaches to neoliberal governmentality. The Foucaultian approach is important because it moves beyond market fundamentalism and considers the analytic convergences of (i) knowledge regimes (and their epistemic practices and 'truth' discourses); (ii) relations of force (at different scales, from the international to the nation and local, and in different forms, be they sovereign, biopolitical or governmental); and (iii) technologies of the self (the forms of discipline and bodily practice that allow subjects to 'fashion themselves' according to normative moral and ethical codes). However, I argue that this approach also serves to normalize a culturally Western paradigm of the body.

According to Rose (1999), neoliberalism is an art of government premised on freedom whereby certain rationalities of rule guide the conduct of citizens without seeming to do so. Experts who act as knowledge workers help to provide the information necessary, for example, in the form of risk assessments that enables and empowers individuals to self-govern (Rose, 1999, p. 147). Rather than making claims on the state, the neoliberal subject becomes 'an entrepreneur of himself' (Foucault, 2008, p. 226), as s/he attempts to maximize his/her own human capital (ibid., p. 224). The subject of neoliberalism is both *responsibilized* and *entrepreneurialized*, and citizens act as consumers of public goods such that their rights are constantly contractualized (Rose, 1999, pp. 139, 165). However, for those who are deemed socially pathological and unable (or unwilling) to self-discipline, a whole host of policies and agencies have emerged to help teach civility and self-determination (ibid., pp. 86–89). Should such processes fail,

peoples' social exclusion must be managed (ibid., p.147), which means that 'governing by freedom' cannot be understood apart from coercive forms of punishment (Dean, 2002, p. 123).

In an eerie coincidence of global proportions, AIDS and neoliberalism share a common chronology and impact. AIDS and the industry that has grown up to manage, control and capitalize on the disease are deeply implicated in neoliberal processes at multiple scales, even more so as biopolitical concerns are increasingly a focus of government at the international, national and civil society levels. Rose (2007) suggests that in the late twentieth and early twenty-first centuries, due to advances in biomedical technology and knowledge, a new biopolitics is emerging, wherein biology plays a primary role in the constitution of subjectivities, in the regulation of populations and in the economization of new forms of capital.

This growing body of Foucaultian scholarship that links neoliberal and health governance through a focus on biopolitics in the contemporary era requires revision from a postcolonial perspective. There are three main ways in which the empirical data explored in this article forces reconsideration of core theoretical tenets within this field: (i) by arguing that biopolitics blurs into thanatopolitics at the thresholds of governance, which shows that concerns of race and nation are still relevant under neoliberal rationality; (ii) by illustrating the structural obstacles that face people attempting to assume entrepreneurialized and biomedicalized technologies of the self; and (iii) by detailing the ways in which citizenship is used as a mechanism for *cultural* imperialism and the normalization of a biomedical episteme. Structural barriers to the uptake of biomedical citizenship illustrate how even people *willing* to assume biomedical subjectivities are unable to fully embody them, thereby exposing the limits of their agency; however, their cultural commitments to indigenous forms of healing provide the basis for their *refusal* of biomedical hegemony – making this lack of uptake a site of resistance. These possibilities for resistance come from the simultaneous embodiment of *both* biomedical and indigenous cultural logics. As such, the article illustrates the ways in which embodiment facilitates resistance, but only if we conceptualize the body as a cultural artifact and not simply a *tabula rasa*. I will take each of these arguments in turn.

Whereas for Foucault (1990), the ancient sovereign power of *taking* life or *letting* live was replaced in the modern era with the power to *foster* life or 'disallow it to the point of death' (p. 138), Agamben (1998) argues that 'taking life' and 'letting live' have become indistinguishable under late modernity. Because sovereignty has become decentralized in the contemporary neoliberal era, the sovereign 'exception' becomes the rule, enabling more and more people to make decisions about the value of human life.

The clearest example here is the way in which contemporary biomedical practices employ various forms of expertise (risk assessment, prenatal screening, counselling, criteria on the futility of further treatment, notions

of brain death, bioethics etc) to constitute family members, prospective mothers and fathers, carers, doctors etc, as loci of decision concerning the termination of life or the attempt to preserve and foster it (Dean, 2002, pp. 133–134).

Against this trend, Nikolas Rose has argued that the blurring of the politics of life and death marked the historical era before WWII; however, the post-war era is distinguished instead by a renewed focus on vitality where questions of the economy come to replace questions of race and nation.⁷ For Rose (2007), the biopolitics of the contemporary era is no longer defined by population and territory, and is rather concerned with the ‘domesticated spaces of family and community ... [where] responsibility now falls not on those who govern a nation in a field of international competition but on those who are responsible for a family and its members’ (p. 64). While Rose admits that people unlucky enough to live in ‘less-developed’ parts of the world are still the target of ‘letting die’ policies, these do not ‘operate according to the biopolitical rationalities of the camp’ (p. 65) because eliminating a population for economic reasons is not the same as maximizing racial fitness (p. 66). If countries do still impose population-based interventions, it is taken as proof that they do not operate according to the same rationality of rule governing advanced liberal democracies (p. 69).

And yet, decisions over AIDS have become sovereign decisions insofar as they throw into question who has the power to decide on life and death (Nguyen, 2010, pp. 7, 13). The fact that more racially oppressed people die from AIDS throughout the world (including in advanced liberal democracies) cannot simply be an accident of history. I argue that it is extremely problematic not only to de-link questions of the economy from questions of race/nation and therefore questions of bio- and thanato-politics, but also to suggest that postcolonial countries operate under a distinct rationality of rule. Although I agree that biopolitics may be less a matter of state responsibility, it is now the responsibility of a multitude of decentralized agents who make sovereign decisions on the value of life and attempt to discipline populations through the mechanism of citizenship.

This brings me to the second theoretical intervention this article makes. A series of theories has recently emerged exploring the relationship between biopolitics and citizenship in a Western context (Petryna, 2002; Rose and Novas, 2005; Rose, 2007) and in the colonial and postcolonial contexts (Ong, 1995; Briggs and Mantini-Briggs, 2003; Biehl, 2004, 2007; Nguyen, 2005; Anderson, 2006). ‘Biological citizenship’ is generally used in two contexts: (i) when the body (or a biological condition like HIV) becomes the basis for making rights claims on either the state or the international community, or when biomedical categories are used to adjudicate claims for compensation (Petryna, 2002; Nguyen, 2005;

⁷ Foucault (1997) argued that ‘[r]acism is the indispensable precondition that allows someone to be killed’ (p. 256).

Rose and Novas, 2005); or (ii) when citizenry (or laypeople and patients) participate in the production of biomedical knowledge and get involved in key struggles over access to treatment and care (Biehl, 2004; Rose and Novas, 2005; Epstein, 2007; Nguyen, 2010). In contrast, I use the more analytically specific term, 'biomedical citizenship' to refer to the ways in which a biomedical industry made up of public health institutions, pharmaceutical corporations, NGOs and various Western governments have imposed epistemic hegemony and disciplinary techniques onto subjects throughout the global South through the mechanism of social citizenship⁸ at the national scale. Indigenous forms of healing and pluralistic health-seeking behaviors, then, are at risk of erasure when a culturally Western ontology of the body is normalized through the mechanism of citizenship.

I borrow the term 'exclusionary inclusion' from Giorgio Agamben who uses it to detail the ways in which neoliberalism's disposable populations are managed. They exist in a juridical threshold – they are internal to the nation-state and yet do not enjoy all of its rights. His archetypical character *homo sacer* (he who cannot be sacrificed but who can be killed with impunity) 'does not sit outside of law, nor is he indifferent to it, but he is *abandoned by it*' (Agamben, 1998, p. 28). In Agamben's usage, *homo sacer* remains a largely abstract concept, he fails to explore the tensions between exclusion and inclusion, and he problematically strips the excluded of agency.⁹ My case illustrates the precise ways in which inclusionary policies facilitate exclusion through the imposition of behavioral norms, and it further argues that without agency the marginalized cannot be blamed. Neoliberalism is a form of government premised on *freedom*. It is essential, therefore, that the poor retain their ability to 'choose' to embody certain technologies of the self in exchange for the rights to citizenship. By turning Agamben's abstract theory into a tool of sociological analysis, my work provides social scientists with a new means of analyzing exclusion in the late neoliberal era.

Certain structural barriers make assuming biomedical subjectivity impossible, such that severe systemic poverty coupled with the privatization of blame leads to a situation in which biopolitics blurs into thanatopolitics, at the threshold of citizenship. And yet, the technologies of the self required in the neoliberal age are

⁸ Following T.H. Marshall, I use the term 'social citizenship' to indicate a bundle of civic rights including access to health care and education, and to distinguish it from political or economic citizenship (Marshall and Bottomore, 1992).

⁹ For an important critique of the limitations of Agamben's theories and their application to the AIDS crisis, see Comaroff (2007). I agree with Comaroff that consigning all AIDS sufferers to the role of *homo sacer* ignores the kinds of positive subjectivities and politics that emerged in the struggle over AIDS. Focusing on a later historical period, my contention is that these politics did, indeed, expand the boundaries of inclusion in treatment support and political recognition, but in so doing, the politics of exclusion also shifted, as did the onus of blame. Recognizing the limitations of Agamben's theories, I find his concept of 'exclusionary inclusion' an apt formulation for capturing this kind of governmental power.

not only entrepreneurial but increasingly *biomedical*, thereby contributing to an imperialistic expansion of biomedical hegemony. In fact, this is the third major intervention I make into this set of literature, which assumes a very problematic view of biomedicine as culturally universal.

For Foucault, the neoliberal subject *homo economicus* is not overtly governed, but instead guided by something akin to an invisible hand so that he functions as ‘an individual subject of interest within a totality which eludes him and which nevertheless founds the rationality of his egoistic choices’ (2008, p. 278). The government of freedom promotes individualism, but through the conduct of conduct it normalizes certain behaviors without seeming to do so. ‘Individual autonomy becomes not the opposite of, or limit to, neoliberal governance, rather it lies at the heart of its disciplinary control’ (McNay, 2009, p. 62). This is done by atomizing social relations and collective values, by construing structural problems like poverty as questions of poor self-management, and by weakening the state’s obligations to its citizens (ibid., p. 64). While Rose sometimes recognizes the normalizing and disciplinary components of this new regime of freedom [as in his discussion of pedagogical citizenship and consumption (1999)], his work on health separates these tendencies of social normalization from a ‘somatic individuality ... opened up to choice ... experimentation and contestation’ (2007, p. 76). Rose (2013) even argues that the increasing biologization of our social identities challenges the determinism and essentialism generally attributed to biologic accounts. He suggests that as personhood is increasingly conceptualized somatically, biology and sociology merge so that our bodies become multiplicities, made up of a matrix of social and natural symbioses. And yet, such a view assumes that the Western scientific understanding of biology and its processes are universal – completely ignoring the fact that people all over the world subscribe to an ontology of the body and health that challenges a biomedical model. In South Africa, this takes the form of an indigenous knowledge system. An implicit and insidious cultural imperialism is at work in defining subjectivity as biomedical *and* individuated. In this article, I show how the technologies of the self required of South African citizens infected with HIV both attempt to responsibilize and biomedicalize their identities, revealing yet another effect of contemporary neoliberal biopolitics.

The Case of South Africa

Practically overnight, the African National Congress (ANC) was forced to transform from a militant revolutionary movement into a reputable governing body. In the 1990s, it faced a legacy of immense inequality, international pressure to abandon social democratic ideals in exchange for market competitiveness and a disease that would become an epidemic of unparalleled proportions.

The transition from apartheid to democracy has initiated a whole host of compromises, as the post-apartheid state attempts to meet the needs of its population (and fulfill the liberation promises it made) while simultaneously fulfilling the demands of international neoliberal capital. In 1996, the ANC unilaterally adopted the *Growth, Employment and Redistribution Macroeconomic Strategy* – a ‘home grown version of structural adjustment’ (Hart, 2008, p. 681).¹⁰ The ANC’s adoption of neoliberalism sparked immediate resistance and drew considerable international attention. Joining forces with activists around the world, South Africans forged sustained social movements around anti-neoliberal themes. It would be impossible to understand the emergence and history of AIDS in South Africa without paying heed to the impact of neoliberal economic restructuring and the country’s often contradictory relationship to globalizing forces.

‘AIDS denialism’ is the label most commonly used to describe the belief held by former President Thabo Mbeki and key members of his Department of Health that HIV does not cause AIDS and that ARV treatment is toxic.¹¹ I argue that denialism allowed Mbeki to meet the contradictory demands of postcolonial nation-building. By challenging the global hegemony of biomedical science *and* avoiding the financing of the public provision of ARV medication, he was able to successfully champion *both* economic liberalization and African nationalism. But such a contradiction required letting a certain undesirable and unproductive component of the population die: ‘[S]ometimes what he has to do for the state is to live, to work, to produce, to consume; and *sometimes what he has to do is to die*’ (Foucault, 2000, p. 409; my emphasis). It has recently been suggested that 365 000 people died as a direct result of denialism (Chigwedere *et al.*, 2008).

By denying poor, African, HIV-infected populations access to ARV medication, I argue that the denialist state engaged in a regime of ‘thanatopolitics’¹² – the political decision on whose life is worth living and who must die for the sake of the nation. This population was rendered disposable, in part, by the adoption of neoliberal macro-economic policies which not only led to large-scale deindustrialization and a reduction of the size of the productive labor market but also made their social welfare too heavy a burden for the newly trimmed neoliberal

¹⁰ For further information on how the adoption of neoliberalism played an integral role in South Africa’s transition to democracy, see Marais (2001) and Bond (2000).

¹¹ The first sign of Mbeki’s ‘denialism’ occurred in 1997 when he supported clinical trials on a touted ‘cure’ for HIV (Myburgh, 2007). In 2000, Mbeki convened a Presidential Advisory Panel on AIDS that included notorious AIDS denialists (Mbali, 2003), and at the International AIDS Conference (held in Durban in late 2000) Mbeki (2000) insinuated that rather than HIV it is poverty that causes AIDS. From 2000 to 2004, Mbeki’s denialism stalled the roll-out of ARVs in the public health sector. The literature on denialism is vast. For comprehensive overviews, see Mbali (2003), Johnson (2004), Natrass (2007) and Fassin (2007).

¹² Foucault (1990) used the term ‘thanatopolitics’ to describe the death function of biopower, which is exercised against ‘those who represent ... a kind of biological danger to others’ (p. 138).

state to bear. But further, this surplus population symbolically represented the failure of post-apartheid liberation. By exposing South Africa's schisms of *contemporary* inequality, AIDS undermined the state's claims to a successful liberation, a narrative upon which its national identity depends. With the legacy and current manifestations of structural inequality so clearly emblazoned on their bodies, AIDS sufferers became the target of a thanatopolitical regime under the Presidency of Thabo Mbeki.

Mbeki couched these 'letting die' policies in a discourse that attempted to make people complicit in their own socio-political exclusion. He used indigenous healing to do so, thereby promoting an 'African' solution to the AIDS pandemic. He critiqued the greed of the pharmaceutical industry, racialized biomedicine as non-African and suggested indigenous healing was a viable *alternative* to ARVs (*Sunday Independent*, 2004), thereby garnering support from the African population, most of whom use some form of indigenous healing (DoH, 2003).

Fighting both a denialist government and the pharmaceutical industry, the TAC came to formulate a demand for biomedical inclusion – a demand that the population have access to ARV medication. From 2002 to 2004, the TAC pursued action against industry abuse of patents through the Competition Commission, essentially suing GlaxoSmithKline and Boehringer Ingelheim and eventually securing voluntary licenses for the drugs (Heywood, 2008).¹³ By drastically reducing the cost of ARV treatment and thereby obliterating the last logical rationale the Department of Health had presented for not providing ARVs through the public health system, a reluctant government was forced to finally adopt a National Treatment Plan that included a large-scale roll-out of ARV medication (DoH, 2003).

Because of the valiant efforts of activists in Brazil, South Africa, Thailand and India, the pharmaceutical industry has finally been forced to allow countries in the global South to bypass intellectual property right protections on essential medications.¹⁴ In his work on Brazil, Biehl (2004, 2007) argues that these new social movements actually forged *both* a new relationship to the state *and* a reconfiguration of neoliberal policy on health care, thereby giving rise to a new form of biomedical citizenship. I argue that biomedical citizenship has become a primary tool of roll-out neoliberalism at the global scale, promulgated through discourses of 'responsibility'.

The TAC sought to introduce biopolitical regulation over the population in order to maintain the health of the species body and thereby enhance the state's biological capital (Rose and Novas, 2005; Rose 2007), through the provision of

¹³ Before this court case, the TAC had been involved in various struggles for treatment, successfully securing low-cost treatment for MTCTP (Mother-to-Child-Transmission Prevention) and PEP (Post-Exposure Prophylaxis). The history of the TAC can be found in Nattrass (2007) and Heywood (2004, 2008).

¹⁴ For a detailed account of the history of this process in South Africa, see Heimer (2007).

ARV medication. However, I will show how this necessitated disciplining the population – in part because 80 per cent of South Africans utilize indigenous forms of healing (DoH, 2003) and in part because biomedical technologies of the self must be learned. Toward this end, two disciplinary tactics have been deployed. First, citizenship rights are provided on the basis of the successful embodiment of the disciplined behavior necessary to adhere to ARV medication. The ARVs themselves, as well as the chronic illness grant (should it be established) contractualize citizenship rights. Second, the discourse of responsibility urges citizens to become self-reliant entrepreneurs. 'Patients on ARVs are not only told that they need to adhere to treatment protocols and change their behaviour in line with biomedical necessities in order, quite pragmatically, to stay alive, they are also told that these actions are "their responsibility"' (Colvin and Robins, 2009, p. 185). People living with AIDS are now asked to adopt certain survival discourses, adhere to disciplinary bodily practices defined and policed by a wide range of health care professionals, and constantly calculate the costs they are willing to pay in order to adhere to these difficult health regimens.

Despite Mbeki's efforts to convince the poor that he had their interests at heart in rejecting ARV provision and promoting indigenous healing in its place, his obvious support for neoliberal policies led to a crisis in state legitimacy. In 2007, Mbeki was ousted from national politics by his own former Deputy President, Jacob Zuma. Despite being implicated in both corruption and rape allegations, Zuma beat Mbeki in a race for the leadership of the ANC in December 2007. In April 2009, he won the national Presidency in a landslide victory. Under Zuma's presidency, responsibilized and entrepreneurialized citizenship has finally been biomedicalized. Zuma made it immediately apparent to the whole world that the reign of 'AIDS denialism' was finally over when he accepted the orthodox science of AIDS and dramatically scaled up South Africa's testing and treatment efforts, which 'United Nations officials say is the largest and fastest expansion of AIDS services ever attempted by any nation' (Dugger, 2010).

South Africa's poor have access to the rights to citizenship and are important to the very definition and political legitimacy of the state. In fact, Zuma would never have succeeded in ousting Mbeki from politics without the electoral strength of the poor, who see in Zuma a leader they believe represents them and their interests. However, the social rights the poor can access are contingent on their capabilities of embodying or at least correctly performing certain technologies of the self, which are very difficult to sustain in squatter conditions and which require them to abandon indigenous healing practices. In this analysis, 'exclusionary inclusion' is used to describe this threshold state where disease is both the basis of citizenship and serves to redefine it in the neoliberal age. In other words, being HIV-infected becomes a means of accessing the rights of citizenship (in this case, ARVs), but also becomes the basis for the institution of a new form of exclusionary citizenship premised on the incorporation of biomedical subjectivities.

The Governance of AIDS at the Margins

Since November 2004, I have been conducting ethnographic research in two informal settlements or squatter camps, outside of Johannesburg: Lawley and Sol Plaatjie. Like most informal settlements in Johannesburg, both are geographically removed from job opportunities, not to mention schools, clinics and other social support services. They lie, quite literally, on the margins of the city – Lawley is 100 km South and Sol Plaatjie is 35 km South-West of Johannesburg. Most of the people who live in these settlements were either forcibly removed from other squatter camps or they ‘chose’ these locations for lack of other options or because it is as close to a city as they could afford to live.

When I first conducted research in Lawley and Sol Plaatjie (from 2004 to 2006), most of the residents (of both communities) lived in informal shacks. The communities lacked electricity and sanitation provision, as well as schools, clinics or community centers. The water provision in Sol Plaatjie was community standpipes, and because it is located on the site of an abandoned gold mine, the groundwater is toxic. In Lawley, Johannesburg Water (a para-statal water company) trucks fill large plastic tubs twice weekly, supplying water for approximately 50 shacks each. This water was also generally polluted, so residents of both communities were forced to purchase alternative energy sources simply to make their water potable (in addition to their other energy needs).

However, when I returned in 2009, both of these communities had been ‘upgraded’ as part of the government’s poverty alleviation efforts. The post-apartheid state had initially pursued a policy of eradicating informal settlements, but once it became obvious that it would never keep up with the rate of informalization (ever-expanding due to rising unemployment and rapid urbanization), the national government developed an Informal Settlement Upgrading Programme in 2004 (Huchzermeyer, 2006, p. 41). A further impetus came when South Africa won the bid to host the 2010 World Cup, thus clinching the policy that ‘visible’ informal settlements should be replaced with formal housing, whereas non-visible informal settlements were to receive *in situ* upgrading (ibid., p. 45). Sol Plaatjie became the flagship upgrading project for the City of Johannesburg and underwent upgrading from June 2006 until June 2009. Overall, 2670 housing units were built, and now approximately 51 per cent of the residents have formal housing.¹⁵ This housing development was accompanied by water but not electricity provision. In addition, the streets are still not paved, there is no functioning clinic and children have to take public transportation for miles to attend school. Lawley was also ‘upgraded’ in 2008. But the outcome of the upgrades was quite different. Residents still live in shacks,

¹⁵ These statistics and those below are taken from a community participatory research survey I conducted in both communities in June/July 2009. Overall, 500 households in each community were surveyed (approximately 10 per cent of the population).

but they now have electricity (but not water) provision on site. There are paved roads, a temporary clinic and one elementary school.

The upgrades in both communities have been accompanied by the privatization of service delivery. In Lawley, residents spend, on average, R80 (\$11) on electricity per month, which constitutes 5–10 per cent of their household income. The water provision in Sol Plaatjie had not yet been privatized when I visited in 2012, but the local councilor assured me it would be.¹⁶ And despite the so-called upgrading process, peoples' access to jobs and incomes has changed very little. In the summer of 2009 (after the upgrades), I conducted a social survey of the residents and found that in Sol Plaatjie 47.4 per cent live in a household that has a monthly income of less than \$65 per month, and 70.2 per cent live in a household that has a monthly income of \$129 or less.¹⁷ These numbers are equivalent to the results of another survey conducted by researchers from the University of Witwatersrand in Sol Plaatjie 7 years earlier (Wilson, 2003). Obviously, despite the 'upgrades', peoples' capacity to find work and other sustainable forms of survival has not changed.

This article began with a story about Pheello Limapo, my primary informant in Lawley. When forced to choose between medications and the disability grant, Pheello chose to stay on the ARVs, in part because his wife is not South African and is therefore not eligible to receive grants; therefore, his illness or death would leave his family destitute. He receives R280 (\$40) each month for a childcare grant, which is his family's only source of income, and yet he says that his costs (many of which are associated with health care as both he and his wife are HIV-infected) range from between R3000 to R4000 (\$429–\$571). When asked how he manages, he explains: 'It becomes a serious challenge. There is nothing that you can do ... Mostly, I live on hand-outs'.¹⁸

In both communities, then, the upgrades (while welcomed) have not significantly altered the levels of poverty or increased the quality of living in these squatter conditions. Informal settlement dwellers' lives are circumscribed by a whole host of structural inequalities and boundaries. In both Sol Plaatjie and Lawley, the lack of social services as well as substandard housing contributes to ill-health. Water is often contaminated; informal electricity sources like paraffin cause pollution and congestion; lack of sanitation leads to higher exposure to opportunistic infections; and extreme heat and cold due to lack of proper shelter has a profound effect on people with compromised immune systems.

Poverty and the conditions in which people are forced to live also exacerbate disease progression, destroy bonds of solidarity and trust, and can lead to increased risk-taking. Again and again in interviews, when I asked people

¹⁶ Interview, Paul Molutsi, 25 June 2009, Roodepoort.

¹⁷ Of those surveyed in Lawley, 37 per cent live on \$62 or less per month, and 75 per cent live on \$156 or less per month.

¹⁸ Interview, Pheello Limapo, 2 June 2009, Lawley.

why community members do not use condoms or avoid multiple partners, despite the fact that they are well educated on HIV transmission and watch their community members die on a daily basis, the reply was:

Many people think that HIV might kill them in 10 years, but poverty or violence will kill them first, so why worry about it?¹⁹

People are dying all the time in my community, so many people just accept that as ... you know, their future. So, they aren't careful about HIV 'cause they expect to die anyway. They don't care what kills them.²⁰

People have reached a point where they aren't afraid to die.²¹

The message is quite clear: until abject desperation is no longer the everyday experience of millions of South Africans, the disease will continue to spread.

What effect does exclusion have on the subjectivities of those abandoned at the social periphery? Over time, precariousness and insecurity infiltrate peoples' bodies and identities. As Thulani Skhosana put it: 'We are not good business according to the government. The poor in this new South Africa, they don't have a space ... Not giving HIV-positive people health care is one strategy that the government uses to get rid of the poor. We are a stress to the government, and they don't want to deal with us'.²²

Because probability is the science of the new regime of neoliberal governmentality, calculating what is known and being comfortable with risk becomes part of subjects' habituses. But those living outside the norm *cannot* calculate risks because they are immeasurable. Their lives are subsumed by constant risk and unmooring contingency, so they have not only incorporated their own disposability but face overwhelming uncertainty.

Why don't people talk about HIV/AIDS in your community if so many people are dying?

Because talking isn't going to change the situation. It is not going to change the living conditions. And so, it's not going to change the fact that people are spreading this disease and dying from it You know, I thought if there could be access to health, access to jobs, access to, you know, basic services, that would enable communities to decide to live. But no one could take a different path, no one could choose from various types of lives

¹⁹ Field notes, 19 December 2005, Soweto.

²⁰ Interview, Thulani Skhosana, 20 May 2006, Sol Plaatjie.

²¹ Female interviewee, 15 April 2005, Soweto.

²² Interview, Thulani Skhosana, 5 June 2006, Johannesburg.

... like you could. We don't have an option but to live in the dark ... we have to live there.²³

And yet, this is not to suggest that people do not push back against their abandonment. In fact, it is partially through the technologies made available through the shift in governmentality that they are able to forge strategies of resistance, as my data below will clearly illustrate. Before I get to their resistance, however, I discuss the kinds of subjectivities being drafted as best practice and imposed on the poor by a whole host of state and non-state actors (like clinic nurses and NGO staff) through the implementation of disciplinary biomedical techniques. My data challenges the viability and feasibility of such inscriptions and prescriptions in everyday squatter conditions. I focus my attention on the shifting contours of inclusion and exclusion. My data shows very clearly how the provision of individualized salvation based on peoples' capacity to assume a series of disciplinary behaviors and norms in structurally uncertain conditions simply absolves the state and global governmental agencies from responsibility for their exclusion and death.

Biomedical Discipline

In this section, I will show how structural obstacles make the uptake of biomedical technologies impossible, despite the disciplinary strategies used to encourage epistemic normalization. Although it depends on the province, there are a series of standards intended to ensure that a patient complies with the ARV treatment program.²⁴ Patients receive training on ART and adherence counseling from nurses (and sometimes lay health workers) at the closest clinics. Adherence counselors sometimes ask patients to sign a contract of agreement,²⁵ and all develop a treatment 'plan' with the patient to be reviewed on follow-up visits. Ideally, a strong support system, made up of doctors, treatment counselors and community social support systems (including home-based care givers), is supposed to help the patient comply. Counselors are encouraged to be open and honest about the difficulties of taking ARVs, especially in poor living conditions including engaging in discussions with the patient on questions of stigma, depression, side effects, drug and alcohol usage, access to sustained nutritious food sources and the patient's capacity to follow the disciplinary requirements for compliance. Here is a list of 'deterrents' counselors are encouraged to discuss

²³ Interview, Thulani Skhosana, 20 May 2006, Sol Plaatjie.

²⁴ The following information was gleaned from DoH (2010a, b) clinical guidelines and modules available on their Website, in addition to interviews with nurses involved in ARV roll-out, and patients who have gone through the trainings.

²⁵ Interview, ART nurse, 7 June 2006, Soweto.

with potential ARV users before they begin treatment:

From DoH (2010b) Adherence Manual

Some deterrents against taking ART (DISADVANTAGES):

- Patients must adhere to the timing, frequency and dosage of the drug regimen for a lifelong treatment period
 - Dosing regimens may be complex
 - There are differing dietary requirements
 - Some drugs require refrigeration
 - Some require preparation
 - Multi-drug regimens require taking numerous pills per day
 - Certain drugs may interact
 - There is a high possibility of experiencing drug side effects
 - Loss of confidentiality as a result of being seen taking the drugs
 - Risk of drug resistance and, therefore, limitations of future ART choices
-

There are, in fact, several factors that can disqualify a candidate from being put on ARVs, including: too low CD4 counts, too many opportunistic infections, alcohol or drug use, or insufficient social support. In addition, patients are discouraged from using indigenous remedies for fear of adverse drug interactions.

From DoH (2010a) Clinical Guidelines on ART: Explain to patients how to avoid adverse drug-drug interactions ... The patient should understand the possible consequences of unknown content and the danger of ...traditional medicines (p. 18).

People living with HIV are advised that if they are on ARV treatment, they should not mix it with traditional medicine ... because if they mix ... the ARVs will be erased or undone.²⁶

In the minds of policymakers, one of the primary concerns is drug resistance (especially given the scarcity of drug combinations available within the public sector). Therefore, those who are not able to adhere to a strict drug regimen might pose a risk to the sanctity of the ARV roll-out by introducing drug-resistant strands of the virus within already vulnerable communities. However, establishing contractual disciplinary standards for life-saving medications effectively demarcates those who are deserving of citizenship rights from those who are not. Here is an exchange from a Focus Group Discussion:

Woman 1: First, they take us and tell us how to take the ARVs – they train us. Then, they ask us if we are ready. Then, they test us whether we

²⁶ Female participant, FGD, 21 June 2009, Lawley.

understand how the tablets have to be taken. If they see you will mix them, or default on treatment, then they won't get them. If you cannot follow the instructions on taking them, then they won't give them to you.

Woman 2: They gave me a test. I failed. I got sick and had to go to the hospital because I failed the test and could not get the ARVs. That's the reason I got so sick in the first place because I couldn't pass the test and get the treatment when I needed it.

Man: Many are failing the test. They have to come back without drugs – even if they are still sick.²⁷

Under a model of biomedical citizenship, survival is premised on the ability (or desire) to adhere to a strict biomedical drug regimen, which includes not only a calculus of the number of pills and their timetables but also food intake, social support *and* an agreement *not* to engage in *other* forms of healing (most specifically, indigenous forms of healing). Patients are told that some 'life adjustments' may be required for compliance with ART (DoH, 2010b, p. 6). People I spoke with who are taking ARVs discussed some of the associated challenges, which include avoiding alcohol and cigarette usage, openly disclosing their status to their families, seeking out nutritious food sources and making sure to keep clinic appointments.

Many of the predictors of poor adherence listed in the DoH's (2010b, p. 7) manual on adherence counseling are associated with living in squatter conditions. The simple lack of resources to purchase food or pay for transportation to the clinic was mentioned again and again in interviews and focus group discussions.

I don't even know when I'm going to have a healthy meal from one day to the next. How can I take these ARVs, when I can't even afford to eat right?²⁸

I have 5 kids, and I'm also living with HIV. There's a problem with regard to checking the CD4 count. Every six months, you have to go to check. Sometimes when you go, you are automatically disqualified from receiving a grant. But I'm taking ARVs, and you are supposed to eat good food when you are taking ARVs – all the time. So, how am I supposed to eat without any money?²⁹

But the biggest problem we have? It's the stress. Because we don't possess money. We don't get grants And we are still expected to take the

²⁷ FGD, 10 June 2009, Lawley.

²⁸ Interview, Thulani Skhosana, 30 September 2005, Sol Plaatjie.

²⁹ Female participant, FGD, 10 June 2009, Lawley.

medication. And you don't have money for transportation. You don't have money for food. And you still have to go there, you know, and sometimes if you miss one or two, then you affect the whole program.³⁰

People are also deemed likely to default on ART if they cannot identify their medications. 'I have become a small pharmacy',³¹ Pheello proudly told me one day as he brought out his box full of medicines. He knew which pills were his ARVs, when he needed to take them, and which were most difficult to take. However, Pheello has scores of other medications in baggies, vials and boxes. Upon questioning, he was quite confused about the drugs' purposes, dosage requirements and expiration dates. Pheello does not speak or read English – not that his English skills are the only obstacle toward understanding the biomedical language used on the packages. Presumably, the doctor had explained each pill when it was first prescribed; however, I have often accompanied Pheello to the clinic and hospital, and there is rarely a Sotho interpreter on hand. Pheello often does not understand his diagnosis or prescription. In the 8 years I have known Pheello, he has been extremely sick – he has suffered from numerous opportunistic infections (including cytomegalovirus, neuropathy and thrush), has often been co-infected with TB, has suffered from almost constant diarrhea – this and his ongoing battle against flus and colds keeps him on continual antibiotics. But because he has been to the clinic so often over the years, he has collected a wide array of medications he no longer knows how to use. This does not keep him from self-diagnosing and mixing these pharmaceuticals with his ARVs when he feels sick. It is important not to misconstrue this story – Pheello is one of the best informed, dedicated and proactive patients I have ever met. He not only takes his ARV treatment seriously, but he tries to convince other people in his community to begin the treatment and counsels them on how to remain compliant. I tell this story simply to show that even those with the best of intentions face serious challenges in adhering to the biomedical requirements for ART.

In each of the communities, I was told that some people are so desperate for food that they are forced to sell their ARV medications to buy groceries:

We sell ARVs so that we can buy paraffin. We don't have food, so we buy food. If they give us ARVs, we sell those to get supplies.³²

Because people are starving, they see the business from the ARVs. They get the medications for free and then they sell it for R30 to the kids, who then use it as a drug. With that R30, a woman can buy veggies, sugar etc.³³

³⁰ Interview, Pheello Limapo, 2 June 2009, Lawley.

³¹ Interview, Pheello Limapo, 21 June 2009, Lawley.

³² Female participant, FGD, 4 July 2009, Sol Plaatjie.

³³ Female participant, FGD, 10 June 2009, Lawley.

Efavirenz is a strong non-nucleoside reverse transcriptase inhibitor that has hallucinatory side effects. In some locations in South Africa (including both Sol Plaatjie and Lawley), it has been reported that a market in the drug has developed among teenagers who grind it up and smoke it to get high (Marwaha, 2008; Hull, 2010). I have heard people pragmatically calculate between the costs and benefits of selling one ARV to buy groceries, telling themselves that they are still taking two out of the three ARVs that makeup their 'cocktail' therapy. Whereas triple ARV therapy completely suppresses HIV replication, double therapy does not, allowing the virus to become resistant to not just the two drugs themselves but other drugs in the same class (Nguyen, 2010, pp. 196–197nn9–10). As such, this gamble compromises the drug roll-out more than patients realize.

And there are other gambles people in squatter camps are forced to make in order to attempt to comply with the drug regimen, despite the structural conditions in which they live. Sandra Mkhwanazi is originally from Zimbabwe, and she has faced severe xenophobia and HIV-related stigma in Lawley. Sandra's husband bought them a plot of land in Lawley in 2000. He then passed away in 2002. She did not know her own status until 2008 when she got extraordinarily sick and almost died. Even though she is not a South African citizen, she was put onto the ARV program. But she cannot receive a disability grant, and she has no income to support herself and her two children.

I had an ordeal last month because, I mean, I didn't have money for transport to go and fetch my treatment ... I woke up very early at around four thirty so that I could walk because people normally walk ... across this empty field between Lawley and Lenasia ... if they don't have money for transport. It takes people one hour to walk, but it takes me two because I have this serious pain in my feet ... So as I was walking and approaching, there's a dam. And then four men actually came from the field, you know. And then they all raped me. And all of them slept with me ... [*crying*] ... I think it happens quite often because, I mean, before my ordeal, a lot of people had already reported that these incidents that are happening, especially around that road.³⁴

Sandra's story unveils the invisible boundaries that circumscribe the South African body politic – the literal void she must traverse to access the privileges of the polis and the price she must pay for the passage, before returning to her precarious position as one who has been abandoned to the margins of the social.

The intention of this article is not to imply that ARVs should cease to be provided in resource-poor settings. Rather, it is to point out a certain logic that undergirds treatment governance throughout the global South – a logic that individualizes blame, contractualizes rights and utilizes technocratic

³⁴ Interview, Sandra Mkhwanazi, 1 July 2009, Lawley.

interventions (like ARVs) in an attempt to responsabilize undesirable populations. As Foucault (1997) himself once declared, 'I have tried to understand power by looking at its extremities, at where its exercise became less and less juridical' (p. 28). New forms of biomedicalized citizenship reconfigure the contours and technologies of exclusion in this new age of 'roll-out' neoliberalism. Endemic structural inequality, deeply entrenched patterns of neoliberal regulation and the ongoing privatization of 'responsibility' are the causal factors that lead to the 'letting die' of the poorest of the poor.

But That's Blackmail

When I explained to my research participants that the government was debating whether or not to change the eligibility requirements for the disability grant from CD4 count to adherence to ART, one respondent exclaimed: 'but, that's blackmail!'³⁵ People believe this policy blackmails poor South Africans into accepting biomedical doctrine by linking it to citizenship rights. As such, citizenship becomes a tool of imperialism, whereby biomedical rationalities are imposed on people who understand their bodies and their health through indigenous or pluralistic paradigms.

African citizens of South Africa overwhelmingly subscribe to indigenous ontologies of the body and health. The most often cited statistic is that 80 per cent of South Africans use some form of indigenous healing (van der Linde, 1997; Campbell, 1998; DoH, 2003); however, this is an estimation at best because there have been no reliable studies on the subject. It is approximated that there are 300 000–350 000 indigenous healers in South Africa (Select Committee on Social Services, 1998; Meissner, 2004; Liddell *et al*, 2005) – 15 times more than biomedical practitioners (Liddell *et al*, 2005). It is also likely this number is an underestimation because many indigenous health practitioners practice under the radar of any regulatory mechanism and are very secretive about their practice and clientele. No matter the exact numbers, my research (which supports the findings of many scholars of health in the South African context) demonstrates that indigenous healing remains a powerful source of knowledge and treatment in an informal and unregulated manner in most African townships and informal settlements in the post-apartheid era.

The indigenous ontology of the body differs from a biomedical conceptualization in a variety of ways.³⁶ According to indigenous cosmology, the body is the

³⁵ Interview, Nomachina Makalo, 1 July 2009, Lawley.

³⁶ In addition to the academic sources cited in this explanation of an indigenous ontology, I drew on the information provided through a series of in-depth interviews with two well-established indigenous healers, Drs. Robert Tshabalala and Martha Mongoya. Interviews were held on 8 April, 22 July, 3 August, 17 August and 3 September 2005, as well as on 13 July 2009.

site of four synchronized components. These are: the spirit, the body or flesh, the blood, and the 'charisma' or 'aura' (Thornton, 2008, p. 213). Healing the body involves a careful balancing of all of these components, 'with excesses of blood or spirit being purged ... and with deficits being made up through ritual treatments involving the "calling" of the spirits (*pahla*) Health results from a balance of substances both within the body and between others involved in the person's social and sexual network ...' (ibid., p. 214). Practices of amplifying the body (because of a bodily or spiritual insufficiency) might be done through the inhalation of herbal fumes, being washed with herbal remedies, or the rubbing of medicines into small incisions made on the body (Henderson, 2005; Thornton, 2008). Cleansing or purging unwanted toxins or infections would call for drinking medicines that will induce vomiting or diarrhea, or steaming the body with herbal infusions to sweat out the infection (Henderson, 2005; Thornton, 2008).

In addition, the body is not 'well bounded' (Niehaus, 2002, p. 189). It is contiguous with both the spiritual world (from which it comes and toward which it is heading) and the social world (the self is built, sustained and enriched through interaction with others). In other words, the self is made up of ancestors who came before, is added to throughout the life through various social interactions, and then in death, will continue to contribute to and shape the lives of the next generation. Peoples' bodies and selves are constantly being incremented by various different gifts (material, social and spiritual) and flows (bodily and ancestral), making them 'compound sites of [the] relations that define them' (Niehaus, 2002, p. 190). The body is, therefore, not the sole property of the individual, but is linked to a whole host of ancestral spirits who use it to communicate with other ancestors and who bestow the individual with a unique cultural and familial identity and guide his/her life choices.

An indigenous ontology recognizes the body as communal, which is very different from the atomized view of illness the biomedical paradigm promotes.³⁷ Within the biomedical view, illnesses can be attributed to specific causes, which are generally biologically based, whereas etiology within an indigenous paradigm is also socially situated. Illnesses can be caused by the ancestors or by witchcraft, and even if they are somehow biological (as an imbalance between the four synchronized components), the source is often social. Treatment may be similarly public, as opposed to individualized and private. Because subjects' selves are contiguous with both the social and ancestral world, the body cannot be healed in isolation; it must be situated within its social, material and communal context. The individual is deeply embedded in networks of not only living kin but also in an entire system of ancestral relations. The individual body cannot be extracted from those bonds of kinship if it is to be properly healed. As indigenous healer Sheila Khama explained it: 'In a family when the husband is sick, the whole

³⁷ For a comprehensive comparison of indigenous and biomedical paradigms, see Digby (2006, p. 284).

family is sick. So a traditional health practitioner has to ensure that there's harmony in that family. That's the entry point'.³⁸

In addition to differences between an indigenous and biomedical ontology of the body, there are important contradictions between the two approaches, which have become sources of contention in the era of AIDS. In fact, Ashforth (2002) argues that the notion of a virus, which is by definition incurable but treatable, is not readily accommodated within an indigenous paradigm of the body because indigenous healing involves the purging and cleansing of pollutants, not teaching the body to live with them. Further, he argues that because indigenous healing locates the causes of disease within the *social* and *ancestral* world, healers should be able to resolve and cure all disorders of the body, including HIV/AIDS.

There are many debates among scholars of African indigenous healing (and healers themselves) about whether or not certain indigenous 'germ theories' help healers make sense of viruses like HIV. For example, Green (1999) has argued quite forcibly that 'when it comes to diseases that account for greatest morbidity and mortality (i.e., those biomedically classified as infectious and contagious), the indigenous and biomedical etiological models are, in fact, not very different in fundamental and important ways' (p. 12). Whenever I brought the topic up in focus group discussions or interviews with indigenous healers, they were largely indignant at the insinuation that their ontology was antithetical to viruses:

The idea of a virus *does* exist in traditional healing. It is sometimes referred to as insects, worms, parasites, or microbes, but it is the same idea. And it can be caused from simply environmental factors. It can be caused from pollution, or it can be caused from witchcraft. The causation theories differ, but the idea of germ and that kind of thing doesn't. And HIV is generally understood as one of these 'germs' – at least by most of the traditional healers I know ... The idea of microbes, for sure it exists. The causation is different than biomedicine, but absolutely ... And you can have something in your body and still be sick, particularly, and it may manifest, not in a physical problem. So you could have a worm in your body that's caused or related to something that ... that isn't tangible.³⁹

As this healer explains, then, the idea of an asymptomatic virus is also part of an indigenous ontology.

And yet, highlighting these differences in corporeal ontology as well as conceptualizations of illness paints a picture of two autonomous and well-bounded systems of healing, which belies the hybridity that is practiced by both indigenous healers and the users of indigenous medicine. Indigenous healing has survived colonialism and postcolonialism through adaptation. Over its long

³⁸ Interview, Dr. Sheila Khama, 14 July 2009, Johannesburg.

³⁹ Interview, Dr. Rebecca Rogerson, 19 August 2005, Johannesburg.

history, it has consistently incorporated Western, biomedical health practices (Digby 2006), and both forms of healing have been available to the Black populations of South Africa since at least the middle of the nineteenth century (Flint, 2008). Rather than autonomy, it is hybridity that marks the health-seeking practices of most Black South Africans.⁴⁰

Biomedicine has staunchly resisted amalgamation with indigenous healing and condemned pluralist health-seeking behaviors, and yet when biomedicine is interpreted and utilized by Black South Africans, it is localized and domesticated – often by combining it with other forms of healing and through engagement with various expert cultures. In the context of my own research, I found that even if people were admonished against using indigenous healing while taking ARVs, they often figured out ways to combine the two sets of treatments. ‘There are certain things they are failing to address at the clinic ... but if you go to the traditional healers, you get rid of that thing ... [the two kinds of healing] complement each other According to me, I think the two can work together. I drink the *muthi*⁴¹ together with the ARVs’.⁴²

This mixing of remedies is one recourse people have to resisting the strict biomedical technologies they are being asked to assume in order to gain access to the rights of citizenship. But there are other strategies as well. Thulani Skhosana, for example, refuses to use ARVs because he fears that they will require him to forsake his identity. First, because the doctors will ask him to avoid using indigenous forms of healing – a contract he is not willing to abide by. But he also fears becoming a ‘machine’ that must follow a rigid timetable and adhere to a regimen he finds not only somewhat ridiculous, given his living conditions, but also undesirable and burdensome.

If I’m told I have to go to the clinic, I don’t want to go. I haven’t liked the clinic since I was young. Even today, I’m HIV positive and don’t attend the clinic ... there is so much speculation about the ARVs ... I don’t want to become ... programmed ... I don’t want anyone to tell me that I have to live like this, and if I don’t live like that, I’ll die. I don’t like discipline Every day, I can’t swallow something at the same time. I’m not a machine. That’s my feeling.⁴³

Thulani is keenly aware of the price he is being asked to pay for inclusion in the body politic – not only will he be ‘programmed’ by biomedical discipline, but

⁴⁰ I explain this in detail and discuss the implications this has for our conceptualizations of action and agency in Decoteau (2013).

⁴¹ An indigenous herbal cocktail.

⁴² Interview, Nozipho Dlamini, 26 June 2009, Sol Plaatjie.

⁴³ FGD, Thulani Skhosana, 11 June 2009, Sol Plaatjie.

should his performance fail, the responsibility for his abandonment will be his alone to bear.

The presence of indigenous healing does offer an alternative ‘toolkit’ of cultural repertoires (Swidler, 1986) Black South Africans can utilize to resist the imperialistic processes of biomedical normalization that have accompanied the provision of ARVs, but agency is also gleaned from peoples’ liminal positionality betwixt the homogenous system of biomedicine and the pluralistic practices of indigenous healing. Further, people gain perspective from the embodiment of two different cultural logics.

Resisting Normalization

The body is in the social world but the social world is in the body.
(Bourdieu, 2000, p. 152)

The body believes in what it plays ... it *enacts* the past ... What is ‘learned by body’ is not something that one has, like knowledge that can be brandished, but something that one is. (Bourdieu, 1990, p. 73)

The Foucaultian literature on governmentality suggests that bodies are the scripts of cultural discourses and imperatives. Subjects become *homo economicus* by learning to practice (through pedagogical forms of citizenship) the entrepreneurialized, self-responsibility required of them by regimes of neoliberal governance. And yet, such an approach does not contend with the historical processes of embodiment which may have bequeathed the contemporary body with practical logics that are out of sort with neoliberal contingencies.⁴⁴ Nikolas Rose, in particular, assumes that ‘biology’ is an unquestioned universal, and yet I would argue that ‘biology’ is a cultural schema attached to a particular kind of knowledge system. In the context of post-apartheid South Africa, Black South Africans have inherited bodily schemas informed by both indigenous and biomedical systems of knowledge, which may at times yield contradiction and incoherence, but which also provides them with a platform for resistance. The body serves as a ‘memory pad’ (Bourdieu, 2000, p. 141), but one that may be riddled with the contradictions of its times.

In this article, I have argued that neoliberal governmentality has initiated a new form of exclusionary inclusion. People who used to be the target of neglect are extended life lines, pathways to citizenship and inclusion in the body politic. But these life lines have disciplinary strings attached – requiring people to assume biomedical technologies of the self. People face structural barriers to accessing the

⁴⁴ Bourdieu referred to this possibility as ‘hysteresis’ (see, for example, Bourdieu, 2000, pp. 159–162; Bourdieu, 1977/1999, p. 83). Elsewhere (Decoteau, 2013), I discuss the likelihood of hysteresis in colonial and postcolonial conditions.

rights of citizenship – obstacles that make the embodiment of neoliberal subjectivities impossible to achieve. But they also sit at the intersection of different cultural logics, which makes them resistant to the imposition of a purely biomedical sense of self. This cultural component of exclusionary inclusion has been ignored in the literature on neoliberal governmentality. Although some have recognized the implicit normalization that accompanies the ‘conduct of conduct’, none of the scholarship on health governance has considered the biomedical expansionism quietly being imposed through forms of contractualized citizenship *and resisted* through complex processes of hybridization.

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