CHAPTER SEVEN  HIV/AIDS LIVED EXPERIENCES IN THE PUBLIC SCHOOLS

Introduction

The purpose of this chapter is to describe and analyse the diverse lived experiences that formed the basis of this research study. The data in this chapter emerges from the semi-structured interviews and the focus group discussions. These narratives and their analysis provide real insight into the ways in which people make sense of the disease and how South Africa’s public schools experience the disease in the workplace. This chapter suggests that the members of South African public schools experience HIV/AIDS in diverse ways. Using the participants’ own words shows that, irrespective of their educational levels, the HIV/AIDS lived experience of members of the education sector (public schools) is not exclusively biomedical and/or legal. The chapter also provides substantial new insights into the social dimension of the disease, specifically about how middle class South Africans experience and describe their experiences of the disease. Finally, there is a concerted effort at capturing the participants’ authentic intentions, meanings or/and experiences.

The central argument in this chapter is that people construct diverse, complex, narrative presentations, or stories to make sense of the disease. Using a repertoire of various knowledge-systems and belief systems namely; biomedical, traditional and religious, they weave together narratives they feel comfortable with to make sense of the disease. These narratives are influenced by the
relative positions of the individuals, particularly their culture, gender and age. While it is clear from these narratives that the epidemic is experienced and enacted differently, I also argue in this chapter that depending on their, age, gender and belief systems, these individuals engage a combination of various perceptions and attitudes to express their HIV/AIDS lived experiences. Thirdly, I posit in this chapter through the narratives, that, biomedical and legal constructs are inadequate in providing vivid illustrations of the HIV/AIDS lived experiences of the members of public schools. These arguments therefore suggest that there are other factors that influence the HIV/AIDS lived experiences of individuals in the education sector. Overall, the narratives show clearly that the disease has meaning that goes far beyond the medical and legal aspects, but intersects with every facet of people’s lives, their faith, cultural heritage, sense of community etc.

I have used two methods to analyse the material obtained from the interviews with the educators and members of the school governing body, and focus group discussions with the learners. First, the experience of each individual public school member has been examined as an identity narrative. That is, I trace the story presented by the participant of their lived experiences of the epidemic and PLHIV, to try to understand how they came to adopt such understanding and practices. I present seven personal case studies here. Secondly, I abstract from the separate narratives, some of the key issues and factors that appear to be significant in the way these members of public schools experience the epidemic and PLHIV. In some extracts, I attempt an analysis of aspects of language used by the participants to bring out the HIV/AIDS lived experiences’ category or
theme that is being put forward by the individual participant. Finally, I treat participants’ verbal expressions as descriptions of their actual HIV/AIDS lived experiences.

**Tea Lady**

A nagging winter Monday, quiet and foggy but shrouded with unclear expectations on my side. I cannot recall saying a prayer for courage to face any assignment like I prayed that day. It was obvious that I was very nervous because of the envisaged xenophobic attitudes expected from my would-be respondents. I walked to the bus stop with the anticipation that this fear should dissipate, but it never did. The human traffic was congested at that hour, and the bus stop packed with learners in their uniforms. As the day brightened, it did so with more chills, feathered with smoke let go from human ‘chimneys’. The noise from the taxi horns could easily misguide one’s directions. The drivers’ positioning of their fingers in different unique positions to indicate several routes, confused me more than the irritating taxi horns. This was the bus park leading to my first port of call for data collection. It was very easy to locate the school from the map in my possession, but it was difficult getting there because of the complicated taxi routes and signs.

At exactly 9 am, I was finally able to secure a place in the taxi going to my destination. I did not understand why the taxi appeared full yet one of the seats in front remained vacant. I would have thought that the seat would be the first to
be occupied. So I sat on it, feeling lucky but not for long as I was slammed with my first cultural shock. In the taxi, I constantly felt a tap on my shoulder: ‘for two’, after a while, another tap but this time; ‘for four’ and so it went on and on until my hand was filled with ‘for twos and for fours’. As it turned out, my role as a passenger sitting in that particular front seat was to collect the fares and hand them in to the driver. At the same time I was supposed to return ‘balance’ to some passengers. My ignorance provoked both the passengers and the driver who felt my uselessness more than me. Their time was wasted trying to sort out the ‘for twos’ and ‘for fours’. Eventually, I was let off the hook.

On arrival at the school, I met the gate keeper who interrogated me for almost ten minutes before showing me the administration office. Contrary to my expectations, I was warmly received. I had been warned about xenophobia so I was not sure what to expect from my participants. The head teacher introduced me to the deputy who eventually handed me over to my key respondent (the Life Orientation educator). The Deputy Principal said to the educator (whom I choose to call Teacher A)

*This is a researcher from Wits. Please help and show her around. Get colleagues to assist her where they can.*

Thrilled with that introduction and motivational statement, I became more relaxed. Teacher A was much more curious about the research topic than the
Deputy Principal. She asked in a very receptive tone, ‘What are you studying and what degree are you pursuing?’ I responded with a very relaxed tone that I am pursuing a PhD at Wits and interested in studying how public school community members experience HIV/AIDS and those living with the epidemic.

After introducing myself and the topic to Teacher A, she became more interested and the next question made me quite uncomfortable. I knew it might come and so dreaded it when it came. At that time, I thought my fair chance for interviews was over. ‘Where do you come from?’ was the dreaded question. I quietly responded with the undertone of boldness ‘I am a Nigerian’. To my surprise, she even seemed to have gained some boldness. She said:

*I will grant you interview first then I will get others to talk to you. I am sure that when they know that you are not a South African, they will also be open to you.*

This moment marked the turning point in my data collection. She ushered me into the seat very close to hers and promised that during the first school break, we would start discussing what brought me to the school. I nodded in agreement and thanked her.

Comfortable before me was a silver flask with a black lid that could contain no more than a litre of tea. It was sitting on top of a medium sized Bible, translated
into one of the South African languages. During the break, she took the flask and tucked it inside her winter jacket and supported it with her left hand as we walked. She led me to the hall where there were other flasks and a kettle for boiling hot water for tea and coffee. There, she quickly opened the tap, filled the kettle and plugged it in for tea. I was not even asked if I would like to have tea; as it was winter, I imagined, she presumed that I would readily have some. Eventually she made the tea for me and before I started sipping mine, she pulled out the flask from her winter jacket, poured the content into the lead cover and sipped intermittently. Though the tea was not hot as I would have expected, she drank it and seemed very contented. I looked at her curiously and suggested, ‘mine is hotter why not warm yours at least. It’s quite cold.’ She declined and said, ‘I will tell you lots about my tea after now.’ With that, I became more inquisitive. After some time, she brought out the little water bottle from her hand bag and drank from it as if to push the tea down her throat. I did not worry much about the water because people in South Africa carry mineral water most of the time.

The interview kicked off in a rather friendly conversation. She began by saying:

*I wanted to be the first to grant you interview before others because they may end up talking about me. You know it is better to hear from the horse than to hear later. The story will be twisted and the truth will not be told. Your being a Nigerian made me more comfortable because you will not*
talk about me and even if you do, it will be far away or in your thesis. No one will know who and I would have told my story to someone very neutral who genuinely cares to listen.

In this interview extract, the interviewee’s opening response is formulated in the context of personal experiences and self assertion about her experiences with HIV/AIDS. However, she was cautious to maintain self defence and also protect integrity in the face of a stigmatised illness. With that, I introduced the topic and the first question. Because South Africans are believed not to talk easily about their HIV/AIDS status and despite not being interested in the participants’ status, I was shocked when she said,

I will tell you about myself. I will answer your questions using myself. I am also positive and have been diagnosed five years now. When I became sick, I thought I would die, my people took me to so many places but none helped me.

This response was clearly not a reaction to the contextualisation of the question because I had just introduced the topic. I could interpret this opening remark as; ‘the respondent thinks she is being judged, but has the opportunity to defend herself.’ I noted an outright expression of the fear of dying and the introduction of an alternative approach to the biomedical strategy as a response to the epidemic.
She sipped from her cold tea. And in strict secrecy, she told me that there are several confusing issues surrounding the treatment of this illness and that people do what they believe will work or is working for them. I was taken aback when she described her own method as ‘most effective’ in spite of not being medically acceptable. Some of her responses to my questions are narrated as follows;

You see, this water and the tea I drink since our discussion started are blessed. They are blessed in the church by my Ufundisi (priest) and I believe that has been what is keeping me alive all these while. I do not take any other tea neither do I drink any other water but the blessed ones, like these. My husband also lived through his sickness on these and that was why he was never thin and no one could suspect that he was sick. Sometimes too, when I am sick and I fear to die, I go to the pastors for prayers and their prayers and my faith; remember, my faith, made me well. They are the most effective medicine for this illness. Just believe and take them, you will live longer than they said you should live.

I was surprised by these expressions. What actually shocked me the most was the confidence with which she spoke about the potency of the ‘holy water and blessed tea.’ However, this response suggests the undying search for a solution in the face of a confused and complicated health related misfortune which could not be helped by the western medical approach alone. This participant seems to have introduced an alternative approach other than the biomedical approach toward the HIV/AIDS experiences. Words such as; ‘blessed water, tea, prayer,
church, ufundisi (priest) and faith’ were used by this participant to introduce a religious or faith based approach which is considered as most potent in the treatment of the disease. Here, this participant seems to be acknowledging the depressing effect of being HIV positive despite her tenacious belief in the religious powers and unorthodox practices. To her, being able to look healthy is based on her belief in the efficacies of prayer and the availability of the faith based artefacts (her husband was never thin and no one could suspect that he was sick). These faith-based objects and practices are indications of desperation linked to the fear of dying. Her prescription that, ‘They are the most effective medicine…live’, could imply the societal loss of confidence in the biomedical approach which is not only expensive but only offers palliative measures for the epidemic. Her recommendations are cheap because they cost nothing but ‘believe and take them.’ This remedy according to her will assist the sick through the sickness with less of the stigma caused by noticeably ‘being thin’. It is clear from this extract that the ‘sickness’ is not the major challenge but the stigma associated to the disease.

She drank from the bottle and flask until the interview ended. Several questions crowded my mind because of the assumption that such beliefs would not have come from someone with such education. I found out that this teacher was freely ready to engage with me. She said:

*Sometimes my dear, you want to talk to someone but you just cannot. No one wants to hear your cries of woes and even when they pretend to be...*
sympathising with you, they will gossip about you later. That is why I am excited talking to someone today about this illness. It is full of loneliness and secrecy in this community. You carry your burden and die with it so that your children will not be discriminated against when you die. No one will know what killed you when you die looking healthy. That way, your children will not be isolated in the society.

In this extract, the interviewee is talking about how she deals with the negative HIV/AIDS related attitudes and practices of the people around her. A major theme of this part of the talk could be; ‘left to deal with it alone’. She talks about the feeling of loneliness she experienced especially when no one will want to listen to her stories without judgment or gossiping. She is relieved that an opportunity has come for her stories to be listened to without castigations. The situations of those with this disease are not the same as those with other terminal illnesses such as diabetes and cancer, but she makes no reference to how she adjusted to this.

She was consistent in emphasizing the acute loneliness and secrecy which makes the disease a heavy burden for her. The participant also talks about how she has to deal with the disease in such a manner that people will not identify her with the signs and symptoms of the disease, especially when she is dead. This is to avoid the possible extension of the isolation and stigma associated with the disease to her children when she is dead. The concept of ‘secrecy’ in this extract could serve dual purposes. The first is to protect the sick from the HIV/AIDS
related social stigma such as discrimination, gossip, and rumours, within the society which generate psychological problems that may lead to untimely death. Another is to shield the victim’s children from being isolated when the sick person is dead. She has a clear idea about what she needs to be able to do in order to live longer and also shield her children from being isolated in the community – carry your burden and die with it. However, although she mentions earlier the potent solution to her illness, she talks more about the emotional torture she experiences.

She demonstrated confidence in the potency of her treatment by saying that:

> My husband passed on three years ago of this disease. I am supposed to be sick according to the medical doctors but, you see, I am not! This holy water and tea, I have been drinking it alone since I was sick and diagnosed five years ago. They keep me alive. I do not drink any other water or tea.

This participant further talks about how her husband and herself manage their condition to remain healthy till death just to avoid negative behaviour towards them. In this context, I see someone who, to avoid being subject to stigma, is forced into secrecy and I wonder how she maintains the sanity with which to effectively and efficiently perform her academic duties. What is visible here is that this participant engaged more than one world view in expressing her HIV/AIDS lived experiences. I noted that she engages medical knowledge (acquired from her teaching of life orientation to learners) at least on one hand and a
combination of Traditional African and Christian religious beliefs on the other hand. HIV/AIDS is part of the curriculum content of life orientation (LO). Her belief in and use of ‘Bible’ combined with her use of a physical representation of African traditional religion (blessed water and tea) makes her Christian belief unorthodox. The combination of biomedical knowledge (from the LO lessons), and physical embodiment in mediating the epidemic were not seen by this participant as contradictory but rather an expression of how she directly deals with HIV/AIDS. Despite the relatively ‘good’ knowledge of this teacher on HIV/AIDS, she still clutched tightly to her beliefs.

The ‘Tea Lady’s’ subjective and inter-subjective views on how to deal with HIV/AIDS are based on her everyday life in the environment presumably rich with biomedical knowledge, beliefs and religious practices. The illness itself is seen as a disease that is too complex to deal with. The ‘Tea Lady’, like some other members of South African public schools despite their good biomedical knowledge of HIV/AIDS, uses religious and ancestral beliefs to make sense of the illness especially when it is described as; ‘having no cure yet’. In this case, refusal to use anti-retroviral (the conventional therapy) against some faith based substances such as ‘blessed water and tea’ is a proof of her lack of confidence in the biomedical approach to the disease. As is likely for this teacher, most of the methods adopted by such individuals for treatment are often dangerous because it is only a matter of time before they succumb to the effects of the disease caused by their misinformed choice of treatment.
However, in this context, this educator reiterated the concept of stigma and secrecy in experiencing HIV/AIDS. She speaks of HIV/AIDS related stigma and secrecy as behaviours that are visible in other people’s attitudes also, making the infected isolate themselves, keeping the infection very private/secret from others for many reasons. The concluding argument here is that because she feels stigmatised, she keeps her distance from others in thoughts and relationships. This makes it very difficult to socialise and share her experiences with colleagues at the work place. Judging from this narrative, it is possible to see how the concept of ‘stigmatism’ when combined with beliefs helps to make explicable the ways the members of educational institutions experience HIV/AIDS, the PLHIV and those affected by the epidemic.

**The Feather Man**

It was luck that linked me to the ‘Tea Lady’. Before leaving the ‘Tea Lady’, I requested her to introduce me to other educators who might be willing to discuss my topic. The ‘Tea Lady’ asked if she could use my mobile telephone to call a colleague whom she believed would be happy to have a discussion with me. However she warned me that,

> He may also decline like others because your topic is not very easy to discuss. But since you are talking about some things that involve culture, I am sure he will be willing to discuss with you because he is very proud of his culture.
She was very helpful in convincing the ‘Feather Man’ to speak with me. She promised me that she would physically be there to introduce me to him on the day he asked me to come. On the appointed day, I was dropped off in the school environment as early as 8 am by my husband. While waiting for the appointment, I decided to engage groups of learners in some informal conversations at their tuck shop. Soon afterwards, I was beckoned by an unknown male to come into the staff room. In the staff room, I made straight to the seat by the door next to the ‘Tea Lady’ (whom I had become familiar and comfortable with). My eyes were immediately caught in admiration by this particularly well adorned man as he hung some teaching materials on the wall and some stuff inside a locker. ‘Feather Man’ as the name suggests, is a teacher who adorned himself with beautiful leather wrist and ankle bands. He also wore some beaded ornaments around his neck and a feather-like ornament around the ankle. He claimed to have some cowries round his waist and there was one cowry tied on a strand of his Rastafarian looking hair. Heading towards the door, he stopped abruptly, turned towards me and with a warm but shy smile said;

*I am sure you came for my interview. Are you ready? I will be going in for a class after break so can we get to the hall and you ask me what you want to ask.*

I was elated at another good reception. This was because I had been turned down by some educators in other schools. As we walked towards the school hall,
I watched in admiration the arrangement of red and white colours in the beads. Inside the hall, ‘Tea Lady’ introduced us and left. ‘Feather Man’ told me that he came to the school because he had been asked by a good friend to come and discuss some issues with me. He taught full time at a nearby school but came as a replacement educator to this school. It was the same hall where I had interviewed the ‘Tea Lady’. This unknown male cleared his throat and asked;

What is it you wanted to discuss with me? I was told it is very important and that I will be helping you by sharing my own experiences. Is that so?

With that I handed the consent letter for him to endorse for me. He declined and said he is an adult and that if he did not want to talk to me, he would not have come. I thanked him and introduced the topic. These exaggerated beads and feathers caught my attention so much and somehow made me uneasy. Trying to comfort myself in a manner that would not embarrass him, I quickly appreciated the feathers as ‘jewellerys’. He responded with appreciation. When I asked questions on how culture influenced the way public school members experience the epidemic, the ‘Feather Man’ said,

I believe that because we are not used to talking about HIV/AIDS, no one knows how to deal with it. Some who know about the disease still believed that we do not know all about it and so will like to keep our distance from the one that has it. I am not sick but I do not want to get sick. The shame
involved is too much and someone like me cannot bear that. I do know what they say about ‘condom’, ‘be faithful’, and the impossible ‘abstain’ stuff. They may be true for others but for some of us, we still know that sometimes, some things will go wrong because necessary precautions were not taken. The things you were admiring are my protection from the Umthakathis and their Tokoloshi. These are the spirits that send isidliso to people. When I am dressed like this, they cannot come near me. These are protective charms from my forefathers and I believe in them. That is why I wear them irrespective of what anyone will think or say. That is my culture and I believe in my cultures.

For the time since the interviews started, I had never seen anyone that bold and infused with such confidence while discussing the topic. Looking at the artefacts, one would think they are for fashion but according to him, they represent something much deeper. When such accessories are worn in large numbers and especially by a teacher, it really looked odd. Walking around Johannesburg, you will see people wearing feather-like bangles, ear-rings and slippers. ‘Feather Man’, demonstrated a stronger sense of self confidence in his traditional practices than the ‘Tea Lady’ who seemed to be very secretive about her religious practices. This is seen in some of his emphatic statements such as; ‘I believe that; …and I believe in them, I believe in my cultures’.

This respondent started with considerable disaffirmation of his identity as an educator who should be able to discuss issues around HIV/AIDS more openly.
He tied the inability to ‘talk’ about the epidemic to not knowing how to deal with the epidemic. This participant talks about the insufficient biomedical knowledge available on the epidemic which strengthens the isolation of those living with the disease. It was his experience in his indigenous cultural background, related to his HIV/AIDS attitudes and practices, which provided understanding and gave meaning to what he believed and which provided practices towards the epidemic and PLHIV. He was able to develop this indigenous approach by embracing supernatural beliefs and practices, wearing protective charms against the epidemic or what he describes as *isidliso* and *Tokoloshi*. With these new approaches (use of charms and belief in the forefathers) he was able to deal with the epidemic (which he believes to be *isidliso* transmitted through the *Tokoloshi*) and PLHIV. As he perceived that his claim of insufficient knowledge was being affirmed, he began to reduce his discussion of the extent to which the biomedical approaches to prevention are effective and then pressed his claim for the indigenous protective strategies as more effectual.

He was outspoken in emphasizing that he was not sick but that he believed in protecting himself and his wife against the epidemic. He commented on the extensive shame associated with the illness which could not be tolerated by someone like him. He has a clear idea about the biomedical knowledge of the illness. He anticipates problems with the biomedical practices alone as a solution to the epidemic and identifies the supernatural approach as the first point of contact to resolve issues relating to protection. However, although he mentions the biomedical ways of protection against HIV/AIDS, he talks more about the use
of charms as more effective. Here, this participant seems to be acknowledging traditional powers and supernatural abilities despite attempts to develop the different biomedical and legal preventive strategies subscribed to in the National Policy.

Although I was shocked at some of his responses which suggested that he has a good biomedical knowledge of the epidemic but with alternative views, I remained composed and was even more inquisitive. The use of the semi-structured interview guide allowed me to probe. I decided to find out more about the Umthakathi and tokoloshi. He explained;

You see, in my culture, we have three major categories of traditionalist, I will make it brief for you. They are the izangomas who are usually women, the Inyangas: usually men and then the Umthakathis. The inangas and izangomas are the good ones. They are the traditional healers. When anyone becomes sick, he or she is taken to the izangomas or inangas for healing or help. But for the Umthakathis, they are the witches that inflict people. They send their tokoloshi (their weird children sort of) to come and inflict their victims with sicknesses or steal from them. I know that HIV/AIDS cannot be cured by the herbalist but they said that prevention is better than cure. My father is an inanga, he gave me these charms, as long as I am wearing it, I will not be infected. But that does not mean that I should mess around. I also protected myself and my partner by putting ikhubalo on my partner. With that one, when she wants to cheat on me,
the snake I have used and put inside her will attack the man when he wants to penetrate her. He will fall down and sometimes die or get sick afterwards. That way, she will not cheat and isidliso (HIV/AIDS) will not come to us.

That was a lengthy narration, an exploratory one indeed. The first thing I noted was that ‘Feather Man’ demonstrated a profound understanding of the epidemic: from both education/training and even from his father. At least he knew that HIV/AIDS had no cure, and that the traditional doctors could not cure HIV/AIDS. He also seemed to know that protection is the only way out. He seems to have thought about the epidemic a lot especially in relation to his family, beliefs and education.

I observed the pre-colonial patterns of the practice of traditions and spiritual beliefs from this extract. He seems to be talking from the perspective of what he called “my culture” suggesting a strong inclination and ownership of the beliefs and practices located in this culture he claims to be his, which is in opposition to the biomedical practices. However, he draws deeply on this particular tradition which he seems to ‘own’ and described as ‘my culture’ to construct this tradition in a very substantial way to reconstruct a position that this tradition may provide a more potent protective measure against HIV/AIDS. Instead of having safe and protected sex, ‘Feather Man’ came up with an answer that reflects both medical and traditional prophylactic ways against the epidemic: ‘medical’ because he
recognises that HIV/AIDS has no cure and ‘traditional’ because he prescribed the use of *Ikhubalo* for protection against HIV/AIDS.

Meanwhile, ‘Feather Man’ appears to emphasize a shift from treatment to prevention. He also seems to be accentuating a swing from the former belief that Izangomas treat disease to acknowledge that in the context of HIV/AIDS, they cannot treat or cure but can prevent or protect. I deduce first, that ‘Feather Man’ is intermixing or blending and combining conventional scientific knowledge with tradition. In other words, he is attempting to incorporate elements of biomedical or western medicine (cure) with traditional prevention (protection). I argue that ‘Feather Man’, like many other members of public schools, demonstrates sophisticated medical understanding of HIV/AIDS but is re-inventing tradition and re-constructing and blending them to replicate the concepts of the theories of social realities.

In one of the schools visited, I requested an interview with a member of the school governing board following the suggestion by my key respondent. She said; ‘ask the principal to hook you up with Mr D. He is very knowledgeable on the issues of culture and this disease. If he will be able to discuss with you, I am sure you will learn more about some of our culture and this disease.’ The Deputy Principal assisted me in setting up the interview with Mr D. I visited Mr D in his office during his break hour as he asked me to do. He was very willing to discuss my topic and seemed very elated when I introduced myself as a research
student. His immediate response was; ‘I like research students and I have dealt with many of them although not on your topic but on school administrative stuffs. I am beginning to wonder if people are no longer interested in HIV/AIDS.’ The interview did not take long because he quickly summarised the issues concerning school and HIV/AIDS by saying that the Principal and the educators know what to do according to the legislation. However, he spent much time trying to convey the absence of culture in the legislation.

During the interview, he said;

You know that there is a better way to protect people from this disease. Although it is not what one will suggest in the school but the fact is that it is very much used by so many people. Do you want me to tell you about it?

I indicated I would be obliged and he did not hesitate to ask me further; ‘...in your interviews, has anyone told you about ikhubalo?’ I replied ‘yes’. Then he requested I tell him what the person said. I narrated the ‘Feather Man’s’ Ikhubalo tales. He seemed very excited. He added another version to this indigenous cultural protection mentioned by the ‘Feather Man’, confirming the authenticity of the belief in using charms to protect partners from contracting HIV/AIDS. He said;
I will tell you another way the ikhubalo works. It is considered to be more potent than the ones the teacher told you. First let me clarify that when you use the dog or snake to prepare the charms, you intend to either kill the man who wants to sleep with your wife or embarrass them. The most potent one which I think is aimed at protection without malice is the ones that when the woman is locked with it, when the man comes to penetrate, he will not see the vagina opening. That way the man cannot sleep with the woman. No penetration, no HIV/AIDS (He chuckles).

I attempted to smile along and when the excitement stopped, I asked him; What about the women, can they also put Ikhubalo on their men? He responded;

_The first thing is that she is not aware that she is locked or is wearing the charm. So how will she know? Except a promiscuous woman who will find out when she goes out with her boyfriends. In that case, she can go to another Umthakathi to unlock herself and then lock the man. But I must tell you, it is usually rare for women but common with men._

This governing body member knows much about the legislation and what is expected of the school in terms of dealing with the epidemic in school. He also has a deeper understanding of the indigenous cultural beliefs and practices in dealing with HIV/AIDS protection. Understanding the legislation implies knowing both the medical and legal approaches to the epidemic. However, he seemed to
have abandoned these conventionally (medically and legally) recommended preventive measures for traditional beliefs in practice. Like the ‘Feather Man’, Mr D believed in protecting himself and his spouse from the epidemic through the use of charms.

Another revealing part of ‘Feather Man’s’ experiences is the belief that Umthakathi (the witch) transmits the infections using his weird children, while the Izangomas and the Inyangas (healers) treat those infected. To him, there is a sharp distinction between the activities of the Umthakathi (witch) and Izangoma/Inyanga (healers). The former is considered bad and afflicts while the later is good and heals. In clarification, Rodlach (2006) classified such experiences as involving sorcery in dealing with HIV/AIDS. He states that because sorcery beliefs have worldwide distribution, they are crucial in understanding perceptions of and reactions to misfortunes, illness, and death. Diseases tend to elicit sorcery beliefs, which may play a minor role in some societies, but are inseparable from virtually all systems of disease aetiology. In regions inundated with HIV/AIDS such as South Africa, people will still engage with and refer to sorcery beliefs as they try to understand the epidemic despite the ‘good’ medical knowledge available about the epidemic. Gausset (2001) emphasises that such belief is the only way of making meaning of an overwhelming situation such as has been created by the epidemic. The ‘Feather Man’ and Mr D’s narratives are typical of sorcery beliefs and practices in HIV/AIDS experiences.
HIV/AIDS is known to be a chronic medical illness and educators with the most minimal knowledge of the epidemic attest to that. This cultural belief which ‘Feather Man’ tenaciously holds on to is not only a reflection of fear of the illness and therefore of death but also of fear of the stigma attached to the sickness, the infected and affected. All these could be attributed to the complex and complicated nature of HIV/AIDS and the fact that medical and legal approaches are still not offering enough for the containment of the infection.

The three reasons advanced for spreading Isidliso by this respondent are as follows; jealousy (especially when your enemy’s children or spouse are doing well or better than before), revenge (when you have been told that someone has bewitched you or a member of your family), malice (just to inflict pain and suffering to someone you quarrelled with). Either way, the best thing to do is to protect yourself and your family by using the feather-like charms such as those worn by the ‘Feather Man’. This does not mean that all feathers worn in South Africa are charms for protection against the Umthakathi and Isidliso but it is also possible to put the protective charms on since they are beautiful. That way, nobody will clearly understand the function but the person wearing them.

Gender issues are also represented in this narration. Both ‘Feather Man’ and Mr D gave the impression that men are the ones with the ability and/or powers to put ikhubalo on their partners. To Mr D, ‘she is not even aware that she is locked or wearing the charm’ and to the ‘Feather Man’, this is his marital and family
‘security’. If the women ‘unlock’ themselves or reverse the *Ikhubalo* in any way, they are considered promiscuous. This is an attribute of a society whose culture favours male sexual dominance, making women vulnerable to what this man also refers to as ‘*my protection*’. The question is; who will protect the woman from his sexual expeditions which seem to be allowed, as the woman cannot put any ‘security’ on him?

‘Tea Lady’ and ‘Feather Man’ use a combination of several measures to mediate HIV/AIDS. They chose to mediate their HIV/AIDS lived experiences in similar ways; through biomedical, beliefs and the use of the physical presence of their spiritual embodiments namely: blessed tea, water, beads, feathers and cowries. However, while ‘Tea Lady’ uses her blessed ‘water and tea’ for treatment and is culturally religious, ‘Feather Man’ uses his beads, cowries and feathers as protection and is culturally traditional. Both of them demonstrated an outstanding fact about HIV/AIDS. They both seem to know more about the epidemic than they are practicing.

**The Christian Gentleman**

The educators became busy with marking the end of term’s examination. I then used the opportunity and the period to conduct the focus group discussions with the learners in school C. I arranged to meet the learners in their hostel. The social worker had become used to me and some of the other members coming to the ‘children’s village’ (as the hostel is called) to assist in remedial coaching. I
arrived at my usual time in the evening to assist them in their home-work and then arrange for the discussions. They were very excited to discuss a different subject other than poetry with me. The first group comprised of four (4) boys and three (3) girls. I brought some apples and snacks as I usually did when I came to assist them with poetry/English assignments. As soon as we were settled for discussion, I noted that the boy who arranged the meeting for me was not around. I was told that he left a note for me. In the note, he requested that I give him a private interview from the rest if I wanted him to contribute meaningfully to my questions. I obliged.

The next day, I drove myself to the school with the intention of picking up the ‘Christian Gentleman’ and dropping him off at his hostel after the interview: that way, we could get time to discuss more. That was how I met my first adult learner from grade 12. I was able to pick him up from school after some interviews with two educators. We had ample time to talk since the teachers were very busy with marking and there were no serious classes going on. At the beginning, he was not very keen to discuss HIV/AIDS with me because according to him;

What do they learn from all that they have been teaching us? What will they even learn from your studies? These people can only be changed in their graves. Why bother talking about it in the first place? They don’t learn.
This quote exemplifies the resigned and hopeless attitude of some members of the public schools towards the epidemic and PLHIV. The respondent’s rhetorical questions followed by condemnation could be attributed to the complexities of dealing with the disease within the society. I pleaded with him and reminded him of his note. Finally he asked me, ‘Do you believe in life after death?’ My answer was a hesitant ‘yes’, fixing my gaze on him because I was not sure what he wanted from me. My response became my break through for the interview. He then offered me the opportunity to choose where the interview would take place. I suggested the school hall since it is usually free and moreover the school authorities had given me access to it for the interviews. As the interview started, he kept using the pronoun ‘they’ referring to his fellow learners. My immediate question was why he thought that it was not necessary to discuss HIV/AIDS, culture and gender. He answered,

This society is very perverted in their minds and behaviours. That is the reason for the HIV/AIDS predicament. They have these very unusual sexual behaviours that are very demonic. Why would any man or boy for example get involved in gay relationships for example? Why should anyone not married be having sex as if he or she is married? For me I believe that sex is right at certain time in ones’ life. I am never happy when I see a young girl suffer in life because one useless boy made her pregnant and as if that is not enough, infected her with HIV/AIDS. Ma’am, there are consequences for every ill actions or mistakes (as they often call
it). We youths are not listening and because of that, we are paying with this illness and then death. We have been taught about this illness, even if we do not believe what they have taught us, we have all seen what it is doing in the society. Children and most of us are orphaned by HIV/AIDS and majority of us are born with it. My worry is that we still behave as if we are not aware of the disease. This is especially when there is no adult around. We think we are pleasing our parents for abstaining but what we do behind exposes us to the infection. The truth Ma’am is that, majority of these youths are already sick because of sexual sins. I know you have heard of fornication and adultery, that is what I am talking about.

I thought the ‘Feather Man’s’ narrations were long but that of the ‘Christian Gentleman’ was even more challenging. He presented a clear understanding of biomedical knowledge of the epidemic by the youths. The ‘Christian Gentleman’ acknowledged that the HIV/AIDS lessons in their Life Orientation subject are enough to create a change in behaviour among the youth. The respondent made it clear that learners are not ignorant about how the disease is being transmitted and its impact on the society. I was impressed by the realisation that a learner at least worries about the lack of behaviour change given the infection rate. However, I observed that the ‘Christian Gentleman’s’ narrative has a strong Christian theme. He blamed the spread and inability to contain the disease on people’s sexual attitudes which he described as ‘perverted’ and ‘demonic’. The ‘Christian Gentleman’ was a bit judgemental with elaborate prescriptions on how
people should live to avoid what he described as ‘consequences’ of their actions. To this respondent, HIV/AIDS is a consequence of ‘ill actions’. Those who are living with HIV/AIDS are therefore paying for their ‘mistakes’. He highlighted the vulnerability of the women in his concerns and seems to suggest that even when they are youths, women are being dominated by their male counterpart and the women suffer more. His narratives posit that learners also combine constructs to make meaning of the HIV/AIDS lived experiences. According to his narratives, they blend Christian beliefs, and biomedical constructs in their experiences. The ‘Christian Gentleman’ added:

*What we do not realise is that people are dying because they are not listening to the voice of the Lord. All these educations and trainings about the disease is a way that God is using to tell His people to avoid sin. What else should I say to you researcher? When a man or woman leaves his/her partner for another, what is that? Sin! When young one who is not married goes to commit fornication and adultery, what is that? Also sin! Not being contented with what they have and not being able to wait at the promises of God. The truth is that people are paying for their sins with their lives. The holy book has it that the wages of sin is death. That is it. Whether you believe me or not, when they turn and return to their Maker, He will forgive them and heal their land.*
In this extract, the respondent identified that the epidemic is a message from God, and that people’s inability to listen to God’s message is the reason for HIV/AIDS. Another revelation from this response is that HIV/AIDS is a product of sin. He suggested that, unfaithfulness, sex before marriage, and discontent are evidence that people are going against God’s message and ethos and so they are ‘paying for their sins’. He finally suggested that ‘when they turn and return to their maker (God), he will forgive them and heal their land.’ Based on this suggestion, HIV/AIDS is therefore redefined as a global sickness that God alone can heal. This participant’s response seemed to suggest that I (the researcher) has a message to relay to my audience regardless of whether I believe or agree with what he is saying or not. The blend of religious beliefs highlighted a religious justification of the stigma towards PLHIV. These narratives also show how people combine different world views and perspectives to make sense of the disease and to deal with those living with the disease. In this case, the ‘Christian Gentleman’ understands the ABC of HIV/AIDS but reconstructs the disease within the context of Christian beliefs.

The ‘Christian Gentleman’ involved God and gave the impression that God is salient in the containment of this illness. He also believed that disobedience to the rules or law of God is the cause of the escalation of the HIV/AIDS epidemic in public schools. Thus, ‘Until they repent and turn away, the disease is yet to claim more people. HIV/AIDS is a curse from God because of sin’. He concluded;
This disease only comes to you when you are unfaithful. Unfaithfulness is disobedience to God and so, it looks like a curse when you fall into it. God is visiting the iniquities of the sinners on the land through the epidemic.

The ‘Christian Gentleman’ concluded that HIV/AIDS is ‘punishment’ from God for disobeying Him. Contracting HIV/AIDS according to his opinion is like being cursed because God must have punished the infected (sinner). These religious attitudes towards and understanding of HIV/AIDS and PLHIV are not only African. A report from Wagoner (1994) stated that even in America, the belief that AIDS is a punishment from God for immoral behaviour is not uncommon. The study revealed that two-thirds of African-American women from an urban area believed that AIDS is a fulfilment of the prophecy regarding plagues from the book of Revelations (Flaskerud & Rush, 1989). The interviewee’s concluding remarks:

The Holy Book called all this disease the beast. It is going to kill very many people before they will discover the cure. And when the cure is found, there will be another thing that will kill many like HIV/AIDS. That is the second beast. These are the signs that the world is about to come to an end.

This eschatological (end time) fatal message is the climax of the ‘Christian Gentleman’s’ revelation of HIV/AIDS. To him the world will soon end and HIV/AIDS without a cure is the sign of it.
The Curse Lady

Before I finished the interview with the ‘Feather Man’, I received a call from a lady I chose to call ‘the Curse Lady’ telling me that I could interview her but on one condition. The condition was that I must not record her voice but that she would be happy to read and sign what I had written as a true representation of our interview. When I finished with the ‘Christian Gentleman’, I proceeded to the restaurant where she wanted us to meet. On my arrival, she was already there and received me with that look of ‘now researcher, what did you say you wanted from me’. As soon as I sat down, I popped out my first question. Her response was very defensive as follows;

I am sure it will be same thing in your country also. But I have not stopped wondering why this disease is mostly brought home by men. You see when my husband was flirting with that young girl; he thought he was hurting my feelings. He actually did, but he hurt the kids much more. Though I have forgiven my husband, I still believe that he brought the curse of the land to our family. He brought this curse home and we are all soiled by it. I wish he is still around to keep smelling it. He has made the kids to be the object of gossip around the community. I do not think about myself any longer but just worried about my children. Any time now, I know I will die so it is no longer about me but them. I know that the ARV is still working but sometimes, I can see that the drugs are also about to give
up on me. But I am now prepared to die. My only worry is the children. The whole family is cursed by his unfaithfulness directly or indirectly.

An outright impression from this response is anger towards the male folk. She blames the men for the spread of HIV/AIDS. However, she described the epidemic also as a ‘curse of the land’. The unfortunate part of the narration was her description of the epidemic as a ‘curse’. She saw the infection as a curse on her family. Her present HIV/AIDS positive status was presented as the direct curse while the effects of the curse could be the stigma that faces the children presently and even after she is dead. She demonstrated the HIV/AIDS’ double effect or ‘stain’ (stigma) within the society; first, in the present (on her) and second, in the future when she is dead (on her children), who though they may not be positive will be isolated and treated with the assumption that they will also follow suit. Seeing HIV/AIDS as a ‘curse’ by this respondent is metaphorically an illustration of something with offensive repercussions on the family. It has the ability of spoiling the aura of the personalities attached or associated with it or the person infected. Her use of words such as; ‘curse’, ‘smelling’, ‘soiled’, and ‘objects of gossip’ to present HIV/AIDS and its related challenges within the community is an expression of bitterness towards men and the disease, blame for the men and the stigma associated with the epidemic. The ‘Curse Lady’ combined the use of biomedical and traditional beliefs to express her lived experiences.
Men-are-Dogs

After many visits to this third school and after literally begging and lobbying using my expert informant, I was finally given an appointment by the principal who reminded me to ‘keep it brief please, we have a lot to do.’ Teacher C was one of the educators who decided to give me attention. She became very willing to talk to me after my key informant (the ‘Tea Lady’) spoke to her over the phone. Nevertheless, she gave me a different condition from the ones in my consent letter as follow:

I have already heard about your topic from my colleague. Promise me looking into my eyes that you will not tell anybody around here what we are going to talk about?

I gave her my word and she asked me to follow her to the school hall. This teacher is from school D. Something notable in that school was that apart from the principal and the deputy, only two teachers agreed to discuss with me. It was one of the most difficult schools in terms of collecting data but then, the most emotional and challenging information came from there.

This teacher requested that I call her Teacher Agy (not her real name) when I report my findings. I do believe that the name ‘Agy’ meant something to her but she refused to disclose that to me when I probed. Her response was; ‘Just call me Agy in your thesis. That will remind you more about me.’ I have chosen to
respect that. Agy asked me to listen and write whatever I wanted to. She, like the ‘Curse Lady’, promised to read and sign my notes when I was done. She told me that she would be happy to read the final report when I finish writing the thesis if she was still alive. I agreed to do that. When I asked her about any HIV/AIDS experiences she could recall, she came closer and whispered with a shy smile;

Mine. I am sick also. You see my dear; the fate of women in this country is very pathetic especially from my cultural background. I come from the culture where men believe they can do anything they like and get away with it. Most of them, such as my late husband believe that they are and must remain ‘Isokas’ even in their next world –if there is any. So my husband had three of us and I am sure more outside. He enjoyed clubbing more than any other leisure. Another weakness he had was going to hang out with young boys at shebeens, our local drinking place. There they get involved with all sorts of girls.

In this extract, the interviewee’s response is constructed in the context of her personal experience of gender power imbalance, an issue which seems to surface especially in culture and HIV/AIDS related discussions. She tied this experience which she considered as ‘pathetic’ to her cultural background. This respondent is bitter towards the culture which is patriarchal and seems to dehumanise the women even with the prevailing HIV/AIDS disease. In this cultural setting, it seems that men are privileged to be socialised as freer than
their women folk. She clarified, using her late husband as an example, that the elderly men among them still enjoy the company of the younger men and women thereby behaving like delinquent youths without responsibilities. She took a long deep breath and asked me, ‘Do you have such men in your country?’ She also answered herself, ‘Well, I think it is all men that do that. Men are polygamous, they said and I believe that.’ She concluded the phase with the question, ‘What do you think?’ This question to me was more rhetorical than requiring a response judging from the mood and context of the discussion. She continued;

A man who paid lobola for three women and was never satisfied with any is a dog. I do not mean to be rude to the dead but my heart is bleeding any time I know that this disease will kill me and my children will always say my mother died of HIV/AIDS. I am very sure that all his wives are polluted with this sickness. I am yet to forgive him for bringing this curses home. He brought the defecation home and we are all polluted. I am talking about a man that had three women legally, what else can women do to help men? Our children will live with the shame if they are also not polluted like their mothers.

In this statement, she likened the promiscuous attitudes of men to that of ‘a dog’. Like ‘Tea Lady’ and ‘Cursed Lady’, Agy seems to have accepted death but lamented on the isolation and stigma which she believed will hurt the children when she is dead. Also, the infection was described by this respondent as
‘pollution’. While Agy was filled with a lack of forgiveness towards her husband who she believed to have infected her, she attributed her woes to the concept of gender. Finally, Agy introduced what I described as ‘residential stigma’. For her, her ‘children will live with shame’ of their parents dying of HIV/AIDS if they are not ‘polluted’ already. Looking into her sad eyes was difficult for some time but she became strong again and lamented;

It is painful when you have such in your heart and you are expected to teach as usual. It is never the same with the days when you are not living with this sickness. You may be wondering why I called it a curse. You see, deep inside, one feels cursed because you cannot freely talk about your sickness like those that have cancer. Our society still treats you like a polluted thing that should be thrown into the bin if possible. That is the feeling. It is a very lonely disease. You even try to hide it from your children to help their morale when they are with their friends.

Yoo!(Exclamation)

This respondent was first to highlight the effect of HIV/AIDS on teaching and learning. Considering the disease to have emotional and isolating attributes, Agy thinks that it will negatively impact upon teaching and learning in schools. She said; ‘it is never the same when you are not living with the sickness.’ Although she emphasises the stigma to both herself and her family, Agy painfully refracted her lived experiences through the women’s experience induced by cultural
practices. These indigenous cultural practices profoundly disempowered women and made them subordinate to their male counterparts. This conception of gender regrettably blamed men: ‘they are never satisfied’. This generalisation may be linked first to, denial on the women’s side of being a source of contracting the illness.

The world bodies (UN, WHO) also paint the picture of women being more vulnerable to the infections biologically and socio-economically. Another argument could be the concept of also generalising that ‘men are polygamous’ and African culture gives the impression of condoning it. Rose-Innes (2006: 2) illustrated this in the following expressions; ‘South African culture is generally male-dominated, with women accorded a lower status than men. Men are socialised to believe that women are inferior and should be under their control; women are socialised to over respect men and act submissively towards them. The resulting unequal power relation between the sexes, particularly when negotiating sexual encounters, increases women’s vulnerabilities to HIV infection and accelerates the epidemic.

Generalisation was used by the ‘Curse Lady’ and Agy, like it was by Rose-Innes (2006) to emotionally present female susceptibility to the infection in contrast to their male counterparts. The concept of generalisation in this context also emphasizes the gender based blame for the transmission of HIV/AIDS. This gender based blame suggests that men are always the culprits while women are
vulnerable. From these extracts, it becomes clear that most African cultures, especially the ones that make men ‘isoka’, equally make women subject to abuse and therefore vulnerable to the infection.

Another notable way that Agy deals with the epidemic is revealed through blame. The shifting of blame to the dead husband presents an exonerating measure and seems to free and make her a victim of circumstances here. Anger towards the dead helps justify her, paints her as the picture of innocence and properly lays blame on the dead man who according to her ‘had everything that should keep him away from the disease’. This educator did not only blame the dead but also the ‘Isoka’ culture where men believe that having one woman and being faithful to her is a sign of weakness. In summary therefore, Agy used a variety of views to arbitrate her HIV/AIDS lived experiences. They are: gender, culture and belief in the ancestors.

Agy met with me in a close-by mall two years after the data collections. She requested a copy of the thesis ‘just to read’. I affirmed to her that I would get it across to her. As we talked she said;

…I am yet to forgive my husband. I am so angry that I even refused to clean his grave. I did not even allow the children to do that either. We are still suffering from the stress and shame he put us into.

Although I do not understand the implications of ‘cleaning the dead grave’, I deduced the off shoot of her anger towards the late husband for infecting her with
HIV/AIDS. According to her, the family suffer from ‘stress and shame’ as a result of the epidemic.

**The Old Lady**

Another morning was filled with hope and eagerness to meet with an educator who was introduced to me by a male teacher on the phone as ‘always willing to talk to researchers’. On arrival to the schools’ staff room I was greeted with a very friendly welcome after introducing myself as the researcher who had been with her friend last week. She was excited and asked me to sit while she completed the filing she was doing. Suddenly, she asked me:

> I hope you are ready with your tape recorder? Others come with them and I enjoy listening to myself after the interviews. I like talking to the researchers because I am also studying and hoping that my turn to conduct research will come and I will be happy to get good responses from people also.

I was happy. At last I would be able to record a teacher for the first time since the interviews started. I quickly showed her my tape recorder and cassette. She quickly tidied up and we moved to the deputy head teacher’s office already prepared for the interview. The office was very quiet though there was intermittent interference from learners coming in and asking for one thing or the other. On noticing that we would be interrupted a lot, she put out the ‘don’t
disturb’ notice on the door. Calmness returned and we started. She requested my consent letter which she calmly read through. Her face dropped immediately and she said;

_Sis, please if you do not mind, put off the tape recorder. I am not confident discussing your topic and recording it will truly embarrass me. I will not be happy to hear what I will say, if at all I have anything to offer on this topic. Do not get me wrong, the interview will still go on but this is one of the topics I am not very comfortable talking about._

This respondent revealed another aspect of HIV/AIDS lived experiences by members of the public schools: timidity. Not being ‘confident’ to discuss the topic suggests that some members consider the topic too tragic, combined with embarrassment and fear of the unknown. The ‘Old Lady’ considered discussing HIV/AIDS an embarrassment of some sort. No possible interpretation could explain the concept of ‘embarrassment’ in discussing the epidemic. However, she revealed that some members of the public schools, despite their levels of education, still find it uncomfortable to discuss some topics relating to HIV/AIDS. For this respondent, it is one of the topics she is not very comfortable talking about.

I was disappointed because the work of scribbling during interviews had not been fun. I conformed and then asked; ‘why do you feel uncomfortable talking about
HIV/AIDS? She looked at me with a changed countenance from the formerly excited one and said;

*I cannot deny who I am. I am not very confident talking about death and sex. I may not be able to give you a good and brilliant answer to why. Especially being a teacher but you have to understand, there are things people do not want to talk about for reasons very personal to them. I also know the importance of talking about HIV/AIDS to the learners especially as one of their mentors. But there are other people who are gifted in doing so. Unfortunately, I am not one.*

In this extract, she gradually began to open up on why she is unable to discuss the topic. First, it is because of the associations of the epidemic: death and sex. To her, HIV/AIDS equals death and sex and these two topics are not easily talked about. While she insisted that the reason for not being able to talk about the topic is personal, nonetheless, she realised the implications of that especially as an educator. I insisted on knowing why an elderly woman and a teacher like her found it difficult to discuss sex and death with the learners when it is obvious that she must. She responded;

*Call it whatever you want. Backward or whatever, I just cannot feel free talking about sex and death with the learners or my children. We were brought up that way. Many women are like me but some have been able*
to come out of it. I just do not know why I have failed to break through that despite all we have been taught about HIV/AIDS. Don’t get me wrong I am not just comfortable discussing that. I know that must have disappointed you greatly especially when I think I have excited you. That is me and I am sorry about that. Is there any other thing you want us to talk about? Otherwise, I will introduce you to the LO educator. I think she is best at your topic.

In this narrative, I was able to appreciate the grip of culture on this respondent: ‘We were brought up that way.’ One thing that is not certain in this response is the ‘we’ concept. She seems to be revealing that women from her cultural group are socialised not to freely discuss the topic of sex and death. The ‘Old Lady’ displayed evidence of the influence of gender and culture interplays on the HIV/AIDS lived experiences. This interplay clearly disadvantaged the women. The strength of culture in these narratives makes a mockery of women despite their level of education and exposure. Irrespective of her cultural practice of not being able discuss the topic, she did not object to teaching about or discussing the topic with the learners. She is well informed on HIV/AIDS judging from the fact that she attended all the training courses she was sent to. The only snag though is like she said ‘not being comfortable to talk about sex and death.’ She saw it as a topic that should be discussed by those talented in discussing such topics. The question is: how is she going to teach about HIV/AIDS without talking about sex and death? One likely way of understanding this respondent could be
what UNESCO (2003) described as ‘a lack of openness, in many societies, regarding sexuality, male-female relationships, illness and death, taboo subjects deeply rooted in the cultures’.

HIV/AIDS is complex and complicated in almost every aspect and this respondent did reflect that. She also replicated the extent to which culture influenced the way some members of South African public schools experience, make meaning of and deal with the epidemic in their institutions. For her, the discomfort of discussing sex is culturally motivated as is evident in the following statement ‘It is the way we were brought up.’ Another offshoot from her few expressions is the fear of death entrenched in these cultures. One of the means of contracting HIV/AIDS is through sex. According to Ashforth, (2001), these two topics (sex and death) are on the list of highly forbidden topics in Africa; yet, they are very visible in all cultures and are common traits of HIV/AIDS. This practice stretches the complication of having fair defining descriptions for the epidemics. In this case, the respondent’s refusal to continue the interview was based on the same concerns.

In an attempt to find out why this respondent was not free to discuss the topic, I decided to bring it up in the informal conversation with other teachers. Some teachers agreed with her but some found it disgusting that at this age and in her kind of profession, she would make such a claim. One of those who concurred with her stated the following:
In my culture, we do not like talking about sex openly. Death is another thing we hate to talk about. It is a spirit and spirits are not subject to discussion. These are why HIV/AIDS is not an easy thing for us Africans to deal with. I may now be talking about your own cultures too. Or do people from Nigeria talk about these two topics easily?

Another respondent puts it this way;

It has two big issues that most of us here do not like discussing: sex and death. Talking about them brings lots of bad feelings to me.

Learners in Love
In the first focus group discussion with the learners, a member surprised me with a question: ‘Will you turn your back on your friend because he or she is now mad?’ That was his way of letting me know that it is improper to discriminate against friends living with HIV/AIDS. As the discussion progressed another learner said;

Maam, this is not a good topic to deal with. It is also not easy. You see, when they say; abstain from sex, what other ways do they want us to use to show our girlfriends that we truly love them? How do they want us to protect our girlfriends from going to the older men? When they also say be faithful. I am sure they mean to one girl. How then will I show that I am healthy and a real man if I get stuck with one girl. Finally, use condom,
how will you feel the babes? You cannot feel them if you are wearing condom. It is plastic and most girls do not like it. I have not finished ma’am, you can see that life is short these days maybe because of AIDS, how can you get children or a child if you have to wear condoms? We need to reproduce before we die. Now answer the following before we advance to other questions.

This focus group discussion began with learners indicating, just like other respondents, the complex nature of HIV/AIDS related discussions. This respondent described it as; ‘not a good topic to deal with and also not easy’. However, while other respondents concentrated on issues around transmission and the stigma associated with the disease, these youths were concerned with the biomedical approaches to dealing with the disease. They seem to worry about ‘Abstain, Be faithful and use a Condom’ rather than the fear of death, stigma and the change of behaviour identified by other respondents. Another difference is that their responses seem not to pay attention to shame and blame but rather to the socialisation practices which limit their level of sexual interaction with one another. For example, the boys consider sex not as a taboo but as a way of demonstrating ‘love’ to their friends, a way of preventing their girlfriends from sugar daddies and a way of showing that they are ‘real’ men (in the case of having one girlfriend/being faithful), and making babies in the very short life span caused by the epidemic.
Although these opinions are unique and radical, they demonstrate that the younger generation mediate HIV/AIDS differently from the educators. It was not only this respondent that was concerned about these questions. The rest of the members of the group were excited and some were cheering him. Others passed on papers that seemed to contain more questions. These learners did not mean to slight or make a mockery of our discussion. Rather, they represented serious-minded learners, open and wanting responses or answers to what could be called juvenile questions by some critics. Yet these were pertinent, topical and real ‘questions’ from a group of youths socially confused and restricted by new sexual rules and HIV/AIDS. One of the critics was the teacher present during the focus group discussions. I requested that she excuse us after seeing her facial expressions and hearing her comments on the questions. Such comments as: ‘get serious, this is not a joke boys and girls.’ For her, she was helping me maintain order or class control, but I let her go and assured her that I could handle the group. I saw her as a threat in getting original data from these mature learners who would not feel free to talk for fear of her reprimands. She was very understanding and excused herself.

The class was relieved and ready to discuss their thoughts without restriction. Although I was unable to respond to all their questions, we were able to discuss at large. More questions and comments that followed were now from the girls. The first said:
Maam, sometimes this condoms burst and some leak. In those cases, will one be guilty of not heeding to the rules as the teachers often comment? Are there no mistakes in life again? I know that some may cost lives but why do they (teachers and adults) do as though some things are intended. Sex is a must and condoms are necessary but what happens when you are really ‘there’ and there is no condom and you cannot say ‘stop’? These are the youths’ predicaments.

In this extract, this learner was giving reasons to justify what she described as ‘mistakes’. Although she realises that such mistakes could be costly she blames the educators and adults who reprimand them for such ‘mistakes’. This participant did not deny reality of sex and acknowledged the usefulness of condoms. However, the participant was blunt in confessing that sometimes it is too late to use condom as is usually the case with them.

Everyone was now calm and appeared to be guilty while agreeing with her. No one offered a solution to her question immediately. After some silence, a member raised her hand and the following were her remarks: ‘I do know that these things happen but we have to try and either be prepared always or lose our lives. Secondly, we should learn to say no.’ They jeered at her and peace returned after some time when they realised that I was just watching quietly. Another opted to summarise what they wanted to put forward to me thus:
Ma’am, with due respect, these are some issues or questions that have been disturbing the youths. We just cannot abstain because it is our turn to explore life at the same time, we do not want to die of HIV/AIDS. What is the practical way to go about these? You heard me, practical or rather solutions to our dilemma!

This response highlighted the two disadvantageous aspects of the complicated situation these youths found themselves in. These are; ‘they cannot abstain from having sex; at the same time, they do not want to die’. The question that followed is not addressed by the medical, human rights, cultural and gender approaches: ‘what is the practical way to go about these?’. This question also suggests that none of the established approaches have been able to provide a constructive or what this participant described as a ‘practical’ solution to the spread of the epidemic.

This discussion ended unresolved among the learners but for me one mission was fulfilled. This event was critical in trying to appreciate how these learners understand the epidemic and the challenges they face as a result. They presented a good knowledge of what causes HIV/AIDS and the recommended protections. Nevertheless, they also seemed to have a good understanding of their cultural expectations and beliefs (reproduction and polygamy). Another visible fact was their fear of contracting HIV that causes AIDS and the inability to control sexual desires.
It is petrifying, though, to note the reasons for refuting almost all the HIV/AIDS prevention strategies despite their experiences of deaths in their families or neighbourhoods. One of them shocked me when he said:

*It is better to die in the name of love. How can we not have sex with our lovers simply because they are infected? First, they will miss out of sex and secondly, we shall miss out in their affections. Everybody will die, it does not matter what kills the person. It could be AIDS, or even accident. Death is death. We cannot give up on sex and our friends because of AIDS.*

A different sense of resignation was also noted in the above contribution. While the respondents during the interviews were resigned to dying but bitter because of HIV/AIDS, this learner accepted death as long as he ‘dies in the name of love’. To this generation, HIV/AIDS-related death is not embarrassing or death with regret and shame. It is death as a result of love, the type that should not be associated with regrets but satisfaction for all parties involved in sexual practices. Again, to them, everybody will die and the cause of the death will be bitter if it is not in the name of love. HIV/AIDS in this context and to this generation carries love along to its death. The fatal conclusion of ‘not giving up on sex because of AIDS’ suggests that these learners see HIV/AIDS differently from adults and most of these learners mediate it in the same way.
The feeling of dying, loved, was also shared by members in another group discussion. Sympathy (i.e. love) among the youths is valued more than life in these discussions. Could that be a way to slight the existence of the HIV/AIDS-related stigma or could it be, like they said, ‘confusion in not knowing how to deal with the epidemic amongst them?’ ‘Learners in love’ discussions revealed that there are evidently several perceptions of how members of South Africa’s public schools adjudicate their HIV/AIDS lived experiences. It is not just about gender, culture, and beliefs but also about ‘your generation’. Gender and their generational positions evidently influence the way the youths make sense of the disease, and PLHIV. They do not have any sense of mortality and so were unable to vividly see an HIV/AIDS-related death as a loss in any way as long as it happens in the name of ‘love’.

In conclusion therefore, this chapter posits that there are varieties of academic and non-academic views used by the members of South Africa’s education workplaces to refract HIV/AIDS lived experiences. Some of these views are very contradictory and the government seems to have been unable to recognise these constructs in planning and implementing the national HIV/AIDS policies for public schools.

**Summary and Analysis**

In this chapter, I have drawn attention to overlaps between various beliefs and practices that characterised the HIV/AIDS lived experiences of the members of
education workplaces. Though some studies refer to these constructs, they do not explicitly identify the combination, or what I identified as ‘hybridisation’, of these constructs in the understanding and practices around HIV/AIDS and PLHIV. HIV/AIDS academic analysts have rarely looked at these combined lived experiences that characterise HIV/AIDS. However, in the South African public schools’ cases, I saw that there is no one approach or strategy that individuals use to mediate the epidemic. I also note that while there are various ways of experiencing the disease: people combine two or more approaches.

Firstly, there is evidence confirming that members of these education institutions have relatively good biomedical and legal knowledge of the epidemic, such as is provided in the National Policy document. A closer look at the HIV/AIDS lived experiences at the individual level confirms the inadequacy of the biomedical and legal approaches to the epidemic. Although most of the educators and principals draw their experiences mostly from the biomedical and legal approaches, most of them also integrate aspects of religious, gender and indigenous cultural beliefs and practices. Also, despite the fact that biomedical and legal approaches are officially recommended, members of these education institutions see these strategies as insufficient, inefficient and ineffective in providing solutions or answers to several questions. Because these two approaches (biomedical and legal) have some attributes which instead of solving the problems, encourage several forms of emotional torment from their high costs, and because of the
culture of secrecy and privacy, alternative measures were incorporated by these individuals to deal with the multifaceted challenges of HIV/AIDS.

The experiences narrated in this study have pragmatic implications for how people experience the disease and PLHIV in education workplaces. From the first respondent, I showed narratives of someone who was very knowledgeable in biomedical approaches to HIV/AIDS, but who chose to embrace religious beliefs and practices in her lived experiences. This educator seems to have successfully maintained her claim on the religious approaches whilst acknowledging the biomedical and other cultural practices relating to the epidemic and PLHIV. There does not appear to have been any significant disaffirmation by her of HIV/AIDS lived experiences; rather, it is the aspiration to the search for a cure and protection from stigma that led her to choose to give up the biomedical approaches to the disease. Her lived experience with the disease has reinforced her sense of being someone who is able to deal with the HIV/AIDS related circumstances in her school. What emerges very powerfully from this respondent’s narrative is the centrality of belief, particularly religious belief in dealing with HIV/AIDS in the work place. This theme appears throughout the research but in a variety of forms. I abandoned the assumption that biomedical and legal constructs are truly accurate versions of a participant’s beliefs, actions and practices towards HIV/AIDS and PLHIV. From the above, the challenges seem to revolve around the treatment of the infection and dealing with the stigma associated with it.
The second case presented here is someone who switched from treatment to protection against the infection. This educator started with considerable dissatisfaction at the western-medicine approach to protection against the disease. It was his experience of his ethnic practices, which provided understanding and meaning to what he prefers to use to protect himself and his wife. He was able to develop this new protective strategy by adhering to his indigenous cultural practices. With this new experience, he was able to protect his family from the disease which carries unbearable shame for someone like him. From this respondent, I posit that people construct their own beliefs and practices towards protection against the epidemic, some of which are in contrast to the protective strategies laid out by the biomedical discourses.

Another example of religious beliefs is one of extended eschatological Christian beliefs and practices. This notion by the Christian Gentleman suggested that HIV/AIDS is God's ways of venting His anger on the generation that has turned their backs on Him. This view does not necessarily provide opportunity for people to learn from their mistakes. People living with the disease have been condemned to pay for their ‘sin’ by death which is their ‘wage’ for not listening to God’s messages and instructions.

The fourth respondent offered an example of an educator who is struggling to accept the challenges of being infected. She started with bitterness, blame and
anger towards the society that seems to appreciate the males more than the females. She took this position because it was difficult to forgive a man who traditionally married three wives and yet was promiscuous. She has now become resigned to a life of shame for her while alive and for her children when she is dead. These narratives highlighted important culturally-related concepts such as ‘curses’ ‘dirt’ and ‘pollution’. This educator (‘Men-Are-Dogs Lady) also sees the disease as dirt and herself and the infected as polluted with dirt. Douglas (1966) asserts that such feelings introduce the concept of sacredness whereby the society isolates the sick person who then keeps his or her distance from other people.

Obviously, the practices of ‘sacredness’ in relation to the illness and the infected ushered in the understanding of ‘dirt’ as associated with HIV/AIDS. At this juncture, I must emphasise that those infected are not treated as taboo or outcasts openly but are indirectly stigmatised. Not all respondents treat them so. According to Stein’s (2003) theory of the ‘latest changing faces of HIV/AIDS stigma’, it can be accepted that symbolic stigma (i.e. stigma based on moral condemnation regarding sexual behaviour) is instrumental or useful here because it serves to distance the individual or group from the fear of infection by facilitating denial of own risk (It will not happen to me because I am a good person/part of a good group of people).
The fifth respondent’s attitude to the research questions constructs the epidemic as a taboo, not discussed or easily talked about. She suggests that some members of the education sector use blame and resignation to mediate HIV/AIDS. The failure to speak openly about the epidemic, irrespective of biomedical knowledge of the disease acquired through training and based on the construction of gender was revealed. Her responses help highlight the influence of gender according to which the women are socialised not to freely discuss death and sex.

Finally, a new perspective on the disease emerges from the youths which contradict in every way the fears, shame and condemnation consistently found in the responses of the interviewees. Taking different perspectives and routes to understand and mediate the epidemic, they appear to attempt to distance themselves from the entire mystifying HIV/AIDS-related stigma because of death. They provide models for reclaiming their desired HIV/AIDS lived experiences. Their sexual relationships and the socialisation practices they engage in provide completely new and contradictory views of their friends and acquaintances living with HIV/AIDS and the epidemic.

What do we learn from this rather long expedition into the realities of the HIV/AIDS lived experiences? I argue that in order to effectively deal with the challenges people face as a result of the epidemic, we need to know the diverse ways people understand and experience the disease. I have presented
information that not only do people mediate the epidemic in diverse ways; they also combine constructs in their HIV/AIDS lived experiences. I also showed that biomedical and legal discourses are not taken very seriously in the practice of HIV/AIDS treatment and protection against the epidemic by the members of education work places. The culture of secrecy and privacy located within the biomedical and legal discourses strengthens the HIV/AIDS-related stigma which I identified in the narratives as ‘residential’ (in the epidemic) and ‘translated’ (not only for the PLHIV but also their children when they are dead).