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# The impacts of culture and gender in HIV/AIDS lived experiences in education workplaces : case study of selected public schools in Gauteng Province of South Africa.

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# CHAPTER EIGHT HIV/AIDS LIVED EXPERIENCES BY MEMBERS OF THE SOUTH AFRICAN PUBLIC SCHOOLS

## Introduction

This chapter presents possible responses to the following questions: how do educators and learners make sense of HIV/AIDS? How does culture and gender come to shape the HIV/AIDS understandings of these educators and learners? While the last segment of the analysis explored the HIV/AIDS lived experiences of the respondents, this chapter examined the possible theories and/or explanations for how these members of public schools make sense of or understand the epidemic, PLHIV and people affected by the epidemic within their various institutions of learning. In exploring these understandings, the focus is on the conceptions of culture and gender especially as they influence the participants' knowledge and perceptions of the epidemic. I drew my analyses from the narratives and descriptions used by these participants during the data collection processes. I begin this chapter by identifying the themes that effectively capture the participants' perspectives of HIV/AIDS from their descriptions and narratives. Thereafter, I provide possible interpretations for these theories and explanations. I endeavour to relate the information collected into a comprehensive analysis to effectively bring out how culture and gender constructs shape the HIV/AIDS perceptions and knowledge of these research participants.

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**Understanding th*e* Major Narrative Descriptions**

I present here the taxonomy of how members of the public schools investigated understood HIV/AIDS and PLHIV. This is aimed at unravelling the HIV/AIDS perceptions in education workplaces in South Africa. I classify the concepts of what the respondents claimed to know or understand about HIV/AIDS, despite their descriptions of the epidemic. I have tried to differentiate the narratives and trends before weaving them together to make sense of them. Efforts are made to demonstrate that these explanations are grounded in their knowledge, attitudes, beliefs and practices (KABP). The argument of this chapter is that many respondents appear to be familiar with the ABCs and biomedical constructions and approaches to the epidemic. However, evidence suggests that rather than holding to one view (biomedical), most respondents held to multiple explanations simultaneously. They do this by; holding conflicting views to the biomedical and attempt to reconcile or interlink these views. These alternative views are due to the 'no cure' hypothesis of the epidemic. Forsyth's (1907) conception of the unknown proposes that all new views are built on prior understanding possessed by the individuals.

Explanations for HIV/AIDS evident in the respondents' interviews and discussions can be grouped into six as below;

a) Biomedical understanding
b) Indigenous understanding
c) Witchcraft narratives

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d) Religious views

e) Eschatological views

f) Race theory

**Biomedical Narratives**

The primary explanation for the HIV epidemic and PLHIV by many respondents was biomedical. Most of the participants were knowledgeable about the globally promoted 'ABC' prevention strategies. The participants who shared this primary perception confined their understanding to the available medical information about modes of HIV transmission, recommended precautions, and HIV/AIDS management/treatments. These perceptions were products of HIV/AIDS education sessions, mass media reports, and life-orientation lessons they had been exposed to in the school or other HIV/AIDS related training.

I have unpacked the responses from the discussions and interviews with the members of the public schools to identify possible interpretations, explanations and theories surrounding the HIV/AIDS biomedical discourse. In doing this, I noted that each informant has unique ways of explaining the biomedical discourse of the epidemic. First, I observed that these participants' possession of biomedical knowledge was being overshadowed by the individual's attitudes and practices. Examining the comment by the Deputy Principal from School C;

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*We are very knowledgeable about HIV/AIDS. Some of us have attended some courses and that includes learners. What I am not sure about is what we do with the knowledge received.*

This deputy principal was prompt to acknowledge that members of the education sector have relatively good biomedical knowledge, and that there is good dissemination of knowledge about the epidemic. However, he raised doubts about the individuals' depth of biomedical knowledge when he softly highlighted one of the factors that may eclipse this biomedical knowledge; '*what we do with the knowledge we posses*'. The second participant from School A is the educator that teaches Life Orientation to the learners in the higher grades of secondary school. She also indicated that members of the public school have good biomedical knowledge of the epidemic and how to deal with PLHIV. However, she believes that there are other factors that surpass the biomedical knowledge acquired. She said;

We *have good understanding of the disease and how to respect those that have it. What I am not sure about is if they really internalise what they have been told about the disease.*

Her use of the word '*internalise*' could suggest that members of the public schools understood the epidemic differently judging from what she observes. The

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biomedical knowledge is therefore inadequate in explaining HIV/AIDS to these individuals.

Another deputy Principal from School B admitted adequate biomedical understanding of the epidemic in his school. He mentioned '*health counsellors and media*' as agents of biomedical knowledge. However, he introduced the concept of 'holistic acceptance' of some biomedical practices towards the PLHIV by the individual members of the educational institution as a challenge to biomedical knowledge. The fact that most of these individuals still see PLHIV as '*risks'* could imply that the biomedical paradigm of the epidemic is insufficient in explaining the epidemic to these individuals.

> *They know a lot about the disease. The health counsellors and media have taught us a lot about the disease so they know. It is only that we are yet to admit that those living with the sickness are no risk to us if we treat them with respect.*

When I raised the issue of 'holistic acceptance' which he indicated as resident in the practices of this biomedical knowledge, this deputy principal insisted as follows;

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*They know a lot about it. Learners start hearing about the disease even in their primary school. The educators must have read and some trained on the disease. I think we have good knowledge of the disease.*

In this response, he emphasised that most of the members of their school have good biomedical knowledge of the epidemic. According to him, this knowledge is based on the taught curriculum (LO) and workshops for the learners while most educators have received HIV/AIDS related training at workshops.

The next respondent, who was confident that biomedical knowledge is visible in public schools, is my key respondent. She gave a summary of the biomedical knowledge of the disease. She considered this information vital because '*it (HIV/AIDS) has no cure*'. She however, confirmed the clause following the comments on biomedical knowledge by the deputy principal of School C, as follows; '*what we do with the knowledge may be different.*' 'Tea Lady' (as I called her in chapter seven) explained that because the epidemic has no cure yet, people engage diverse theories to make meaning of the epidemic and these diverse interpretations of the epidemic are reflected in the individual's HIV/AIDS treatment approaches. She said;

*I think we have good understanding of the disease. At least we all know that it has no cure and so we must try out anything that could work. From*

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*what we have been told by both doctors and government, we are sure that it is an issue that should be dealt with as any deems right.*

From 'Tea lady', I noted that the inability of the biomedical discourse to provide treatment for the epidemic is a big hitch in the actual acceptance and integration of the biomedical knowledge in the ways these public school members make meaning of the disease. While they symbolically know a lot about the epidemic from the biomedical interpretation, they practically clutch at the inefficiencies of this discourse.

*'We have very good knowledge of HIV/AIDS more than most African countries. We are rated highest in Africa in terms of prevalence and that should tell you that even if the school or what we teach did not help us enough, experience they say is the best teacher. From what we have seen, it is better for individuals to learn whatever they want, do whatever they want because we have only seen nothing but suffering and death with this sickness.*

While this educator from School D compared the HIV/AIDS biomedical knowledge among members of the public schools in South Africa to other African countries, he also indicated that 'experience' is another source of knowledge acquisition to them. However, he posits that people have experienced so many deaths as a result of the epidemic, and they have resorted to explaining the

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disease in diverse ways (some may be unconventional) because biomedical knowledge is inadequate in explicating the epidemic.

From the second learners' focus group discussions, I also observed that the learners share similar disgruntled perceptions of the biomedical knowledge to those of the educators. This learner reluctantly admitted during the FGD that they have been educated about HIV/AIDS but the knowledge acquired is of less value to them because of other factors that seem to overshadow and possibly conflict with the biomedical knowledge. She said:

> *With due respect, ma'am, we have been taught by our LO teacher and AIDS agencies and I am sure we have relatively good knowledge of HIV/AIDS. What we do with the knowledge may be different but we have been taught*.

The biomedical theory or understanding of the epidemic and PLHIV is advanced among these public school members, but it fails to provide adequate interpretations to the ways they make meaning of the epidemic and PLHIV. While there is evidence of good biomedical knowledge of the epidemic, these individuals concurrently hold alternative views, understanding and interpretations.

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**Indigenous Understandings**

The general narratives of indigenous understanding that also explain the public school HIV/AIDS understandings are distinct from the narratives of the biomedical. Some implications of these differences are as follows: first, the indigenous understanding which characterised part of these individuals' alternative explanations to HIV/AIDS came as a result of the inability of the biomedical discourse to provide convincing explanations for the epidemic. Second, while the biomedical discourse has three flaws: insufficient knowledge, inadequate explanations of some HIV/AIDS related challenges (e.g. cure) and it emphasizes risks, the indigenous explanations have many permutations some of which are not consistent but may have similarities to the biomedical narratives. The indigenous understandings tried to resolve the tensions between the biomedical and other narratives used to make sense of the epidemic. However, while these narratives may be contextual, they are sometimes not credible.

An analysis of the respondent's explanations of HIV/AIDS, suggests that they fall into two distinct categories. The first are respondents that hold to one specific conception of the epidemic and uphold a view that is consistent. The other category consists of respondents that hold two or more perspectives or perceptions that may be discordant, at the same time. However, these alternative opinions are not discrete. I also noted the appearance of hybridization of indigenous and biomedical practices in the narrations of how the members of the public schools make sense of the epidemic. The strength of this hybridization is

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further seen in the statement by another respondent who seems to have a full grasp of both the indigenous as well as the biomedical knowledge of the epidemic, narrating how an anomaly such as HIV/AIDS is taken care of in their cultural settings.

> *In our culture*, w*hat we do when the unknown comes to us is to first seek the spiritual guidance of the ancestors through the Izangomas. We normally isolate, (what the modern medicines called 'quarantine') the one with the strange illness which cannot be cured by the medical doctors or the witchdoctors to the family until the person is cured or cleansed by the ancestors*.

This respondent is a female teacher from School D. At the onset of her response, she identified herself with indigenous culture. This respondent adopts attributes of pre-colonial cultures in her narratives. From her, I note two hierarchical indigenous groupings; the first group, in which she also located herself, is that of the ordinary members with no supernatural powers or abilities. The second group are those who are specialists with supernatural powers and unique communication abilities for talking to the spirits. These are the *Izangomas, Inyangas* and the *Umuthakatis*.

This educator developed a theory that the way HIV/AIDS is understood and dealt with in her indigenous culture is similar to the way the biomedical approach

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understands and deals with contagious disease. She borrowed the quarantine metaphor from western medicine to explain her theory. Because HIV/AIDS is unfamiliar, it remains unknown and therefore outside the knowledge bands of the *Izangomas* and *Inyangas*. The sick are therefore set aside. However, in trying to authenticate this understanding of the epidemic, this respondent engages the pre- and post-colonial understandings of the epidemic especially in dealing with a disease understood as 'strange'. Her interpretation of quarantine differs from that of western medicine. For while western quarantine is used in the cases of contagious diseases and the like, her own concept of quarantine is on the basis of the disease being 'unknown to the traditional healers'.

Although not biomedically admissible, this indigenous '*set apart*' understanding and dealing with HIV/AIDS and PLHIV could be argued to have a sound basis in medical practice. Justifying the '*set apart*' attitude as replicated above, is the existence of some HIV/AIDS related opportunistic infections such as tuberculosis that may encourage opportunities for the '*set apart*' strategy.

How then can we understand this '*set apart*' theory as used by this respondent? One possible explanation is the suggestion by Douglas's (1966) theory of purity and danger. According to Douglas, there can be a correspondence between the avoidance of contagious disease and ritual avoidance. The separation in this case, which serves the one particular purpose (avoiding contracting the disease), may be effective for expressing this participant's indigenous motive of

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'separation', because HIV/AIDS cure is still unknown. But in the case of dealing with PLHIV, applying this 'isolation' seems exaggerated and baseless because PLHIV are obviously not contagious and these participants have 'good' knowledge of that.

Although most participants claimed to know a great deal about HIV/AIDS and how PLHIV should be medically looked after, some augmented that knowledge with indigenous beliefs and practices. These indigenous perceptions of disease by respondents provided a theoretical scaffold according to which HIV/AIDS has been perceived and PLHIV treated by some of the members of the public school community. Some of these treatments could be judged as a contradiction between what individuals have indigenously known or understood as disease and what is conventional in the case of HIV and AIDS. Forsyth's (1907) suggestion that individual understanding of new concepts or challenges is based on one's prior knowledge of similar issues applies.

> *In the past, when someone suffers from disease that is uncommon in the society, such person is seen and treated differently because of fear that it may spread to others. Disease such as leprosy for example, qualifies in this category. What we do is to reserve the person's treatment and everything to the family to deal with. Except if you are consulted to assist in finding solutions, otherwise, you keep your distance. I believe that may be one of the reasons why those who have Isidliso are avoided by others.*

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*The families of those who have it do not and cannot run away from them like others.*

This is an explanation from the 'Feather Man' (See chapter 7) on how unusual diseases are being dealt with. Examining closely these responses, the '*set apart*' concept replicates itself. Although he used the mild phrase '*treated differently*' to suggest the '*set apart*' construct, the concept of '*fear of spreading*' was introduced and used as a justification for the '*set apart*' construction of the disease and the attitude toward PLHIV. A sense of denial is visible in this response. It is not clear why this individual, identified earlier as possessing a good knowledge of HIV/AIDS, is comparing the pattern of HIV/AIDS transmission to that of leprosy. He explained that in a situation where there is evidence of an unfamiliar disease, the sick are 'quarantined' and only family members attend to the sick. He believed that this understanding is one of the possible reasons for stigmatising PLHIV. Evidence from this response reveals that respondents frequently mobilise indigenous knowledge to make sense of HIV/AIDS and PLHIV. This crossbred system of understanding the epidemic in public schools is a reflection of the complications associated with meanings and the complexities that characterise PLHIV and the disease itself.

**Witchcraft Narratives**

One of the assumptions of this research at this stage was that members of these public schools would need to balance the indigenous understandings of

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HIV/AIDS, PLHIV and biomedical explanations and expectations. This balancing was found not to occur, essentially because there was a silent substitution of (or a need to supplement) formally acquired biomedical knowledge with alternative knowledge which includes the use of witchcraft to explain HIV/AIDS and PLHIV. Some respondents understood HIV/AIDS as a product of witchcraft. Forsyth (1907) posits that when some aspects of any phenomena are unknown or unclear, people will interpret the concept in different ways. Positioning HIV/AIDS as unknown in the sense described by Forsyth as unknown, Ashforth (2001) states that the witchcraft discourse forms one of the various interpretations of the HIV/AIDS epidemic in some South African communities. Members who understand the epidemic according to this concept do so because of *'the fear of dying'* and *'the culture of blame'* associated with HIV/AIDS. Ignorance and fault-finding could be blamed for contributing to this perception. Some people may refuse to accept their mistakes and bear the consequences of the behaviour that exposed them to infection.

In School A, I met a female educator who refused to grant me an interview but was willing to engage me in an informal conversation. While I was waiting for the scheduled interview in the school, she was curious that instead of conducting an interview, I was sitting beside the school canteen doing nothing. She invited me into the staff room and wanted to know my schedule for the day. When I told her that I was waiting for my appointment, she ushered me to a nearby seat and kept

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me company. While we were talking about my topic, I brought up the discussion of what people know about HIV/AIDS. She responded as follows;

> *You may not believe it, but I know it is from the witches. They use it to either eliminate any one who seems to be coming out of poverty. They also use it to punish the family they hate very much. You see, when someone is hated by the neighbour, the only way to show that is by sending isidliso [AIDS]. The last way I know they do it, is to use it to punish a man or woman who goes out to have sex with another person outside their marriage. Both men and women are guilty of that.*

These excerpts highlight the modus operandi of the witchcraft theory in understanding HIV/AIDS and PLHIV. From this statement, I realised that this respondent was aware that the witchcraft construct of HIV/AIDS and PLHIV could be contested as invalid. But, as nebulous as the witchcraft theory may seem, she failed to appreciate that some of these understandings could be a reaction to the fear associated with HIV/AIDS related deaths. While this response inevitably included either a personal or communities belief system, it was possible to observe there was a fundamental conflict with the indigenous understanding of the epidemic and PLHIV. I observed that the focus in this witchcraft narrative was primarily on the features of 'elimination and punishment'. But whether I believe it or not, she claims to '*know*' that HIV/AIDS is a product of witchcraft. She identified thre*e* possible ways this witchcraft discourse operates: to eliminate

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people who are progressing, to punish hated families, and to punish infidelity. She stated that these acts of witchcraft are perpetrated by both men and women. To provide further analysis, I thematically grouped these responses as indicative of a fundamental disagreement with the indigenous knowledge system into authentic and contrived discourses.

I attempt to discuss the perceptions and practices of the witchcraft discourse as authentic or contrived acuity of making sense of the epidemic. I admit here that there may be other ways of categorising and or interpreting this discourse. These two terminologies are chosen for the purposes of conveying the participants' beliefs, perceptions, and practices as experienced during the data collections. The authentic perception could imply a genuine attempt by some of these members of the South African public schools to make use of a whole range of intellectual experiences drawn from their indigenous knowledge about the epidemic. The authentic discourses of witchcraft as presented by the participants are based on the knowledge and concepts of what some of these participants believe and have known to be the disease. It suggests that when what they knew and/or understood throughout their lives as disease failed to match the presentation of this (HIV/AIDS) sickness, the only interpretation of or explanation for such an ailment becomes that it is a supernatural affliction commonly described as witchcraft.

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Unfortunately, HIV/AIDS, with its complications and complexities coupled with no cure, provides some justification for it being seen as a product of witchcraft. My key respondent described their common views of disease as follows;

> *This disease is very difficult to understand. It completely conflicts with everything our forefathers Izangomas and the Inyangas know and thought us as disease. Even the medical doctors failed to find cure. I also think it is from the hand of the supernatural whether of the devil or witches, otherwise, why it is that it has no cure till now?*

From this understanding, it is evident that the lack of cure associated with HIV/AIDS makes some of the participants see and tag the epidemic as unknown. However, because of the complications in making sense of the disease without a cure, the witchcraft metaphor was engaged by some of these respondents. Therefore, this participant labelled it a product of the devil or witchcraft. Dying may not be the main concern or fear in any disease because they know that diseases can kill. The emphasis however is on the fact that in the context of HIV/AIDS, there is no cure either by the traditional healers or the western doctors. This is further clarified by another respondent (the 'Feather Man') as follows:

> *…Some people may die of a particular disease but the same disease will not kill others. But in the case of AIDS, the person must die. That is the difference between this disease and others. What kind of disease is it that once one is suffering from it, the person must die?*

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Exploring this authentic discourse further, the changing faces or manifestations of HIV/AIDS are other concepts significant in branding the epidemic as witchcraft. For the respondents who propose this ideology, a particular disease is known by its particular manifestations or symptoms. Most of these participants believed that because HIV/AIDS, when contracted by an individual, presents itself through diverse opportunistic infections, this suggests that it is strange and the majority of strange things in most African communities are attributed to witchcraft especially when they claim ignorance of the cause. This respondent from School E during the interview elaborated as follows;

> *What kind of disease is it that today, the person is sick of TB, tomorrow, it is diarrhoea and the next day; falling hairs and it goes on and on. The list is endless until the person dies. It is clear that such person is afflicted by the gods and destined to die. We are used to when they say you have cancer for example, the person will have one type of sickness until death but this one that transforms to so many sickness and even when you are treated of that same disease, another will kill the person is nothing but witchcraft.*

Given the unpredictability of the epidemic and the various related illnesses that accompany it, this respondent reverts to 'witchcraft' to explain the phenomenon. In this response, the participant has an extensive knowledge of the cause and

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course of the disease but because HIV/AIDS does not follow the conventional disease pattern, this respondent reverts to a 'witchcraft' discourse to make sense of the disease. This pre-colonial world view uses the indigenous or traditional approach in explaining how members of these public school institutions experience HIV/AIDS and PLHIV. It employs the indisputable strategy of: 'if you do not know or understand how to deal with the disease, you isolate those that are suffering from the disease' to deal with issues related to HIV/AIDS and PLHIV.

Some people view the indigenous perceptions and practices as contrived. HIV/AIDS for these groups is conceived as a product of witchcraft because people get 'Isidliso' mostly when they are in their prime. The first reason for this contrived discourse given by some of these respondents is the jealousy of other people towards their children who are considered to have been liberated from poverty and who will soon free their families from their very low social status in society. For these participants, the only way for these other people to demonstrate jealousy was to inflict their youths with '*Isidliso*'. In the words of 'Men-are Dogs' (see chapter 7);

> *This is the handiwork of witches. It gets our children when they are young and just finished their education. Imagine when your child whom you have suffered to train in education gets work and then becomes sick. What is that and how do you describe that? Why didn't this illness start when they*

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*were in the school? Now that they are about to help in the family, they become afflicted with Isidliso. It is nothing but witchcraft. The enemies are just at it.*

In this instance, the respondent is saying something else. She argues that given the huge injustice, it must be witchcraft, otherwise, how can anyone explain it? This extract also suggests a denial of the medically accepted causes of HIV/AIDS.

The second explanation is that the *Isidliso* is used to punish the partner who defiles an existing established relationship by having sex outside wedlock or the relationship. This opinion is held by both Christians and the traditionalists. By implication, just like the religious beliefs, those who are affected are paying for their sins: they sinned and so their sins (in this case, sleeping with someone not your partner or spouse) should justify why *isidliso* afflicts them.

The third discourse is that *Isidliso* is being used by witches to punish the people they hate. The *Izangomas* and *Inyangas* are excluded in this case as they are regarded as the healers. The *Umuthakatis* are the ones that provide the supposed complainant with the *Isidliso* venom for their victims. The contrived versions are summarised in the following narratives by the 'Feather Man';

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*Isidliso is sent from the Umuthakatis. Believe it or not! It is an act of wickedness especially directed to the youths and upcoming men and women.*

Finally, the contrived discourse seemingly represents intentions by participants to shift blame for the reckless sexual behaviour of the youth to an elusive concept such as witchcraft even when they clearly demonstrate relatively good understanding of the biomedical knowledge of the epidemic. Whether we view the witchcraft discourse as authentic or as contrived may be based on the fear of the unknown, stigma and death that are associated with the infection.

**Religious Views**

Another way in which the members of these public schools made meaning of the epidemic was through religious perceptions. Smith (2004) in his study on 'Youth, sin and sex in Nigeria: Christianity and HIV/AIDS-related beliefs and behaviour among rural-urban migrants,' identified religious understandings of HIV/AIDS and PLHIV among the Nigerian youth. The religious views in this discussion are not one-dimensional as there are various categories of constructions in this discourse. These religious views are mostly woven around judgement, curse and damnation. The conventional attributes that characterise religious beliefs, such as mercy, love, repentance, forgiveness and the like are absent. These positions may suggest that the religious understandings of the epidemic are more complex and contain various strains and tendencies.

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I begin this religious views analysis with the presentation of narratives from my key respondent. She uses blessed water, tea and soap to deal with the epidemic because she understands the disease as *'a curse of pollution*' that needs cleansing. To her, the use of '*blessed*' objects serves as a spiritual cleanser from the curse. Generally, respondents with religious views understand HIV/AIDS as a product of the supernatural — 'a curse from God.' This introduces a new factor in the concept of stigma attached to PLHIV and even to people affected by HIV. They could no longer be regarded as suffering from a contagious disease (an indigenous understanding), which was supposed to separate them from others, but they were now understood as *'sinners who are cursed.'* The following extracts are taken directly from narratives by respondents to illustrate religious understandings of the epidemic:

> *'The disease is a curse from God'. (Angry Lady*)
>
> *'I do not claim to know all, but one thing I know and strongly believe is that HIV/AIDS is a curse from God'.* (Educator: School A)

While 'Angry Lady' and the educator from school A understood HIV/AIDS to be a curse from God just like the 'Tea lady', the 'Christian Gentleman' gave an elaborate interpretation of not only the religious views of the epidemic but also PLHIV. According to him,

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> *This is a curse from God to sinners. Sin has consequences and the wages of sin is death. HIV/AIDS came because we disobeyed God and did not listen to HIM. If we repent and return to Him, He will hear us and heal our land from HIV/AIDS.* (Christian Gentleman)

Looking critically at this extract, not only is HIV/AIDS a curse from God, those who are infected are described as '*Sinners*'. His emphasis was not only on the epidemic but also on PLHIV. To him, they are paying for their sins through the infection and ultimately, death. Even an educator from School A agreed with him in the following statement*'…Sins have repercussions. You pay for your sins… '* He identified disobedience and not listening to God as the sources of the epidemic. The last phase of his narrative is contradictory to the earlier definitions of the disease and interpretations of how God deals with PLHIV; '*If we repent and return to Him, He will hear us and heal our land*'. How then can God curse the land with the epidemic, make those infected pay with their lives and at the same time 'if we repent….' How will the same merciless God '*forgive and heal our land*'?

> *This is a curse, because if one is faithful he/she will not get it. Even when a couple has the disease and they want to make babies, the doctors will help and protect the baby from being infected. This is just to prove that the disease is a result of fornication or adultery and that the unborn baby is innocent.* (School board member)

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The governing board member from School B attempted to justify the 'curse' metaphor by bringing in the concepts of '*faithfulness*' in sexual relationships and protecting the unborn while in the womb. Like the 'Christian Gentleman', he concluded his argument with the judgemental assertion of HIV/AIDS being '*a result of fornication and adultery*.'

An additional consequence that emerged from the religious narratives of how these individuals make sense of the epidemic is that PLHIV are 'cursed' and that is the reason for the lack of a cure: *'Though I regretted treating that teacher the way we all did, I still believe that those with the sickness are cursed from the gods. That is why there is no cure'* (Educator, School D). This understanding may have prompted the ill treatment that PLHIV experience which the educator claimed to be regretting.

I have shown in Chapter seven that religious beliefs have strong influences on the HIV/AIDS lived experiences of these individuals. However, current observations drawn from their understanding and perceptions have shown that most of these respondents also have a primarily systematic religious orientation in their ways of making sense of the epidemic. These excerpts illustrate the two factors which seem to be keys in explaining the religious beliefs systems of these members of South African Public schools. First, some of these respondents that uphold this religious understanding emphasise faithfulness, curse, fornication, adultery, punishment, consequences, death, repercussions, and disobedience as

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elements of divine retribution. As part of the critique of these perceptions, one questions what happened to the divine nature of forgiveness, mercy and God being on the side of the meek and helpless?

As a follow up to these understandings, I argue that the persistent stigmatisation of the PLHIV is as a result of spiritual beliefs. In this context, stigmatisation may not be apparent because it is disguised as spiritual belief. Thus, those with HIV infection are perceived as *'paying for their sins'* (as a result of sex outside marriage or with someone who is not your partner), since, after all, *'the wages of sin is death*,*'* and those affected by the epidemic are understood to be suffering from *'the curses'* of their deceased parents. To these individuals, *'sex is only for the married'* and the relation of sex and HIV/AIDS is portrayed as sex-pollution.

These respondents consider those infected with the epidemic as '*must perish*' because they deviated from God. This judgemental conclusion also contributed to the guilt-related self-image of those infected making them see themselves as 'dirty' and 'polluted' people who need cleansing. The proponents of this perception in public schools will perfectly maintain the symbolic boundary not only to avoid infecting others as may be erroneously inferred but because of their religious beliefs. At this level, the laws of nature are dragged in to sanction the moral code: this kind of disease is caused by adultery and fornication. The mobilisation of religious understanding of HIV/AIDS and PLHIV is not as simple

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as it may seem. The following two statements can summarise the religious presentation of this system of belief;

1) Understood as a curse, and
2) Punishment from God for sin.

In conclusion, other religious or faith-based ways to mediate HIV/AIDS according to some respondents are: wearing relics, chaplets, charms, wearing some sections of the Koran round the waist. According to Douglas (1966), these practices are expected to produce an immediate intervention in their affairs. The belief in the supernatural, either via the *Izangomas* and *Inyangas* or the religious leaders and priests, is significant among these respondents. These respondents no doubt have the understanding that their rites and symbols will have external efficacy with regard to the epidemic. Irrespective of the position adopted by these respondents, Douglas writes that miracles do not occur through enacted rites, nor were rites always performed in the expectation of miracles. To synthesize this, these rites and symbols are simply some HIV/AIDS treatment-related complications, expected to be dealt with through physical manifestations of world views and opinions that lack legitimacy and potency.

**Eschatological Views**

I have chosen not to include the eschatological views in the religious views although they can be viewed as an extension of these religious views. This is because, first, not all religious belief systems agree with the concepts of

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eschatology but may agree with ideas such as sin, disobedience, faithfulness, curses. Second, it will help me to unpack the extreme views located in the ways people make sense of the epidemic and PLHIV. Third, eschatological beliefs are common among the Christians.

An interesting understanding of the epidemic is related to doctrines about death and its aftermath, or eschatology. Some of these individuals perceived HIV/AIDS in terms of a biblical exegesis of the New Testament, focusing on the idea of the holiness of God, which men could recreate in their own lives. With this understanding, society appears as a universe in which people prosper by conforming to holiness, or else they perish when they deviate from it (Douglas, 1966). Specifically, some individuals understood HIV/AIDS as one of the 'beasts' from the Bible's book of Revelation (chapter 13) signifying the signs of 'end times'.

Talking about 'end times', Schaefer (2006), citing II Timothy 3:1, describes these days as "perilous times". According to her, there are milestones that are bringing us closer and closer to that appointed day when the Rapture takes place. She categorically stated that the time we are now living in is known as the 'end times'. Schaefer believes that many people erroneously think that no signs have to happen before the Rapture occurs. She described this notion as a myth. She backs her claims by concluding that a good twenty-five percent of the Bible is prophecy, and much of it concerns the 'end times'.

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Individuals with this perspective believed that the presence of HIV, the lack of a cure, and the fact that the virus is contracted through a natural yet 'sinful act' (sex) is a symbol that 'the world is coming to an end.' One participant surmised:

> *With the present-day troubles where nations are against themselves and siblings against each other, now with this disease without cure, these are telling us that the world is coming to an end…* (Educator, School B)

This respondent mentioned some situations which she considered to suggest 'end times' and that include '*this disease*'. Confirming the opinion that HIV/AIDS is regarded as a sign of 'end times', Philadelphia (2006), reporting on the 2006 Christian 'world day of prayer' he attended in South Africa, stated that the proponents of the programme had some slight intuition that the pandemic of HIV/AIDS was an eschatological sign. This educator considers HIV/AIDS as creating a very disastrous situation that will wipe out the entire world if no cure is found. Just like other Christians, this educator misrepresented eschatology. Schaefer noted that eschatology is a big issue and the majority of Christians are confused about it. According to her, people view it as "gloom and doom", and disease and pestilence (Revelation, 6: 8; Matthew, 24: 7) are part of the signs of 'end times'. HIV/AIDS is identified as one of these diseases. She writes concerning AIDS:

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*In 2005, 5 million people were reportedly infected with AIDS in India alone. Despite efforts to contain the virus, new cases keep coming to the surface and the epidemic is continuing to outstrip any containment efforts. Ignorance and poverty is still the root cause in many third world countries along with limited medical resources. Also, we are living in times where homosexuality and casual sex is being accepted as the "norm" in society. Our thinking and sense of responsibility have gone down the tubes. Instead of good morals, monogamous marriage and abstinence, we have free sex in our society and we have been paying the price since 1981. And part of that price is the disease of AIDS and other STD's. It is part of the last day's problems and it keeps getting worse because we are not learning anything from our actions. There is still no cure despite heroic efforts by the medical community to find one; yet those irresponsible, lusty people who enjoy their sinful activities complain because the disease is spreading. Well, duh!*

All of the above according to Schaefer are indicative of an imminent return of Jesus Christ, and there are probably many more "signs" that were not even touched on. Schaefer argues that when one looks around, one sees that the signs are really everywhere and that no one should look very far to see them. We learn from Revelation 9: 13-18 that because of the sinfulness of the Antichrist and his followers, exactly one-third of the approximate 4.5 billion people on earth who survived the opening of the Fourth Seal will die at the pouring of the Sixth Bowl of God's Wrath (Revelation 9:13-18). Because of the Fourth Seal, and the

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Sixth Bowl of God's Wrath; approximately three billion people, or exactly one-half of the people who are alive on earth at the beginning of the Great Tribulation, will die during the three and one-half year Great Tribulation (Luke 17:26-37, Matthew 24:37-41). These revelations may have prompted the 'beast' saga among these respondents.

The eschatological views are derived by respondents from the fatality levels and plague-like characteristics of the epidemic. To these groups of respondents, the 'no cure' attribute of HIV/AIDS which leads to massive death can only be justified by the Biblical 'end times' prophecy. While the sins' results or retribution discussed under the 'Religious Views' were those committed and being punished on an individual basis, the sin that seems to be categorised in this eschatological construct is societal. This plague-like attribute of the sin and punishment is therefore believed to suggest the 'end times' or the 'Last Days' beliefs of some religious groups.

To these people, HIV/AIDS is personified as 'beast' and it is one of the 'beasts' that will come and claim as many people as possible before the Second Coming of Christ. The use of the metaphor 'the beast' to describe the epidemic may have further symbolic bearing in relation to such devastating effects as stigmatisation against PLHIV within the public school community. The victims of the epidemic, based on this scripture, fell into the hands of 'the beast' that will evidently devour them. Some statements to these effects are as follows;

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*My dear, I know that most of you who have read so much do not believe in bible even if you were raised with it. The truth is that this disease is prophesied in the bible. In Revelations; go there, read and learn more. If you do not understand, then you can come back to me and I explain. Everything about this disease is there. Please read.*

This respondent is also an educator but from School E. He began his narrative with a sense of biased towards the eschatological views possibly because he understood that this perspective is not easily tolerated. He linked his claims to the prophecies in the Bible and was certain that issues around HIV/AIDS are mentioned there. The next educator was also certain that HIV/AIDS will '*wipe us all out*'. However, I note, following his narrative that no one is safe from this plague. Both the 'faithful' and 'unfaithful' are going to be affected by the epidemic;

*You know something my dear; this disease will wipe us all out. See, even if you are faithful, your partner will not be. And the disease does not ask who is faithful or not.*

The eschatological narratives may have been inspired by the number of people who have died or those who are infected with the epidemic. The ever increasing infection rate of the epidemic may have also contributed to this understanding.

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**Racial Theory**

Some controversial racial perceptions were visible among the participants' understanding of HIV/AIDS and PLHIV. Here, I define race, following Sellers & Shelton (2003), as simply an obvious difference between individuals in terms of skin colour. Sellers and Shelton noted that race has been a way to separate people throughout history (and, historically, it has almost always been non-whites who have been discriminated against by whites; Black Africans were, and in some cases still are, seen as inferior). Participants who perceived HIV/AIDS through a racial-conspiracy discourse understood HIV/AIDS in South Africa's public schools as 'a black disease.' The offshoots of apartheid were blamed by these respondents for the epidemic's racial narrative:

> *These people chased us out of our land and made us carry passports when attempting to enter what they called South Africa. How can such people be trusted with lives and things such as HIV/AIDS education? Though we coexist, deep inside, we are yet to develop true trust in them. These policies you are asking us about were drafted by them and those they believe will protect their interest. I do not trust them and that is why you hear people say that HIV/AIDS is a black disease. What else can they do to us?* (Deputy Principal, School A)

The extract above shows that some HIV/AIDS related understandings are not the preserve of culture and gender. Racial understanding is shown to have a place

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in the political content of how the epidemic is understood. This respondent is making this statement on the basis of numerous political, social and HIV/AIDS related experiences of death and stigma. This showed that prior to the medical interpretation of diseases and the associated training, there existed hidden emotions with some cultural influences and as such, it is very difficult for some of these participants to absolutely accept the Western approach to or the biomedical interpretations of HIV/AIDS. I also note from this extract, an extensive lack of trust and blaming of the South African Whites by some members of the Black community. The reason for the above may be located in the experiences of oppression, the long and deep history of enslavement by the apartheid government. Another expression by the deputy principal from School C, who apparently is White; *'Although we know how it is transmitted and that there is no cure, in our school, one thing that is clear among my colleagues is that it is a black disease. They think it is only the blacks that are sick of AIDS,'* may encourage such racial understanding. The fact that he entertained the interpretation of HIV/AIDS being 'a black disease' revealed gaps in the clear biomedical understanding by some members of the public schools who share similar HIV/AIDS and PLHIV perception to those of the deputy principal from School A. UNESCO (2003) confirmed that there is pre-existing distrust concerning HIV (and towards whites in general), which affects people's perceptions. Among South Africans, HIV/AIDS information is understood to reside more in the hands of Whites.

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The race theory, like other understandings of HIV/AIDS and PLHIV, has a variety of manifestations. In the following extract, I note a shift from the experientially based information, rich with emotion, to a suspicious and more controversial aspect of the racial theory.

> *I guess we all know, but one question I always ask is — how much does this knowledge help the Blacks and Coloured in South Africa? I said this because we often do not see the white communities orphaned by HIV/AIDS. Somewhere inside of me, I think they have better knowledge than other racial groups in South Africa and this knowledge is hidden from the others.* (Deputy Principal, School B).

This respondent believed that the White communities of South African are not orphaned by HIV/AIDS because they have better knowledge of the epidemic than the Blacks and Coloureds. It will be noted that questioning the value of HIV/AIDS-related knowledge by some South African racial groups is a strategy for refuting that there are any effective interpretations of the epidemic available. This type of perception may be because most of the research done and published on HIV/AIDS in South Africa was conducted in the rural villages of South Africa which are predominantly Black.

The executive summary of the Giraldo (2002) and Shishana et al (2005) recognises that all South African races are affected by HIV, although differences

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in prevalence exist between different races. The summary by Shishana et al, (2005) states that the disparities are largely due to social, economic and behavioural determinants, such as living in informal settlements, poverty, access to the kind of information and education necessary for HIV prevention, associations with people who have HIV infection or have died of AIDS illness, and having multiple partnerships, as well as having a sexually transmitted disease.

To most South Africans, the search for an understanding of the reasons for the high prevalence of HIV/AIDS and death of Blacks outside the parameters of the apartheid regime could be interpreted through the genocide theory. Another respondent believes that HIV/AIDS is a product of research in America and that it is an invention designed to eradicate the Black race from the world. They embrace the conspiracy theory within the historic resonance of the enslavement of Africans by the West, in this case, Americans.

> *This American invented disease was spread in Africa to wipe the blacks and prevent them from migrating to their countries. They took our fathers slaves and they laboured in their sugar cane plantations. Now they want to wipe their generations because slave trade is abolished. I wonder sometimes why God created the whites in the earth.*

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This response contains aspects of a convenient-myths-discourse such as '*American invented disease'* which is only intended to heighten the racial theory of HIV/AIDS. But the point he seems to be making is that HIV/AIDS-related deaths are at a genocidal level in South Africa. The logic of this extract is essentially about the application of lived practices or real life experiences and what meanings people attach to phenomena and what constructs these understandings. Based on the above, I will argue not just that these respondents hold these alternative views, some of which are cognitively dissonant in beliefs and practices, but that these are extremely compressed varieties of understanding borne out of experiences and expedient myths.

Another variety of racial theory in understanding the HIV/AIDS epidemic is located in the urban 'Monkey myth'. Some participants were responding to the 'convoluted' interpretation by some writers that HIV/AIDS originated from the 'Monkeys'. Most respondents were insistent that the 'Monkey myth' is another way to demean the Black race. To these participants, whether the monkeys were eaten or slept with is unclear, but the respondents believe it is a ploy by the White race to dehumanise the Black race who are believed to have contracted the disease through the monkeys. The first respondent, a grade 12 learner from the first focus group discussions asked;

> *My dear researcher, they said it is from monkey, I believe it is not from monkey because, these Whites have never wanted the black races. This disease I have read somewhere was invented in a laboratory in America*

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*to wipe out the Black Americans. They brought it here during the apartheid era to help them with the struggles to clear the blacks and inherit our land. Have you seen any one of them orphaned by AIDS and how many are they that have it?*

This respondent dismissed the 'Monkey myths' but rather suggested that it is one of the genocidal strategies of the apartheid government. A more aggressive response came from the 'Feather Man' who although he is tenacious in his belief in the indigenous theory especially with regard to protection, stated as follows;

*How many whites do you see dying of AIDS? Are they not having sex? Are we doing it with only the monkeys? How many monkeys have you seen roaming Johannesburg and having sex with human beings? What are they saying? This disease is another racial ploy by this very unaccommodating white race to wipe us from the face of the earth. Why should they hate us so much to bring such a terrible disease in Africa?*

To him, HIV/AIDS orphans are not the major concern here but the sex and sexual partners. He interpreted the 'Monkey Myths' on the basis that the Blacks are believed to have had sex with the monkeys in Africa and that is why the epidemic was more in Africa and affects the Blacks more than the Whites. This opinion was supported by the educator from School B as follows;

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*Some people say the disease is from monkey. Does it mean that our people ate the monkeys without cooking? Or does it mean that people slept with the monkeys? I find it very provoking and racially motivated because, we have enough men and women for sex and we are not barbarians. We cook meat before eating them. Sleeping with animals is western and not African. They must find another story rather than monkey rubbish tale.*

These series of rhetorical questions mixed with an outburst of indignation expressed the hidden emotions that underpin the racial theory. These questions and responses demonstrate the anger, bitterness and embarrassment associated with this theory.

In summary, the racial discourse, in the understanding of the epidemic and PLHIV in some of these South African public schools sampled in this study, works differently from the renowned imperialist conceptions of the racial discourse. While Africans were accorded the lowest status in the colonial hierarchy and Western imperial power in Africa was premised on a powerful racial discourse which influences both popular images of Africa and imperialist policies (Bush, 1999), the South African racial discourse concentrate on the historic apartheid legacy. 'Trust' is one of the strongest phenomena in understanding the racial issues in relation to HIV/AIDS treatment in South Africa. Evidence from these extracts suggests that some respondents carried forward very powerful emotive views of the apartheid regime to their understanding of the

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epidemic. Second, racial theory is also used not only to highlight the element of 'blaming' associated with the disease and its spread, but also as a way of explaining one of the implications of apartheid legacies: the poor education that notably was provided mostly for Black South Africans during the apartheid era.

**Conclusions**

The HIV/AIDS and PLHIV understandings have been the subject of avid interest and curiosity in this chapter. The chapter presented a significant sampling of responses from the semi-structured interviews and the focus group discussions with the participants, and explored both their HIV/AIDS narratives and meaning.

Many participants would still subscribe to the biomedical theory in understanding HIV/AIDS and PLHIV; many think that there will always be 'confusion, strife and dispute' in making sense of the disease and PLHIV especially considering that there is still no cure for the epidemic. The fact is that today neither biomedical nor legal discourses (common with researchers and policy designers) are satisfactory in explaining issues around HIV/AIDS and PLHIV. But the question is to know whether there are alternative ways people understand or make meaning of the epidemic and those infected that may explain the existing implementation gaps between HIV/AIDS policies and practices in the South African schools.

Biomedical and legal understandings notwithstanding, no one discourse explains the HIV/AIDS and PLHIV understandings of these participants. The truth is that

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these individuals engage more than one realm of ideas in making sense of the disease. Indeed, even with the most extreme religious and indigenous theories, it is possible to demonstrate the existence of a rivalry between these two discourses and one or two other discourses. It is clear from the extracts discussed in this chapter that there is more than one alternative way people make sense of the disease in their individual schools. But these understandings are very ambiguous and unconventional.

These interpretations do not unfold on a conventional level of understanding of the disease. Further, no one theory has ever seemed sufficient to define how people make meaning of the disease, to furnish in itself the key to human explanations of the disease, or to express the totality of a situation (especially with PLHIV) that it only helps to define. These realms of ideas are products of their lived experiences and belief systems. Based on these systems of understanding, the concept of 'hybridisation' as identified in the lived experiences (see chapter 7) summarises ways these individuals make sense of the epidemic and PLHIV.

Hybridisation theory in this context suggests that people combine one or more views to make sense of the disease. With biomedical knowledge as top on the list, there is less evidence of or emphasis on the legal discourses in these narratives. People combine one or more of these alternative discourses with their existing biomedical knowledge of the disease. These alternative discourses are;

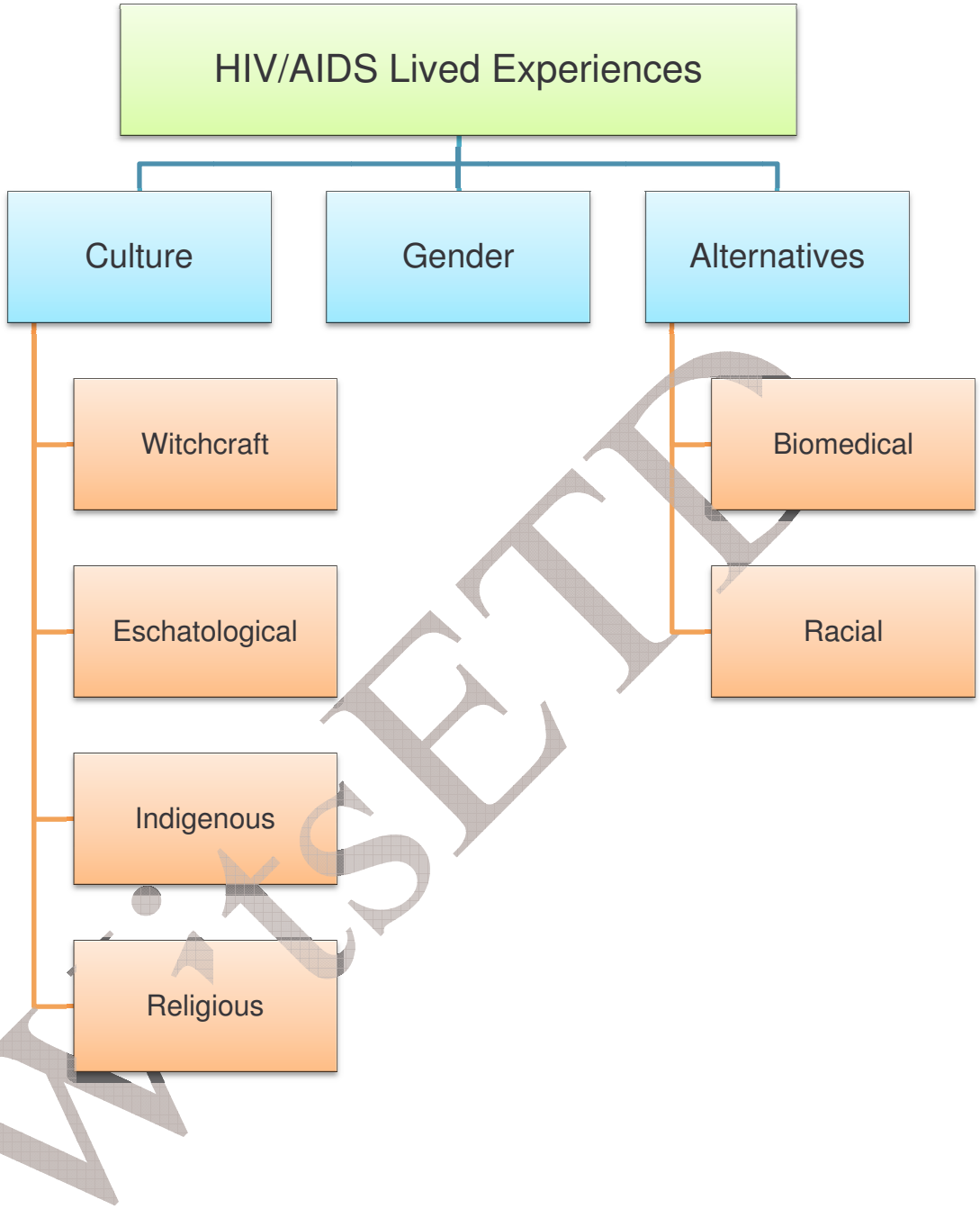
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indigenous (including witchcraft), religious, eschatological and racial discourses. It is vain to apportion praise or blame to any of these theories. The hybrid theory for explaining the disease and attitudes towards PLHIV will go on as long as the biomedical discourse fails to discover the cure for HIV/AIDS. These men and women fail to recognise a single system of understanding as the ultimate in explaining the epidemic.

For a long time there have been efforts to disguise this misfortune (complicated understanding of the epidemic and PLHIV) in South Africa. For example, the indigenous theory of the epidemic has been accused of escalating HIV/AIDS transmission. No one has been able to pinpoint the fact that it is first one way individuals make sense of the epidemic and PLHIV; the religious and eschatological views have not received much recognition and the constructions of the racial discourse was not very different from the legacies of apartheid. However, the innumerable conflicts that set biomedical discourse against others (which I described as 'alternatives') come from the fact that neither is prepared to offer credible, effective and efficient explanations for the consequences of this epidemic.

The six lived experiences are summarised in Figure 7 below:

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**Figure 7** **Diagrammatical representation of the interconnectivity of the impact of culture and gender on HIV/AIDS lived experiences**