HIV and AIDS in the Tapestry of Meanings:

Towards understanding perceptions of AIDS by men in a rural community

George Shakespeare Mboweni

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Supervisor: Professor C J Groenewald

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Declaration

I, George Shakespeare Mboweni, hereby declare that the content of this thesis is my own original work, and that I have not previous in its entirety or part thereof submitted it to any university for degree purposes.

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Thank you.

Abstract

Purpose

The purpose of the study is to demonstrate the significance of words and their meaning in knowledge development and perception formulation. Meanings attached to the AIDS epidemic are used to test people's understanding of this disease. The study is also aimed at demonstrating how false perceptions and wrong concepts are likely to occur if the problem of meaning is not addressed.

Method

For this qualitative case study the community of Sekororo as a unit for observation was selected. A literature review preceded a questionnaire design which aimed at finding out from the people what AIDS means to them. Personal interviews took place followed by data processing.

Male respondents, aged between 35 and 65 years, were chosen because of the presumed patriarchal dominance in the community, and the assumption that they dictate terms on matters of sexual reproductive rights, and that women are mostly denied a say in the struggle against AIDS.

Findings

The question of meaning is very important. There are many contending explanations of AIDS, but no consensus on its meaning. This condition applies for both scientists and lay people, and is also true of the community of Sekororo where cultural practices and traditional way of thinking still influence people's perceptions.

Conclusion

The problem of meaning will remain indispensable in the knowledge community, and meanings will always be expressed through words.

MIV en VIGS in die tapisserie van betekenisse

Opsomming

Doel

Die doel van hierdie ondersoek is om die belangrikheid van woorde en hul betekenisse vir kennisontwikkeling en formulering van persepsies te demonstreer. Betekenisse wat aan die VIGS epidemie gekoppel word, word gebruik om mense se begrip van hierdie siekte te toets. Die ondersoek beoog ook om te demonstreer dat vals persepsies en verkeerde konsepte kan voorkom indien die probleem van betekenis nie aangespreek word nie.

Metode

Hierdie kwalitatiewe gevallestudie het die gemeenskap van Sekororo as eenheid van waarneming gekies. ‘n Literatuuroorsig het die vraelysontwerp voorafgegaan wat beoog het om by mense vas te stel wat die betekenis van VIGS volgens hulle is. Persoonlike onderhoude is onderneem en daarna opgevolg met data prosessering.

Manlike respondente tussen die ouderdomme van 35 en 65 jaar is gekies vanweë die veronderstelde patriargale dominansie in die gemeenskap, en die aanname dat hulle seksuele reproduktiewe regte dikteer en dat vroue ‘n sê in die stryd teen VIGS ontneem word.

Bevindings

Die aangeleentheid van betekenis is as belangrik gevind. Daar is baie kompeterende verduidelikings van VIGS maar geen konsensus oor die betekenis daarvan nie. Hierdie toestand geld vir wetenskaplikes én leke en is ook waar van die gemeenskap van Sekororo waar kulturele praktyke en die tradisionele wyse van dink steeds mense se persepsies beïnvloed.

Gevolgtrekking

Die probleem van betekenis sal onmisbaar bly in die kennisgemeenskap en betekenisse sal altyd deur woorde uitgedruk word.

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Prolegomenon

The study is about the knowledge and perceptions which have been formed of AIDS by the male community at Sekororo. The lifelong relevance of meaning in its broader phenomenological context is recognized, and hence meaning is used throughout the study as catalyst and a tool which shapes and limits people in their understanding and interpretation of the disease. In this study, tapestry is used as metaphor to illustrate the complexity and controversy surrounding the meaning of AIDS in South Africa and the rest of the universe.

To assess the perception of people and their interpretation of HIV and AIDS, male respondents in the rural community of Sekororo were selected as the unit of observation. The selection of male respondents was based on the assumption that this community is rural and patriarchal. Men were expected to dominate in decision-making and in influencing lifestyles in the community.

The study treats meaning in its broader phenomenological expression and includes those factors and systems that are catalysts in the process of nomenclature and the interpretation of phenomenal knowledge. An individual internalizes the sense or understanding he has deciphered of his environment and relays it to others as shared or communal property. This sense or understanding becomes a code of knowledge and it translates into perceptions which unify people together and guide them in their social interaction. The study presupposes the need to find out what AIDS means to the people at Sekororo, and to identify the factors and systems which guide them to understand the pandemic the way they do. This would determine whether there is a need for proper AIDS education or not, and at the same time, suggest the approach and the modus operandi which could replace the present meaning of AIDS if necessary.

Various factors and circumstances are explored to determine their role and influence over people's understanding and perceptions of AIDS. These perceptions, or understanding, give rise to a meaning which people may use to explain, describe and interpret the disease. In this case study, *the people* refers to the male portion of the rural community of Sekororo.

It should be noted from the beginning that semantics or scientific dialogue with the problem of meaning, and of what it means to talk about a thing, is much more complex and intricate than it is often thought to be. Meaning, or a meaning, often goes along with knowledge or perceptions which have been formed and internalized by an individual person and yet shared with others in the community. The possibility is that in the end, meaning may remain relative and not absolute as would be seen in the story of four blind men who had never seen an elephant before they lost their sight. They wanted to know an elephant in order that they may understand what it means to talk of an elephant.

An elephant was brought to them, and they each had to touch and feel it in order to form their own meaning of an elephant. One touched the foreleg of the elephant. He had the leisure to move his hands around it. He was satisfied because he now knows an elephant. To him, an elephant is like a trunk of a tree. The same procedure was followed with the second blind man touched the flank of the body, and with ample chance to move his hand over its large body, he was also happy because he could now tell what an elephant is, it is like a wall of a building. The third blind man, touched the tail, and he concluded that an elephant is like a huge strong rope. And the last of the blind men touched its big ear, and moved his fingers around the ear until he was satisfied that an elephant is like a large, broad and thick leaf of a tree.

Each of the blind men has a metaphor to describe what he thinks of an elephant, and yet none of them got it right! A zoological scientist would have probably loved to describe the animal as an herbivorous mammal with four legs, and the largest of animals found on land. In their presentation, or description of an elephant, both the zoologist and the blind men have some valid facts about an elephant, even if those facts are not necessarily conclusive or comprehensive of the animal.

The HIV and AIDS debate is not far from what happened with the description of an elephant. What is AIDS, and what does it mean to talk about AIDS? The analogy as presented in the foregoing paragraphs could assist in explaining HIV and AIDS. The relevance for the analogy is its ability to compare the various notions, or perceptions which arose from each of the four blind men

and from the zoologist. A scientific approach explains the epidemic as acquired immunodeficiency syndrome, caused by HIV. This perspective is broadly accepted by epidemiologists and virologists although a dissident group led by Peter Deusberg persists in their opposition of this broadly accepted perspective.

As the discussion unfolds, the epidemic is explained in different ways without consensus, making it hard to know exactly what this epidemic is. This was seen already from the statement on the lack of consensus of the scholars on the causes of the epidemic. The problem of the meaning goes beyond the laboratories and seminar rooms to include the general public who are also affected by this epidemic, and they seek to explain what it is in essence, where it comes from, and how to stop it before it wipes out all mankind. Affected is used here to include those who seem unworried about the epidemic because they think that they are “unlikely” to die of AIDS.

The meaning of the epidemic depends on its interpretation by different communities. Scientists have their own consensus and differences, depending largely on the background of those engaged in the debate and discussions. Laypersons also have their own understanding which is based on their personal and social circumstances. These factors make it impossible to have one agreed understanding of the epidemic.

These differences create a situation where a subject for interpretation into a meaning becomes a single object made up of different components, nicely knitted and woven together like the fine and beautiful colours embroidered on a tapestry. The epidemic is in the end compared with those beautiful colours, with each of the colours telling its own piece about AIDS, either correct or incorrect, complete or incomplete!

Chapter 1 Problem Statement

1.1 What is AIDS?

The study grapples with the meaning of AIDS and what the disease is conceived to be. Although the case study is limited to a rural community of Sekororo, it concerns the questions, “what is AIDS and, where does it come from? Where did it originate and how did it spread worldwide, how is it acquired and spread from one person to another, does HIV cause AIDS, and what is HIV? How can the spread of AIDS be stopped or controlled? All these questions are intended to give answers which will give AIDS its meaning.

Many people have heard of AIDS without a clear understanding of the disease. The first recorded cases of the Acquired Immune Deficiency Syndrome (AIDS) occurred in the United States of America in 1981. Almost 25 years since the epidemic was diagnosed, ignorance about the Human Immunodeficiency Virus (HIV) and AIDS remains a serious concern, and this ignorance is presumed to assist in the rapid spread of the epidemic. This situation is linked to the lack of consensus on understanding and interpretation of this epidemic, and as such, different people understand and interpret the epidemic in according to what they think it is. These loose and disjointed types of perceptions about the epidemic result in the distorted or false presentation of AIDS, sustaining or even denying the prevalence of the epidemic.

The study recognizes the catalytic role of meaning to either unify the people and consolidate them to think and act as a collective, or divide them into camps or groups wherein each group behaves in solidarity to support what is normative for their group. If people could share a common perception and understanding of the epidemic, what it is, how it is acquired and spread, and what could be done to control its spread, people would be able to stop its rapid spread.

The premise of the study is the significant role of a meaning in prescribing a special behaviour and response shared by a specific group of people or a community where a specific knowledge or perception has been developed. The rapid spread of HIV and AIDS in South Africa is an appalling concern,

and it raises the feeling that this rapid spread is accelerated by people's false perceptions and incorrect information and distorted knowledge of what in essence the epidemic is. The spread of HIV and AIDS would be reduced and eventually stopped if all people could be equipped with relevant information which enables them, through appropriate knowledge, to embrace the correct meaning of AIDS. Understanding the meaning of AIDS inherently requires essential knowledge of where the epidemic originated, its causes and its spread, and how the spread of the infection from one person to another could be stopped.

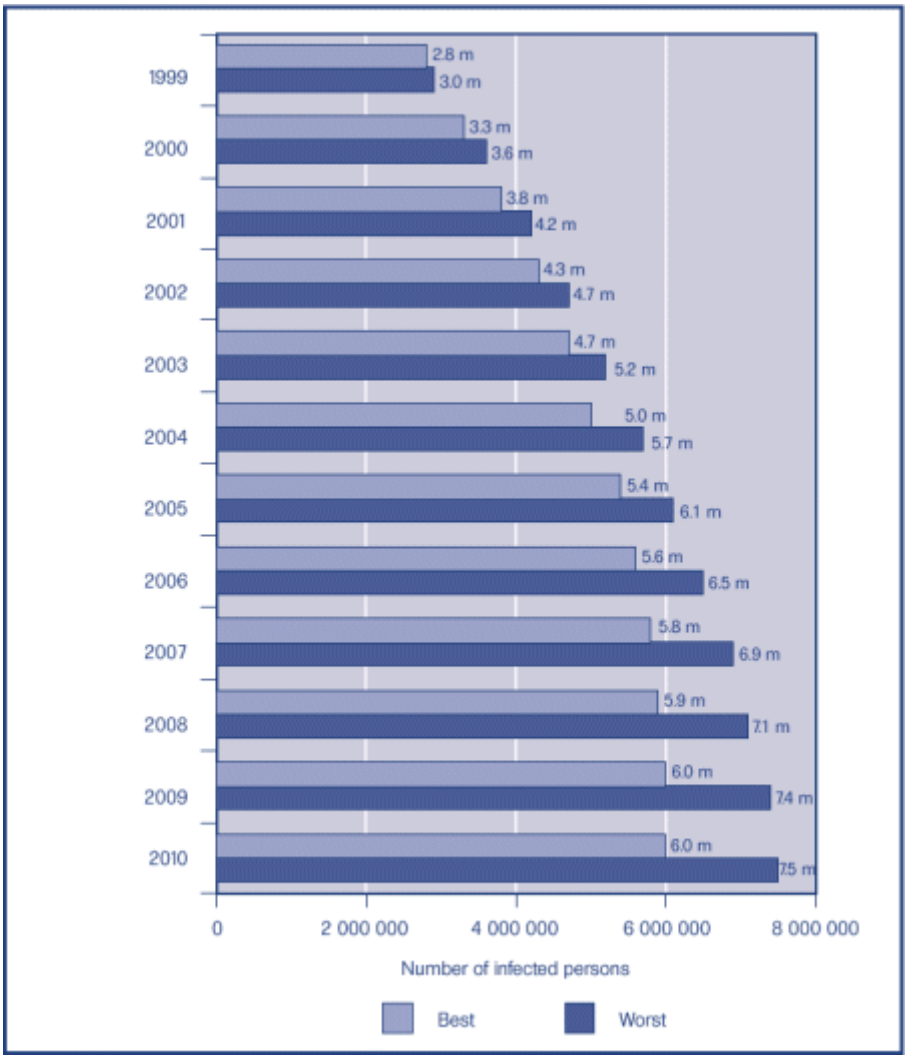
1.2 Background information

From 1981, when HIV/AIDS was first diagnosed among American gays, to the present, the origin of the epidemic has remained a puzzle, leaving many people ignorant of the disease and also perplexed with regards to its origins and how to stop it. Contending opinions and perceptions have been developed and propagated by epidemiologists and virologists, molecular biologist, and lay people. These opinions and perceptions continue to disagree and vie against one another while many people are dying because of the pandemic.

According to the evidence provided by UNAIDS, AIDS is at present the number one cause of death in Africa. Also, evidence indicates that Sub-Saharan Africa has the largest proportion of such deaths. In South Africa, for example, the first two AIDS cases were recorded in 1982. The epidemic had soared from 0.76% in 1990 to an alarming 22.81 in 1998. By this time, 3.6 million people were estimated to be infected, with approximately 700 new infections everyday. The rate of infection was doubling every fifteen months. With infection increasing at this rate, a total of 6 million AIDS is estimated for South Africa by year 2009.

Figure 1 below shows infection for South Africa for the period 1999 – 2010 as projected by the Actuarial Society of South Africa (ASSA 2000).

Figure 1 HIV infection rate, South Africa, 1999 – 2010



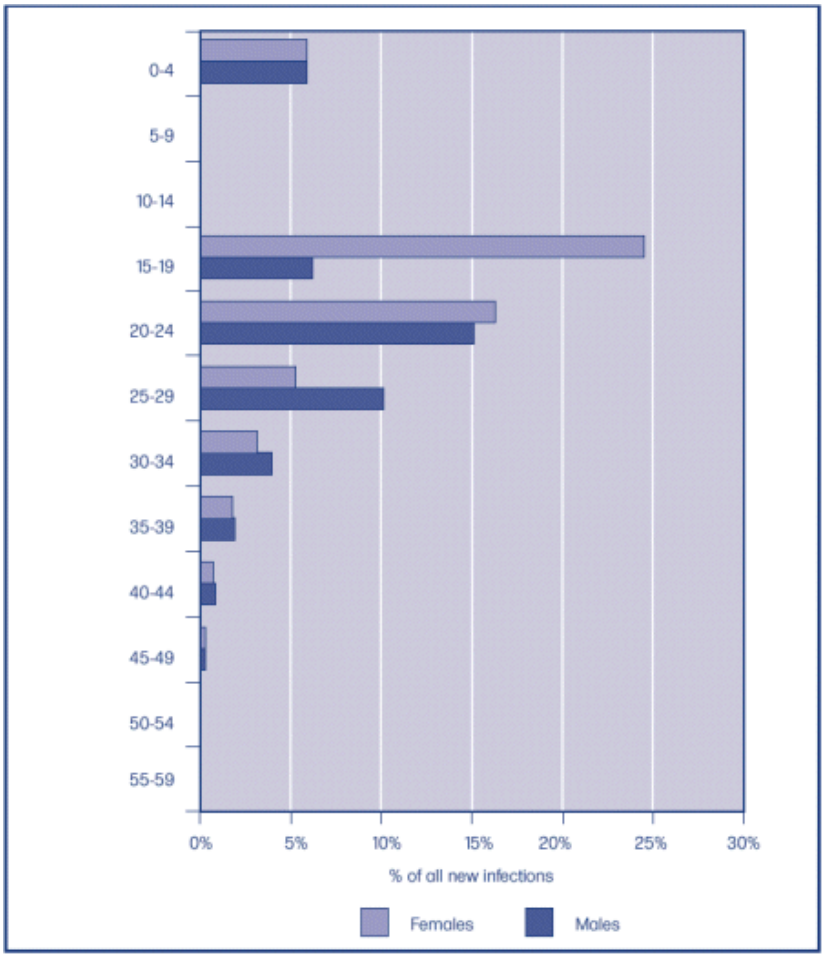
Source: Dorrington, (2000)

1.3 Demographic consequence of HIV/AIDS

Most AIDS deaths occur amongst young adults, thus creating a serious demographic problem. Prior to the AIDS epidemic, South Africa had been enjoying a drop in mortality rate with an increase in life expectancy. Now with the epidemic, life expectancy is expected to decline in specific age groups, particularly 0-4 year-olds, and 25-34 year-olds. Ages 25-34 are in most cases economically active, and are often providing financial support to their families. Deaths occurring within this age cohort mean that the number of dependants, both children and the aged, will increase, as the economic active proportion reduces and leaves a vacuum.

Figure 2 below shows the proportion of all new infections projected between 1995 and 2010 by gender and age categories. It is clear that there is a serious problem of infection amongst youth in the ages 15 – 25. Gender differences are also quite pronounced, with women at highest risk between the ages of 15 and 20, whereas men achieve their highest incidence at older ages.

Figure 2 New infections, South Africa, projected between 1995 and 2010



Source: Dorrington, (2000)

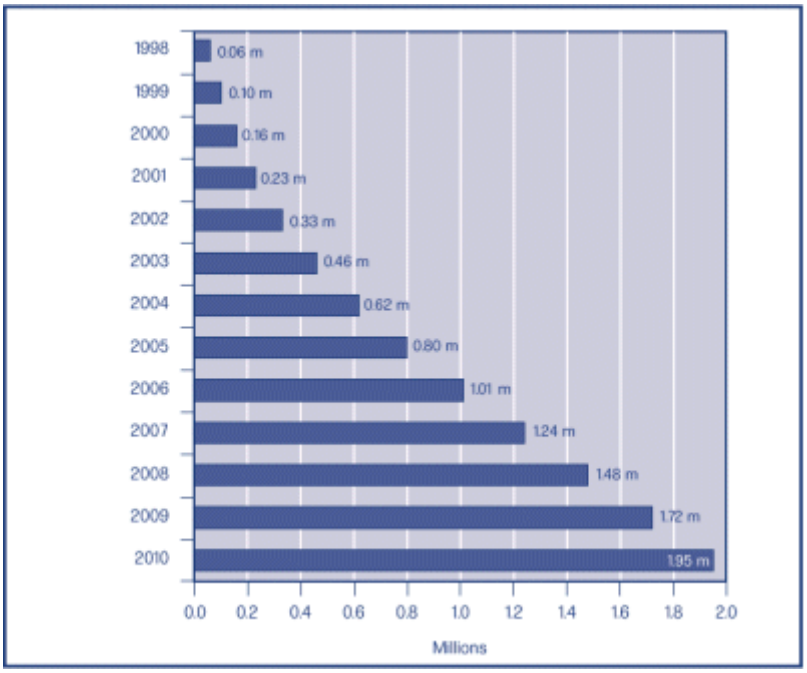
South Africa had about 100 000 full orphans in 1999 as direct result of AIDS (Department of Health, 1999). The same source projected that a million children under age 15 would be orphaned by year 2005.

Under normal circumstances, full orphanhood is rare. If one parent dies, the other remains to take care of the children. AIDS deaths often claim lives of

both parents and leave a serious burden to aged grandparents to care for orphaned grandchildren. There are also cases of child-headed families because their parents have died, and families and/or relatives refuse to care for orphaned children because of the stigma associated with AIDS. Orphans have to carry both the trauma of losing their parents and the stigma of the virus. “Friends” and peers often brand them as though they are also infected or suffering with AIDS. This condition is depressive and hard to cope with.

Figure 3 below shows ASSA projections of AIDS orphans by the year 2010.

Figure 3 AIDS orphans, South Africa, by the year 2010



Source: Dorrington, 2000

The epidemic has introduced a serious challenge and a threat to life for all South Africans. The magnitude of the challenge is well captured in the words of Robert Shell: “IF THE HIV/AIDS PANDEMIC WAS A WAR, South Africa would have to consider surrender” (Shell, 1999). In a well constructed metaphor, Shell creates an image of a defence force that has been penetrated and infiltrated by the enemy during the military operations, and defeat is inevitable. Caught in a dilemma such as this one, should people surrender, or go on to find out why the enemy was so powerful and formidable? Would

there be wisdom in understanding the secret strategy that supplies the enemy with such profound reservoir of strength?

This study suggests that there is a need to understand exactly what HIV/AIDS is and to find out why it destroys lives the way it does!

1.4 Overall purpose of the study

The overall purpose of this study is to assess the extent of AIDS knowledge and AIDS awareness amongst men at Sekororo. The study is itself concomitant upon a hypothesis that rural communities do not know well what HIV and AIDS is. Their knowledge of AIDS and of HIV is instead distorted, and as a result, there are tendencies to confuse AIDS with one or another of those curable diseases which have been prevalent for ages. Following this hypothesis one would reach a conclusion that AIDS should be given equal consideration with other diseases which can be treated by traditional herbal medication since time immemorial, and it should, as such, be considered equally with any other disease, and it can be treated.

As indicated above South Africa is faced with a serious plight caused by HIV infection and deaths caused by AIDS. Many people are dying. Young parents leave behind children orphaned. Aged people are increasingly becoming bereft of sons and daughters to care for them in their last years in life. At present, the plight is even made worse because of lack of cure or vaccine for AIDS. The only way to protect oneself and stay safe from this epidemic is by avoiding infection. It is widely assumed that people tend to make wise decisions if they are informed. The study seeks to find out from men how they perceive the answer to the following questions, *"What is the best way to fight the spread of HIV/AIDS? What role can men play in AIDS education campaign?"*

This study wants to inquire from men what they know about HIV and AIDS. Lack of consensus and controversial debates on this subject made the researcher to feel that, if high profile persons cannot resolve their debate on this matter, simple communities, rural ones in particular, should be more perplexed on this matter. It has become necessary to find out what they know about HIV and AIDS. It is important to have the proper understanding of the

epidemic in order to propagate correct messages and to stop the spread of the disease. For example, the statement by President Mbeki that there is no direct link between HIV and AIDS caused a serious confusion and controversy, and had likely received support from those who deny the existence of AIDS, and those who indulge in unprotected sexual practices. According to the president, poverty is the main cause of the epidemic. His statement fails to take into account a very basic distinction between the cause of the epidemic and the social context within which it thrives (Anton A van Niekerk et al, 2005)

The study will find out from men what they know about HIV and AIDS. Their knowledge about the epidemic should include the origin of the disease, how the disease spread to the point where it is now, the means and ways of its spread, and whether the disease is new and foreign, or had existed in the past with different names. It will also be important to know who is most likely to catch the disease, and why.

It is assumed that people respect their values and cultural beliefs. The study seeks to find out how cultural and socio-anthropological factors have over the years moulded a particular lifestyle which impacts on the community's ways of thinking and of making sense of their environment and construction of meaning. The social system of the people will be studied with a view to bringing out cultural identity and meaning for that community. Such identity is expected to paint a clear picture reflecting how a woman is treated in the community, her roles and position in relationship to a man. This exercise should also show what men they think of the social order and how disease and illness are caused, gender relationships and their role in the construction of meaning. Social factors that inhibit programmes for gender equality and equity should be identified. Identification of such factors should create a basis for further study and development of programmes targeting men for change in support of gender equality, and empowerment of women.

The study will also determine if there is a link between poverty and sexual reproductive rights of women as perceived by men. It has been reported that HIV and AIDS prevalence is high amongst women and youth. Rural women generally depend on their male partners for financial support. Because of this

dependency, women tend to be often subservient to male domination, and their rights often compromised, and they may therefore not take part in decision-making, nor negotiate on matters that concern them. Conversely, the youth find themselves hit hard by unemployment, and young girls become involved with older men for monetary benefit. This condition renders them vulnerable since they cannot negotiate for their sexual reproductive right in favour of using a condom. The study will find out from men if women can be allowed to take part in decisions, especially on matters affecting their reproductive health rights.

1.5 Specific objectives for the study

This is a case study based on primary research in the community of Sekororo where no study of similar nature and approach has been conducted before. The following specific objectives were set for the study:

- To ascertain the prevalence of AIDS at Sekororo.
- To assess the level or degree of understanding by men at Sekororo on the subject of AIDS, and to establish whether they consider it to be a threat to life, how to deal with it if it occurred, and whether or not they feel that the disease could be cured.
- To find names and connotations associated with AIDS, and the history and trend of diseases which are associated with AIDS.
- To determine the status of women in the community and participation by women in decision-making in the community. This will relate to sexual and reproductive health of women and determine to what extent women control their fertility and sexual responsibilities including the use of condoms.
- To investigate the role of social and cultural influence in the construction of meaning which give rise to the perceptions and understandings of HIV and AIDS at Sekororo.
- It is believed that these objectives would contribute to the knowledge of the community with regard to the recognition of semantics and the problem of meaning when addressing all important issues, such as

HIV and AIDS. It should also contribute reliable and original information about HIV and AIDS in Sekororo.

1.6 Assumptions

The study is based on the assumption that Sekororo is predominantly a rural community and that life in the community is to a great extent traditional. Because of distance from urban influence, and from modern media, the lifestyle remains typically rural, and resistant to change in favour of new knowledge.

The study assumes that the lack of electronic media to facilitate change, with the majority of people unable to read and write, causes most members of community to have a distorted knowledge of HIV and AIDS. This assumption includes the presence of various and mixed explanations and interpretations of the disease. The following are examples:

- HIV/AIDS is a new name for an old disease. The disease had existed from long ago, and had been possible to cure it with the use of African muti available from a *sangoma* or *ngaka* (both traditional healers). Those were powerful and skilful, and could treat and cure all types of diseases and could cast away evil spirits as well. The current absence of traditional healers with that knowledge causes the epidemic. There would be names given which are associated with the epidemic.
- AIDS prevails in the community, but no one knows its causes or origin. There are traditional healers who can treat it. It is also possible to prevent the infection by taking some medicine prior to sleeping with an untrustworthy sex partner. The medication may also be taken soon after the sexual act has taken place. The belief is that all diseases can be cured by a rightfully qualified traditional healer, unless they are a curse from God or ancestors.
- HIV/AIDS is a new disease developed by whites with the intention to eliminate blacks. Women are responsible for the further spread of the disease because they sometimes sleep with their partners at the

wrong time, when they are expected to abstain from engaging in sexual intercourse.

- There is no HIV/AIDS. If it is there, there must be treatment for it because ancestors would not allow an incurable disease that might wipe out their children. HIV/AIDS is an imaginary disease and has been introduced to encourage men to use condoms during sexual intercourse and deprive them of the pleasure of natural sex.

Another assumption is the patriarchal structure of the community. Much as it is with many rural communities, men act as decision-makers, and women obey their male partners. This male superiority is manifested in the right of the man to choose between monogamous or polygamous marriage. Even in monogamous marriage, a man is free to go out for extra-marital relationships. A low educational level amongst members of the community is assumed to promote an environment for sustaining patriarchal tendencies. Men are regarded as traditionally superior to women and women do not possess the means to lobby for promoting their rights.

The assumptions cited above suffice to pre-empt the profound presence of contending meanings and interpretations of HIV and AIDS. The study wants to portray the various meanings and levels of understanding of the disease within this community. The merits or demerits and the implications of these assumptions will be assessed in the conclusion.

1.7 Outline of the thesis

Chapter 2 of the thesis focuses on the rise of the disease, its origin and its development world wide, and how South Africa was eventually affected. The purpose of the chapter is to portray the differences and confusion at the level of scientific debate on the disease. Chapter 3 spells out the methodological approach of the research, that is, how the research was planned and conducted. Chapter 4 presents a brief overview of Sekororo. It offers a profile of the community, the socio-economic dimensions and cultural beliefs as expressed in the life and

thinking of the people. Chapter 5 presents the data as received during the interviews. It is followed by chapter 6 where research findings are analyzed, interpreted and weighed against the assumptions stated above. Finally, chapter 7, which concludes the study, provides some recommendations and a way forward.

CHAPTER 2 HIV and AIDS in Global Perspective and How South Africa is Affected

2.1 Rationale for the chapter

From the time of its first appearance to the present, HIV/AIDS remains an enigma. There is still no consensus on the origin of the epidemic, where the epidemic was identified for the first time, and to some extent, on whether HIV causes AIDS or not. With the many contending theories and debates on these questions one begins to understand why the metaphor of a tapestry has been selected. The metaphor, tapestry, describes well the complex nature and history of the disease. This chapter will attempt to sketch the presumed origins, or causes of the disease, and also the course that theories and thinking about the disease followed, from its beginning to date. An attempt will also be made to illustrate how medical scientists, micro-biologists and virologists hold contending views on this matter. It is therefore no surprise that unsophisticated lay people in rural areas with a low education or none at all, , would require a coherent and appropriate explanation and interpretation which could enable them to understand this epidemic.

The main source for this chapter is Edward Hooper. In 2000 this ardent journalist published his thick volume, The River, where he reports in detail his findings on the origin and the history of the epidemic. Hooper dedicated his time to dig deep into the source and origin of the epidemic. Through more than ten years of extensive research, based on over 600 interviews and more than 4 000 written sources, he suggests that HIV may have been spread to humans, not from the "natural" result of human/chimpanzee encounter as previously contended. The spread of HIV, he believes, happened during medical experiments done in Africa in the 1950s. He charges the vaccine testers with performing experiments shabbily and reckless behaviour, and offers substantial ethical evidence suggesting that racist inclinations underpinned the nonchalant conduct of the scientists. These arguments will be reported and discussed in this chapter.

2.2 History and origin of the disease

2.2.1 What biologists say about AIDS

There seems to be ample research evidence to support that the disease AIDS is caused by HIV. This virus (HIV) is described as part of the family or group of viruses called lentiviruses (http://www.avert.org/origins.htm:1-5). Hooper has suggested that HIV could be traced to the experiments for oral polio vaccine in the then Belgian Congo, Rwanda and Burundi in the late 1950s (Hooper: 2000). Hooper goes on to describe how HIV divides into HIV-1 and HIV-2. HIV-1 is predominant worldwide, and it further subdivides into ten sub-types, A – J within group M, and group O with a distinct group of heterogeneous viruses (Hooper, 2000: 176-178). The dissimilarities between the two types of HIV suggest that the two HIVs evolved independently of each other, and AIDS related to either of the HIVs would represent a separate zoonosis. HIV-1 is described as more easily transmitted as compared to HIV-2, and people infected with the former take a shorter time (ten years latency) while the latter has a longer latency (twenty years) (Hooper, 2000: 340-346)

Hooper makes reference to lentiviruses other than HIV which have been found in a wide range of non-human primates, and are collectively known as simian immunodeficiency viruses (SIV), denoting their species of origin (Hooper, 2000: 175-80, 345)

In 1989 and 1990, the simian immunodeficiency viruses (SIVs) - the sooty mangabey and the chimpanzee - were sequenced, and these viruses (SIVsm and SIV cpz) were closely similar to HIV-2 and HIV-1 respectively. Following this analysis, there is supporting evidence that HIV-1 and HIV-2, originated from simian immunodeficiency viruses (SIVs) found in a certain sub-species of chimpanzee, *Pan troglodytes troglodytes* (Ptt), that is found only in west central Africa (notably Cameroon, Gabon and Congo Brazzaville) (Hooper, 2000). It is claimed therefore that HIV-1 crossed species from chimpanzees to human. It is not clear though that chimpanzees are the original source of the virus since they are themselves only rarely infected with SIVcpz. It is possible, as suggested elsewhere, that chimpanzees and humans have been infected from a third carrier primate, as yet unidentified (Harp P M. et al, 1994).

If monkeys have these viruses, could it be possible that people have become infected after eating monkey meat, and thereafter spread it to other human beings either through blood transfusion, or sexual intercourse? If eating monkeys can cause infection with HIV, it would mean that HIV and AIDS began long ago among people who ate those animal species.

Debate around the origin of AIDS, and of the composition of HIV, becomes more complex with scientific evidence that there are many sub-groups of the virus. In his research report, Hooper makes this observation: "It seems significant that of the ten sub-types of HIV-1 Group M recognized in 1996, six (A, C, D, F, G, H) have been found in the Congo, one (J) in Congolese living abroad, one (E) in the south of the Central African Republic that borders the Congo, and one (I) in Cyprus, the Greek community which has always had strong links with Stanleyville/Kasangani in Congo (Hooper, 761). Robert Root-Bernstein illustrates how AIDS as disease and its meaning, mutated over different phases and with various communities. “In 1982”, he reports, “the Centers for Disease Control (CDC) in the United States defined AIDS, as *a disease, at least moderately predictive of a defect in cell-mediated immunity, occurring in a person with no known cause for diminished resistance to that disease*” (www.virusmyth.net/aids/data/rrbdef.htm). Diseases or conditions associated with AIDS at that time had included, amongst others, Kaposi's sarcoma, Pneumocystis carinii pneumonia, and serious other opportunistic diseases. The same institution has in 1993 expanded the definition of AIDS to include all human immunodeficiency virus (HIV) infected adolescent and adults aged 13 years and older, who have either;

- less than 200 CD4+ T- lymphocyte percentage of total lymphocytes/uL;
- a CD4+ T- lymphocyte percentage of total lymphocytes of less than 14%; or
- any of the following three clinical conditions: pulmonary tuberculosis, recurrent pneumonia, or invasive cervical cancer (Hooper, 2000).

The definition of AIDS as presented above seems to suggest that CDC was in 1982 not sure of what AIDS was. From 1981-84 leading researchers,

including those from the CDC, proposed that recreational drug use was the cause of AIDS. What seems to be clear from the explanation of AIDS by the same institution is that the disease is a result of immune deficiencies of unknown origin, and it is manifested through serious opportunistic diseases. Grmek, a French physician and historian, describes AIDS as a phenomenon that did not exist before the mid-twentieth century (Grmek, 1990: 109), and is reluctant to call AIDS a disease in the old sense of the word. He instead argues that its definition by biomedical researchers cannot allow it to be considered a disease. His argument is based on lack of clinical symptoms, or lesions, observable by the old means, and he concludes that there can be no AIDS unless there are opportunistic diseases first (1990). The disease, or syndrome, depending on what scientists want to name it, is likely to be named differently until scientists reach consensus and conclusive agreement on the term. This lack of concise universal definition of AIDS created an environment which allowed nomenclature and description of AIDS flexible to suit different groups, both in the research community and laymen.

Notwithstanding the above discussions, HIV seems to have been decisively established as the cause of AIDS (Hooper, 2000). Hooper asserts that the AIDS virus was identified for the first time in 1959. He goes on to report that in the mid 1980s, a scientist at the National Institute for Health, with a prolific profile in cancer research, claimed to have proved the link between HIV and AIDS. The claim was disputed by some scientists who, in their desperation to find a cure, focused on trying to find a treatment or vaccine for the new epidemic, and not in the study of what the disease or illness is. For purposes of this study, this thesis will only highlight crucial facts of the debate regarding the origin, or source, of AIDS and HIV, and speculations on where the epidemic began.

2.2.2 Research and the origins of HIV and AIDS

After more than 25 years that HIV/AIDS has been playing havoc on mankind, scientific researchers are still not agreed on the origins and causes of the epidemic. Research findings have often shown serious controversy, and sometimes antagonism rather than moving towards a consensus.

There seems to be abundant evidence that the first cases of AIDS in the USA occurred in 1981, but little information about the source of the disease (The Origins of AIDS and HIV, www.avert.org./origins.htm, accessed 18/12/2001). The first case of AIDS in Africa was reported in 1983 (Hooper, 2000). Report of deaths with symptoms similar to those of AIDS in the late seventies suggests an even earlier occurrence of AIDS cases for Africa prior to 1983 (Hooper,2000:90-99). Dr Wolinsky and his colleagues have determined that AIDS began to spread decades before, in 1959. This information is based on the oldest known HIV-1 infection which was discovered in 1959, that of a man in what is now known as Congo. He was one of the 1,200 Africans who had given blood sample as part of the study of the immune system.

Whatever scientific research says on the origin of AIDS and the trend of its spread, two hypotheses seem to run parallel in this regard. The first one suggests that the disease, or epidemic, began at one particular point, and from there the disease spread to other countries through, for example, international travels encouraged by good infrastructure (Shell, 1999), blood transfusion and prostitution, particularly in countries with a severe unemployment crisis. The second one favours sporadic and contemporaneous origins of the epidemic in different parts of the world (Hooper, 2000:). The latter hypothesis removes the blame from any particular country as being the source, or origin of the disease. If this hypothesis is accepted, claims linking the origin of the epidemic with laboratory experimentation can no longer hold, since such experiments could not have taken place simultaneously in more that one place.

2.2.3 Arguments in favour of sporadic and simultaneous development of AIDS

Whilst Africa is suspected as place of origin of AIDS, sporadic starburst of the epidemic is possible, and Haiti, a tourism paradise, is suggested by Hooper (2000) as one of the places where AIDS originated. Hooper reports that by mid-1982, a total of 44 Haitian AIDS patients had been recorded in Miami, Brooklyn and elsewhere in the USA. In June 1983, 5% of the 1 641 AIDS cases in the USA were from Haiti. These figures of AIDS patients build a strong argument in favour of Haiti as possible origin of AIDS. This hypothesis links with homosexuals and the outbreak of swine fever in that country. "By 1983, American and Haitian doctors were writing to medical journals, suggesting that the origin of AIDS might somewhat be linked to the recent outbreak of African swine fever in Haitian pigs and the eating of undercooked pork, to bloodletting as a medical practice in rural areas, of Haiti, or to voodoo ritual, which allegedly involved the drinking of animal or human blood." (Hooper, 2000: 76).

The European country that provides the earliest evidence of AIDS among gay men is Germany. A 21 year-old soldier from Rheinland fell ill in 1977, and died in 1979. France identified the most pre-epidemic cases, with seven cases recorded in hospitals in Paris alone by the end of 1979. Meanwhile, the first known victim to have died of AIDS in Britain was a forty-nine year-old gay man who died in 1981, and he had visited gay friends in Miami on an annual basis (Hooper, 2000:).

Hooper goes on to report that by 1983, 243 AIDS cases had been diagnosed in Europe. Thirty three per cent of these cases involved gays who probably had been infected in the United States; 105 were gays who had probably been infected in Haiti; and 21% were gays who had sexual contact with other men in Europe. By 1983, Belgium recorded 38 cases, of which 34 were African and some link to the areas where CHAT had been administered. The distribution pattern of the epidemic in Europe, and the major thrust on gays, can support the Haitian and American hypothesis. Hooper turns to what he calls the *African myth* which suggests Africa as the place where AIDS

originated. He goes on to support this claim with evidence of cases linked to French West Africa of the colonial epoch.

2.3 AIDS in Africa

Hooper suggests that civil wars and political instability amongst African states propelled the swift spread of the epidemic in Africa. There was a mass uprising in 1959 in the former Belgian colonies (in what is now called Rwanda), and it resulted in mass exodus of Tutsis. By 1964, some 200 000 Tutsis, had crossed to the Congo, Burundi, Tanganyika (today known as Tanzania) and Uganda in the span of just over four years. There are reports by major hospitals showing an increase in deaths related to AIDS amongst those who left Rwanda and Burundi in late fifties and early seventies (Hooper, 2000:)

Reference is also made to Butare (Hooper, 2000) a home to both the main army camp and the national university where 88% of the prostitutes tested HIV positive in 1984, and this suggests that the virus might have been present much earlier in this community. The situation in Butare tells it all. Political instability, civil wars and exodus, account for the rapid spread. Military operations and war situations are often accompanied by prostitution, and thereby create a fertile environment for the quick spread of AIDS.

2.4 Iatrogenic origin of AIDS

2.4.1 Polio oral vaccine theory

Hooper (2000) suggests that AIDS is possibly a manmade pandemic caused by a virus which may have been created during oral polio vaccine development by Dr Hilary Koprowski in Philadelphia in the fifties. Hooper's account of AIDS and the contaminated polio vaccine depends largely on Louis Pascal, an American philosopher who argues that AIDS originated from contaminated live polio vaccine used in Africa in the 1950s (Pascal, 1991). Pascal contends that Dr Hilary Koprowski was responsible for the outbreak of AIDS in central Africa. He bases his argument on the assumption that certain batches of CHAT, an experimental oral polio vaccine (OPV) developed by Dr

Hilary Koprowski in Philadelphia in the fifties, may have been prepared in a substrate of chimpanzee kidneys, and that an SIV latently present in some of those kidneys may have infected a proportion of the million persons given those vaccines in central Africa between 1957 and 1960, thus sparking the AIDS pandemic of today. He also makes reference to similar campaigns involving vaccine produced from the kidneys of primates being conducted in French Equatorial Africa and French West Africa during the fifties, and that these could be related to minor outbreaks of AIDS.

In 1987, Pascal proposed that the virus may originally have been transmitted to humans in a live polio vaccine which was used during an experiment on nearly a third of million men, women and children in the Belgian Congo, now the Democratic Republic of Congo, in the late 1950s. Pascal presents his case very clearly and with many references. He handles this subject with passion and he deals with this topic in a manner depicting great socio-ethical significance and caring, and suggests that there was negligence on the part of the scientist who conducted the tests. He notes that the earliest confirmed sample of human blood testing positive for HIV which came from Kinshasa, and that the highest and fastest growth rate of AIDS was in those regions where oral polio vaccine was tested. His report goes back to 1959, the same year in which some 70 000 inhabitants received the experimental polio vaccine. Other early reported cases of AIDS were from Congo's neighbour-states of Rwanda and Burundi (Pascal, 1991).

The hypothesis of Hooper and Pascal found support later in the 1980s. For example, there is a recorded 82% of 46 serologically confirmed African HIV-1 infections through 1980, and 64% of 28 medically plausible and serologically confirmed HIV-1 related AIDS cases through 1980 which came from towns and/or villages in the Democratic Republic of Congo, Rwanda and Burundi where CHAT was administered between 1957 and 1960 (Hooper, 2000).

Scientific research has not produced a final word as yet on the nature of the virus that contaminated the Congo vaccine. What has been pointed out, based on scientific grounds, is that it was possible for a monkey immunodeficiency virus, or SIV, to grow in culture, be administered to humans

in a vaccine and cause an infection. If SIV-infected chimp kidneys were used to make CHAT (as Hooper believes they were), then it is entirely plausible to propose that different chimp SIV variants would have been transferred to humans in the different vaccination campaigns.

Lack of any vehement challenge or denial of the link between the origin of HIV and the polio vaccine by an independent body or individual outside the vaccine producer institution could be interpreted as support for the polio vaccine theory as the origin of the virus HIV, and eventually AIDS. Further evidence points out that the region where this experiment was conducted has the highest AIDS prevalence in the world (UNAIDS, 2004). This correlates with the hundred of thousands of inhabitants who received the experimental polio vaccine.

Hooper's assertion on the racist inclination of the scientists could not be ruled out but rather be treated with caution. There are reports that experimental polio vaccination which took place in the former Belgian Congo was done by colonial scientists, and on the indigenous people. In his records Hooper alludes to harsh treatment of the natives or indigenous people by the colonial government which did not seem to show passion and love for the indigenous people at the time of the research. It would, however, have been expected of the researchers in their eagerness to achieve desired results to be meticulous in every respect in their quest without endangering humankind. In his report Hooper feels that, like a stray bullet, the research created an innocent victim, that is the anti bodies in the human immune system, being sacrificed as an unintended consequence.

2.4.2 Segal and the Military Ambition Theory

Amid this controversial debate on the African origin of HIV and AIDS comes in Jacob Segal and his military ambition theory of the origin of the disease. The human ambition and laboratory theory as origin of AIDS had been circulating in Europe, particularly in Germany, since 1986. According to Segal, the origin of AIDS is blamed on United States of America government biological warfare

research laboratory in early 1989 (Morrissey, Was There an AIDS Contract? www.africa.upenn.edu/Urgent_Action/AIDS_Contract.html, accessed 31/03/2001). Segal challenges the African origin of AIDS theory and rejects it on the evidence of the epidemiological history of AIDS. He argues that there is no solid evidence of AIDS in Africa before 1983. Meanwhile, it is historically accepted that the earliest documented cases of AIDS date from 1979 in New York.

Segal quotes from a document he maintains was presented by a Pentagon official, Donald MacArthur on June 9 1969, which was directed to a Congressional committee, whereupon $10m (ten million US dollars) is requested to develop, over five to ten years, a new, contagious micro-organism which would destroy the human immune system. (Morrissey: 2). The new virus was tested on prisoners who volunteered for the experiment in return for their release from prison. Failing to show any symptoms of the disease, the prisoners were released after six months, and returned to New York where the disease was first diagnosed in 1979. If this theory is accepted, there is logic in his claim, and consistency with the earliest recorded cases of AIDS linked with young, well-educated (mainly homosexual white men) in Greenwich village, south of Manhattan, New York in early 1979 (ten years from 1969, and a period consistent with HIV-1).

The major difficulty with this theory is to reconcile how a progressive scientist would develop an interest in producing a lethal disease which would destroy mankind! What is difficult to accept is, *"how would anyone embark on a malicious venture of that magnitude unless he was certain that it would be possible for him to reverse the disease?"* It is possible, however, that a person might have embarked on this venture, with the hope that the virus would be stopped at a later stage. The problem with this assumption could be compared to the gun which was made by man for purposes of killing, and the same man who produced the gun cannot get man immunized against the bullet.

A similar theory to Segal's is Hooper's African myth that suggests West Africa, the Belgian Congo and the Congo Brazzaville as the cradle of the disease.

Hooper (2000) reports how the disease was produced as a deliberate act of human beings. According to this view AIDS is man made and not a disease with a natural origin. HIV had been deliberately created from the combination of two animal retroviruses - visna virus and bovine leukemia virus (BLV) - grown in human tissue culture. The assumption is that the new virus was spread first in Africa through the smallpox vaccination programme, and then in America via contaminated oral polio vaccine and the hepatitis B given to homosexual men. Virologists find this hypothesis unconvincing. They contend that visna, HTLV-1, and BLV are only distantly related to HIV, and far too distantly therefore, to have played a role in its origin.

Following Segal's claim very closely and at length, Morrissey (35) concludes that the theory that AIDS originated in a bio-warfare laboratory is inhumane and undesirable even though it remains plausible. The same document refers to MacArthur's testimony where it is revealed that scientists were looking for an agent refractory to immunological processes. In other words, the scientists were, following this testimony, looking for a new agent for which people do not have natural immunity. A natural body has no immunity to HIV, and once HIV enters the human body it infects the immune system in human tissues, and the viral load increases and continue to maim and destroy cells.

2.4.3 AIDS and the malevolent sinister god

Proponents of this theory suggest that sin is the cause of AIDS. The Biblical cliché is exploited: "the wages of sin is death" (What is the real cause of the AIDS pandemic? http://www.oldpaths.com: accessed 21/08/2007)). The theory claims that AIDS came as the result of an angry god who had become unhappy and disgusted with the recent development on earth. This would include new life styles and disobedience to the god as will be seen in the next paragraph.

According to this theory, one malevolent god had grown disgusted with increase in drug addiction, homosexuality, promiscuity and pornography, caused AIDS as consequent punitive measure. The angry god is here seen showing characteristics of a sadist because he appears to be meting out a punishment that causes pain and suffering not only to the immoral people, but

innocent ones also suffer the doom, for example, newly-born children who are born with the virus and yet they had done nothing wrong, recipient of blood transfusions, and hemophiliacs and monogamous wives of men with multiple partners.

2.5 AIDS in the pre-AIDS era

The trend AIDS and HIV showed seems to support the possibility that sporadic early AIDS cases might have occurred over the years, some of them possibly recorded in the medical literature, but appearing under different diagnosis. In August 1990, the Dutch epidemiologist, J P Vandenbroucke, shared the same view and remarked that astute physicians have always felt the urge to write down and publish the unusual (Hooper, 200). His research suggests that early reports of isolated AIDS patients are hidden in medical journals. This remark by Vandenbroucke should not be ignored. It is possible that earlier AIDS cases may have not been recorded for lack of knowledge of the disease, particularly in the less developed countries and rural hospitals. Wolinsky had already alluded to AIDS in Congo in 1959, with another earliest case of AIDS reported at St Louis Hospital in 1968 – both cases supporting earlier prevalence of the epidemic. It has been pointed out that HIV-prevalence in Rwanda in 1986 was recorded as being 17.8% in urban locales and 1.3% in rural communities (Hooper, 2000). The argument could further be supported by Hooper's reporting that in Rwanda, as in Zambia, the presence of AIDS was only noticed in 1983, probably ten or more years that HIV had been there.

Pre-AIDS cases might have existed in these regions but were "missed" by the medics. For instance, when AIDS was first recognized in Congo and Rwanda in 1983, it was as a result of doctors who had flown in from Europe and America, and who were familiar with the concept of AIDS from gay and intravenous patients in hospitals where they came from (Hooper, 2000). By contrast, African doctors had little context with which to associate the new and diversely-presenting phenomena of immunodeficiency, little access to medical journals, and less of a tradition of reporting unusual cases in those journals.

It would, however, be a misleading conclusion to accept that there is no evidence of AIDS related diseases prevalent among Rwandese in the years preceding 1983. There is a report of extremely high levels of tuberculosis (16 of 21 cases tested) were detected in Rwandese refugee children who fled Rwanda for the Congo in the early sixties (Hooper, 2000). Furthermore, three unusual cases of fatal generalized herpes were detected in the mid-sixties in Rwandese and Burundian infants whose parents had fled or migrated to Uganda. Three other unusual deaths in Ugandan pathology records involved Rwandese and Burundian adults - who have most likely migrated from areas where CHAT had been administered a few years earlier. All the conditions cited above involved typical AIDS indicator diseases. In chapter 9 of *The River*, Hooper argues that there are many factors other than HIV infection which are capable of causing immunosuppression (and spark AIDS-like indicator diseases), but concludes that it is undeniable that these early Rwandese and Burundian cases may have been caused by HIV infection.

Hooper's enquiry on this subject led to an extensive report on the pandemic. He traces its origin to what he calls the pre-AIDS era, and he reports on those earlier cases of AIDS which occurred before 1981. As examples he lists six cases, namely a teenager from St Louis, Missouri, who died in 1969; a young woman from Washington state (1964): Ardouin A. from New York (1959); David Carr, the Manchester sailor (1959); George Y. from Toronto (1959); and a young man from Memphis, Tennessee (1952). Earlier cases of AIDS include a Japanese-Canadian woman, Mrs Sadayo F who had died in Montreal in 1945. Sadayo first fell ill in June 1945 with breathing difficulties, sleeplessness, diarrhea, and loss of weight. That was followed by penicillin resistant pneumonia, and her death in July 1945. At autopsy she was diagnosed with a range of ailments that led to her death. Penicillin resistant pneumonia would be consistent with a condition which does not respond to a treatment, and AIDS fits in well in this (Hooper, 2000).

2.6 Conclusion of the debate

The relevance of "the tapestry" is becoming increasingly noticeable.

The debate on HIV and AIDS is seen from its beginning to be intricate and much more complex than often thought. Various positions were taken in the debate, with a number of possibilities offered to explain the nature and origin of the disease. Amid those debates and contradictions, a growing group of bio-medical scientists claim that the cause of AIDS is still unknown. These so-called heretics do not believe in the lethal AIDS virus called HIV. “If there is evidence that HIV causes AIDS, there should be scientific documents which singly or collectively demonstrate that fact, at least with a high probability. There is no such document” (Duesberg), www.virusmyth.net/aids/data/alinterviewrg2.htm

CHAPTER 3 Methodology and Design of the Study

3.1 Introduction

The study focuses on the phenomenology of meaning which is an attempt to illustrate the interdependent relationship of human beings and a meaning. In this relationship, man gives meaning to action, or praxis, and the meaning in return controls and limits man (O'Malley, 1978:112). In pursuing its objectives the study will prefer a predominantly qualitative approach with a limited use of statistical figures. Because the study is concerned with meaning, understanding and perceptions a qualitative approach is relevant for this study. The significance and relevance of a qualitative approach for this study lies in its ability to explain all pieces of information reliably related to the subject being investigated in such a manner that they are not in contradiction with the interpretation presented.

The concept of *being and becoming* will be used to explain why the phenomenology of meaning was selected as relevant for this study while at the same time it forms a basis for social identity and social solidarity. It is very important on this point to understand the relationship and interplay between the world as locality where man finds himself and the man himself as he relates to that world. As a starting point, a human being derives the sense of meaning from himself as a socialized entity (Giddens, 1984). From childhood, and throughout various stages of their lives, human beings are engaged in the process of making sense of the world in which they live, and of the immediate environment where they interact with others. This process occurs through the individual internalizing the immediate surrounding – things they hear of and learn of. In other words, the process begins with cognitive learning that deals with things that can be touched and seen, then to conceptual learning that involves abstracts such as the attitudes and values current within a specific milieu (O'Malley, 2000). Castells summarizes this process as identity that develops through a process of construction of meaning on the basis of cultural attributes that are given priority over other sources of meaning (Castells, 1999:5).

This process is a dynamic relationship that is expressed in the attempt by man to give meaning to or explanation of the phenomenal world. This invented meaning makes man what he in return, becomes. In this sense, meaning compares with a totem that serves as unifying force and gives the sense of identity and solidarity to a specific group of people. In this context, the sociological function of the meaning emerges, and it assumes an identity symbol since a specific group of people living in a particular place, would identify themselves as a unit because of their common understanding and interpretation of their world and environment.

Meaning constitutes a sociological function when man gives meaning to action, which becomes praxis, and the meaning in return, controls man as member of an institution. In this sense, man has the freedom to act in accordance with what is perceived to be right. Right would in this sense refer to what is considered normative within the confines of the social mores in a specific society or community. This freedom, however, may only be enjoyed if it is practised under the control of the sanctions of social behaviour as constituted in the cultural thinking that unites a specific society. Man is seen in this process to be free, and yet enslaved by the demand to comply with what is held by the society as normative and acceptable.

It was demonstrated in the foregoing paragraphs how human beings are interdependent in their day to day action, and how they influence one another during their day to day life. It was also observed that human beings act as a collective, and their freedom of actions remains limited by the codes of social conduct for the group where they belong. It is for this reason that a qualitative approach was selected for this study. The rationale for the choice was outlined already in paragraph 1 of this chapter.

3.2 Approach for studying Sekororo

This is original research and the first of its kind to be conducted at Sekororo. This fact was borne out by a literature review. A comprehensive questionnaire was developed for the gathering of information from selected categories of respondents. The questionnaire covered biographical information, and extended to include social, economic and cultural information. The purpose of

broadening the questionnaire to that level was to extract as much information as possible that would enable this study to come up with a richer understanding of the unity and diversity of the community.

3.3 Literature review

Because of the dearth of relevant literature pertaining to the area of study and the people, the literature review was restricted to social anthropology of the Bapedi people in general. Books were available on the Balobedu tribe of Modjadji, which shares much in common with the Sekororo community, and those books were consulted.

The literature survey of socio-anthropological material covered the social life of the Bapedi people in general. Some attention and consideration was given to the traditional and cultural dynamics within the Balobedu and Bakgaga clans, with focus on the Banareng clan which includes the Sekororo community. There was much to read and gather in the form of oral tradition on these clans. They had in the past mingled together, and as such, a rich cross-pollination of their lives cannot be escaped. This exercise provided insight into the dimensions and frame of thinking of these related clans, and therefore, a springboard for zooming into the study of the community of Sekororo.

This process aimed at contributing towards a better understanding of the unit of analysis but has in return also contributed during that time to the formulation of the hypothesis and assumptions that have guided the drawing of the questionnaire. It enlightened, for example, issues surrounding patriarchy and the role of women and their participation in decision-making in the day-to-day life of the people.

Another area that was covered during the literature survey was the health systems, past and current, amongst the Bapedi people. The review took cognizance of how traditional beliefs and cultural heritage influence health systems. This exercise increased perception of how strong and powerful traditional healers are in influencing traditional and current trends of health systems. Such interjections remained to be examined during the process of this research. This aspect was essential for understanding HIV and AIDS

prevalence in the context of the rural health system and the power of the ancestors and traditional healers.

The researcher has a fair knowledge of the people around the area. He was born about 25kms from Sekororo. His birthplace is surrounded by Bakgaga, Banareng, and Balobedu – all of them are Bapedi tribes. There is a fair interaction and mingling amongst these communities and the community where the researcher comes from, and the social life of these communities is known to the researcher. This information was used by the researcher as springboard during the elementary phases of the study.

3.4 Sampling

Stratified sampling was implemented. This option was selected because it enabled the researcher to focus on homogeneous populations as a unit of observation during the research process. In this case, males of specific age groups were targeted as informants, and their responses were taken to represent the general perception of men at Sekororo.

3.5 Selecting informants

The overall objective of the research was to establish exactly what the community at Sekororo understands by HIV and AIDS. A tapestry was selected as metaphor applicable to reach into the meaning of the epidemic among men in this community. Their understanding and perceptions of the epidemic were expected to take into account broader sexuality issues and reproductive health, male-female relationships within a community which is assumed to be patriarchal, and what HIV/AIDS is and what it means to the community at Sekororo. This objective was expected to be achieved, if possible, according to the analogy of a tapestry, which would portray a rich formation of threads of meanings. For purposes of the assumed tapestry a careful selection of the respondents was done, and it comprised 42 male respondents, aged 30-65 years who were selected for interviews. During the interviews, three elderly men aged more than 80 years volunteered to give information as well, and their contribution enriched the study by revealing information which could not have come out from the initial selection.

The age group 30-65 years was selected for the following reasons:

This age group consists of contemporaries of our time. This group represents a knowledge continuum which had been gained from the past but still moving on to the future – a kind of a link connecting the youth, middle-aged, and the elderly, and a full picture of male representation in Sekororo. They are sexually active, and also influential as parents and role models in the community.

Both the middle-aged and the elderly (45-65 years), were assumed to be still sexually active but strict in preserving the old and patriarchal thinking and therefore to be relevant as resource persons on sexuality and reproductive health patterns in their community. They were also expected to have authentic information and the final word on social issues including sexuality and male-female relationships.

Meanwhile, the younger ones, aged 30-36 would likely be assumed to represent some kind of a shift from the traditional pattern of life, and a move therefore toward a modern approach, which may perhaps not fit in very well with that of older ones, the 45 and above. This bridge is expected to join together the generation gap, namely the youth in general (15-35 years), and the older generation (45 years and above).

The three old men, all in their mid-eighties, brought an authentic historical perspective, and thereby offer a kind of a yardstick to measure the past and balance it with the present.

On the whole, the respondents' age distribution is assumed to represent a balanced presentation regarding views of the community on socio-cultural matters, health, diseases, health care systems, and the status and role of women in the community.

3.6 Questionnaire design

A detailed questionnaire was prepared and discussed with Professor CJ Groenewald for his comment and suggestions. The questionnaire covered a broad scope and included questions related to social systems of that community, the cultural and religious perceptions as influenced by social environment, health and illness and diseases prevalent in the area and how those diseases compare with AIDS. This content was guided by the literature

study that was conducted and the prior knowledge and assumptions the researcher had of the community. Although half of the questions intended to bring out socio-cultural dimensions, and to understand the place and role of a woman in the community, the major focus was on HIV/AIDS.

Respondents were asked what they knew and/or understood of HIV/AIDS. They also were asked questions regarding where it came from, its origin and history, and to tell if it was prevalent in their community, and what they would do about it if it prevailed, sexual relationships between men and women, and social relationship with people infected with HIV/AIDS.

3.7 Access person and research facilitator

Rural communities respect leadership and as such a research of this nature could not have been possible if the tribal chief had not supported it. Arrangements were made for a meeting with Kgosi Solomon Sekororo. The meeting was intended to discuss with Kgosi the intention, purpose and objectives of the research, and to solicit his support. Kgosi called another meeting where he informed his councillors of the research, and requested them to support the research and to inform the community. Matrons Mrs Mashanya and Miss Shale Makwala were nominated to support and assist during the course of the study because of their expertise on public health in that area, and they generously availed themselves for consultation and confirmation of public health data in that area. They also assisted in validating some of the data that related to HIV prevalence and the existing cooperation between the hospital and traditional healers.

3.8 Interviews

Direct interviews took place with 45 respondents in the ten villages of the community of Sekororo. On the average, four respondents were interviewed per village. The interviews were conducted over six weeks and in two phases of three weeks each. During interviews, questions were simplified and explained to those respondents who required help to understand what exactly the questioned sought to establish.

Chapter 4 Overview of the Community of Sekororo

4.1 Rationale for the chapter

This chapter will introduce the community of Sekororo within its socio-cultural context because socio-cultural context is believed to have moulded and unified the community of Sekororo into a particular social solidarity. The chapter will also show how this social solidarity has developed specific systems and values which guide and control them in their day-to-day life. Social systems which will be discussed include the role of leadership vested in men as custodians of tradition, with a responsibility to maintain the social coherence and cosmic order. These systems, together with selected social institutions, are seen to be operational throughout the life of this community as manifested in their way of thinking and their interpretation of events and phenomena, including their perceptions and understanding of health and diseases and illness, and of HIV and AIDS which is the interest of this study.

Theoretical and conceptual apparatus which will be considered in this chapter will include patriarchy and the status of women in the community, rural characteristics and developmental factors, and culture as articulated in day-to-day life and conduct of the people. At the end of the chapter, the study is expected to have demonstrated the link between the social environment and how men at Sekororo make sense of their environment, how they create and develop knowledge, and how they interpret and give meaning to their immediate environment. This link should be seen as pivotal in the formation of perceptions and the interpretation of concepts and knowledge created in day-to-day life. It is important that the dual relationship be identified between the quest by human beings to interpret and make sense of their environment, and the environment guiding and limiting human beings in this process.

4.2 General background

The rural community of Sekororo is located about 67 km southeast of Tzaneen on the slopes of the Drakensberg mountains. This community is surrounded by white farms which provide economic resources for the people in this community. This fact explains why the community is considered rural. The majority of people are unemployed, with little or no development, and

severe poverty. Poverty is worse amongst women because they generally have very narrow career scope available, and at Sekororo, women seem to be under institutionalised male dominance. This condition has favoured the perpetuation of women's dependency on men for financial support. Even those who work earn a meager salary which could be as little as R250 or R300 per month, with long hours and harsh working conditions with no opportunities for career path and development.

4.3 Population size

At the time of the research in April 2000, the population register in the royal office recorded a population of 77 522 people distributed over 10 villages as follows:

Table 1: Villages, families and population size of Sekororo

Name of local village	**Number of families**	**Number of people**
Balloon Mantjana	449	3 395
Bismarck	586	7 514
Enable	764	5 372
Hlohlokwe	1 524	15 897
Lorraine	1 466	12 974
Madeira	753	3 234
Makgang	701	3 359
Moshate	1 330	10 783
Sofaya	704	6 319
Turkey	1 403	8 677
Total	**9 680**	**77 522**

Source: Population Register, Office of Chief Sekororo, 2000

These figures were collected by community agricultural officers who had no orientation on matters of census, and did not indicate precisely the year when they were collected; and should be treated with caution and as a guide and not necessarily accurate. In the opinion of the researcher the population as observed could have been more than 77 522 at the time of this survey. This

opinion is based on the geographical area as well as the density of dwellings in each of the ten villages. Another factor worthy of consideration is that many people at Sekororo live and work in large cities like Johannesburg and Pretoria. Some of those people stay in those cities cohabiting with other women while others come home seasonally for holidays. No indication was made of whether or not the figures included the migrant workers who sojourn at their places of work and return home once a year to spend an annual leave. The population size of Sekororo as presented above would most probably refer to only those citizens who are living there permanently.

4.4 Rural characteristics of Sekororo community

The advent of modern life with its mixed cultural practices seems to destabilize communities and often breeds a lifestyle that makes it difficult to draw categorical sociological demarcation between rural and urban life. This blending seems to be conspicuous more amongst the youth where the exchange and fusion of cultural attributes is abundantly manifested and constant. This process is facilitated by travel, either for purposes of education or a holiday, or change of employment, and by the media. Those who had travelled return from their sojourn, bringing back to their place of origin new cultural attributes acquired during their experience outside their home community. As a result, this newly acquired fusion of culture is expressed in their style and manner of dress, and their choice of music and dance. This cultural cross-pollination process may result in some kind of tension and resistance by those who are reluctant to be inducted into the new life. This could lead to an amalgamation of cultures which allows options each time an individual is faced with a particular situation at a specific point in time! The tension is expected to increase as cultural experience and ethos are shared with peers who had little or no external exposure to life outside their place of birth. The same applies when immigrants arrive and become influenced by lifestyle and culture of their newly acquired home whilst they also influence, even if on a small scale, the culture of the aboriginals. Although the difficulty distinguishing between urban and rural is acknowledged, Sekororo would be regarded as a rural community because of the following considerations:

- A rural area is classified geographically as being far from the influence of a large city. Contrary to urban people living in suburbs and apartments, rural people live in villages and farms, as in pre-industrial societies.
- Lifestyle in rural areas is different from those in urban areas. This is caused by lack of services and amenities such as libraries and centres for information dissemination, recreation facilities such as cinemas, arenas and parks where people converge for various purposes. As a result, people in rural areas are little affected by constant changes and influences of the world outside their social milieu, or not affected at all.
- The characteristics of the place which include remoteness form large industrialized cities, lack of natural amenities, and lack of skills, create a context that in turn results in poverty and unemployment. In reality, many rural families continue to live in very poor conditions compared to their urban counter-parts. For example, a craftsman employed in the urban area is likely to earn much better income than his counterpart of the same knowledge, skills and experience working on a farm in the rural area.
- Men in general migrate to urban areas in search of opportunities. As a result, there are more women and children in the rural area, and poverty abounds because of the many single parents left alone by men who moved to the cities. Men exploit this condition as opportunity to take mistresses or concubines and extend patriarchal domination.

Chapter 5 will demonstrate in some detail the broader rural picture of this community. It will also indicate the low education levels, the indigenous type of thinking including the lack of an external influence and critical thinking, except for some few graduates with tertiary qualifications. The power of the sensory knowledge and the influence of the social environment seem to be strong and dominant.

4.5 Socio-economic factors

Sekororo shows a skewed economic environment, which varies from citizens who earned R200 per month on average to those who earned up to R8 000

per month at the time of the survey. The former would include farm workers and people with no formal training or professional skill to perform a specific job, and those casual workers who relied on sporadic and temporal opportunities. The latter include small numbers of elite consisting of teachers with tertiary qualifications and other government employees with similar or equivalent education. Because of scarcity of employment in the area, lots of men have, as indicated in 4.3 above, migrated to Gauteng where they are working. Their wives are left behind and are often neglected and forgotten by their husbands who cohabit and sometimes start new families and would only return home as retired pensioners or after they had been retrenched from their employment and cannot be employed again elsewhere. The irony is that in most cases they come home as hobos after their concubines or urban wives had sucked them of their pension money and related benefits before pushing them into the street. This phenomenon explains why rural women and children remain victims of severe poverty in general. The role and status of a woman in the community is compromised, and women are often seduced to promiscuous sexual relationships in exchange for economic survival.

4.6 Social environment, health and illness at Sekororo

Social environment is seen as a catalyst in the construction and management of knowledge amongst the people of Sekororo. The interpretation of knowledge and formation of meaning, including the meaning of HIV and AIDS at Sekororo derives from the people's knowledge and understanding of health and illness. Their understanding of health and illness is based on the interpretation of their social environment as well as their perceptions of all known diseases and illnesses prevalent in the area. In this process, diseases and illnesses prevalent in the area influence the response by the community to those diseases and illnesses. Health systems, the response to and the treatment of all diseases and illnesses prevalent at Sekororo, are influenced and determined by the community's understanding of those diseases and illnesses.

Social environment covers a broad spectrum or milieu which could be considered a watershed for the development and nurturing of the notions of both health and illness. As a broad spectrum, social environment includes

amongst others, tradition and social mores inherited from the forefathers, and culture, which provides a medium through which people articulate themselves. Social institutions were seen to be strong at Sekororo. There are traditional leaders comprising the Kgosi, matona and councilors, and they are responsible for governance and stable human relationships while the traditional healers are there to maintain and perpetuate cosmic coherence with the social order, and to restore harmony and coherence in the event of cosmic disorder. Ancestors, shrines, graves and rites also form part of the social institutions, and will be seen to have a significant role in influencing the interpretation of health, disease and illness at Sekororo.

Social environment as defined above creates social control or a system which maintains social coherence and induces the members of the society to follow the normative and acceptable rules. Social control or system enables the members of a specific society or community, Sekororo in this study, to adhere to actions that will ensure social solidarity and natural or cosmic order. This occurs through the application of shared beliefs, shared values, approved actions and rules, and material objects shared by a people at Sekororo. This role played by social environment in the social interpretation of health and illness amongst communities and society contributes to a specific understanding of diseases and illnesses and their manifestations as patterns linked to variables such as gender, age, and social class. For example, a person from a simple and indigenous community located in the remote rural area would think, conceptualize, interpret things and act differently from a snob from a modern and sophisticated city.

Health, as well as its opposite, illness, is a human condition which may be explained by applying a shared knowledge which a society has inherited as a source of unity with natural order, and a power that gives them their identity. This shared knowledge could be equated with wisdom for each person to know and understand their actions and behaviour in a given situation. Since men and women are responsible for their actions, this wisdom would guide them to know the difference between an acceptable action and a vetoed action as attached to their positions and roles in the cosmic order. The significance of this statement is its power to prescribe some code of conduct,

and failure to observe this code would constitute deviance, and the deviant is considered as not belonging to the realm of the society and the cosmic order.

This kind of interpretation of knowledge, and derivatively of meaning, is expressed in a strong reciprocal relationship between man and a meaning. This relationship begins when man invents or constructs a meaning, and after its invention or construction, a meaning limits individual freedom since they cannot behave contrary to the normative. Robertson (1987, 5) contends that the meaning of health or illness is largely shaped by the groups to which people belong, and by the social interaction that takes place among those people. As a notion therefore, health, or its opposite, illness, is a social ideal, and may vary widely from culture to culture.

While this chapter focuses on the role played by social environment in the construction of the meaning of health and illness and how these concepts influence the perception of the people's understanding and interpretation of AIDS, chapter 2 has explained how research scholars have used their scientific and research background to approach their quest to understanding the nature and origin of HIV and AIDS. The scientific explanation of this epidemic and its historical information show the profound influence of the background each researcher acquired from their academic training and professional interests. This academic background and professional expertise created a cultural milieu which transformed and informed their way of understanding and explaining the epidemic. In chapter 2, explanation and meaning of HIV and AIDS begins with a study of the unknown in order to discover new information about this new and strange disease, and research is applied to discover what HIV and AIDS is and where the epidemic began. This chapter shows the people at Sekororo deriving the meaning and origin of AIDS by comparing the new disease with existing diseases which are prevalent in the area. Both approaches as used in chapter 2 and what the people at Sekororo are doing seems to show a strong influence of the cultural milieu, or background knowledge which is linked to some social context (as seen at Sekororo) or academic inclination based on an institutional environment (as seen with scientific research in chapter 2). Both approaches

seem to illustrate that meaning should, to some extent, be treated as a social construction, and will often describe its sources.

4.7 Culture and the meaning of health and illness at Sekororo

As starting point, a man derives the sense of meaning from himself as a socialized entity. This theory goes well with Michael Polanyi's explanation of the knowledge spiral (Nonaka and Taukechi, 1998). From childhood, and throughout various stages of their lives, human beings are engaged in the process of making sense out of the world in which they live, and of the immediate environment where they interact with others. Castells describes this process as construction of meaning on the basis of cultural attribute, or related set of cultural attributes with priority over other sources of meaning (Castells, 1999:5). This process occurs through the individual internalizing the immediate surrounding – things they hear of and learn of. In other words, the process begins as cognitive learning that deals with things that can be touched and seen, then proceeds to conceptual learning that involves abstracts such as the attitudes and values current within a specific milieu.

The cognitive learning process as described above, enables human beings to learn attitudes and values current within a particular community or society, and incorporate them into his total psychic formation in such a manner that he could spontaneously strike on socially appropriate actions. In this sense, sense making or making meaning of one's immediate environment and actions, finds pragmatic justification in the mutual fulfilment between a human being as an actor and the universe or environment as social context where actions take place. Actors are in this regard able to account with discursive consciousness (Giddens, 1998:374).

This actor-context relationship presupposes fixed social conditions into which a human being is born. Born into such conditions, a human being must comply with prescribed demands. To look into this condition, William James makes this observation:

> "Consider for a moment the habits of life into which we are born. There are certain social conventions or customs and alleged requirements, there is a theological bias, a general view of the world. There are

> conservative ideas in regard to our early training, our education, marriage, and occupation in life. Following close upon this, there is a long series of anticipations, namely, that we shall suffer certain children's diseases, diseases of middle life, and of old age: the thought that we shall grow old, lose our faculties, and again become childlike, while crowning all is the fear of death." (James, 1957:110)

For James, human beings are born into a set of beliefs and conventions, behaviour and practices that cannot be wished away. These factors are social constructions, and very influential in determining a meaning for a particular illness, or epidemic. In the rest of this chapter focus will be on the Sekororo community, a rural community where this study on the meaning of HIV/AIDS was conducted. Social expectations of health and illness within this community will be used to unveil the meaning of the epidemic to them, and/or how their interpretation of this epidemic is influenced by the social and cultural identity of the people.

Both James and Castells seem to agree that reinforcing the notion of identity, belonging, and social solidarity is crucial to the human quest for security and stability through social institutions. This notion is itself not bad as it provides a sociological base for normative systems and values that unify and hold together the community. This feeling of unity assures security as individuals in relationship to the community,and facilitates social coherence and the maintenance of natural order, with the community being responsible for taking care of this coherence in order to secure cosmic order. This notion is in itself a noble one except that it seems to favour patriarchy where men manipulate this notion to further their interest to the disadvantage of women. This structure has been turned into a social power control mechanism used to safeguard the institutional systems and enforcement cum perpetuation of certain norms and values in favour of male dominancy and the exclusion of women in the sharing of power.

Because of the precarious role played by social solidarity in the conservation and preservation of security and stability, mechanisms for the maintenance of such solidarity often go with sanctions of deviance which is described as "the departure by human beings from rules" (Shoham, 1976: 6). Durkheim

suggests that deviance is necessary (Kleinman, 1980) as a phenomenon that serves to remind the entire social group of a certain important value, or collective values which have been transgressed. Sickness as deviance is therefore the creation of social awareness whereby culture has developed collective or set of mores and norms to sustain stability and healthy living. For example, a human being could in this sense be the cause of illness, and therefore a part of the collective treatment.

This is a clear expression of social power and the ill person, or patient would be linked with some taboo. The ill person would be accused of having transgressed some established collective prescriptive rules. For example, there are certain apodictic rules governing the conduct of human beings, and such rules apply at Sekororo. A violation of those rules would normally be disastrous either to a particular individual or to the entire community. As an example, if a woman aborted, the aborted foetus could cause drought. These rules seem in most cases to apply to women, thereby reducing their rights and dignity.

This notion of unity and its emphasis on the relationship with nature and responsibility towards cosmic order would rather oppress women, as long as such oppression would preserve harmony and keep away illness that would otherwise be caused by the wrath to be unleashed if the cosmic order were to be upset. Observance of culture, as well as fear for social consequences of cultural deviance can be severe to the point of blaming women for certain illnesses. Hence as deviance, some men feel that HIV/AIDS may be associated with *makhume* (or illness of defilement). A man acquires this illness after he has had sexual intercourse with a widow whilst she is still in the period of mourning the death of her husband. *Makhume* is believed to cause the body of the man to swell, and both the anal and urinary systems become dysfunctional. This is a serious condition and it usually results in death. This illness is believed to attack men only, and cannot occur unless a man transgressed a taboo, and had intercourse with a woman described above.

It is important to note that *makhume* represents a late stage of illness. Suffice it to state, however, that this illness is usually identified after it had caused

severe damage to the ill person so that recovery or healing from the illness is completely discounted. In the contrast, there is no known record of a man being accused of causing death of a woman because she had sexual intercourse with him during his period of mourning the death of his wife! It is not possible to point out what precisely causes *makhume*. The questions that remained unanswered are: what makes the body of a widow different from the body of a woman who is not widowed? What is in the body and system of a widow which can kill men who had sexual intercourse with her and how did this lethal substance enter the body since it had all the time been safe to have sexual intercourse with her until she lost her husband?

Another illness associated with women is *rixixa* (literally an illness caused by loading off). This illness is believed to attack a man after he had sexual intercourse with a woman who had aborted or miscarried. The body of the man swells up, and the top of his head moves up and down with the rhythm of the heartbeat like the top of the head of a small baby. He may eat and drink, but much the same as with *makhume*, his anal and urinary systems do not function, hence causing him serious discomfort, and eventually, death. There is treatment for both *rixixa* and *makhume* if the victim reports the illness on time. There is unfortunately, some mystery underlying both illnesses because the victims or patients often prefer not to disclose until it is too late, and often on the point of death – hence those illnesses are also known as "*vuvabyi bya tingana*" which literally translated means the "*illness of shamefulness*" in Xitsonga. The silence and non-disclosure may be explained as unconscious behaviour caused by external powers as punishment for failure to comply with the taboo which prohibits men from having sexual intercourse with a widow or a woman after she has had a miscarriage or had aborted until a prescribed period had lapsed and she had undergone the prescribed purification rites.

Friedson (1970) captures this perception well in his viewing of certain illnesses as the responsibility of the sick individual and thus are seen relatively punitively, like a crime. Illnesses in this category carry a stigma of disreputability and even evil (Peter at al: 1995:127). In such cases, women are denied their rights and status, and are marginalized in the activities of the community where women are in the majority. In summary, men are seen as

uniformly zealous and eager to preserve harmony and wellness of life and of nature. These characteristic patriarchal tendencies are expressed more generously in the next chapter where marriage and role/status of a woman are covered.

4.8 Health and health care systems

Health may begin as an individual focus and yet extends beyond the individual to become a concern for the entire community. This imperative relationship and interdependency expressed in the anthropological and sociological views have in a strong way influenced the interpretation and understanding of health in this community. With anthropology putting a person or an individual (ho anthropos) at the centre, a human being is healthy if he or she feels safe and secure from any threat of a disease or illness, and is in harmony with the rest of mankind and with the cosmic order, including the realm of the ancestral spirits. This interpretation compares well with the religious notion of healthy, being the absence of sin, and therefore, reassurance of the protection and providence of the Supreme Being. The sociological consideration of the same subject presents a richer and broader context since its focus is human beings collectively, and the harmony with the rest of mankind, both the living and the deceased, and with the cosmic order. Hence, unhealthiness or illness would accord with transgression of religious prescriptions or violation of a religious sanction, or a cultural observation.

In response to unhealthiness or illness, health care systems will apply a specific or particular approach to treat the condition in question. An illness may require treatment of the individual patient, or a treatment that begins with the ill person and extends to cleansing of the land, or restoration of alienated relationship with the deity which had been caused by the illness and the ill person. This is done through *mphahlo* or libation, and traditional beer or *mqombhoti*, is brewed, and a goat or beast is slaughtered. The beer and the goat/beast offered to the ancestors in accordance with the prescription of the diviner. The same procedure would follow in the case of a strange or unusual illness likely associated with the wrath of the ancestors. The illness itself

serves as a warning sign, a symptom or reminder pointing out to the people that *something had seriously gone wrong and should be put right.*

4.9 Observations

Sekororo has been described as a rural community with indigenous characteristics. The role of social environment was seen as catalyst in the construction of meaning by the people, and how meaning in turn unifies the people, and gives them meaning, identity, coherence and security within the cosmic order. In chapter 5 the study will continue to demonstrate the power of this catalyst and the extent to which it controls and limits individual freedom to think and act contrary to the normative. This control and limit may, as will be observed, allow individuals to think of alternatives but not carry out those wishes if they would be repugnant to the prescribed norm.

Chapter 5 Presentation of Data

5.1 Introduction

In the previous chapter the overview of the community of Sekororo was presented. It illustrated how the environment influences the way people in that community think, how they describe, interpret and understand their environment, and their social systems, their roles and duties to maintain the social order and to preserve stability and cosmic order. This chapter will present data collected from the respondents. The chapter will demonstrate the close relationship between social environment and how men at Sekororo develop knowledge and perceptions, and how knowledge and perceptions are interpreted and developed into a meaning.

The chapter will report on what the respondents think of HIV and AIDS, its origin, causes, historical background, and treatment. Ideas and perceptions of men at Sekororo will be presented, expressing what they feel about the use of condoms and the status of a woman, or man to woman relationship in relationship to sexual reproductive rights of women in a patriarchal society.

A qualitative approach will be used to present data. It was mentioned already in chapter 3 that this study is about a meaning, understanding and perceptions, hence a qualitative approach was preferred over the quantitative. This approach, however, will not rule out as irrelevant quantifying of data if it is necessary, for example, where it edifies a particular point or perception by indicating the number of people who shared or emphasized a common view or a particular understanding or a perception.

5.2 Patriarchy, marriage and status of a woman

The purpose of this theme is to investigate the man to woman relationship in the society which believes in male supremacy. This man to woman relationship is very important for this community because women are an integral part of the community and part of the problem of HIV and AIDS. Women should be involved as partners in the fight against the spread of HIV and AIDS, but there are cultural practices still insisting on limitations that exclude women from active participation in social life. Polygamy and patriarchal structures of families and the broader community create a rigid

milieu with a culture resistant to the bill of rights and basic human rights for women. If men are seen to be the caretakers of the social environment, responsible for conservation of social coherence and natural order, what role can women play to promote this coherence and order, and the prevention of calamities, natural catastrophes, plague and epidemics, including HIV and AIDS?

Despite being an integral part of the community, women are still treated as inferior to men. Their human rights and equal status with men seem to be very sensitive issues, and like quicksand, they are avoided. Recognition of women as equal with men is being delayed or postponed indefinitely. In the meantime, social institutions continue to support male dominance. Men's major roles would include preservation of peace and harmony, promotion of good health and absence of illness, assurance of wellness and concord in the community. They need to appease the ancestors and follow in the footsteps of the forefathers. Failure to comply could result in illness disrupting the order of every day life. And the community would strive to avoid an illness ensuing as a curse, or sign of disobedience and deviance. They become conscious of the failures and correct them. Men were reported to be uncomfortable collaborating with women as partners in defining and interpreting illnesses and diseases, and women were not permitted to be involved as partners in the diagnosis and the fight against diseases. Recognition of the status and the rights of women could be *tantamount to violating a taboo, thereby unleashing the wrath of the ancestors and resulting in cosmic disorder.*

Respondents were asked the question, *"Are women allowed to participate in decision-making on matters of the community or not?"*

Of the 45 respondents, 16 replied with a categorical no. Their explanation could be summarized as follows: a woman is expected to submit to a man, whether in marriage or not. It would therefore be wrong to allow women equal rights with men. This response came specifically from the elderly group aged between 51 and 65 years, and with education level of below standard 8. Seventeen respondents, with an average of standard 8 and 9 education with ages 43 – 50, felt that women cannot take part in decision-making, but may be allowed if invited, to make input and recommendations, but the decision-

making rests with men. Only 12 respondents replied that women have rights to take part in decision-making. They also remarked that it is premature to recognize and confer full human rights to women, but they could not say when it will be the right time for women to be recognized, and allowed to take part in decision-making and to enjoy their full and constitutional human rights. This was the position of the younger group, with education beyond standard 10. The group seemed to recognize the rights of women and yet they are intimidated by the social environment which requires them to identify with the traditional way of life. They seem to be willing to accept change and to empower women, and yet they were still attracted to the benefits accorded by patriarchal practices. The implication as deduced from the responses, is that men, in general, enjoy at the expense of women. This practice begins with men as dictators at home. They then go on to boost their ego by assuming power to engage in extra-marital relationships without being queried since it is allegedly considered by the community to be a normal practice for men.

The consensus of the respondents on the role of women in the community suggests that women may be invited by men to make input on very specific issues. It is otherwise the prerogative of men to make decisions, both for the community and at home. Women may be honoured with an invitation by men to make input and recommendations that men may, during the process of their decision-making, consider. Practically, neither married nor unmarried women are allowed to participate in decision-making, save by request for input, or recommendations.

Respondents were asked questions related to marriage, for example, are you married, what type of marriage did you conclude, how many wives do you have, and are you engaged in any extra marital relationships. Their responses seemed to concur that marriage provides an institution through which men show their dominance over women. Although a woman is a fully developed human being, women are restricted in their rights and limited in their scope. Women were presented by respondents as *expected to act in accordance with prescribed mores, and are excluded from participating in decision-making on matters affecting the community.* Women may be seen as adding numbers

to the community, and exist not as full human beings, but for the convenience and comfort of men.

Conditions seem to be worse in marriage or for a woman who is in a steady relationship. Even her limited rights seem to be forfeited to the man who will assume power to decide for the woman. Once married, a woman remains loyal and subservient to her husband. He makes rules and regulations that govern the household. He may also enter into polygamous marriage with a number of wives, or extra marital relationships, as he pleases. Sexual intercourse is not negotiated. Men decide on how often and when to have it. A woman cannot advise her husband or her boy friend or partner that they should use a condom. She would be thought of as *nghwavava* or *skhevereshe*, meaning a cheap woman of very low morals, or a prostitute. Respondents made a general statement that any form of contraceptives reduces the sensation or pleasure during intercourse, and worse still, contraceptives cause illness to men, including HIV/AIDS, because contraceptives, administered by injection or taken by mouth, weaken the body of a man, starting with sexual organs and gradually affecting the entire body and eventually causing man to be vulnerable to illnesses.

Marital status of the respondents was asked. Of the 26 married respondents, 19 are married in customary union, and only 5 have concluded civil marriages. 2 are on permanent conjugal relationships. Apart from civil marriage being unpopular, men in civil marriages are often engaged in extra marital relationships, and this practice is considered normal and acceptable.

What is also strong is the practice of *concubinatus*, or keeping of mistresses. Twenty-three respondents of whom 19 were married men, 2 widowers and 2 divorcees, confessed that they had concubines, or permanent girl friends. Single men who have girl friends are not included in this category. Roman Law defines *concubinatus* as “a lasting relationship between a man and a woman who lived together without being lawfully married” (Van Zyl, 1983). Originally the institution was not rejected, but regarded as inferior to a civil marriage. Children born out of such relationship were known as natural children in contrast with illegitimate children born out of other extra-marital relationship (Van Zyl, 1983).

Respondents made a strong case of male freedom and liberty to enjoy sexual intercourse beyond the marital bounds whilst women's infidelity is condemned as taboo and is intolerable. A woman, whether widowed, divorced, single or unmarried mother remains bound to one man; and once she gets involved in a relationship with a married man, she becomes restricted to that man alone and she is obliged to obey his rules, and she may not have an extra conjugal relationship. Only a man has the right to have many women. A man could marry two wives or more as he pleases. He may still do for those single women who seem persuaded to opt to become a *nyatsi* (a private lover), a common law wife or a concubine. The average response of informants, including those with one wife, and whether affirmed extra marital relationship or not, was that women have to accept to share a man, or starve alone without a man of their own. If men are scarce, they would rather make do with what is available.

It has been established that multiple love relationships practiced by men is common. Married respondents were asked if they had a second and/or third girl friend. Seven of the respondents preferred not to respond to the question. 27 respondents confessed that they had a girlfriend, 11 further admitted to a second and even a third girl friend. Nine did not want to answer the question on a second and/or third girl friend. What was established is a clear prevalence of inferior status of women and superiority of men. From the facts presented above, women seem induced to surrender and to admit to male domination, and to accept their institutional status as normative.

Twenty-seven respondents replied that a man is allowed to have more wives and may enter into extra marital relationship whilst a woman is restricted to one partner – be it her one husband, or a boy friend. It is considered to be a disgrace and not acceptable for a woman to indulge in any form of extra conjugal relationship. Thirteen respondents reiterated that it is both disgrace and a taboo for a woman to have more than one partner. The remaining five replied that even a single woman/mother cannot change partners.

The prevalence among men of the practice described above is supported by ratio imbalance between men and women in the community (cf paragraph 4.3). One respondent affirmed that *women have to accept to share a man, or*

starve alone without a man of their own. This situation is further escalated by demographics of this area: women and children including the youth form the majority of the population. This population component represents the poorest in the community, with very high unemployment. In response to this situation women are induced to exchange and forfeit their rights and dignity and support patriarchal oppression as they succumb to men because of economic dependency and need for financial support. This kind of exploitation was reported to be common mostly amongst a small elite of financially affluent and stable men, usually in the public service and teachers, and those practicing private entrepreneurship, and, or, anyone with a financial capacity to maintain women who in return would depend on them for their financial support. This practice gives serious support to unjust male domination and supremacy and to perpetuate women's subordination and dependency in the community.

5.3 Education

Education has in many ways challenged the existing order, and often wrought fresh ideas and new perceptions. The French Revolution, for example, was triggered off by those new and radical ideas of thinkers like Voltaire and Rousseau. Corollary education would for the purposes of this study be expected to dialogue with people and influence them to develop fresh understanding of themselves and of their environment. This would change the social system and introduce a new social order with a changed interpretation and meaning of social environment, social mores, health and illness, social coherence and cosmic order. Cognizance should, however, be taken of the themes, subjects and topics that were selected during the study. Those with tertiary qualifications graduated in Anthropology, Biblical Studies and Mathematics. The first two fields of study would likely encourage readers to perpetuate the prevailing social order because of their tendency to glorify the past and create a nostalgic connection between the past and the present. This would account for the respondents being aware of the ills of the community, for example, patriarchy and women domination, but feel that it is rather better to leave the social order as it is instead of upsetting the status quo. According to them, change is necessary, but they think that it is inept to

change the social order in favour of recognizing the status of women now, postponing it for some time in the future.

This community is obviously disadvantaged because many people have not completed a grade 12 education. Respondents with very little education or none at all had very little to say on the epidemic. They have no clear knowledge and understanding of the epidemic, and cannot compare it with any other disease or illness. They also had difficulties in pronouncing the word AIDS itself. Three respondents who cannot read or write, replied that they heard of the disease but do not know what it is. They called the epidemic *ensiah*, *entshi* and *hendzi*, but without explanation of what it is. From what they have heard, the disease is transmitted from one person to another through having sexual intercourse with an infected person. The mode of infection caused the respondents to think that AIDS is *tshofela* or gonorrhea, because *tshofela* is also transmitted in the same manner as AIDS. Respondents in this category find it difficult to understand why AIDS cannot be cured. Their argument for the cure of the epidemic was based on their belief that all diseases caused by sexual transmitted infections can be prevented or treated by the use of African herbs. This group of respondents feels that AIDS and *tshofela* is the same thing, and that if AIDS is a different disease from *tshofela*, AIDS is not prevalent at Sekororo. There are strong traditional healers who would be capable to offer a cure for all diseases acquired through sexual intercourse.

One respondent from this group associated the epidemic with *makhuma* which was described above. His argument is based on the symptoms of full blown AIDS which comes at the end before death, after a long period of infection. He failed however, to answer why *makhuma* blocks the excretory system and resulting in swelling of the body and pain and discomfort before death while AIDS leaves the patient emaciated and bony, and sometimes with severe diarrhea. This group maintains that there are new diseases which whites inoculate into black people to reduce their numbers, and they suggested, but without certainty, that HIV and AIDS could be included in the list of those diseases.

Younger respondents presented a broader perspective of the epidemic. This group includes professionals with university qualification. They have a good academic training, but still strongly portray some rural influence. Two respondents portrayed strong political influence which is expressed in their seemingly hostile relationship with whites. This attitude influenced them to speak antagonistically towards white people. Those respondents support their parents in the claim that there are diseases and illnesses that are caused by whites. These diseases and illnesses are produced and spread to blacks by whites with the intention to reduce or annihilate blacks. This view was spearheaded by one respondent, a science school teacher with a university qualification. He described HIV and AIDS as lethal and a reality, and that it is spread through sexual transmission if unprotected sexual intercourse takes place with an infected person.

According to him this pandemic was produced by man in the laboratory and was intended to be used as a biological weapon for military operations. Some evil scientist injected the virus into blacks and those infected with the virus spread it through sexual intercourse with an infected person. This theory, even if it has no scientific base to support it fit in with what was seen in chapter 2 where the epidemic was explained as unintended results of an experiment that had gone awry (Segal). As mentioned already, the respondent is a science teacher with good knowledge of biology and physics, and he probably had read material on the origin of the pandemic. He argued very strongly in favour of this theory, but failed to produce evidence to support his claim.

Another respondent, also with a university qualification, affirmed that the pandemic is an old disease and had existed in the past, but with a different name. The disease could not plunder in the way it does today because there were strong and capable traditional healers who could cure it. With the demise of capable healers the disease has turned into a serious killer and no cure seems to be known at present. The disappearance of the remedy to treat and cure the disease could be counted as punishment by the ancestors for lack of interest by children of the deceased healers who refused to inherit the gift of healing from their parents. Some of these children referred to have discounted

the practice of traditional medicine and healing in favour of the western medicine.

That theory introduces another dimension wherein the epidemic is seen to be caused by the wrath of the ancestors, and could be used to serve as indication of a situation of disease as deviance. Man has offended the cosmic order by refusing to inherit from their parents the ancestral gift of healing and of maintaining social coherence and order. Because of this lack of special talents and capacity to appease the upset natural order, there are no healers left to cure the epidemic. To support his position, the respondent pointed out that statistics show a high prevalence of the epidemic amongst black people. He was prepared to admit that blacks represent very high population group in South Africa, but maintained a strong position on the ancestral wrath and punishment theory.

The middle-aged group was very significant for this study. There are only a few respondents who completed standard eight, and the majority of respondents have no professional qualification. Their knowledge is mainly rooted in oral tradition, and they had not lived outside Sekororo in their life except on short visits to families away from home, and therefore they do not have external exposure as such. As a result, they seldom have any experience outside their community life which they could use as point of reference to compare with their world view and perceptions. This lack of exposure to different social systems has resulted in limiting their thinking and perception of life in a serious manner. An illness, or epidemic, would be interpreted or explained in terms of its symptoms, or by association. For example, it would be said, HIV/AIDS occurred in the remote past during the epoch of drought and famine, and many people became thin and weak, and lost weight, and eventually died. There could be some similarities between the symptoms of AIDS and the condition described above, and yet the description of the conditions during drought could as well have been caused by hunger, and followed by death as the inevitable result of starvation.

Respondents in the middle-aged group category presented some inconsistency. It was mentioned above that the epidemic had existed for a long time with the examples given above of people becoming thin and who

died during the period of drought and famine. One respondent of ardent religious faith denied that ancestors could allow the existence of HIV and AIDS if it would destroy mankind in the manner it is doing. His position is that ancestors will always enable traditional healers to cure all diseases unless the disease was caused by the wrath of offended ancestors. Even within this situation, his argument is that such wrath cannot last long since the ancestors would soon be pacified once it has been discovered that relationship between the ancestors and their offspring had been alienated. The perception of HIV and AIDS within the middle-aged group is not very clear compared with the younger group. There is a vague notion of the epidemic amongst the middle-aged, and even though they heard of it, one trend is that it existed from the remote past and had killed people in the manner it does now. The other trend believes in the benevolence of the ancestors and their protection. There was no information on the origin of the epidemic except that it is an old disease with long history, or a sign of alienation with ancestors.

5.4 Age of the respondents

During interviews, respondents aged between 35 - 44 years showed some strong influence of the social environment. Most of them are professional teachers with tertiary qualifications, and also understand Act 108 0f 1996, with its entrenched bill of rights and the basic human rights. They still feel that women would rather be fine as they are, and it is tricky and dicey to invite them to participate in power sharing and decision-making. This age group is not worried about empowering women provided such empowerment remains limited to assisting them to improve their qualifications for purposes of employment and economy.

This group admits that change is inevitable, as everyone wants to enjoy the fruit of democracy. But for them, it is not the opportune moment. Rights of women will be recognized, conferred and realized at the right time, or the *kairos* of the Greeks. They also believe that change should not mean a complete break with the past, and filling of the gaps with innovations! Change, in their understanding, should be a continuum. “*Rihlampfu lerintshwa ri tiya hi lera khale”* – the new fence becomes strong if supported by the old one; and for them, there is a need for “the old and the new” to work together. The

question raised out of this proposal is, what would the mix be called, and what will it look like? An answer from this group would likely show some pedantic support of tradition, and willingness with uneasiness to move forward for a change – a kind of tension.

The second group, aged 45-54 years, agrees that change is necessary, but goes on to limit change to men. Men are at the centre and in control and will make the necessary adjustments to respond to the social imperatives for change. This accommodative approach comes as a result of fear of giving power to women as they are likely to dominate men. Women are full human beings, and yet are made to be under men and to serve the interests of men. Asked to comment on life in the past and life today, there was a strong feeling of nostalgia. The past is painted as glorious, with coherence and order, and the present life cannot compare to the past!

One respondent, a school teacher with a university degree, mentioned that he spends much of his leisure time with old men. During this time, old men tell him oral tradition and history, and he stated that he respects the wisdom of those sages. He also reported during interviews that in the past, elders were consulted for advice on various matters because of their wisdom. This wisdom was expressed in the realm of social interactions including political and natural arenas. This wisdom was used by elders to help maintain the unity and balance of the ecosystem, and therefore unison and harmony in life. In this sense, all aspects of life, be they political, cultural, or ecological, fitted together very well into a unit, and there were no gaps. Because of this holistic picture, illnesses could be controlled, and everyone knew where they fitted, and what to do. The respondent was also firm in his assertion that there were right and authentic elders and healers who had been endowed with special gifts and knowledge to understand the cosmic order. Because of these gifts and knowledge, they were capable of also understanding when cosmic order and harmony had been disturbed, and they would remedy the situation by appeasing the cosmic order and restoring peace! According to the respondent, cosmic disorder is often caused by foreign invaders who upset the natural order and causing life threatening conditions such as diseases, natural catastrophes, and death. When asked why he emphasized the right

elders and healers, he reiterated that there are only a few of those elders and healers today. He said that there are many who claim this position but do not have the knowledge which is necessary to understand the cosmic order and therefore they cannot appease and restore peace and order when things go wrong. He refers to these elders and healers as “dishonest, not reliable and untrustworthy”.

5.5 Role of religion

Like culture, religion is a strong unifying factor that binds people together, both as a community or society and to the rest of creation – the cosmic order and the ancestors. Harmony and peace will always abound when there is a balanced relationship between the natural order and human beings. Illness may come as sign of alienation or broken relationship with ancestors or with the cosmic order. If a situation of this nature arose, illness could be stopped by restoration of peace and harmony with nature.

The community embraces both Christianity and African traditional religion. Since the inception of the democratic government in 1994, youth became increasingly sensitized to value their tradition and to aspire to restore their past. Respondents were asked the question: What is your religion, and why did you choose this religion over the others? Youth in general seemed to support African traditional religion but without criticizing Christianity. They however, have a strong feeling that people need to go back to their roots, and worship in the way they understand better. Asked what they meant by “the way they understand better,” they all agreed that all Africans understand better how to communicate with the Almighty via the ancestors. They referred to the past as nostalgic and think that the community should balance between the modern life and the golden past. There is a call therefore to return to African religion. In this manner they would appease the ancestors and increase cosmic order and harmony that is referred to in the previous paragraph, and reduce the risk of epidemics like HIV and AIDS. African religion has sustained the forefathers, and maintained harmony of nature, health and wellness, absence of illness and control over calamities, natural disasters and epidemics.

Respondents with strong religious convictions presented a feeling of strong protection by the ancestors or the supreme being, and see the epidemic as punishment from the ancestors or God because people have abandoned their tradition. The middle aged group seems to support more existing Christian religion. Asked to say more on why they support Christianity, two respondents did not understand well the difference between African traditional religion and the practice of traditional medicine which for them includes witchcraft and magic. Five support Christianity because the Christian missionaries introduced schools and hospitals. For example, a number of hospitals near Sekororo, including Sekororo Hospital were founded by the missionaries. They also recognize the problem of moral decay in modern communities and blame it for the emergence of unknown diseases such as HIV and AIDS. Two of the respondents alluded to the overturning of nature by man and cited homosexual practice by lesbians and gays as heinous sin. Men and women were created to enter into marriage and have children, and not man taking another man for a partner, or a woman and another woman becoming life partners.

Their perception would however, fit in well within the history of the spread of the epidemic, as seen in chapter 2. Brooklyn in the USA, and other places of contemporaneous origin of the epidemic, are allegedly associated with corruption, gays and transgression of the biblical ethos. They feel that religious groups should be involved in healing the country of new and strange diseases, including HIV/AIDS. Religions are as such, challenged to purge the universe of the evil which had caused the punishment of HIV and AIDS. With regard to treatment or the solution, this group presented a strong belief in the efficacy of the prayer. For them, HIV and AIDS could be terminated by the power of the prayer. The solution is, reconcile with the creator, the ancestors and the cosmic order (repentance) and the universe will be restored to order.

Because of cultural factors, the use of condoms in the community is contentious. Respondents were asked, Is your culture in favour of the use of condoms by men? Of 45 respondents, 5 gave positive replies and affirmed that men may use condoms. In support of their replies, they stated that condoms prevent sexual transmitted infections, including HIV. They admitted

that the use of condom is however, not popular in the community because men insist on the pleasure of sex when enjoyed *flesh to flesh.* Twenty-five respondents were vehement in their opposition to the use of condoms, while a further 15 felt that there was no normative answer to the question. Of those 15 respondents, 4 feel that the community considers the use of condoms as contrary to the will of God. Apart from pleasure of sexual intercourse without a condom, a woman is expected to prove her fertility and must have many children.

Also, it was strange to hear that condoms increase the chances of contracting sexual transmitted infections, including HIV and AIDS.

Two respondents affirmed the perception that the spread of the pandemic may be reduced by use of holy water obtained from the Zion Christian Church, and not the use of condoms. These respondents continued to allude to the religious function to combat the spread of the epidemic by being honest and faithful to one partner, and especially in the married relationship. They reflected an ardent adherence to the Biblical injunction, “Thou shalt not commit adultery” (Exodus 20). However, as a comment, the patriarchal community seems to expect women to be faithful to one male sexual partner only while a man is allowed to engage in multiple partnerships with his wives, girlfriends and concubines.

5.6 Initiation rituals and HIV and AIDS

Traditional circumcision amongst men has always been an integral part of the community at Sekororo. In the past, it was practiced as a right of passage from boyhood to manhood, hence initiation took place when boys reached puberty and began to develop physical changes in their body which showed that they were entering an adolescent stage. They would be assisted to understand and cope with those changes, and incorporate them as part of their male development. They would also understand that they were not boys any more, but men. This would be the time to instruct them on manhood, and what would be required of them as men, and their responsibilities as citizens and as husbands and fathers.

The ritual is also valued for hygienic considerations and its efficacy to protect men against sexually transmitted infections, including HIV and AIDS in the present days. It involves the cutting and removal of the foreskin that covers the head of the penis, and is recommended for its advantages in controlling sexually transmitted infections. This view seems to have been embraced from the beginning of this practice, and it is today perceived as a means by which men can avoid HIV infection and AIDS.

Scientific evidence to support that circumcised men may not be infected with HIV is at this stage a contentious field. In 1986, the New England Journal of Medicine published a letter from Aaron J Fink, MD. Fink was an urologist who argued that the foreskin “increased infection by HIV”, and that “the keratinisation of the penis of the circumcised male reduces the chances of the HIV penetration (CIRP). A case is made of Australia with a fairly high proportion of circumcised, sexually active males, but a very low incidence of HIV infection (Circumcision Information Australia). Edward G. Green, a senior researcher at Havard University, who has been looking at circumcision and HIV in Africa, concludes as follows: “if all males in Africa were circumcised, the HIV/AIDS prevalence rate would be reduced from 20% in some regions to below 5%.” With increasing research supporting male circumcision as a means to reduce the risk of HIV infection, there are those who do not entirely negate the advantages of circumcision in relation to HIV infection, but still insist on known safer sex practices such as use of condoms.

No research was conducted at Sekororo to test the relationship between male circumcision and the risk of HIV. An argument based on oral tradition, is applied to support their views which had been handed to them from previous generations who also held that male circumcision reduces chances of men being infected with sexually transmitted infections (including HIV and AIDS in present days).

According to their logic, removal of the foreskin that covers the head of the penis keeps the penis dry and clean. The head of an uncircumcised penis remains covered over the foreskin of the penis and therefore accumulates sweat and other secretions which attract and accommodate germs which cause sexually transmitted infections. On the contrary, the head of the

circumcised penis is always dry and does not allow accumulation of secretion and other substances which attract and keep germs.

The evidence of the health benefit of the initiation ritual and of circumcision is supported by the extent to which the practice is popular amongst men in that community. Of the 45 respondents, 39 went to the initiation school, 6 were circumcised in hospital. There are three categories of those who went to the initiation school: the first went there voluntarily and out of own choice because of the value attached by the community to initiation and circumcision. The second went there because their friends or peers had gone there, and they went to join them to share the same experience and information. The third category went there when they were adolescents, and would probably have realized the benefit of the initiation cult and circumcision. Respondents affirmed that they went to the initiation school on their own, either after they had become aware of the benefit of the initiation, or simply admired a friend or a relative who had been through the cult. No one was forced to go there.

Circumcision may be considered one option that can be used to avoid HIV infection and AIDS. This perception seems to explain HIV and AIDS as an epidemic which occurs when an uncircumcised man had sexual intercourse with a woman who is infected with the virus. The perception seems to suggest that HIV is by definition a disease or illness that occurs to uncircumcised men; and circumcised men are by this definition excluded, or immunized, from the infection. This perception is a deviation from the meaning of HIV and AIDS. To adopt this position would support a complete detour from what the epidemic is and towards inventing another epidemic in the place of HIV and AIDS.

There is, however, scientific evidence available to affirm that uncircumcised men are more susceptible to the virus compared to those who are circumcised. The advantages of a clean and dry head of the penis cannot be discounted. What should be cautioned is that the proper and correct understanding and knowledge of HIV/AIDS includes the blunt and unconditional claim which says that the epidemic cannot be passed on to a circumcised male. . The epidemic is spread through sexual intercourse during which the infected partner transmits the epidemic by sharing the semen or fluids with the other partner.

5.7 Diseases common in the area

Respondents listed the following as common diseases prevalent in the area: malaria, bilharzias, sexually transmitted infections, particularly gonorrhea and syphilis, diarrhea and tuberculosis.

Of the 45 respondents, 28 mentioned malaria as a serious problem in the area. None of them furnished the number of cases per year, and this was reasonable since none of them were medical professional. The prevalence is at least consistent with the tropical climate of the place. The area is infested with mosquitoes, particularly during summer. The geographical features of the place create favourable conditions for the presence of mosquitoes. The rich fertile soil produces abundant wild or natural fruits such as figs and morula, especially in summer. There are also domestic fruits like papaws, guavas and mangoes, and they all attract mosquitoes and provide them with a hiding place during the day until at night when they enter the huts or houses and play havoc with the citizens. Mosquitoes increase during morula season between January and March. Some of these mosquitoes are carriers of malaria. Pit toilets also attract mosquitoes to the houses, and families cannot afford mosquito repellents.

Thirteen respondents mentioned bilharzia as also prevalent especially amongst boys. This disease is caused by unhygienic environment, and use of unclean water. Also, boys love to swim in stagnant pools of water after summer rains. In most cases such water is not clean and after their swim, boys contract the disease.

Twenty-seven respondents mentioned tuberculosis as a serious problem. Of the 27 respondents, 19 associated the disease with poverty and subsequently lack of proper diet, abuse of alcohol and drugs, specifically the strong tobaccos people grow at home.

Of the 27 respondents, 5 of them confirmed that there is high death rate caused by tuberculosis. During discussion of the illness these respondents demonstrated inability to distinguish clearly between tuberculosis and *makhuma*, and treated them as linked. The same respondents argue that patients with both *makhuma* and tuberculosis may survive if they consulted a

capable traditional healer before the illness reaches what they called *point of no return.* As pointed out when describing *makhuma* (supra), the body of the victim swells up, and with tuberculosis the position is reversed; the patient becomes thin and bony.

Possibilities that HIV and AIDS are being explained as tuberculosis may not be discounted. The social environment of the area pointed to various factors which created a favourable climate for multiple and unprotected sexual intercourse. Prevailing rural conditions in this area cannot provide amenities and facilities for recreation. Being bereft of entertainment and recreational facilities, the citizens find themselves pushed to the abuse of alcohol. As a result of unemployment and poverty, local people cannot, in general, afford healthy drinking styles. Local home brewed concoctions include *mukhubi, chayoni, bhadama ndzi ku secha*, all quick brews which combine yeast, sugar and other artificial fermenting agents. These are cheap and affordable, but fast intoxicators, and are said to be corrosive to the the intestines, and very unsafe for permanent consumption. HIV and AIDS may not be ruled out in this case.

This high prevalence of tuberculosis may as well be equated with the high prevalence of HIV/AIDS, since many AIDS deaths are diagnosed during post-mortem examinations as tuberculosis. At first, the said concoction is consumed into an undernourished body. Consumers get drunk; and drunken people are known for getting aroused easily, and therefore more likely to engage in random and unprotected sexual intercourse. This view is supported by the high prevalence of sexually transmitted infections confirmed by 33 respondents (representing 73% of the respondents).

Respondents were asked, “Why are sexually transmitted infections a serious problem in your area?” Respondents replied in four categories as follows:
6 respondents think that people are ignorant of the consequences of sexually transmitted infections, which include HIV and AIDS. This category comprises a group with education above standard 10, and ages between 30 and 40 years. According to them, people need proper sexuality education and should be informed of the linkages between the various sexually transmitted infections, their harm to the body and how to prevent infection with those

diseases. This group seems to affirm that people will arrest the spread of the infection once they have acquired necessary knowledge regarding the various infections transmitted through sexual intercourse.

Sixteen respondents alluded to the traditional consideration of the disease or illness as “illness of shame and disgrace”. Infected persons are scared or ashamed to reveal to their partners that they have an infection. They would instead prefer to take treatment secretly while their partners are left untreated. In this manner, the infection cannot be stopped, because after taking the treatment re-infection takes place by their partners who had not received treatment. These were respondents aged between 41 and 49 years.

The third group reaffirms the power of the traditional healers and the herbs over the treatment offered in hospital and clinics. This group comprises 10 respondents who think that infected persons go to hospital and clinics to receive treatment. What they receive from western medical treatment is temporal, and the infection is lulled, but reappears after some time. They further recommend traditional healers whom they believe to cure the infection permanently.

The last group of respondents blames the youth for their reckless sexual behaviour. Youth are loose, and they go drinking and in the end indulge in random sexual intercourse.

All categories of respondents seemed to avoid the real issues. A follow-up question was asked, what is the real cause of sexually transmitted infections? Random and irresponsible sexual behaviour of the youth was raised as the cause of high prevalence of sexually transmitted infections. Elderly respondents felt that there is no sexually transmitted infection that can cause death. They argued that sexually transmitted infections, including *makhuma*, can be cured with the use of right herbs. The corollary, if HIV and AIDS is a sexually transmitted infection, HIV and AIDS can be cured, or else it is not transmitted sexually, and it should be one of the illnesses which whites introduced to the blacks.

The foregoing perception of sexually transmitted infections and HIV and AIDS as curable was reinforced by an elderly respondent who volunteered to be

interviewed. The perception by 34% of the respondents who contended that p*artners acquire and spread sexually transmitted infections because they don't go together for treatment,* was affirmed by the elderly respondent who said “the disease is caused by having sexual intercourse with an infected person, and yet it is easy to treat the disease if both man and woman took the treatment together” (Personal interview, Ngaka Manosa, 2001).

Of the 45 respondents, 11 confessed that they had the disease in the past 3 years. Of the 11 cases, 4 went to traditional healers for treatment, and they claimed to be completely healed. Seven went to either a hospital or clinic, and they claimed that they received partial healing because the disease apparently stopped for some time, but reappeared at a later stage.

It is difficult to draw conclusions on this point because of two possible scenarios. The first one would be a situation where a man took treatment alone, and later went to have sexual intercourse with the same woman who still had the infection. The second one could as well suggest the existence of multiple sexual partners, which is a common practice in the area. Respondents seem to argue in support of total healing of the disease by traditional healers *vis a vis* temporal relief offered by the western medicinal treatment. This seems to be a popular belief amongst people, including those who would not name the cause of the disease, nor affirm having once had the disease themselves. Some respondents also demonstrated strong support for the effective use of *chikwane* or *mvusankunzi*, which is alleged to prevent the infection if taken before engaging in sexual intercourse or kills the germ that would cause the infection if it is taken soon after the act if intercourse had occurred.

5.8 Observations

Social environment plays a significant role in the development of meaning. The chapter demonstrated a close relationship and interaction between social environment and people’s interpretation of illness, and also of the health systems available as response to illness. People’s perception of and response to a disease or illness is largely influenced by individuals acting in response to their social environment. This occurs as a response to and compliance with

socially acquired and established normative rules which were internalized until they had become part of the individual's social actions. There is an inherent danger in this process, for example if information institutionalized or introduced into the system is incorrect, vague or ambiguous which in the end leads to uncertainty and false perceptions. A person who was socialized and introduced to a society where they hold that all sexually transmitted infections can be cured will find it absurd, illogical and irrational to say that AIDS cannot be cured and yet the disease is acquired through sexual intercourse with a person who had been infected with HIV. Respondents in general had difficulties to admit that HIV is a sexually transmitted infection which cannot be cured, and that it multiplies in the body cells until they are depleted before the carrier is ill with AIDS. A consensus by majority of the respondents that all sexually transmitted infections can be treated and cured reflects a failure to understand what AIDS is, how it is acquired, and how the spread of AIDS could be reduced or stopped. Their way of thinking and understanding, both of which undermine the meaning and interpretation of the epidemic, can be represented in the following logical syllogism:

All infections acquired through sexual intercourse can be cured,

HIV and AIDS is acquired through sexual intercourse

Therefore HIV and AIDS can be cured.

In the syllogism above, a valid conclusion is reached. But a logically valid conclusion is not necessarily true (Mouton, 1996:74-79). The perception of the respondents is that traditional healers can heal all sexually transmitted infections. Scientific research holds that at present, HIV and AIDS cannot be cured. What seems to come out according to them from the argument in the syllogism is that of an unknown illness, which is transmitted through sexual intercourse. This perception represents another distortion of the meaning of HIV and AIDS.

Chapter 6 Research Findings

6.1 HIV and AIDS at Sekororo

The study has up to this point indicated the complexity and controversy surrounding the interpretation, perceptions and understanding of AIDS, its origin and causes. This was seen from the problem statement as outlined in chapter one. The chapter also demonstrated the extent to which the epidemic is unknown to many people, and how it continues to plunder and destroy lives in the communities as the number one killer in the Sub-Saharan Africa. In chapter two we saw various theories and trends contending in an attempt to trace the origin and causes of the epidemic. This has been a thought provoking chapter, but without consensus by scholars on the origin and causes of the epidemic, Chapter three dealt with the methodology of the research with a qualitative approach, and focusing on male respondents of specific ages. Chapters four and five dealt with the role of socio-cultural dynamics which influence and shape the life of the people of Sekororo into a social order with its institutional systems and rules which are believed to maintain the natural order. Meaning and formation of perceptions would very much be determined by these systems and institutions.

This chapter will summarize the research findings. In chapter five respondents were speaking, giving their views and perceptions. In this chapter I will condense and interpret what the respondents said.

There was no consensus from the respondents on whether the epidemic is prevalent or not in their area. Some denied its prevalence on the basis of lack of evidence of persons who had died of AIDS. There were also respondents who agreed that the epidemic was prevalent, and they pointed out that some of the deaths reported by those respondents were in fact AIDS related. Those who denied the prevalence of AIDS reported tuberculosis and diarrhea as major diseases in the area, and also mentioned that they knew of neighbours and relatives who had died of these illnesses. The prevalence of HIV and AIDS at Sekororo could be indicated by the high death rates caused by tuberculosis, malaria, cholera and excessive vomiting since these conditions tend to be associated with opportunistic diseases consistent with AIDS.

The prevalence of the disease was also confirmed by evidence from Sekororo Hospital. The epidemiology unit of this hospital revealed that new cases had been diagnosed every month since 1998. An old traditional healer, Ngaka Manaso, asserted that he could treat the disease and confirmed that people with HIV went to him for treatment. He had kept a record of patients he treated.

During the interviews, Ngaka Manaso mentioned that he treated people who had tested HIV positive at the clinic or hospital. He produced as evidence two registers, one with a list of ordinary patients who suffered from various illnesses, and another one he purported was strictly for HIV patients. Many people believed in him and his healing powers and the ability to treat patients with HIV and AIDS. It was also reported that some of the people who had tested HIV positive tested negative when retested after four to six months of taking Manaso's treatment. According to his register for the HIV patients, Manaso had during the period August 1999 and April 2000 recorded 67 patients. There was no figure given specifically for those maintained to have tested negative after they had taken his medication.

This information was verified by the researcher with the hospital authorities who confirmed that they knew Ngaka Manaso, and that he was a well-recognized traditional healer, with an ability to cure different diseases with traditional herbs. The hospital confirmed collaborating with this old man, and also affirmed that some patients who had tested HIV positive had tested negative after they had taken treatment from this old man. They did not, however, want to comment on the healing strength of the herbs to reverse the status of those who tested positive to become negative again. They probably were not prepared to comment on this point for of lack of scientific evidence to explain how the herbs act on the virus, and whether the virus is in fact destroyed or rendered inactive or lulled for sometime.

Two hospitals located about 40 and 46 kilometres from Sekororo confirmed that the epidemic was prevalent in their areas. Between September 1999 and May 2000, 131 cases of people who tested HIV positive were recorded for Phalaborwa Hospital. Fifty-five were men and 76 women, and 58 were aged between 30 and 39 years, and 30 were between 40 and 49 years.

It is quite possible that more men than the recorded 55 were HIV positive. The figure 55 was recorded from patients who came to hospital with other complaints, example, tuberculosis, malaria and pyrexia. The recorded figure for women was based on those who came to hospital because they were pregnant as well as similar conditions as men. Husbands and male partners of the pregnant women who tested HIV positive did not accompany their female partners to be tested. The assumption is that some would likely have tested positive too, and thus increased the figure for men with HIV.

The age-ratio presentation of the prevalence of HIV infected persons show that the majority of HIV patients are the youth below 30 years of age. As indicated earlier in the discussion, elderly respondents blamed the spread of sexually transmitted infections on the youth indulging in random or freelance sexual behaviour in a community where the use of condom is not encouraged. The HIV analysis from Phalaborwa Hospital show that 4 cases of children under 3 years were recorded, 23 were aged between 20 and 29 years, 12 aged between 50 and 59 years, and 4 aged 60 years and above. The 4 children under 3 years were possibly born with the virus while the 4 aged 60 years and above were admitted in hospital either with tuberculosis or a severe headache or pneumonia. Two of those patients had died.

6.2 What is HIV and AIDS

There was a consensus by the respondents that the disease is dangerous, and can kill. This is what they had been made to believe, but most of them had no clear understanding of the disease beyond what they were told about it. Some respondents affirmed having heard that the disease begins with an infection after having had sexual intercourse with a partner who is infected with HIV where a condom was not used. This view was common amongst younger respondents and with an educational level above grade 12. Two informants, both school teachers with university degrees described the epidemic as a disease that occurs after the immune system in human body had been destroyed by the HIV. They explained that after entering the body, the virus eats up or weakens the human immune system of the body until the defense is destroyed while the volume or numbers of the virus increase.

Because the body can no longer defend itself, opportunistic diseases are able to enter the body easily, and cause death.

Inadequate understanding of the epidemic was demonstrated by the respondents who believed that they were unlikely to contract the disease. Their denial of the possibility of an infection was based on their belief that traditional herbs can treat all sexually transmitted infections, and therefore their assumption that if AIDS enters at first as a virus transmitted through sexual intercourse with an infected partner, the virus can be treated before it developed to AIDS. In the discussion on the role of the initiation ritual in the understanding of AIDS, AIDS was interpreted by respondents as a disease which is found amongst uncircumcised men since the foreskin on the head of the penis accumulates dirt which ferments and promotes chances of infections.

AIDS was also explained as a new name for an old disease which has been there for ages. Two respondents, both over 80 years of age, mentioned that they heard of AIDS, but the way it was explained to them, AIDS seems to be a disease which was there for ages. It could be treated and cured, and it is now presented as a new disease, and with a new name. They compared the progressive manner through which AIDS kills after it had reached a full-blown stage with another disease known as *rincilana* in Tsonga. *Rincilana* is explained in traditional medicine as a complex condition which may represent existence of one or more serious illnesses within a person, which had been there and neglected over a long period until a terminal point was reached. According to their information, a patient would loose weight, often with a serious cough and wants to sit in the sunlight or in front of the fire all the time. His body is weak, and may as well be infested with sores; and may complain of pains all over the body, particularly the chest and the lower ribs.

Ngaka Manaso, the traditional healer, confirmed that the illness was rare, but increased around 1935 with the influx of migrant miners who came to Penge Mines from Malawi. *Tshofela* and *Tshusula* were introduced for the first time in the former Eastern Transvaal (which would cover part of the present Limpopo and Mpumalanga), and became a serious problem in 1937/38 as women went to sojourn with those miners and returned home with the disease. The disease

was cured and for some time controlled. But those who did not go for the proper cure had a big cough, or *mokgohlwane o moholo,* and this cough deteriorated health its victims to the point of death.

The foregoing account of the pandemic is significant in view of the fact that the first recorded cases of AIDS occurred in the United States in 1981. A search of the medical literature published since 1950 disclosed 19 probable AIDS cases that were reported before the start of the current epidemic. These cases retrospectively met the Centers for Disease Control's surveillance definition of the syndrome and had a clinical course suggestive of AIDS (Huminer *et al*: 1987). The account claiming the possible prevalence of the disease at Sekororo in the pre-AIDS era is based on oral evidence and lacks a scientific base. This account should be taken seriously because of its influence on how the pandemic is perceived and interpreted to date.

It seems difficult to come up with a single or coherent perspective on the epidemic. This trend was seen when the social environment was examined to see the extent to which it influenced the interpretation of the epidemic in the community. The notion of health and illness became normative, and the diseases prevalent in the area were used as clue or key to explain and interpret AIDS, sometimes with the denial that AIDS is caused by HIV. According to the respondents AIDS and HIV are known to the people but the level of the understanding is still varied. There are those who present what is generally accepted as correct (that is, the scientific) interpretation of the disease, and then those who reflect the assumption that the disease has been known for a long time albeit under a different guise and name. Finally, there are also those who show very little understanding, if not a distorted version, of the disease.

6.3 What is the cause of the epidemic?

The Sekororo social environment continues to influence people's perceptions of the origin of the epidemic. Through the process of socialization respondents showed a tendency to consider certain kinds of behavioural patterns as morally right and culturally acceptable whilst there are those which are sanctioned as immoral and as such tabooed. The immoral and the tabooed

constitute deviance which often upsets the cosmic order, and punishment follows. The epidemic is, following this trend, a punishment unleashed by God because of people's deviation from the divine commands. Gays in particular are examples of deviance which provoked the wrath of God. God became indignant and unleashed AIDS as punishment. This was the view held by some respondents, particularly the religious fanatics and the elderly who cannot condone immoral behaviour which they equate with challenge of the supremacy of God.

No scientific evidence was produced to support this view, and yet AIDS is said to be caused by HIV which entered the human body the first time through sexual intercourse. It was acknowledged in chapter 1 that from 1981, when the epidemic was diagnosed the first time among American gays the disease has remained a puzzle. If gay practice involves a man having sexual intercourse with another man, the argument makes sense even if it does not have to be true. Man was made to have a woman for a sexual partner. It is against nature and God's order for a man to have sexual intercourse with another man, and hence sexual intercourse of a man with another man is thought of by some religious adherents as the cause of AIDS.

Moral decay was cited as another cause of the origin of the epidemic. Young people indulge in sexual intercourse at an early age, sometimes resulting in abortions. Birth and death were treated with much respect without consideration of the age of the deceased. There were formalities to comply with for both the birth of a child and the burial of the deceased person, including a fetus. Non-compliance with such requirements could bring misery and trouble to the living, and as mentioned already, deviance may cause illness to an individual or to the entire community. Respondents argued that there are many young children who get pregnant and abort. Abortion is immoral and taboo, and hence the ancestors are offended, and they allow diseases like AIDS.

There is a belief shared by the African people in what is known as *Xikwembu xa nhova.* This belief is based on the power of the spirit of the dead person to inflict pain and suffering on the living, especially if the person died painfully like in the case of brutal murder at the hands of an enemy, or death by wild

animals, or drowning. People who died in this manner may revenge their death on their human killers. Such revenge could include inflict the killers with a deadly an incurable disease such as AIDS, or a plague which could teach the entire community to refrain from such killings. Revenge could come as serial deaths in the family of the culprit, or as ill luck to the culprit, any form of pain which would deny the culprit happiness and expose them to misery till they die. This is likely to happen after the brutal killing of a Mundzawu. Some elderly respondents suggested that the disease could have originated as revenge on the person who had killed a Mundzawu. The spirit of the dead Mundzawu went on to haunt the culprit to the point of introducing the disease in that person, and the person went on to spread the disease. The same explanation would apply to how *xikwembu xa nhova* could have caused the disease as revenge on the killers.

6.4 How is the epidemic acquired/spread

Social constitution of meaning is seen to be strong amongst rural areas across Southern Africa where the epidemic is blamed on witchcraft, instigated, for instance, by a jealous neighbor. Others link the epidemic with a curse inflicted on an individual by the spirit of an unappeased ancestor. Some go on to blame the epidemic on whites who introduced the disease in anger after the end of apartheid government (McGeary: 2001). For some this may explain the high rate of HIV and AIDS prevalence amongst the blacks in Sub-Saharan Africa. These myths and misconceptions seriously impede HIV and AIDS prevention programmes amongst communities throughout the country.

There is consensus that the disease is contracted by sexual intercourse with an infected person. Some respondents believe that circumcised men are unlikely to get the infection. The perception also prevails that the risks of contracting the disease could be minimized by taking some African *muti*, for example *chigwana*, prior to having sex with a woman, or soon after the act had occurred. Some respondents do not know whether sharing of needles/syringes and blades with an infected person can pass on HIV or not. The majority of respondents do not know if sharing of utensils, example, spoon, plate, and even sharing a meal from the same plate with an infected person, could transmit HIV and cause AIDS.

There seems to be a fair level of HIV and AIDS awareness among the younger generation compared to the older ones. It was further observed that those with better education had better understanding of HIV and AIDS. Two school teachers, both with university education, demonstrated that they are well informed about the epidemic. One of them suspected that Dr Basson introduced the disease in South Africa to eliminate Blacks. Wouter Basson is a South African cardiologist and former head of the country's secret chemical and biological warfare Project Coast during the Apartheid era. The other teacher linked the origin of the epidemic to the laboratory experiments that went awry in the United States (refer to Chapter 2 supra).

6.5 What could be done to stop the spread of the disease?

One respondent, aged 44, argued that moral regeneration and honesty of the partners was the only way to stop the spread of the disease. By moral regeneration the respondent seemed to refer to some kind of social return to the traditional way of life where men could have many wives and remain faithful to them and they in return behave honestly and faithfully to him only. In religious terms, it is argued by respondents that people need to recognize the place and role of the ancestors in their daily lives. They control the well being of the people, and yet people have gone astray. The school teacher aged 44 supported this view by condemning modern lifestyle which includes indulgence by youth in drugs that in return cause them to go for random and unprotected freelance sexual intercourse. Seven respondents took a harsh line and felt that those with the disease or the virus must be isolated from those who are not infected yet. Only four felt that the use of a condom may stop the spread of the disease. They also felt that people with HIV and AIDS are still human beings and will always be human beings belonging to families and the community; these people deserve love and support, and cannot be removed from their families and the community. Two thought that the use of the tea supplied by the Zion Christian Church with *chigwane* may stop the spread of the disease.

The discussion above of some respondents seems to affirm that men at Sekororo still need more awareness campaigns and strategies to assist them with the better understanding of the pandemic. This need for the

demythologization of the pandemic was confirmed by twenty-one respondents who proposed that people need a proper educational programme to provide the general populace with relevant information.

Chapter 7 Conclusion

7.1 Research findings

In the prolegomenon, the study alluded to the four blind men who had each touched a part of an elephant as means of knowing what an elephant is. In the end, each of the four men had constructed their own meaning and understanding of an elephant. The meaning and description of an elephant for these four men depended on the part of an elephant they had each touched – tail, flank, an ear, or the leg, and yet none was the right meaning of an elephant. This analogy continues to explain the relevance of the tapestry which was seen progressively shaping itself from chapter one of this study. The study demonstrated major controversy and contending theories, perceptions and interpretations – all irreconcilable.

Each of these positions reflects the particular background, or milieu which had been operational in the construction of the meaning and understanding of the epidemic. Chapter one is confirmed; the pandemic still puzzles many people, science community and laymen equally. Chapter two introduced major trends and theories, all seemingly parallel, and without consensus. The respondents at Sekororo presented many faces of the epidemic. With all this information, what would be the conflation of the study?

7.2 The tapestry

There is scientific consensus that AIDS was first recognized in 1981 among a small group of gay men. The definition of the syndrome has been inconsistent, with different understanding between what is called AIDS in North America and Europe, and what is called AIDS in Africa (De Harven, 2006). This statement by De Harven affirms that AIDS is like a tapestry, one piece with many threads of different colours, with no single thread of the tapestry as the orthodox one over the others.

The scientific community accepts the causative role of HIV as proven. This view became generally accepted in the scientific community in 1986 with the benchmark publication “Confronting AIDS,” published by the National Academy of Science and the Institute of Medicine. This view has become predominant, and explains how this virus causes immune deficiency by

depleting the body of T helper cells, leaving 50-100 percent of infected people to develop AIDS. A group of dissident scientists which has been increasing since 1987, does not agree that HIV causes AIDS. According to Peter Duesberg, a leading proponent of this view, “there is no virological, nor epidemiological, evidence, to back-up the HIV-AIDS hypothesis. Instead,” he continues, “the virus is biochemically inactive and harmless, and AIDS is not behaving as a contagious disease” (http://www.virusmyth.net/AIDS/whistleblowers.htm). Some of his supporters went on to also assert that AIDS is not a viral but multi-causal behavioural disease.

The former group wants to convince the world that HIV causes AIDS. This happens after the immune system of the human body had been overcome by the virus, and eventually succumbs to the control of the virus which would have infiltrated the entire immune of the body. The latter, better referred to as the dissident group, deny that HIV is the cause of AIDS, and maintain that “the consensus that HIV causes AIDS has resulted in inaccurate diagnoses, psychological terror, toxic treatments and squandering of public funds, as well as unprecedented deviation from scientific method and standards”(AIDS reappraisal).

The orthodox versus heretic debate on AIDS and HIV is very important for this study. Scientific research has been conducted by epidemiologists, virologists, and molecular biologists – all aimed at gaining knowledge and understanding of AIDS, to know what, in essence, AIDS is, what causes it, the source or origin of this cause, and how then to stop it. The research failed to bring the consensus of the researchers, and instead, different research groups seem to compete for recognition over the others. Lack of consensus by these researchers and scholars of profound recognition and commanding authority in their specific field of study constitutes a serious concern. It is imperative to understand the cause and effect relationship as an important factor in understanding the resultant condition. In this study, AIDS is the resultant condition and is linked to HIV as its cause. The disagreement between the orthodox and the heretics on this matter confirms the confusion caused by

different perceptions about the nature of AIDS, and it enriches the weaving of the tapestry of this study.

Hooper also attempted to trace the origin of the disease and the course the disease had followed. His report reveals that there are two types of HIV, namely, HIV-1 and HIV-2. The AIDS virus, as he calls it, was discovered the first time in 1959. His report is elaborate and confusing when he breaks down HIV into its anatomical composition, with one type dividing into A – J of small subdivisions of one HIV type.

Hooper does not seem to be convinced that the disease originated in Africa. Instead of Africa, Haiti is suggested by Hooper as the place where the epidemic originated before it was spread into a pandemic. He points at Haiiti, a tourism paradise. His report indicates that by 1982 there were 44 AIDS patients from Haiiti who had been recorded in Miami, Brooklyn and elsewhere in America. Lack of consensus on the place of origin, with suggested simultaneous and sporadic origin, contribute some of the many threads of the tapestry.

There is also no conclusion or agreement amongst virologists and epidemiologists on the nature of the disease. Robert Root-Bernstein (quoted in chapter 2 above) maintains that AIDS as disease and its meaning has mutated over time and among various communities. De Havern (cf paragraph 7.2) also asserts that the definition of the syndrome has been inconsistent. These are statements from the dissident group, but worthy of consideration. Lack of consensus in the science community should be regarded as a caution and indication of the magnitude of the problem of the meaning and interpretation of AIDS – a riddling sphinx to be taken note of when drawing concluding remarks on the meaning of AIDS at Sekororo.

Sekororo is a rural area. The majority of its population is uneducated, and therefore simple and lay people. There is a scarcity of amenities and resources and people cannot access information and knowledge as they would in a large city with modern facilities which could expose the community to the scientific and technological world. The prevailing circumstances as described above limit the community's ability to develop and access proper

and relevant information which would improve their knowledge base. What seems to prevail is the distorted and perverse information which limits the community's understanding of AIDS.

The study assumed that Sekororo is a rural community, and that the rural situation of the community isolates the community from the global world and thereby deprivies the people of participating and sharing information and knowledge in the bigger picture with the rest of the world. The community is enclosed and confined to indigenous life, and with little or no external stimuli to start change in the life and attitudes of the people.

Paragraph 4.5, demonstrated that people's perceptions of AIDS are influenced by their environment. This process was seen to begin with an individual making sense of his environment as shared with others. Having internalized the sense which had been formed of that environment, that sense is transformed into a communal knowledge which is shared with the rest of the community. AIDS is perceived in the context of prevailing diseases, and could only be interpreted in terms of known diseases with symptoms similar to those of AIDS, for example, *rincilana*. HIV is, however, a totally foreign concept, and does not seem to find place amongst the people. From what they know, sexually transmitted infections can be cured. If HIV causes AIDS, and HIV is an infection transmitted during sexual intercourse with an infected person, HIV could be treated before it caused AIDS. If AIDS cannot be stopped by a cure of HIV before it caused the disease, there is no connection between HIV and AIDS. The cause of AIDS is, following this argument, still unknown.

A similar picture was seen in 5.2 where patriarchy and marriage were discussed. The study made assumptions that rural communities including Sekororo are patriarchal. This male domination defines the relationship between a man and a woman, and also shapes the role of women in the community as well as the way in which women respond to health and illness. Respondents have portrayed men as dictators with women as subservient subordinates. Women cannot negotiate their human rights to sexual and reproductive health and responsibilities.

Deviance could also cause illness, and examples were cited to show when a human being becomes the cause of illness, an epidemic or a plague. This punitive condition would follow as result of an upset cosmic order, precipitated by transgression of prescribed normative rules, as when a woman had killed an unborn child through an act of abortion.

Cultural and ritual practices were also confirmed as an important base for the interpretation of AIDS at Sekororo, and a catalyst for the formation of perceptions of the epidemic. This assumption was supported when an initiation cult was seen as one method that could be used to stop the spread of the epidemic. This view claims that AIDS is prevalent amongst uncircumcised men. The corollary is that all men who had been circumcised are unlikely to become infected with HIV, and as such, may not get AIDS.

The entire AIDS dialogue is seen to hinge on the people's lack of relevant information on the epidemic. Environmental factors and cultural practices continue to guide the course the community follows in their conceptualization of the disease. This trend has produced some kind of indigenization of the disease which is based on puritan principles wherein AIDS is associated with punishment meted on the immoral within the community because they had transgressed the laws of nature. This approach would be true of the gay communities in general, and of all men who become ill with *makhume* or *rixixa*. Although both examples make reference to deviance, lack of relevant information remains unaddressed. It still has to be explained why *makhume* and *rixixa* cause death of the male partner in the act of sexual intercourse while nothing happens to the female!

Use of condoms as a means of preventing, or at least reducing the risk of infection was not entertained for two reasons. The first seems to be built around ignorance of AIDS, its causes and how it is spread from one infected person to the other. Linked to this trend of thinking is the skeptic's position which denies the prevalence of AIDS, and therefore would not find justification for the use of condoms. For them, if the disease or epidemic existed, there would be a cure for it. The other has a cultural flavour where sex is pleasurable if enjoyed the natural way, flesh on flesh and without a condom;

and also with sex being procreation oriented whereby a woman must bear many children for a man.

In conclusion, there are those who believe that AIDS prevails at Sekororo, but do not think that they are in danger or at risk of getting infected, and can go on with life as usual. This group contends that diseases existed from long ago, and it has always been possible to cure the diseases before they could play havoc on the patients. There are also those who think that AIDS is there and fear that it is a dangerous disease, but the cure or non-cure for the disease could not be confirmed. There was also lack of consensus on the cause and nature of the disease.

The attempt to embroider a tapestry of AIDS seems achieved in this study. Much like what was seen with the four blind men and their making sense of an elephant.

7.3 Gaps and challenges

Education was seen to be an important factor in the knowledge creation and interpretation of the disease. The distance from large cities and the rural characteristics of Sekororo limit the chances of the people to develop. There are no infrastructure and amenities such as modern libraries with internet facilities which would boost innovation and creation of the appropriate knowledge based on current relevant debates on AIDS. Because of this lack of access to the global world and the knowledge outside, the community remains to some extent indigenous, with small scope of thinking. This view is supported by the two respondents with university qualifications who gave a brilliant and outstanding account of AIDS when compared to the rest of the respondents.

Many communities around the country are assisted with heath programmes by not-for-profit organizations. These organizations are established on philanthropic foundations and work on their own with no mandate from government, and they seem to have a big impact on the lives of the communities, partly because of their commitment to philanthropic principles and also partly because of enormous trust and confidence between such organizations and the communities they serve. Kodumela is one such

organization at Sekororo. This organization focuses on AIDS education and awareness, gender violence and the support of the victims of violence. This organization is reported to be doing well, but not for profit organizations depend on donor support, and it is recommended that this organization and others with similar services be supported and strengthened.

7.4 Recommendations

Information gathered from the respondents suggested a very low level of awareness of AIDS within this community. As recommendation and a way forward, educational programmes for the people seem to be one of the ways in which knowledge of the disease could be increased. The increase of AIDS awareness would assist both those who deny the prevalence of the illness in the community as well as those who believe in the prevalence of the disease but with little information on AIDS. Such campaign or crusade would reduce the spread of the disease in the community.

Educational programmes as suggested above should focus on behaviour change. Behaviour change moves individuals from an existing conditions of risk of HIV exposure to a condition of lower risk by adopting a number of risk reducing strategies. Approaches of this nature are based on the early responses to the pandemic and were targeted at homogenous groups, and it is believed that this approach has demonstrated some measure of success – particularly amongst gay men in the United States of America, sex workers in Thailand, and drug users (Parker, 2004).

Other interventions to stop the spread of the epidemic which were recommended included, amongst others, health promotions projects, training of peer educators, youth for change against violence, programmes on human rights and gender equality, and the status and role of women in society. Despite the nobleness of these programmes, contextual factors that influence high risk include poverty, unemployment, illiteracy, poor communication infrastructure and strong cultural practices.

From this study, the environment itself emerged strongly as the life force and heartbeat of the community, with cultural practices forming an orbit round which the entire AIDS debate or dialogue revolves. Educational programmes aimed at behaviour change as suggested above may not work unless cognizance is taken of the mind-set of the people. Parker "*notes the limits of cognitive approaches to behavior change when applied within complex contents and variations of risk to HIV infection"* (Parker, 2004). Airhihenbuwa et al, (1999) feel that these theories and models do not provide adequate work for advancing behaviour change if applied in specific contexts of Africa, Asia and Latin America and the Caribbean. Behaviour change, as a vehicle to halt the spread of the pandemic must address the milieu and the social environment which shape the cultural practices of people, including their perceptions on health and illness, and HIV and AIDS!

Education programmes for behaviour change must be based on a broader scope of gender and power bias and stereotypes. Behaviour change may focus on increased awareness of human rights including sexual and reproductive rights, and the full right to human dignity and the right to report gender violence including rape and all forms of violation of sexual and reproductive rights. All those endeavours will collapse if women continue to submit to male domination as culturally correct, where defiance may have serious cosmic repercussions. Hence role models and leaders in the communities, especially men, need to be educated first in order to solicit behaviour change from them in favour of adopting values and practices which will enhance programmes on AIDS awareness and reduce the risk factors. Poverty relief programmes and small business opportunities should be provided, specifically for women who hitherto depended on men. It is this supplier-dependency relationship which perpetuates male domination of women. Not for profit organizations should be consulted for their input to work in this area. Such organizations gained the trust of many people because they work independently of government, and have demonstrated a wealth of skills and ability to address sensitive and difficult issues. Their contribution would add value to this quest.

7.5 Way forward

The study has demonstrated the need for knowledge. Information and understanding are intricately woven for the formation or development of a perception. Being the first of its nature, the study could provide a basis for further research in Sekororo or similar communities. It is proposed that a semantic approach be applied in future studies of this nature.

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