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Coexisting Discourses: How older women in South Africa make sense of the HIV/AIDS epidemic.

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Abstract

In South Africa has made great efforts to provide knowledge about HIV/AIDS to the general population in an attempt to halt the epidemic that has affected millions of people. For the most part, the general population has had access to this knowledge and can repeat the ABCs of prevention: abstinence, be faithful, use condoms. However, local constructions of the disease exist, which at times contradict and challenge education-based information. This study examines how older women in rural South Africa talk about and make sense of HIV/AIDS in the context of their personal experiences. The women employ a variety of coexisting discourses that draw on both education-based information and local constructions of HIV/AIDS to explain its origins and effective ways of avoiding the disease. The discourses often serve to place the blame of the epidemic on certain groups of people, including whites, government officials, migrating Africans, and promiscuous women. Discourses concerning possible cures from medical doctors or traditional healers exist as well. These discourses shape the way older women experience the epidemic and condition their responses. Older women often counsel their children and grandchildren about HIV/AIDS, making it crucial to understand how they have constructed the disease. Thus, campaigns aimed at reducing transmission need to take into account local interpretations of the disease as well as Western-based “knowledge.” Given older women’s access to family members at risk of infection, ensuring that older women are passing on messages that will help to prevent transmission could have important implications for the future of the epidemic.

Introduction

As rates of HIV/AIDS infection continue to rise in sub-Saharan Africa, various organizations are scrambling to provide local people with better education concerning the disease, especially information on routes of transmission and methods of protection from infection. Health interventions have come in the form of radio and television programs, school education programs, church services, and other community-based activities meant to inform the general population about HIV/AIDS (Forster, 2001; Posel, 2005; Rugalema, 2004; Smith, 2003; Stadler, 2003). Social researchers have revealed, however, that while most people in sub-Saharan Africa have access to Western-based information about HIV/AIDS, local discourses expose indigenous constructions of the epidemic that differ from, challenge, and sometimes contradict Western-based knowledge (Campbell, 2004; Forster, 2001; Hoosen & Collins, 2004; Mabachis, 2005; Robins, 2004, Rugalema, 2004; Schoepf, 2004; Smith, 2003; Stadler, 2003; Posel, 2005; Yamba, 1997).

Local discourses are constructed as a means of placing the HIV/AIDS epidemic within an understandable framework based on local contexts and notions about disease (Liddell et al., 2005; Yamba, 1997). They vary by location according to specific economic, social, and political factors (Mabachis, 2005). Local discourses, whether they are in the realm of the public or are manifested through rumor and gossip, reveal various ways in which people construct knowledge of a disease which is having tremendous social and economic impacts (Posel, 2005; Rugalema, 2004; Stadler, 2003;). These discourses often serve to explain the origins of HIV/AIDS, place blame on certain social groups, and shape individuals' behaviors, including sexual behaviors (Hoosen & Collins, 2004; Liddell et al., 2005; Posel, 2005; Rugalema, 2004). At times, the

constructions of the disease may act as barriers to Western-based education programs, especially if local notions of the cause and/or source of HIV/AIDS do not reflect the sexual nature of the transmission of the disease (Liddell et al., 2005; Yamba, 1997).

If HIV/AIDS prevention messages are to be effective in South Africa, education programs must take into account local interpretations of the disease. Scientists and medical doctors must better understand local interpretations of the origins of and means of avoiding HIV/AIDS if they are to effectively encourage people to change sexual behavior (Campbell, 2004; Hoosen & Collins, 2004; Liddell et al., 2005; Rugalema, 2004; Yamba, 1997). Simply providing Western-based information about the disease is an ineffective means of changing what is considered to be risky behavior, unless Western-based educators can also incorporate local interpretations of HIV/AIDS (Robins, 2004).

This paper seeks to explore the various discourses older women in rural South Africa employ to understand the HIV/AIDS epidemic in the context of their lives. The aim is to better understand how these women construct the epidemic and to determine if competing discourses exist among them that may interfere with education efforts. As these women often advise their young children and grandchildren about HIV/AIDS, it is important to better understand how they have constructed the disease. Given their access to family members who are at risk of infection, ensuring that older women are passing on messages that will help to prevent transmission could have important implications for the future of the epidemic.

Data and Methods

This paper makes use of data collected as part of a qualitative research project conducted in the MRC/Wits Rural Public Health and Health Transitions Research Unit (Agincourt) field site in the rural Agincourt sub-district. Agincourt, situated in the Mpumalanga Province near

South Africa's border with Mozambique, conducts the Agincourt Health and Demographic Surveillance System (AHDSS), which has collected demographic data on all residents in the field site's 21 villages since 1992 through an annual census and update of vital events, including verbal autopsies specifying a cause for each death in the site (Kahn et al., 2000). The study site population in 2003 was just over 70,000 people residing in approximately 11,600 households.

The sampling frame for this qualitative study was provided by the AHDSS 2003 census. Three in-depth, semi-structured interviews were conducted with a randomly selected stratified sample of 60 women between the ages of 60-75 who live in the Agincourt site. The sample was stratified by the nativity and mortality experience of the household. Half of the respondents were registered in the AHDSS as being 'South African,' while the other half was registered as 'Mozambican.' Those identified as 'Mozambican' had sought refuge in South Africa during the war in Mozambique in the 1980s. A third of the respondents from each of these groups lived in one of three household types: (1) those with an adult HIV/AIDS death between 2001-2003 (as determined by the verbal autopsies), (2) those with an adult death from another cause between 2001-2003, and (3) those with no adult death during the period. Surprisingly, there were no significant differences in the discourses of women from households where an HIV/AIDS death had occurred and those without. This may be due to the pervasiveness of HIV/AIDS in the area, such that nearly every household is affected in some way, whether or not an HIV/AIDS death occurred in that household (Schatz & Ogunmefun, 2005). The region has an antenatal prevalence rate of above 30%, making it a highly affected area, and suggesting that nearly every household is in fact connected to someone who is infected or has died from HIV/AIDS-related illnesses (South African DOH, 2005). The research also found no significant differences in discourse about HIV/AIDS between those identified as 'South African' and those labeled 'Mozambican.'

This is likely due to the fact that the majority of our Mozambican respondents emigrated to South Africa prior to the emergence of the AIDS epidemic. Thus, they had little to no knowledge of HIV/AIDS prior to emigrating, such that both categories of women learned about and constructed their understanding of the disease while living in the Agincourt subdistrict.

The interview guides included an array of questions related to pension use, caregiving of orphans, foster children, and sick relatives, and beliefs about HIV/AIDS. The interviews were conducted by three local women who were trained in qualitative interviewing. The three women each conducted 20 interviews in Shangaan and were responsible for the transcription and translation into English of these interviews. The interviews were coded by the authors using NVivo 2. NVivo 2 (formerly NUD*IST), a product of QSR International, allows users to code and group data from qualitative interviews for discourse analyses (Babbie 2004). These data were then used to identify Western-based and local discourses of HIV/AIDS employed by the respondents. The authors counted the frequency of each type of construction of the disease the women discussed, but found no differences between women living in households with an AIDS death, households with another type of death, or households with no deaths.

Results

Elderly women use a variety of discourses to speak about HIV/AIDS. The respondents displayed a high level of knowledge of information consistent with Western-based education programs, including knowledge that HIV is transmitted through unprotected sex. However, many respondents also answered questions about the disease that demonstrate local discourses used to explain the presence of HIV/AIDS in the social and economic context of the community. The local discourses seek to explain the origins and existence of the disease, as well as place blame on certain groups. Western education-based and local discourses are not mutually

exclusive; many respondents hold both beliefs, despite the seemingly contradictory nature of some of these constructions.

Competing or coexisting discourses?

Most people living in sub-Saharan have been reached by HIV/AIDS education efforts sponsored by national governments and non-governmental organizations (NGOs). Due to these efforts, most are able to identify routes of transmission consistent with education programs and recite the ABCs (abstain, be faithful, and use condoms) of HIV/AIDS (Campbell, 2004; Kaler, 2004; Rugalema, 2004; Smith, 2003; Stadler, 2003). Our research confirmed a high level of knowledge based on this biomedical construction of the disease.

Almost all (58 out of 60) of the respondents in our study had heard that sexual intercourse is a route of transmission of HIV/AIDS; only two never mentioned sexual transmission as a possible source. Not all of the women who had heard of the sexual nature of HIV/AIDS, however, fully believed the discourse. Of those who had heard that HIV/AIDS is transmitted through sex, one respondent expressed doubt that this claim is accurate and an additional three asserted complete disbelief. These four women all expressed confusion that AIDS could be transmitted by sex today, when a few decades ago the disease did not exist despite higher rates of polygamy and the virtual non-existence of condoms.

Even while these four women verbally rejected the belief that HIV/AIDS could be transmitted sexually, they worried that their children or grandchildren could contract the disease through sexual activity. The women volunteered this information either when directly asked how to avoid AIDS or when asked how they were counseling their children or grandchildren. Because only a small percentage of the elderly are at risk for contracting HIV/AIDS, they are much more likely to be *affected* by the epidemic because of their children and/or grandchildren

being at risk, rather than being at risk of becoming *infected* themselves (Schatz, 2005). Whereas some older women may claim disbelief and attempt to resist the biomedical construction of HIV/AIDS, they do employ education-based discourses when discussing the disease with relatives, particularly when telling their children and grandchildren how to behave. The vast majority (51) of the respondents was aware of the ABC's of prevention and cited that the use of condoms, abstinence, or being faithful to one's partner drastically decreases one's risk of becoming infected. The most common preventive measure mentioned was the use of condoms, followed by being faithful and abstaining. Despite the presence of dueling explanations regarding the origins of HIV/AIDS, even our respondents who rejected sexual intercourse as the source of the disease used the biomedical discourse when advising their children or grandchildren.

The worry that led our respondents to advise their children and grandchildren came from a conviction that grows out of both experience and education-based knowledge: once infected with HIV, there is no cure. Most (48 out of 60) explicitly said that the disease cannot be cured and that once someone is infected it leads to death. However, two of these 48 women asserted that whites within the South African government have a cure, but refuse to distribute it to black South Africans. They both claimed that the government wants black Africans to die. Suspicion of the government and white people will be discussed in more detail below; it is important to recognize, however, that while respondents understand there is no cure for the general population, this is not the same as trusting that the medical community would distribute a cure if one were found. This is an example of how local discourses can demonstrate Western-based education while reflecting local knowledge, experiences, and beliefs.

Despite our respondent's knowledge from Western-education based sources, our respondents at times gave seemingly contradicting answers. For example, despite claims that there is no cure for AIDS, many of our respondents believe that traditional healers can cure AIDS in certain circumstances. The coexisting presence of Western and local discourse allowed our respondents to both accept that the Western medical establishment does not have a cure for HIV/AIDS and to maintain hope that traditional healers are or will be able to cure the disease. Even as health workers strive to inform the population that HIV/AIDS cannot yet be cured and the only way to stay safe is to follow the ABCs, nine respondents claimed that the disease can be cured by *sangomas* or *inyangas*.¹ Six out of these nine women held this belief while also saying that there was no cure for AIDS and anyone who became infected would die. This contradiction, however, may stem from a belief that legal restrictions prevent traditional healers from achieving all of which they are capable. As Alucia,² who emigrated from Mozambique and lived in a household where an AIDS death had occurred, explained, "I think HIV/AIDS can be treated by traditional healers but the problem is that the government doesn't allow them to go to the forest and look for medicine. If they can give them chance to treat people who are HIV-positive, they will cure them." Another two women claimed that one must go to a traditional healer immediately after infection for the cure to work.

Rumors of cures have perpetuated these discourses (Stadler, 2003). Auphrey provides an example of personal knowledge that lends evidence to the power of traditional healers:

Like now I know someone who is HIV-positive who was also cured by the *inyanga*. My son is married. His wife was pregnant and when she went to the hospital to give birth, a doctor said she must not give breastmilk to the child because the results said she was HIV-positive. When she came from the hospital, she called me and her husband. She said what the doctor said. I went to this *inyanga* and she gave me medicine, and both my son and his wife drank. But now when they go for blood tests, they say they are negative. The child is now three years old.

Importantly, Auphrey is a native South Africa woman who receives pension. She is one of a few women in our study who is married and her husband receives a pension. She shares her compound with only four others, and due to the family receiving two pensions, was determined by the interviewers to be “rich.” This may be how her family could afford to see an *inyanga*, a doctor, receive medicine, and get blood tests.

Auphrey’s decision to seek medical advice from an *inyanga* is not uncommon. The presence of traditional healers has a long history in sub-Saharan Africa (Ashforth, 2002; Campbell, 2004; Forster, 2001; Hoosen & Collins, 2004; Liddell et al., 2005; Lwanda, 2004; Schoepf, 2004; Smith, 2003; Stadler, 2003; Yamba, 1997). Many sub-Saharan Africans consider traditional healers to be experts in both treating a wide range of illnesses, including sexually transmitted infections, and in diagnosing the source of the illnesses. *Inyangas* often construct new diseases such as HIV/AIDS as both a new disease that requires biomedical attention, and as a result of witchcraft from a jealous person in the community (Lewando-Hundt et al., 2004; Liddell et al., 2005). Traditional healers not only diagnose illnesses and seek cures or treatments, they also provide an answer to an individual’s question of “why me?” by explaining the presence of HIV/AIDS with witchcraft (Liddell et al., 2005; van Dyk, 2001). Traditional healers, by blaming witchcraft, employ a discourse that may recognize HIV/AIDS as a new phenomenon, but also places the illness within the context of older, more familiar diseases. This discourse allows local people to understand the presence of HIV/AIDS as a new disease with familiar causes, helping to place the emergence of the pandemic in the context of other diseases.

These discourses about traditional healers challenge the biomedical construction of HIV/AIDS as a brand new disease that cannot be cured by traditional healers or the biomedical establishment (Stadler, 2003; Liddell et al., 2005). Additionally, discourses which promote

traditional methods of healing may be reactions against the newfound authority of the biomedical establishment and against modernity in general (Yamba, 1997). At the same time, while these discourses may contradict Western-based knowledge in some ways, they also accept certain claims of health workers and education programs. For example, all of our respondents who asserted the effectiveness of traditional healers also believed that following the ABCs is the best way to avoid HIV/AIDS.

Sexual Immorality & Othering

As confirmed by other researchers (Campbell, 2004; Kaler, 2004; Rugalema, 2004; Smith, 2003; Stadler, 2003), many people in sub-Saharan Africa have a high level of knowledge of routes of transmission and ways to avoid getting HIV/AIDS. However, the sexual nature of the disease has led to the othering and blaming of certain groups due to perceived sexual immorality. The term ‘othering’ is used here to describe the process by which older women separate themselves from a given group of people in order to allocate blame for HIV/AIDS, while dissociating themselves from responsibility. For example, research has demonstrated that women are more likely to be blamed for spreading the virus than men, often due to their perceived unchecked sexuality (Castle, 2004; Hoosen & Collins, 2004; Lambert & Wood, 2005; Marks, 2002; Petros et al., 2006; Schoepf, 2004). The respondents in this study also blamed the spread of HIV/AIDS on certain groups, while citing sexual immorality and an erosion of traditional values governing sex (Smith, 2004).

This discourse seeks to identify the source of the epidemic by accusing ‘others,’ those who are sexually immoral, while employing the discourse of the education programs that promote safe sex, fidelity, and abstinence. The discourse on sexual morality and the blaming of ‘others’ reflects the expectations governing sexual relationships and gender roles, as well as the

stigma surrounding sexuality and HIV/AIDS. Female prostitutes, men, people in the city, adolescents, and 'foreigners' were identified as sexually immoral groups responsible for the epidemic. Discourses concerning each group will be discussed in this section.

Female prostitutes are often blamed for spreading HIV/AIDS in sub-Saharan Africa (Kaler, 2004; Smith, 2003). Of the 60 women involved in this study, 27 claim that HIV/AIDS comes from prostitutes. The construction of the term 'prostitute' varies widely, although the term invariably refers to an immoral sexual relationship. Some of our respondents defined 'prostitute' as any girl or young woman who gets pregnant outside of marriage (Lambert & Wood, 2005). The term 'prostitute' is used in this context to reflect the perception that this is immoral behavior. As one of our respondents, Ethel, notes, "Our culture doesn't allow a girl to become pregnant without marriage. It lowers the dignity of us and the whole family."

Another belief amongst the respondents is that women who live in the cities or at the mines are prostitutes (Kaler, 2004).³ Our respondents claimed girls who have sex with boyfriends for financial gain (two respondents cited school fees as a reason for prostitution) are prostitutes (Kaler, 2004), as are women who have many sexual partners. Finally, several respondents expressed the belief that if a woman dies and family members or the community believe the cause is HIV/AIDS, she must have been a prostitute. This statement reflects the notion that HIV/AIDS is the result of sexual relations that are perceived to be immoral (Smith, 2004). Therefore, it is important to remember that discourses about 'prostitutes' may not necessarily be referring to the Western construction of the term. The discourses on prostitution reflect local sexual relationships, gender expectations, and the stigma surrounding AIDS deaths.

Only five of our respondents explicitly accused men of spreading HIV/AIDS. These respondents accused men living in cities of having sex with prostitutes, getting infected, and

bringing the disease back to their wives or girlfriends. Yet even when our respondents blame men, their relationships with prostitutes remain at the core of this blaming. This discourse also highlights the notion of the city as a site of sexual immorality and disease (Lambert & Wood, 2005). In total, 19 respondents identified cities and mines as the site of HIV/AIDS, and all but five of these women explicitly put blame on the prostitutes who reside in these places.

The local discourses that blame city life may be reactions to modernity and the erosion of traditional values, including traditional gender and generational roles (Lambert & Wood, 2005; Marks, 2002; Smith, 2004). Emelda, a woman of Mozambican descent who uses her pension to help support the thirteen family members sharing her compound, highlights the way in which traditional gender roles are changing in the face of modernity and how many older women in our study perceive this change:

The reason [women have many boyfriends] is that they think that they will get money and with that money they buy trousers that make them prostitutes... They know that if they have trousers and put them on, they will get many boyfriends, meanwhile they will get AIDS.

At the same time, local discourses take into account HIV/AIDS prevention education by focusing on the sexual transmission of the disease, citing multiple partners and sexual immorality as the primary reasons of infection.

Our respondents not only associated sexual immorality with 'prostitutes' and city life, but also with adolescent girls and boys within their communities. The women of this study expressed concern and frustration with the youth of today, with 26 of the 60 women expressing unease at the perceived promiscuity of adolescents. Promiscuity was identified as young boys and girls having sex before marriage, and the respondents expressed great concern about the high number of pregnancies outside of marriage. Several respondents felt that early sexual intercourse is an indication of the erosion of traditional values and represented a parental lack of

control over youth. Many of the respondents worried that their children or grandchildren would contract HIV/AIDS because they are sexually active outside of marriage and some reported telling these children that they would die if they engaged in non-marital sexual relationships.

Connected to the concern over young sexual relationships, our respondents conveyed a feeling that youth no longer respect their elders or a more traditional lifestyle (Lambert & Wood, 2005). Fourteen respondents explicitly said that youth no longer listen to their elders, including parents, grandparents, and health workers. Discourse bemoaning a sense of loss over traditional lifestyles and rules governing sexual relationships seemed to infer that young people who are infected with HIV/AIDS are responsible for their fate. Abigail is of Mozambican descent; she lives with one family member, does not receive pension, and lived in a household where there was a non-AIDS death between 2001-2003. She claims, "Nowadays our children don't listen to us...Just because they don't listen to us that makes our children cause a lot of AIDS." There was a general sense, concurring with previous research, that to halt the AIDS epidemic, society needs to return to more traditional values (Lambert & Wood, 2005; Lwanda, 2004; Posel, 2005; Rugalema, 2004; Smith, 2004; Stadler, 2003).

Four of the respondents' claim that HIV/AIDS is not a new disease, but a traditional illness that is a consequence of not observing cultural norms, demonstrates how some South Africans construct the disease in terms of modernity and loss of tradition. This illness occurs when someone eats food at a funeral and then engages in sexual intercourse within a week afterward. Belief in this taboo exhibits the coexisting ideas of sexual behavior as a potential cause of infection (an idea promoted by Western education programs) and the belief that HIV/AIDS is the result of an erosion of traditions and the cultural changes brought on by

modernity. Mumsy, a South African woman from an HIV/AIDS death household, describes this taboo as follows:

I don't believe in AIDS. What is happening now is that children are dying because they don't follow instruction or rules of our culture. Because when someone dies in a family, they give that family laws or rules to obey. If they fail to obey the instruction, they would become sick and doctors would not know [how] to cure the disease. If the doctors see that they don't know how to cure the disease, they say it's AIDS.

This construction of the disease places blame on sexual immorality and failure to observe traditional rules yet does not explicitly recognize Western biomedical information, although it does recognize sexual intercourse as a route of transmission. In fact, the discourse serves to place HIV/AIDS in a context that makes the epidemic understandable and returns to the idea that traditional healers may be better equipped to combat AIDS than biomedical doctors. HIV/AIDS, as constructed by this discourse, is the result of youth embracing new norms of modernity in place of observing traditional values, and is the result of breaking sexual taboos (Forster, 2001). One respondent went as far as to say that HIV/AIDS is a punishment from God due to these changing values and relationships. Similar ideas have been reflected in findings from previous research (Forster, 2001; Kaler, 2004; Smith, 2004).

All of the women who claimed that HIV/AIDS is caused by failing to observe cultural taboos, however, also asserted that the disease is spread by having sex with someone who is already infected. All four of the women advised their children or grandchildren to use condoms, to be faithful, or to abstain from sex until marriage. Mumsy herself, who provided the quote above, expressed concern that her grandchildren will contract HIV/AIDS by having sex and believes condoms can help save them. Mumsy is a native South African who uses her pension to help support the seven other household members. She believes that white doctors know the origins of HIV/AIDS. Believing that HIV/AIDS is caused by having sex after funerals does not

presuppose a rejection of the biomedical construction of the disease as transmitted through unprotected sex with an infected person. This demonstrates how Western and local discourses coexist, with individuals using both.

In addition to discourses concerning prostitutes and the youth of today, other groups were accused of bringing and spreading HIV/AIDS in South Africa. Again, these discourses use the biomedical, education-based information of sexual transmission while targeting groups who are perceived to be foreigners. This discourse reflects a frustration and fear of emigration into South Africa, as well as xenophobia (Landau, 2006). Xenophobia allows certain 'others' to be constructed as sexually immoral or as carriers of disease. Besides those women who blamed HIV/AIDS on those living and working in the city, an additional eight women blamed people from other nations. Of these eight, two cited Indians, one American soldiers, one Zimbabweans, one Mozambicans, one cited all whites, and one generally stated that HIV/AIDS was introduced to South Africa by migrants but did not specify another nation. All said that men from these nations had sex with South Africa women, causing the disease to spread quickly. This discourse is gendered in the sense of recognizing males' power, not blaming men for sexual immorality or promiscuity.

The blaming of the foreign 'other' is common in sub-Saharan Africa and around the world (Petros et al., 2006; Schoepf, 2004; Smith, 2003). The respondents were attempting to explain how HIV/AIDS could enter South Africa and spread so quickly, when a few decades ago they had not heard of the disease. The discourse recognizes sexual transmission, yet dissociates native South Africans from blame. Additionally, the blaming of 'foreigners' demonstrates how discourses are constructed and shaped by the social and economic contexts of the respondents' lives (Hoosen & Collins, 2004; Posel, 2005; Schoepf, 2004), as well as how social positions (in

this case being classified as ‘foreign’) may increase stigma (Castro and Farmer, 2005). In the context of this study, ‘foreigners’ may be whites living in South Africa, whites from Western Europe and the US, blacks from other African countries, particularly Mozambique, and South Africans from outside Agincourt, such as people from the cities or mining areas.

Our respondents commonly expressed discourses about perceived sexual immorality, erosion of traditional values, and incursion of “others” into their landscape. These discourses seem to contradict the biomedical and Western constructions of HIV/AIDS but when we look closer, we see that individuals often co-opt Western-based knowledge to fit their own notions of disease and morality in an attempt to make sense of the chaos HIV/AIDS is bringing to their lives. They reiterate the sexual nature of transmission and recognize that the disease has come to their communities fairly recently. The social and political changes that have happened concurrently with the spread of AIDS epidemic in South Africa give weight to this discourse.

Racial Tension and Slow Poison

Not all discourses that attempt to explain the origins and existence of HIV/AIDS reflect the biomedical construction of the epidemic as a sexually transmitted disease. Other discourses seek to explain how AIDS entered the community and how it is transmitted, apart from sex. As racial tension between the white and black populations remains high in sub-Saharan Africa, discourses concerning HIV/AIDS often reflect distrust of other races and of national and international governments. As medical scientists began to recognize the seriousness of the HIV/AIDS epidemic, many governments and NGOs scrambled to set up education programs and awareness campaigns. At first, many sub-Saharan Africans refuted the information from the education programs. Many felt that this new disease was not real; whites both abroad and at home were contriving a scheme to limit the black African population (and their political voice).

Medical doctors were asking that young people abstain from sex and that everyone use condoms, two acts that could clearly impact population size. They felt that HIV/AIDS was simply a fabricated disease designed to frighten blacks away from sex and reproduction (Ashforth, 2002; Forster, 2001; Lwanda, 2004; Schoepf, 2004; Stadler, 2003). This discourse clearly represents the suspicion that many black South Africans feel toward whites and reflects the racial tensions and social contexts which shape HIV/AIDS discourses.

In South Africa today, almost everyone is aware of HIV/AIDS, and our research found that most of our respondents do believe that AIDS exists. Still, many resist the biomedical construction of AIDS as a disease that is predominantly contracted through sexual intercourse. Some health activists charge that this discourse is prevalent in part due to the South African government's stance on HIV/AIDS. The government, under the leadership of President Mbeki, lends support to the rejection of AIDS as a sexually transmitted disease, as Mbeki has not yet explicitly acknowledged that AIDS may be spread through unprotected sex (Posel, 2005).

Despite the fact that this discourse directly contradicts the biomedical construction, by claiming that AIDS is transmitted without the transfer of bodily fluids, our respondents often expressed belief in both. Previous research has also demonstrated that these discourses now often assume HIV/AIDS does exist, while continuing to blame whites and national governments, reflecting political and social inequalities in South Africa (Kaler, 2004; Robins, 2004; Smith, 2003).

Of the 60 respondents in this study, 28 identified whites as either causing HIV/AIDS or refusing to cure the disease. The most common theory involving a white conspiracy was that whites put HIV/AIDS in food to eliminate the black population and reduce their political expression. Pearl explains this theory:

I think it is from the whites who put poison in the mealie-meal...Because the whites are worried. They say we blacks are more than them. And that's why they do this to us. They want to eliminate us so that next time when we vote we must not vote in large numbers. Then they will win back this land.

Seventeen women claimed that they had at least heard of this conspiracy and only one woman said she did not believe it. An additional three women asserted that HIV/AIDS comes from the food, although they did not specifically mention whites as putting it there. The respondents claimed that HIV/AIDS was in a variety of foods, the most common being in the form of tablets placed in mealie-meal, the staple food of the black population in rural South Africa. Others identified water, oranges, and sugar as targeted foods. Some, like Alucia, who is quoted above in reference to the barriers the government creates for traditional healers treating AIDS, claimed to have evidence of this conspiracy. "I said this because I also bought mealie-meal and inside the bag, there were small tablets. What are these tablets for? They must have them for [people to be infected with] AIDS." Of the 17 women who accused whites of putting HIV/AIDS in the food supply, nine explicitly mentioned that the purpose was to eliminate the black population so that whites would be better able to win the next governmental elections and reclaim power. This is a clear example of how HIV/AIDS discourses reflect the social contexts of these women's lives and experiences.

When pressed about how whites avoid HIV/AIDS if it is in the food supply, most women were able to give precise answers. Most answers were in one of two forms. The first claimed that all whites know about the tablets in the food, but are able to buy more expensive food, in this way avoiding danger of infection. Ethel, a native South African who lives with sixteen family members, but did not live in a household where a recent death had occurred, offers this explanation:

These whites are too clever. They don't buy the same mealie-meal and the same sugar we [are] use[d] to buy[ing]. They buy the very expensive one, [in] which they know that there is no poison. And they know that we are too poor. We can't afford to buy it. They put poison in cheap mealie-meal.

The second asserted that whites have access to medicine that prevents infection, so they are able to eat even poisoned food without becoming ill. This discourse reflects social and economic inequality, demonstrating a wealth and power distribution that favors whites and their better access to medical care.

Further suspicion was demonstrated by two women who claimed that HIV/AIDS is actually on the condoms and is distributed this way (other researchers have heard similar reports: Kaler, 2004; Stadler, 2003). An additional two women believed that nurses purposefully inject patients with the virus. While none of these four women explicitly mentioned whites, they imply that the Western medical establishment is at least complicit, if not to blame for the epidemic. One woman blamed the South African government for the disease, saying that they were attempting to kill youth who were having children in order to receive the child grant (a means-tested government sponsored monthly social grant to assist poor children).

A slightly different discourse from those that explicitly accuse certain groups of purposely spreading the disease concerned the knowledge of HIV/AIDS that whites are perceived to possess. Six respondents claimed that whites had a cure, but were refusing to distribute it to the black population. An additional four claim that whites know where AIDS is from. The women believe that whites know more about the disease than they are willing to share. These ideas are similar to the discourse concerning food. While whites are not being blamed for creating the disease per se, they are perceived as wanting the black population eliminated since they will not distribute the cure or share information about the nature of HIV/AIDS.

While the most common discourses involving whites included putting HIV/AIDS in the food supply or of refusing to share a cure for the disease, the respondents expressed other theories as well. One claimed that whites spread the disease with airplanes. Another felt that whites brought HIV/AIDS, but did not say how. An additional two felt that whites gave the disease to blacks through sex. These particular ideas were not widely expressed, yet they along with the others above demonstrate deep distrust of white South Africans, and whites in general, a reflection of the social and economic context of the nation. It is essential to recognize that even though so many of the women in this study accuse whites and government officials of purposely spreading HIV/AIDS, they also all believe that the disease is spread through sex with an infected person. While the discourses appear to be incompatible, it is entirely possible to believe that HIV/AIDS can be contracted from food and from sex. Constructions of the disease that seem to be incompatible can in fact coexist; individuals make use of a variety of interpretations of HIV/AIDS depending on the context in which they are involved and the question about AIDS they are answering.

Discussion

The respondents in our study made use of a variety of discourses to make sense of the HIV/AIDS epidemic. They displayed a very high level of knowledge of information promoted by Western-based education. But they also expressed many other ideas that seem to contradict this education. These discourses serve to blame certain groups who are perceived to be sexually immoral, to act as direct challenges to modernity and urbanization, to provide evidence of the need to return to traditional ways of life, and to demonstrate a sense of general suspicion of white people, government officials, and the biomedical establishment.

In many cases, these discourses seem to contradict each other. Yet many women simultaneously held beliefs reflecting educational programs, while expressing other notions of the cause and source of HIV/AIDS. Their ability to employ many seemingly contradictory discourses reflects the limited success of educational programs and the need to place the epidemic in terms which make sense based on these women's life experiences and local knowledge (Campbell, 2004; Forster, 2001; Hoosen & Collins, 2004; Liddell et al., 2005; Mabachis, 2005; Posel, 2005; Robins, 2004, Rugalema, 2004; Schatz, 2005; Schoepf, 2004; Smith, 2003; Stadler, 2003; Yamba, 1997).

Educating older women about the sources and causes of HIV/AIDS is vital if the pandemic is to be stopped. While they may not be at high risk for contracting HIV themselves, the disease directly affects them. In many cases, older women in South Africa are responsible for raising and caring for both their children and grandchildren. An essential component of this care is understood by many older women to include talking with these children about the dangers of HIV/AIDS.

Most of the women in our study worry that their children or grandchildren will become infected, and in response, advise them about safer sexual practices and about other perceived risks that are results of local constructions of the disease. If part of the discourses they employ does not recognize HIV/AIDS as a sexually transmitted disease, they may be less effective in protecting their children. Promoting programs that educate older women about safer sex practices, such as condom use, is crucial, especially given these women's access to family members who are at risk. However, these programs must find a way to discuss local constructions of HIV/AIDS if they are to be effective. Simply lecturing older women about the biomedical construction of the disease may not be the best way to help them to contextualize the

pandemic in terms of their personal experiences (Robins, 2004). This study exemplifies the need of educational programs to take into account local discourses when providing older women with information about the nature of the pandemic. In order to give older women the tools to assist in reducing transmission among their children and grandchildren, educational programs directed at the elderly must recognize and incorporate these coexisting discourses.

Notes

¹ The terms “*Inyanga*” and “*sangoma*” both refer to traditional healers. Inyangas specialize in herbal remedies while sangomas rely on divination for healing purposes. Both types of healers are active in the area where our respondents live.

² All names have been changed to pseudonyms in order to protect the identity of the respondents and their family members.

³ South Africa has a long history of labor migration to mines where precious metals and gems are extracted. In the past, men lived in boarding houses in these mining towns, often far from their families and sexual partners. Due to this isolation from outsiders (particularly women) and miners’ emphasis on sex to demonstrate masculinity, many women from impoverished, rural areas migrate to mines in order to earn money from prostitution. These women migrate from both South Africa and other neighboring countries. Condom use is very low, while STI’s and HIV/AIDS rates are high (Campbell 2000).

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