Changing the Course of AIDS
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Published by Cornell University Press

Deutsch, Charles and David Dickinson.
Changing the Course of AIDS: Peer Education in South Africa and Its Lessons for the Global Crisis.


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A half dozen or so peer educators are holding their monthly meeting in Robert Mokwena’s office in the mining hostel where well over a thousand men live far from their homes. Mokwena has had an office for only a couple of years, though he’s been a peer educator for six. He was promoted to a clerk after twenty years working underground. He is short but powerfully built; underground his job was to shovel loose rock that the mechanical grabs were too clumsy to scoop after blasting. A table is stacked high with brightly colored government leaflets on HIV/AIDS and other sexually transmitted diseases in a range of languages next to several large boxes of condoms. The walls are plastered with posters, photos, and newspaper clippings about AIDS.

The peer educators have come in from their various jobs on the mine. Those who work underground have supportive supervisors that approve their attendance. Nelly Tlouane has to keep nipping out of the meeting to check on her office just down the corridor; there is nobody able to cover for her today. Everybody, except myself, is African and, apart from Nelly,
all are men. They are all ethnically Batswana\(^1\) and, although for my benefit they speak in English, when the discussion gets animated they break into Setswana in which they are more comfortable. Most can speak several African languages as well as Fanagolo—the hybrid language of instruction used on the mines. Less than half the active peer educators were able to make it to today’s meeting, but even if they all had been able to attend, the profile of the group would be the same.

The meeting starts, as it will end, with Isaac Taung, who works in a maintenance team but is a moruti (preacher) on Sundays, leading them in prayer. There are several items of business, but not infrequently the agenda gets sidetracked into discussions around AIDS, where the problems lie, and what they should be doing about it. That’s when the discussions heat up. There is, as in almost every meeting, criticism of the government’s handling of the epidemic. Saul Makoko is explaining that the government isn’t doing enough to push prevention because it argues that it is not AIDS that kills but poverty. “Does poverty say ‘don’t use a condom?’” he asks rhetorically. But Tlouane doesn’t agree. “The poor concentrate on having sex because they don’t have enough to eat!” she counters—making an eating motion with her hand as she speaks. Peter Mopedi, a big man who operates a winch underground, attempts a compromise, “poor women who have to work as a prostitute can’t refuse [to have unprotected sex].” Nevertheless, Tlouane is not mollified, “it’s one [and the same thing]” she stubbornly maintains about poverty and unprotected sex. The matter is clearly unresolved, but another topic is already melding into the discussion. “What about rich people, they can also be infected,” Charles Mothibi, a store man, throws out. He tells an apocryphal story about a man with the three Cs: cell-phone,
cash, and car. Enough for him to tempt a woman. “When can I pick you up?” and they arrange to meet. He lies to his wife and uses cash to put petrol in the car. “He gets infected; she [the wife] gets infected.”

Mokwena, always wanting to focus on what can be done, asks the group, “How can we as peer educators empower women?” Makoko counters, consistent with his line that it’s not poverty that determines condom use, that it’s a problem of machismo culture; *ke monna* (I am man). He draws on the Jacob Zuma rape trial and how his wives are in no position to negotiate safe sex with him (after he’d had sex with an HIV-positive woman). The group now launches into a discussion as whether it’s best to empower women or change male attitudes.

Suddenly, Taung, who has said nothing since his opening prayer, asks everybody, “Why do nurses and doctors get HIV/AIDS?” The point brings everybody to a halt—doctors and nurses are educated, are not poor, and must know about HIV and AIDS. There is no satisfactory answer on hand. Mothibi breaks the silence by making the point that anybody can be infected and starts to list them: “Teachers, doctors…” Tlouane jumps in enthusiastically and adds to the list, “Managers!” On this they agree wholeheartedly—managers can also be infected (and by this, they mean not just managers but whites). Mokwena sums up this point of consensus because we are now well over time and the meeting needs to be brought to an end. “It cuts across [everybody]; it’s just that we’re still in denial.”

These overlapping discussions about HIV infection looped endlessly within and through the peer educator meetings that I attended. What is driving the epidemic? And what, if the epidemic is to be checked, should they be doing with whom? If they were moving to consensus on these questions, it was a very slow process. But that is not surprising; some of their debates closely mirrored the confused discourse of experts who, despite prodigious AIDS research, have yet to produce a unified model of how and why the AIDS epidemic is unfolding with such aggression in South Africa. But I suggest the peer educators’ discussion is valuable. I hope this, not untypical, vignette highlights three points.

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2. In December 2005 Jacob Zuma, a polygamist and then the country’s deputy president, was charged with the rape of a family friend in Johannesburg. He was found not guilty but admitted to having unprotected sex with a woman he knew to be HIV-positive—despite being the chair of the South African National AIDS Council.
First, that in many respects the peer educators in Mokwena’s office were very similar: all Africans from the same ethnic group, all workers, most were men, all were Christian, and all had received some formal training on HIV/AIDS. The second point is that they disagreed with each other over why people get infected and what they should be doing about it. The third is that the problems they were grappling with are complex, interlinked, and stoutly defended from different subscribed perspectives.

The ability to grasp these points depends partly on perspective. From the viewpoint of, say, a white, university-educated, English-speaking manager running a mining company’s HIV/AIDS program, a group of African, polyglot workers who volunteer as peer educators seem—on the face of it—to represent the majority of employees the program wants to reach. However, from the point of view of those same peer educators, the difference between themselves and their peers, and, indeed, among the peer educators themselves, has a tremendous influence over the work they will do largely out of management’s sight.

Both views have validity. Compared to management, peer educators do have an advantage in communicating with workers about HIV and AIDS. When they operate they are functioning on one side of, rather than across, the industrial divide within South African companies and its extension outside workplaces as social divisions between white/rich and black/poor communities. This allows peer educators to circumvent an initial set of communication barriers, between distinctly dissimilar individuals. However, what this chapter explores is how quickly differences and tensions emerge among seemingly similar individuals. This phenomenon, and its implications for peer educators, is illustrated using gender, race, and belief in traditional and spiritual healing. These three important facets configuring individuals’ identity determine, in part, the degree of similarity between peers. They do not, of course, form the sum total of any individual’s identity. Additional facets of identity are potentially endless and attempting to describe them all would produce a very long chapter. The three examples of gender, race and belief in traditional healing illustrates, rather than comprehensively charts, how different identities structure backstage social spaces and what this means in the era of AIDS. The next two sections draw on Erving Goffman’s dramatic conceptualization of social interaction to build an analytical framework that will assist us in understanding the work of HIV/AIDS peer educators.
Conceptualizing Social Space: Front- and Backstage Presentation

The use of peer educators acknowledges the differences between people that influence communication. The nature of interaction between people demarcates social spaces and the norms or rules that operate within them. Goffman’s *The Presentation of Self in Everyday Life* (1958) outlines a dramaturgical conception of social interaction to supplement four existing perspectives: technical, political, structural, and cultural. This perspective differentiates between public, front-stage and private, backstage spaces.

Front- and backstage spaces are socially constructed understandings of a situation with different characters and roles. *Front-stage spaces* are the site of public performances or encounters between individuals or teams of actors and an audience. As with a staged play, the actors seek to convince the audience of the credibility of what they are watching—something that requires intimate cooperation between the cast or team members to project the appropriate image. The audience also constitutes a team with its own image to project because they are simultaneously aware of their own credibility being assessed as a performance itself. The important thing is to carry off performances convincingly and to maintain consensual understandings of the social situation for actors and audience. If achieved, social order is maintained, with actors and audience reproducing social relationships between them and the credibility of individual actors within teams sustained.

In contrast to front-stage space, there is only one team present in private, *backstage space*, and there is no need for staged performances. As Goffman (1958, 69–70) outlined, frank preparations for front-stage performances can be made in these private spaces: “illusions and impressions are openly constructed...Here the team can run thought its performances.” Moreover, in backstage spaces “the performer can relax; he can drop his front, forgo speaking his lines, and step out of character.” Backstage, Goffman argues, performances are not necessary; one can be oneself, not an actor.

Thus, for example, a family will put on a public performance when entertaining a (nonintimate) visitor to the home that is likely to be very different in content and style to what takes place in the absence of an outsider. Homes, if large enough, may be physically divided into front-stage
space—a reception or best room were public performances are staged—and the backstage spaces such as the kitchen or family living room when only “team members” spend time and where a different, less scripted mode of interaction takes place. But, in Goffman’s conception of social space, front- and backstages are not physically determined. Thus, a manager’s office may be the setting for front-stage performances, such as instructing a subordinate. Here the manager, supported by the stage props his office provides, will ensure a desired definition of the situation, including their managerial prerogative, is maintained. Yet, with only a minor change in stage props, such as putting one’s feet up on the desk, the same office becomes an intimate backstage space where the manager may share uncensored criticism of the way the company is being run with another manager.

Although much of Goffman’s work focuses on front-stage performances (1958, 1961, 1966), he is aware of constraints on just how far one can truly move out of public character in backstage spaces. Thus, he notes, in a chapter of *The Presentation of Self in Everyday Life* (1958) on backstage space, that members of a team need, even when backstage, to sustain the impression that he or she is reliable and will, when an audience is present, perform well front stage. Additionally, morale needs to be maintained backstage—limiting the extent to which criticism can be expressed—if the team is to be able to sustain effective front-stage performances. Both these points are pertinent to the central focus of this chapter: the recognition of back stage social space as complex and structured terrain for peer educators to operate within rather than straightforward, honest and relaxed social spheres. A third point made by Goffman about backstage limits provides a more direct entry to this idea. Constraints on behavior also occur when members of a backstage team are not the same. Thus, if the team, “[c]ontains representatives of fundamental social divisions, such as different age-grades, different ethnic groups, etc., then some discretionary limits will prevail on freedom of backstage activity. Here no doubt, the most important division is the sexual one, for there seems to be no society in which members of the two sexes, however closely related, do not sustain some appearances before each other” (1958, 79).

This chapter explores backstage divisions concerning HIV/AIDS, starting with gender. Before this, however, we link some of the key aspects of peer educator activity—formal talks and informal discussions, described
in the previous chapter—to Goffman’s conception of social space to establish the value of dramaturgical theory in understanding the work of peer education.

Peer Education, Front-Stage Encounters, and Backstage Advantages

Although the need for peer educators is often rationalized in terms of language barriers and educational differences, the idea of a manager educating workers about HIV/AIDS is additionally inappropriate because whenever a manager encounters workers a front-stage performance comes into being. However genuine intentions might be, it will not be possible, irrespective of prop changes such as invoking AIDS as a national crisis rather than company concern, for either side to engage frankly about HIV and AIDS. Communication will be curtailed by the power differential inherent in the relationship. It does not take long for employees to learn that when interacting with management they must maintain a performance as a competent and capable worker. To do so includes guarding information about health that might compromise this performance. Such performances may need to be maintained even in encounters with company medical practitioners because, despite their professional status, they are part of management. As a peer educator in one of the auto companies explained, workers feared that managers, keen to maintain production, would use information on their health to remove them from the workforce.

Most of the people they don’t trust the medical department. They don’t trust even the [medical] sisters…[T]hey think that at medical department…they want to eliminate those who have this [HIV] and send them home…. They don’t trust anyone…Not actually about HIV/AIDS only. Some have been taken from their department because they are diabetic. They [management] have now taken them to a labor pool [i.e. on standby to fill in when other workers are absent]…They are waiting there, they are going to float in the plant…. They’ve been diagnosed at the medical department that they’ve got the diabetes. [But] they are always present at work, they did not complain about their job, and they are always doing their job in a right way. So, why on earth are their managers choosing
them? Why on earth are they the first people to be taken out from their job?

Thus, there may be tangible concerns on the part of employees that underlie the need for carefully guarded performance during encounters with management. Any spoiling of an image as a competent and capable worker may have negative consequences. In the highly charged atmosphere that surrounds AIDS even taking too much interest in the topic can be (mis)interpreted as indicating that the questioner is HIV-positive, or at least at risk. Given the possible consequences, managers, far from being people who can be confided in, are to be feared. One peer educator from a retail company vividly demonstrated this point in an interview with her own improvised stage props. Reaching over and grabbing some of my papers, she raised her hand as though holding a pen over an imaginary disciplinary letter. “They don’t listen! They just reprimand! He [the manager] has a pen and paper, he’s going to reprimand you! [Her hand lunges down as though about to sign the letter.] Just reprimand! [Again, she lunges forward with the pen.] Just reprimand! [A final lunge.] While you are trying to explain your problem. [She exaggeratedly signs the disciplinary letter and pushes it across the table toward me.]”

Because the relationship between management and workers invokes front-stage performances, workplace peer education is a better way of communicating about HIV/AIDS. As a peer educator in Finco put it, “There is an open-door policy in this company [for employees to approach managers], but peer educators can be trusted.” Peer education offers a more effective communication channel on HIV/AIDS because relationships of power present in front-stage encounters between management and workers are sidestepped and the need of the audience to perform is less prominent.

Peer educators giving formal talks on HIV/AIDS (as described in Chapter 3) represents a first step in this direction, but it is limited. Rather than a manager standing up to deliver messages on HIV/AIDS to workers, a worker volunteers to do so. This confers advantages, but the context retains many aspects of a front-stage encounter and its disadvantages.

One problem is that the peer educator is seen as acting on management’s behalf because, for example, they may be given time to speak during the shift meeting while the supervisor stands by, tacitly demonstrating that this
is managerially approved activity. There is some irony here. A frequent problem for peer educators attempting to conduct formal talks is not being given time to talk to coworkers because of production pressures, or, when permission to speak is given, this is constrained by the supervisor’s evident desire to keep the session short and start production. Yet, such talks may be viewed by workers as management’s attempt to advance their own agenda. If so, such talks will be passively endured or actively subverted by difficult questions and undermining stage whispers.

Even if peer educators can demonstrate independence from management, formal talks may invoke other familiar front-stage encounters such as the teacher instructing a class or the preacher delivering a sermon to a congregation. These associations with other front-stage encounters with deeper psychological grooves affect both the audience’s interpretation and the peer educator’s own performance. For many South African workers, encounters following these familiar patterns are likely, reflecting their experiences of schooling, to suggest that there is information that they must learn, without necessarily understanding its relation to their own lives. Alternatively, reflecting their experiences of organized religion, that there is a set of values to which they should publicly subscribe but about which they may feel ambiguous in their daily lives.

Formal talks can be done well or badly. At its worst, a peer educator may deliver information they do not understand, while the audience feigns appreciation; and the module is ticked off as “done” by the HIV/AIDS program coordinator. At its best, well-understood information is presented clearly, and the audience is engaged and asks questions. Nevertheless, even in this latter situation, individuals within the audience may hold back on what they ask given the presence of coworkers. Formal talks can also be replicated away from the workplace wherever performances between actors and an audience are staged. These can include church services, formal speeches at funerals or other social events, talks to youth groups, meeting of clubs, unions, political parties, and so on. But even when staged away from the front line of industrial and class divide, pressure for both sides to maintain appearances—the peer educator as competent authority, the audience as competent recipients of information—may hinder communication within this setting. This is not to dismiss the value of peer educators’ formal talks, but to highlight that this form of activity is likely to remain
framed as a front-stage encounter despite the change of actor from manager, or AIDS expert, to peer educator.

Only with informal peer educator activity are the constraints of front-stage encounters shaken off. Backstage spaces, where only one team is present, include the family watching TV in their living room, employees sitting together in the work canteen, friends drinking in a shabeen, members of a church congregation chatting after the service, banter in the changing room, traveling to or from work, preparing food during a night vigil, and so on. The idea that backstage space is one in which people are able to relax and drop pretenses should mean that communication within them should be easy and effective. The advantage of similarity and familiarity lies at the heart of peer education. Peer educators should, it is assumed, make rapid headway in these backstage spaces. Introducing appropriate information on HIV/AIDS should facilitate open discussions leading to a clear understanding of the disease and a consensus around how best, as a group or team, to respond individually and collectively. The following examination of backstage space in terms of gender, race, and belief in traditional healing, illustrate why this is rarely the case.

**Gender Relationships and the Family: Intimacy by Proxy**

In a heterosexually transmitted epidemic, relationships between men and women are central to the transmission of the HIV virus. These relationships, which contain the potential to transmit disease, also anchor families, which are regarded as the most intimate of all social spaces. The bond between the couple is seen as one of the closest of all relationships and that between parents and children as one of guidance, protection, and care. It is to these relationships that we most readily resort to the idea of love—the prioritization of another over the self—as explaining what holds together individuals of different genders, in the case of (heterosexual) couples, and ages, in the case of parents and children. While we recognize these as idealizations that cannot live up to all we hope for, they remain powerful projections; considerable effort is made to support the intimate privileges of these relationships and concern expressed when they fail.

Such relationships should provide myriad centers of resistance to the spread of HIV/AIDS, with regular sexual partners—whether in a marriage
or not—seeking to protect each other from infection, and with parents preparing children for a world in which HIV and AIDS is ever present. Yet in the experience of most peer educators, this is far from what happened within families. Often, rather than protecting family members from AIDS, the emphasis within families was to keep members ignorant about AIDS.

This was especially so when the disease was close to home. Thus, a number of peer educators explained how after company training on HIV/AIDS they had come to realize that family members had in fact died of AIDS but that this had been denied and disguised. As Ntokozo Ndlovo, a peer educator in the financial institution explained, “I had one of my cousins [who died of AIDS], all the signs were there. My mother is a nursing sister [professional nurse]...my mother knew what was wrong, but she kept on saying it was something else, not this [HIV/AIDS].” Public denial of AIDS is widespread, and this silence extends into the most intimate of family spaces. Tlouane in the mining company recorded in her diary how, during a visit to a sick teacher whom she knew, she discovered that the teacher was attempting to hide her HIV-positive status from her daughter.

I understood that Edna [the teacher] was not well for some time. I then went to check her at her place. She then told me that the doctor said its “gripe.” When I [had to] leave, her daughter, Mpuse, volunteered to take me half way [accompany her part of the way back home; a common politeness in African cultures]. On the way, she told me that she saw ART [antiretroviral drugs] in her mother’s bedroom when she was busy cleaning it, but her mother never told her about that. Mpuse said Edna was hiding the treatment, saying the doctor said she had gripe. She was so upset because her father passed away in 2002, and she is the only child.

Tlouane also recorded a more dramatic betrayal of family relationships in which a husband had been hiding his HIV-positive status from his wife. In a diary entry, entitled “Playing innocent but dangerous within the family,” Tlouane recorded her visit to a hospital where Bongi, the husband of Mando, had been admitted.

Bongi was a man aged forty-one [who] lived with his family for ten years. He was a hard worker, and also treated his family with honor and respect. The amazing thing was that he never told his wife, friends, nor his family
that he was HIV-positive. He took the treatment and even the diet secretly. As time went by he became tempted, no longer taking treatment as usual as he thought he was 100 percent fit. The sickness struck him like lightning [and] he ended up being admitted in hospital diagnosed [as] a long-term HIV patient who failed to stick to the treatment…

His wife, Mando, [had] only [just] realized that he was HIV-positive. Her husband felt so ashamed and asked for forgiveness. Bongi also said to his wife that he was aware that he acted so humble and innocently to his whole family while dangerous within them.

Commenting on this account of how Bongi had maintained a deceit within the intimate sphere of the couple and family, Tlouane pointed to the gap between expected family relationships and what had happened. “Bongi was not supposed to hide his HIV status from his wife or family especially. Because they are the first ones who are expected to support him.”

Any explanation of why a man hides his HIV-positive status from his wife or a mother’s from her daughter underlines the extent to which HIV and AIDS remain stigmatized. Appreciating this is critical in understanding how someone might “play innocent but dangerous within the family.” But this only shows one side of a coin; there remains the need to understand why the supposed intimate relationships of family frequently fold so completely in the face of HIV and AIDS.

One explanation focuses on aberrations from the family ideal: adultery, married men using sex workers, rape, child sexual abuse, sugar daddies, and so on. Answers incorporating deviations from idealized relationships are easy to construct. They feed off a number of social narratives: moral breakdown in South African society, which can be projected from a Christian standpoint or a traditionalist world view; the detrimental effects of poverty on peoples’ ability to control their lives, and the subordination of women within South African society. There is frequently juggling among proponents of particular explanations as to the relative weight of these factors and often consensus building around particular social pathologies to which all can agree. For example, the sex worker who is forced to accept risky sex from a married man because she needs the money and cannot turn down his demand for sex without a condom—a scenario that neatly incorporates moral, economic, and gender perspectives. Such deviations from an idealized set of family relationships are responsible for HIV transmission. However, this pathologizing approach to the problem all too
easily sets up a cast of villains and innocents that is emotionally satisfying but distracting. The more mendacious the plot, the further it becomes removed from problems that lie at the heart of a “normal” family (Baylies and Bujra 2000) and the belief that (normal) families constitute an intimate backstage social space.

Eilsa Sobo’s (1995) research among poor African-American women stresses how they employ interlocked narratives to convince themselves that they are in a faithful relationship. The first is a Monogamy Narrative, in which their partner is seen as being faithful to them despite other women’s men being unfaithful; the second is the Wisdom Narrative, in which they regard themselves as astute judges of their partners, which has enabled them to select a partner who will be faithful. The use of condoms within a relationship negates both these narratives: “Because condoms are associated with infidelity and deceptive behaviour, using them implies that partners do not truly care for one another” (137). The rupture of these narratives in the face of undeniable evidence to the contrary, such as being tested positive for HIV despite themselves being faithful, leads, in Sobo’s view, to a third narrative, Betrayal, in which it is retrospectively determined that their partner must never have really loved them.

What Sobo describes is not an intimate backstage space that a couple share together. Rather, the relationship is one in which individuals separately construct “intimacy,” which is confirmed not with their partner but by symbols—such as not using condoms. This is intimacy by proxy, rather than being truly oneself with another.

This understanding of how intimacy is achieved through the symbolic abandonment of condoms without direct communication between partners was one that South African peer educators are familiar with. In explaining why she thought people continued to be infected with HIV, Rachel Baloyi in Finco explained, drawing on her own experiences as well as more broad generalizations, that part of the problem was,

The way we conduct our relationships. Unfortunately, we [start a] relationship and we come to a point where we feel comfortable and you think you know somebody… Maybe [we’re] not communicating enough in a relationship, because I feel if we are going to be in a relationship and decide that we’re not going to use condoms we need some commitment from both parties. And it’s probably because people don’t even think of sitting down and
discussing about such things...Ja, people being comfortable, you know, you reach that stage. “I’ve been going out with him for six months...I know him.” And you feel comfortable and you think it’s the right time, without even discussing it with him, you know? And it’s something that you wake up one day and guess what? We forgot to use one [a condom]...why should we use it the next day? And it becomes a pattern.

In Mineco, Karabo Semenya, made a similar observation, also drawing on her own experience.

From my personal point of view, when you are going out with a person, at first you use a condom, and you use a condom, and you use a condom, and then once you get used to the person and everything [clicks her fingers] just happens so quickly and you just forget the condoms, you just do whatever. And you think, because I was with this person for this long period, I think we trust each other now, not to play around...It just happens. Like you have to do something, and it just happens...So, if like um, for example, let me talk about me. I used to go with my boyfriends. And like, there were times when you would think, “Oh, you are stranded and you have to do something,” [laughs briefly] and there are no condoms around, but it just happens. [But with your boyfriend,] you come to trust him. You give your life to him. You think that, “Okay. This is the person I want to be with. Why should I not trust him?”

A key point made in these two accounts is that intimacy within a couple is achieved in silence with discontinuing condom use. Doubts are overcome, not through discussion and agreement, but through one-sided narratives that use symbols rather than communication for verification. This form of intimacy between two people, far from reducing risk through open talk about the dangers that unprotected sex might bring, introduces risk because unprotected sex becomes the foundation of the couple’s intimacy.

Given this, attempts to talk openly within close relationships about the risk of HIV infection may well break implicit understandings on which backstage family order is based, including acceptance of unequal power between men and women. Janet Bujra (2006, 5) argues that “[t]he micro-politics of sexuality reflects a strategic conjuncture of power struggles at more macro levels...AIDS emerges as a terrible threat to existing patterns
of sexual behaviour and expression of sexuality, it is also a threat to power relations because the rules no longer apply.”

Bujra’s point here is to demonstrate how sexual behavior for couples is determined by a broader set of gender-biased rules governing what is acceptable. Because these rules are not effective in protecting against HIV infection, both men and women are threatened at a biological level, but a response in which women question the status quo, starting with the micro-politics of their own sexual relationships, threatens the wider social rules of gender relationships. Tlouane’s report on a women’s meeting at her church touches on how women are constrained in what they can initiate with their husbands.

We as Christian Women’s League decided to spend the day at the church to share ideas and information about HIV/AIDS. The league’s chairperson, Sibongile . . . made us aware of the [actions] of our husbands, especially [those] who have extra [marital] affairs. She said that married [women] are the most at risk…. What Sibongile was saying is true, because a women cannot tell the husband all of a sudden that he must use a condom because he can turn things and say you slept around.

Here, even when the dangers within intimate relationships is publicly, and collectively, recognized, doing something about it drops back from the public, to the private, and the man can retaliate, invoking public norms in which the idea of a women sleeping around brings shame and sanctions. However, we need to take care before reverting to the idea of relationships in which women lack agency because of wider, socially constructed, rules. Tlouane, in an interview, talked about an incident in which she had first asked, and then confronted, a group of Xhosa male colleagues over the value of circumcision. In most, but not all, African ethnic groups in South Africa, ritualized circumcision is regarded as an important right of passage into manhood. Generally this is prepared for over a period of weeks or months at initiation schools in which boys are isolated from the rest of their community before the process culminates in circumcision.

I don’t know the reason why do they attend circumcision school. That’s why I wanted to know from them. There are always the Xhosa’s…they do this circumcision stuff…So I wanted to know from them, “Why?” …Some
said, “If you aren’t from the circumcision school, they don’t allow you to marry. Because you are not a real man.” . . . and then I disagree.

I said to them “Most of you are from the school. That school, neh? What are you doing now? You left your wives at home [referring to Xhosas from the Eastern Cape]. You are not supporting [them]. You don’t respect your wife. You’ve got nyatsis [girlfriends] here. So, what is the use of that circumcision school? You are not real men.” . . . I told them straight, “What’s the use of going there because you don’t respect your wives, neh . . . You don’t give them money. You are not a real man. ‘Eh-eh [No], you don’t support your family. A real man supports his family…. There’s no good relationship between yourself and the wife. Because there’s no commitment. There’s no honesty. There’s no whatever. You lack so many things. But you are from circumcision school.”

Here the power of a socially assumed set of values—that circumcision confers manhood—is challenged. Tlouane, who had “chased away” the father of her daughter because he didn’t support their child, points to the need for men to provide for wives and also to the lack of honesty within their relationships. Working in the company’s HR department, she frequently witnessed the breakdown of these social relationships, with abandoned wives arriving at her office to complain that remittances from migrant husbands had ceased. Like Tlouane, a number of women peer educators had, despite social constraints, engaged the micropolitics of their own relationships. Baloyi in Finco explained how confronted with incontrovertible proof that her husband had been unfaithful without using protection (a child outside of their marriage), she had forced the use of condoms.

You know. I was married and I chose not to use any contraceptives so that I can use a condom with my husband because I have seen that he is capable of being unfaithful. And it was a choice, in a marriage, I had to make. And I did it…. And you know, it’s not something that he denied. When I confronted him about it, he said, “Yes, there were no condoms for the day.” Not even to say that something went wrong with the condom. There weren’t condoms…. So, that’s when I said I’m putting a stop to this.

But while these circumstances, in which her partner was caught acting recklessly, enabled her to introduce condoms into the relationship, she
recognized that for others similar action would not be easy. “How do you just come one day in the house and say ‘Love, I want us to use condoms’ if there aren’t any signs [of him being unfaithful]? If he asks you why, what will be your defense?” When I asked Baloyi if she though any man could be trusted in a relationship, she responded at first softly and then with increasing emphasis: “No. Much as no woman can be trusted. We tend to push everything onto men, but you still get unfaithful women. Unfortunately, we [women] are too clever. When we cheat, we do it right! [Laughter] Especially now [with HIV/AIDS]. It’s everyone for himself. Everyone for himself and God for us. So, if you’re going to say, ‘I trust you with my life,’ guess what? You’ll be down six feet!”

She concluded this point by asserting that, in responding to AIDS, “The battle will be in marriage.” But what this battle consists of can take two distinct forms. One, that Baloyi and some other peer educators took, was to win the “war of risk” by separating from their partner-cum-potential-death-sentence. Among the 598 peer educators who reported on their marital status in the 2005 survey, 11.4 percent of women were divorced (Table 8 in Appendix 1), compared to 3.5 percent of women (15 years and over) nationally (Statistics South Africa 2004). In being able to take such decisive action, female peer educators probably represent a more empowered group, both because of their self-selection and correlated leadership qualities and, at least in part, because of training that not infrequently stressed the importance of looking after oneself.

Peer education training often reinforced individual responsibility, sometimes quite starkly. In an observed training exercise, peer educators were told to imagine they were on a sinking ship with only one lifeboat that could not save everyone. First, participants were required to make a short speech to justify why they should have one of the limited places, and then they cast three votes, in secret, for who should get in the lifeboat. In fact, the votes were never counted; instead, the organizers asked who had voted for themselves. The few who admitted to doing so were praised; those who hadn’t were chastised: “You have to look after yourself first because you can’t trust other people without trusting yourself. You can help the community when you know how to help yourselves. It’s important to look after ourselves.” This message was focused specifically on the risk of being infected with HIV in a relationship, but at a deeper level clearly encouraged individual agency.
The limitations on what people, women especially, could do in relationships was however widely recognized. Reflecting on the lifeboat exercise, a nursing sister who coordinated a regional grouping of peer educators in Finco explained how peer educators might recognize their own situation as ones that put them at risk, but that confronting this would not be easy:

When I did the [lifeboat] exercise, I thought “Shit! I’d like to be on the boat,” but I never put myself on the boat. And that’s wrong. We’re wanting women to be empowered, but we are not showing them how disempowered they allow themselves to be…. It also made me realize it’s OK to make choices for myself. In my interests. OK. I’m sorry Tommy, you’re not going on the boat, but actually I want to be there… And it was a good penny drop [realization] for a lot of women…. They [the peer educators] got it. They got it. A lot of them got it loud and clear. But a lot of them I could see they could never change. Because they are caught in their whole way of life, whether it’s for religious or cultural reasons. But they could never change it. Or they would have to wise up on how they would change it if they can’t do it bulldozing [i.e. forcefully].

Some peer educators had left partners because the “penny had dropped” and because they had the courage and resources to follow through. In a couple of cases, this was attributed in part to their peer educator training. Others, like Tlouane, had left their partners before AIDS was a threat but for similar reasons of male unreliability that they had been unable to rectify within their relationships. For Nicol Manuel in Autostar, the lesson about needing to take no nonsense from men in a relationship had been learned from her mother, who had demanded that her husband leave because he was a joller (someone who enjoyed partying). “He used to go out and enjoy himself, he used to drink and he used to come back and fight.” Although Nicol had a boyfriend, she pointed out that, “One thing that my mother taught me is that as a lady, an independent woman, you don’t need to have a man in your life really because at the end of the day, if you’re going to stick a man’s nonsense, it can cause you to maybe lose your life.” This point had been tragically underlined shortly before I interviewed Nicol.

I count that [her mother separating from her father] as a blessing. It was hard for us growing up with a single parent, but at the end of the day it paid
out because...on the eleventh of July [three weeks before the interview], my birthday, I spent half my day, from about two o’clock to six o’clock at the hospital with my father. I had to go and give him a bath and change him and feed him because he had thrush all over his throat and everything...he was really bad, and the nurses wanted my mother’s consent to take blood tests and, obviously, he was [HIV] positive [and died a few days later]...

So, as I was saying, I believe...that it was a blessing in disguise that he had to go because obviously if my mother stuck his nonsense, she’d have been infected...you know, um, he was the man. He could have done what he wanted to do and then still come back home, and my mother was, like, in a situation where she had to play the wife’s role there, you know, wives have to sleep with their husbands...So, I believe that he would have definitely infected my mother and I would also have to be burying my mother, so I’m happy in a way, that she stood up for what was right.

But this ability to take control of their lives, and protect themselves from HIV infection, by doing without partners was not open to the majority. Louise Rasool, a female peer educator in Bestbuyco, explained how the women approached her for advice because their male partners were beating them or having affairs. She concluded that the most important thing she could do was help them stay HIV-negative even though they would most likely remain in an abusive relationship. “It’s not easy to have him arrested or leave him because it happens to a lot of women and people have lived and stayed with men that are abusive for years and years and years. So you can’t just tell somebody to leave her husband or go and have him arrested, you have to try and get better solutions that will suit her.”

These better solutions, of smarting up to the danger of HIV infections within risky relationships, are explored in Chapter 5. For the moment, and in summary, peer educators sought generally not to undermine these relationships, but to support those within them; even when, as frequently was the case, there was little if any prospect for direct communication around sex and the risk of HIV infection as the result of one, or both, partners being unfaithful.

The central point of this section has been to establish that the social space of the family, and the couple in particular, is not a relaxed backstage social space in which communication between peers, albeit of different genders, is frank, relaxed, and straightforward. This is not a surprise; Goffman flagged gender as an exception to the backstage dropping of
performances. Within the context of AIDS, however, it takes on added significance. Putting on performances in a relationship is likely to put you six feet under.

That performances are maintained in the backstage space of relationships is in part because of the privileges that, as Bujra points out, wider social values afford to men within their relationships. Speaking frankly about these would openly expose gender inequality and undermine them. Not surprisingly there is resistance to this from men and, given potential sanctions, reluctance on the part of women to challenge them. But women also maintain performances and, as Sobo outlines, play themselves into these roles.

Getting yourself out of these performances—of intimate sex without intimate knowledge—is not easy. As grassroots leaders a number of peer educators had taken direct personal action: closing down the show through separation or divorce. Peer educators recognized that this was not possible for many women, but that the threat of HIV infection required that something be done without the relationship itself being directly challenged. Neither of these responses fundamentally changes the sexual partnerships of backstage space nor the supposed intimacy of families that often remains a no-go zone for frank talk about HIV and AIDS.

Race: Similarity Undermining Credibility

In contrast to gender divisions that permeate most backstage spaces, race in South Africa still approximates to homogeneous backstage spaces. Frontstage industrial relations encounters are between different races, as well as classes. This picture is complicated by South Africa’s four racial categories: African, colored, Indian, and white (see Chapter 1). Upward mobility of blacks (Africans, coloreds, and Indians), accelerating under post-apartheid affirmative action legislation, means that this situation is far from static, but racial division across the industrial divide remains. In the five companies researched during 2005, whites dominate management positions, while blacks, particularly Africans, constitute the bulk of lower-skilled workers (Table 9 in Appendix 1).

Depending on companies’ location, the absence of significant numbers of coloreds and Indians in the workplace can simplify this situation to a
stark contrast between white managers and African workers; this was the case in Mineco, which was included in the 2005 research and was also the company researched in 2006. Over 93 percent of Mineco’s top and senior management was white, as was 85 percent of middle management. Africans made up 97 percent of semi-skilled, and 98 percent of unskilled workers (Table 10 in Appendix 1).

The salience afforded to race within South Africa powerfully projects similarity within, and difference between, racial categories. Despite the importance of “subsidiary” identities such as ethnicity, race provides an apparently clear-cut advantage for peer educators seeking to change behavior. White peer educators should be recruited to work with their white peers, while African peer educators should work with other Africans. However, there was not a proportional racial balance between company employees and peer educators. In the five researched companies, 82 percent of employees were black (African, Indian, or colored), but among peer educators the percentage was 92 percent. Whites composed 18 percent of employees, but only 8 percent of peer educators (Table 11 in Appendix 1). In Mineco, with its simpler and starker racial divisions, Africans made up 87 percent of employees but 93 percent of peer educators; whites 13 percent of employees but only 6 percent of peer educators (Table 12 in Appendix 1).

Thus, blacks are overrepresented, and whites, although not absent, are underrepresented (and few in number) as peer educators. In the mining company, with few coloreds and Indian employees, a simpler picture emerged in which Africans are overrepresented as peer educators, by 7.4 percent, and whites underrepresented, by 56 percent. What this should mean is that whites with a lower number of peer educators are subject to less peer communication on HIV and AIDS, but that Africans are better catered for with racially similar peer educators. At a statistical level this is true. But to see this double imbalance—in the racial structuring of the workplace and in the racial profile of peer educators—as unproblematic for African peer educators working with their African peers is mistaken. This section examines how the skewed racial composition of peer educators creates barriers to African peer educators within their racially homogeneous backstages spaces.

Data demonstrating an objective underrepresentation of white peer educators confirms what peer educators already knew from their own experiences. In a meeting of peer educators at Autocircle, the racial composition
could not be overlooked: all twenty-five peer educators were African, as were the company’s peer educator coordinator and the nursing sister attending the meeting. During a discussion on the need to have peer educators drawn from all levels of the company, one of the peer educators commented in open session that, “The peer education program is too black, it says hourly [paid workers].” In meetings of the Mineco group, again exclusively African in composition, this acknowledgment of a racial division of peer education was thinly coded as the “us and them issue” to which discussions not infrequently circled back.

Sometimes perceptions trumped objective evaluation of whites’ role in company peer education programs. Thus, at one of Mineco’s operations, a young African woman complained bitterly that there were no white peer educators. Yet that same day I interviewed a white man who had been an active peer educator at the site for six years. Nevertheless, despite sometimes overstated perceptions, the reality of a racial division of concern within companies around AIDS was evident. In Bestbuyco, Abraham Kgaba, an African who had been a peer educator for three years, talked about the lack of interest whites showed in their activity.

In the [HIV/AIDS] talks that I have given I only saw one white person. And it hurts me a lot. Because even in the [company HIV/AIDS] booklet itself there’s a questionnaire where it says, “Do we think that HIV is for blacks or for whites?” The majority in the talks are blacks and we only see one white. They [whites] don’t want to attend because they believe it is [our problem]. I’ve complained about it, but you don’t even get the support of the [white] GM [store’s general manager]. We’ve now got a new GM, it’s almost a year and a half [that he’s been at the store], he’s never asked me as a Peer Educator what problems do I have, how can he assist me…It’s the same [with, also white] Human Resource [management]. They have never asked us [what we are doing], they don’t even attend. Not even to come and monitor what we do.

In Finco, Sibongile Muthwa, an African woman, explained how she felt when selected to attend training to become a peer educator as the only black person in her branch. “I was very uncomfortable when they nominated me [to be a peer educator] when I was in Richmond [branch]…[A]t that time I was the only black person there. And at the time of nomination I thought I was nominated because of my color and my [pause] and there’s
a stigma [pause] you know, with HIV [pause] black people.” Nevertheless, she had attended the training and, as a result, had her own concerns about the racial profile of the disease addressed. “After attending the course, I didn’t want to look at it [HIV/AIDS] as a color disease. I didn’t want to see it as a black or a white person’s disease. I looked at it as a disease out there and it affects everyone. No matter the color.”

However, when Muthwa got back from training it was clear to her that, while the branch needed to have a peer educator, because of instructions from Head Office, they didn’t want peer education. “Within the workplace people still feel that it’s a black disease. It’s your problem. You’re black. You need to deal with it. [Attitudes] are still there. I requested that they give me a slot to give a talk [to colleagues], but it was very difficult for them to give me [time]. It was like, ‘Who do you want to speak to here? Everyone is safe.’”

Where unions were racially mixed, a similar understanding of the epidemic was evident. Thus, in response to my questioning as to why white shop stewards were not peer educators, a union official of one mixed-race white-collar union in Mineco explained that problems around HIV/AIDS among the membership were confined to the few Africans members of the union. In a matter-of-fact way, he went on to observe that the union’s one African shop steward dealt with any AIDS issues. Moreover, he added that white shop stewards steered clear of peer education because it would, they felt, mean interacting with Africans.

The view that AIDS is a problem for Africans and not for whites is not without basis. There are stark differences in HIV prevalence levels between races, with Africans statistically far more likely to be infected than whites (see Chapter 1). But, irrespective of this, a racially skewed response in the workplace creates a number of problems. Whites’ disinterest over AIDS threatens to re-racialize South African workplaces at the very time that attempts, albeit often sluggish, are being made to overcome apartheid divisions. Additionally, since the trajectory of the epidemic is still unknown, the possibility that HIV will bridge groups and equalize racial prevalence levels cannot be discounted. Such a possibility will be more likely if whites continue to maintain psychological distance from the epidemic as an African problem, which an absence of white peer educators facilitates. As one member of Autocircle’s all-African peer educator meeting noted, “A group like this feeds the view that it [HIV/AIDS] is a black problem.”
Less obvious, but critical to understanding the contested nature of back-
stage social space around HIV/AIDS, is the impact that this racialized re-
response to the epidemic has on the ability of African peer educators to bring
about behavioral change among their African peers. Within South Africa’s
black population there continues to circulate folk theories that HIV is a bio-
logical weapon whites use to control the black population. A lack of con-
cern on the part of whites about AIDS serves to support such theories. So,
too, does a history of white attempts to limit black fertility in South Africa
(Schneider and Fassin 2002; Stadler 2003; Webb 1997) and the Truth and
Reconciliation Commission’s revelations that an apartheid security pro-
gram led by Dr. Wouter Basson investigated the use of biological weapons
that would target blacks (Niehaus and Jonsson 2005; Washington 2007). In
hearings of the Truth and Reconciliation Commission, it was established
that while the front companies used by Basson developed a wide range of
chemical and biological weapons, these did not include HIV. In 2002, Bas-
son went on trial for seventy-six charges including murder and fraud. The
trial collapsed, but in 2005 the Constitution Court ruled that a retrial could
proceed. To date this has not happened.

Genocide-linked beliefs around AIDS are not confined to South Af-
rica. In a study of 520 black American adults, 27 percent “endorsed the
view that HIV is an artificially created virus designed by the federal gov-
ernment to exterminate the black population” (Klonoff and Landrine
Americans found belief in AIDS as a form of genocide against blacks to
be held by 15 percent of respondents. Sobo (1995) describes a range of
conspiracy theories present in African-American and Latino communi-
ties in the United States in which AIDS is seen to be a form of germ war-
fare waged against blacks. The U.S. equivalent to Basson’s germ warfare
program is the Tuskegee Syphilis Study (in which treatment was with-
held from poor black participants) that discredits white scientists by link-
ing them to the oppression of blacks. Such theories, which resonate with
personal experience of racism, provide a psychological defense mechanism
against the collective stigma that racially concentrated HIV prevalence
creates.

In South Africa, such theories are located within the context of the
apartheid regime’s war against the liberation movement, white control of
scientific knowledge, racial voting patterns, and majority rule following
the 1994 elections. They also counter Western medical explanations of the
disease and prevention messages based on this understanding. Much of
this is concisely captured in a diary entry by Moses Direko, a peer educa-
tor in Mineco, when explaining why he thought peers had incorrect in-
formation on HIV/AIDS. “Most of the people they ask me about HIV
and AIDS. They ask, ‘Where does this come from? Because before there
was no HIV and AIDS.’ [They say,) ‘This disease comes from those white
people. They put injection into us black people because we get more ba-
bies every year. When we vote, black people pass [win] because we are
many.’”

Dr. Basson not infrequently makes an appearance in these theories
around the origins of AIDS. Mokwena also at Mineco recorded the com-
ments of an African teacher during a discussion on a court case in Libya
where a number of health professionals were on trial accused of infecting
children with HIV. ‘Pule [the teacher] said, ‘The nurses and other health
workers are puppets of evil doers.’ ‘How?’ [I asked her] ‘Doctor Basson,’
[she replied] ‘infected soldiers with HIV and gave them money to sleep
with black women, because they [whites] want to kill us and be able to win
the elections.’”

Explanations as to how a white minority might want to use AIDS to con-
trol the majority black population can be expanded onto a global scale—
with the racial dimension scaled up so that AIDS is viewed as a weapon
of more powerful (white) countries to dominate developing (black) coun-
tries. Kgaba, in Bestbuyco, explained that prior to seeing people die of
AIDS, he had assumed that it was something thought up to prevent Afri-
cans from having more children. “I always had the impression of Amer-
ica specifically not wanting Africa to grow. [So] I took the abbreviation of
AIDS as an American Invention to Discourage Sex.” He then went on to
note that many people may continue to think like this because death cer-
tificates in South Africa do not record the cause of death as AIDS. Sam
Mangala, a peer educator in Mineco, suggested that the nature of the dis-
ease supported the idea that it was a deliberate plan to control developing
countries.

HIV/AIDS is killing . . . [so] how are we going to stand on our own as a na-
tion? Because we need to grow and when we grow we need our offspring . . . to
take us forward and to compete with other nations . . . And another question
is that, I understand, yes, the virus keeps on changing [. . .] that’s where our people become doubtful of this changing. So, isn’t this a biological [war] issue? A biological disease that’s been created by some scientists who are now trying to rule the world? [. . .] Isn’t this type of virus coming along with the intellectual status [knowledge] of various [developed] nations? Because here it looks like a chess [game] to manipulate other countries, you know, because the more you’ve got knowledge of controlling that virus, the more powerful you become and then the nation with lesser knowledge of controlling that type of disease will remain subjugated to the one who has got more knowledge.

These accounts of how white scientists and doctors are using AIDS to control the African population, by reducing the birth rate through the use of condoms or by killing Africans though the use of AIDS as a biological weapon, utilize a range of explanations of how HIV is transmitted. In the teacher’s account, there is a combination of injecting the virus and sexual transmission. Other accounts dislocated this white-induced disease from sex, with white doctors simply injecting the virus into their black patients, “Some people believe that white South Africans are injecting the virus purposefully. And they are not consulting white doctors when they are sick.” In other versions, the Western medical explanation of how condoms prevent the virus being sexually transmitted is turned on its head: condoms are the mechanism that transmits HIV as the virus is deliberately put into them. A common detail of this explanation of how whites infect blacks with HIV-laced condoms is that if you pour hot water into a condom, you can see worms that are responsible for infection.

The details of alternative transmission mechanisms form technical elaborations to the core, racial, hypothesis at the heart of these genocidal explanations of HIV/AIDS. These elaborations buttress the central argument because, in themselves, they can often be verified: if you put hot water into a condom you can (just) make out the alleged worms (i.e., dissolving lubricant). However, the real power of these explanations lies not in how subsidiary hypothesis support the core argument, but the extent to which this core idea resonates with audiences. In this respect, racialized explanations of AIDS often find fertile ground given South Africa’s apartheid past and legacy.

A peer educator in the mining company detailed in his diary how a white doctor at a private hospital conducted an HIV test on his daughter
without consent from him or his wife. Having remonstrated with a nurse that this was unprofessional conduct, he suggested that they not tell his wife that they had conducted an HIV test without permission. Unfortunately, the doctor took it upon himself to ring and apologize, but then compounded the situation when he gave the child’s negative test result—no doubt assuming this would calm the situation—over the telephone. The peer educator’s wife had exploded in anger, hung up, and refused to collect the medicines that the doctor had prescribed for their daughter’s actual complaint saying, “It is true that doctors can infect people with HIV.” Talking about this incident later, the peer educator explained that, “She’s not accusing all the white doctors, [but] because of some of his attitude and the way he handled things she become very angry and very bitter. … It boils to something. Bad memories come from the past.”

Thus, historic inequalities as well as current behavior support racial AIDS theories. Within workforces in which whites continue to dominate higher positions, inequality and behavior meld, and it is an easy step to see why company AIDS programs are viewed as a managerial cover to hide true actions. As a result AIDS program protagonists, in the form of peer educators, are viewed with skepticism. Mokwena in the mining company explained,

The attitude or the actions of the whites in the company makes people believe that those perceptions [of whites using AIDS to kill blacks] are correct. [And] what we [peer educators] believe and what we are saying is wrong. [They say] “They [management] have brainwashed you; you are one of them. You want us to believe [you] but why don’t you have white peer educators in your group?” So, in fact now it’s very difficult for us as peer educators to convince them.

In this situation, the racial homogeneity of peer educators, far from being an advantage in communicating with peers, becomes a disadvantage. That there are no white peer educators, or at least no white peer educators visible to the majority of employees and their families, raises questions in an environment where racial division and inequality remains salient. Racial similarity between peers, given a configuration of meaning around AIDS that draws on race and the conflict between races, can, paradoxically, discredit peer educators.

Racial explanations of HIV/AIDS do not constitute a unified entity. Rather, they circulate in a range of contradictory theories: that AIDS is a
fiction propagated to prevent the African population multiplying, that it is
germ warfare waged by whites on blacks and/or to dominate developing
countries, that whites do not see themselves at risk of infection and do not
care that blacks die, and that HIV/AIDS programs are to implement man-
agement’s agenda. Nevertheless, any one of these theories may, in itself, be
well constructed with a range of buttressing arguments and observations.

That different racial understandings of HIV/AIDS may be contradic-
tory is probably of little practical importance and certainly unlikely to win
many arguments. More important is the platform that racism, both as a
historical legacy and as continued practices, provides for these arguments.
For Africans who have experienced generations of discrimination and
continue to live and work in segregated environments, any theory rooted
in this understanding has a dramatic head start to the racially neutral ex-
planations of Western science.

Racially rooted theories derive their power not only from explicit rec-
ognition of the racism that pervades the lives of many South Africans. Be-
cause they provide an alternative explanation of HIV/AIDS to Western
medical science, they can be used to defend and justify actions that are de-
sirable but threatened by the recommendations of biomedical doctors and
AIDS specialists. At a broad level, as Paul Farmer (1990) argues, conspir-
acy theories provide a rhetorical defense for people with little power. To
the extent that AIDS, a sexually transmitted disease, is portrayed as a dis-
ease of blacks and Africans in particular then racial explanations of whites
deliberately infecting blacks provides a defense of African identity. When
it is believed that infection results from the use of condom, then racial the-
ories have the additional advantage of justifying more pleasurable and in-
timate unprotected sex (Bogart and Thornburn 2005). Similarly, when
racial theories incorporate medical personnel directly introducing infec-
tion, avoiding injections by white doctors is an easier prevention strategy
to follow than abstinence, being faithful, or using condoms.

For men at least, there is the further attraction that subscription to some
form of racial explanation of HIV/AIDS maintains their privileged gen-
der position. As described in the previous section, gender roles and power
can remain unchallenged if the problem lies not in sexual behavior and
gender relationships but in the malevolence of whites. Here we see how
two domains of identity—gender and race—can interlock to create a more
entrenched set of beliefs. In this case, the belief that AIDS is a disease
inflicted on blacks by whites not only provides a defense of the dignity of blacks but also continues gender privileges along with a license to have unprotected sex.

**African Traditional and Spiritual Healing: Competing Cosmologies**

Belief in African traditional and spiritual healing marks differences and tensions within backstage social spaces that, from the outside, are often invisible. This section explores traditional and spiritual healing and its alternative messages to Western medical science around HIV/AIDS. In doing so, we further add to the picture of how backstage social space is divided and difficult terrain for peer educators to operate within.

Belief in traditional and spiritual healing presents across social space differently from either gender or race. On the side of, largely white, management there are few believers in African traditional healers. This is a result of different cultural beliefs (though this does not mean that whites do not put faith in other alternative or complementary healing), but it is also emphasized by Africans’ realization—whichever side of the industrial divide they might be on—that belief in traditional and spiritual healing is not acceptable when whites are present. As a result, Africans entering into white-dominated management structures keep any views on healing to themselves. This further obscures management’s collective understanding of healing practices. To Africans, however, traditional and spiritual healing is visible because, rooted in their own communities, they know who is involved and how it operates. But this knowledge does not mean that there is uniformity of belief. Far from it: Within the African population, intense, often complex differences exist between peers on this issue.

**African Traditional and Spiritual Healing**

*African traditional healing* refers to indigenous practices linked to an African cosmology, while *spiritual healing* refers here to the practices of African churches that, additionally, draw on an introduced Christian cosmology. This section links traditional and spiritual healing and treats them, in
regard to peer education in backstage social space, as essentially similar. Many practitioners in either healing form regard themselves as different from each other; indeed, some see themselves locked in conflict with each other. But, I argue here that it is the locking together of their cosmologies, albeit it sometimes conflictual, along with similar processes of diagnosis (or divination) and, often, treatment, that allows us to treat them as similar phenomena.

The extent of belief in African traditional healing is unclear. In its 2005 questionnaire of 16,000 South Africans over the age of fifteen the Human Sciences Research Council (HSRC) asked where they usually went for healthcare. Only around 1 percent said that they went to traditional healers. By contrast, the Department of Health (2003b) estimates, it is not clear how, that there are 200,000 traditional healers in South Africa. Clearly one—or both—figures are misleading. If they are both accurate, each traditional healer would have an average practice size of just 2.3 patients, yet observations of township-based traditional healers not infrequently reveal a steady stream of clients coming for consultations. One problem with the HSRC survey is that it did not allow for medical pluralism with both traditional and Western or allopathic medicine consulted. Additionally, the use of nursing sisters to administer the HSRC’s questionnaire no doubt influenced responses since the use of traditional healers is not something that Africans will readily admit to when dealing with someone that forms part of the Western medical establishment. (The same survey reported that over 80 percent of African’s claimed not to drink any alcohol, a finding that can only be described as incredulous. By contrast, whites, responding to the same question, appeared to be more truthful, but also knew how to “correctly” respond; just under 40 percent claimed to be abstainers, while over 50 percent gave responses that put them in the low-risk drinkers’ category.) The World Health Organization (2002) estimates that up to 80 percent of Africa’s population makes use of traditional healers; for many people it is the only health system available to them. South Africa, with its greater level of economic development and relatively large non-African population, almost certainly comes in under this level: though what it is is impossible to know.

Traditional healing represents indigenous knowledge. Such knowledge is often far from welcome in colonized and divided societies because it provides an alternative power source. Within a colonized society, indigenous
knowledge systems are typically suppressed, but do not disappear (Mam-
dani 1996). Within divided societies alternative world views coexist but
rarely come into open conflict (Scott 1990). As Max Gluckman (1956) points
out, increased tensions are likely to promote traditional responses to stress.
Far from disappearing, it may be that—though it is impossible to verify—
under the twin strains of mass unemployment and AIDS, for which offi-
cial responses are at best weak, that the use of traditional healing in South
Africa is increasing.

Not infrequently, interviews with African workers reveals that they
have some, often strong, beliefs in traditional healing. But typically these
are not immediately forthcoming, indeed they initially may be explicitly
denied only to be later reintroduced and expanded on, sometimes in depth,
when the researcher is able to indicate familiarity with and acceptance of
such practices. Thus, for example, when interviewing a shop steward who
was not a peer educator but had attended a number of course on HIV/
AIDS, it emerged, as the interview progressed, that he had been a tradi-
tional healer for nine years. He had, among the workforce from which he
drew most of his patients, five who had come to him because they were
HIV-positive (though he had his own parallel diagnosis to that of HIV),
and a sixth was due to come for an initial consultation the next day. De-
pending on the patient’s condition, his treatment might take up to two
years, and he needed the help of the company clinic’s (antiretroviral) medi-
cine, but unlike Western medicine he claimed to be able to completely cure
his clients of their “HIV.”

Appreciating how practitioners and users understand how these healing
practices work requires placing them within a traditional African cosmol-
ogy that operates very different logical systems to that of scientifi c inquiry.
To place this in perspective, we should note that few, if any, people any-
where in the world rely purely on scientifi c understandings in regard to
their own health; they also draw on a range of nonscientifi c practices, such
as prayer or positive attitude. However, given the composition of peer ed-
ucators and their peers, the focus here is on alternative beliefs among Afri-
cans, which draws on traditional African healing practices.

African culture covers a wide span of ideas, values, and beliefs. Some,
such as ubuntu, the philosophy that “a person is a person because of other
people,” are much more acceptable within contemporary South Africa than
others. David Hammond-Tooke (1989) identifi es South African traditional
healers, in line with writers describing traditional healers in other parts of Africa (e.g., Evans-Pritchard 1977), as part of the traditional African “world view” that includes a belief in ancestors, witches, and the polluting nature of certain objects and practices. These elements of the traditional African worldview constitute—as do all worldviews—an attempt to “make intellectual sense of the world and of life, so that in the broadest sense it involves theories of explanation” (Hammond-Tooke 1989, 33). Operating within this traditional worldview, African healers are often divided into diviners, who, though a range of rituals, such as “throwing the bones,” (see Chapter 1) establish the underlying cause of a person’s problem, and herbalists who specialize in treatment. In practice, apart from a small number of specialized herbalists, most traditional healers combine divination and treatment. Treatment includes rituals to allow the patient to communicate with disgruntled ancestors, holding appropriate cultural events that may have been neglected, protection against witchcraft, emotional empathy and support, and a range of herbal treatments to purify or protect individuals and property.

Healers, while constituting a distinct element of the traditional African worldview, are linked with its other elements. Thus, Hammond-Tooke (1989, 121) explains that traditional healers are often, “Highly respected, indeed an indispensable, member of traditional society, whose activities are closely linked to the benevolent ancestors and whose role is quite specifically [but not exclusively] that of combating the forces of evil [emanating from witches] that constantly threaten the lives and well-being of his patient.”

This articulation is now rooted within modern settings. Workers in manufacturing companies report that (always other) workers employ muti (usually a mixture of plant and animal substances) to gain favor with superiors so as to be promoted or to doctor their machines so that others cannot operate it with the same proficiency. In response, workers procure their own muti from traditional or spiritual healers that will counter any negative impact on themselves. This belief in measures and countermeasures means that, viewed from within, traditional healing, even when making specific claims, is impossible to prove or disprove (Evans-Pritchard 1977).

Alongside traditional African beliefs are more recently introduced religions, notably Christianity. As essentially rival cosmologies, they are competitors over the construction of meaning. However, the relationship
between traditional beliefs and Christianity is, in practice, complex. Although some churches take a strong oppositional position to traditional beliefs, individual church members may practice traditional beliefs in (concealed) defiance of church practice or with tacit acceptance on the part of other churches that this is not incompatible with membership. But there are also a large number of African churches that openly synchronize traditional and Christian beliefs and operate their own, parallel healing practices. In a simplified scheme, traditional African cosmology consists of the following: the ancestors, who are supportive when paid sufficient respect in terms of traditional rituals, slaughtering animals, and libations of beer; witches representing evil; and traditional healers who can help communicate with ancestors, counter the power of witches, and restore individual and community health. When synchronized with Christianity, supreme representations of good and evil (God and Satan) and prophets are added. Simplified, this cosmology links God to church prophets who are engaged in constant warfare with witches who operate under Satan. Traditional healers may, in secret, also be witches—since God and Satan can be at work in everybody. Ancestors continue to remain important and, indeed, may be your best bet in ascertaining whether a traditional healer, or even a church prophet, is really what they say they are and not also a witch.

Although members of these churches may see themselves as locked in a battle with evil, prophets combat witches in much the same way as traditional healers do. Divination processes are often different in form: typically traditional healers “throw the bones” while prophets use trance states, but both rely heavily on ancestral help. Treatment often follows similar ritualistic lines, though prophets emphasize simpler substances, such as water, ash, and tea, that have been blessed, while traditional healers use a vast array of plant, animal, and sometimes synthetic substances in their treatment mixtures. Since the real enemy of both traditional healers and prophets are witches (who may or may not be operating on behalf of Satan), then, although they may view each other as opponents, it is also possible for a person to openly combine both positions. Thus, since traditional and Christian cosmologies are synchronized around common beliefs and similar methods—something that applies to AIDS as well as other problems—we consider them as similar phenomena in regard to backstage beliefs and HIV/AIDS.
A second introduced belief that traditional beliefs engage with—though very differently—is Western medical science. In contrast to the more malleable beliefs of the Christian churches with the possibility of synchronization, Western medicine has refused to contemplate any role for traditional healing. Thus, the South African Medical Council successfully lobbied government for the closure of nonallopathic medical colleges in the 1960s (World Health Organization [WHO] 2001), and traditional healing is, aside from some weak voluntary associations, unregulated and without any systematic referral between the two systems. Indeed, traditional healers complain that when they do refer to clinics or doctors for problems they perceive to be beyond their competency, patients are frequently instructed not to return to them.

Essentially then, traditional healing and Western medicine represent rival healing systems in which the latter dominates publicly through an alliance with the state and employers, but the former privately retains considerable sway within large sections of the population. Despite being driven underground, traditional healing retains its influence because it is rooted within a wider cosmology that colonial institutions have not been able to dismantle. Thus, the term “traditional” in regard to an African worldview should not be seen as synonymous with “past” but as encapsulating a still-active worldview that can claim—for the African population—deeper and more legitimate roots than Western medicine offers. In addition to this cultural base, traditional healing can be superior to Western medicine in that traditional healers are more accessible to many South Africans and—unlike the majority of Western doctors—live within African communities and therefore understand the problems that Africans face.

Any examination of peer educator activity in backstage social space in regard to traditional healing and HIV/AIDS needs to consider not only the suppression of traditional healing, which creates on one side of South Africa’s industrial and social divide an inability to see these practices, but also sharp differences among Africans on the other side of this divide. Although reliable data on these differences is lacking, many African do not believe in traditional healing. Where these nonbelieving individuals are located in management structures or other white-dominated groups, such professed beliefs need to be treated with caution; however, the rejection of traditional healing is also present among Africans who work and live
Changing the Course of AIDS

alongside the majority of Africans. This rejection comes, most commonly, from religious beliefs where denominations take a strong line against traditional healing, but it can also come from atheism or any other philosophical structure that provides an alternative worldview to a traditional African cosmology. Thus, for example, one occupational nurse whom I interviewed explained how she had stopped using traditional healers herself because when studying psychology during her training she had realized that “prophets and healers are just another belief” and that the divination process of healers could be replicated by clever guesswork and suggestion. More generally, African nurses tend to express skepticism about the value of African traditional healing because they are allied to Western medicine through training and employment and because they see the problems (such as renal failure) caused by traditional treatments. Nevertheless, this rejection is usually specific to the efficacy of traditional healing, rather than a wholesale rejection of African cosmology. Few Africans would go so far as to deny the importance of ancestors and the value of holding traditional cultural events that honor their memory, even if they do not believe in their ability to actively influence the living. These individuals who understand traditional healing but do not believe in its efficacy could be viewed as a potential bridging group between traditional healing and Western medicine.

Yet despite the presence of these bridging groups, who understand but do not believe in traditional healing, this African worldview is often all but invisible to those outside African communities. In Mineco, an African clerk explained how he regularly accepted sick notes from medical doctors knowing full well that this was just a necessary cover on the part of the employees for sick leave to be approved since they were in fact consulting traditional healers. The ease with which sick notes can be bought from doctors facilitates this (and represents an additional health cost that provides an economic rent to the Western medical establishment based on their legislatively entrenched monopoly position). But peer educators, forming part of African society, both see and need to respond to traditional healing when it conflicts with their attempts to educate people on HIV/AIDS and bring about behavioral change. Here Nosimo Mpengu, a peer educator in an Eastern Cape supermarket who strongly disapproved of traditional healing, describes how she responded when visiting an HIV-positive friend in another town who was taking traditional medicine.
When I visit her, she was alone in the bedroom. Then I said to her, “Undress” and she did undress. And then I take cold water, because I could see she was sweating and very hot, and I tried to sponge her so that she [her temperature] can come down. Then I look on the table, I could see what medicines she’s drinking, and then I said to her, “Listen here my friend, I’m going to call your doctor [though she didn’t]. This [traditional] medicine, Xhosa medicine, you’re drinking, it’s not going to help you. What you must do? You must throw it away. Because these medicines, you don’t know who made it, you don’t know what it was made of, but you’re drinking it and I know the way you are sick, you are not eating properly. So, this medicine is going to give you diarrhea, you are going to have a running stomach all the way. [Many traditional treatments involve inducing diarrhea, vomiting, or enemas (colonic irrigation) designed to assist purification by removing pollution from the body.] Then you won’t be strong so that you can go for your [antiretroviral] treatment again.” [I don’t know if she took my advice,] but she did pass away.

More publicly, Mpengu went on to describe how she had confronted a colleague in the supermarket’s canteen who was advertising a traditional healer who claimed to be able to cure HIV/AIDS.

There was a lady in our work. At lunchtime she used to give the people the address [of a traditional healer] where they must go when they’ve got this [HIV]. I said to her, I stand up and said, “This won’t help.” I’m telling you, she said she knows that there’s somebody who’s giving this medicine for HIV. Then I said “There is no such [thing], we’ve never heard of such thing in our [peer educator] training. Never.” She did shut up, but the people did write [down] the address.

Such private and public confrontations illustrate peer educators’ ability to see, through their physical and sociocultural access, this alternative health system that is all but invisible to managers and health experts. In this case, however, it is far from clear whether Mpengu’s approach achieved a change of heart among those she addressed.

Division over the merits of traditional responses to HIV/AIDS is also present within families, and this setting proved no easier for peer educators to win over those who prefer traditional explanations of the disease. Thabo Seloba, a peer educator in Mineco whose father and grandfather had been full-time traditional healers, explained how he was unable to persuade an
aunt of the efficacy of antiretroviral drugs. The aunt, despite having tested HIV-positive, was blaming her illness on her sister who she believed, on the advice of her sangoma (traditional healer), had bewitched her. That a third sister had died only a few months earlier, refusing to take antiretroviral drugs despite an HIV-positive test result, did not convince her otherwise and was, rather, used to strengthen the bewitchment explanation. At the request of the accused sister, the peer educator visited the sick aunt with his wife, but their attempts to convince her of the value of antiretroviral drugs failed. The sick aunt—who was unaware that her visitors had already been told that she was positive—told them that the doctors had said there was nothing wrong with her and that she would continue with the medication that her sangoma provided to counter the bewitchment. Two weeks after the visit, the aunt died, and Seloba noted how, “It is not easy to change peoples’ beliefs, particularly when sangomas are involved.”

In Mineco peer educators frequently discussed traditional beliefs on HIV/AIDS among the workforce. Those who conducted induction talks for employees returning from leave included a short awareness session on HIV/AIDS. This provided a rough gauge on employees’ beliefs around AIDS. They estimated that around 30 percent of the company’s employees—many of them migrant workers from rural areas of the Eastern Cape—believed traditional healers’ explanations of HIV/AIDS. This estimate was admittedly crude; on good days, when they felt they were making progress, it could drop to 20 percent. Numerical certainty aside, peer educators viewed traditional healers’ explanations of HIV/AIDS as important. Indeed it was suggested that peer educators could use belief in traditional healing as a lightning rod to identify peers who needed to be targeted.

Explaining HIV/AIDS through Traditional and Spiritual Healing

Traditional healing provides two main alternative explanations to Western medicine regarding HIV/AIDS: (1) that AIDS results from bewitchment and (2) that AIDS is not a new disease, but the current epidemic is a manifestation of a breakdown in social order and the abandoning of practices that previously kept these older diseases in check.
A belief that AIDS emanates from witchcraft frees a person from the stigma that is attached to the disease and/or the relatively unattractive implications of accepting the Western-medical explanation: a lifetime on medication and the need to always have protected sex. Rather than having to accept how the disease was acquired and face its implications, citing witchcraft as the cause allows the person to portray themselves as the victim of malevolent deeds perpetrated against them. As is often the case with witchcraft, specific accusations around AIDS frequently mesh with existing social tensions and conflicts over material resources. Hence, the accused person is often a family member or neighbor. Seloba, the peer educator who was unable to dissuade his aunt that she was bewitched, reported three deaths from AIDS in his extended family over the three and a half months of the diary project. The second of these, in which an older (half) brother died, also involved a witchcraft accusation. In this case the accusation was leveled against the brother’s former wife who had returned to help care for him when sick. The particular accusation in this case was one of *sejeso*. Sejeso entails a witch introducing a small animal into the person’s stomach, usually through doctored food, that eats the person away from the inside. Personal accounts of people who claim they were cured of *sejeso* by a traditional healer report, however, less dramatic objects being discovered when induced to vomit under the guidance of a traditional healer, such as a piece of food regarded as being too big to have been swallowed whole. It is conjectured that this was the introduced animal still in the process of reconstituting itself after having been introduced and having been caught before it could do more serious harm. But, irrespective of quibbles over agency, symptoms of *sejeso* fit those of AIDS reasonably well. In this case, the accusation against the woman linked into the prior history of tensions leading to the couple’s separation, and her return shortly before his death was interpreted as her coming back to “finish him off.” At stake was the house that they had previously lived in, which was now open to conflicting claims between the deceased wife and other family members who were making the witchcraft accusations.

The tense nature of backstage social space in regard to AIDS is well illustrated by what the peer educator was able to say in his speech at his brother’s funeral. The extended family, with its web of intimate ties, did not provide an environment in which the truth could be openly spoken.
Rather, there were tensions over how the death was to be understood and explained. Any public statement on this required a degree of consensus unless there was to be open family conflict (which would, in traditional belief, anger the ancestors). In this regard, family members held a spectrum of belief over the cause of death, and each one had different implications. When speaking, Seloba needed to make a choice, constrained by consideration of family unity. The options were (1) that his brother had died from AIDS, (2) that he had died of TB (which was on the death certificate signed by a medical practitioner), or (3) that he had been bewitched. The easiest, fourth, option was to avoid any of these choices and remain silent over the cause of death as is so often the case in funerals where AIDS is involved.

Graveside silences are a cause of frustration for AIDS campaigners—especially because funerals are significant communal gatherings within African society. These silences, however, as this account illustrates are not induced only by shame or by considerations for the deceased. Rather shame and respect, along with other considerations, feed into different, opposing views, over what has happened. Silence may be the only way to avert open conflict within families. In this case, Seloba, despite intense discussions with other relatives, was unable to get agreement to say that his brother had died of AIDS. He was able to avoid silence, however; the family agreed he could say that his brother had died of TB. It was a partial victory, and he used the opportunity as best he could, encouraging everybody to test for TB and to take treatment if they were infected.

The second explanation of AIDS that traditional African beliefs provide is that AIDS is not new but a new name for older afflictions that result from failures to correctly follow traditional practices. These cited practices vary in detail but focus on sexual transmission from somebody who has not been cleansed of polluting influences; for example, the failure to ritually clean a woman or man after the death of their spouse and/or to have sex with them before cleansing can be completed—often regarded as being a complete year. In Setswana culture, for example, failure to comply with these traditional processes results, in the event of a woman’s not being purified (ho nwa dipitseng, literally; to drink from the pots [of ritually cleansing herbal mixtures]) after the death of her husband, in boswagadi with symptoms similar to AIDS. Related diseases that may also be
confused with AIDS within this traditional perspective results from a failure to correctly purify a woman after an abortion, miscarriage, still-born child, or infant death.

These explanations of “AIDS” as traditional diseases that have become rampant because of widespread failure to follow traditional practices are usually put forward as intellectual explanations for the AIDS epidemic. In contrast to the desperate hopes of sick people that witchcraft is the source of their problems, this explanation is promoted in a measured way by believers in traditional practices as well as traditional healers who seek a coherent overview of the epidemic rather than individual explanations of sickness.

The two explanations do, however, overlap. Within an African worldview, people who neglect their ancestors by failing to conduct appropriate ceremonies are more vulnerable to witchcraft because their ancestors are less closely protecting them. It is important to note here that believers in traditional African cosmology are mounting an intellectual counterattack against rival forms of Christianity that offer a worldview more closely aligned with Western medical practice. Thus, for example, traditional African wife inheritance (practiced by some ethnic groups), in which a man takes over his brother’s widow, is often critically cited as a cause of HIV transmission by AIDS campaigners. This is, of course, a position that resonates with most contemporary Christian teachings that frown on such practices. In contrast, believers in a traditional African cosmology argue that the problem is not traditional practices but rather the breakdown of these practices as a result, in part, of Christian proselytizing.

Thus, proponents of traditional beliefs are able to put forward explanations of HIV/AIDS that not only provide comfort but also a coherent intellectual structure mobilized in contradiction to the publicly dominant scientific canon and, often, against predominantly Western forms of Christianity. Not surprisingly, the presence of these rival cosmologies often divides backstage social space; within families, there are often sharp divisions as well as synchronization between traditional, Western-science, and Christianity. Peer educators have to work in these spaces, and the difficulties that they encounter are not hard to see. As the next section outlines, tackling these difficulties begins by recognizing that peer educators are themselves embedded within this divided backstage space.
Peer Educators as Backstage Team Members

It is tempting, for those running HIV/AIDS programs, to believe that peer educators unambiguously champion information on HIV/AIDS that is based on scientific knowledge. Given this, we might expect peer educators to offer alternatives to the belief that bewitchment or the failure to observe tradition causes AIDS. Certainly, this was the publicly articulated modus operandi of the peer educator group at the Mineco operation, with peers’ adherence to traditional beliefs regarded as a barometer of the conditions that they operated within. However, below this public stance there was a more complex set of understandings.

There were some peer educators who, like Mpengu, the peer educator who confronted her coworkers in her canteen, simply had no dealings with traditional healers. They believed that such healers could achieve nothing and needed to be sidelined. Any shift on the part of peers toward this position was progress. Here Tlouane, in the mining company outlines, in private, a very similar view to that publicly articulated in group meetings.

**Dickinson:** Do you think traditional healers educate people in the right way or the wrong way? …

**Tlouane:** [Interrupting] No. In the wrong way!

**Dickinson:** …about HIV/AIDS?

**Tlouane:** In the wrong way. In the wrong way …Because everyday I’m giving people induction [sessions, during which she gave an awareness talk on HIV/AIDS] …So, I’m so happy because today [in the induction session] they tell me that “Nelly, there’s no cure really for HIV. This treatment [of] traditional healers, they can make you better, but after that, you’ll become sick again.”

Other peer educators conceded that healers could usefully contribute to the response to AIDS, but only if they acted in support of Western medicine. After explaining how many traditional healers made their patients worse by prescribing treatments that involved “making your stomach run,” Florence Diseko, also in Mineco, explained what a traditional healer should do if a patient came to them with symptoms of AIDS without having first consulted a medical doctor.
Our traditional healers, they are just looking for money. The problem is there. That is why they don’t ask you [the patient’s relatives], “Is this person from the doctor or not?” If it’s a professional one [traditional healer], . . . he will say, “I will ask you [the patient’s relatives] to take this poor man or lady to the doctor first. Then you must come and tell me what the doctor say.” [So that the healer can support any treatment prescribed by the doctor.] The professional ones [will]. But most of them they are not [professional].

Some healers are working, at least partly, along these lines. For example, they ask to see patients’ HIV-test results and even CD4 counts (immune system strength) to complement their own diagnosis and treatment process. However, Diseko’s suggestion, similar to that most medical practitioners and champions of antiretroviral drugs such as the Treatment Action Campaign offers what amounts to a “partnership” between two healing systems based on the surrender of one to the other. While there is a strong desire on the part of many traditional healers for public legitimacy, this cannot, in their perspective, come at the cost of abandoning any claim to knowledge or power.

Some peer educators recognized the need to offer more meaningful roles to traditional healers. Despite skepticism about the value of traditional healing, they tried to educate traditional healers on HIV/AIDS and appropriate treatments so that they could operate in a complementary fashion alongside Western medicine. However, such endeavors could be frustrating. The fragmented structure of healers, with no regulation or agreed standards in place, meant that even when peer educators established good relationships with some healers, there were others who would claim, in competing for clients, they could cure AIDS and undermine these efforts.

Seeing peer educators as either hostile or cautiously willing to accommodate traditional and spiritual healers conceptualizes them as being apart from their own social spaces. In thinking about how I would structure this book, I considered a chapter that would focus on peer educators’ own beliefs, as distinct from their peers. I realized that this would be a mistake. As peers, rather than as professional, socially distant educators, they reflect the values of their peers. This is no more clearly illustrated than over the issue of healing. Just as in the wider African population, there are opponents and supporters of traditional healing among peer educators. Thus, in the case of the peer educator group in the mining operation, beneath
the public articulation that belief in traditional and spiritual healing was a marker of peers’ failure to properly understand HIV and AIDS, there was a less visible plurality of beliefs that not infrequently included traditional and spiritual healers as a component of maintaining physical and psychological health.

Jacob Senabe, at Mineco, is a good example of how peer educators may hold a range of beliefs around questions of health. As a lay preacher, shop steward, peer educator, and father he would appear as an ideal person to engage with his peers around HIV/AIDS. Trained by the company on the basics of prevention and treatment of HIV/AIDS and other sexually transmitted diseases, a superficial evaluation would assume that he would consistently put forward a Western medical perspective. But in additional to these “acceptable” identities, Senabe held other beliefs that were woven into his understanding of the world.

Some time back his late father had visited him in his dreams telling him that he was getting cold. This was interpreted by Senabe as meaning that he should erect a tombstone for his father. Once this was done, the dreams ceased. After a close lightning strike, he had on the advice of family members visited a sangoma, since this was a sign of witchcraft aimed at his household. His most recent trip to a sangoma had been triggered when the wheel of his car came off shortly after he had seen a cat near his car. The sangoma had identified a relative who was attempting to kill him. At the time he had believed the sangoma, but when the interview took place, he had revised his view and put the accident down to the wheel nuts not being strong enough. He now thought that what the sangoma had told him was “nonsense.” This shifting illustrates the fluidity of explanations that individuals can choose to prioritize—an issue we examine in Chapter 6.

Although Senabe generally used a medical doctor when ill, this was partly because the company medical aid scheme helped pay for prescribed medicines, and he would forfeit funds if he did not spend his annual medical allowance credited to his scheme’s account. In an interview, Senabe explained that he believed Western doctors were “stronger” than traditional healers when it came to AIDS, but that traditional healers were sometimes stronger on other problems. As an example, he explained how he had been cured of “burning urine” (probably a sexually transmitted disease) by drinking muti that a sangoma prescribed. Several of his friends had reported
similar success for the same problem. Finally, it emerged outside of the interview that he had, along with another peer educator, taken an HIV-positive colleague to a nearby village for treatment by a spiritual healer. He, and the other peer educator, reported that this healer had a strong track record regarding HIV/AIDS. The other peer educator had a friend whose HIV-positive test had, he reported, been reversed after treatment. They liked the insistence of this particular healer that people had to go to the hospital and bring their HIV test results back to him before he would treat them.

Senabe did not view these beliefs and actions as incompatible with the medical explanation of HIV/AIDS that he had been given in his peer educator training, nor with his role as a peer educator. But they do illustrate how much more complex his beliefs on health and healing are than what we might expect from a peer educator who may be seen as a mere delivery mechanism for information. Of the eight most active peer educators I interviewed from the mining group, five of them consulted traditional or spiritual healers for health or family concerns. When asked why they did not raise their views in the peer educator meetings, where at times they would have been in the majority, they said that they believed such views were not acceptable to others. To some extent this was an open secret, for at least some of the peer educators who expressed public hostility to traditional healers had a fairly accurate idea which of their fellow peer educators privately dissented from this publicly expressed view.

This should not be a surprise. If peer educators are peers, we should expect them to represent the full range of social beliefs. Indeed, it would be a disadvantage if this was not the case. Nevertheless, this group of peer educators demonstrates that, even within backstage social space— with all the peer educators Africans and at roughly similar occupational levels in the company— the issue of traditional and spiritual healing is disputed, divisive, and, at times, disguised.

Traditional and Spiritual Healing and HIV/AIDS in Backstage Space: Summary

Although it may not be visible to those in charge of company HIV/AIDS programs, different beliefs around traditional and spiritual healing and
its efficacy in regards to AIDS create tensions in the backstage social settings that African peer educators operate within. That many people give credibility to explanations of HIV and AIDS and treatment that traditional spiritual healers put forward complicates the roles of peer educators seeking to provide information and influence behavioral change.

South Africans turn to these alternative explanations of HIV/AIDS for a number of reasons. These include limited access to Western medicine in general, and antiretroviral drugs in particular; the shoddy way health practitioners often treat patients; the stigma attached to AIDS (but not to falling victim of witchcraft); and that understandings of AIDS plays into domestic and community power struggles over status and resources. If this was all, it could be thought that increased access to antiretroviral drugs and greater openness around the disease should see beliefs around the power of traditional and spiritual healers over AIDS diminish and peoples’ behavior change in line with this.

What this view fails to consider, however, is that alternative healing response to HIV/AIDS is more than the choice of individuals, but a confrontation between competing cosmologies. And in this regard AIDS is but one battleground on which traditional and spiritual beliefs compete with science, medicine, and monotheistic Christianity over the construction of meaning. Even if those championing modern medicine against other health systems were to win outright over AIDS, this would be victory in only one battle; the war would continue.

What is perhaps most striking about this battle is the parity between the competing cosmologies of medical science and traditional and spiritual healing over HIV/AIDS. Never mind the failure to get Western medicine’s best shot—antiretroviral drugs—to people. Even when this is achieved, its promise is distinctly limited; a lifetime on treatment, with the dangers of side effects and resistance, and eternal condoms. On the other side is a hydra of traditional and spiritual practitioners able to promise hope and better the claims of Western medicine. Operating in the shadows, this hydra cannot be comprehensively confronted or disproved. But most important, until Western medicine demonstrates an unambiguously better solution to the problem of AIDS, the power of traditional and spiritual healing around AIDS lies not in its specific responses to the disease but in its embeddedness within a wider cosmology, deeply rooted within African society.
What is happening over AIDS and traditional and spiritual healing is not only an individual process of decision making but, rather, a conflict of cosmologies that cuts across the African population. The divisions among peer educators themselves illustrates this. Given the arguments made, this should not be surprising. But it does provide us with a clear understanding of why, when peer really means peer, we need to think of peer education as most effective not as a vertical communication aid but as horizontal communication in which peer educators are active agents of change.

As vertical conduits for experts, peer educators are unlikely to faithfully reproduce messages given their own immersion in traditional and spiritual healing. If we bothered to find out what peer educators really think, we would know this, but instead we send out messengers that hold beliefs that are not fully compatible with the messages we wish them to transmit. Some will attempt to do what we ask, though how effective given the wider conflict that they are stepping into is questionable. Others will give mixed messages—though these will not be reported back. And others will try to resolve for themselves the different, conflicting information that they now possess.

If, on the other hand, peer educators operate as active agents engaging in horizontal communication, the question of AIDS and traditional and spiritual healing becomes a process in which Africans are able to reconfigure their own cosmology. Not as the defeat of the old by the new, tradition by science, but rather by establishing, in the era of AIDS, what traditions remain of value and what needs to be adapted and changed.

Conclusion: Backstage Social Order and Changing Belief

Peer educators, drawn from the ranks of employees, sidestep the communication barriers of industrial and social divides and the front-stage performances that are enacted at these frontiers. But, that should not prevent us from seeing the differences that lie behind these divisions and the difficulties that these present to peer education. Indeed, once away from more obvious divisions between workers and management, and its wider embodiment in class difference, it is clear that there are many differences among peers. Such an examination calls into question overconfident assumptions on the automatic effectiveness of peer educator similarity. These
Changing the Course of AIDS

opinions may have more to do with a homogenizing view of the “other” than with careful evaluation of what constitutes peer status.

Reacting against this, we may overcompensate with ever-narrower categorization of peers. But the identities of gender, race, and healing beliefs used to illustrate this chapter cannot be organized into subgroupings of peers that will constitute homogeneous subcommunities. While it is theoretically possible to define peer identity in ever-more detail, there are not, in reality, corresponding closer circumscribed social spaces. In other words, identity permutations are myriad and analytically separable, but the social spaces individuals inhabit are more constrained in type and are internally heterogeneous. They are shared. Thus, for example, in desiring similarity between peer educators and their peers we could consider the categories of race, ethnicity, gender, religion, age, occupational level, sexuality, marital status, traditional beliefs, urban or rural background, and so on. Taken to extremes we might seek to recruit as a peer educator an African, Zulu, woman, Catholic, in her twenties, manual laborer, heterosexual, married with children and living with her partner, who believes in the importance of traditional customs, and comes from a rural background, but is now living in a township. Such individuals exist, but they do not work or live in communities of identical individuals. While peer educators are able to sidestep the primary lines of divisions in South African society, they are not able to avoid subsidiary divisions. Peer educators inevitably work with peers who are different from themselves.

Gender, race, and healing beliefs do not fully account, by any means, for the lines of conflicts that peer educators encounter around HIV/AIDS in backstage spaces. Far from being a relaxed, frank, and open environment, backstage spaces, despite their insulation from the main lines of organized social conflict, are sites of tightly constructed, complex social order. There are divisions specific to particular backstage spaces, such as belief in African traditional and spiritual healing; divisions found in nearly all backstage spaces, such as gender; and identities that correspond to primary social divisions but which can divide backstage space over the issue of HIV/AIDS, such as race. Peer educators enter this space with concerns about HIV/AIDS that has implication for this social order. Their messages, however well-intentioned and humanistic, cannot remain neutral but inevitably stir up opposition.
If we take this on board, then the bluntness of peer education exclusively designed and supported as a vertical communication strategy to bring about behavioral change is obvious. Yet, it is also obvious that without peer education (or a similar process of lay involvement) operating in backstage spaces, we will not make the slightest impact on beliefs. In Chapter 5 we look at how peer educators operating backstage attempt to bring about individual behavioral change within this dense set of interlocking and defended beliefs.