Changing the Course of AIDS

Deutsch, Charles, Dickinson, David

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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People Hear What They Want to Hear

While peer educators strive to change the behavior of their peers, some also recognize the limits of strategies restricted to working with individuals. To put it simply, there are too many avenues of escape for those who prefer, for one reason or another, not to listen to the messages of peer educators, irrespective of its vernacular delivery or sociocultural proximity. In response some peer educators encourage all social actors to “speak with one voice” and to close down these psychological escape routes. One of the main targets of their efforts are the South African unions that have, to date, been reactive in their response to HIV/AIDS. Other targets are churches and traditional healers.

Convincing unions, churches, and traditional healers to speak with one voice about the epidemic is critical because contradictory explanations about AIDS and what to do about it make peer educators’ efforts difficult if not impossible. As Louise Rasool in Bestbuyco put it, “It’s easy to forget [what we’re saying] if you don’t want to see the truth.”
The long incubation period of the virus, which de-links HIV infection from AIDS symptoms, fosters this amnesia and denial. As Semenya in Mineco explains, the uncertainty around the cause of deaths further complicates the link between cause and effect that is essential to understanding HIV and AIDS.

[We need to] tell people about HIV/AIDS, everybody has the choice, they can make . . . It’s either you make the right choice or the wrong choice. . . . [But] some people they’ll say, “I don’t really believe HIV is there.” . . . Even if you explain the numbers [of infection and deaths] they want to see the person who is dying of AIDS . . . But they are not very sure. Because the family will not disclose . . . You just heard that that person has died of AIDS, but you are not sure about that . . . You cannot be sure. In fact, it’s a rumor. You just hear that “Oh! That person has died of AIDS.” But you’re not sure about that.

If most AIDS deaths are maybe-AIDS-but-we-cannot-be-sure deaths, then even those standing at the graveside may not be certain as to what is killing so many young adults. The living are free to pick and choose explanations, as Robert Mokwena in Mineco explains when he describes interacting with a colleague who recently joined the local Zion Christian Church (ZCC) and is teetering on the edge of realizing that he may be HIV-positive:

I used to work in the same department with this man. He is now a supervisor. I did not know that he was sick. He told us that he was diagnosed with pneumonia. He is a man of big stature, but he was like a person who has full-blown AIDS. I struggled to recognize him. One of the peer educators [who previously] suffered from pneumonia helped to advise this man. He [the supervisor] was worried that people are suspecting that he is HIV-positive.

He joined the ZCC. They are giving him [blessed] coffee and tea to drink and told him about people who want to kill him [i.e., witchcraft]. This man was on his way to Moria ZCC headquarters because he has a new religion. We tried our best to convince him that his [pneumonia] treatment must come first. . . .

I think we must do something to convince church leaders that HIV/AIDS is a killer. People are going to spiritual healers to hear what they want to hear.
In discussing how peer educators have reflected on the limits of their work, we see why and how they have expanded their targets to include working with unions, churches, and traditional healers to do what the country’s leadership has yet failed to do: build a strategic response to the epidemic.

They Just Sign the Paper

During 2006, Kabelo Mothotse, a peer educator in Mineco went to the Eastern Cape for a month to resolve some outstanding benefit payments. His primary task was to identify dependents of deceased mineworkers and assess how money owed them should be allocated. During the course of this work, Mothotse found that some workers who had been medically boarded (found too ill to continue working) by the company were simply being cut loose or abandoned once they left employment. Without easy access to medical facilities, they were failing to keep up HIV and TB treatment that they received while employed. In other cases HIV-positive employees were medically boarded without any prescribed treatment. Mothotse told me about the conditions that were hidden from view in a remote part of the Eastern Cape.

We were investigating a death benefit case. We found a sick [HIV-positive] woman. She was hungry and angry. Her late husband was working for the company. She told us that “I hate Middleburg [where Mineco operations were located], my husband brought me AIDS from Middleburg. I hate Middleburg.” The late husband was medically boarded before he died. And he was not on ART [antiretroviral therapy] and his wife also [was not on ART]. . . . These people are dying like dogs. They are staying in the mountains far away from doctors and other health workers. It is not easy to reach them. I was not angry because the woman was angry, hungry, and dying of AIDS. I am angry because Mineco is not doing enough. We are dumping our sick people after serving our company for many years. . . . I want my leaders to see these people.

Although Mothotse’s anger was directed at the company, he recognized that it wasn’t only high-level executives who were at fault. The company’s HR managers, medical practitioners, and union representatives were also
not doing enough. All of them sat on the medical boarding committees that were allowing HIV-positive people to leave the company without either starting treatment or making sure it would continue. Mothotse’s discovery far from the mine’s operations brought home the fact that key leadership groups in the company had failed to deal with the disease despite the policies and procedures put in place to do so.

When HIV-positive employees quietly leave companies via this “sick route,” there is often a conspiracy of silence, which doctors, managers, unionists, and the sick employees themselves tacitly maintain so as not to confront the ill individual’s HIV-positive status. In such cases, an opportunistic infection, such as TB, and not HIV/AIDS is the documented cause of disability. The Department of Labour’s *Code of Good Practice on Key Aspects of HIV/AIDS and Employment* (2000, Section 11.3) states that “the employer should ensure that as far as possible, the employee’s right to confidentiality regarding his or her HIV status is maintained during any incapacity proceedings.” Sick route misrepresentation is not confined to Mineco (Dickinson 2003). Each party may have different reasons for going along with the collective fiction, including fear, respect, and convenience. Nonetheless, their decision to take the path of least resistance has far-reaching implications.

Describing another case that he had investigated during his visit to the Eastern Cape, Mothotse told how another employee had been diagnosed as HIV-positive but had refused to start antiretroviral drug treatment. After his wife died, he had impregnated a seventeen-year-old girl (herself an orphan) before he himself had died. Both the girl and her baby were now sick. While this child was to be included as a beneficiary of the employee’s pension payout, along with the children he had had with his wife, the peer educator noted bitterly that this would only be the case “if she’s still alive [by the time payment was processed]. Because she was very sick [when he had visited].”

In Mothotse’s view, “It is his [the employee’s] fault. *But I blame the [HIV-test] counselors.* Someone who counseled him, they could have convinced him [to take antiretroviral drugs]. Just look what he has done, he got a seventeen-year-old [pregnant], he impregnated her. There is another life that is HIV positive.” Nonetheless he added:

I think all of us [are responsible]. Because the unions are involved when somebody is medically boarded. And they can see the doctor’s report. And the doctor is there. He will tell them that, because of this and this, the person
cannot do his job any more. So he must go home. And they’re going to give
him medical board. The unions are there to see the record and demand, make
sure that if this person goes home he falls in good hands. But, they just sign
the paper. And then the person is on his own. Like this man. In his records,
the file shows that he was HIV positive and he refused to take the treatment.

We do not know precisely why this man refused treatment. What we
do know is that he may have been influenced by alternative explanations
of the epidemic. His decision to impregnate a young girl may have been
shaped by the myth that sex with a virgin will cure him of the disease
(Leclerc-Madlala 2002; Meel 2003).

This story illustrates how an individual can easily slip through the
system—and the hands of the medical boarding committee designed to pro-
tect both the interests of the company and employees—that has been put in
place to treat HIV-positive employees. This expanding tragedy also points
to a wider failure on the part of all those who came into contact with this in-
dividual to speak with one voice. Critical front-stage players at all levels did
not challenge this man’s actions—actions that were almost certainly encour-
aged if not promoted by other voices from within backstage social space.

Responding to Apathy and Opposition

Peer educators see the direct impact of the failure of institutional systems
of care and protection that appear weak, indifferent, and incompetent
when it comes to HIV and AIDS. Trapped between conflicting explana-
tions of AIDS and flawed institutionalized responses are the individuals
who, fearful of the consequences, take what appears to be the path of least
resistance only to find a degrading, painful, and often lonely death. Peer
educators see all this with different degrees of clarity. Knowing what to do
about it is a different matter. Most, peer educators limit their focus to in-
dividuals they know or work with and tend not to strategize about how to
confront institutional weaknesses in their company HIV/AIDS responses
or beyond. Yet, even these peer educators discover that they must learn
how to negotiate with higher-ups in their companies if they are to do their
individual work successfully.

Consider, for example, one peer educator’s journey in Finco. She’d at-
tended a company HIV/AIDS training session where she had been asked
to start giving talks on HIV/AIDS. The supervisors in her area, however, refused to release workers for the sessions that she had set up because they were under pressure to meet “hectic” production targets. She then met with the HR manager, who was supportive and set up a meeting with the management team, which agreed to approve her activity. With this official support, and now considerably smarter about how to get things done in her workplace, she organized a meeting with the supervisors and brought them on board. Only once this had been achieved was she able to get reasonable attendance at the training sessions.

Getting a platform to speak to peers is simply a first step. The logic of peer education leads from the shop floor, to the company, and finally to the larger society. This attention to a broader picture leads to the inevitable question of why so many other social actors fail to respond wholeheartedly to the epidemic. Nobody is “for” a deadly virus.

At the risk of oversimplification, we can identify four categories of social actors and a gap between what they are doing and what they would be doing if there was truly a united front against AIDS. First, there are professions, such as health care, that should be unambiguously in the front line of any response but, in practice, not infrequently fall short of providing what could be expected of caring professions. Certainly the (Western) medical establishment has dragged its feet, given their limitations in the face of HIV/AIDS, in reaching out to other potential allies of a united front. Second, there are organizations such as unions, government, and academia that should be central to any response given their mandates but that (as we shall see below in the case of unions) have not been aggressive in dealing with the HIV/AIDS crisis. (Others have discussed the South African government [Fourie 2006; Nattrass 2004] and academia [Cairns, Dickinson, and Orr 2006]). Third, there are organizations, such as companies, that should be supportive but, as we saw in Chapter 2, prioritize competing demands. Fourth, and finally, there are organizations, such as the churches and traditional healers, that have the potential to be part of the solution, or part of the problem, but have not meaningfully joined in a united front against AIDS. All of these organizations and institutions can play major roles in dealing with HIV/AIDS. The role that is perhaps most overlooked is how they can help to close psychological escape routes in backstage spaces. These are the open fire doors through which HIV and AIDS are currently raging and that, if closed, would help contain the epidemic.
One Voice, Backstage

Mokwena reflected in his diary how changing beliefs about HIV/AIDS requires action by a range of social actors. “Culture and beliefs are playing a big role here. I think cultural leaders must be work shopped on [brought together to discuss] HIV/AIDS. Because the chiefs, headmen, sangomas and herbalists [both types of traditional healers], and spiritual healers are the only people who can manage to convince their people to change their beliefs or attitudes. Priests and pastors also need workshops.”

Peer educators recognize that they operate within a tangled weave of conflicting opinions about the meaning of HIV/AIDS. They thus understand that all those whom their coworkers, family, friends, and community members find credible must speak with one voice about the meaning of and solutions to HIV/AIDS. For peer educators, credible leaders can be helpful only if they go beyond pro forma expressions of concerns about the AIDS epidemic, obligatory representation on committees, and passing resolutions at organizational conferences.

Rather, peer educators want leaders to mobilize by genuinely and consistently attempting to drive discourse around HIV/AIDS down into their organizations so that these discourses occur at the lowest levels of operation. In other words, genuine social leadership on this issue means more than giving front-stage performances; it means working to penetrate messages through the networks and structures of their organizations into backstage space. If leaders can’t do this, they are revealed as “talking heads” without real links into constituencies.

When judged by this more demanding leadership criteria, it is clear that not all social leaders are speaking with one voice—or speaking at all—in backstage spaces. This is evident when we explore the case of South Africa’s unions.

“We Only See Them in Meetings:” Unions and HIV/AIDS

In Chapter 3, we learned that peer educators are overrepresented in lower-skilled occupational categories, which are more heavily unionized: over 77 percent of peer educators were union members, and just over 30 percent
were or had been a trade union representative. In short, workplace peer educators can be seen as essentially a working-class movement.

Given this common working-class background, one might assume that cooperation between peer educators and unions would be extensive. In interviews peer educators identified a number of ways in which unions did, indeed, assist in their activity. Through collective action, unions have—at least in some companies—successfully demanded that employers provide antiretroviral drugs and other AIDS-related benefits. When asked, peer educators often identified individual shop stewards who were themselves peer educators or could be relied on to support peer education. Peer educators also valued union officials’ speaking about HIV/AIDS in meetings or lending support to workplace AIDS programs, such as voluntary counseling and testing campaigns.

However, when I asked peer educators what the union was doing about HIV/AIDS in their companies, I frequently drew a blank: They didn’t know because they hadn’t seen any union activity in this area. This despite the fact that most peer educators are union members with many holding office in the union. Some said their union might be doing something about HIV/AIDS, but they were unaware of it. In Mineco, unions provided more structured support, though peer educators felt that the unions could be doing more. Beyond this, what emerged was a marked distance between peer educators and unions. When asked to rate how supportive a variety of different company players were, peer educators ranked union officials much lower than occupational nurses and HIV/AIDS managers. This was not entirely surprising, but what was surprising was that peer educators felt that their line managers or supervisors gave them as much—or as little—support as union officials, something that remained the case even when peer educators who were not union members are excluded from this rating (Table 14 in Appendix 1). Since unions are there on behalf of their members, while supervisors’ role is to ensure that production objectives are achieved, this “parity of support” between union officials and supervisors toward peer educators is startling.

After pointing to cases of shop stewards who were active peer educators, criticism of the union in regards to HIV/AIDS activities was sometimes harsh. An African female peer educator in Autostar who was a union member explained:

To tell the truth they [shop stewards] are not active, but most of the time management are focusing on them [in the HIV/AIDS program]. They
[shop stewards] say they are busy, but I don’t know what they are doing. They don’t come with us on community visits. [Or] they come late, asking if they are going to get something. They just come to clock in for their voucher [a monthly token of R50 given by this company for those active in the peer educator program]. We don’t see support from them. We’ve [peer educators] complained [to management] in meetings that the shop stewards are not active, but nothing has changed to date.

In a group interview of peer educators in the same company, a union member said: “I’d like to see the union doing something. They could make a difference, but they have no program of their own. The union is supposed to be for the people, but we only see them in meetings. There is no motivation from the union side… Let us fight for life too [and not only money].”

In several companies there were partnership agreements between management and the unions on company HIV/AIDS programs, but for many peer educators this did not filter down. In general, across the five companies researched, peer educators noted unions’ institutional absence from the work they were doing.

Many in the South African union movement recognize and are troubled by the union’s limited response to HIV/AIDS. In July 2007 the research unit of COSATU, the country’s main union federation, produced a document that highlighted the role of unions in forcing government to provide antiretroviral drugs in the public sector. It also discussed discrimination against HIV-positive workers by other employees and the limited value, in practice, of workers’ rights around HIV/AIDS. “Cases of abuse and discrimination [against] HIV/AIDS [infected] workers have become rampant despite the existence of policies prohibiting such behaviour.” The report acknowledged that this “depict[s] the weakness of labour in ensuring that employers comply with the regulations advocated by ILO [International Labour Organisation] and National [Department of] Labour policies.” Overall, the document noted, “Despite the high levels of HIV/AIDS in South Africa, unions’ response to HIV and AIDS in South Africa has been minimal and ad hoc” (Guliwe 2007).

This inaction exists even though unions have long been aware of the issue. In 1992 COSATU produced a video, AIDS: A Union Issue (Hodes 2007), and it has discussed the disease at the highest levels of union leadership. A 1998 joint statement from the three largest union federations
(COSATU, FEDUSA, and NACTU) indicated a clear understanding of the threat that HIV/AIDS posed to its members and proposed a response.

We, the representatives of organized labour in South Africa, comprising the Congress of South African Trade Unions (COSATU), the Federation of Unions of South Africa (FEDUSA), the National Council of Trade Unions (NACTU), as well as independent trade unions, acknowledge:

- The HIV/AIDS epidemic affects the economically active people in our country, South Africa.
- The proportions to which the disease is spreading and the serious challenges it poses to the country’s development and future.
- Poor living conditions and low wages are factors that make it difficult for many people to change behaviour that puts them at risk of HIV infection.
- Our response, therefore, must be to campaign for HIV prevention and care with the same determination and energy with which we fight many other working class struggles. We say AIDS must be made a priority issue for every trade union member. Campaigns to stop AIDS must be discussed at every trade union meeting.

Why then is there so much union inertia about HIV/AIDS?

Understanding Union Inertia over HIV/AIDS

Union inaction seems particularly disheartening when one considers that, unlike South African corporate management that has been largely insulated from direct contact with the AIDS epidemic, union members have, to date, borne the brunt of it. Union inaction is in part a product of the complicated history of apartheid and its end.

In post-apartheid South Africa, unions had to deal with very particular problems. First, many union leaders were recruited to help lead the new democratic state. With open political organization all but impossible for blacks under apartheid, the trade unions carved out a space in the industrial sphere where organization was legal and, albeit grudgingly, tolerated. Not surprisingly, many saw the newly emerging unions as a vehicle for mobilizing resistance to apartheid. The result was an extraordinarily
strong leadership cadre. With the transition to democracy, many of these trade union leaders moved into parliament and positions in provincial and local government. Additionally, many union leaders, who remained committed to working-class interests, moved into the Department of Labour where they felt that could better implement the labor market reforms; earning the Pretoria-based Department of Labour the sardonic nickname “COSATU’s Pretoria office” among business leaders.

Alongside this move of union leaders into government, companies accelerated their own process of bringing union leaders into junior or supervisory management positions. For companies this kind of recruitment met two goals: Companies were able to change the demographic profile of their workforce (something that new employment equity legislation required, see Chapter 2) while simultaneously removing the most capable stewards from union leadership.

Widespread illiteracy and innumeracy—one of the most enduring legacies of apartheid—has undermined union attempts to develop leadership cadres to replace those it lost to government and management. Even when unions have trained replacements, this often does nothing more than provide individuals with a platform to move on (and up). While the post-1994 labor legislation is decidedly pro-labor, unions have often been unable to take advantage of it because of the complexity of engagement with processes with which they are unfamiliar. Skills development, cooperation over productivity gains, and employment equity require unions to engage jointly with management over what should be issues of mutual interest. Stripped of skilled officials, unions have generally been unable to move beyond the more straightforward strategy of opposing management over traditional industrial relations concerns such as pay and working conditions.

While these constraints on organized labor are relevant in understanding the limits of any trade union response to the AIDS epidemic, they do not fully explain the unions’ failure to provide more support to peer educators than company supervisors. What else accounts for this?

Cultural differences between unions’ modus operandi and that of peer educators helps explain unions’ inaction on this issue. As John Kelly has outlined (1998), unions operate by mobilizing a constituency to make demands on another social group whose policies or practices they oppose. Thus, unions have demanded that their members have access to antiretroviral treatment. Unions have also used their institutional weight to support
the demands of pressure groups such as the Treatment Action Campaign (TAC) that petitioned government to provide antiretroviral drugs in public-sector hospitals that workers and their families rely on. Typically, then, unions convince individuals to form collective groups that can through pressure and action achieve collective gain.

By contrast, peer educators tend to work at the individual rather than collective level. Peer educators’ emphasis on the individual requires that oneself change and not the social “other.” Rather than mobilizing enough collective power to force concessions from another group, peer educators seek to assist individuals to change what they do in their own lives.

Unions do, of course, deal with individuals when the rights that have been secured for all members are violated. But around HIV/AIDS, while legal rights are in place, their enforcement is not easy. A story told by Juliet Hennings in Bestbuyco (whom we met in Chapter 3), helps illustrate this. Two staff members in her store had gossiped about the HIV-positive status of a coworker. Because of this, the woman’s new boyfriend discovered her status before she had felt ready to tell him herself. Juliet then gathered the peer educators together and openly confronted the two women responsible for what turned out to be a destructive act. Although Hennings wanted to make their conduct the subject of a disciplinary hearing, a shop steward, while firmly behind her on the principle, did not want a conflict between union members to be dealt with in the company’s disciplinary process. They thus settled on an assurance from the women that the gossip would not happen again. This example illustrates that rights-based safeguards against discrimination have to be imposed by active agency and that stigmatization around HIV/AIDS can be horizontal as well as vertical. In this case the union’s ability to act as an enforcing agency was compromised because both stigmatizer and stigmatized were union members. Only the moral agency of the peer educator was able to assert the rights of the individual and impose sanctions.

Contrasting the collective and individually focused activity of unions and peer educators helps explain why each has different strengths and weaknesses in responding to HIV/AIDS. A peer educator in Autocircle, for example, explained that his union was party to the company’s HIV/AIDS program but was reluctant to raise the issue when meeting their members. “The members don’t want to hear them [on HIV/AIDS], unions avoid the issue—it would cause chaos,” he commented. That’s because, like other
South Africans we have encountered, union members have many varied views of the meaning and solution to HIV/AIDS. Unions, as agents of collective action, have mobilized their constituencies to stage front-stage encounters with management (and sometimes the state) to improve wages, benefits, and working conditions. They place a premium on internal unity and function particularly well when there is a clearly distinguishable opponent on whom they can make demands. This means that within unions some differences, such as class, are legitimate, in fact desirable, because they are projected outward. Other differences, internal to a union’s membership, while just as real are unwelcome because they divide rather than unite. As far as possible, such internal differences are suppressed in the name of front-stage unity. Many of these differences are salient backstage, but are for the most part contained, stifled, and hidden.

Gender differences are an example of internal differences that are often suppressed. Even where a particular union is largely male, the class that these members are drawn from and the backstage spaces they inhabit consist of both men and women. In South Africa, the need for gender equality is, in public discourse, taken for granted, and unions have progressive policies in this regard. Yet, for all the talk of “gender mainstreaming,” little is actually done and the gender offices of unions, if they exist at all, are marginal to unions’ key concerns. The reason is obvious: if unions took gender seriously enough to shift the status quo of gender relations in the backstage spaces of their members, this would provoke a civil war that would deflect attention from other critical issues. As long as gender equality is confined to resolutions, and token gestures, members can get on with their, often deeply gendered and deeply unequal, daily lives; the boat is not rocked.

Unions’ relation to HIV/AIDS reflects the same dynamic. Beyond HIV/AIDS treatment and protection from discrimination, to venture into the HIV/AIDS issue further risks unleashing controversy and contention among union members. This kind of conflict may weaken a union when it wants to confront management about other workplace issues. In the South African context, it can also weaken a union that faces competition from rivals. In Mineco, for examples, several unions competed fiercely for members. In the section of the company research in 2006, there were six unions in the main bargaining unit. The majority union was hovering around 50 percent representation (something that gives a union considerable rights under South Africa’s labor law), raising the possibility of rival unions
overtaking it as some point. Peter Mopedi, who was also a shop steward, explained the dangers of rival unions in the company stealing members if he started to talk about AIDS. “You can’t speak about something that people don’t want to [speak about], because you look [at] the other union[s] [and] those people are going to take [your members] while you are talking about the AIDS.… [The members will say.] ‘We don’t want that, the only thing that we want is money. Stop talking about the AIDS.’”

This contest over HIV/AIDS is not only among union members but also among union shop stewards and officials who share the same backstage spaces. One shop steward at the mining company, who it turned out was also a traditional healer with a number of HIV-positive patients, was selected for me to interview in part because he had a good working relationship with the peer educator group. This relationship was genuine, and the shop steward was full of praise for the group’s coordinator, Mokwena, because he was pushing peer education onto the agenda of the local management-union forum. Nevertheless, as previously raised in Chapter 4, even though this shop steward had participated in HIV/AIDS training, he still questioned the Western explanation for the disease.

It get diffi cult for them [peer educators] whenever someone asks, “where does AIDS come from?” Because some of them doesn’t know clearly that this has been developed by having sex with a [polluted] woman [i.e., the breaching of purification rituals]. But…because I’m a traditional healer then I understand what was the basic cause of this [HIV/AIDS]. Whenever [somebody’s] wife dies, he [the husband] gonna sleep with another woman within two to three months. He doesn’t believe that he must wait and clean his blood. Because the blood have got the maggot [pollution]. [As an example,] whenever I dies and they buried me, my blood [be]comes vrot [rotten] underground…and also the one which is in my [living] wife makes the very same thing as the one who has been buried. That’s why we use the traditional medicines. We try to pump the blood of one who has been dead from the one who is alive.

Shop stewards and union officials are equally divided around HIV/AIDS in other important dimensions. Thus, if a union is to move beyond high-level conference resolutions and partnership agreements and address the details of getting members to change behavior over HIV/AIDS, they will inevitably engage competing worldviews among rank-and-file
membership and leadership. With these constraints the typical union response to HIV/AIDS has been to pass appropriate resolutions and act on issues that are relatively uncontroversial to their membership: bargaining for treatment provision and taking a public position against management discrimination. Backstage space has been left alone.

**Projecting the Unions’ Voice Backstage**

For peer educators, unions are an important potential ally that can help ensure that company programs operate as the HIV/AIDS policy stipulates; that is, that all workplace agents “walk the HIV/AIDS talk.” Additionally, and importantly, unions and educators need to be speaking with the same voice. For unions this means not only “talking HIV/AIDS talk” front stage, but projecting that voice into backstage spaces. Only this will close psychological escape routes for those who seek out more palatable explanations and responses to the disease. This, of course, is not an easy thing to ask, and it is even harder to achieve. It is requesting unions to take sides on an issue that divides their members and the very network of officials and shop stewards that would have to drive such a process in backstage space.

Given this, the previously quoted union resolution that “campaigns to stop AIDS must be discussed at every trade union meeting,” may not be appropriate. Ten years since the resolution was passed, this has not gone very far. Rather than repeating ineffectual front-stage performances, what is needed is a strategic alliance between unions and peer educators in the workplace that synergizes their respective strengths—the mobilization of collective power and the ability to reach and work with individuals.

**A Strategy of Specialized Roles between Unions and Peer Educators**

It was clear during my research that many peer educators in the mining company and other workplaces lacked both power and resources. Although this did not affect informal activities, it restricted their ability to mount campaigns or collaborate with other groups which, in turn, sapped their effectiveness and morale. At Mineco, peer educators, could, in theory, go to a liaison officer who would request resources from the company’s
HIV/AIDS Office. In practice, during the five-month period of my research with the peer educator group, all requests—for refresher training for peer educators, training of new peer educators, as well as requests for “uniforms” (effectively shirts and caps)—were stalled. On two occasions the liaison officer attended meetings, acknowledged peer educators’ problems, and promised to resolve them. At the end of my research period, one peer educator suggested in exasperation that the liaison officer be invited once again so that he “could make more promises to them.”

When the peer educators asked local managers to provide resources for a community clean-up project in nearby informal settlements, this was also turned down. Peer educators wanted to use a company truck to collect trash that filled the settlement’s road and alleys. They also wanted to convert old oil drums into rubbish bins that would be painted with AIDS logos. Such a campaign would obviously bring peer educators into contact with community members. Mokwena, the group peer educator coordinator, explained their rationale: “If the people see that we care then they can listen to us. They will love us. They will be close to us. So if we speak to them, then they will understand us. But if they see that they are suffering, but we are doing nothing, we don’t even come and visit and speak to them, then they think ‘Okay, you are just like them. You don’t care about us.’” The company’s refusal to agree to the peer educators’ request led them to jettison the project undermining the group’s attempts to make itself relevant to local communities.

To mobilize both internally and outside the company, Mokwena asked for a seat on the local Partnership Forum, a joint consultative body largely made up of management and union representatives. This was granted, however, Mokwena quickly realized that just having a seat on the Forum was not going to ensure that he could get the help peer educators needed. Under pressure to contain costs, managers were reluctant to meet requests for resources, and without union backing for Mokwena’s requests it was obvious that his seat would be little more than token. Through direct talks with union leaders, he thus began to educate the unions on HIV/AIDS in general and the role and needs of peer educators in particular. He brought a Person Living Openly with HIV/AIDS (PWA) to talk to the union and tried to exert pressure on unions by informing them about progress other, competitor unions had made on HIV/AIDS. He noted that when making or hosting a presentation either at a union meeting or at the
Partnership Forum, the critical response he was looking for was simple: Did union leaders ask him questions? For Mokwena, this was the first sign that an audience was beginning to grapple with the issues he presented.

With union support, the value of the peer educators’ single seat on the Forum was magnified. The peer educator group was able to leverage more resources from management that would support their formal and informal work through training and capacity building, securing the right to give formal talks in the workplace, and obtaining resources to run community projects. The strategic partnership that was formed allowed unions to do what they did best—support claims on management that needed, because of their collective power, to be taken seriously. Peer educators could then exploit the benefits the unions had won by doing what they did best—talking with individuals at work and in the community.

Opening Up Contestation within Unions over HIV/AIDS

By promoting union-peer educator alliances, peer educators force unions to critically examine their attitudes and policies toward HIV/AIDS. These alliances can also add to the ranks of peer educators. Thus, Mokwena describes what happened when a trade unionist, Thabo Nonyane, visited his office the day after he had brought a nursing sister to talk to the Partnership Forum to talk about HIV/AIDS and peer educators.

Thabo came to congratulate me for bringing the professional nurse to the Partnership Forum. He also wants to be trained as a peer educator to enable him to speak to the people of his union during meetings. And to introduce HIV/AIDS and Wellness Programs to his church.

I was very happy because Thabo was one of the people who asked a lot of questions at the Partnership Forum. I really need strong leaders like him to be trained as peer educators. I realize that our managers/supervisors and unionists think they know [about HIV/AIDS], although they don’t.

When unions publicly back peer educators as part of a strategic workplace alliance around HIV/AIDS, a valuable signal is sent—one that may, however, be only weakly received in backstage space. To address issues more effectively here, unions need to engage in the risky process of challenging their members’ differing beliefs and practices about HIV/AIDS. This is a gradual and complicated process that also involves other powerful
institutions and actors—notably South African churches and traditional healers.

Churches and the Response to HIV/AIDS

Most peer educators are religious; almost 80 percent of the six hundred surveyed peer educators reported attending religious services at least twice a month, and it was clear from interviews that many were extremely active in the life of their churches or other religious organizations (see Chapter 3). Having become peer educators, they saw the silence of churches on HIV/AIDS and, more generally, sex as a critical problem. Joe Rantete in Mineco, referring to his own church, put it, “The church is not doing enough in the fight against the pandemic. They only want to pray for those who are involved.”

For many peer educators, churches, like unions, represent a potentially powerful ally in the fight for behavioral change—one that has also not fully mobilized. As Mokwena, during a group discussion on the role of churches and HIV/AIDS, put it: “The churches have been silent for a long time. They don’t want [to talk about] condoms, but they are burying their own people [from HIV/AIDS]. We can go deep into churches. They have loyal people who can help us.”

Rantete went further to talk about the failure of the church in responding to those who came to it for help on sex and HIV/AIDS with “stony silence.”

I believe that if the pastors and priests can include the issue of HIV/AIDS and sex in the theological programs this will make people more aware of this pandemic virus. The church is regarded as a conscience of humanity and the custodian of moral values, therefore if churches break the silence on sex and HIV/AIDS instead of stony silence or a counsel of [sexual] repression when people turn to the church for direction on sexuality, we will win against this virus. Putting a blanket on the subject of sex sabotages any serious attempt in fighting HIV/AIDS.

As Rantete indicates, the silence from churches around sex is often based on rigid moral codes that do not address the actual sexual practices of many church members. Sticking dogmatically to these ideal codes can,
as Rantete put it, result in “simplistic answers that HIV/AIDS is God’s punishment for the immoral corruption of humankind.” Some churches went further to suggest that if HIV/AIDS was a punishment from God, then prayer could cure people of the disease.

My wife and I were listening to a pastor on a local [Setswana language] community radio station. People from his church were claiming that the word of God had healed their sickness. They were weak, HIV-positive, but now they are cured by the pastor…. Some members of the pastor’s church testified that Jesus is the Anti Retroviral Treatment…I know that religion can strengthen someone’s faith. Christians know that Jesus died for every one of us. By accepting him while in this life is like preparing for life after death, but no prayer or religion can cure AIDS.

Alternative explanations of HIV/AIDS need to be challenged, and for this to be successful churches need to break the silence and address AIDS in the context of their own congregations’ daily lives. This is not easy because congregations are often divided about what should be done about HIV/AIDS. Here, a peer educator’s account of what is happening in his own church illustrates the difficulty:

The assistant of the Reverend sometimes when he sees that there is a lot of people and after the service he used to say [to] the parents they must teach the children about HIV/AIDS. They mustn’t be afraid to talk about [HIV/AIDS]. [But] some other parents they say, “No, this is rubbish. We can’t say, we can’t talk to children [about] HIV/AIDS. How can I face my children and say ‘When you sleep with your girlfriend or boyfriend you must use this and this, this.’ ” They say, “This is nonsense.” There’s some people who don’t understand. They say “No! We’re misleading our children.” Because they say we teach the children to go and sleep together with their boyfriends or girlfriends.

Churches in South Africa, while not all-powerful, are critical in dealing with the AIDS epidemic for at least two key reasons. First, when pulpit messages correspond to the realities of AIDS—that is, acknowledge that church members are being infected with HIV and are dying of AIDS—this delegitimizes alternative explanations of the disease. Second, and perhaps more important, when church leaders promote lay (peer) activity
within church congregations—through women’s meetings, choirs, and cell meetings—this allows the message about HIV/AIDS to reach the backstage spaces to which church leadership has only limited access.

**Traditional Healers, Alternative Health Beliefs, and the Response to HIV/AIDS**

Outside mine hostels one sees a typical scene that is replicated across South Africa wherever street traders set up shop: healers and their sales agents hawking herbal remedies for every conceivable illness and problem. Today, those who have or fear contracting HIV/AIDS are some of the most eager buyers. In the contest over explaining and advising on HIV/AIDS, one of the most difficult challenges a peer educator faces is dealing with alternative therapies that run directly counter to Western medical experts’ explanations and advice about what has caused the epidemic and what to do about it. In backstage space peer educators enter the ring to do battle with opponents often well above their own weight—healers and hawkers who draw on sources that, for many South Africans, are far more powerful than the information produced by a raft of Western scientific experts: the ancestors, traditional knowledge and beliefs, or God.

At one of Mineco’s group meetings, Peter Mopedi raised how in his attempts to educate coworkers about HIV/AIDS, he constantly came up against sellers of Aloe Extra—an herbal tonic widely promoted though a network of agents in townships. Pitchmen and women for Nature’s Health Products, the company that manufactures and sells Aloe Extra, would extol its virtues. Nature’s Health Products is careful not to overstep the line and claim its products cure HIV/AIDS, but it comes close enough to imply that it does just that. Its Original Formula, claimed to be the “No. 1 Best Selling Health Drink in South Africa,” and which contains “unique herbs used by traditional healers in South Africa for centuries” will, among other things, “strengthen your immune system.” Alternatively, you can buy the company’s Anvirem, a “natural antiviral remedy” that “supports and boosts immune system [and] helps in overcoming viral infection which can cause: weight loss, coughing, flu, boils, skin rashes, loss of appetite, lip sores, shingles, low energy [and] thrush” (Nature’s Health Products ND). In townships and informal settlements, where the writ of advertising standards
authorities is absent, the company’s agents, working on commission, have free reign. The latest sales pitch, Mopedi reported, involved taking a glass of dirty water and putting in a small amount of the herbal tonic. The water would clear. It was explained that Aloe Extra would do the same in your blood, removing pollution, including HIV.

Other hawkers of herbal remedies regularly make similar claims about their products and HIV/AIDS. Attempting to scrape a living from commissions, they are constantly seeking sales. Tlouane, working in Minco’s HR, complained that she’d had to eject one such salesperson. This saleswoman had come into her office and asked if she could talk to workers about her wares. Tlouane did not hesitate to refuse her request and tell her to leave immediately. “She must say it [the claims for her products] outside, not in the office where I’m telling people there is no cure for HIV/AIDS [other than containment with antiretroviral drugs].” She was nonetheless frustrated because she knew the woman would be able to approach people only a few meters from her office outside the building.

These peer educators were working assiduously to convince people to change their behavior but after they finished talking, all a coworker had to do was leave work and on sale were many “quick fixes” that, for a few Rands, claimed more than Western medicine had to offer. To make matters worse, some of those selling herbal remedies were retired nurses or other “wise” people. Peer educators, with their limited training and knowledge, might have difficulty countering people who had great credibility in the community and who were peddling a message that was far more attractive than the one peer educators were promoting.

This is why many peer educators, like those in the mining group, believe they have to work with traditional healers. Although convincing traditional healers and quack practitioners not to sell “cures” for AIDS may seem overly optimistic, Mokwena told me of a church member who had sold herbal remedies but stopped when one of his clients, also a church member, died after substituting his herbal remedy for diabetes medications. “He warned us [church members] to be careful of people who are selling medicines and tablets like him because they are confusing the people by telling them their medicines can cure HIV if you stop your treatment and drink their herbal medicines. The brother promised to be honest when dealing with people.”
Peer educators realize that it will be very difficult to work with traditional healers in the current South African context. As we saw in Chapter 4, in South Africa, Western medicine has not replaced traditional healing; it has merely driven it underground. For this reason, unlike working with unions or churches, which operate in both front- and backstage spaces, traditional healers work exclusively in backstage space. They thus lack any formal structures of leadership and organization, functioning either individually or in scattered, often fractious, groups.

The lack of formal structures among traditional healers means that there is no leadership that peer educators can approach, and it is difficult for even enlightened healers to attempt to voice a coherent front-stage message around HIV/AIDS. Among traditional healers there is no equivalent to the union’s network of branches, local officials, and shop stewards that provides channels that can reach into backstage spaces—a structure potentially replicated by church office bearers, deacons, and other lay leadership. While there has been an overreliance on leadership pronouncements among unions in responding to HIV/AIDS and a failure to drive down the issues into the membership, something that churches are replicating, the limited structure among traditional healers means that there are no systematic routes into backstage space. Moreover, there is no regulation of traditional healers who are in direct competition with each other.

Yet, despite these difficulties, getting traditional healers to speak in harmony with peer educators around HIV/AIDS is important. While it is unlikely that every traditional and spiritual healer, let alone the hawkers of supposed cures, can be brought on board, there are some who could. Sam Mangala in Mineco, who occupied a junior management position and was completing a bachelor’s degree by correspondence, identified his religion as “traditional Northern Sotho” (i.e., traditional Sepedi, non-Christian beliefs). His mother was a traditional healer, and he explained what he thought might help control the epidemic:

Doctors, medical doctors, maybe they think that the traditional healers are going to take bread away from them. But I don’t think they should have that idea. If we look back to history itself, the Africans were with [traditional] medicine… They [medical doctors and traditional healers] need to supplement one another somehow. And they [traditional healers] should
not be undermined... there are chancers [i.e., charlatans] in the field, but not all are chancers.... I think [we need to] work hand in glove with traditional healers. That may work.

It will obviously be far easier to work with traditional healers if they have an organizational structure that will allow them to engage in a broader social discourse around HIV/AIDS and give them the ability to set standards of counseling, treatment, and care that will prevent individual healers bettering what they collectively agree upon. The Traditional Health Practitioners Act (Government of South Africa 2007) makes provision for the recognition, registration, and regulation of traditional healers in South Africa. When promulgated a range of structures will be put in place to oversee registration and regulation. Given the challenges of regulating practices that encompass social, pharmacological, psychological, and traditional knowledge in addition to the use of ancestral guidance, this will be difficult. But it is clearly an important step in aligning the voice of traditional healers around HIV/AIDS.

Conclusion: Harmonizing Voices in Backstage Space

Peer educators have access to backstage spaces, but it is clear that they are no more than one voice among many. Up against competing explanations of HIV and AIDS, told by people with equally appropriate linguistic repertoires and similar sociocultural familiarity, peer educators need support. This support needs to move from rhetoric delivered from front-stage platforms to the penetration of backstage spaces if individuals are to confront the implications of HIV/AIDS for themselves and for their own behavior.

Unions are an important influence on many South Africans. But unions have yet to respond to the epidemic outside of the familiar terrain of collective action. Attempts to overcome the paralysis of union leadership in grasping the need for individual behavioral change in the era of AIDS are instructive. In contrast to calls for more conferences and resolutions—which simply replicate previous attempts to implement flawed solutions—peer educators need the unions to project their voice into backstage space. Until this is the case, it will be all too easy for individuals to slide away from the difficult realities of dealing with HIV/AIDS.
For unions this will be challenging. Nevertheless, if the difficulty unions have in responding to HIV/AIDS is clearly identified, a start can be made. The first step is for unions to drive the issue of HIV/AIDS into lower leadership structures in ways that will raise internal difference and a difficult process of peer alignment around HIV/AIDS. Only then will unions be able to add their voice within the backstage social spaces where it is so clearly needed. Much the same is necessary with other important social voices, such as churches and traditional healing, though each one will have to take into account its particular structures and mission.

This process of harmonizing voices backstage is not a discovery of the limitations of individual change and a realization that collective action is necessary—though superficially it may resemble this. Peer educators may realize the limitations of their work with individuals, but this rises from backstage conflict around HIV/AIDS that will not, cannot, be resolved by collective action. As peer educators attempt to get others to project their voices backstage, this will involve lobbying if organizations are to be turned. But if peer educators abandon their quest for individual behavioral change and seek rather to capture unions, churches, traditional healers, and other social agents by means of resolutions of support, then their work will come to naught. The value of turning these institutions in support of individual behavioral change is the resonation of all voices backstage.