DEMONIZING WOMEN IN THE ERA OF AIDS

An Analysis of the Gendered Construction of HIV/AIDS in KwaZulu-Natal

By

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DECLARATION

I hereby declare that this thesis is my own original work. Any work done by other persons has been properly acknowledged in the text. This thesis has not been submitted for any other degree or examination at any other university.

SIGNED: ..... DATE : 15 March 2000

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ABSTRACT

As the second decade of AIDS draws to a close, researchers and others involved in the AIDS effort have come to appreciate that complex interactions between social, cultural, biological and economic forces are involved in shaping the epidemiological course of the disease. Nevertheless, the process by which these variables interact and affect each other remains poorly understood, with many of the shaping forces yet to be fully explored.

In South Africa, the sociocultural matrix in which the AIDS epidemic is embedded and its role in shaping the interpretation and experience of AIDS have not been fully analyzed. This thesis represents an attempt to elucidate the finer nuances of some commonly-held local beliefs, perceptions, symbolic representations, ethnomedical explanatory models and mythologies associated with AIDS. These associations are viewed as directly informing the way in which Zulu-speaking people are experiencing and responding to HIV/AIDS in KwaZulu Natal, currently home to 1/3 of the country's estimated 3 million HIV infected people. In particular, the focus is on the gender patterning of AIDS, with ethnographic data drawn from extensive field experience at St Wendolin's Mission, a peri-urban settlement in the Mariannhill district of Durban. The shared perception of women as naturally 'dirty', as sexually 'out of control' and suspected of using witchcraft in new ways, are identified and discussed as key

conceptual strands contributing to the sociocultural construction of HIV/AIDS in that community. It is argued that these notions are metaphorically joining and combining in ways that 'gender' the AIDS epidemic and simultaneously 'demonize' women.

The central tenet of this thesis is that HIV/AIDS is fundamentally associated with women as a female caused and transmitted disease that can and does affect men. The author argues that the gendered construction of AIDS in St Wendolin's is a reflection of patriarchal resistance to women's changing roles and expectations that represent an overstepping of culturally defined moral boundaries. Deeply embedded ways of thinking associated with notions of gender are viewed as germane to the disempowerment of women that ultimately impedes the fight against HIV/AIDS. The thesis concludes with a discussion on the opportunity which the current AIDS epidemic presents for wider sociocultural transformation, and how this might be achieved through an AIDS 'education for liberation' based on the philosophies of Paulo Freire.

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To my supervisor Professor Eleanor Preston-Whyte, Deputy Vice Chancellor for Research at the University of Natal, who became a friend. Her enthusiasm for this study was only matched by my own. This kept me going through some grueling months of putting down on paper so many thoughts and insights that were not at all easy to articulate. I am deeply grateful for the consistent level of support, empathy, encouragement, and the incisive suggestions she provided during supervision.

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There is little sense in attempting
to change external conditions,
you must first change inner beliefs,
then outer conditions
will change accordingly.

BRIAN ADAMS
How To Succeed

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CHAPTER 1

INTRODUCTION

Anthropologists who turn their professional attention and research activities to AIDS, start with the understanding that AIDS is more than a simple biomedical entity; it is also a cultural construction. Disease from an anthropological perspective, especially a contagious disease of epidemic proportion, is a phenomenon heavily laden with meanings that shift, expand and change as the epidemic grows. This thesis is an attempt to elucidate some of the meanings attached to the cultural construction of the current HIV/AIDS epidemic among Zulu-speaking people living at St. Wendolin's Mission in KwaZulu-Natal. The thesis deals with AIDS in terms of the people's words, images, ideologies, myths and the metaphors that they associate with the disease.

This study is essentially about conceptualizations of HIV/AIDS and women. My main argument is that in the current South African AIDS epidemic, a largely heterosexual epidemic, the two notions are closely linked at various levels of cognition. These linkages reflect a gendering pattern that locates HIV/AIDS in the female body and symbolically 'feminizes' the disease and 'demonizes' women. The aim of this thesis is to explore the gendering of HIV/AIDS by:

1. Describing the process by which the cultural construction and representation of women at St. Wendolin's informs the cultural construction and representation of AIDS, and vice versa.
2. Analyzing the values, myths and meanings, including symbolic meanings, attached to these constructions.
3. Discussing how the shared knowledge, meanings and symbolic representations shape local understandings of gender, sexuality and the experience of HIV/AIDS.

4. Arguing that AIDS education must become more culturally sensitive and part of an effort to promote 'critical consciousness' and change by challenging sociocultural assumptions including hegemonic gender ideologies.

This thesis is essentially an attempt to understand the cultural roots of non-medical representations of AIDS which, it is argued, affect the ways in which people are prone to think about and respond to the disease in South Africa. Related local studies have focused on specific aspects of AIDS-related phenomena, such as a recently commissioned nationwide study by the Department of Health on sociocultural aspects of condom use (1). To the best of my knowledge there has been no local attempt to deconstruct the 'reality' of HIV/AIDS by disentangling the complex web of meanings attached to the disease called AIDS. This thesis represents a humble attempt at disentangling that web. With a primary focus on the gendering of the HIV/AIDS epidemic, this thesis extends and complements research from other parts of Africa including Zaire (Bledsoe1990), Botswana (Ingstadt 1990), Uganda (Obbo 1995), Kenya (Udvardy 1995) and Tanzania (Haram 1996) which suggest that women are being blamed for the spread of HIV/AIDS. No previous study has been undertaken in South Africa to explore what I would argue is this most fundamental link between women and AIDS.

The AIDS epidemic, that many now refer to as a pandemic due to its high rates of infectivity and widespread nature, is currently in a transition stage in South Africa. Up until now it has been primarily an epidemic of increasing HIV infection since the start of its recorded growth in the white population in the early 1980s, and in the black population from the late 1980s. HIV infection refers to a latent condition that is diagnosed by the presence of HIV antibodies in the blood. No somatic symptoms are manifested with HIV infection. After several years of HIV incubation and growth in the blood, the virus begins its

progressive depletion of the immune system. With a depleted immune system, the person easily falls prey to various opportunistic infections and chronic conditions. For many people infected with HIV in this province, the somatic symptoms associated with progressive immune system breakdown, referred to as AIDS-related illnesses, are now beginning to manifest themselves. Concurrently, death through AIDS is rapidly becoming a common occurrence.

Last year (1998) KwaZulu-Natal's daily newspapers have for the very first time, carried several stories on how various communities are coping with the new need to care for AIDS-affected relatives, orphans, and those who are dying or who have died through AIDS (2). Such reports, coupled with my own experiences of researching AIDS-related issues over many years in this province, have led me to conclude that 1998 represented a significant year in terms of people's acknowledgement of the AIDS crisis. Previous studies on local attitudes towards AIDS concurred with the finding that many people, especially young people, have denied the existence of AIDS (see Friedlander et al 1991; Naidoo et al 1991; Preston-Whyte et al 1991; Roos et al 1995; Varga and Makubalo 1996; Lerclerc-Madlala 1997). Since 1998, I have not encountered anyone who has denied the existence of AIDS. Conversations about AIDS today often include mention of actual first or second-hand knowledge of an AIDS-related death. It would appear that whereas the increasing rate of HIV infection could be ignored because of its lack of visibility, AIDS-related illnesses and death cannot be ignored in the same way. For an increasing number of people, seeing is believing.

As the growth of HIV infection makes way for a concurrent growth in AIDS, the meanings attached to the disease and its symbolic representations are also shifting and changing. Herein lies a limitation of the current thesis. Like the disease itself, the cultural construction of AIDS is changing and growing. My attempt here is to capture and describe the cultural construction of AIDS at one

point in time, as the epidemic transforms from having been largely an epidemic of HIV to becoming an epidemic of AIDS. This thesis is based on events during a particular period in the on-going adaptation of one small community, St Wendolin's Mission near Durban, to the growing AIDS epidemic. In the case of a chronic, progressive and currently incurable disease such as AIDS, the ticking of time represents steps closer to death. Thus time, quite literally, changes everything. With AIDS, the human body undergoes a transformation marked by opportunistic infections that eventually debilitate a person, requiring him to seek care and assistance. Along with bodily changes are psychological and spiritual changes that can be expected as the person adjusts to his/her new role as 'sick-person'. In the case of AIDS-related illness, the infected person must deal with the added burden of having an illness that currently carries a strong social stigma. Increasing morbidity will bring with it changes in how immediate family members and caregivers respond to the sick-person. As the epidemic grows in the community with an ever-increasing number of people requiring care and a growing population of orphaned children left behind by parents who have died of AIDS, peoples' experiences of the AIDS epidemic will change. Thus, when undertaking an ethnographic study of a chronic, debilitating disease such as AIDS, the fact that the ethnographer is dealing with one particular 'slice of time' presents the most apparent shortcoming of the study. As people's experiences with AIDS change and grow over time so too will the sociocultural construction of the disease change through time. Much still remains to be seen (and studied) in people's on-going adaption to this 'new' disease of HIV/AIDS.

MOTIVATION AND BACKGROUND

Early in 1995, I was contracted as an external evaluator by a local non-government organization known as The Valley Trust. My task was to evaluate their recently launched AIDS prevention education program. The Valley Trust is one of the largest and best known of KwaZulu-Natal's non-government

organizations. Its programs aim to promote the medical and social upliftment of the large semi-rural African population residing amongst the rolling green hills of the Valley of a Thousand Hills, some 60 kilometers from Durban. From an anthropological perspective, a good deal is known about the history and culture of the Zulu-speaking people in the Valley of a Thousand Hills. Two of South Africa's most famous black anthropologists, Absalom Vilakazi and Harriet Ngubane, undertook professional fieldwork in the area. Both produced books on the way of life in the Valley, the one in the 1950s and the other in the 1960s, which are still read by anthropology students in South African universities today. Ngubane's book entitled Body and Mind in Zulu Medicine (1977) dealt specifically with the ethnomedical knowledge of the people she studied. Reading these books inspired my interest in how an organization such as the Valley Trust might 'fashion' a relevant AIDS education program for the people who shared this particular sociocultural background. I then set off in my task to interview the 'target population' of The Valley Trust's AIDS education program, study the various documents and health promotional materials used in training, and speak to other 'relevant stakeholders' involved in AIDS education in the province.

Three months later, as I sat to write the final report, my thoughts were focused on an overwhelming (and sickening) feeling that AIDS education in this province was 'missing the mark', and headed in a wrong direction. My assumption had been that years of accumulated sociocultural knowledge about the 'target population' would somehow be reflected in the design of local AIDS interventions, or at least would be used to inform the methodology or content of these interventions. My assumption had been naïve. The program had been designed by an outside 'expert' who had drawn far more from her AIDS education work in gay communities in the United States than from anything local. I came to learn that this organization was far from unique in its reliance

on foreign AIDS education models and expertise. Very limited efforts had been made at that time to adapt these models for local consumption. After having completed this evaluation, I went on to evaluate several other AIDS education programs in the province. I found that AIDS prevention education has changed only slightly through time, and not enough to make any kind of real impact on the growth of the HIV/AIDS epidemic in KwaZulu-Natal.

My initial experience as an evaluator of AIDS education programs convinced me of the need to develop more socioculturally sensitive and relevant AIDS education. My experiences in KwaZulu-Natal up to that time had made me realize how much 'cultural baggage' was being brought to people's experiences with and responses to AIDS. Much of this was either poorly understood by AIDS educators, unacknowledged, or dismissed as being 'unscientific' and therefore unworthy of consideration in a proper biomedically-oriented AIDS education program.

Moreover, it seemed that the cultural dimension of AIDS was being ignored due to a peculiar racial dynamic that continues to exist in South Africa. Black South Africans are frequently seen as uneducated, a conception which might well be exacerbated by acknowledging some of the more commonly held beliefs about illness. A black colleague co-ordinating another AIDS program succinctly (and bluntly) summarized the problem: "Whites here already think of us as animals. We don't want to give them more to support their case." For a variety of reasons then, valuable sociocultural information and indigenous knowledge that could help to make local AIDS education more culturally sensitive, relevant and perhaps more effective, was being overlooked.

My professional training and interest in anthropological issues of health and illness have compelled me to try to make a contribution towards a more culturally-informed AIDS effort. The initial research I conducted in 1996 sought

to assess responses to the growing AIDS epidemic of high-school and university students from several urban townships around Durban, including Clermont, KwaNgendezi and Chesterville (see Leclerc-Madlala 1997). Soon afterwards, and with this aim still in mind, I began working towards a Ph.D.

METHODOLOGY AND FIELD EXPERIENCE

This thesis is based upon my experiences and observations in the community of St Wendolin's Mission in the Mariannhill district of Durban. 'Formal' fieldwork for this thesis took place mostly during 1996 and 1997, but the totality of my field experience actually spans the time I became a resident in that community to the present. From 1985 I began to collect material on ethnomedical beliefs among the people in St Wendolin's that I intended to one day use as a basis for a doctoral thesis. In my case, the role of the anthropologist as a professional insider/outsider was supplemented by my personal role as insider/outsider in the community. I came to this country in 1985 from the United States in order to marry my husband who is from the St Wendolin's community. Although we were married in the local Catholic Church in accordance with Catholic matrimonial ritual, this did not preclude my participation in some traditional rituals to mark our marriage. My participation was seen as a necessary step from the perspective of my husband's family, and I therefore complied. Among other things, this involved the slaughter of *isikhumba* and y*okucola* beasts through which the bride becomes integrated into the descent group of her husband's lineage.

Apartheid laws of the time defined several aspects of my life including where I, as a 'white' person, could live legally with my 'black' husband. Accordingly, a person who married someone of another racial group was considered, for residential purposes at least, to take on the racial classification of the darker spouse. This provided me with the legal privilege of living with my husband in St Wendolin's, then officially defined as a 'black spot' within an officially 'white'

South Africa. Hence I had little choice but to become a resident of St Wendolin's until the demise of the Group Areas Act in 1991. During my 'enforced' residency the word AIDS began to be heard on the radio, and seen in the newspapers and popular magazines. Beginning in 1987 I was involved in coordinating a Saturday School project in the community, where I incorporated AIDS awareness as part of the program. School-going youth were the primary participants in this project.

The academic background that I brought as a new member of the St Wendolin's community consisted of formal training in anthropology and social psychology. In the early 1980s I conducted research in Gabon on therapy management groups among the Nbedi-Ndzabi people. This experience informed my Masters degree studies. I was, and am, keenly interested in African cosmology and how it relates to conceptions of health, illness and the management of disease. Early on in my stay at St Wendolin's, I started to collect material of a medical anthropological nature. Sickness, death and many funerals due to political violence characterized life in many African communities in this province, including St Wendolin's, during the latter part of the 1980s and early 1990s. While my primary concerns at the time were more about survival than research, this violent epoch in South Africa's history did provide ample opportunities to engage people on topics related to illness, therapy, ritual impurity, death, and the meanings attached to all manner of misfortune.

The 1996-1998 period of fieldwork consisted largely of interviewing people on issues related to HIV/AIDS, issues that I knew existed and I had some insight into as a result of many years of conversations and discussions held with people in the community during the course of my previous residency. From 1996 to 1998 I conducted interviews with ordinary people from the community, professionals from the local Mzamo Clinic and St Mary's Hospital in Mariannhill, young people who were participants in the Saturday School project, and

traditional healers from the community and surrounding African townships. I sought to elicit the views from as wide a cross-section of the local community as possible. During this time period I was also engaged by the AIDS Foundation of South Africa to evaluate their AIDS education program for traditional medical practitioners. This brought me into contact with a much wider network of traditional healers and provided the opportunity for collecting much valuable information from them on people's experiences with and responses to HIV/AIDS throughout the province. As the community of St Wendolin's was beginning to confront the physical manifestations of the growing AIDS epidemic, many people turned to me for information and advice. By 1996 it was well-known that I was knowledgeable and interested in AIDS, having conducted my own AIDS awareness campaigns in the community since 1987. I was also a trained AIDS counselor. Thus, much of the information and ethnography submitted in this thesis was collected (and pondered upon) over the course of many years.

THE EMIC/ETIC CHALLENGE

In large measure, my personal background as a white, educated, female foreigner proved to be an advantage rather than a handicap during my stay in St Wendolin's and while doing research. The fact that I was married to a well-known and well-respected member of the community who was politically active in the area was certainly advantageous. Being white and living much like any other married woman in St Wendolin's brought admiration from the people. Indeed, in the early years people used to gather around our home just to watch 'the white *makoti*' (the white bride) wash clothes in a bucket and sweep the verandah. The fact that I was not South African seemed also to be a significant factor in the open and honest way in which many people dealt with me. Often people would remark on how I wasn't like 'these whites in South Africa.' Not fitting the stereotypical mould of a white person, being married to a 'home-boy', and living in a black area during the apartheid era, I was a novelty and a

hero of sorts. Being an enigma had its advantages. For one, it lent itself to less emotively-charged and more expectation-free social interactions. I was generally well received by the people of St Wendolin's. Having defied the laws of the regime which they were struggling against along with the rigidly upheld and accepted norms of racial segregation that existed at the time, the community was eager to accommodate me.

Being from a foreign country and mostly ignorant of the finer nuances which defined the local political dynamics in the community, people seemed to be both eager to protect and inform me about all aspects of their lives, most especially their culture and their politics. Essentially, I was a '*makoti*', a young wife, and my primary expectation was to look after my husband and produce children. My home in St Wendolin's was my husband's family homestead. We shared a small three-room house with my unemployed brother-in-law and a veranda full of chickens. A few meters away was the house of my husband's eldest brother where he lived with his wife and seven children. In the next small house was my husband's elderly grandmother with her numerous goats. Much of my first few years in St Wendolin's were spent chatting with my sister-in-law, looking after children, getting to know other relatives, and listening to and learning from the women's gossip. My first two children were born during my stay there, and my sister-in-law had two children of her own during that time. I learned much of the local ways and means (and meanings) of womanhood and motherhood during that time. Being a Catholic, I joined Catholic woman's circles in an effort to get to know other women.

In summary, my life in St Wendolin's was defined by my primary role as a wife and then as a mother in the community. It is this role rather than my role as a professional researcher, that opened the way for in-depth discussions and thus provided the real opportunities for the collection of finer-grained ethnographic

data. It was primarily in the process of becoming a 'wife' and becoming a 'mother', that I learned about the deeper meanings and sociocultural expectations embodied in those roles. As an in-marrying woman in what soon impressed me as a very patriarchal community, reflecting on the sociocultural construction of femininity was essentially an exercise in self-examination.

PARTICIPATORY RESEARCH

Cornwall (1996:94) has argued that most conventional modes of social science research tend to be a one-way process that places the researcher in a pivotal role of gathering disparate items of information to be processed elsewhere. From the onset of formal research in 1996 I was determined that the strategies and methodologies that I used in acquiring information would not be part of a process of merely 'finding out'. As a respected member of the St. Wendolin's community, one to whom people turned to for advice on all manner of life issues including health and HIV/AIDS, I felt a strong sense of duty and responsibility towards the people. Any research that I was going to undertake amongst them would have to involve not only a process in which the participants would be actively engaged in exploring and representing what they know, but learning something of value in the process.

The approach I chose was what Korten (1980) has termed a 'learning approach', whereby the conventional separation between researcher and participant is broken down. I selected the aforementioned Saturday School project as the site for conducting my initial research. From a group of thirty-two school attendees, I organized six gender-specific focus groups of six to seven individuals. Eighteen women were divided into five groups, and fourteen men were divided into two groups. The ages of participants ranged from fifteen to eighteen years. My intention was to initiate discussion about HIV/AIDS while developing an atmosphere of mutuality. After explaining the aims and objectives of my research, I would express my desire for openness

and a two-way commitment to learning. This helped to ensure that discussions opened up in a non-threatening way as we focused upon local concepts, local explanations and local interpretations of issues related to sexuality and HIV/AIDS. A conscious effort was made to maintain an informal atmosphere whereby the data collection process would, as near as possible, resemble familiar conversation. This relaxed manner of research allowed informants to ask questions that some claimed to have been too shy to ask health authorities or parents. I used in-depth interviews to collect sexual life-histories of some informants. In these free-flowing unstructured narratives, people spoke at varying length (and at varying levels of disclosure) about circumstances surrounding their fist sexual encounters and how they have experienced AIDS in their lives. In addition to sharing knowledge about HIV/AIDS the research process was used as an opportunity to examine local interpretations and meanings attached to femininity and masculinity, and to explore the ways in which these notions inform expressions of sexuality that may be putting people at risk for HIV/AIDS.

The methodology that best describes my approach to research for this thesis is participatory research. By actively engaging people in the process of exploring and reflecting upon what they know, I intentionally sought to use the research process as a means for people to validate themselves as knowledgeable, active subjects who were capable of interpreting and ultimately changing their behaviors and situations themselves. Rather than 'taking away' the insights and knowledge that I had gained as a researcher/co-learner in this process, my intention was to use that information as a basis for suggesting ways in which AIDS education may become a site for initiating the sociocultural transformation needed to fight the growing threat of HIV/AIDS. Thus, a major part of my motivation for pursuing this research was to explore ways in which research can be linked to action, in this case action in the form of AIDS intervention.

KNOWING, LEARNING AND DOING

By choosing to pursue a research agenda that served the shared interests of both the researcher and the researched, I was following a tradition of knowledge production that owes much to the theories and practices of Paulo Freire, the Brazilian liberation theorist. Set down in his famous book entitled The Pedagogy of the Oppressed (1972), Freire provided a framework for transforming adult education into a program for developing 'critical consciousness' among learners. Armed with such a 'critical consciousness', Freire (1972) argued that learners would then be in a position to challenge and change the circumstances that often ensured their oppression. Most practitioners of participatory research today (or participatory action research as some refer to it), acknowledge the widespread influence that Freire's work has had on the development of contemporary participatory research. While it is not possible within the limited space of this current thesis to discuss Freire's work comprehensively, his theories warrant some discussion since they have also influenced my research.

Freire was primarily concerned with the nature and aims of the educational process. He critiqued general practices in education and asserted that most educational activities did not challenge inequalities in the learners' lives but kept them passive and uncritical. This 'domesticating' approach to education failed to help people break through apathy and question the situation they were forced to live in. Freire argued that people who have lived their lives in marginalized and deprived positions need to develop a critical insight into the structures, ideas and practices in society and themselves that place and maintain them in positions of inequality. Only then, would they be better able to develop initiatives to change their situations.

Freire suggested an alternative 'education for liberation' which had as its main goal a 'desocialization' together with the development of 'critical consciousness.'

Freire's methodology consisted of what he termed a 'critical pedagogy' in which knowing and learning were linked through an ongoing cycle of action and reflection. He argued that the combination of learning and reflecting led to 'conscientization', the development of a critical awareness about the world participants lived in. This, according to Freire, was the essential first step needed for people to be 'liberated' from mythical ways of thinking that he saw as contributing to peoples' oppression. It was only when people had been conscientized through learning and reflecting that they then became full participants in their lives (Freire 1972:153). While primarily developed as a teaching approach for adult educators, Freire's pedagogy of 'education for liberation' has been widely applied beyond the realm of adult education. It is currently receiving much attention in the field of health, including health research (see de Koning 1996).

In Chapter 2, several recent health-related studies which have drawn upon Freire's philosophy and have incorporated participatory research methodologies in an effort to facilitate greater learning and reflection on the part of those being researched are discussed. It can be argued that health promotion has conventionally aimed to make knowledge available to those who lack it through the use of 'domesticating' approaches that fail to engage people in a critical way. Indigenous knowledge, often cast as folk beliefs, is all too often disregarded and treated as an undifferentiated morass of indigenous ignorance. 'Domesticating' approaches fail to take into account the internalized images and attitudes of those who are the objects of health promotion. This thesis represents an active attempt to move beyond conventional approaches to both health research and health promotion. The methodology was in the first instant exploratory, prompted by a desire to see more culturally sensitive and 'transformative' approaches to AIDS education. My objective was to elucidate local knowledge (including shared values, myths and meanings), and to argue that these indigenous perspectives and interpretations must be used to inform

HIV/AIDS interventions. In the second instance, the research process itself was interventionist and offered as an opportunity for learning and reflection on the part of participants. In the course of interviews, conversations, discussions and on-going AIDS education workshops, I intentionally sought to create a space in which people could reflect upon those cultural assumptions, myths, values and perspectives which they so graciously or sometimes hesitantly shared with me. Such an opportunity was well appreciated by participants, judging from the number of times participants, especially the younger ones, have expressed their gratitude and remarked on how they had never really talked nor thought about those things before. Thus, a major objective in pursuing the research for this thesis was to facilitate a rethinking of previously unchallenged cultural ideologies and assumptions about sexual behavior, notions of gender, and HIV/AIDS. This was done in the hope that it might lead to changed attitudes and an opening of spaces for behavior change, or at least serious consideration of it and possibly experimentation. The possibilities for incorporating and sustaining this process as part of a deliberate effort to develop an AIDS 'education for liberation' is discussed in Chapter 10 of this thesis.

THE THESIS

What started as an ethnographic study of AIDS soon became a study of both women and AIDS. Early in my stay at St Wendolin's I was impressed by the recurrent theme of women's 'natural' uncleanness that featured in numerous conversations and discussions about disease and about misfortune more generally. By way of being 'dirty', the English term used to refer to woman's 'natural' uncleanness, she was often blamed for or at least perceived to be somehow a causal agent in much of the misfortune that befell the community during my stay. These notions are further discussed in Chapter 5. The Zulu term *umnyama* was a term informants often used to describe a woman's 'dirtiness' in their language. Ngubane (1977:76) defined *umnyama* as a contagious pollution or a mystical force most often associated with women.

While Ngubane claimed that *umnyama* was believed to result from events such as birth, death, menstruation and miscarriage, my experiences led me to conclude that contagious pollution associated with women went far beyond specific reference to biological events and ideas of 'ritual' pollution. The notion of women as 'dirty', as possessing unique polluting qualities, seemed to coalesce around notions of women as representing a general danger to men and to society, with disease being one form of that potential danger.

A central argument of this thesis is that people's experiences of and responses to the new disease of HIV/AIDS in St Wendolin's are informed by some pre-existing ideas linking women and misfortune. For the most part, people's interpretation of HIV infection reflected a process by which the disease has been 'worked into' existing notions of pollution. People understood HIV as 'something in the blood' said to have no somatic symptoms. The blood that harbored this 'germ' and passed it onto others was discursively represented as female blood, as discussed in Chapter 8. Many informants claimed that they did not believe HIV existed at all because there was no 'proof' in terms of visible illness. Previous writers such as Krige (1950:331) and Bryant (1970:15) have noted that the great rule of pathology among the Zulu is that symptoms define the disease. Illness is realized through physical symptoms. A person who looks, feels and acts 'normally' is a healthy person, not a person with an illness. The concept of latency, of being 'sick' but not showing it, is not a well-developed notion in the Zulu way of conceptualizing illness. The exception to this rule would be a person affected by *umnyama* or ritual pollution. Here the person appears 'normal' and healthy, but he/she is 'infected' by a potentially dangerous or debilitating condition, which is believed to be contagious. HIV infection as a latent, invisible 'germ' in the blood, has lent itself to ethnomedical interpretations of pollution and 'dirt'. These points are further developed and discussed in the proceeding chapters, most especially in Chapter 8.

My reflections on this theme led me to conclude that indigenous explanatory models of HIV/AIDS were intimately bounded as part of the larger sociocultural construction of femininity in St Wendolin's. For the people of St Wendolin's, women and disease were linked notions, and any ethnographic study of the meaning of a disease in that community must necessarily involve a deconstruction of the linkages. Such an undertaking presented me with a challenge, for the linkages seemed to form a 'symbolic chain' with parts existing in a synergistic and changing relationship to one another. Along with deeply-embedded notions of pollution and ethno-explanatory models of disease, changing perceptions of women based on the negative way people viewed some of their contemporary activities, was seen as contributing to and reinforcing symbolic constructions of women as 'dirty' and dangerous. Chapters 6 and 7 are an analysis of some of the important 'new' perceptions that I argue are contributing to the cultural construction and the process of making meaning of HIV/AIDS among the Zulu.

What has become increasingly clear to me over the course of my continuing engagement in AIDS-related research and activities with Zulu-speaking people in St. Wendolin's and beyond, is that the current HIV/AIDS epidemic is adding new substance and a new dimension to a deeply entrenched and probably ancient symbolic construction of patriarchal society; a construction that links women, disease and death.

THESIS STRUCTURE

This thesis is divided into two parts. The first part consists of background information, which provides the context for the study and encompasses the first four chapters. The second part of the thesis examines all the 'conceptual strands' that I argue are being brought to bear in the process of gendering the current epidemic. How these contribute to the metaphoric construction of HIV/AIDS as a 'feminine' disease, (and 'demonize' women in the process),

and what implications this level of understanding may have for AIDS intervention strategies conclude the second part of the thesis.

This Introductory Chapter is followed by Chapter 2, a general review of current literature relevant to the thesis. As an anthropological contribution, this thesis draws upon several different bodies of literature and is essentially interdisciplinary. It relates to three areas of academic inquiry; AIDS, gender and symbolism, and a specific type of methodology, namely participatory research. Some of the more pertinent qualitative works on AIDS in Africa are discussed along with recent feminist literature on AIDS, studies that deal with AIDS and its symbols, and some recent health-related research that incorporates participatory research methods.

Chapter 3 looks at some facts and figures of the AIDS epidemic in the local context of South Africa, particularly with reference to KwaZulu-Natal province. An overview of the government's response to the growing epidemic as well as the response by local social science researchers is included.

Chapter 4 is a look at the St Wendolin's community. A brief history of the community is presented along with a description of the present day environment. Thought patterns relevant to the way people view disease is discussed, followed by a brief description of the people's experiences with and responses to HIV/AIDS.

Chapter 5 examines in broad perspective the notion of female pollution as a recurrent theme in ethnographic and other literature throughout the world. The Zulu notion of pollution, including ideas of *umnyama* and notions of women as 'dirty', are discussed. Ethnographic reference to and an analysis of the

behavioral implications of pollution among the Zulu are provided. My main argument in this chapter is that notions of women as metaphorically 'polluted' are still applicable today.

Chapters 6 and 7 focus on the 'sexual cultures' of men and women in St. Wendolin's and perceptions of some new sexuality-related behaviors associated with the changing role and expectations of women. Here, the question of women being perceived as more sexually active than in the past, and women using witchcraft medicines previously reserved for male use, is explored. Both of these general perceptions (that seem to have some grounding in reality) are seen as contributing to and reinforcing notions of women as 'dirty' and dangerous.

Chapter 8 is a look at some of the myths and metaphors that signify the current HIV/AIDS epidemic among the Zulu. I argue that deeply embedded notions that link women with HIV/AIDS draw upon folk-constructions of female bodies and local understandings of ethnopathological processes. Further it is argued that these common conceptualizations serve to 'demonize' women in this era of AIDS by representing the epidemic as something that is caused and spread by women; hence the title of the dissertation.

In Chapter 9 I analyze current AIDS discourse and discuss the growing discontent among women in St Wendolin's with culturally-sanctioned 'gender scripts'. Women's discontent and efforts to take control of their own lives, together with national trends towards greater gender equity, are viewed as threatening the patriarchal social order and contributing to the association of AIDS with women. The lack of communication among people on matters related to sex and the need to 'talk sex' while aiming to disrupt (rather than reproduce) the dominant AIDS discourse is discussed.

In Chapter 10 I argue that HIV/AIDS presents us with an opportunity to foster sociocultural change by critically examining existing gender ideologies, including symbolic representations and associations between women and AIDS. To facilitate this process the author argues that AIDS education needs to focus more on 'conscientization' rather than the dissemination of information, and provide the opportunity for critical reflection on sociocultural assumptions about gender and the many myths that signify AIDS. How such a gendered and transformative AIDS education might be initiated within the framework of a Paulo Freire-style 'education for liberation' is discussed.

TERMINOLOGY

Demonizing

My choice of the title "Demonizing Women in the Era of AIDS" was made after much careful consideration and discussion with numerous people. The central concern revolved around the use of the term 'demonizing'. According to the Oxford Dictionary 1998 Edition, the verb 'to demonize' derives from the noun 'demon' and refers to 'daemon' of Greek mythological origin. The demon is defined as a supernatural being, an inferior deity, an evil spirit that is cruel, malignant and destructive. To demonize someone or something is to "make into or present that person or thing as a demon". As used in popular Western discourse, 'demonizing' is often associated with medieval fears of the devil, which were derived from Christian beliefs and practices at that time.

My use of the term 'demonizing' in this thesis does not refer to early Christian social constructions of evil. Rather, it is used to describe the process by which, I will argue, predominantly women are being blamed for the presence and spread of HIV/AIDS among the Zulu in KwaZulu-Natal province. I believe that this process both reflects and contributes to women's already marginalized and subordinate status in society. My research suggests that the way in which the

current AIDS epidemic in KwaZulu-Natal is given meaning involves the creation and even the recreation of images and associations with women that can aptly be described as 'demonized' representations. This 'demonizing' process is discussed and analyzed in the proceeding chapters. Other words, such as 'stigmatizing', 'denigrating', or the post-modern word 'othering' describe aspects of this meaning-making process, but do not capture the essence of this meaning, nor the implications of the 'demonizing' process. In using the term 'demonizing' I am not referring to the Christian theological interpretation of the supernatural, nor intending any insult to women. Rather, it is the metaphoric construction of AIDS as a 'feminine' disease, which is ultimately insulting to women. Other feminist writings on women's health and HIV/AIDS in Africa and elsewhere (see Chapter 2 for recent examples) describe similar 'demonizing' processes which have linked women with disease.

HIV and AIDS

In referring to the epidemic, I use varied terminology: 'the AIDS epidemic', 'the HIV epidemic', 'HIV/AIDS', or 'AIDS-related illnesses'. In short, HIV (Human Immunodeficiency Virus) is the virus that damages the immune system to such an extent that infected individuals eventually go on to develop AIDS (Acquired Immune Deficiency Syndrome). AIDS describes the chronic condition of progressive immune system depletion that leaves the body vulnerable to a host of opportunistic infections, including viruses, fungal infections, protozoa, cancers, etc. AIDS itself is not a disease, nor can it be transmitted from person to person. Only HIV – the virus – is transmittable. It is important to note that the clinical diagnosis of AIDS is subject to continual redefinition, especially as the epidemic progresses in Africa (Jentsch 1997). Therefore, many clinicians tend to speak of 'HIV diseases' or 'AIDS-related diseases', the terms that are used in this thesis. Prevention of HIV infection represents the primary health emergency, and has therefore become the focus of health education campaigns

across the world. To prevent the development of severe immune system deterioration in people with HIV infection is the second health emergency, while the development of therapies to prevent, control or cure the many opportunistic infections that arise with HIV infection would be the third health emergency (Bolton 1989). The fourth challenge of the epidemic would be the social one, such as dealing with orphans and the socio-economic and political implications of a matured AIDS epidemic.

As many writers on AIDS have pointed out, the term 'AIDS' may be a relatively broad clinical term, but it has enormous cultural significance and meaning (Stall 1986 , Sontag 1988 , Bolton and Singer 1992 , Schoepf 1992 , Wilton 1997 and Farmer 1997). Frankenberg (1994) states that the term 'AIDS' is overburdened with proliferating and contested meanings encompassing notions of clinical disease, social disease, contamination, discrimination, economic/material inequalities, religious doctrines, morality, sexuality, deviance, blame and death. These are but some of the notions attached to the term 'AIDS' which are embodied in its 'meaning' within a given context. Therefore, *the cultural construction of this epidemic is a phenomenon in itself, above and beyond the clinical constitution of disease.* Moreover, the cultural construction takes many forms, and differs across cultures and even within cultures. In this thesis I use 'HIV infection' and 'AIDS-related illness' to refer to clinical entities, 'AIDS' to refer to the culturally constructed disease and epidemic, and 'HIV/AIDS' to refer to both, where it is not necessary to distinguish the two.

The Zulu

This thesis is about how HIV/AIDS is being experienced by the people of St. Wendolin's Mission, a peri-urban African settlement of the Mariannhill district of Durban. The people there are overwhelmingly Zulu-speaking, with most laying claim to the proud 'tribal' grouping of 'Zulu'. Previous writers on the Zulu of southern KwaZulu-Natal (where St. Wendolin's is located) such as Vilakazi

(1965), Reader (1966) and Ngubane (1977) to name a few, have argued that the term 'Zulu' must be understood in the broadest and most inclusive sense. While many of the Zulu-speaking people in this region claim a common heritage to the famous Zulu King Shaka of the last century, many never came under the direct control of Shaka rule. Indeed, as further discussed in Chapter 4, many of the ancestors of the current residents of St. Wendolin's settled in the area after fleeing from King Shaka's conquering warriors. Therefore, they have never formed part of the great 'Zulu Kingdom' at any point in their history. Nevertheless, most residents of St. Wendolin's today identify themselves as Zulu.

But who are the Zulu? A simplistic definition would be one such as that offered by Gluckman in 1948. Gluckman defined the Zulu as "an Nguni tribe of southern Africa who are united by shared bonds of mutual custom, common attitudes and traditions, most of whom claim common descent from the clan or house of Zulu of which King Shaka was a member" (Gluckman 1948). However, such a popular definition is problematic from a modern academic point of view, for it presupposes the existence of a neatly bounded society and culture. Asad (1973) was amongst the first anthropologists to argue that much of early anthropology was marred by this type of positivist approach which described 'tribal' or 'traditional' societies as a collection of kith and kin who shared common beliefs, values and social practices. Implicit in this definition was the assumption that members of the society shared both common descent and a common culture. Anthropology has taken a long time to free itself of the self-imposed burden of positivism and to accept that the discipline is, and always has been, essentially an interpretative study of people. When trying to define 'the Zulu', not only must the shortcomings of past anthropological scholarship be confronted, but the larger problem of 'tribal' or 'ethnic' labeling in South Africa (both in the past and today) must also be dealt with. Currently, labels such as 'the Zulu' or 'the Xhosas' carry with them the stigma of the

apartheid past and recall the former regime's attempts to forge 'homelands' for separate 'ethnic' groups. Notions of race, language and ethnicity have all been used by the apartheid government as a basis for discrimination, oppression, and the use of violence against groups of people. Therefore, attempts at classifying people on the basis of race, ethnicity, language or anything else, is a highly sensitive undertaking in South Africa. It is charged with the emotive experiences of and associations with the immediate past (3).

In spite of the current negative imagery associated with the use of 'ethnic' and 'tribal' labels, terms such as 'Zulu' and 'tribe' are frequently used (and accepted) in most exchanges, especially in the discourse of African people themselves. Post-apartheid democratic society, with its emphasis on multi-culturalism, (and multi-lingualism), has lent new legitimacy to local forms and claims of 'ethnic' identity. Many people in St. Wendolin's, for example, are happy and proud to call themselves 'Zulu'. Therefore, in many ways, the 'problem' of ethnic/tribal labeling today is essentially a 'problem' amongst academics and other intellectuals. While many local people use (and value) such terms, academics have largely avoided them, and continue to avoid them.

Acknowledging all the 'historico-political baggage' and debate which is brought to present-day discussion on 'the Zulu', I too have tried to avoid its use as much as possible. Still, I find the term useful and justifiable in some respects. When referring to older ethnographic or missionary accounts of 'the Zulu', I have tried to make specific reference to the geographic location of the people under discussion, where identified by the author, and to use the more cumbersome but less problematic phrase 'Zulu-speaking people'. Where specific authors make reference to 'the Zulu' more generally, beyond a specific group in a specific location, I have followed that author's terminology. When referring to the people of St. Wendolin's, I have used that precise phrase, 'the

people of St. Wendolin's'. My use of the term 'the Zulu' features when suggesting that a notion or perception may apply to Zulu-speaking people beyond the boundaries of the St. Wendolin's community. The historic and contemporary relationship of the people in St. Wendolin's to the larger community of Zulu-speaking people in the province of KwaZulu-Natal is discussed in Chapter 4.

Mindful of all the suffering caused by the inconsistent and unjust ways in which some of the terminology used in this thesis once formed part of what Sharp (1988) called the 'discourse of domination', I offer this ethnographic study of HIV/AIDS in a 'Zulu' community. I humbly acknowledge that anthropology is and always has been a "dialogue between what the anthropologist knows and believes and what he/she observes" (Sharp 1988:5). I accept that any findings or arguments that have been put forth in this thesis are ultimately my interpretations of what I have learned as a resident and participant observer in St. Wendolin's Mission.

Notes

1. Research for this project on sociocultural aspects of condom use and what actually happens to all the free condoms distributed by the government, was initiated in February 1999. The Medical Research Council of South Africa is supervising and providing technical support for the project, which aims to gather data from four sites in four provinces including the town of Empangeni in KwaZulu-Natal.

2. See for example the following 1998 articles from the Daily News of Durban:
   - "15 000 people contract HIV/AIDS virus in a week, Dr. Zuma says of epidemic", 15 March
   - "Scary statistics on children with AIDS". 10 April

- "Villages for children", 10 April
- "AIDS time-bomb", 4 June
- "Graca's plea for orphans", 11 June
- "A killer making its presence felt", 8 October
- "Why the nation must unite now", 8 October
- "Prejudice against AIDS victims", 27 October
- "AIDS corpses piling up", 25 November

3. Assigning people to separate categories for political purposes was nothing less than an obsession with the former apartheid government. Sharp (1988) makes the point that the vision of a divided population comprising discrete 'ethnic groups' and proto-'nations' was functionally necessary to the policy of apartheid. It provided a rationale for allocating people to their respective 'homelands', which led in turn to the government's much despised and resisted policy of forced removals. Shortly after coming into power in 1948, the National Party government supplemented the older, colonial divisions of 'race' and 'tribe' with new categories of 'ethnic groups' and 'nations' as the basic building blocks for a fundamentally divided South Africa. Additional categories were added to further the cause of those who wielded power, with 'population group' and 'ethnic national citizen' being two peculiarly South African terms that were invented for government convenience (West 1988). These finer breakdowns of classification allowed the government to better implement such laws as the Mixed Marriages Act (1949), the Population Registration Act (1950) and the Group Areas Act (1950), as they allowed for great scope in ideological maneuvering.

CHAPTER 2

REVIEW OF RELEVANT LITERATURE

Wright (1997) has observed that the freedom to look at human behavior in all of its many variations and the ability to draw on established theories from other academic disciplines is one of the most laudable qualities of anthropological research. It is this holistic perspective that has allowed anthropologists to cast their investigative nets broadly in their efforts to decode human behaviors and their myriad meanings.

This thesis, on the relationship between cultural constructions of HIV/AIDS and women, includes a perspective that essentially looks across disciplines and relates to several different bodies of literature. In reviewing the literature relevant to the current thesis, three separate (though sometimes intersecting) bodies of literature will be discussed. These include:

1. The broad field of gender studies and HIV/AIDS.
2. Sociocultural studies on AIDS in Africa.
3. Studies on symbolic representations of AIDS.

The first body of literature serves to locate the thesis within a general field of studies that deal with constructions of gender and their implications for the study of AIDS. The second body of literature relates to a certain geographical location, namely Africa. Recent studies on AIDS in Africa that are relevant to the current thesis, in particular qualitative studies that elucidate the sociocultural context, are discussed. The third body of literature reviewed includes studies that focus on AIDS symbolism, and serves to locate the current thesis theoretically.

As this thesis is also offered as a contribution to the growing body of literature on participatory research in health, relevant studies of this genre are included for review.

STUDIES ON HIV/AIDS AND GENDER

Much of the early research on AIDS during the first decade of AIDS (the 1980s) used discreet biomedical paradigms, which adhered strictly to a medical or disease-centered model (Bolton and Singer 1992). With the dawn of the second decade of AIDS (the 1990s) there was a growing realization that HIV transmission was as intricately tied to social and cultural factors as it was to biological factors (Farmer 1997). Along with race, socio-economic class, geographical locations, kin/peer relations, and self-esteem, gender had been identified as one of the important influencing factors in the initial adoption and continued practice of safer sexual behaviors to prevent HIV transmission (Berer and Ray 1993). One of the first books to examine gender patterns in the current HIV/AIDS epidemic was a book entitled Sex and Germs: The Politics of AIDS by Cindy Patton (1985). Patton drew upon Foucault's (1976) famous work on sexuality, which argued against a merely biological understanding of gender in favor of a sociopolitical understanding. The developing feminism in the West at the time of Foucault's writing, received a 'theoretical boost' from Foucault's perspective on human sexuality and its malleability. Foucault (1976) argued that the body was enmeshed in and subject to an array of social and political forces that affected its performance in every way. Patton's (1985) book was one of the first to explore these sociopolitical forces and the implications that they held for women in the time of AIDS. Essentially, Patton (1985) argued that women's continuing subordination to men made them especially vulnerable to HIV infection.

Another early work that addressed the gender dimension of HIV/AIDS was a work entitled AIDS: The Burden of History (1988), edited by E. Fee and D.Fox. This book comprised a series of articles that clearly illustrated the 'burden', or consequences that historical patriarchy held for the fight against AIDS. Contributors to this book such as Brandt and Trichler drew upon analyses of western biomedical discourse on venereal disease since the last century and concluded that a similar discourse linking female sexuality with disease was still evident in biomedical discourse today.

These early studies were a prelude to the 1990s where studies of gender and the cultural constructions of sexuality in the context of HIV/AIDS represented a rapidly expanding body of literature. Based on his studies in Brazil, Parker (1992a and 1992b) emphasized the need for finer-grained anthropological studies on HIV transmission. In 1995 Parker and Gagnon argued in favor of new approaches to sex research in general, as the existing approaches and existing conceptual tools of sex researchers were viewed as limited. According to these authors, the dominant biomedical model of sexuality, whereby sexuality is understood primarily as a universal physiological drive, was inadequate as a model for understanding human sexual behavior. Rather, Parker and Gagnon (1995) argued in favor of a constructionist approach to the study of sexuality, whereby sexuality is viewed as socioculturally constituted and therefore a unique product of a specific context. By approaching the study of sexuality in this way, Parker and Gagnon argued that researchers would be able to better understand the 'sexual culture' of a specific population and therefore better understand some of the determinants of sexual 'risk' behavior.

Fullilove (1990) was amongst the first to explore gender-related power issues and gender role expectations (and their implications for HIV transmission) amongst African-American teenagers. Drawing upon the insights from feminist writers like Miles (1991) and Graham (1993) who asserted that health delivery

systems in general failed to meet women's needs, writers such as Berer and Ray (1993), Squire (1993), Patton (1994) and researchers from the Panos Institute (1990) began to argue that women's needs were not being properly identified nor met in the context of HIV/AIDS. Squire examined the discursive construction of AIDS in the early 1990s in Europe and the United States and drew the following conclusion:

> Discourse on AIDS – medical and social policy writing, political rhetoric, media representations and public talk about HIV and AIDS – tends to ignore, sideline or *pathologize* women. *The discourse is both under and over-gendered.* The categories of 'women' often seem like screens onto which other social conflicts – around for instance race, sexuality and poverty – are being projected in disguised forms. (Squire 1993:5).

The early part of the 1990s was characterized by the repeated calls of feminist writers for more studies which focused specially on the gender dimension of AIDS. This marked the beginning of the sub-field of AIDS research and the AIDS effort more generally known as 'Women and AIDS'. This sub-field was based upon a feminist discourse that prioritized women. In a seminal work that argued for the necessity of a gender-focus in AIDS interventions, Doyal et al (l994) called for the setting of a 'feminist agenda' in the fight against AIDS. According to those authors contemporary sociocultural, political and economic forces were contributing to women's overall powerlessness in society and ultimately obstructing the practice of safer sex.

In 1990 the Women and AIDS Research Program was established by the International Center for Research on Women (ICRW), based in Washington D.C. The ICRW's specific research agenda was to support studies that examined the challenges faced by women in the face of the growing HIV/AIDS epidemic. Seventeen studies in thirteen developing countries including South Africa (Abdool-Karim and Morar 1994, Hadden 1997), Zimbawe (Bassett and

Sherman 1994), Sri Lanka (Silva et al (1997), Thailand (Cash and Busayawang 1997), Brazil (Goldstein 1995 and Vasconcelos et al 1995), and Senegal (Niang 1995) were initiated by the ICRW in an effort to provide much needed data on socioeconomic and cultural factors influencing women's risk of HIV infection. From these base-line studies, the ICRW hoped to identify opportunities for program interventions. Abdool-Karim and Morar (1994) carried out the first ICRW sponsored research for South Africa in the province of KwaZulu-Natal. These authors identified some key contextual factors influencing women's vulnerability to HIV infection which included lack of sexual decision-making power, pressures to form sexual relationships at a young age, and associations of the condom with lack of trust and promiscuity.

Drawing upon the information gathered through this research, the ICRW sponsored another study in this country, one with an interventionist component. This study was carried out at a sexually transmitted disease (STD) clinic in KwaMashu and reported by Hadden (1997). The objectives of this second study were not only to collect qualitative data from STD clinic-attendees on attitudes and behaviors associated with STD and HIV prevention, but to develop a skills-building intervention and to assess the feasibility of interventions within an STD clinic setting. Hadden reported that intervention sessions conducted as part of this study included single-gender and later combined-gender sessions that were led by Zulu-speaking group leaders. The sexual-risk of participants was measured using the epidemiological 'Sexual Risk Behavior Assessment Schedule' (SERBAS) that involved calculating a specific 'Vaginal Episode Equivalent' score for each participant based on the number and type of unprotected sexual episodes reported. Hadden claimed that the intervention resulted in a highly significant reduction in unprotected sex reported by women at post-intervention and was successful in terms of reducing sex-risk behavior among women participants. For men however, Hadden reported a statistically insignificant reduction in sex-risk behavior. The

author observed that in spite of the interventions women seemed to continue to accept that men had numerous partners, and men seemed to regard numerous partners as part of a cultural norm. Hadden's study is significant in that it provides a model for a reportedly successful, as least to some extent, HIV/AIDS intervention. It also indicated that it is feasible to conduct interventions and research on sex-risk behavior in a STD clinic setting that may be replicable in a range of similar settings in South Africa.

Among other things Abdool-Karim and Morar (1994) and Hadden's (1997) studies suggest that 'condomless sex' held meaning for Zulu-speaking women as a demonstration of trust in one's sexual partner. Sobo (1993,1995) argued that a similar attitude exists among low-income African-American women. The author suggested that 'condomless sex' was an adaptive practice that helped women to maintain idealized images of relationships and selves. These women viewed condom use as insulting, suggestive of infidelity and disrespect for one's partner. For these reasons condoms were avoided in sexual encounters with preferred partners. Associating condom use with lack of trust is a persuasive theme is many of the more recent studies on AIDS in South Africa. Works by Akande (1997), Varga (1997), Abdool-Karim (1998), Meyer-Weitz et al (1999) and Eaton et al (1999) for example, all suggest that while a large proportion of South African men and women consider condom use permissible and even necessary with a casual partner, they are strongly adverse to its use within a relationship considered to be long-term or symbolic of permanence and 'love'.

Gender power differentials was the major focus of Judy Bury (1994; Women and HIV/AIDS); and Kate Butcher (1994; Feminists, Prostitutes and HIV) who sought to illustrate how women were made vulnerable in the current HIV/AIDS epidemic through culturally sanctioned gender power relations. Bury and Butcher both provided very persuasive arguments for the necessity of a feminist

agenda in addressing AIDS. The implications, which gender held for women's health more generally, were further argued by Doyal (1995) in a work aptly, entitled What Makes Women Sick? After 1995 the literature on AIDS began to more clearly reflect a feminist agenda as more researchers, especially women researchers, responded to the call. In South Africa on-going work by Campbell (1992, 1995, 1997), Varga (1996, 1997 a and b), Wood and Jewkes (1997, 1998) stand out as having possibly the most consistent focus on constructions of gender or gender power dynamics and their implications for AIDS risk and prevention.

Complementing the global growth in feminist literature on AIDS after 1995 was the concurrent rise in what writers such as Boffin (1990), Kayal (1993) and Edwards (1994) referred to (and has since come to be known as) 'queer theory'. Essentially queer theory, as applied to HIV/AIDS, goes beyond feminists theory that views women's subjugation to men as the pivotal problem in the fight against AIDS. Queer theory argues that gays and lesbians are equally disempowered through hegemonic, gender power relations and the discourse and representations that reflect and support these relations (Weeks 1991). According to Herdt (1997) queer theory has provided the most potent critiques to date of the theoretical coherence and practical unity of modern sexual taxonomies. Along with feminists and other post-structural theorists who contest the essential or universal character of sexual identities, queer theorists also contest the accepted binaries of male/female, hetero/homo. Queer theorists such as King (1993) have argued that gay men had been equally marginalized and stigmatized as 'the others' from the onset of the AIDS epidemic in the West *precisely because homosexual men were 'feminized' through representation and discursive practices.* Works by Abelove (1994), Butler (1990 and 1994), Edwards (1994), Raymond (1996) and Wilton (1996 and 1997) are examples of a more recent genre of studies, which have

examined issues of gender in the context of HIV/AIDS from both a queer and a feminist perspective.

There is a growing and intersecting body of literature on gender and AIDS that takes a queer/feminist position. Wilton's (1997) recent work on the 'gendering' of AIDS in health promotion representational practices is one such example. Based on an analysis of texts used in western (mostly British) health promotional materials for HIV/AIDS prevention, Wilton (1997) argued that existing gender power relations were left unchallenged and actually being reproduced in the context of HIV/AIDS education. As a lesbian writer, she acknowledged the contribution of feminism to the study of AIDS but concluded that it was not sufficient to deconstruct properly what she called 'patriarchal heteropolarity' in order to fully understand its consequences for the continued growth of the epidemic. According to Wilton, a queer perspective allows for a more thorough and finer deconstruction (and hence better understanding of) gendered power relations.

Insights on gender gained from queer theory have helped propel the move away from considerations of 'women' and 'women and AIDS' discourse, towards a more comprehensive understanding of 'gender' and its construction as a significant factor in the HIV/AIDS epidemic. The focal area of 'women and AIDS' is making way in the later part of the 1990s, for a more inclusive 'gender and AIDS' discourse and related body of literature. Recent studies by Setel (1996) on AIDS and constructions of manhood in Tanzania, Whitehead (1997) on gender identity and sex-related 'risk' behavior of low-income African-American men, and Campbell (1995, 1997) on masculine identity in South Africa, represent a trend in studies on the construction and meaning of male gender identity and its relation to HIV transmission. What is being increasingly argued as the second decade of AIDS draws to a close, is that the previous emphasis on women and AIDS is inadequate. For example, while being asked

to take responsibility for safer sex, Berer and Ray (1993) argued that AIDS interventions intended to empower women failed to engage with the complexities of power that existed in male-female relationships. Wilton (1992) suggested that feminist interventions that focused on women and the need to empower women served to *relieve men of responsibility in sexual matters.* The need to expand the gender focus of local AIDS interventions to **include men**, is also a main point of argument in this current thesis (see Chapter 9). Several years later, Wilton (1997) still saw a need to argue this same point. In the closing chapter of her work on textual representations of AIDS, Wilton called for a collective political activism in this time of AIDS. She argued that there was an urgent need for an informed and sophisticated critique of relations of gender and the sexualization of gender.

> Traditional liberal critiques ..... are simply not adequate to deal with the complexities of the oppressions that have coalesced around and been compounded by this (HIV/AIDS) epidemic. (Wilton 1997:137)

More recently Giffin (1998) argued that the concept of 'empowerment', when understood as the power of women to convince men to use the condom, contributes to the reproduction of both gender hierarchies and dominant conceptions of sexuality. Giffin stated: "The positive version of female sexuality and female 'subject of desire' is missing in cultural accounts of both patriarchy and its contestation by feminist activism" (Giffin 1998: 152). The trend in much recent literature on AIDS is indeed in the direction of developing more sophisticated and useful concepts and critiques on gender and sexuality which merge feminist and queer theories. A study entitled Culture, Sexual Lifeways and Developmental Subjectivities by Hostetler and Herdt (1998) is an example of this more general trend in recent gender studies. These authors propose that the new concepts of sexual lifeways and sexual cultures be used in place of the current concepts of sexual identity, sexual orientation or sexual preference. Like Wilton (1997) these authors take a queer/feminist theoretical

position to argue that the current concepts are inadequate. Hostetler and Herdt (1998:244) define sexual lifeways as the 'culturally specific erotic ideas and emotions, sexual/gender categories and roles and theories of being and becoming a full social person that together constitute life-course development within a specific sexual culture.' In developing the related concepts of sexual lifeways and sexual culture, the authors drew upon Herdt's (1997) previous cross-cultural study of gays and lesbians.

These more sophisticated concepts of gender and sexuality hold much promise for future studies on AIDS. According to Hostetler and Herdt (1998) the concepts of sexual lifeways and cultures provide formulas for gender performances and for the control of gender roles in sexual relations. The consequences of these formulas for the practice of safer sex are obvious. Recently Buga et al (1996) and MacPhail (1998) have argued that there is a great need for studies on adolescent sexuality in South Africa which engage with a broader concept of sexuality and its socially influenced construction. As we enter a third decade with AIDS, it is probable that researchers and writers on AIDS will increasingly draw upon conceptual and theoretical insights on sexuality gained from merging feminist and queer theory, as I am attempting to do here.

SOCIOCULTURAL STUDIES ON AIDS IN AFRICA

Literature on AIDS in Africa represents a vast and ever-expanding area of professional writing. As the epidemic continues to grow throughout the continent, academics and other researchers are continuing to produce published materials in an effort to understand better the course and impact of the disease. Unlike much of the early literature available on AIDS and the gay communities in the West, the early literature on AIDS in Africa was largely quantitative as opposed to qualitative in nature. This was probably due to a combination of factors that included the perceived urgency of the AIDS 'crisis'

in Africa where it is primarily an epidemic affecting the majority heterosexual population who are breadwinners and caretakers sustaining economies that are often fragile and volatile in the best of times. Also the relatively time-consuming research required for qualitative study was often considered impractical. Unlike western gay communities, problems of access to many African communities made research difficult. Although such factors continue to hamper AIDS research in Africa, there has nevertheless been a steady growth in qualitative AIDS research over the past two decades. However, the overwhelming type of studies available on AIDS in Africa are largely quantitative studies produced through the use of various research techniques such as those described by Scrimshaw and Hurtado (1987) called 'rapid assessment procedures'. Studies based upon the implementation of rapid assessment procedures (RAP) along with studies based on surveys of knowledge, attitude and practice (KAP), bear the dubious distinction (in professional anthropological circles at least) of being essentially 'quick and dirty'. Often researchers use these methods in order to elicit quick qualitative information, which in effect is never really qualitative.

Pelto and Pelto (1997) have argued that RAP and KAP methodologies in health-related research can only lead to a piecemeal understanding and limited insights into a people's complex experience with disease. Based on Pelto and Pelto's argument, it could be argued that academic knowledge of AIDS in Africa is still largely piecemeal knowledge, and limited in terms of depth and quality. The actual role and usefulness of RAF and KAP studies in the social science study of AIDS is a matter of much debate in the literature of French anthropologists. Dozon and Vidal (1995) and Benoist and Desclaux (1995) have argued against the use of these research techniques primarily because they 'rip events, behavior and knowledge from their context' (Dozon and Vidal 1995:293). These authors suggest that information on AIDS in Africa

obtained though these methodologies is of little use in terms of contributing to any real understanding of the epidemic.

Nevertheless, there have been substantive studies done on AIDS in Africa which focus upon sociocultural factors and their influence on people's behavior in the face of the growing AIDS epidemic. On-going work by Caldwell et al (1989, 1993, 1995) continues to draw out the sociocultural context as a key factor in maintaining the high rates of HIV transmission in Africa. Citing cultural forces such as the subordinate position of women in society, including female economic dependence on men, and a general breakdown in traditional moral and institutional structures that once acted to constrain the sexual behavior of women, Caldwell et al have consistently demonstrated the importance of understanding the role of culture (and cultural change) in sustaining the AIDS epidemic.

Like Caldwall et al, Green (1988, 1993, 1994) continues to provide qualitative analyses on AIDS in Africa. As an anthropologist who has worked for over a decade in mostly U.S. government-funded projects throughout sub-Saharan Africa, Green has produced studies on a variety of illnesses throughout the continent. His work on AIDS has mostly centered around traditional healers and their experiences with and responses to the growing epidemic in Southern Africa. Green's 1994 study on AIDS and STDs in Africa provided an overview of ethnomedical knowledge on AIDS and STDs in several different countries from the western, eastern and southern parts of Africa. He argued in favor of closer collaborative work between traditional healers and biomedical practitioners as a strategy for halting the relentless pace of HIV transmission in Africa. People's perceptions of the condom and how these perceptions influence sexual activity in Rwanda were analyzed by Taylor (1990). Taylor argued that cultural frameworks condition people's beliefs and need to be taken into account when designing interventions aimed at influencing sexual decision-making. Similar

arguments regarding the necessity of acknowledging local interpretations and beliefs about AIDS were put forth by various researchers from Tanzania including Killowo et al (1989), and Nnko and Poole (1997). The latter authors examined the sexual discourses of school children and suggested that they were much more pre-occupied with thoughts about sex and sexuality than was widely believed. Nnko and Poole argued that HIV/AIDS interventions in Tanzania must target a younger age group than was currently the case. Presenting case studies of women in Zaire who did not fit conventional notions of 'high risk groups', Schoepf (1992b:275) suggested that HIV was spreading "not because of exotic cultural practices but because of many people's normal responses to situations of everyday life." Understanding the cultural context (which includes shared meanings and assumptions) in which sexual negotiations and behavior occurs, should, according to Schoepf, shed some light onto the forces acting to propel the spread of HIV/AIDS in Africa.

A fair amount of qualitative AIDS research has focused on sexual negotiations and sexual decision-making in Africa. The work by McGrath et al (1993) on Ugandan women suggested that women accepted multiple sex partners due to economic need and sexual satisfaction. When negotiating sex, the women interviewed by McGrath et al felt that they were defenseless against HIV infection and did not *even suggest* condom use because they felt that their partners would never comply. The authors provided much discussion on how women's powerlessness in sexual matters accrued from their continued economic dependence on men and acceptance of culturally sanctioned high-risk behavior on the part of male partners. An earlier study by McGrath (1992) demonstrated how Ugandan women's social responses to the growing HIV/AIDS epidemic in their midst was contributing to the rapid transmission of the AIDS virus. Similar findings were reported by Varga (1996, 1997a, b), whose on-going work in South Africa has consistently focused on the dynamics of sexual negotiations.

Research by Orubuloya et al (1993) amongst women in Nigeria supported McGrath et als (1993) suggestion of women's economic dependence on men being a factor in the (non)-practice of safer sex. These authors argued that Nigerian women's apparent success in refusing unwanted sex and negotiating condom use, was largely attributed to their economic independence. In Kenya, research by Balmer et al (1995) explored sexual decision-making and negotiation between partners in long-standing, stable relationships. Here, acceptance of gender-specific sexual behavior and the lack of open communication about sexual matters between partners, was cited as cultural barriers to safer sex practices. Recently, Nzovu and Lwanga (1997) have provided a qualitative study, which deals with the multiplicity of sociocultural factors influencing sexual behavior patterns of adolescents in Zambia. These authors argue that reciprocity in male-female sexual relationships which includes the exchange of goods and services was pivotal for understanding why young teenage girls in that country were so vulnerable to HIV/AIDS, a similar argument made by Haram (1995) in her study of sexual relationships in Tanzania.

Of particular relevance to this current thesis are several studies in Africa that have focused on the 'gendering' of HIV/AIDS. Ingstadt (1990) was amongst the first to study the cultural construction of AIDS in Africa and note the theme of the particularity of women's bodies and their capacity to 'hide' diseases such as STDs and HIV. Conducting her research in Botswana, Ingstadt discussed how informants often used female sexual anatomy as a point of reference when describing women as 'dirty' and potentially more disease carrying than men. That author's suggestion that such notions lent support to ideas of women being *ultimately to blame for the spread of HIV/AIDS*, is a major point of argument in this thesis. From her studies among the Giriama of Kenya, Udvardy (1995) reported similar 'gendered' notions about HIV/AIDS. According to informants' descriptions of women's bodies, women were conceived as

natural 'containers' of HIV infection. Udvardy reported persistent analogies drawn between women's bodies and suitcases: "They are perceived as suitcases for male blood, special kinds of containers, and vehicles in which goods are transported" (1995:326). In the era of AIDS the transported goods are HIV infections which are perceived as being carried and distributed to various men by women.

Research by Haram (1996 and 1997) on STDs and AIDS among the Meru of Tanzania reveal similar gendered notions in regards to HIV/AIDS. Haram sought to understand how the Meru came to conceptualize the AIDS epidemic as a 'women's epidemic', and argued that by transgressing norms of female conduct through their spatial mobility, *Meru women have come to be seen as the cause and transmitters of AIDS.* Haram (1997:6) states: "Women who leave Meru society do not only cross physical borders, but they also cross moral borders. Once they return to Meru they become doubly wicked persons because they, in turn, endanger others. Simply, men argue, women are in need of male control or else they become morally loose. Once women leave Meruland and 'get out of sight'; they get out of male control. The assumption is that they do not only trade in their wares, but are apt to trade with their bodies." For the Meru then, it is widely believed that HIV/AIDS was brought into the area by women who ventured beyond its borders. Indeed, Haram (1996) reports that the Meru even go so far as to 'credit' one particular woman by the name of Bibi as being the one who originally brought STDs to the people years ago. Like STDs, Haram reveals that discourse on AIDS among the Meru places blame for the disease on women. *"Whereas women are held to be the (active) transmitters and carriers of AIDS, men are the (passive) victims"* (1996:48).

The theme of 'dirty' women being held responsible for the cause and spread of HIV/AIDS is the major theme and point of argument of this thesis. While

it may be said that the 'gendering' of AIDS in Africa has not been adequately explored, analyzed and understood in terms of its role in determining AIDS risk and transmission, the process has begun. While this thesis may be viewed as complementing and extending the works by Ingstadt (1990), Udvardy (1995) and Haram (1996, 1997), notably all women researchers, it must be noted that the general theme of women being blamed for AIDS has been documented in varying degrees throughout Africa. Obbo (1993, 1995a and b) referred to similar pervasive notions in Uganda, for example. Consistently during her fieldwork, Obbo came across the idea of HIV infection being 'uni-directional' from women to men. Obbo (1993) argued that a strong 'Black Feminism' was needed to address these deep-seated notions that point to and underpin women's continued oppression in Africa. Schoepf (1992a and b) reported a similar 'gendered' assumption about HIV/AIDS in Zaire. That author states: "When men are infected, their wives are suspected of infidelity. Where women are infected they are assumed to have had multiple partners" (quoted in Bledsoe 1990:208). In either case, it is *women's sexual activities* that are held to blame for the spread of HIV/AIDS.

HIV/AIDS and the commercial sex industry has been a major focus of much South African research as studies by Campbell (1991), Posel (1993), Abdool-Karim (1995), Marcus et al (1995) and Marcus (1997), Varga (1996), Pauw and Brener (1997), and Preston-Whyte et al (1997) demonstrate. These studies have sought to understand the dynamics and meanings associated with commercial sex work in order to develop appropriate interventions that might reduce HIV transmission within the networks of sex workers. Women's powerlessness and vulnerability in the face of violence by male clients were identified as significant features in the lives of commercial sex workers in South Africa. (See Abdool-Karim et al, (1995), Varga (1996) and Pauw and Brener (1997) for example). From the perspective of sex workers' clients, Marcus et al (1995) and Marcus (1997) sought to establish the meaning of AIDS 'risk' for

long-distance truck drivers who perceived the buying of sex as tantamount to a condition of work. For these men sex with a woman other than one's wife for whom bridewealth was paid, necessitated a payment known as *ukujika* in exchange for her service (Marcus et al 1995). Whereas the truckers were prepared to use condoms with sex workers, most were strongly opposed to using them with wives. As in other studies, Marcus et al's and Marcus' research reveals that many African men associate condom use with a lack of trust between partners.

The impact of violence on the lives of young people in general and how violence often forms part of the 'sexual repertoire' of young men, was discussed in a study by Wood et al (1996) of Xhosa adolescents. Sexual violence and its impact on South African women's health generally is a major theme in the on-going work by Wood and Jewkes (1997, 1998). Miles (1992) explored issues of power and the politics of sexual negotiations through a study of women's discourse. More recently Strebel and Lindegger (1998) have analyzed local women's discourses on gender and AIDS and suggest that these may be changing as women increasingly challenge and reject what they view as out-dated social prescriptions. Varga and Makubalo's (1996) study of pregnant teenage girls from Durban found that violence or the threat of violence from male partners were over-riding factors in the sexual decision-making of these adolescents. Culturally-defined gender role expectations among Zulu-speaking youth, and their impact on sexual negotiations was explored by Varga (1997b), as well as the symbolic meanings associated with condom use by commercial sex workers (Varga and Blose 1997). The previously mentioned ICRW-sponsored studies by Abdool-Karim and Morar (1994) and Hadden (1997) explored some of the cultural determinants to the adoption of safer-sex practices among young men and women from an urban township environment. These researchers identified women's fear of violence and feelings of powerlessness when negotiating sex with male partners, and called for more

work to be done identifying ways to engage men to explore and challenge social norms that support multiple partnerships for men. Preston-Whyte et al's (1997) cross-cultural study on sexual networks, race and gender issues related to AIDS in South Africa highlighted the overall paucity of qualitative works on AIDS in Africa and called for closer attention to be paid to sociocultural factors as determinants of sexual behavior.

The call by South African researchers for more qualitative research and a better appreciation of the sociocultural context in which HIV transmission occurs is of fairly recent origin. It still remains to be seen how the findings emerging from these studies will lend themselves to informing local HIV/AIDS interventions. As the spread of HIV/AIDS continues across Africa and as it enters new phases in its maturation, new qualitative studies have emerged which focus on a variety of new sociocultural challenges being introduced by the epidemic. For example, the problem of orphans is receiving a fair amount of social science attention. Foster (1992) and Drew (1995) have both studied the economic and sociocultural circumstances under which AIDS orphans had been cared for in selected communities in Zimbabwe. Both point to the negative impact of widespread poverty on the extended family system and its traditional role of absorbing orphaned children of related kin. Jackson et al (1996) studied several southern African home care programs to help AIDS patients. Those researchers analyzed sociocultural structures within communities and discussed their role and impact on the care of people dying with AIDS. Along with studies by Barnett and Whiteside (1990), Toupouzis and Hemrich (1996) and Cohen (1998), Jackson et al (1996) argued that continued high levels of poverty in Africa provided a formidable barrier to the giving of adequate care to family members ill with AIDS and orphans left behind by dying parents. Similar findings were revealed by Marcus (1999) in a recent study of care giving in selected peri-urban communities in KwaZulu-Natal. According to Marcus many local households consist of little more than an elderly grandmother supporting

several grandchildren on a meager pension. Such households are naturally reluctant to take on the added responsibility of caring for an orphan. The result is a rise in new 'child-headed' households forced to survive with no sustained form of income.

INTERVENTION RESEARCH

A number of sociocultural studies of HIV/AIDS in Africa are calling for increased use of community-based, peer education strategies in the fight against AIDS. Individually-focused interventions, such as those commonly used in health promotion and AIDS education are increasingly being seen as inadequate, while community-based interventions are argued to be more likely to result in sustainable sexual behavior change. For example, selected case histories of men who had recently tested positive for the AIDS virus were used in a study of male factory-workers in Zimbabwe by Ray et al (1998). The aim of the study was to understand better the circumstances in which men who had been beneficiaries of extensive HIV prevention education programs were later exposed to infection. What emerged from the case histories presented, was that denial of risk was taking place both at the individual and societal level, despite the fact of ever-increasing numbers of Zimbabweans dying and dead from AIDS. The authors suggested that conventional health promotion methods had little appeal among the men studied, and called for health promotion methods that helped to create 'enabling environments' in which to examine issues around risk of HIV infection. According to Ray et al necessary behavioral change required changes in the environment and that 'fundamental changes in attitude towards consistent condom use, trust in relationships and judgements about risk exposure were needed, but cannot be made by individuals on their own' (Ray et al. 1998:1440). These authors argued for better use of peer-education strategies in HIV prevention programs.

In another study, Beeker et al (1998) considered the relevance and meaning of the term 'empowerment' to community interventions for persons at risk for HIV, particularly women. These authors noted the growing influence of 'empowerment' and related concepts in recent HIV-related policy, research, and interventions, and suggested that further theory and measurement development is required before program planners adopted a 'community empowerment' framework for HIV prevention. Contributing to the debate on individual versus community empowerment for health promotion, Jewkes and Murcott (1998) made the point that along with further theoretical development, there needed to be a clearer understanding of the nature and meaning of the term 'community'. These authors argued that the term 'community is in itself vague, but carries with it many assumptions about people and the nature of their interaction as members of a particular community. Therefore, AIDS interventions that target a particular 'community' must be based on a clear understanding of what exactly constitutes that community. A point of argument in this current thesis is that the community approach to the problem of HIV/AIDS is a promising one, insomuch as it takes as its focus the particular 'sexual culture' that exists and is sustained by a given local 'community' context, be it a collection of people at a goldmine, a university campus, a residential township, or sex-workers along a particular trucking route. As will be further argued in Chapter 10, peer education strategies, as education by and for members of the same 'community' who share a similar 'sexual culture', may be one way of understanding and addressing the role played by the community in the shaping of HIV/AIDS risk behavior.

Increased research attention is currently being paid to sexual abuse and gender-related violence as significant factors in HIV transmission in Africa. Noting that violence against women has been a neglected area in public health more generally, Wood et al (1997, 1998) have argued that in the era of AIDS, the role of violence in sexual relationships is poorly understood and under-

researched. Wood et al drew their conclusions from a qualitative study of Xhosa-speaking youth in South Africa. For many of the young people who participated in the study, male violence and coercive sexual practices dominated male-female sexual relationships. The authors noted that much of this abusive behavior was accepted by the teenaged girls and reinforced through their silence and submission. In a study of social anxieties associated with HIV prevention in adolescents from three African countries (Nigeria, Kenya and Zimbabwe), Venier et al (1998) suggested that gender-based violence and the fear of violence on the part of teenaged girls were part of a cluster of social barriers to reduction of HIV infection risk that needed to be addressed in AIDS education. Gregson et al's (1998) study of sexual behavioral change amongst Zimbabwean women also noted the continued threat of violence faced by women who insisted on condom use during intercourse. These authors called for attention to gender dynamics and greater moves towards community-based peer education strategies, calls that are also made in subsequent chapters of this thesis.

Thus, there are two very discernable trends in socioculturally focused studies on HIV/AIDS in Africa. One is an increase in research that deals with HIV/AIDS intervention strategies and argues in favor of peer-education as part of an effort to create 'enabling environments' for behavioral change. The second trend is an increased focus on the consequences of gender-based violence for the transmission of HIV. Overall, a review of the available professional literature on AIDS in Africa reveals a paucity of qualitative studies, especially book-length works on the epidemic, with nevertheless a slow but steady growth in rich, in-depth studies.

STUDIES ON AIDS AND ITS SYMBOLIC REPRESENTATIONS

The third body of literature relevant to the current thesis includes studies of the symbols used to signify AIDS. These studies have as their central focus the role of myth and metaphor in creating representations of the disease. Along with studies which seek to analyze the political, ideological and cultural dimensions of the representations of AIDS, studies on the metaphors of AIDS aim to understand how the disease is given meaning within a given context. The current body of literature on AIDS and its symbols is small, but represents a growing area of interests for social scientists. This thesis represents an attempt to add to this expanding body of literature.

The underlying assumption in these studies is that the meaning of AIDS extends well beyond the purely medical and is heavily weighted with symbolic meaning and significance. What all these studies demonstrate (including the current thesis) is that representations of AIDS tend to associate the disease with images typical of a culturally-specific characterization of a dangerous and anti-social 'other'. The influence of Mary Douglas and her work entitled Purity and Danger (1966) is clearly visible (and acknowledged) in most studies on AIDS and its symbols.

Susan Sontag's (1988) book on AIDS and its Metaphors is perhaps the most popular literary work on the symbolism of AIDS. Sontag (1988) sought to demonstrate through an analysis of ordinary American discourse, that to say someone had AIDS was to say much more than that a person was experiencing a progressive exposure to the ravages of common infections. It implies that the person is dangerous and untouchable. As cancer was once regarded as "the diminution of the self" argues Sontag, today AIDS is the generic rebuke to life and to hope. Sontag suggested that through its metaphoric representation, "AIDS had reinstated something like a pre-modern experience of illness .... when the infectiousness of the disease deters them who should assist, from

coming" (Sontag 1988:34). What Sontag's work makes clear is that the *symbolic meanings* attached to AIDS are more potent determinants of people's responses to those living with HIV/AIDS than any 'factual' medical understanding of the disease.

Following Sontag, Clatts and Mutchler (1989) provided an early anthropological study on AIDS symbolism. In an article entitled "AIDS and the Dangerous Other", these authors provided an academic analysis of the ways in which American discourses on AIDS (as reflected in the popular press, ecumenical circles and scientific/medical literature) constituted a complex 'muddle' of cultural notions on sex, disease and social and moral order. With AIDS being almost exclusively associated with the gay community at the time, Clatts and Mutchler argued that discourse on AIDS centered around notions of promiscuity, deviance and abnormal desire. As a disease associated with an already stigmatized and marginalised 'other' the metaphoric construction of AIDS was an easy exercise in 'meaning making' for the American (heterosexual) public. Clatts and Mutchler's study provided much in the way of discussion on the role of metaphor in defining the identity of 'self', 'us', and 'others', and specifying the relations that ought to obtain between these. By analyzing how metaphor signified differences of experiences as both symbols of distinction (e.g. male/female, light/darkness, raw/cooked) and as symbols of fictions (e.g. virtue/vice, clean/unclean, saved/damned), Clatts and Mutchler sought to demonstrate the power of metaphor in our lives. They concluded that the American 'metaphoric fixation' on AIDS and the deviant 'other' had lulled the public into believing that they were safe from the virus.

Clatts and Mutchler's study only alluded to the implications of metaphoric thinking for people's behavior vis-à-vis the transmission of HIV. Marshall et al (1990) took up the issue of behavior more explicitly in their study

entitled "Touch and Contamination: Patient's Fear of AIDS". The authors' main argument was that fear, discriminatory attitudes, and beliefs about pollution have hindered and sometimes paralyzed efforts to provide treatment for the afflicted. Metaphoric meanings attached to AIDS, and their consequences for behavior in the face of the epidemic, were further explored by Douglas and Calvez (1990). In "The Self as Risk Taker: A Cultural Theory of Contagion in Relation to AIDS" Douglas and Calvez used Douglas' previously published insights on notions of pollution and contagion (Douglas 1966) and applied them to the study of AIDS. Rather than viewing AIDS as a disease of a marginal 'other', Douglas and Calvez proposed the concept of the 'enclave culture' as more accurately representative of the group which comprised the dangerous 'others' in the AIDS epidemic. As defined by these authors, enclaves may "hang loose, unimpressed by the prestige of established medicine, and open to alternative advice" (Douglas and Calvez 1990:451). Enclave cultures were described as being relatively autonomous, a condition that allowed them to reject some of the central community's advice. Douglas and Calvez's (1990) focus was primarily on gay and inner city ghetto communities in the West. Another useful notion proposed by these authors was the idea of a two-layered metaphorical body: "one (layer) in its own physical skin with specific points of entry and exit; the other protective skin is the community, which codifies risk and safe behavior" (Douglas and Calvez 1990:454). The authors argued that the existence of these two bodies may reinforce the discrepancy between the patient's inner experience of AIDS, and his 'outer' experience in terms of how other people experience and respond to his external appearance. The concept of the two-layered body was further developed and its consequences for illness experience more generally was further explored by Kirmayer (1992).

Metaphorical representations of AIDS and their contributions to the cultural construction of the disease was also the theme of an article by Treichler

(1992). Treichler argued that people's perceptions of 'reality' were in large measure composed of numerous fictions and fantasies that bore little relation to reality . Rather,Treichler argued, reality itself was made up of metaphor. The cultural reality of AIDS, according to Treichler was a study in cultural metaphor.

By 1994, authors like Frankenberg (1994) were calling for more in-depth studies on the impact of symbolic representation and metaphoric ways of thinking on the course of the AIDS epidemic worldwide. In 1995 Mogensen produced a book-length piece of work on how cultural symbolism and cultural mythology had informed people's ways of thinking about AIDS in Africa. Her study of how the Tonga of Zambia had worked AIDS into older interpretive frameworks demonstrated the need for more work on the cultural construction of AIDS in Africa. According to Mogensen, AIDS among the Tonga was really *kahungo*, an illness caused by intercourse with a woman who had miscarried. As I shall argue, the Zulu have 'reinterpreted' AIDS in a similar manner, though not specially as a miscarriage-related condition. Mogensen (1995) called for a more careful consideration of discourse and narrative in ethnographic studies in general.

Weiss (1997) has offered a symbolic analysis of the cultural construction of AIDS in Israel. Through informants' depictions of cancer, heart disease, and AIDS, Weiss demonstrated that the key symbols of both cancer and AIDS were pollution and bodily transformation. Weiss (1997: 456) argued that these diseases were metaphorized within a "symbolic space that was 'beyond culture' where body boundaries are dissolved and cultural categories are dismantled." Heart disease on the other hand was metaphorized as a localized defect in the 'body machinery'. Weiss concluded that the analysis of 'cultural tropes' should be added to the often-contested symbolic array surrounding the 'epidemic of signification' that AIDS and cancer have introduced into our lives.

The study of disease and its metaphor, particularly in regards to AIDS, represents a relatively new direction in medical anthropological studies. There is a paucity of such studies on African populations. Frankenberg (1994) suggested that studies of disease and its symbolism should represent a growing body of anthropological literature in the next century. Clearly, in the time of AIDS and other chronic illnesses of the post-industrial era, there is a need for a better understanding of disease symbols and their signification.

PARTICIPATORY HEALTH RESEARCH

Concurrent with the growth of health-related studies of the past decade that reveal an increased sensitivity to feminist concerns, gender, and disease symbolism as forces and factors requiring special research focus, there has been a growth of studies conducted through the use of participatory research methods. Following the lead taken by researchers who incorporated participatory research methodologies into rural development programs (see works by Korten 1980, Chambers 1983, Welbourn 1991, Pratt and Loizos 1992 as examples), health researchers of the 1990s sought ways to apply participatory methodologies. Works by Ackroyd (1990), Welbourn (1992), Vlassoff and Tanner (1992), Rifkin (1994), and Cornwall (1994) are examples of studies where the authors argue that participatory research approaches have much to offer to the field of health research in general.

Writing in the 1980's, Mies (1983) was one of the first to address the problem of researching women's health issues through the use of conventional research methodologies. Acknowledging the growing feminist movement of the time, Mies argued that a 'feminist' research approach must involve the researcher's active participation in the struggle for women's liberation. The methodology used in research, according to Mies, should aim to reduce the distance between the researcher and the researched and serve the purpose of enabling women to

increase control over their lives. Mies suggested that a more participatory approach to research was called for to ensure that the rapidly expanding research agendas focusing on women contribute to women's empowerment and 'conscientization'. Maguire (1987) further developed the notion of a feminist approach to research, which was in essence participatory research. Drawing upon Freire's (1972) ideas of 'education for liberation', Maguire identified the objective of participatory 'feminist' research as that of transforming power structures and relationships, and empowering women to develop a critical understanding of the forces of their oppression. Maguire suggested a framework for research which included placing gender at the centre of the research agenda, giving feminism and women's participation a central place in the research process, and giving explicit attention to gender issues. Women participating in the examination of issues and the creation and use of knowledge and information was key to Maguire's framework for a feminist participatory research methodology.

Amongst the first researchers to consider the applicability of Freire's learning/reflection/action pedagogy to the business of health promotion were Lindemann and Olivier (1982). These authors examined the then current state of health delivery in the United States and argued that a re-orientation in approach was needed. While politicians at the time were pressing for widespread reforms in the government provision of health care, Lindemann and Olivier argued that the essential first step in any medical reform was to promote the development of a 'critical consciousness' in both health consumers and medical professionals. These authors described what they saw as the pervasive form of doctor-patient relationships in the U.S. as being one akin to the classic oppressor-oppressed relationship addressed by Freire. Health reform, they argued, could be achieved if doctors used a participatory research approach when conducting interviews and taking medical histories of their patients.

In an ICRW-sponsored study to discern barriers to the promotion of safer-sex amongst poverty-stricken women in India at high risk for HIV infection, George (1996) applied participatory research methods in an effort to understand the meaning of sexuality for these women. Drawing from her experiences, George provided a discussion on the effectiveness of participatory research in health and identified some ethical dilemmas and concerns of doing participatory research. These included the problem of continued unequal power relations in the research process (participants involved mostly in the data-gathering stage only), the 'authoritative voice' continuing to be that of the researcher as she/he makes the decisions on the final format and text in the selection of the content, and continued dilemmas over the purpose of sharing information and the invasiveness of the research process (George 1996). At an international symposium on participatory research in health held in 1994 that attracted researchers from around the world, many of whom were experienced in the use of participatory methodologies (see de Koning 1994), these issues were discussed. According to de Koning, this symposium was organized as an effort to understand better the challenges and value of participatory research techniques used in health promotion and to discuss ways of sustaining the 'participatory process' after research.

Focusing on Africa and its rapidly growing AIDS epidemic of the 1990s, researchers such as Manji (1994) argued that a participatory research process that included a component for learning and reflection on the part of those being researched had much to offer to the study AIDS in Africa. For Manji the challenge of AIDS in Africa was part of the greater challenge of women's liberation on the continent. AIDS research she argued, had to become participatory, action-oriented, and feminist in approach in order to be relevant. Preston-Whyte (1993 a and b) was one of the first to consider what participatory research methodologies had to offer to the AIDS effort in South Africa. That author argued that intervention-oriented AIDS research should be

based upon a clear understanding of local perspectives and interpretations of AIDS-related variables that could be discerned through the use of participatory research. As an anthropologist, Preston-Whyte argued that participant observation and other qualitative anthropological techniques could provide an ideal basis for participatory action research in the AIDS intervention field. Focusing on research amongst secondary school children, Mathews et al. (1993) considered the insights that may be gained by using participatory methodologies for gathering information on sexuality. Like Preston-Whyte, Mathews et al suggested that participatory methods used in qualitative research had much to offer in terms of gaining knowledge on which to base AIDS education strategies.

Theatre and drama used as a vehicle for conveying the AIDS message in South Africa was one way, according to Dalrymple and Preston-Whyte (1992), of incorporating participation and action into an AIDS intervention. These authors described ways in which community-based theatre productions could be used to stimulate a 'learning, reflection and action' process on the part of participants. Reporting on the aims and objectives of a Health Department-sponsored AIDS education initiative called the DramAide Schools Project that had been implemented in over 400 high schools of the KwaZulu Natal province, Dalrymple and Preston-Whyte drew upon an 'education for liberation' philosophy to provide the theoretical underpinnings for this intervention. Through role play and opportunities for rehearsing alternative courses of action and expressing alternative attitudes, the DramAide project sought to challenge and change conditioned ways of understanding the self in relation to society. According to Preston-Whyte and Dalrymple the drama exercises "crystallize real-life experiences and stimulate cognitive learning in order to assist young people to develop a critical consciousness leading to co-operative social action and self-reliance" (1996:117).

Participatory methodologies used in health and AIDS research is a relatively new and growing approach to both research and intervention. Different reasons have been put forth to explain its growing popularity. Most authors identify two significant developments of the past decade, which helps to explain the current popularity of participatory research. According to de Koning and Martin (1996), there has been an increased recognition of the gap that exist between the health concepts used by professionals to interpret reality, and those used by different groups in communities. Second, researchers have come to realize that many factors, cultural, historical, socioeconomic and political are difficult to measure but have a crucial influence on the outcome of health interventions. These inter-connected realizations on the part of health professionals and researchers have combined to not only foster the development and use of participatory research in health, but have acted to give renewed credibility and provoke greater interest in qualitative health research in general, including anthropological research in health.

Much still remains to be done in terms of social science research that elucidates the myriad components that comprise the context that informs, gives meaning to, and shapes people's experiences with and responses to the AIDS epidemic in their midst. The current thesis is an attempt to make one such qualitative contribution to the study of HIV/AIDS in Africa. Drawing upon the theoretical orientations and insights gained from the three bodies of literature reviewed – gender, symbolism and HIV/AIDS in Africa – and the methodological approaches and philosophies of participatory research, this thesis represents an effort to peel back some of the layers of cultural meaning being brought to the HIV/AIDS epidemic as currently experienced in one community of Zulu-speaking people of KwaZulu-Natal, South Africa.

The next chapter is an overview of the current AIDS epidemic in South Africa, with particular focus on KwaZulu-Natal province, the province with the highest rates of HIV infection in the country. The response of government and local researchers to the growing threat of AIDS will be discussed, with some of the studies mentioned being the same as those reviewed in this chapter. Nevertheless they are highlighted again as they are deemed to be an essential part of the unfolding of South Africa's unique AIDS narrative.

CHAPTER 3
THE SOUTH AFRICAN AIDS SCENARIO: AN OVERVIEW

Less than two decades have elapsed since the acquired immune deficiency syndrome (AIDS) was first identified in 1981 in the United States. Since that time it has become the most infectious disease in contemporary history, and quite likely the most serious new menace to human health around the world this century (Quinn et al 1986:955). The United Nations AIDS Report of May 1999 showed that 33,4 million people world-wide were infected by HIV/AIDS, with approximately 2,5 million people dying of the disease. It is estimated that between 40 and 50 million people globally will have the HIV virus by the year 2000.

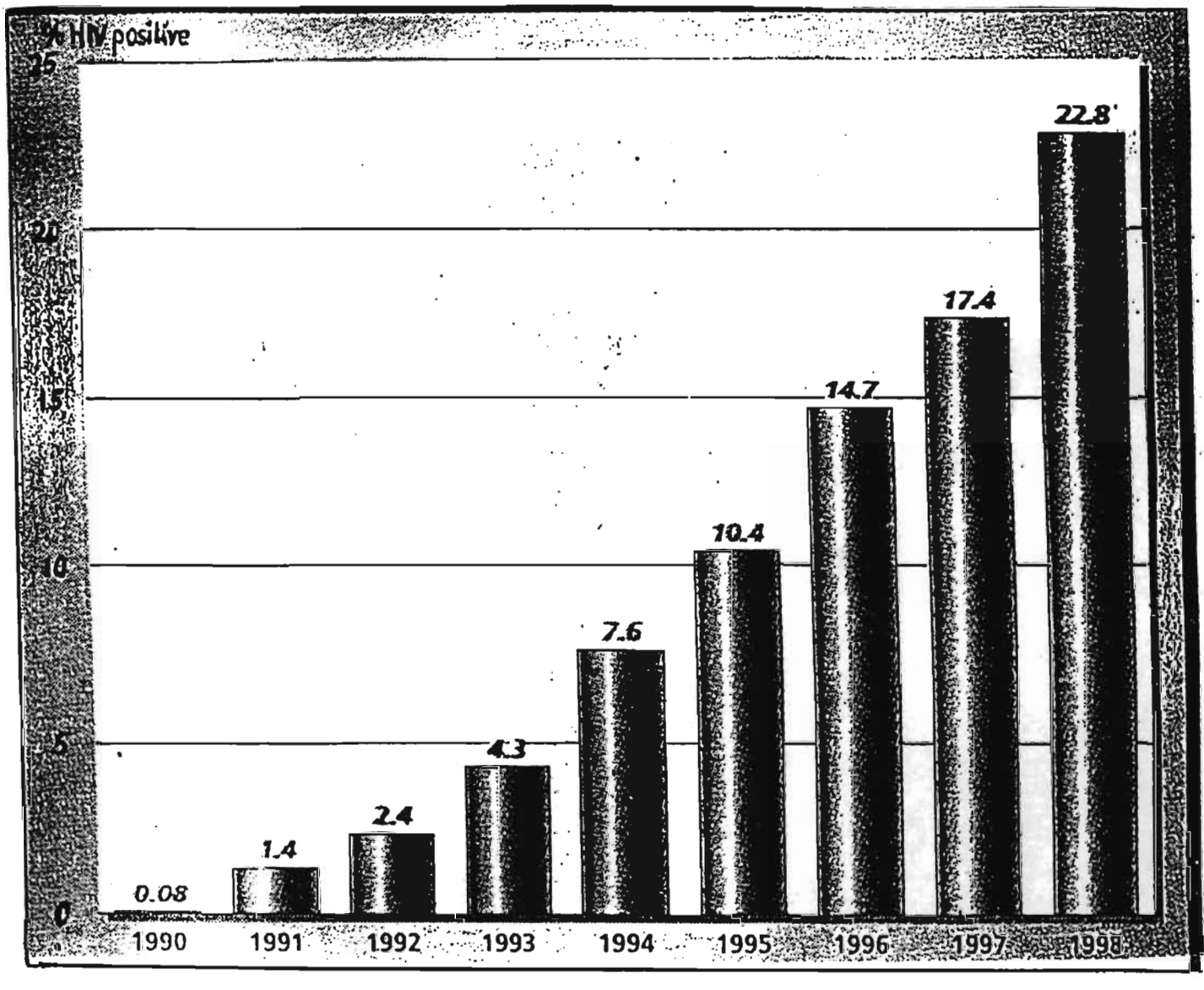
Nowhere is the AIDS epidemic set to have such profound impact as in Sub-Saharan Africa, where about two-thirds or 22,5 million of the world's 33,4 million already infected reside. Poverty, civil unrest, lack of government financial resources, structural inequalities, labor migration, limited access to adequate health services, and the low-status of women are some of the factors behind the havoc being brought in the wake of AIDS in Africa (World Bank 1997). The rapid spread of the disease in Africa has reached pandemic proportions. Uganda stands out as the country where early research and media coverage exposed the high degree of HIV infection and the impact that AIDS was having on the people (see Barnett and Blaikie 1992). Recent studies indicate that the AIDS epidemic in some parts of eastern Africa may have reached a plateau stage whereby the rate of increase in new HIV infections has slowed considerably, especially in Uganda (U.N. AIDS 1999).

As we enter the third decade of AIDS, international health organizations are turning their attention to Southern Africa. Recent studies reveal that the countries of Southern Africa could be just as affected by the AIDS epidemic as East Africa, if not more so (Cohen 1998). The latest report on AIDS by the United Nations (U.N. AIDS 1999) indicates that southern Africa was facing a long-term emergency with patterns of mortality approaching those found only in major wars. In places with a mature AIDS epidemic such as Zimbabwe, AIDS was already established as the leading cause of infant death by 1990 (Whiteside 1990). Life expectancy there has dropped from 61 years to currently 40 years, in just one decade (1). In ten years' time life expectancy in Zimbabwe is expected to decline to 32 years (US Bureau of Census 1996). In the local *Sunday Standard* newspaper of Harare, dated 16 March, 1998, the Minister of Health and Child Welfare was reported as stating that AIDS was claiming 700 lives a week in Zimbabwe. The Minister also suggested that AIDS discrimination had overtaken racial and tribal discrimination in that country. By the start of the decade, Zambia had the second highest number of reported HIV infections in the subcontinent (Sato et al 1989). Among a sample of STD patients at a Lusaka clinic, the HIV seroprevalence rate at that time was 44%. Currently life expectancy there has dropped to currently 42 years, mostly as a result of young adult mortality due to AIDS (U.S. Bureau of Census 1996). Studies from Mozambique (Green et al 1993) and Botswana (Ingstadt, 1990) reveal equally serious AIDS crises. In Swaziland, AIDS has been made a notifiable disease, which means that cases must be reported to the Ministry of Health. Researchers say that being identified as an HIV positive person or as an AIDS sufferer has resulted in considerable discrimination. Partly because of this, AIDS cases tend not to be reported, and the disease has largely been 'driven underground'. The result has been a considerable underestimate of the true size of the problem (Whiteside 1990). Nevertheless studies show that the epidemic has affected a considerable proportion of the Swaziland population (Green 1994).

It is important to bear in mind that most statistics on AIDS in Africa are under-representations of the true size of the epidemic. Many governments still seek to conceal the magnitude of the problem. According to Whiteside (1990) there is a fear amongst many government officials that public acknowledgement of the true size of the epidemic in their country may negatively affect tourism and foreign investment. Also, in many countries there is a lack of proper medical reportage. In rural areas, for example, records may not be kept at all. In urban areas poor quality reporting and uneven coverage is often a problem (World Bank 1997).

Here in South Africa records of HIV and AIDS incidences have been regularly gathered and made available to the public since the beginning of the decade. The primary source of AIDS statistics comes from studies done on mothers attending antenatal clinics. Although the first statistics on HIV infection in the black community were gathered in 1987, the seriousness of the HIV/AIDS epidemic was not grasped until information was forthcoming from the antenatal clinics (Swanevelder 1994). Repeated every year since 1990, antenatal surveys from which nation-wide infection rates are extrapolated reveal an increase in HIV infection from less than 1% in 1990 to over 22,8% by the end of 1998 (see TABLE 1, p 61). At the start of 1999 it was estimated that 3 million South Africans were seropositive for HIV (Ninth National Survey 1998), with the epidemic showing no sign of slowing down. Rather, recent surveys indicate that the disease is spreading rapidly and young people in the 15 to 25 year age group are particularly at risk (Mohoebi 1997). Whereas the rate of HIV infection has increased by 34% between 1997 and 1998 in the general South African population, it was estimated that among young women under age 29 the rate of increase during that time was 64% (Ninth National Survey 1998). Currently it is estimated that 1500 people per day are contracting the AIDS virus, resulting in a total of 50 000 new infections per month in South Africa.

TABLE 1: HIV Prevalence among women attending ante-natal clinics in South Africa by year.



Source: Department of Health. HIV Surveillance of Pregnant women, Ninth Annual Survey 1998

According to the United Nations AIDS Report of May 1999, South African HIV infections accounted for 10% of all new infections in the world, and this percentage was likely to increase over the next couple of years. Early in the decade medical professionals predicted that HIV prevalence rates would start to decline or at least level off when South Africa reached an overall 16% HIV infection rate. This has not happened. It seems likely that national HIV prevalence will be just shy of 25% by the turn of the century. Such high infection rates have led to South Africa being considered as having the fastest growing AIDS epidemic in the world (2). The epidemic is expected to peak within the next ten years. At that time, about 5 million South Africans will be infected with HIV and an estimated 130 000 people are expected to be dying from AIDS, each year (Whiteside 1996). According to a 1998 Human Development Report of the South African Demographic Services, life expectancy was expected to drop over the next few years from a current 68 year average to 48 years (Michaels 1998). This report also predicted a negative population growth for the country by 2010 when deaths start to outstrip births, a process, according to some researchers, that has already started in KwaZulu-Natal.

AIDS IN KWAZULU-NATAL

The South African AIDS scenario is nowhere grimmer than in the province of KwaZulu-Natal. Routine antenatal testing indicated that by the end of 1998 an estimated 750 000 people will be living with HIV in the province, representing about 1/3 of the country's total estimated 3 million HIV infections (Ninth National Survey 1998). From the start, this province has maintained its reputation as the epicenter for the AIDS epidemic, leading the country in both HIV infection and deaths due to AIDS. An indication of the proportional size of the HIV/AIDS epidemic in KwaZulu-Natal is demonstrated through the number of HIV blood specimens received on a monthly basis by provincial virus

laboratories. In the month of August 1998, 2707 of the nationwide 5283 total HIV-positive blood specimens received by these laboratories were from KwaZulu-Natal. This represents over one half of the nation's total new HIV infections for that particular month (Surveillance Bulletin, Sept. 1998). The estimated provincial infection rate is 32,5%, against a national average of 22,5%. Indications are that 60% of all patients currently at hospitals throughout the province are HIV positive. In 1997, AIDS alone was said to have killed more people in the province than all other causes together (3). By 2006 the cumulative total of AIDS deaths in KwaZulu-Natal will have surpassed a million (see Appendix 1 page 249).

These statistics reveal disturbing developments. As the epidemic of increasing HIV infection matures and becomes an epidemic of AIDS-related illness and death, new challenges reveal themselves. Among other things, a generation of AIDS orphans is being created. Already there are about 200,000 orphans in the province due to AIDS, and the problem of housing and caring for these children – many of them HIV positive themselves – still remains to be solved (Smart 1995). In June of 1998 a conference was held in Pietermaritzburg, the capital of KwaZulu-Natal province, to specifically focus attention on the problem of AIDS orphans. Opening the conference, Graca Machel, wife of the past President Nelson Mandela, called on government to help subvert this impending disaster by 'empowering communities to cope with the AIDS epidemic and the tragedy of being orphaned'. What the orphan problem is revealing is that most communities in the province, as elsewhere in Africa (see Cohen 1998), are unable to cope. In many parts of the province, the much-lauded extended family is often comprised of nothing more than a pensioned grandmother left with the responsibility of providing for several grandchildren and great-grandchildren (Marcus 1999). Parents, who left the rural areas to take up informal residence around towns and cities in the province, are now coming home to die of AIDS. Recent newspaper reports reveal that most of these AIDS

'returnees', do not reveal their sickness to their families or neighbors, for fear of abandonment (4). In communities ravaged by poverty and violence, there is little hope that the problem of hundreds of thousands of AIDS orphans will be solved within the community by the extended family system alone, as studies from other African countries show (see research by Foster (1992), Drew (1995), Jackson et al (1996) and Toupouzis and Hemrich (1996).

The situation for those in need of treatment for AIDS-related illnesses and those in the latter stages dying with AIDS, is equally unpromising. Already provincial hospital beds are overflowing with AIDS patients, and many have begun to turn away even those desperately in need of help due to lack of space and resources to care for them. In June of 1998, the budget of the Provincial Department of Health was slashed, seriously impacting on the treatment of AIDS patients and the provincial AIDS awareness campaign. While the number of people infected with HIV continues to grow, the budget cut was interpreted by many in the medical profession as the government 'shooting itself in the foot.' As one City Health nurse commented during the course of an interview: "The government is mad. This is the time when we need more money, not less." Yet, the government hopes that with the lack of funds making institutional care of AIDS patients impossible, home-care programs within the community will provide a solution. It is likely that the already over-burdened communities will be overwhelmed by the AIDS challenge, as on-going work by Marcus (1999) indicates, and has been the experience of other African countries (see World Bank Report 1997).

The grimness of the situation was revealed to me through several visits to rural homesteads in the province where the residents were said to be sick or dying from AIDS. It immediately became clear how the problem of AIDS management was part-and-parcel of the wider development challenge. Shortage of medical personnel to cover large geographical areas is one

problem. Lack of medical supplies, lack of transport, poor roads.....all of these are obstacles to the proper care of AIDS patients. Factors such as lack of piped water made it near impossible for caregivers to practice any degree of infection control. The sick were often to be found in small back rooms with windows closed (where there were windows) and curtains drawn, so as not to alert passers-by to the fact of a dying person in the home. Dirty plates of half-eaten food were found under beds, along with piles of dirty clothes, rags and buckets used for coughing and spitting into, along with used chamber pots. In some homes, chickens and dogs moved freely in and out of the sickroom. According to the community health workers who accompanied me on these visits, having the primary caregiver aware of the patient's sickness was necessary so that infection control procedures could be followed. Most often, the terminally ill person did not want any person, including family members alerted to their true condition. Legalities aside, experience had taught health workers to be very careful with disclosing information regarding a patient's AIDS status. Many AIDS patients had been altogether alienated or rejected by their families. Some, especially women, had been barred from their marital homes. In other cases, where family members did involve themselves in the care of a dying relative, they invariably claimed that the person was sick with some other disease. Rarely would people admit the fact of an AIDS patient in the home.

Rural areas in the South Coast reveal the extent of the AIDS crises in communities ravaged by on-going violence and poverty. While it has been well documented that northern KwaZulu-Natal is the most HIV-affected part of the country, some medical personnel believe that the virus has hit the southern KwaZulu-Natal region even harder. According to the director of South Coast Hospital's community-based AIDS program, about 20 people from that area are dying each week from AIDS, while over 30 new patients are added to their list of people to visit. Here, in rural communities such as Inzingolweni and Umbumbulu, AIDS victims are being buried quietly on family plots. The general

fear is that a burial in the church graveyards would invite too many questions from neighbors. Families want to avoid the social stigma of AIDS. According to one elderly woman who was caring for two family members who were both bed-ridden from AIDS, friends and neighbors would no longer visit if the true nature of the sickness were known. "We say its TB, and its very bad. People know TB, so they still help us. Otherwise, they would stay away." It was obvious that even the most basic forms of infection control were not being practiced by most of the patients' caregivers.

In the semi-rural communities in the Valley of a Thousand Hills, some 60 kilometers from the Durban city center, families caring for sick relatives are even loath to be visited by health workers. It was feared that this would alert neighbors to the fact of an AIDS infected person in the home. They preferred to make the trek themselves to local clinics or community AIDS centers and condom distribution points in order to obtain medicines and materials needed for home care. Some have even complained that being seen emerging from these places raises suspicions. This has resulted in health workers selling used clothing at some of these places just so the AIDS-associated stigma could be mediated. To say that AIDS carries a strong stigma in KwaZulu-Natal's rural areas, is an understatement. At present, AIDS carries an *extreme* stigma. In some communities found in the Thousand Hills Valley such as KwaNyuswa, Embo and Emolweni, people known to be AIDS sufferers have had their houses burnt to the ground. Some barely able to walk, have been chased by mobs into the bush. Here they have built makeshift shelters and receive food parcels and nursing care by visiting staff members from the nearby Hillcrest AIDS Centre. These dedicated health workers basically risk their lives to get food and supplies to those who have been banished from their communities and left to die alone. "You can't believe what poverty and superstition together can do to people. They can become like animals." This was the comment of one woman who had decided to dedicate the remainder of her life to assist those whose

disease status invited the full wrath of a people so conditioned by violence and want (see Appendix 2 page 250).

Even the children living in those communities who are known to be HIV positive but have no AIDS-related symptoms, are not wanted in the local schools. People say that teachers and pupils act together to chase children away who are said to be 'unclean'. When a leading non-government organization in the area sponsored a "PLWA" (person living with AIDS) from another African country to come speak about AIDS in those communities a few years ago, he had to flee for his life as armed men and angry women accused him of coming to 'bring AIDS to our people'. As things stand today, terminally-ill AIDS patients urgently needing help are either dying silently at home in their communities, or at local hospitals and hospices (if they are lucky enough to get a bed), while some are dying as pariahs in the bush. How people's responses to AIDS will change as they continue to adapt to the maturing epidemic, remains to be seen.

Being sick or dying of AIDS in the urban settlements is no less stigmatizing and frightening a prospect. In Cato Manor, a sprawling informal settlement just a few kilometers outside of Durban, several of those who were regularly visited by health workers had been abandoned altogether by family and friends. For them, their last days were being spent alone in small makeshift shacks. Donated radios provided their only source of conversation and contact with the world around them. Despite their desperate circumstances, some still remained cheerful, with more than a little help from dagga (marijuana). One sickly young man said he preferred dying in his one-room shack because his neighbors there never showed much interest in him. "They don't ask questions here," he said, "they leave me alone, I like that." The home-care challenge in the midst of so much poverty and fear is proving to be a big challenge indeed. Yet, in an era

of dwindling resources and rising numbers of people needing care for AIDS-related illnesses, everyone seems to concur that there is little choice but to pursue the home-care option.

GOVERNMENT RESPONSE

Against this backdrop of worsening crisis, the national government is just beginning to take concrete steps towards a multi-sectoral response to AIDS. Up until now, the political will to put AIDS firmly on the agenda has been lacking. In the early 1990s AIDS was still being seen as a health issue with the hope that a cure would soon be found (AIDS Consortium 1993). Government response at that time was almost non-existent, with the business of AIDS awareness being left largely in the hands of non-government organizations. Before the 1994 elections, the National Aids Coalition of South Africa (NACOSA) drew up a national AIDS program which was adopted by parliament in 1994. It clearly stated that AIDS was not just a health issue, and that any government response to the epidemic would have to include all departments and government ministries. This was not to happen. In spite of its official adoption by parliament, the AIDS program remained under the wing of the Department of Health. Other, more urgent needs took precedence after the 1994 elections, such as the provision of housing and water supply. The new government's early HIV/AIDS policy only extracted key aspects of the proposed AIDS program that included the promotion of lifeskills, a focus on legal and human rights issues, condom distribution, and raising awareness in regard to AIDS (5). For many observers, the government response at this time was far from adequate. Their general view was that valuable time in halting the growth of the epidemic in this country was being lost (see AIDS Consortium 1993).

In late 1995 the government, in an agreement with the World Health Organization, began test trials of the drug popularly known as AZT. HIV

positive mothers in two government hospitals were given the drug in the hope of preventing pediatric HIV infection (Koornhof 1995). In October 1998 the results of these test trials were reviewed. According to Dr Zuma, the then Minister of Health, even with the use of AZT, 33% of babies would still be infected with the virus, and most of the rest would be subjected to the possibility of infection through breast-feeding (6). Ultimately, the benefit derived from treating HIV pregnant mothers with AZT is believed not to warrant the financial outlay required. This led to a government decision in October 1998 to discontinue test trials of AZT with pregnant women, a decision that has been widely criticized in the popular media. The government defended its decision by developing a policy to concentrate its efforts and resources on raising public awareness through a concerted 'partnership' approach. In late 1998 the soon-to-be President Thabo Mbeki announced the launch of a national initiative to involve all stakeholders in the fight against AIDS; government departments, the private business sector, non-government organizations, and people living with the AIDS virus. This initiative, officially called the 'Partnership Against AIDS', marked the beginning of what many hope will be a real commitment on the part of government to adequately address the growing epidemic in a co-ordinated and comprehensive manner (7).

There are moves currently afoot to make AIDS a notifiable disease, as is the case with tuberculosis. Early in 1999 a meeting was held by various Ministers of Health from the Southern African Development Community (SADC) where a resolution was taken to make HIV/AIDS notifiable, thereby compelling people to reveal their HIV status. This move was seen as a necessary step for proper planning to take place in the fight against the disease. Many observers see this as a retrogressive step that would only serve to drive the disease 'underground' as has happened in Swaziland, where people hide their AIDS status. Those who oppose this move feel strongly that it will only exacerbate the problem of stigma that AIDS already carries to such a high degree. Others, such as Dr

Rabinowitz, health spokesperson for the Inkatha Freedom Party (which draws most of its support from KwaZulu-Natal province), see this move as a way of protecting the public. According to this doctor, making AIDS notifiable would facilitate monitoring of the disease and treatment to prevent the birth of infected infants. While the debate on making AIDS officially notifiable continues, there are increasing calls being made to make it a criminal offence for people with HIV not to disclose this to sexual partners. (see Appendix 3, page 251).

Meanwhile, amidst much controversy, the search goes on for better medicines to treat AIDS-related illnesses and a vaccine to counteract the strains of the virus more prevalent in Africa. The strains of HIV which exist in the West, are not the most prevalent strains found in many parts of Africa, including South Africa (Bhighee et al 1993). One of the most promising initiatives to date in this regard is a recently announced 9 million U.S. dollar grant from the University of Carolina to work with virologists at the University of Cape Town in the development of an AIDS vaccine using virus samples from KwaZulu-Natal (see Appendix 4, page 252).

Up until very recently the government response to AIDS has not reflected a serious commitment to halt the exponential growth of the epidemic in South Africa. Characterized by piecemeal initiatives that were often contradictory and controversial, the 1998 launch of the intersectoral 'Partnership Against AIDS' is seen by many to be at least a move in the right direction. Although the government's 80 million rand pledge for this program may seem like a great deal of a money being put towards addressing a singular challenge, it may in fact prove to be not nearly enough. As a recent World Bank report makes clear, HIV/AIDS tends to exacerbate existing development problems through its catalytic and systemic impact. It states:

> Given that many problems arising from the epidemic are not specific to HIV/AIDS, policy and program responses must address the root causes and consequences of the wider challenges to development. In other words, a development rather than an AIDS-specific focus is critical to tackling the multi-sectoral complexity of the epidemic and its systemic impact and to ensuring the sustainability of both HIV/AIDS responses and development efforts (World Bank 1997:10).

With so many conflicting yet intertwined development challenges facing the government at the turn of the century, 80 million rand may ultimately seem like small change.

SOCIAL SCIENCE RESPONSE

Faced with a new and rapidly growing epidemic, local academics have responded to the need for an accurate and comprehensive understanding of AIDS. Like elsewhere in the world, as the rates of infectivity began to show patterns of infection that differed between sub-groups within the population, social scientists began to explore different variables that could explain these differences. In South Africa, HIV infection was first reported in 1982 among the white homosexual community. By the start of the 1990s, it became clear that the course of the AIDS epidemic would follow the typical pattern of transmission found in other parts of Africa. This epidemiological pattern has since come to be known as "Pattern II" transmission, whereby the key features include a predominant heterosexual spread, a male/female infectivity ratio of 1:1, pediatric AIDS is a commonality, and the national prevalence rates of HIV infection can be as high as 20% or more (Sato et al 1989). The noticeable surge in recorded HIV infection in the black heterosexual population by the beginning of the 1990s served as a wake-up call for many researchers.
Early on in the epidemic economists such as Whiteside (1990, 1995, 1996) and Doyle (1991) began to try to assess and predict the overall socioeconomic

impact that AIDS would have, both locally and nationally. Along with the economists, much of the early research on AIDS in South Africa was initiated by medical scientists and took the form of quantitative questionnaire surveys. Most of these studies were typical K.A.P. (Knowledge-Attitude-Practice) studies as discussed in Chapter 2 and really revealed very little about sociocultural forces shaping the course of the epidemic. Studies by Friedland et al (1991), Nicholas (1992), Perkel et al (1991) and Roos et al (1995) are examples of this genre of research. Generally, it was found that a good basic knowledge but fear of AIDS was prevalent in South Africa before mid-decade, along with a sense of fatalism, many misconceptions, and continued engagement in 'high-risk' sexual activity. In KwaZulu-Natal, early studies about knowledge and practice corroborated most of these same findings. Naidoo et al (1991) found a similar set of attitudes and reported behaviors among students at the University of Natal in Durban. Studies by Preston-Whyte et al (1991) among women in one of Durban's townships revealed that although the majority knew what steps to take to prevent HIV infection, not a single one reported to have used a condom during intercourse. It soon became clear to researchers that knowledge alone was a dubious predictor of behavior. Sociocultural factors such as pressures from both partners to prove fertility were cited early on in the epidemic by Preston-Whyte and Zondi (1989 and 1992) as important forces influencing sexual behavior.

What these studies of the early 1990s revealed was that there were in fact many forces influencing health actions. Social scientists such as Boulogne (1995) began to call for more interdisciplinary research on AIDS in South Africa. As Boulogne rightfully argued, the social sciences could make a considerable contribution towards a better understanding of the epidemic by "indicating that there exists a symbiosis between the sociocultural and psychobiological needs of man" (Boulogne 1995:39). Presumably, this author meant women as well.

By mid-decade research on the growing AIDS epidemic in South Africa by social scientists represented an expanding body of literature on AIDS. Researchers at the Epidemiology Research Unit based in Johannesburg were amongst those to call for closer collaboration between medical and social scientists in developing more effective responses to the growing threat of AIDS (see Campbell and Williams 1995). Drawing from their experiences with AIDS interventions on the gold mines, these researchers argued that the sociocultural environment played a key role in determining the effectiveness of any intervention aimed at changing sexual behavior. On-going studies by Richter (see Richter et al 1994, Richter and Swart-Kruger 1995, and Richter 1997) among street children who are particularly at high risk for HIV, consistently point to social factors that need to be considered and addressed before interventions could be effective. As Richter et al (1994:964) argued: "The AIDS risk of street children epitomizes the dilemmas of contemporary health, particularly the tension between the medicalization of the problems of the poor, and the recognition that health is deeply and inextricably rooted in social conditions and social relations."
My own research on young people and AIDS in KwaZulu-Natal (see Leclerc-Madlala 1997) examined the impact that apartheid-era violence and social disintegration may have had on the youths' attitudes towards and responses to HIV/AIDS. In this study I argued that young people had been psychologically brutalized by the political events of the immediate past, with the result being that many of them did not seem to be especially concerned about becoming infected or infecting others with a slow-acting, deadly virus such as HIV.

The 1995 Beijing Conference on Women helped to propel researchers both here and abroad, to study the special problems HIV/AIDS presented for women. The World Health Organization's report on Women and AIDS (see WHO 1995) presented at the Beijing Conference, revealed that by the turn of the century 4 million women will have died from AIDS. More frightening was the fact that women, because of their anatomical structure, were more susceptible to HIV

infection by way of the vagina's mucosal surface area and the fact that semen remains there for some time. The vulnerability of women to HIV/AIDS soon became a popular focus of academic activity worldwide. Researchers, following the lead of Berer and Ray (1993), began to analyze factors that led to women being especially vulnerable in this epidemic, and the sub-field of 'Women and AIDS' (as described in Chapter 2) was born.

As elsewhere in the world, researchers in South Africa responded to the call to put women on the HIV/AIDS agenda. Early work by Campbell (1991) focused on commercial sex-workers and HIV transmission, while Strebel (1992) demonstrated the depth of women's powerlessness in general and feelings of helplessness that prevented them from practicing safer sex. In KwaZulu-Natal, the previously mentioned work by Abdool-Karim et al (1995) along with that of Marcus et al (1995) and Varga (1996) presented similar arguments with regard to the barriers faced by commercial sex-workers in preventing HIV transmission. Preston-Whyte et al's (1991) previously mentioned study on AIDS knowledge and condom use by teenaged girls in a Durban township was followed by work which examined the application of qualitative methods in intervention-oriented AIDS research (Preston-Whyte 1992, 1993 a, b and c). Varga and Makubalo (1996) highlighted the role of physical abuse and feelings of powerlessness that prevented adolescent girls from engaging in sexual negotiations with their partners. These findings were similar to those of Abdool-Karim and Morar (1994) and Hadden (1997) who addressed the sociocultural context in which sexual behaviour occurred among urban-dwelling young people in the province. In 1997, Varga (1997a and b) argued for a deeper appreciation of the role played by economic and sociocultural factors in people's continued practices of 'un-safe' sex in an environment reaching near-saturation with HIV infection.

Women who disclose their HIV infection were the subjects of a study by Seidel and Ntuli (1996) in northern KwaZulu-Natal. These authors found that women faced rejection and increased violence by male partners when they revealed their HIV-positive status. Seidel and Ntuli (1996) argued that health status was being used to control women and maintain their subordinate status and traditional functions that included being carers of men. These authors called for more gender-sensitive policies on AIDS. Focusing on gender and sexual networks in different cultural groups in South Africa, Preston-Whyte et al (1997) argued that there was a need to re-conceptualize notions of sexuality in order to 'sharpen the tools' of researchers who aim to better understand sexual dynamics in the era of AIDS.

While economists continue to lead the way in social science research on AIDS in KwaZulu-Natal, the anthropological contribution is growing. As we go into the next century the social science literature on AIDS in South Africa including KwaZulu-Natal is steadily increasing. Indeed, one could argue that AIDS research is currently the leading growth area of research activity in this country. The trend is now firmly towards finer-grained bio-sociocultural studies with a focus on the context in which HIV transmission takes place (Campbell and Williams 1996), and towards the development of new AIDS intervention strategies (see Hadden 1997). More than anything else, local studies on AIDS reveal how much work still remains to be done. For anthropologists, many variables that play a part in the AIDS epidemic and lie within an anthropologist's field of expertise remain to be studied and analyzed. These would include among other things, the nuances of shared meanings, values, perceptions and beliefs which inform the way in which people act in the face of widespread terminal illness and death. Local studies could take their epistemic points of departure from works by Clatts and Mutchler (1989) and Douglas and Calvez (1990) on metaphoric representations of AIDS, or studies by Taylor

(1990) on Rwanda, Schoepf (1992a and b) on Zaire, Mogenson (1995) on Zambia or Haram (1995, 1996) on Tanzania, all which have sought to elucidate the ways in which the sociocultural context conditions beliefs and sexual behaviors that impact on AIDS risk. Similar studies could make vital contributions to our understanding of the AIDS epidemic in South Africa and our attempts to manage it by pointing out some key shaping forces that needed to be addressed and modified within the context of AIDS intervention.

As Gupta and Weiss (1993) have argued, effective AIDS intervention strategies targeting sexual behavior change must be based on a thorough understanding of the higher order influences that shape interpersonal dynamics and sexual practices. Anthropologists are well placed and well equipped to address those higher order influences. As women continue to be at greater risk of contracting HIV and caring for those already infected, their sexual behavior, health status, occupation, socio-economic situation, levels of confidence (or rather lack of it) and domestic roles, among other things, need to be better understood and studied more closely.

Still, there are other ways in which women and AIDS are linked together that have been, as yet, unexplored in the context of HIV/AIDS in South Africa. I refer to the link which exists between women and AIDS at the cognitive level, in the form of symbolic representations and conceptualizations. The rest of this thesis is an exploration of this link as it exists in St Wendolin's and as it is reflected in the discourse and behaviors of both men and women. The next chapter provides a description of St Wendolin's Mission and the people who live there, amongst whom research for this current thesis was undertaken. As one community representing Zulu society, an historically patrilineal and unarguably patriarchal society, the male voice dominates the AIDS discourse in St Wendolin's. Although women's voices at times are different, increasingly

questioning prevailing norms (as is discussed in Chapter 6), they are largely still muted, with women often adhering to the same explanations as men. Thus, in exploring the metaphoric links that exist between women and AIDS in that community, it is valid to say that both men and women share common conceptualizations, and those conceptualizations have been shaped by a particular patriarchal 'reality'.

Notes

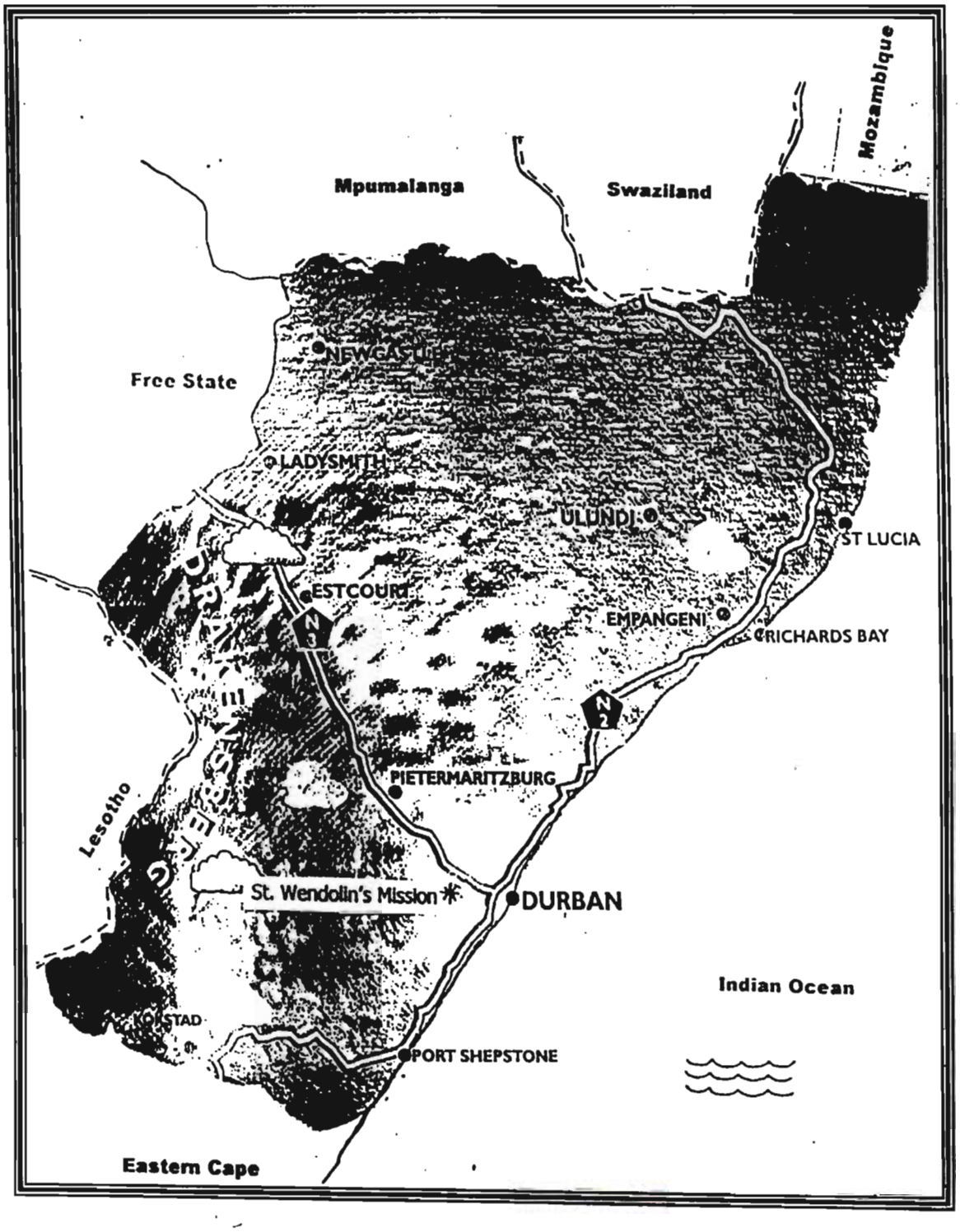
1. Taken from the magazine New Scientist, 14 October, 1998. Reported in the Natal Mercury, 15 October, 1998
2. Statement made by the Minister of Health, Dr Nkosazana Zuma during a parliamentary session to urge all political parties to join the newly launched "Partnership Against AIDS", a government initiative. Quoted in the Daily News; October 8, 1998.
3. Reported in lead article of the Daily News. (June 4 1998) entitled "AIDS TIMEBOMB." Gathered from official Health Department sources.
4. See for example Sunday Times (September 6, 1998) article entitled "The Death that dare not speak its Name."
5. Taken from speech made by Deputy President Thabo Mbeki at official launch of "Partnership Against AIDS" October 10, 1998. As reported in the Daily News October 11, 1998.
6. From article entitled "Zuma defends AZT policy", The Weekly Mail and Guardian, October 16-22, 1998
7. The debate over the use and effectiveness of AZT has not been resolved with the launch of the 'Partnership Against AIDS' program. Whether the government should prioritize and fund AZT therapy for HIV-positive pregnant women or rape victims is still very much a hotly debated and emotional issue in South Africa.

CHAPTER 4
ST. WENDOLIN'S MISSION

St. Wendolin's Mission is perhaps best known by its Zulu name of *KwaSanti*, 'the place of saints'. This name is significant. It speaks of the intimate history which the community shares with early Christian missionary activity in the province. Essentially, the history of St. Wendolin's Mission is the history of the Mariannhill Monastery and its Trappist founders. In 1812 Trappist monks from Europe purchased a large tract of land west of Durban from the Land Colonisation Company of Natal (see FIGURE 1 page 79). Then known as the farm Zeekoeigat, ('Hippo-pool'), the land encompassed present day St Wendolin's and was re-named Mariannhill.

Under the leadership of Father Francis Pfanner, an Austrian Trappist, the monks set about realizing what they referred to as 'a calling' to break from the monastic ideals of routine prayer, hard physical labor, and the oath of silence (Schimlek 1953). Their desire was to do Christian missionary work amongst the African people in their vicinity, but such an undertaking was in direct conflict with their religious vows as Trappists. Soon after settling, the monks at Mariannhill petitioned the Vatican to allow them to be separated from the Trappist order. Their petition was successful, and in 1909 the monks at Mariannhill reconstituted as the Religious Missionary Order of Mariannhill. What started thus as a Trappist monastery soon grew into the Mariannhill Mission Institute that today comprises schools, a hospital, a convent, a retreat house, small manufacturing industries, a guest lodge and a commercial farm among other things.

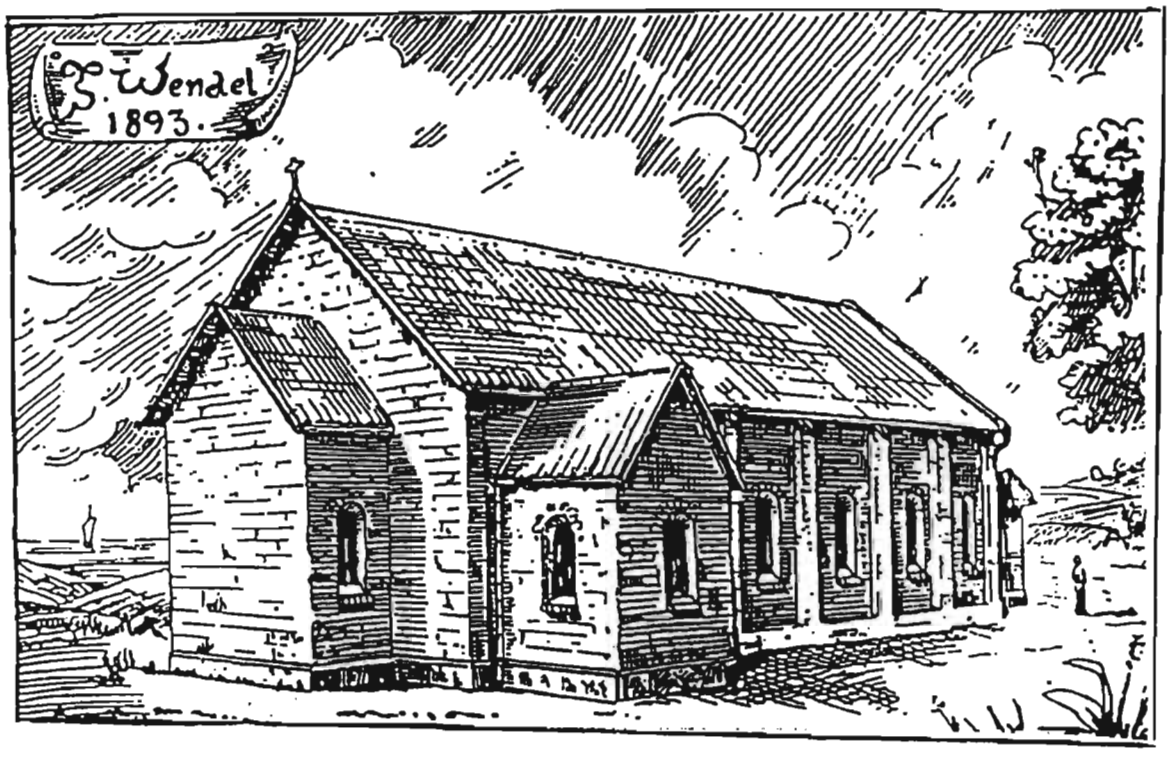
FIGURE 1: Map of KwaZulu-Natal Province showing approximate Location of St Wendolin's Mission, Mariannhill



Even before the Pope approved their breakaway from the Trappist Order, the Mariannhill missionaries had commenced converting the Zulu-speaking people in their midst. One year after settling in the area and building a monastery for themselves, a school was built and opened in 1883 to attract Zulu children from nearby homesteads. According to historical records kept by the Mariannhill missionaries (1), the vision of Father Pfanner was to develop self-contained Christian villages on their land in order to accommodate these Zulu tenants and others who agreed to become Catholics (Adelgiza 1984).

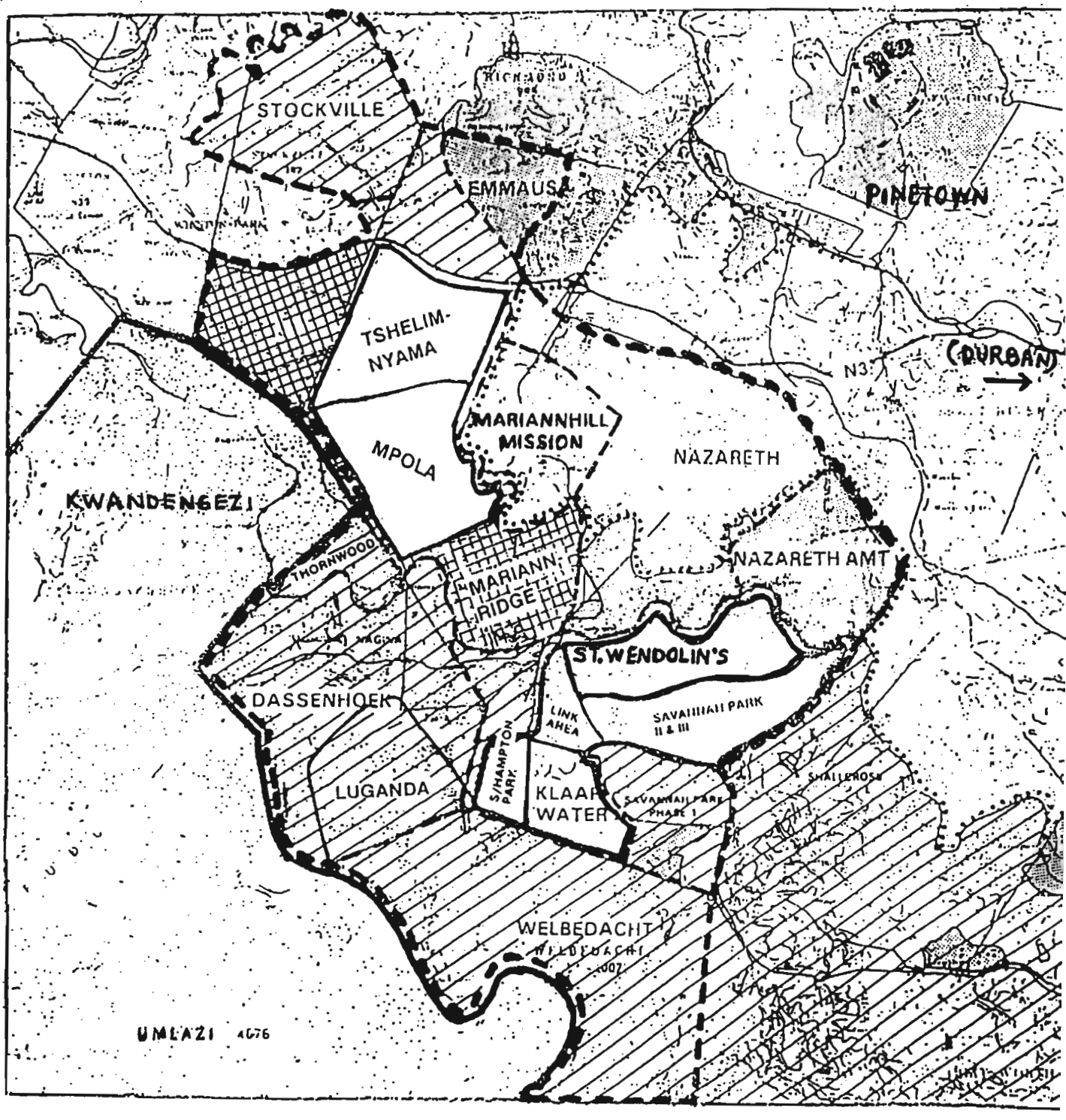
To facilitate this process, the monks subdivided their land known collectively as Mariannhill (see FIGURE 2, page 81). Biblical names such as Nazareth and Emmaus were given to some of the subdivisions. One of these was called St. Wendolin's. Wendolin was the baptismal name of Father Pfanner, and the name of a venerated German Roman Catholic Saint. It was decided

PLATE 1: First drawing of the St Wendolin's Church, circa 1893



Source: History of St Wendolin's (H England,1996)

FIGURE 2: Geographical Map Showing the Various Communities Comprising the Greater Mariannhill Area



Source: Cartographic Studio, Geography Department, University of Natal, Durban

that the new Christian village at St. Wendolin's should become the site of a small Catholic church. Thus, the settlement at St. Wendolin's was officially opened in 1895 as the first outstation of the Mariannhill Mission.

EARLY HISTORY

Archaeological evidence suggests that the Mariannhill/Pinetown area had been settled many thousands of years ago by the ancestors of San Bushmen, who are believed to have lived in the area until the early 1800s (Kaplan 1990). According to Kaplan, excavated stone implements from various sites in the area revealed that there was human occupation of the area over 100 000 years ago. Iron Age grinding stones, furnaces with slag deposits and pottery were all discovered, and used as proof that the area was under continuous occupation from that time (Dominy and Guest 1989).

Written records kept by one of Natal's first European settlers, Sir Francis Fynn, named the *Amatuli* as the African tribal group occupying the St. Wendolin's area during the early decades of the last century (Steward et al 1986). According to Fynn, internal conflicts and systematic attacks by the warriors of the Zulu King Shaka led to the tribe's demise. Bird (1880) reported that remnants of the *Amatuli* fled southward to the Umgababa region and settled there. Soon afterwards, another grouping of Zulu-speaking people, the *Amanganga,* who had fled from Shaka's marauding *impis* (warriors) were said to have sought refuge on land owned by the English Colonial government during the 1840s. The *Amanganga* were later given land which encompassed St. Wendolin's, under the Colonial Government resettlement program for the displaced Zulu people around Durban (Bird 1880).

Thus, it was in the midst of the *Amanganga* people that the Trappist monks settled in 1882 and established the religious community that became known as

the Mariannhill Mission. Although vague as to the exact date, historical records kept by the monks maintain that Chief Manzini of the *Amanganga* (who was already a Christian convert) approached the monks and made a formal request that they, the monks, purchase the land on which the chief and his people lived (England 1996). This marked the beginning of the Monastery's influence over the lives and destiny of the African people in the environs. It also placed legal rights to the land (which later became a highly contentious issue) firmly in the hands of the Mariannhill Mission.

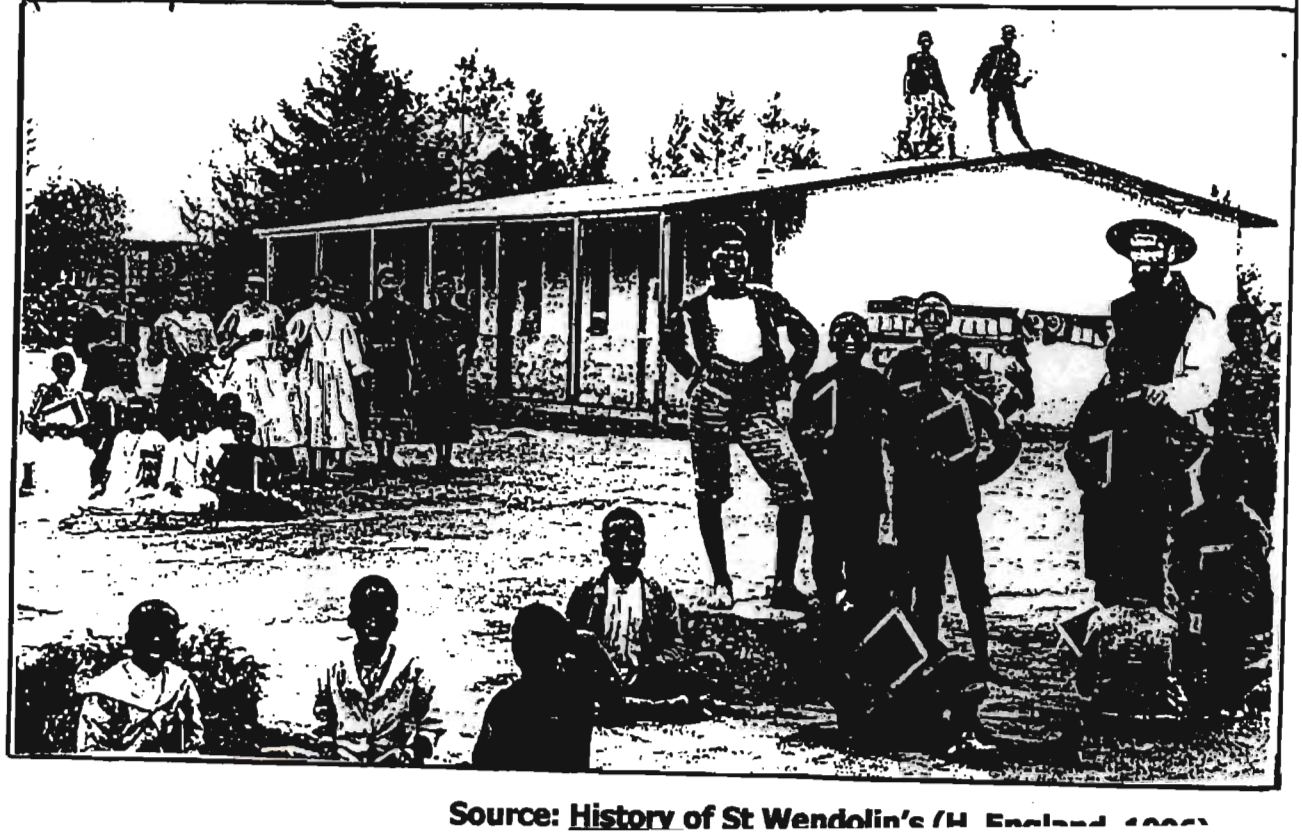
A MODEL OF CHRISTIAN LIVING

As mentioned previously, the missionaries sub-divided their land, chose St. Wendolin's as their first outstation and erected a small church there in 1895. The first resident priest was Father David Bryant. This was the religious name given to A.T. Bryant, one of the most famous and prolific writers on the Zulu. Bryant did much in the way of recording early Zulu history, language, ethnography and ethnomedical practices, both before and after joining the missionaries at Mariannhill (see for example Bryant 1929, 1949, 1970). Records reveal that conversion to Catholicism in the greater Mariannhill area was rapid (Adelgiza 1984). The missionaries' plan was to construct self-contained Christian villages wherein the newly converted could settle and live a life "free of traditional restraints and tribal pressures" (Schimlek 1953:16). This strategy was not unique amongst the Roman Catholic missionaries. The Christian village strategy was used by early missionaries of other denominations throughout the country. For example, in the township of Clermont, some 10 kilometres from St Wendolin's, the early Lutheran missionaries built similar 'native villages' around their mission station (Adelgiza 1983). From the perspective of the missionaries, African customs and beliefs were regarded as key obstacles preventing Africans from converting and maintaining a Christian way of life (Schimlek 1953). The missionaries stipulated that those wanting to

settle in the new Christian villages had to be converts, and a man had to be married to one wife only. The Trappist motto of *"Ora et Labora"*, (prayer and work) was adopted as the cornerstone of life in the new villages. The main objectives of the missionaries were to spread Christianity and to introduce a farming lifestyle to their Zulu tenants, based on small-scale commercial farming. Previously, the people sustained themselves largely through subsistence farming (primarily the work of women), and cattle-keeping (viewed as the special preserve of men) (Bryant 1927, 1949). The missionaries aimed to make Zulu men into market farmers. To facilitate this process, and to help instill a sense of pride in men who considered hoeing and planting to be women's work, the missionaries held annual agricultural shows at Mariannhill and awarded prizes to the best 'native farmers' (see Appendix 5, page 253).

Soon, the church at St. Wendolin's was supplemented with a school where the children of the new converts received a Western-style education, along with Catholic instruction. The original structures of both the church and school at St.

Plate 2: First School at St Wendolin's with Some Early Converts as Pupils



Source: History of St Wendolin's (H. England, 1906)

Wendolin's are still standing and in use today. Straight rows of rectangular sod, stone or brick houses were built along the main road, which extended from the church. Shops, fruit trees and communal grazing areas beyond the village, soon became features of the new way of life for the early resident converts at St. Wendolin's.

As the community grew in popularity, many other Zulu-speaking people, some from far distant areas, converted to Catholicism and were given permission to settle in one of Mariannhill's model villages. Many factors contributed to the growth of St. Wendolin's as a community, and the growth of Mariannhill in general. Some of those identified by historians include the fact that many African people in the province had been displaced by King Shaka's roving armies, and had never fully settled elsewhere before the turn of the century (Bird 1880). The Mariannhill villages offered, among other things, land security (tenant contracts which later became ownership contracts), Western-style education for children, skills training for men (who were rapidly being drawn into the cash economy and forced to pay taxes), and the availability of western-style medical care. Another significant force which brought many new residents to the Mariannhill villages, was the Spanish Influenza epidemic of 1918 – 1919. Schimlek (1953) described a situation where people in the greater Mariannhill area and beyond died in large numbers from this 'flu epidemic. Some people who approached the Mariannhill missionaries for permission to settle on their land claimed that all their relatives had died. Their wish, according to Schimlek (1953:22), was to "get far away from the misfortune that had befallen their kraal and to seek the protection of the Lord and Savior, Jesus Christ". By the 1920s the Christian villages at Mariannhill, most especially St. Wendolin's, were large and active residential areas for what are still referred to today as the *AmaKolwa*, the Christians.

Today, the St. Wendolin's community represents what the missionaries call the third generation of Zulu Christian converts. Over the past several decades, the

original Christian residents were joined by successive waves of people who have migrated into the area, building shacks or renting rooms from established residents. Many of these newer residents have come from far rural areas of Zululand and the former homeland of Transkei, as well as from other communities within the greater Durban region (2). Many have come to the area in an attempt to secure employment in the nearby industrial areas of Pinetown and New Germany. In more recent years, the community of St. Wendolin's has experienced another influx of people who have fled ongoing violence and poverty that still characterizes many of the province's rural areas. In a study commissioned by the Department of Planning in 1992 of residential migration in Mariannhill including St Wendolin's, researchers found that conflict and violence in their previous home environs was a major factor influencing migrants to settle in the area (see Cross et all 1992). For many people then, and over the course of many years, St. Wendolin's was and still is a haven of relative peace and calm in a province marred by conflict.

THE STRUGGLE YEARS

Maintaining its reputation as a community where a degree of peace, stability and order could be found, has not precluded the community from confronting and challenging injustices foisted upon it by the former apartheid government. No history of St Wendolin's, no matter how brief, would be complete without mention of some significant events of the more immediate past which have shaped and forged its character as a community. The single most significant government decree that affected the destiny of the growing Christian community of St Wendolins was the passing of the 1913 Land Act. This government law prevented Africans from owning land outside the boundaries of what were called Native Reserves (Tribal Trust Lands). Mariannhill was not a Native Reserve. With the passing of the 1913 Land Act, the Mariannhill Mission's policy of granting land rights to Africans put them in direct conflict with the government. Up to that point tenant contracts, which were later

converted to ownership contracts, had been drawn up for well over 100 plots at St Wendolin's (Luthuli 1983). Undeterred by the legal restrictions that were imposed by the 1913 Land Act, the Mariannhill Mission continued to sell land to African residents on their property. Defying the government's land-ownership policies at the time was justified by the Mariannhill Mission on the grounds that the land in question was owned by the Mission, and therefore the Mission would determine how it was used (Adelgia 1984). In 1936 the Mission was notified that no more blacks were allowed to own sites anywhere in South Africa including on Mission-owned lands. From this time onwards, the Mariannhill Mission continued to provide people with sites on which to build homes and settle, but it could no longer issue the legal title deeds that signified actual land ownership (Cross et al 1992).

Like other African people who had settled on property owned by missionaries in other parts of the province, the landowners at St. Wendolin's constituted a small but determined group of people. Their status as actual landowners presented a problem for the evolving apartheid State as they forged ahead in their efforts to create well-defined residential areas based on race. Matters came to a head with the passing of the government's Group Areas Act in 1957, whereby St. Wendolin's was declared an Indian area. After protracted negotiations between the Mariannhill Mission and the government, in which the Mission sought to retain their non-racial character by having their land unzoned, their efforts failed. By the mid-1960s, the people of St. Wendolin's were told to prepare for relocation into new townships, which would fall under the tribal authority of what was then called KwaZulu.

Thus, the era of fighting against forced removal from their community dawned for the people of St. Wendolin's. The 1960s marked the beginning of living with uncertainty, internal conflicts, and being unable to plan for the future.

People lost their motivation to repair homes and maintain the general quality of life, which had drawn people to the area in the first place (Luthuli 1983). A tour of the area in the 1970s by women of the Black Sash, an organization of mostly white women who were active in assisting blacks in their struggles against the injustices of the time, left the following impression:

> We left St. Wendolin's aware that here was a township which had grown with the needs of the people; where ingenuity had overcome difficulties and where a community spirit was very much alive. But one was conscious of the shadow of the threat of removal to a strange area, of higher rents, increased bus fares and the loss of freehold rights (for which there is never full compensation), and above all, of the breakdown of a self-reliant and self-respecting community which has grown over the years. (5)

While the public face of the community started to deteriorate, the determination of the people of St. Wendolin's not to have their community destroyed by apartheid decree grew. In 1977 South Africa's first multiracial Community Council was formed in Pinetown, with Mr Herbert Luthuli, then a prominent community member and school principal at St. Wendolin's, as its African representative. As a member of the Council, Mr Luthuli sought to make the needs and struggles of the community known (England 1996). Soon after, water stands were installed along the main road, a creche was built and a small clinic opened in St. Wendolin's. Nonetheless, plans to move the people remained, and by 1981 a total of 68 families had been forcefully removed, most without any financial compensation. The community responded by forming the 'Save St. Wendolin's Committee". With the help of several outside individuals and organizations, they petitioned the government to halt the forced removal of people from the community. This marked the beginning of another protracted struggle with government officials. Meetings between government

representatives and community members were often heated and characterized by many confrontations, accusations, and fears of being killed. Finally, in 1983, the people's bid to remain on their land was successful and St Wendolin's was rezoned as an African group area. This was agreed to on condition that the Mariannhill Mission provide the major financial resources for the community's infrastructural development. With the Mission agreeing to take on this task, the success of the people of St Wendolin's in resisting forced removal by the apartheid government is reported to have been the first such success by an African community anywhere in the country (Luthuli 1983).

Celebrations to mark the end of forced removals in St. Wendolin's were short-lived. By the mid-1980s, the country entered the final decade in the demise of the apartheid government. Violence and unrest, which started in other parts of the province, reached St. Wendolin's by 1985 and were exacerbated by government attempts to incorporate St Wendolin's into the semi-autonomous homeland of KwaZulu and under Zulu tribal authority. Having originated as a community of Christian converts, most of the people of St. Wendolin's had never owed an allegiance to any tribal authority. Strong tribal or ethnic identity and ties which were at the time associated with Inkatha membership (a Zulu cultural organization which later became the Inkatha Freedom Party of today and draws its majority support from Zulu-speaking people), did not exist to any real extent in St. Wendolin's. Hence, the community was and continues to be, a stronghold of African National Congress support.

Throughout the later part of the 1980s and early 1990s, ongoing conflicts characterized life in St. Wendolin's as it did in other African townships throughout the province at that time, and indeed throughout South Africa. With the lessons learnt in its fight against forced removals, the community was able to organize itself against the apartheid forces and prevent a total descent

into social chaos and community destruction. Even during the darkest days of what is now popularly referred to as the 'total onslaught' period (the late 1980s until the 1994 democratic elections), the community of St. Wendolin's remained intact and managed to present a united front. Thus it prevailed; the reputation it had gained as a haven of relative peace and calm was not entirely destroyed. Amid so many setbacks and potentially explosive situations, the community of St. Wendolin's seems to have emerged with a sense of pride and solidarity, which, from my experience, is a rarity among urbanized settlements in KwaZulu-Natal today.

ST WENDOLIN'S TODAY

Encompassing approximately four square kilometers, St Wendolin's today is a community of roughly 50 000 people, the majority of whom speak Zulu as their home language and identify themselves as Zulu. The area lies inland from the coastal belt of the province of KwaZulu-Natal, about 32 kilometers from Durban and eight kilometers from Pinetown, the two largest industrial centers in the region. These cities provide most of the employment opportunities available to the people of St. Wendolin's. The land, although very hilly, is largely fertile and is bounded on the north by the Umhlatuzana River. The community still retains its Catholic character today, with over 80% of its residents being members of the Catholic Church. The St. Wendolin's Mission church (and Mariannhill) continues to play a central role in the social and religious life of many community members.

The main settlement and the most densely populated region of St. Wendolin's is found along its one main road. This road leads straight to the Catholic Church, the St. Wendolin's Mission, from which the community derives its name. This church and the surrounding school buildings are situated on the crest of the

Insiswakazi Mountain. The spine of this mountain provides the natural topology for the main road, which runs along its crest. The thickly settled area along both sides of this road is known as the Ridge. The Ridge settlement is approximately 202 hectares in extent, and comprises several hundred families whose houses straggle down the slopes of either side of the road. The average household size for the community is approximately six people per household. There is a wide disparity in levels of education amongst residents, with some older residents having had very little formal schooling while others, mostly younger residents, having completed matric (high school) or gone beyond. The average number of years of formal schooling is reported to be about six years (4). Textile factories in nearby Pinetown and New Germany provide a major source of employment for St Wendolin's residents, with most formal sector employees employed in low skilled and low paid jobs as laborers or factory workers (Cross et all 1992). For women, domestic work in the neighboring suburbs provides an alternative and popular form of employment.

Apart from formal sector employment, informal sector activity (both legal and illegal) provides income for a growing number of St Wendolin's residents. Shebeens (informal drinking establishments) abound, with shack-shops and hawkers selling cold drinks, paraffin and small household commodities. There are a number of backyard mechanics, informal construction workers, and informal herbalists operating in the area. Women's groups are fairly common, with members involved in a range of activities from dressmaking to selling vegetables, baked-goods, and second-hand clothing. Informal credit organizations, more commonly known as *stokvels,* are prevalent, with the money saved used mainly for festive seasons for consumption purposes. Supplementing formal and informal sector employment are pension-derived incomes that make an important contribution to household incomes, as in other African communities in the province.

Currently unemployment estimates for St Wendolin's stand at 45%, an increase of approximately 10% in less than a decade (see Cross et al 1992). Most residents could be characterized as working-class or underclass, with an estimated average monthly income of less that R1000, approximately 165 US dollars (6).

The large number of female-headed households in the community reflects a trend that has been noted since the beginning of the decade. Cross et al (1992) stated that the percentage of female-headed households in the Mariannhill region as a whole was estimated at that time to be about 44% of all households. The authors noted that this figure was unusually high in terms of the average 25% female-headed households of the Durban Functional Region. Although more current figures are not available, my impression during the course of my research was that at least half of all households in St Wendolin's are headed by women. The attractiveness of the Mariannhill communities in terms of their relative stability and safety for single women with families, along with the natural 'aging' of the communities, were factors identified by Cross et al (1992) as contributing to the high incidence of female-headed households. I would suggest another contributing factor in addition in those cited, that is that women, especially young women, are increasingly choosing to eschew marriage and form households based on consanguineal rather than affinal ties (see Chapter 6).

Having secured its reputation as a stable and tranquil community, St. Wendolin's has enjoyed much in the way of infrastructural development since 1994. Water stands along the main road have made way for piped water into many homes. Electric lighting has replaced candles and paraffin lamps for hundreds of families in recent years. Telephones along with television sets, refrigerators, music systems and electric stoves now supplement radio as common features in the homes of many St. Wendolin's residents. The main

road has been widened and re-tarred. Streetlights extend the full length of the Ridge and beyond. The large and modern Mzama Clinic marks the entrance to the community. Its services supplement those of St. Mary's Hospital, the private hospital operating at Mariannhill since the 1920's. A new local high school has been built to complement the primary schools located on the church grounds. The St. Wendolin's Mission Church itself has been extended and renovated. Many solid and brightly colored new homes have been built to replace the small mud and daub structures that previously characterized the dwellings at St. Wendolin's. All of this has been achieved in the past ten years, with most of these developments occurring in the past five years.

A sense of permanence and an eagerness to improve the living environment pervades in the community today. Nevertheless, many challenges still beset the people. The currently unfavorable economic climate means that in spite of relatively high levels of literacy, the community is faced with rising levels of unemployment. Criminal activity such as theft, drug abuse, child molestation and rape has increased in the past several years. Overcrowding and a proliferation of informal shacks have also become a problem as people continue to flock into Durban's urbanized areas. New challenges confront the community as it develops and grows. To a large extent, these stresses and strains are the inevitable result of a community in the process of transformation. For St. Wendolin's, the transformation entails a move away from having been a small, closely-knit community of many interrelated Zulu Catholic families, to becoming a large, loosely-knit residential area made up of different religious and ethnic groups. Following the 1991 demise of the Group Areas Act, several of the community's professionals have moved out of the community and into the surrounding suburbs, which were formerly reserved as 'white' residential areas. This out-migration of professionals has been and continues to be a matter of concern for some residents. Along with the loss of role models for the youth, residents express concern about the loss of people with leadership skills,

especially during these times of rising criminality and what the older people refer to as 'confusion' among its youth. Much remains to be studied in terms of the impact that the demise of the Group Areas Act in 1991 has had on the historically 'black' areas in South Africa. As educated black professionals continue to seek residence beyond those areas in which they were once forced to live by apartheid decrees, some of the country's formerly 'black' urban areas may increasingly take on characteristics similar to other urban communities around the world which are home to the poor. A process similar to that which occurs in the American inner-city neighborhoods, whereby anyone in a position to move out usually does so, has already started in St Wendolin's as elsewhere, and will most certainly continue. The unfortunate result may be, as Whitehead (1997) so succinctly describes, a 'ghettorization' of communities where poverty, crime, drug abuse and female-headed households have become an entrenched way-of-life.

For many of the established residents in the community, especially those of the older generation, the transformation of the once small and cohesive St Wendolin's community is not easily accepted nor readily embraced. Nevertheless, there are some things that have an enduring quality and seem to persist in spite of pressures aimed directly at their demise. This would include some common conceptualizations linked to the ways in which people experience life and which the Christian missionaries sought to 'modify' as part of their Christianization efforts. As some of these shared perceptions inform the way in which people in St Wendolin's understand and experience health and illness, including AIDS, they warrant some detailed discussion.

PERSISTENT TRENDS: WORLD VIEWS

In July of 1914 the Mariannhill missionaries held their first regional conference. This was an event designed to reflect on past successes and failures in bringing

Christianity to the African people and also to plan future missionary and development activities. According to Schimlek (1953), discussion at the conference soon turned to what the missionaries saw as the single greatest obstacle in the African people's path towards salvation ... their 'superstitious beliefs.'

Schimlek described how a particular Father Albert rose to deliver the opening address with the following statements:

> Venerable Father Abbot, my dear Confreres: Our work has extended beyond expectation ... But all of us who are in daily contact with our Bantu Christians will agree with me when I say that the quality of Christian religion in the hearts of our converts is far from being perfect, and the practices to which many of them secretly resort are evidence that paganism is still a strong force in their daily life. (Schimlek 1950 : 13)

Father Abbot went on to describe the pagan 'superstitions' of the people, including their beliefs in witchcraft, the ancestors, traditional diviners and medicines. All of these were viewed as inveterate convictions that lay at the bottom of almost all problems faced by Africans, including African Christians. Schimlek (1950) described how all the missionaries present nodded their heads in full agreement with Father Albert, who closed his speech as follows:

> Superstition depresses the soul with its eternal fear ... it is the code that directs their (African) morality and which has in many cases not been rejected with the acceptance of the Christian faith. Our intensive missionary method must set about the destruction of superstition, and if we fail in this, we have failed in the elements of Christian teaching. (Schimlek 1950: 15)

The conference continued for several days to debate the problems presented by existing belief systems, which were viewed as obstacles to 'proper' Christianization. A decision was taken to approach the problem not only from a spiritual angle, but also from a practical one. By paying more attention to the physical and medical needs of the people, the missionaries hoped to steer the people away from reliance on the traditional *sangoma* (diviner) and *nyanga* (herbalist), who were identified as key figures in maintaining 'superstitious beliefs.' The missionaries resolved to join forces with modern medicine in their struggle against what they called 'the forces of darkness and evil' (Adelgiza 1984). The conference ended with a decision to commence a medical mission in the territory of Mariannhill. Almost immediately following the conference, building plans for a hospital were drawn up.

It was thus that in 1918 St. Mary's Hospital was opened. Today St. Mary's is a large, fully operational hospital which serves not only the people of St. Wendolin's and the other Mariannhill communities, but well over 700 000 people, drawn from all over the province of KwaZulu-Natal. The effectiveness of what could be called the missionaries' biomedical strategy was immediately tested with the 1918 outbreak of the Spanish Iinfluenza. Historic records indicate that St. Wendolin's and the surrounding villages were hard hit by this epidemic (Luthuli 1983). As they flocked to the new mission hospital, the people were introduced, many for the first time, to Western medicine.

TRADITIONAL AND WESTERN MEDICINE

It has been little more than 80 years since the established community at St. Wendolin's has had access to modern medicine. Complementing these services has been instruction in Western biology and science through the schools started by the missionaries. Today the people of St. Wendolin's have the option to seek either traditional forms of medicine and medical care, or to use Western medicine that is readily and easily available through the local clinic and the

nearby St. Mary's Hospital. The two systems are often used in a complementary way by many people in St. Wendolin's. Indeed one could say that two systems of thought co-exist. One is the more 'traditional' and commonly referred to by informants as 'the Zulu way', or what writers such as Vilakazi (1965) and the mission historians previously called 'pagan'. The other is a more western and Christian way of life. Both orientations play a part in influencing the thoughts and behaviors of St. Wendolin's Catholic residents.

From my experiences in the community Christianity in the form of Catholicism has not significantly eroded what the missionaries referred to as 'superstitious beliefs.' The persistence of people's beliefs in witchcraft, the power of the ancestors, and faith in traditional forms of medicine and therapy has consistently impressed me throughout my stay in St. Wendolin's. While professing to be Catholic, fully subscribing to Catholic doctrine, and engaging in prayer and attending church services, many people also maintain traditional beliefs and act accordingly. The brewing of Zulu beer and the slaughtering of goats to appease ancestors is not an uncommon occurrence in many Catholic homes. Seeking advice and answers from the *sangoma* is not something reserved for the unconverted. Sprinkling homes with traditional *umuthi* to strengthen and protect the inhabitants is as common among Catholics as non-Catholics. A form of dual devotion, whereby people participate in ritual activity associated with both Christianity and 'traditional beliefs' is the prevailing pattern in St. Wendolin's. Nevertheless, people are aware of the conflicting values being expressed by the different forms of ritual behavior and are sensitive to associations made between Zulu tradition and paganism. For the most part, rituals to honor the ancestors and the use of various *umuthi* are practiced quietly, behind closed doors and out of view from passing strangers.

A full account of current beliefs and associated behaviors of the people of St. Wendolin's is beyond the scope of this thesis. Those beliefs, especially those

regarding health, illness and disease causation that are relevant to the arguments presented in the thesis, are discussed and analyzed in the proceeding chapters. Some rituals such as those once performed in the past to ensure adequate rains and a good harvest, are being revived both locally and nationally as part of a post-apartheid revival of 'tradition' (see Chapter 5 for further discussion on this topic). The important point here is that the Catholic character of the St. Wendolin's community and its history as a model Christian village has not served to eradicate what Mbiti (1969) would call their 'African world view', and what the people of St. Wendolin's call their 'Zulu way' of doing things. Along with many other African communities in South Africa and indeed throughout the continent, beliefs about such things as the power of ancestors, witchcraft and traditional medicine have persisted, despite tremendous alterations in the material and social circumstances of life . Perhaps, as Ngubane (1975:158) has suggested, traditional ways of thinking and traditional interpretations of illness and its treatment provide people with deep and satisfying answers to suffering. In an environment marked by rapid and unrelenting change, this might explain why certain beliefs prevail. How some of these 'traditional' beliefs are embodied in people's behaviors regarding health and illness management, especially regarding HIV/AIDS, is a central theme underlying many of the arguments put forth in this thesis.

AIDS IN THE COMMUNITY

In Chapter 1, I have argued that AIDS has only recently come to be acknowledged as a reality in the lives of many of KwaZulu-Natal's residents. This also applies to the people of St Wendolin's. Early in 1998 the parish priest at the mission church read a newspaper article about AIDS in the province. This prompted him to ask a visiting Red Cross worker to inform him of the HIV infection rate in his community. After collecting information from the local clinic, the Red Cross worker returned to inform the priest that 49% of the clinic users tested positive for HIV. The priest confessed to being stunned. Up until

then he had doubted the very existence of HIV and AIDS. After reading the particular newspaper article, he claimed that he was willing to concede that AIDS 'might be a problem in some other communities'. During the course of a conversation with this priest, he admitted to me that he would never have suspected his parishioners, his 'Catholic flock', to be infected with 'such a disease as AIDS'.

The high rate of HIV infection among the clinic's users impressed upon the parish priest the need to address this problem in his capacity as a community leader. Soon thereafter, an AIDS educator was given permission to speak at the church. The following month, the community participated in the first Holy Mass to pray especially for Mariannhill community members living with HIV/AIDS. Unfortunately, as awareness grows and people begin to address the problem of HIV/AIDS in their communities, the epidemic is no longer in its initial growth stage, as discussed in Chapter 3. A maturer epidemic with rapidly increasing numbers of people ill and dying from AIDS is already upon the people in St. Wendolin's. Youth league members of a local political party are reporting numbers of their members dying quietly at home. The St. Mary's Hospital is no longer admitting AIDS patients, as it has no beds available. It is also facing the problem of the bodies of patients who have died of AIDS being left unclaimed in the hospital mortuary (see Appendix 6, page 254 and Appendix 7, page 255). Home-care programs to care for terminal patients in the communities have been established by the Hospital. The rise in the numbers of burials during the weekend, especially burials of young people, are beginning to make an impression on community residents. The word 'AIDS' is being heard more in conversations, albeit still in whispers.

Being a relatively old and established community, one that was able to unite under the threat of forced removals and political violence, there exists today a collective sense of community. While some residents would argue that this

sense of community is on the wane, there is nonetheless a degree of what some academics such as Kreuter (1997) refer to as 'social capital'. Social capital has been defined as the sum total of support structures within a community, including social networks, institutions and organizations that act to allay the forces of alienation and hopelessness in people, by enmeshing them in a social support web (Kreuter 1997:2). Recently, researchers such as Gillies (1998) have argued that high levels of social capital are associated with a range of positive health benefits. Perhaps this can help to explain why people who are sick with AIDS in St Wendolin's and in need of care, have thus far enjoyed a degree of support. To date, I am not aware of anyone who has been abandoned or chased from the community, as has happened and is continuing to happen in other KwaZulu-Natal communities.

However, this does not mean that the patient's AIDS status is acknowledged and made public. The social stigma attached to AIDS is as strong in St. Wendolin's as in other African communities. The same fear of being socially excommunicated from one's wider network of friends and neighbors applies in St. Wendolin's. The AIDS status of a relative is a closely guarded secret. Even if it is widely rumored that a certain individual has AIDS, or has died of AIDS, the family will insist that the cause of death was something different. When confronted with questions about a suspected AIDS illness or death, a standard response given by family members is: "We don't know." For those who do attach a name to the illness, it is usually tuberculosis or pneumonia, two of the most common AIDS-related illnesses seen locally.

The most common ethno-explanatory model used for AIDS is witchcraft. As previous writers on the Zulu such as Bryant (1949, 1970), Krige (1950) and Berglund (1976) have noted, and which is still relevant in St Wendolin's today, the concept of chance plays little part in the causal explanation for sickness and death. While minor illnesses such as colds, flu and childhood measles are

attributable to natural causes (referred to generically as *umkhulane),* more serious illness is usually attributed to the actions of intelligence, whether human or spiritual (Ngubane 1977). In St Wendolin's today, the ancestors are believed capable of causing serious illness, although their main function is said to be primarily a protective one. While they may cause sickness, the ancestors are not believed to cause death. Only an agent with evil intent, somebody using witchcraft, would make a person die. These ideas are more fully explored and analyzed in Chapters 6 and 7, as they are central to the main arguments of this thesis. As latent HIV infection is increasingly making way for AIDS-related illnesses leading to death, witchcraft explanations are increasingly coming to the fore in people's day-to-day discourse on AIDS. What these explanations all have in common is that they resonate with *notions of women's agency in the cause and spread of the disease.*

Conversation about AIDS in the community reflects the strong stigma attached to both AIDS and the people believed to be infected. Indeed, people dare not even mention the word 'AIDS', as if a mystical power will be unleashed by the very uttering of the word. It is a situation not unlike that which existed in Europe in the first half of the last century when dealing with tuberculosis. According to Sontag (1978:10) there was widespread fear of this 'mysterious' illness, and for some, the pronouncing of the word 'tuberculosis' was thought to hasten the course of the malady. Today, many people in St. Wendolin's would rather say, literally, 'the three words' (*amagama amathathus*) when discussing AIDS. These 'three words' refer to Acquired Immune Deficiency. To talk about someone as having "the three words" is understood to mean that he or she is infected with HIV/AIDS. However, this terminology is not without its challenge. The Catholic church 'mothers' of the community strongly object to use of 'the three words' as a code-name for AIDS. For them, reference to 'the three words' relates too closely to the Holy Trinity: the Father, the Son and the Holy Spirit. Any association between the Trinity and AIDS is considered offensive.

As one woman argued: "We must use some other words. God would not like this at all! It's awful to call AIDS 'the three words'." Another popular way to refer to the disease without uttering its dreaded name is to call it 'the new sickness'.

An alternative way to imply HIV/AIDS, is not to use words at all. Rather, one could whistle or hum a particular tune. This method is particularly favored by the youth. It works as follows: in the course of discussing somebody who is ill, someone will suddenly start singing or whistling the theme song to the television program 'Soul City'. Those engaged in the conversation are expected to know that reference is being made to AIDS. 'Soul City' is a popular television drama series, which was initiated several years ago as a way to teach viewers about health-related issues and ways in which they could improve their health. Several programs have featured HIV/AIDS as the main theme, with issues around disclosure, sexual negotiations, care giving, and dying of AIDS being explored. 'Soul City' has now come to be associated with HIV/AIDS. A simple whistling of the program's theme song implies that the conversation is about AIDS.

Of all the popular nicknames for HIV/AIDS used by the people of St Wendolin's the one that is most significant in terms of the arguments put forth in this thesis is the name 'Helen Ivy Vilakazi'. To point to a person and refer to him or her (gender does not matter) as 'Helen Ivy Vilakazi', is to say that he or she is infected with HIV. Thus HIV infection and death from AIDS is the work of 'Helen Ivy Vilakazi', a disease essentially conceived as 'feminine' in nature.

As the epidemic continues in its growth, the impact of AIDS on the community of St. Wendolin's will be profound. This will bring changes to the way in which

people talk about, respond to, and cope with the disease as they continue to adapt to its presence. This thesis is an interpretation of how the people of St. Wendolin's are currently experiencing this new disease of HIV/AIDS. I argue that current ways of thinking about the disease are being informed by many conceptual notions, including some that appear to be very old in origin and others that appear to be relatively recent. Together, these notions are given meaning through the shared understandings and values of the people, and give rise to a particular sociocultural construction of HIV/AIDS in that community, a construction metaphorically represented as Helen Ivy Vilakazi, a 'feminine' disease.

The rest of this thesis is an exploration and analysis of the sociocultural construction of HIV/AIDS in St. Wendolin's and the ways in which constructions of gender inform constructions of AIDS. It begins with a focus on what, to some readers at least, is a very familiar, very ancient and very pervasive notion associated with patriarchal society; that is, the idea of female 'impurity'.

NOTES

1. The actual layout of these Christian villages is described in detail in Adelgiza's (1983) collected works. The sermons, instructions and articles by Mariannhill's founding father, Abbot Francis Pfanner include much reference to the 'model Christian villages' (see Adelgiza 1983: 210). Also Brookes and Hurwitz (1957) provide an overview and description of the various reserves in the province that were set aside for African occupation up until that time.
2. A comprehensive study of residential migration in the Greater Mariannhill area was commissioned by the Department of Planning and Provincial Affairs in 1992 and reported by Cross et al (1992). Aspects of changing demographics, settlement patterns, employment and community control were analyzed at that time. One of the study's main conclusions was

that migration into and within Mariannhill provided an example of how social and political factors can converge in a way, which is highly favorable to sound, well-planned development (Cross et al 1992:60).

3. These figures have been obtained from the Housing Department of the Borough of Pinetown and reflect mid-1992 estimates. From a document entitled "St. Wendolin's Ridge in Development: Overview with Emphasis on Residential Development in Pinetown South" April 1992.
4. Information gathered through an interview with the Principal of the local primary school in St Wendolin's in July of 1998.
5. Reported in The Highway Mail, Bonus Edition: July 1979. Article entitled: "St. Wendolin's ... where ingenuity has triumphed over difficulties".
6. Information provided by a representative of the Mariannhill Mission Institute involved in the infrastructual development of St Wendolin's. Estimates of an average monthly income of R800 were made by Cross et al (1992) in a study of St Wendolin's and Greater Mariannhill in the early 1990s. Incomes have risen since that time, concurrent with rising rates of unemployment and a steady influx of residential migrants into the area.

CHAPTER 5
DIRTY AND DANGEROUS: CULTURAL CONSTRUCTIONS OF WOMEN

"For most bad things, the fingers will point at a woman. We are dirty and jealous. We bleed and men are afraid of all that. These are women things that men can never understand." ... (*middle aged female diviner - sangoma*)

"It begins to look as if, in the post-modern millenium, disease itself is female" ... (T. Wilton, 1997)

In this chapter I shall argue that present-day associations between women and AIDS in St Wendolin's have their roots in much older culturally constructed beliefs about female impurity; beliefs that are echoed in many societies. In her seminal work entitled Purity and Danger, Mary Douglas (1966) made the point that notions of women's impurity and the social perils associated with them, are a part of the worldviews of many people. From Sri Lanka (Yalman 1963) to New Guinea (Mead 1940), Zambia (Richards 1956, Mogenson 1995) and Congo (Douglas 1963) to Northern California (Kroeber 1925) and the Yucatan (Wilson 1995), anthropologists have systematically recorded strongly held beliefs that certain contacts with women weaken male strength and bring misfortune. Throughout the ethnographic literature and in texts from a variety of cultural settings, notions of impurity associated with women are tied to beliefs about pollution and the state of 'ritual' impurity (see for example Balzer 1981, Constantinides 1985, Devisch 1985, Thompson 1985, Keesing 1987, Buckley and Gottlieb 1988, Ramussen 1990). Ritual impurity is generally defined in the literature as a state which is defiling or dangerous to self or others and inheres in certain life events and conditions (usually associated with female

reproduction or death), in certain categories of people, (the untouchables of the Indian caste system for example), or in people whose labor involves contact with pollution (butchers or gravediggers for example). The idea of ritual impurity has wide currency in social and cultural analysis, with the focus often tending towards normative accounts of local taboo restrictions and practices designed to contain the perceived negative potency of the polluted state.

An example of an archetypal polluted/polluting state that has received a fair amount of scholarly attention is menstruation. Many societies in the past and still today impose restrictions upon women during their menstruation. Most of these have to do with coming into contact with men, their activities and possessions (Kessler 1976). Menstrual blood especially invokes much apprehension. Drawing from her own studies of the matrilineal Bemba and pondering on the near universality of menstrual taboos, Richards (1956: 19) commented thus: "Blood would appear to be the object of a set of emotionally tinged ideas in all human societies. It stands for death, life-giving force, murder and kinship. Menstrual blood, with its mysterious periodicity is considered especially terrifying and disturbing, perhaps serving as a reminder that women are potentially dangerous."

Notions regarding the negative potency of menstruation support beliefs that to a Westerner at least, would today seem a bit extreme. For example, among the Enga people of the New Guinea central highlands area, a total paranoia of contact with a woman's menstrual blood prevailed. Meggitt (1964:45) described it thus:

> They believe that contact with it or with a menstruating woman will, in the absence of appropriate counter-magic, sicken a man and cause persistent vomiting, 'kill' his own blood so that it turns black, corrupt his

> vital juices so that his skin darkens and hangs in folds as his flesh wastes, permanently dulls his wits and eventually lead to a slow decline and death.

Lest we think that ideas of pollution associated with women and their bodily processes are only to be found in non-western, preliterate societies, we have only to start with the original father of western medicine, Hippocrates himself, who famously stated "What is woman? Disease!" Grappling with the question of how the Christian church should deal with the presence of menstruating women in its midst, the Penitentials of the Archbishop of Canterbury dated between 668-690 AD state clearly that a penance of three weeks' fast will be imposed on any woman, lay or religious, who enters a church or communicates during menstruation (Douglas 1966: 61). Many women today remember mothers or grandmothers warning them to refrain from too much physical activity, to rest, avoid washing one's hair or swimming during menstruation. Such advice left no doubt that 'the curse' (as it was popularly called) was something to be reckoned with. The origins of such widespread beliefs are obscure, but as Wilson (1964) stated they probably lie somewhere near the very beginnings of human society.

A review of the literature (see Chapter 2) reveals that it has been little more than a decade since some writers have turned their attentions to concepts of pollution associated with women and their implications for our understanding of and abilities to fight the spread of AIDS. One of the first writers to engage with notions of gender pollution and disease was Cindy Patton (1985), who argued that female impurity concepts have long been a part of the sociocultural construction of women in western societies. Other writers such as Fee and Fox (1988), Miles (1991), Graham (1993) and Squire (1993) have argued that ideas about female sexuality being somehow 'pathological' and women themselves perceived as 'unclean', are products of historical patriarchy. Studies of western

biomedical discourse by Wilton (1997), Ussher (1991), Patton (1994), and Treichler (1988) have demonstrated how western medicine has played its part in sustaining the female-pollution complex. Of note is Gilman's (1988) work on the history of sexually transmitted disease in the West. That author traces the development of syphilis in European society as well as its increasing feminization as a disease. Constructions of the female body as unruly, flawed and inherently pathological were apparent by the Middle Ages when women were portrayed as both seductive and physically corrupt. "Female beauty only served as a mask for corruption and death .... By the eighteenth century the corrupt female is associated with specific disease, syphilis ... an extension of her innate corruption/contamination to her potential for corrupting/contaminating men" (Gilman 1988: 95-6). Summarizing western discourse on the female body, Doane (1985: 153) made the point:

> Disease and the woman have something in common – they are both socially devalued or undesirable, marginalized elements which constantly threaten to infiltrate and contaminate that which is more central, health or masculinity.

From the early missionary accounts of the last century to ethnographic studies of this century, writers on the Zulu have remarked on similar notions of pollution that were held in relation to women (see for example Shooter 1857, Callaway 1870, Bryant 1949, Krige 1950, Vilakazi 1962, Berglund 1976, Ngubane 1977). These writers describe pollution concepts among the Zulu as closely related to notions of ritual impurity and female reproduction, as in many other societies. Nonetheless concepts of pollution among the Zulu have multiple significations and extend beyond associations with specific life events and female bodily processes. I argue that while the social meanings attached to beliefs about ritual pollution and their close association with women become more apparent during certain times in her life when she is thought to be more

of a danger to herself and others (times associated with birth, menstruation and death), these times only stand to highlight a basic deep-seated cultural construction that defined *and still defines* women as naturally impure and representing a threat to the wellbeing of men and society as a whole.

For the men and women of St Wendolin's ideas of pollution associated with women form part of a broader culturally constructed framework of beliefs which finds expression in social relations and behaviors at various times, in various ways, and in varying degrees. However, these social relations and behaviors are not immune to changes brought about through increasing westernization and urban lifestyles. In a semi-urban environment such as St Wendolin's, where (as mentioned in the previous chapter), the extended family has become more the exception than the rule, and where single-parent, female-headed households are common, traditional taboos such as those preventing menstruating women from preparing meals have largely fallen away. Either a woman prepares the meal or the family goes hungry. Questions put to live-in partners and husbands as to whether they could consider preparing food for themselves and their family as a way to avoid possible 'pollution' while their female partners were menstruating, were always met with great laughter and comments to the effect that real men did not 'prepare pots'. It would seem that the desire to preserve masculine role integrity and status as a real Zulu *umnumzane* (man, or literally a kraal head) outweighs fears of misfortune or illness traditionally believed to result from eating food prepared by a menstruating woman.

Krige (1950:188) stated that a menstruating woman once avoided anything that had to do with cattle and crops, as it was believed that her contamination would cause the udders of the cows to dry up and the crops to wither away. Cattle kraals have disappeared in St Wendolin's, with cattle having not been kept in the area since the 1960s. Fields once used by women as agricultural

plots have become soccer fields, dumping sites or are dotted with small dwellings rented out to the large number of inhabitants from rural areas that have poured into the community in recent decades. Thus the modern urban environment and changing domestic arrangements have resulted in the loss of certain structural preconditions which would be necessary (or so it seems) if a woman were to practice some traditionally prescribed rules regarding pollution.

However, culturally embedded notions of female impurity are far from dead. Dynamics within a more contemporary sacred place in the community are revealing. I refer to the local Catholic church, St Wendolin's Mission, the hub around which the original village of St Wendolin's was established in 1896. In some respects the mission church has taken over the functions of the family cattle kraals as the sacred site of ancestral spirits and associated ritual. The church stands as a large community 'kraal' of sorts, being the sacred site of Christian saintly spirits and associated rituals. As such, the church is a holy place where the head male (parish priest) and his juniors (male altar boys, catechists and others) preside over the ritual activity. On-going efforts in the past 10 years by progressive minded elements of the parish council to get girls to serve as altar-servers during Holy Mass were repeatedly blocked by other parish members including the parish priest. Reasons given were reminiscent of the previously mentioned Canterbury Penitentials of over 1000 years ago. The notion of women's basic impurity and potential defilement of the church and its holy service necessitated that they stay away from the sacred altar area. Efforts to introduce adult women as scripture readers during Holy Mass have met with even greater resistance, with people recoiling at the thought of a woman standing and speaking from within the sacred altar area known as the sacrarium. In the words of the well educated Zulu parish priest: "A woman is dirty. She just doesn't belong there."

THE TWILIGHT ZONE

Douglas (1966:3) has suggested that ideas of social morality and order are maintained and reinforced by beliefs regarding the potential danger and misfortune which women represent in some societies. An exploration of traditional notions of social morality and order reported in the literature on the Nguni and including reference to the Zulu, can help to shed some light on the sociocultural values being reflected in female pollution beliefs.

In both a social and spiritual sense, a woman in Zulu society is essentially 'on the margins'. As reported in the ethnographic literature, a woman forms a bridge between lineages (hers and her husband's). She also forms a bridge between worlds (the living and the dead). Not only does a woman deliver babies into this world, but she also 'delivers' the dead into the spirit world, as will be discussed. Along with other Nguni groups of Southern Africa such as the Mpondo (Wilson 1936, 1949), the Swazi (Kuper 1950), the Ndebele (Lye 1969), the Xhosa (Mayer 1971) and others, Gluckman (1940), Krige (1950) and Preston-Whyte (1974) have described the Zulu as traditionally presenting a picture of a strongly patrilineal society with well-developed lineages, strict descent group exogamy, a clear distinction between blood relatives (consanguines) and relatives through marriage (affines). Although much has changed with increasingly urbanized and westernized lifestyles, that description still rings true today inasmuch as it represents *an ideal* pattern of kin relations, if not necessarily the real one. This patrilineal ideal is clearly articulated in St Wendolin's today through ritual activity. When a goat is slaughtered or beer is brewed as an offering to the ancestors, or when *impepho* herbs are burned to call the ancestors to be present, it is always the forefathers of the husband's patrilineage who are spoken to and petitioned by the senior man of the household for their protection or assistance in achieving certain aims.

For a man to live with his marriage in-laws is considered to be a disgraceful situation for the man concerned, although it does occur. The social expectation is for orphaned children to live with the brother of their father, although once again, it is not unusual today for a woman's sister to take over guardianship of her children. Strong feelings are attached to exogamous marriage rules, especially those that proscribe marrying a person who bears the same surname or clan name. People in St Wendolin's often recalled this rule as evidence of the inferiority and debauchery of the local population of Indian descent. On numerous occasions I have had it pointed out to me that a Pillay will marry a Pillay, or a Naidoo marry another Naidoo. There was no doubt in people's minds that this was considered to be incestuous. Nevertheless, informants claimed that marriage rules are broken more today than they were in the past, and a special ritual and offering to the ancestors is required before such a marriage can take place. Unmarried girls claim that they must be vigilant in order to avoid sleeping with boys whom they say often lie today about their surnames and clan names. "These guys today just lie. They want to have love with you. Finish. They know we won't sleep with our brothers. How can we sleep with our brothers? So we must be careful." I would suggest that traditional rules that once maintained the exogamous patrilineal system among the people of St Wendolin's are being bent more today than in the past. However, they are still important as constructions of a cultural ideal that still forms a strong part of the people's modern-day perspective.

SOCIAL AMBIGUITY

Nguni marriage rules that still apply today ensure that men marry 'stranger-women' – a term used by both Gluckman (1940) and Wilson (1951) to describe the in-marrying women of the exogamous system. Jurally and legally, a Zulu woman falls under the control of her husband's group upon marriage. The husband's ancestors then take over the task of partially protecting her as a

makoti or wife (more literally as a married woman of the lineage). However, it is believed that her own lineage ancestors continue to protect her as a daughter, and will be called upon during rituals performed for reasons that directly concern her. For example, whenever I was about to leave on a journey outside of the province, including travel abroad, herbs were burnt to call my husband's ancestors and to ask for their protection. Towards the end of the ritual, and almost like an afterthought, I was encouraged to 'speak' to my own ancestors and to solicit their protection as well. Ngubane (1977:91) stated that in a symbolic way, a woman provides a bridge which links through kinship ties some members of one corporate group with another corporate lineage group. While the woman represented a bridge between her lineage and that of her affines, she also represented a point of division; division between her own children and those of her co-wives in a polygamous situation, or between her children and those of her husband's brothers.

In St Wendolin's today, people's discourse reflects uncertainty as to where a woman's real loyalties lie. Informants say that a woman is always 'having her feet in two kraals.' This basic uncertainty regarding the loyalties of women give rise to suspicions that are further compounded by the fact that descent group members are enjoined by religious sanction against practicing sorcery to harm one another, while such sanctions do not apply to the in-marrying woman. Not being a full member of her husband's group, she is out of reach of the complete control of his ancestors. According to Ngubane (1977:88) this places women in a position of basic ambiguity, a position that represents a threat to the well being of the male-centered and male-linked corporate group.

Gluckman (1956) regarded the position of women within the classical extended patrilineal homestead as the weak point in the unity of corporate agnatic groups. He saw this position as representing a danger, one that was symbolized as an evil inherent in women. Wilson (1951) correlated the

common association of women with witchcraft among the Mpondo with the institution of clan exogamy that excluded many locally situated persons from possible sexual access. The in-marrying 'stranger-woman' as 'witch' seems to have been a common conceptualization throughout the strongly patrilineal southern African societies (see Hammond-Tooke 1974:337).

As in other southern African societies women in Zulu society reflected and, I argue, still reflect a witchcraft image. Traditional *ukuyala* customs as described by Krige (1950:136) support this notion. After leaving her home at marriage, the bride was lectured to by her 'mothers' about how she should behave in her husband's home, and what she was to expect in terms of the in-laws' treatment of her. The fact that she will be suspected of and accused of witchcraft featured prominently in these traditional pre-marriage talks (from the verb *yala*; to warn; put on one's guard). *Ukuyala* customs are still practiced today in St Wendolin's, but in a different form. If a girl and her family are members of a formal church, fellow women church members often act as the new 'mothers' instructing the soon-to-be *makoti*. A girl who is a member of the Catholic church in St Wendolin's will be instructed to attend at least one meeting of a formal women's church formation, usually with the office bearers of The Women of St Anne's, a Catholic women's solidarity group.

Having been advised to attend such a meeting myself before my impending marriage in that community, I found the proceedings intriguing. Essentially it was a tea party in the parish reception room; a pretence to meet 'the white *makoti*', as the women readily admitted. However the anthropologist-*makoti* took the opportunity to probe the women about what they usually tell about-to-be-married women, and what they themselves were told as young women. The need to show respect and work hard for one's new family was the central bit of advice, along with emphasis on the importance of keeping clean and washing

one's self and one's clothing regularly. Also, the fact that one would always be watched, suspected and from time to time accused of using witchcraft was stressed. I found this surprising, coming from the mouths of women who represented the very pillars of the Catholic Church in their community. When questioned along these lines they stated that it was advice that reflected simple reality, in the past and today (but of course they themselves didn't believe in such things!). However being a white *makoti*, the church mothers agreed that I need not worry about witchcraft accusations as 'my heart was white also', and nobody, including in-laws, would suspect me of using 'these demon things.'

WHO IS A WITCH?

A woman/bride then is a person to be watched, whose movements need to be controlled by her husband (and his family) as nobody can ever be sure of what 'demon things' she might be up to. It seems to be well known, assumed and expected that as a perpetual 'outsider' of unclear loyalties, a woman is regarded with suspicion not only by her affines, but by the community in general and may even be suspected of being a witch. I would suggest that associations made between women and witchcraft as reported in previous ethnographic accounts of the Zulu (see for example Gluckman 1940, Krige 1950, Berglund 1976, and Ngubane 1977) are still largely valid today.

Much anthropological debate has centered around the search for suitable terminology to distinguish between witchcraft and witches on the one hand and sorcery and sorcerers on the other. Following Evans-Pritchard (1937), many writers have used the term witchcraft to refer to the use of psychic, personalized power used by a witch herself (almost always a woman), or through the vehicle of familiars-helpers. The term sorcery commonly refers to the use of magical substances (usually by a man) e.g. medicines, charms, often

used with nail pairings, hair clippings and other bodily parts of intended victims. While such a distinction is important for analytical purposes, the distinction is not always expressed terminologically by the people among whom these practices exist, a point noted by Middleton and Winter(1963:3) and Hammond-Tooke (1974:337). This would appear to be the case among the Zulu, with the term *abathakathi* most often used to signify a person who uses magical powers in any form for evil purposes. The Zulu use the English terms witch and witchcraft when translating *abathakathi* and his work. For this reason, I have chosen to use the terms witchcraft and witches in the same way as the people of St Wendolin's use the terms today, referring to the practice and persons who use magic for evil purposes, whether male or female. Nontheless, my experiences in St Wendolin's lead me to conclude that in the vast majority of cases where witchcraft activity is suspected, it is women who are initially accused of being the witches.

FERTILITY AND AMBIGUITY

The importance placed upon and values attached to kin solidarity among the Zulu are only rivaled by the importance and values that surround fertility. To be fecund and grow the lineage is good, said to be what the ancestors desire most, and what the evildoers in society (collectively known as the *abuthakathi*) ultimately aim to destroy. In her reproductive role, the straddling by women of two worlds (the earthly world of the living and the sacred world of the dead) gives rise to some of the most clearly articulated notions of female pollution. Birth is a mystery associated with the other world from which people are believed to come and to which people return in spirit form upon death. Ngubane (1977: 76) stated that although 'this world' and the 'other world' are viewed as two separate entities, the beginning of life, whose source was believed to be in the 'other world', happens in 'this world', and death that happens in this world is believed to mean continuity of life in the 'other world'. Notionally, there is believed to be an area of overlap between the two

worlds which is expressed by the term *umnyama*, literally 'darkness', and used to describe the state of ritual pollution. According to Ngubane (1977:77) pollution is an expression of the marginal state between life and death, neither here nor there, but somewhere in between. During certain times in life when a woman is believed to be especially dangerous to others, childbirth, menstruation and death being amongst those times, women were said to be affected by *umnyama* . Expressing these concepts in English, informants today say that a woman is 'dirty' during these times, and being 'dirty' in this way makes her both vulnerable and dangerous.

As regards death, the contagious pollution or 'dirtiness' is believed to emanate not only from the corpse, but also from the chief mourner, who is necessarily always a married woman. In cases where the assumed or 'natural' chief mourner is not married, such as in the case of the death of a child of an unmarried woman, the mother's role as chief mourner will be shared with another female family member, one who is married. Informants say this is necessary in order for that child to be recognized and accepted as a family member among the ancestors.

Ngubane (1977:85) provides a persuasive analysis of the symbolic meaning of a woman as chief mourner, whereby, much like with a newborn child, a woman would deliver the prepared corpse at the doorway to the awaiting lineage men for burial. Today, where the corpse is collected at a mortuary, the woman chief mourner is expected to be there as it is loaded into the hearse, and ride with it to the cemetery. Symbolically, she delivers it to the men awaiting at the gravesite. Once at the gravesite, the chief mourner positions herself where the head of the corpse will enter the grave. Ngubane (1977) interpreted this as a dramatization of the birth process, but in reverse; from other world to this world (birth) from this world to other world (death).

Parallels between death and birth can also be made by looking at the development of a woman's pollution status during her time as a chief mourner and as a new mother. In St Wendolin's today, if death is preceded by a period of illness whereby the patient is likely to be periodically treated with traditional medicines, the whole family is said to be in a state of pollution (known as *ukuzila*) and is expected to withdraw from normal social intercourse. The degree of pollution is believed to build up during this time until the death of the patient, when it reaches its highest intensity and potential for contagion in the form of the female chief mourner. Slowly it fades until the end of mourning. With birth, pollution is believed to build up slowly over the nine months of pregnancy and reaches high intensity during birth. At first the pollution is believed to make the woman vulnerable to misfortunes of all sorts and a danger to herself and unborn child. Over the months her vulnerability and potential for danger is believed to strengthen and become capable of affecting other people around her. The name *umdlezane* is applied to a newly delivered mother and implies a state of high pollution when she is dangerous to herself, her baby, and especially to males. Slowly this form of pollution subsides, ending only after a woman ceases lactation and breast-feeding of her child, which could be several years. The woman and her baby are believed to be especially vulnerable during this time, and she is encouraged to avoid strange people and strange places lest something 'bad' should happen.

A man is said to have his virility threatened should he be in close community with an *umdlezane.* Traditionally, a man would avoid sharing eating utensils with her and accepting food cooked by her (Ngubane, 1977:78). Today, strong emotional concern for male virility during this time still applies, and was brought home to me when it became known that my husband attended the birth of our firstborn child and acted as a labor coach. So shocked was his family that after having the experience confirmed by him, they abruptly demanded that he not discuss the matter further. Such a reaction was in line with what seems to be a

common Zulu propensity for avoiding discussion or talk about 'bad things', usually things associated with illness, death or misfortune, as it is believed that this would 'open the way' for more 'bad things'. My husband considered himself lucky to have escaped with only a stern warning that such behavior was not the Zulu way and therefore he must act quickly (by way of traditional magico-medical applications) to cleanse himself of this *umnyama*. Subsequent inquiries around the subject of men attending the birth of children confirmed strong beliefs regarding the weakening effect that being near a woman at this time would have on a man. Most informants claimed that by doing this a man wouldn't be a man anymore. This would destroy him, make him weak and sickly forever.

POLLUTION AS METAPHOR

Throughout the world polluting and polluted states have been associated with complex symbolic elaboration, represented and upheld by strict rules of conduct. Mary Douglas (1966), the anthropologist most closely associated with pollution theory, has argued that the cultural coding of a substance as a pollutant derives from a shared perception of that substance as anomalous to a given symbolic order. According to Douglas, anomalies are powerful, their power being granted a positive or negative valence (polluting or sacred) according to specific cultural circumstances. Previous analyses of pollution concepts among the Zulu have tended to stress their association with married women, and the fact that pollution was essentially a happening associated with menstruation, birth and death. As women fulfilled their role of forming bridges between two worlds, one social and one spiritual, they occupied a type of twilight zone. Having this fuzzy terrain proclaimed as natural 'woman's space' made a woman dangerous by way of being marginal and ambiguous. Her very existence generated doubt, a doubt that was reflected in the peril potential that women represented and which was reinforced by pollution beliefs.

Far from placing women in a position of weakness, I suggest that this marginal 'woman's space' provides women with the room needed for manipulating the patriarchal structures which define the parameters of her life. With her 'feet in two kraals' men have to be constantly on guard not to provoke her ill-will lest she resort to witchcraft. However men have little choice in allowing this dubious creature into their midst for they are totally dependent on her for the physical continuity and perpetuation of the patrilineal society, exogamous rules prescribing that a man must marry a stranger-woman. If she is not indulging her natural propensity for evil (informants concur that witchcraft comes 'naturally' to women whereas men require more serious provocation and assistance from the *nyanga* to do evil to others), then a man must be mindful of her *umnyama* which can taint and debilitate. Also, where women – married or not – say that they are in no position to refuse the sexual advances of their men, invoking menstrual *umnyama* by saying that they were 'dirty this week', was said to usually dampen his libido. "Unless he's drunk, he'll stop all his nonsense." "A man is afraid of this thing. He won't want to take a chance." Inadvertently or deliberately a woman has the power to cause others misfortune. Thus, the culturally dubious 'woman's space' provides women with a measure of strength and room for negotiating the male-dominated environment.

Representations of women as 'dirty' and dangerous apply in St Wendolin's today, and I would suggest that they extend beyond associations with birth, death, menstruation and married women. In a metaphorical sense, these notions apply to all women at all times. Birth and death especially are extra-ordinary life events and as such provide the best opportunities for the expression of pollution concepts and viewing pollution-related behavior in action. It is during these times that the mystical force of *umnyama* is said to be most intense, most dangerous, and most contagious, and provide the occasions when people are most consciously aware of the danger potential of

women. For such times of exceptional pollution, tradition proscribes against intercourse with women. Both male and female informants agree that intercourse during these times is still for the most part avoided today. However, these taboos were often said to be broken when the man was drunk as previously mentioned, or on other occasions when he was considered to be 'not in his right mind'. Having ignored this taboo people say that such a man could expect all kinds of trouble because his 'blood' had been 'weakened'.

Traditionally even in the best of times when a woman was not contagious with a specific form of *umnyama,* a man would avoid intercourse the night before any important undertaking such as conducting a family ritual, or going to war (Berglund 1976:136). Today, some male informants said they would avoid intercourse before events such as job interviews, football matches, or even writing exams, so mindful are they of the weakening effect that sexual intercourse with a woman can have on a man. Thus, while a woman's pollution is most potent at certain times in her life when she is believed to be more of a danger to those around her (these times being marked by ritual or prescribed rules), I would suggest that there is a deep-seated notion that women are *at all times* fundamentally 'dirty' and dangerous.

THE PERIL OF 'DIRTY' WOMEN

In the course of my research I was impressed by the recurring theme of women being held somehow to blame for most of the misfortunes which befell individuals, families or the entire community. If children were not performing well at school, it would inevitably be said that some woman (often a married female relative but sometimes just a neighbor) was jealous. As a result she was said to be 'doing something' to ensure that nobody else's children progressed academically except her own. It was always said to be a woman causing couples to quarrel or marriages to break-up, or husbands to seek extra-marital

affairs. It was even said that women were to blame for bad weather, drought, heavy rains and flooding in the community. If planted crops did not grow as well as expected or were destroyed by animals or stolen before they could be harvested, women were held responsible.

Many of these allegations were not made in the form of serious accusations, but rather seemed to be in the realm of off-hand remarks or initial judgements which were expected to be obvious to all within hearing distance. The quick and casual way in which these remarks were made, and the way in which they were often received with little comment, indicated how well established and pervasive these thought patterns were. Sometimes these snap remarks were met with laughter, as in the case where a boy's acne was said to be the result of living too close to an elderly aunt who was recently widowed and therefore 'dirty'. At other times, the allegations were of a very serious nature, especially in cases where the use of witchcraft intended to harm or kill others, was suspected.

Such was the case when a neighbor's goat gave birth to a stillborn kid amid much bleating and baying. What appeared to be a difficult birth resulted in the delivery of a lifeless offspring that became stuck in the birth passage. What a pitiful sight it was to watch this goat trying to walk around with the head and forelimbs of the dead offspring dangling out of its posterior. Immediately suspicions fell upon one of the neighbor's women 'lodgers', staying in a rented one-room backyard shack. Had she not remarked more than once on how beautiful and numerous were these goats? This was taken as a sign that she was jealous and therefore the obvious one responsible for this terrible mishap. Discussions with the family were held that very evening to decide what should be done with the lodger woman. Causing such a thing to happen to a pregnant goat was said to be a sure sign that she was against the prosperity and

proliferation of the family. As there were two family women pregnant themselves at the time, it became a matter of urgency to get the woman off the property, and ideally out of St Wendolin's altogether. Along with a two-day notice to vacate her room, the young men in the family started to spread rumors that she was a supporter of Inkatha, then a conservative Zulu cultural organization believed to be aligned to the apartheid regime. In an overwhelmingly ANC (African National Congress) supporting community, being labeled an Inkatha supporter in the early 1990s was akin to being given a death sentence. The accused woman was gone before nightfall the very next day.

While men were occasionally thought to be responsible for particular mishaps and misfortunes, it was overwhelmingly women who were the first to be accused and the ones most likely to be blamed in the end. Much research attention was paid to trying to understand how the people of St Wendolin's conceptualized women's involvement in and ultimate responsibility for so many day-to-day problems. I eventually concluded that the essential 'crime' which established a woman's guilt in life was the fact that she was born a woman in a patriarchal society. The ideal of exogamous marriage placed women in the 'stranger-woman' category of social/spiritual dubiousness, a category fraught with suspicions and fear of witchcraft. Customs and beliefs associated with feminine pollution helped to maintain the 'masculine mystique' of Zulu male centrality and dominance in society, and also helped to maintain the 'feminine mystique' of Zulu female marginality and subordination. Pollution made her dangerous through no real fault of her own. Whether she acted intentionally as a destructive force (as in the case of using witchcraft) or acted unintentionally (as in the case of being infected by *umnyama*), women reflected an image of danger and havoc. However negative the image, it is nevertheless a reflection and representation of a woman's power in society.

In trying to understand how people constructed their beliefs in female complicity in life's misfortunate, I drew the conclusion that it hardly mattered to the people of this community how women were involved. They just were. "Women don't belong near the altar. They are dirty." The Catholic priest who made that statement was simply affirming local beliefs. Women were just 'dirty'. The peril, which they cause arose from their 'dirty' quality, a word that was often used as an adjective synonymous with woman.

EXPLORING THE NOTION OF WOMEN AS 'DIRTY'

According to symbolic analyses, pollutants are coded as 'dirt' (Douglas 1966). Related notions of 'dirt' and 'dirtiness' are not without problems in any language. The concept of 'dirt' in English is a slippery one, as an examination of its meaning reveals. For example the Webster's Dictionary (1990) defines it as a noun meaning "1) soil or earth; 2) obscene or profane language; 3) scandalous or hateful gossip". 'Dirty' the adjective means "1) not clean, grimy; 2) indecent or obscene; 3) mean, despicable; 4) lacking in clarity or brightness". As a verb 'to dirty' means "to become or make soiled". The notion of 'dirty tricks' refers to "unethical behavior, especially in politics." In Zulu, notions of dirt and dirtiness are likewise polysemic. *Umnyama* is used to mean dark/darkness and is generally used in reference to the state of ritual pollution. The word *ngcolile* is used to refer to physical dirt as well as deviousness and immorality. Another term, *igciwane,* is often used to mean dirt or germs associated with illness and somatic symptoms.

The explanation offered by many informants when asked to explain how a woman (or women) was causing any particular negative event was that 'women are dirty'. Often, that statement was the only explanation offered, as if it was the reason in itself. The English term 'dirty' was used not only in cases where informants referred to a woman's *umnyama* causing problems, but also in the use or suspected use of witchcraft; her 'dirtiness' referring to *ngcolile,*

her devious and immoral behavior. Undesirable personality traits such as being secretive, gossipy, loud-mouthed, domineering, overly curious or envious were also associated with a woman's 'dirtiness'. Physical qualities were also used in discursive descriptions of 'dirty' women. Having a repugnant body odor, wearing the same clothes over and over again, never wearing a petticoat, using too much make-up, having elongated ear-lobes, all were said by informants to be representative of qualities of 'dirty' women. Being either overly sophisticated or unsophisticated were both associated with being 'dirty'. Unless she was 'just right' in some perceptual way (and it seemed women seldom were) she was 'dirty' .

Mary Douglas' (1966) analysis of perceptions of 'dirt' and 'dirtiness' is useful for understanding how the terms are used in relation to women in St Wendolin's. Douglas suggests that the state of 'dirtiness' is associated with things which people perceive as out of place, existing or found where they should not exist or be found. Thus a 'dirty' room is one where things are strewn about such as clothes (which belong in cupboards), dirty dishes (belonging in kitchens) or dust (belonging in bins). Blood belongs in the body. The regular menstrual flow of women is then something perceptually akin to regular 'dirtying', a rhythmic displaying of a vital life substance which belongs inside the body, not outside. To say a woman with elongated ear lobes is dirty makes sense when perceived in this way, as such ear lobes are associated with a more traditional way of life in the rural areas. Elongated ear lobes do not belong in the peri-urban environment. Similarly, the use of heavy make-up is associated with prostitutes or women who are said to be out to get men. People would often comment that such women belong at 'truck stops', places associated with commercial sex work, or 'Point Road', an area renowned as Durban's 'Red-light' district. Most often the ideal woman was described as someone who was 'quiet', 'dignified', 'respectful'. Indeed, when extolling the

virtues of a particular woman, one of the highest compliments one could make in St Wendolin's was to say that 'she can hardly speak'. It would follow then that a 'loud-mouthed', 'domineering' or 'overly curious' woman would be 'out of place' when viewed against the social perception of the ideal muted woman. One could take this further and argue that the in-marrying stranger-woman, occupying a symbolically ambiguous social space, is someone 'out of place' or at least marginal to the male-link patriarchal social order.

It is perhaps significant that English language instruction and the introduction of western medicine and medical concepts such as the association of 'dirt' with germ theory, was brought to St Wendolin's through the agency of Catholic missionaries. One of the greatest challenges faced by these early missionaries in trying to 'civilize the natives' and 'rescue them from their superstitions' (a task so eloquently recorded in the historic documents of Mariannhill and described in Chapter 4), was the persistence of existing beliefs such as those regarding health, illness, ritual pollution, ancestors and witchcraft. For these Catholic missionaries, a soul corrupted by sin was seen as the root of all evil in African society (see Schimlek 1950). Original sin, not only the first and most profound of all sin but the ultimate cause of all misfortune on earth, was traceable to Eve. The missionaries introduced their beliefs about the original evil woman who corrupted mankind and tainted the Garden of Eden forever. However, a review of some of the oldest accounts of Zulu society containing reference to beliefs and practices surrounding notions of female impurity (see Calloway 1870, Bryant 1929) would seem to suggest that ideas of pollution and peril associated with women pre-date the coming of Christian missionaries. Rather than 'rescuing the natives' from these particular beliefs by usurping or supplanting them, I would suggest that Christianity has helped to reinforce and maintain them. That women are 'dirty', that they are to blame for most of the troubles in life, is something that, for the people of St Wendolin's at least, is practically taken for granted today. Catholic doctrine and traditional ideologies

have come to function together to maintain the female pollution complex in St Wendolin's.

NEW RITUALS

Catholic women church members regularly make rounds praying at each other's homes whenever there is a domestic or community problem. Men never do this. It would seem that the sins of women require the prayers of women. The ritual of going to pray on the mountain is a good example of the Church's view of the relationship between women and misfortune. If women are believed to have the power to cause so many misfortunes, so too are they believed to have the power to set things right again. Women in St Wendolin's are regularly instructed by the male church fathers to go as a group to pray at a certain hilltop during times when misfortune befalls the community. During the course of my years as a resident in that community, women went *en masse* to a high hill on the outskirts of the community to pray for many things. These included praying for less rainfall (during the floods of 1987), better relations between youths and parents, a stop to the politically-inspired carnage between UDF and IFP supporters, fewer teenage pregnancies, greater employment opportunities for the menfolk, special blessings for local boys about to enter the Catholic priesthood, and more respect between husbands and wives. The women who participated in these rituals were drawn from all walks of life, and did not need to be members of the Catholic church. As long as she was a woman, she was encouraged to attend. Many of the women who attended these prayer services clearly expressed that their reasons for going (although a whole Saturday was lost in the process, a time when they could have been washing clothes, ironing, relaxing, whatever), were to make sure that others *did not suspect them of wanting to perpetuate or being responsible for* the problems at hand. "Men say that we cause all this, so we must end it. They can't do anything. We must."

So said the leader of the St Ann's Women's Solidarity. In late 1998, the women trudged up to the hilltop to make protestations about a new blight in the land, the HIV/AIDS epidemic.

Going to the hilltop for prayer seems to represent a combining of older pre-Christian ritual with Christian ritual. Describing what were then referred to as pagan agricultural ceremonies among the Zulu, Lugg (1929) stated that young girls and women used to go to a sacred site and sow seeds in a special garden in honor of *Nomkhubulwane*, the Goddess of rain and fertility. Here, they would perform sacrifices and ask *Nomkhubulwane* for rain, a good yield for the next harvest, and for fertile marriages. Gluckman (1935) also described this same ritual among the Zulu, and later considered how this communal ritual involved an element of rebellion on the part of women whereby "they milked normally tabooed cattle, went naked and sang lewd songs" (Gluckman 1954:5). Hammond-Tooke (1974: 354) stated that similar communal rites to guard against drought and crop failure were found in all groups in Southern Africa, and the ultimate responsibility for initiating these rituals lay squarely with the chiefs. For the people of St Wendolin's, the problems of today are not about crop failures and the need to raise more children for 'the nation'. The problems are typical modern problems that have more to do with unemployment, teenage pregnancy, sexually transmitted diseases and the need to live together peacefully. Here, it is not *Nomkhubulwane* who is petitioned to bestow her blessings, rather it is Jesus Christ, the Son of the Christian God.

In St Wendolin's, going to the hilltop to pray for rain and blessings of all sorts is an activity usually initiated by the parish priest. If the Catholic church 'mothers' decide themselves to go to the hilltop, the parish priest – the community's 'chief' – has to be informed and give his approval. Not only have some communal rituals been 'reinterpreted' with Christianity, some, like ceremonies for *NomKhubulwane*, have been resuscitated on a province -wide scale in

recent years and given a new interpretation in the era of AIDS. This is further discussed in Chapter 6 (also see Appendix 8, page 256).

In St Wendolin's today, it does not really seem to matter *how* women are involved or *why* they are to blame for so many problems in the community. Women are 'dirty', and everybody knows that. For the misfortunes of life, this is often explanation enough. At a time when women are increasingly rejecting the yoke of oppressive traditions while becoming increasingly economically and socially independent as well as politically vocal, cultural constructions of the dirty and dangerous woman are alive and well. As will be argued, some of the changing behaviors and expectations of women today in St Wendolin's are possibly helping to maintain and give new sustenance to the symbolic equation of woman-pollution-and peril. In particular, women's behavior in relation to their sexuality and the misfortunes that are viewed as directly resulting from that behavior (including the AIDS epidemic) is, I argue, playing a part in not only sustaining but giving renewed strength to the female pollution complex. This is the topic of the next chapter.

CHAPTER 6
OUT OF CONTROL: PERCEPTIONS OF CONTEMPORARY FEMALE SEXUALITY

> "Our women are running wild. That's why we have all this AIDS, HIVs and STDs and whatever. See what women's liberation has brought us? It will destroy Africa."..... (*21 year old male informant*)

Many people in St Wendolin's would probably agree with the young man who offered the above comment when he spoke at a funeral in late 1997. One of his male friends had died of what was rumored to be AIDS, and like many other misfortunes, women featured prominently in the causal explanation for this new peril sweeping through the community. As a disease said to be primarily transmitted through sexual activity, there is a common perception in the community that the sexuality responsible for transmitting this deadly virus is female sexuality. It is female sexuality that is perceived to be 'out of control' and spreading disease. For many people in St Wendolin's, there was a strong sense that adolescent girls and young women had lost all manner of 'self-respect' in very recent times. There was a collective sense that young women had transgressed moral boundaries, and this represented a loss of culture and tradition. For some, the situation was viewed with fear that it would not only spread disease, but that it would also precipitate social chaos to the extent of 'destroying the Zulu nation'. The idea that female sexuality needed to be contained and controlled was echoed through numerous conversations and discussions with informants, both men and women.

Beauty Makhaye, a middle-aged and highly respected married woman in the community, was one such person who had no doubt about the widespread

destruction that would result from what was generally perceived as a new degree of sexual permissiveness among young women. Having just returned from the funeral of a neighbor's child, a woman in her mid-20s who was rumored to have died of AIDS, Mrs Makhaye was very vocal and confident in her assessment of 'this new disease'. When I spoke with her in her kitchen shortly after the funeral, she had this to say: "You see, this girl had many boyfriends, many. Now that whole house is sick; her brothers, her mother, and even the children. They'll all die. Just wait. Its AIDS, it's true. Everything is bad there." Mrs Makhaye's brother-in-law, who was listening from the lounge, came to offer his insights into this new problem. "Our forefathers didn't live like this. Unmarried girls had respect, even for their own bodies. They didn't go up and down with men like today. It's not our way, but now nobody cares. This is what we see... so many people dying now."

Indeed, the Makhayes' words were echoed through countless conversations with people in St Wendolin's. Young women and even pre-pubescent girls, were 'out of control', 'running wild', and nobody, especially parents, could tell them anything. The net effect of this new situation was construed as imminent disaster not only for the girls concerned, but for the whole community, sometimes the entire 'Zulu nation' and even the whole of Africa.

When comparing the situation today with that described by previous writers on the Zulu, where sexual activities of particularly young people were traditionally monitored and controlled through a system of social sanctions, it seems clear that the nature and substance of contemporary pre-marital relations in the urban areas represents a marked change from the past. For example many previous writers refer to once highly regulated pre-marital love affairs which were announced to the community through the exchange of variously colored beadwork, and a system of raising various colored flags onto the kraal fence of the boy's family homestead (see Krige, 1950: 152-160; Vilakazi, 1965:46-59;

Reader, 1966: 175-212). These rituals have given way in St Wendolin's to what many informants perceived as an unregulated sexual permissiveness and a pervasive (and to some extent socially condoned) pattern of concurrent sexual partnerships.

One 30-year-old male teacher described the situation as he saw it: "If the truth be known there is a lot of sexual trafficking going on today. But it's really all underground because we still want people to see us as an honorable someone. It's hidden with silence." Most informants under the age of forty profess no knowledge whatsoever of traditional practices of hoisting flags to announce the development of a new love affair, and display a minimal knowledge of beaded 'love letters' and their color significance. It was not uncommon to hear young people speak of such practices as being 'insulting', a sign that youngsters in the old days were not 'respected' by their elders. Asked whether elders respected young people more today, most young informants answered in the affirmative. When asked to explain how this respect came about, many young people described a scenario which seemed to imply that rather than having *earned* that respect from the older generation, the older generation was *forced* to concede it.

It is possible that the politics of the last two decades has played a major role in fostering the development of this new 'respect' which the youth claim to have gained from their elders. During the aforementioned days of 'total onslaught' by apartheid forces in the late 1980s early 1990s, young people in St Wendolin's were increasingly in the forefront of local politics. As Sitas (1992) has pointed out, young men and women formed the shock-troops of the internal struggle against apartheid in KwaZulu-Natal, as in other parts of the country. During the late 1980s, youth in St Wendolin's seemed to be fully in charge. They burnt the homes of suspected informers, 'necklaced' others

(having a rubber tyre placed around the torso and set alight), or paraded selected 'enemies of the people' down the main road. The fear that adults confessed of these unbridled, wild and courageous youth was no doubt tinged with a measure of respect and admiration. Today, almost five years after the political 'liberation' which the youth fought so hard to secure, young people seem intent on maintaining their newfound 'respect'. In many ways, this respect seems to manifest itself in day-to-day social interactions as a defiance of those in authority and is maintained by an ever-present threat of extreme brutality that was evidenced during the struggle years. The values, attitudes and behaviors that the youth developed as a response to the political stresses of these very recent times are reflected in their interpersonal relations including sexual relationships that are described by both young men and women as often violent and coercive.

THE IDEALIZED PAST

In order to appreciate the contemporary nature of sexual relationships and the impact of change on a peoples' intimate behaviors, it is necessary to examine some past patterns of sexual behavior. Having said this however, one must admit that such an examination is difficult. A perusal of professional anthropological writings on sexual behavior patterns among the Zulu before the advent of the HIV/AIDS epidemic shows that most of it, like the writing on other non-Western peoples, focused on marriage rules including polygamy, the stability of marriage, adultery, beliefs regarding love potions and sexual intercourse with witchcraft familiars. The teaching and learning of norms regarding sexual behavior, courtship behavior, pollution taboos related to sex, and the ritual expression of obscenity in song, dance, etc. were all described in earlier studies of Zulu sexuality. The works of Schapera (1933, 1940), Krige (1950) and Vilakazi(1965) stand out amongst others as illustrative of the genre of previous anthropological scholarship which considered sex-related behavior

patterns. While the qualitative indicators of sexual behavior, such as frequency of sexual intercourse and cultural meanings attached to sexual relationships, could hardly be obtained from these sources, they nevertheless provide some insights into the sociocultural context of sexual activity.

Indeed, as Parker et al (1991) suggested it was only with the recent occurrence and spread of HIV/AIDS that issues of sexuality and sexually-related behaviors have received any kind of concerted attention by social scientists. From the start of the epidemic, the underdeveloped state of sex research in the social sciences in general, whether focused on Europe, Asia, America or especially Africa, presented itself as a challenge to the academic community. According to Parker and Gagnon (1995) social scientists researching sexuality in the early years of the AIDS epidemic worked mainly within a biomedical framework, focusing largely on survey research in order to collect quantifiable data (see Chapter 2, Literature Review). It is only recently that social scientists have begun to focus their attentions on the sociocultural organization and construction of sexual life in order to obtain more insight into how people interpret and understand their sexual experience. The works of Boulton (1994), Parker (1992 a and b), Gillies and Parker (1994), Altman (1995) and most recently Hosteller and Herdt (1998), are examples of this new trend in sex research which essentially takes a constructionist approach to the study of sexuality. The recent development of 'queer theory' as discussed in Chapter 2, is part of the constructionist trend in sexuality research which questions the assumptions made in previous studies that relied on a biomedical model. From a 'queer' perspective, notions of sexual taxonomies and identities are far from being human universals. Rather, they are viewed as highly specific constructions of a given cultural context (see Raymond (1996) and Herdt (1997).

Along with an essentially biomedical understanding of sexuality which still characterizes much social science research on sexual behavior, there is a derth of historical ethnographic studies which have formally reported details of peoples' sexual behavior. Malinowski's (1929) study of the sexual habits of the Trobriand Islanders is a notable exception. The reluctance of anthropologists to study details of sexual behavior may be due to what Barton (1988) believes are fears of accusations of improper interest or violation of trust that is typically established over the course of long-term ethnographic research. As Pellow (1990:71) noted in regard to research in Africa: "For a Western (white) social scientist to write on the topic opens the door to charges of voyeurism and prurience, even racism." As a result of this paucity of adequate research, we are faced with a situation in Africa at least where, according to Ankomah (1992), a Ghanaian sociologist, many governments and health policy makers are themselves poorly informed of the very lifestyles which are the target of modification efforts in the era of HIV/AIDS.

What emerges from a review of some of the early writings on the Zulu of sex-related behaviors is a portrait of a society where the developing sexuality of both boys and girls was marked and acknowledged publicly, and where female sexual behavior was subject to a great deal of social regulation. In general, premarital sexuality was recognized, but controlled. Writing in the 1950s, and drawing upon much older records of the Zulu, Gluckman (1956) described a people among whom divorce, adultery and illegitimacy were once rare. He stated that chastity among the Zulu in the pre-Christian days during the time of King Shaka, was highly valued, and was part of the ethical code enforced by the age-set regimental organization (Gluckman 1956:181). Regiments of Shaka's army could only begin to marry when the king gave them permission as a set to do so. Gluckman's analysis corroborated Krige's (1950) observations

that traditional courtships were a highly regulated and ritualized affair. Writing on the consequences of a girl engaging in pre-marital intercourse and becoming pregnant in more traditional times, Krige (1950:157) stated:

> When a girl was seduced, she had to answer for her conduct not only to the mothers of the village who will swear at her, spit upon her and call her by the most insulting terms, but also to her age-mates in the district, which will be angry with her for degrading them. These girls will take her to the river.....where they will swear at her, spit upon her and beat her very cruelly. She had brought shame upon them and deserved punishment.

In addition, damages were payable in the form of cattle to the girl's mother, sometimes to her father as well, and to the girl's age-mates, by the accused boy's family (Krige 1950:158).

According to Vilakazi (1965:53) sexual activity between young unmarried persons was permitted and accepted as something good and natural before the coming of Christianity. The only social taboo in this regard was the avoidance of full sexual intercourse. Instead, young people were instructed by older siblings to engage in intracrural sex, or intercourse which did not include vaginal penetration, as this was considered to be the preserve and privilege of married couples (1). Krige's (1968) analysis of Zulu girls' puberty songs demonstrates the extent to which pre-marital sexuality was a ritualized and highly managed affair among the Zulu in the past. Based on her studies of the Mpondo, a closely related Nguni group, Wilson (1936) suggested that the main guiding rule of pre-marital activity in pre-Christian society was to avoid pregnancy. This composite picture of a highly regulated pre-marital sexuality was one, which was repeatedly described to me in the course of numerous conversations with the late Dr A C T Mayekiso of the University of Durban-Westville, a highly respected and self-proclaimed expert on Zulu custom and tradition. From her point of view, the young women of today were truly like

"lost sheep" who received absolutely no guidance or advice from home or elsewhere on matters of sexuality. "Zulu parents can't talk about such things with children. Sex is a taboo subject. Before there were elders and big sisters of the community. Today there's nobody, and what do big sisters know anyway? Their knowledge is poison." My own ethnographic research in St Wendolin's would support Dr Mayekiso's view that there is very little if any sexual education taking place in the homes. According to most informants, parents simply do not talk about sexual matters with their children. The advice columns of popular magazines and discussions amongst peers were reported to be the major sources of sex-related information for young people in St Wendolin's.

PARENTAL WOES

In the course of innumerable discussions with older people about what courtship and pre-marital relationships were like in the past, I have found the aforementioned descriptions to be accurate portrayals of how many elderly Zulu-speaking people chose to recall and construct 'traditional' pre-marital relations. Such discussions were easily prompted in St Wendolin's since the sexual activities of the youth and the endless stream of new teenage pregnancy cases were regular features of the local gossip and the conversations of mothers. Informants were very eager to have me understand that things such as unmarried girls falling pregnant, taking contraceptives, having abortions, being seen with three or four boyfriends, and basically "running wild like hyenas" – as one grandmother put it – were definitely *not* the way things were in the past. "This is all new. We never had children like this before. Especially the girls! We can't do or say anything. They think they know better." "Before, I remember these girls (unmarried mothers) had to sit in the back of the church on Sunday. They were a shame and disgrace. Now? Ha! They are everywhere. EVERYWHERE." "Look at their short skirts. School girls! What do you think

they want? They don't want schooling. We can't do anything. They know what they're doing."

Comments such as those quoted above were typical. There was a strong sense among the parent generation in St Wendolin's that they had lost control over their children, and believed themselves to be powerless in re-claiming authority and control over them. While these parents were naturally very anxious about this state of affairs, many also seemed to be resigned to accepting a situation which they felt unable to change.

My observations led me to conclude that in general, communication between parents and children was poor. When children were young they were expected to be at the 'beck and call' of parents at all times. Boys and girls were regularly given commands to fetch items from the local shack-shops, to mind younger siblings, to bring things to neighbors, to help around the house and the like. In the case of disobedience on the part of children, or when their performance of some task did not meet parental expectations, they could expect some loud sharp words, often supplemented with a hiding. Mischievous children in St Wendolin's simply grew up with corporal punishment or the threat of corporal punishment as the main form of disciplinary action used by parents. When the child reached his or her teenage years, these threats and thrashings no longer seemed to work. This left parents of older children feeling that the days of control and authority over those children were now over. Other forms of asserting authority over older children, which might be used in more middle class families, such as withholding allowances, taking away car keys, restricting social or recreational activities, did not exist. Neither was there much evidence of parents talking to and counselling their adolescent and young adult children on matters which concerned them as parents. Too often, when the stick could no longer be used – when parents said it made no difference and that the youth resented it – parents would concede defeat and abandon efforts to

discipline their children. The persistent comment by parents that they 'can't do anything' was indicative of how paralyzed and powerless they felt when it came to affecting or modifying the behavior of their nearly grown-up children.

Writing on her observations of African family life in the urban environment during the late 1960's, Hellman (1967) stated:

> Many children fail to find in their homes the emotional security they need or in their parents the models with whom they want to identify themselves. Parental control has weakened and youthful indiscipline has grown. The *tsotsis* (delinquents) disrespect for authority and cynical disregard for the lives and property of others – are the bitter fruits of family breakdown in an unfavorable physical, social, economic and political environment. (Hellman 1967: 11-12)

Sadly, Hellman's description of 40 years ago could easily be a description of life for many of St Wendolin's youth, and probably the youth of many other South African townships today.

The recent passing of legislation in 1998 to allow for the legal termination of pregnancy was perceived by the older generation, and males in general, as yet another 'nail in the coffin' which would help facilitate the loss of social control over the sexual activities of young people and women in particular. Many informants saw this legislation as something akin to an open invitation for girls to be promiscuous and abandon any remaining 'self-respect'. "Why should she hold back now? What for? She can just have an abortion anytime. So she can have all the fun she wants." These words by a mother of three teenage daughters who were "not yet pregnant" reflected a more general attitude in the largely Catholic community that easy access to abortion would compound an already problematic lack of sexual restraint (discursively constructed as 'loss of self-respect') on the part of young women. The effects of 'easy abortion' on the sexual activities of ~~males~~, was hardly ever mentioned.

Proof of young peoples' 'loss of respect' in general was often said to be found in the ways they conducted their sexual relationships, often flaunting accepted rules of behavior. Common complaints centered around how young unmarried men did not see anything wrong with bringing their girlfriends into their rooms for lovemaking sessions. Parents claimed that they did this in broad daylight, at anytime of the day, often after school, and did not seen to mind that small children or others were about. Likewise, young unmarried couples were increasingly seen walking hand-in-hand along the main road in St Wendolin's. It was the opinion of most informants that any public display of affection of sexuality was 'not good'. Some said it set a bad example for children, believing it would make them eager to have sex. Others said that such 'showing off' was sure to provoke envy in others and therefore to be 'inviting problems'. From the point of view of parents in the community, open displays of affection provided further proof that young people 'lacked decency' and most of all 'respect for their elders'.

In fact, it seemed that the most acceptable form of conduct between young unmarried people was a display of antagonism. When a boy whistled or shouted at a girl in order to get her attention, she was expected (if she as a 'good' girl) to either ignore the boy or to respond with a rude look or sharp word. Any friendliness shown on her part could be taken as evidence that she was 'interested' or 'eager' and therefore had low moral standards. Girls who were seen on the road standing idly and just listening to a boy were often gossiped about as 'out to get sex'. "Why should she just stand there if she wasn't interested?" "A good girl always hurries home from the shop, or is busy with work around the house." Only 'bad girls' hung around near the road where boys always gathered. It seemed that only when a girl had absolutely nothing to do with boys outside of the family, never greeted them, never talked with them, and certainly never entertained them, could she be considered 'good' and by way of implication, chaste. A smile, a giggle, a short skirt, a too

slow walk home from the shop or school, all could be construed as evidence that a girl was 'looking for it'. "She'll be bringing home a baby soon, just wait." This was the comment of a mother observing her daughter in conversation with a young man at a local shop. Her comment resonated with the common view expressed by many adults in the community that young people and especially young women, had 'lost respect' and no longer knew how to conduct themselves sexually.

The fact that it was the girl who would be left to shoulder the burden of a new baby, was no doubt a factor in the parents' much keener interest in the girl's sexual activities as opposed to the boy's. Parents did worry about their unmarried boys becoming fathers, but the concern here was mainly about how the jobless boy would provide for this baby should he admit to paternity. If he were unable to 'buy at least one nappy' as mothers would say, then the onus would fall upon his parents to 'do something'. For the most part, pregnancies resulting from early liaisons between teenagers, or where boys were unemployed and still in their early twenties, were not expected to precipitate a marriage. Similar expectations in regard to early pregnancies were reported by Pauw (1962) and Wilson and Mafeje (1963) among urbanized Africans in settlements of the Eastern Cape, Brandel-Syrier (1971) among the African middle-class of the Pretoria-Johannesburg area, and Preston-Whyte and Zondi (1989) among teenaged girls in other African townships around Durban. It was very common in St Wendolin's as in other African urban areas, for boys and girls to have at least one child before marriage.

Besides concerns about fatherhood and its financial implications, beliefs that a boy could 'get disease' from women today was another cause of concern. However, the primary concern about perceived increases in male promiscuity seemed to revolve more around questions of decorum. The main problem was not that a boy brought home so many girlfriends, nor that he fathered children

out of wedlock, or that he made continual visits to the local clinic for STD treatment. Of greater concern was the perception that the young men were openly flaunting their sexuality and thereby flouting accepted social norms of discretion. "That Sandile, we call him Revolving Door. The girls are coming and going out of his room so quickly. What a shame and disgrace to his parents." The disapproval here had more to do with the public embarrassment that resulted from the boy's revolving door policy, rather than the implications of this policy. Overall, male sexual activity, even when viewed as excessive, was accepted by informants as something essentially natural, and basically a sign that the boy was healthy and unquestionably a 'real man'. For the girls however, no good connotations were ever attached to public displays of sexuality.

In many respects the parent generation of St Wendolin's is no different from other modern-day parents who are struggling to understand and accept the sexual norms of a younger generation seeking to adapt to a rapidly changing world. Their concerns as parents echo the concerns of all parents everywhere, and probably as much in the past as today. Whether this generation of urbanized young people is any 'worse' than previous generations in terms of how they conduct themselves sexually, is a moot point. Nonetheless, in the present day environment of St Wendolin's, a community situated in a province said to be home to the world's fastest growing HIV/AIDS epidemic, concern about the sexual behavior of one's children has taken on a new degree of urgency for today's parents.

BOYS WILL BE BOYS

"A man must have several girlfriends. It's our tradition and still our way!" This statement, by an unmarried man of twenty-two years with two children by two different women, reflects what several writers on the Zulu have interpreted as

the traditional ideal of masculinity; that is that a man should have more than one sexual partner. That a high socio-cultural and conceptual value is placed on men having multiple sexual partnerships was apparent through many interviews with informants whether old, young, male or female. That a man would have outside 'girlfriends' was also viewed as an inevitable part of married life. The expectation was that this would provoke jealousy on the part of a wife, but she would have to deal with it. "Our men are like that. Our mothers tell us when we marry but sometimes we don't believe them. Then we see it, and it's no use crying. That's men." Dudu, a newlywed at age twenty-one shared a view of the improbability of male fidelity in marriage that was far from atypical of women's views in general, whether married or unmarried. While monogamy and sexual exclusivity were seen as the ideal in marriage, in reality it was only the woman who was expected to be faithful. Some married women in St Wendolin's said they knew their husbands had extra-marital relationships, but felt that there was not much that they could do about it. Brandel-Syrier (1971:83) reported that similar views were held by married women of Johannesburg's black middle-class, whereby the majority of the sexual partners of these women's husbands were known to the wives.

For a young unmarried man, the ideal of achieving a reputation as an *isoka* was often emphasized. As described by Vilakazi (1965) this term was used to refer to a young man who was popular with women, much as the term 'Casanova' might be used in English to describe such a person. Proof of his popularity was to be found in having many girlfriends, as well as children from several different women. Forty years after Vilakazi's fieldwork, and in the locale of St Wendolin's, I have found the cultural ideal of being an *isoka* still relevant. "To be an *isoka* is to be proud. The other boys just look at you....they're so jealous." "Many girlfriends are nice. You have a choice for who you want at different times". "Girls love an *isoka*, they fight over you." Such statements were typical of young St Wendolin's men in the 15 to 25 year age group. To

be called an *isoka* by others was obviously a compliment, and something that the young men of the community seemed to be expected to at least strive for. Many young men mentioned how *isoka* status was proof of one's normality and health, and especially proof that one was not homosexual. Ironically, being known to be popular with women, and being seen to have many girlfriends was also mentioned as proof that one was not infected with HIV/AIDS. "You have to be strong to have many girlfriends. If you are weak or sick with AIDS or something like that, you can't do it. So girls know you are healthy when you go for lots of them."

While having many girlfriends was viewed more or less as a cultural birthright that was natural and normal for males, so too was the necessity of sexual intercourse viewed as part of any normal and natural male-female relationship. In the eyes of many community members, a relationship was established with the occurrence of intercourse. For the boys, this was the most important way that girls proved they were really interested in them. The act of intercourse was the necessary ritual and precondition before a girl or boy could call themselves the girlfriend or boyfriend of so-and-so. Any boasting on the part of young people that a certain someone was their boyfriend or girlfriend could be expected to be met with the key question: "Did you do it yet?" If no substantial proof was offered in the way of details about dates, times and places of rendezvous, the kind of radio or hi-fi he had in his room, or her favorite music for love-making, then the person's claims would be scoffed at. Sex was the necessary and all-important rite of passage. Without it, there simply was no 'relationship'.

Writing on gender relations in West Africa, Ankomah (1992:139) stated that "No matter where they met, a woman was perceived by a man as primarily a sexual being. For men, sex seemed to be the primary reason for any friendship." My experience in St Wendolin's would tend to support Ankomah's

assessment of young men's perceptions of relationships with women. Whether or not a relationship will be sexual or not does not seem to be a decision that needs to be made. The *expectation* is that a relationship is, by its very nature, sexual. It must be noted that earlier writers have all concurred that premarital relationships among the Zulu were primarily sexual in more traditional times. The key difference is that in the past non-penetrative intracrural sex was the socially sanctioned form of sexual activity. Today, the intracrural sex of young people has been replaced, in St Wendolin's at least, by vaginal intercourse as probably the most common form of premarital sexual actitity.

MANAGING FEMALE RESOURCES

As important and praiseworthy as it is for a young man to have multiple sexual partnerships, so too is it important that he be seen to command control over his women. Young men often spoke of the need to show 'good governance' over 'one's woman'. To be the 'controlling force', the one 'in command' in a relationship was construed as an important role of a man in a relationship with a woman. One youngster of nineteen years, a self-styled *isoka,* put it this way. "They (the girlfriends) can have their say. We're not as strict as our forefathers, we have democracy. But they must know who's in charge. It's us (the males), and they must respect that." For most young men the issue of control in a relationship was an important one, but it was not a question in need of an answer. The assumption was that the man must always be in control, no matter what. This was considered 'good', 'natural', 'traditional', and also a way to 'prevent chaos' in the relationship. From their point of view, not much in day-to-day gender relations was more of an anathema than a woman having the upper hand. Such a situation pointed to weakness on the part of the man, and provided much fodder for local gossips. A man had no excuse for allowing his women to 'take control', unless of course he could claim that he had fallen prey to witchcraft.

As a point of illustration, the case of Mr Dlamini was one such example of a man who had 'lost control over women'. This was evident by the way his wife 'ruled the roost', so to speak. Dlamini was a reliable sort of chap. With a steady job cutting meat at Checkers (one of South Africa's largest supermarket chains), he always arrived home at about 5:30pm every day, newspaper under arm. He was a quiet man, whose life seemed to revolve around his family (wife and three children) and his work. But Mr Dlamini was often the butt of local jokes as living proof of a man who had 'become a donkey' and allowed his wife to rule the roost, as it were. For the young men, Mr Dlamini was a classic case of a man who never achieved success as an *isoka* in his youth. Therefore, he lacked the necessary training and practice in managing his 'domestic human resources', as some of the youngsters put it. The fact that the Dlamini household seemed to be a stable one and the house itself displayed a more comfortable lifestyle as compared to the majority of homes in that section of the community seemed to do little to enhance Mr Dlamini's reputation as far as the male youth were concerned. He was but a fool, a weakling, a shame and disgrace to the ideal of a 'real' Zulu man, a *umnumzane*.

It was during the unmarried years of young adulthood that men were expected to learn and practice how to get and maintain the upper hand in relationships with women. Being an *isoka* would provide him with much practice in dealing with women of different personalities and characters. Achieving success as a young *isoka* bode well for his success as a real *umnumzane* in later years. "Dlamini never learned anything in his youth. He was stupid". Such were the comments of young men eager to define and assert their developing masculinities. "Like a man controls his cattle, so he must learn to control his women". That was the way old Mr Ngadi put it, followed by a hearty laugh. It was not the way the Zulu-speaking Catholic priest put it when he slipped in a similar statement in the course of my own wedding vows in St Wendolin's

church. Our well-prepared nuptial vows were momentarily suspended as he looked me straight in the eye and said in a stern authoritative voice: "As Christ is the head of the Church, so too is the Man the head of the house!" The need to 'control one's women' (or at least to portray oneself as doing so) was brought home to me time and again, not only through conversations with men of all ages, but through observations of daily of gender dynamics. In the privacy of couples' homes, I often observed affection and communication that betrayed the illusion of stereotypical gender inequality and the separateness of the sexes. When I met those same couples at public functions, such as funerals, weddings or after church services, there was often very little evidence of shared intimacy between them. In public, men and women commonly gravitated towards same-sex groups. During Sunday services at St Wendolin's mission church, pews to the right of the center aisle were occupied primarily by men, while women occupied the left side of the church and children sat towards the front.

While visiting in the homes of friends, I was often impressed by how men and women would quickly move into expected role behavior when an adult visitor (man or women) would enter their home. It seemed that culture prescribed that the man of the house should lift his voice several tones and the woman quickly set about serving tea, moving to the kitchen, or just sit still in silence. I was constantly impressed by the lack of any fuss, the smoothness, the naturalness with which couples switched back and forth from what I interpreted as different public and private faces of gender dynamics. A woman seemed to know instinctively how and when to defer to the man, to give him his dues, just as much as the men knew how and when to display their authority, and thus leave no doubt in the minds of observers that they were fully 'in charge'. Of course for some couples no switch in gender dynamic was necessary. For them, the public and private personas were more closely matched. But my

impression was that the public and private face of the drama called gender relations often differed markedly.

CONSTRUCTING MASCULINITY

Two things appear to be key essentials to the project of constructing masculine identity in the St Wendolin's community. Firstly, the need (of young unmarried men at least) to publicly be seen and acknowledged as striving for (and ideally achieving) *isoka* status as a man with multiple sexual partnerships. Secondly (though no less important), the need to create and maintain the public impression that one is 'in charge' as far as women go. Looked at in a global context, there is certainly nothing new about the time-honored tradition of patriarchal society whereby women defer to and heed authority to their men. What *is* new in many societies is the fact that women are no longer willing to play the gender game according to the prescribed rules and are questioning the assumptions and reasons behind these rules. The importance placed on the necessity of 'good governance' over women by modern young men is perhaps a reflection of their growing awareness of change in gender role expectations of young women, and men's desire to avoid losing control over women. For many young men in St Wendolin's, gender power relations characterized by the men in charge and women 'under control', is simply right, normal and natural. More importantly, maintaining this balance of power in favor of male dominance and female subordination is justified because it is viewed as 'traditional'.

Writing on the meaning of manhood among low-income African-American men from one inner-city ghetto, Whitehead (1994 and 1997) argued that the urban ghetto environment, characterized by high levels of unemployment, violence, female dominated households, and a lack of male role models, amongst other things, presented contextual barriers that prevented men from achieving the American ideal of a "male gender self". Instead, men developed "fragmented gender selves", which that author saw as contributing to men's *exaggeration of*

their sexual capacities, and their need to sexually control and/or conquer females (Whitehead 1997:419). Considering that rates of HIV infection are currently growing at a faster rate among urban low-income African-Americans as opposed to other sub-groups within the U.S. population (see Wright 1993, Nossiter 1997, UN-AIDS 1998), Whitehead's suggestion that "fragmented gender selves" put men and their partners at increased risk for HIV transmission, may be worth considering when trying to explain the ever-increasing rate of HIV infection in South Africa. Granted there are many sociocultural, political, historical and other differences between urban African-Americans and black South Africans. Nonetheless, there exist similarities in the living environments of both groups. Many African communities in South Africa, including those in KwaZulu-Natal are likewise characterized by high levels of unemployment, violence, female-headed households and a lack of adequate male role-models. It is possible that African men are experiencing similar "fragmented gender selves" which may help explain what, in St Wendolin's at least, seems to be a similar need of men to control and/or conquer women. There is a need for local studies that explore the formation and social impact of 'male gender selves', which some researchers, including this author, believe to have serious consequences for the transmission of HIV.

Recently, Morrell (1998) has attempted to discern some of the historical roots informing contemporary constructions of African masculinity in South Africa. He argues that an understanding of African masculinity must be based upon an understanding of both critical changes to and continuities with 'traditional' constructs of masculinity. According to Morrell the political and socioeconomic changes brought to African life with the intrusions of colonialism resulted, among the Zulu, in a decline of the indigenous age-cohort institution (the *amabutho*) that previously existed. Concurrent with this decline was a rise in inter-generational struggles and the emergence of new (black) masculinities in new (urban) contexts, which, according to Campbell (1992) contributed to

the high levels of violence, which characterized the local townships during the 1980s. Further, Morrell argues that 'traditional' constructions of masculinity characterized by patriarchal authority and the subordination of women were never really destroyed. Indeed, as Lambert and Morrell (1996) argued previously, colonial laws may have acted to resuscitate and entrench gender inequality among the Zulu.

It would seem that contemporary constructions of African masculinities, including those of the Zulu, have been shaped by a plethora of historical forces reflecting both continuities and changes (2). As reflected in the discourse and behavior of young men in St Wendolin's, the traditional patriarchal ideal of male control over women as a cornerstone of Zulu manhood, has not been eroded in the modern urban context. Rather, the urban environment has given new meaning and new support to the culturally valid notions of male dominance and female subordination.

GIRLS WILL BE .... BOYS (?)

"They're trying to be like us. Many boyfriends and even taking the lead to kiss a boy! No man, this is not right." As far as Keke and his friends are concerned girls simply do not want to be girls anymore. The cultural ideal of unmarried girls being shy, demure, waiting for the advances of young men, anticipating marriage, children and preparing for that eventuality, is perceived by most informants to be on the wane.

One would be hard-pressed to come across a community member of St Wendolin's who does not claim that the girls of today are different from those of just a few decades ago. As mentioned previously in this chapter, there is a general sense that young people, and girls in particular, are 'running wild' and are 'out of control'. This is said to be evidenced through their sexual behavior, which is substantiated through the common occurrence of teenage

pregnancy, and more recently, with the growing awareness in the community of people infected with HIV or dying of AIDS. There is a shared perception that foreign influences and the rigors of modernization have eroded traditional moral values that once acted to contain the sexuality of youth. Significantly the local discourse on the changing morality of youth was a clearly 'gendered' discourse. It was the perceived moral values of contemporary women, that presented a problem to society. There was a collective sense that the ideally quiet and complacent Zulu woman had transformed, and this transformation represented an overstepping of moral boundaries and a threat to the social order.

Based on their on-going research in eastern Africa, Caldwell et al (1989 and 1993) have made similar 'gendered' arguments regarding the general breakdown of traditional moral and institutional structures which once acted to constrain the sexual behavior of women. Likewise, Green (1994) related how traditional healers in both Mozambique and Swaziland also blamed the loss of traditional values and structures for what they claimed was an increase in the sexual activity of girls in the past few decades. Both Caldwall et al's (1989 and 1993) and Green's (1994) work suggests that these cultural changes and the subsequent loss of traditional ways of managing female sexuality, may be helping to sustain high levels of HIV infection in Africa. The problem, once again, is viewed as a problem in the management of female, not male, sexuality.

In St Wendolin's, contemporary female sexual behavior was often compared to male sexual behavior. According to most informants, this was not the way things should be. To say that a double standard applies to expectations of female and male sexuality is a great under-statement. A female *isoka*, or one with many boyfriends, is likely to be called an *izifebe* or whore. No positive associations apply. That young women today have several boyfriends simultaneously and are far more sexually active than in the past, is a perception

shared by most, if not all residents of St Wendolin's, including the young women themselves.

WHAT DO GIRLS WANT?

"Today, it's all about money. If you've got that, you've got everything. That's why we do it." Eighteen-year-old Thembi was speaking on behalf of herself and her four friends who were waiting on the benches of the local Mzamo Clinic. They had come for contraceptive advice and condoms. Having known Thembi since she was ten years old, she tended to treat me as an older sister (or perhaps even a grandmother!), someone with whom she could be honest and need not worry about harsh judgements or that the information imparted would get back to her parents. Thembi was certainly street-wise and old beyond her years, but in her school uniform and white ankle socks she looked as innocent and sweet as any schoolgirl. In the late 1980s she watched her uncle burn to death through a 'neck-lace' murder. Thembi was a girl who projected an image of knowing it all, and never held back on the subject of contemporary male-female relationships.

"I have three boyfriends right now. One he's mostly useless, he's poor but we know each other. The other one buys food for my family. Those potatoes (pointing to a sack in the corner) came today. The other one – oh, la,la – he can buy jewelry. He's married." Thembi's comments were not unusual. Relationships with older married men were viewed, from a financial point of view, as especially rewarding. Women were quick to explain the advantages of such associations over those they could hope to enjoy with younger, single men. "It's the married men who will give you everything. Young ones, forget it. You can only take the bus with them and go to Pinetown to walk around (laughter). But, the married man – you'll get pocket money, clothes, make-up – everything. Plus, a nice car to go places." Young women (many still school girls), stressed the importance of liaising with older married men outside of the

St Wendolin's community. For this, they had to make the effort to 'go to town' (Durban) or visit friends in other townships to find such partners. Otherwise, the most popular place within the community where the girls said it was 'easy pickings' for older outsider men, was at a particular local tavern. Opened a few years ago, this tavern was owned and operated by someone from outside the community, and frequented by professional men who lived in Pinetown and surrounding townships.

Parental perceptions of sexual permissiveness amongst young women and male perceptions of women having multiple sexual partnerships as the norm today rather than the exception, seem to have some basis in day-to-day reality. For many young women, having relationships with a number of men was seen as the pre-marital ideal situation, a situation which many were prepared to initiate and maintain. Many young women believed that sexual permissiveness had increased substantially in just the past few years. Some even associated it with newfound human rights in the post-apartheid era. "Why shouldn't we do it? We are free, as much as the boys are free. We now have human rights. We won't be stupid anymore." For most, the present economic situation seems to be a major driving force in their new sexual assertiveness. It was apparent from my fieldwork experience that many young women 'played the field' for all it was worth, and the worth was definitely calculated in financial terms.

Some women claimed that their parents encouraged multiple relationships, both directly and indirectly, as it ensured an additional flow of money into the household. "I wanted to leave that chap (a local taxi driver), but my mother said I mustn't. He pays our bills, gives sweets to the children. But I'm sick and tired of him." One young woman with two children from former liaisons was loath to put up with the attentions of an older, ex-patriot Englishman from a nearby suburb who often came to visit her when he was drunk. The community seemed to tolerate this relationship while at the same time

proclaiming contempt and disapproval. The fact that the man was the boss of the girl's mother may have explained it all. From the mother's point of view, her daughter just had to tolerate a liaison with this man as long as she could. Often the mother would speculate on how this man was in a position to buy them a house. Therefore, her daughter 'mustn't be stupid', and must just 'keep the tap open', at least until the material goods were secured. In the end the man returned to England with his wife. No new house was bought, but the young woman did get some new clothes and a radio, and her mother had a new kitchen suite to show off to her friends.

The notion and practice of reciprocity and gift giving as a pivotal feature of sexual relations in other parts of Africa has received a fair amount of recent research attention. Studies from Zaire (Schoepf 1992b), Zimbabwe (Bassett and Sherman 1994), Senegal (Niang 1995), Ghana (Fayorsey 1996), Tanzania (Haram 1995, 1996), Uganda (Agyei and Epema 1994 and Obbo 1993, 1995) and Zambia (Nzovu and Lwanga 1997), have described the exchange nature of sexual activity in a variety of African settings. These writers have all argued that 'sex for gifts' was putting many young girls at increased risk for HIV infection, and was playing a major role in sustaining the AIDS epidemic in Africa.

Drawing upon his own research in West Africa, Dinan (1983) speculated on the reciprocity implied in marriage in many African societies, whereby exchange of women's sexual/procreative services in return for maintenance was sealed with the passing of bride wealth or bride service. He noted that only recently with Christianity had sexuality become bound up with religious belief-systems, which imply notions of sinfulness, but it was never bound up, as in Europe, with the refinements of romanticism. Sex, Dinan (1983:353) argued, could legitimately be viewed rather more objectively and instrumentally in an

African context. The urban environment in South Africa, such as that of St Wendolin's, has provided women with many opportunities for using their sexuality in just this instrumental manner. Previous studies by Longmore (1954), Pauw (1962), Brandel-Syrier (1962) and Wilson and Mafeje (1963) have all suggested that African women living in urban environments have not been averse to using their sexuality to gain an economic or material advantage. Economic realities, increased material desires, a loosening of traditional rules and regulations, and changing expectations, among other things, have prompted many to make use of their sexuality in instrumental ways. A recent article in the Mail and Guardian dated 18 September 1998, carried a report on female students at a tertiary institution in another part of the country who were selling sex in return for cellphone payments, tuition fees and new clothes. Some of them were from middle-class homes and were not in need of money. When asked if they considered what they were doing to be a form of prostitution, all were adamant that their exchange of sexual favors for financial gain was not prostitution. What Varga (1996) referred to as 'exchange relationships' among commercial sex workers in Durban (physical/sexual relationships based primarily on material exchange, not emotional intimacy or commitment) are evident in St Wendolin's. A schoolteacher's daughter put it this way. "The fact is – the money at home is not enough. My father gives me pocket money, my mother buys me clothes. But I still want to be smart, ... go places, enjoy life ..... you know. The more boyfriends, the better. You can do more things that way."

Studies on commercial sex-workers in KwaZulu-Natal (see Posel 1963), Abdool-Karin et al (1995), Marcus et al (1995), Varga (1996, 1997a), Preston-Whyte et al (1997), have tended to highlight the survival aspects of commercial sex. These studies emphasize the fact that sex work is about making money to stay alive, to feed one's children, and in some extreme cases, to find a place to live.

While this is most probably true for the vast majority of women engaged in the exchange of sexual favors for financial or material gain, I would suggest that not *all* 'exchange relationships' in St Wendolin's can be associated with basic survival.

Many young women are keenly aware of the important role they play in meeting the *isoka* needs of young men. They know that having girlfriends is an important criterion determining status within male peer-groups, not only as evidence of female conquest but as a means of expressing differential wealth amongst men, especially in the case of older men. Therefore, even if a man was young and unemployed he was said to be under pressure to 'try hard to buy something'. According to women informants even if a man 'occasionally stole a lipstick from Clicks' (a local chainstore), this would be enough to satisfy a woman that she was not 'completely wasting her time'. The women were aware that they played an important role for the men, and most were quite happy to continue boosting male ego-strength as long as they could continue siphoning his monetary strength. When a man no longer compensated their services and just started 'taking you for granted', for many women this was a sign that a relationship was over. "Sex with no money ..... no ..... what for? He can go tell it to his other girlfriends. We're not married, he must just go."

HAPPILY EVER AFTER?

The basic normative prescriptions defining the cultural framework of these women's activities was that they should marry and have children as a nice, quiet *makoti* within her husband's natal household. Young women say that they feel the social pressure to marry, referring to the criticism and insults to which older unmarried women in the community are subjected. However, despite the ideological importance of marriage in their community and the social condemnation of their sexual liaisons with several men concurrently, many young women today seem not at all keen to tie the knot in matrimony.

Female informants generally had very strong ideas as to what marriage should entail but found nothing remotely likely to meet their expectations in the marriages they saw around them. "As far as I can see about 10% or 15% of marriages here are happy. Most aren't". Another said: "Actually for a woman, it's just your children who make you happy. Our men .....terrible".

It was evident that many of today's young women were ideologically committed to the idea of romantic love as being the basis for a happy and successful marital union. They also believed that marriage should be an institution for the containment of sexual activity on the part of both spouses, and not just expected on the part of the wife. Young women were convinced however that such aspirations were unrealistic and that 'Zulu men' adopt an authoritarian role in marriage and expect a considerable degree of subordination from their wives. "Our mothers play this game. They will even let our fathers beat them. We don't want to play this". This was the view of an unmarried twenty-four year old with no children.

Many families in St Wendolin's have acquired televisions only in the past ten years, and many of the young women can recall the story lines of "The Bold and the Beautiful" (simply called "Bold") or "Days of Our Lives" (called "Days") which go back several years. Many young women have been imbued with the messages of romance, easy relationships, beautiful clothes, wealthy older men and other values portrayed in these Hollywood soap operas. Young women refer to these shows as examples of life as it should be, without realizing that such day time dramas are produced abroad primarily as a form of escapism for bored, middle-class American housewives.

Sibongile in St Wendolin's wants what the character Brooke Logan-Forrester has, namely everything. That real life, and real male-female relationships *anywhere* are seldom like those portrayed on the television, does not seem to

have entered the thoughts of many young women in the community. To a large degree, those electronic images of love have come to represent the ideal towards which a lot of young women in St Wendolin's today are aspiring.

"Our Zulu men ... ei, ei, ei. They don't know anything about how to treat a woman. Nothing. They are barbaric." Such sentiments were echoed in the words of many female informants. As far as young women are concerned, little had changed in men from the days of their forefathers. While they, on the other hand, were (according to their own assessment) 'truly modern women'. They felt that men only married women to get a domestic worker around the house and to make children, which they said was 'another thing he needs in order to feel like a man!' Women seemed to think that men regarded sexual relations with wives as being functional and obligatory, while any romantic sexuality (which was said to be minimal anyway) was reserved for outside girlfriends. One eighteen-year old school girl put it this way: "Our men say they can't eat cabbage every night. They like to show off to their friends and get a girl who likes their jokes. It makes them feel big."

Young women seemed to accept that it was hopeless to expect husbands to be faithful, but at the same time they were highly critical and resentful of this adulterous behavior. Women often drew comparisons with polygyny in former times, and claimed that not much has changed. Rather, polygyny had been somewhat 'reinterpreted'. Young women described contemporary marriage as 'monogamous on the outside only.' In reality the pattern described more closely resembled monogamy supplemented with sexual partnerships outside marriage. Men they said, want to be *isoka* all their lives, not just when they are young. For some of the young women of St Wendolin's, the desire for multiple sexual relationships was prompted by a desire to get even or get back at men who professed to be faithful but who were not. Most however

claimed a desire to "have fun" and "get things" before marriage. For them, marriage was felt to be a kind of death whereby they would be expected to keep their mouths shut, curtail their social activities, be faithful, and put up with their husband's infidelities and accept whatever bit of money he might contribute to the household.

Many young women viewed the contemporary state of marriage as an unsatisfactory arrangement. Therefore, it was up to them to use that time period between adolescence and marriage to their advantage. Their bargaining chip in this gender game was their sexual favors. The general view of what many perceived as a growing trend in young women's attitudes towards sex and marriage may be summed up as follows: While you're young, you must just get as much as you can. One 18-year-old said: "If men want you, then they must be prepared to buy you things, like clothes, take you to cinemas, the beach, show you a good time. After you're married, that's the end. Don't expect a thing, not even a petticoat." For modern young women, nothing much has changed in the institution of marriage and what was expected of them as *makoti*. What had changed perhaps was their determination to "enjoy life" as many of them put it, by using their sexuality before marriage in order to gain material and financial benefits.

TRADITION TO THE RESCUE

With the exception of young women themselves, almost everyone else in St Wendolin's seemed to agree that the sexual behavior of young women today was in need of some form of regulation. Whereas a great deal of social regulation of female sexual behavior may have been the norm in the past, economic, population, migration, political and other factors seem to have led to a weakening of such regulation today. The resulting 'loss of control' over women's sexuality, or the relative lack of moral and institutional constraints on women's sexual behavior are viewed by many observers, including researchers

such as Caldwell et al (1989), as part of a pattern in Sub-Saharan Africa that is tied to the greater process of corrosion of traditional institutions in general.

Sixteen-year-old Zanele's parents are very aware of how young women in the community seem to be 'out of control'. For them it was almost a Godsend that they heard the news of a *uKuhlolwa Kwezintombi* (virginity testing) ceremony taking place in September 1998 at Durban and followed by the larger *Nonkhbulwane* Festival, as mentioned in Chapter 5. Checking unmarried girls to see if their virginity was intact, was part of these events. The event in Durban coincided with the launch of *Isivane Samasiko Nolwazi*, a campaign aimed at reviving long-established Zulu custom as a way, according to its organizers, to restore the 'frayed moral fiber' of the Zulu people. By encouraging girls to value their virginity by abstaining from sex, the organizers of this campaign are supported by many parents in St Wendolin's (and no doubt in many other African communities) in their strong belief that a re-introduction of virginity testing will go a long way in addressing the ever-increasing trends of teenage pregnancy and more recently HIV/AIDS infection. Zanele was accompanied by seven other girls from the community, one as young as ten, whose parents saw great value in virginity testing (see Appendix 8, page 160).

Soon after the Durban event the fourth annual provincial-wide *Nomkhu-bulwane* Festival was held in the Midlands region of the province. This festival was revived a year after democratic elections, and resuscitated in an effort to reacquaint young women with 'Zulu traditions'. The theme of the *Nomkhubulwane* Festival in 1998 (which reported to have attracted 15,000 'Zulu maidens' as participants) was "No to Premarital Intercourse". The virgin girls were asked to pray to *Nomkhubulwane* to put an end to rapes, pregnancies and the high rate of HIV infection among the youth in the province. The organizers of this event claimed that the only way to put

an end to pre-marital intercourse today was to ask *Nomkhubulwane* to help children abstain from sex. Even members of the provincial Department of Health have turned to *Nomkhubulwane* for assistance in stopping the spread of HIV. As one Health Department spokesperson stated: "Our AIDS efforts have failed. Instead there is an increase in young people with AIDS. I think the traditional way of dealing with this problem will be the solution" (3).

The revived and updated ritual of virginity testing and asking *Nomkhubulwane* to help solve modern-day problems shows every promise of becoming an increasingly popular strategy for managing female sexuality and addressing the problems associated with it. From the point of view of parents in St Wendolin's, these ceremonies are a way to re-introduce traditional checks and balances that once shaped and sanctioned the expression of sexuality between young people. Most parents believe that bringing them back will help reverse the trend towards increasing teenage pregnancies, STDs and the ever-expanding number of new HIV infections.

Yet, the sexual behavior of young men is never an issue. The social 'pathology' is clearly perceived to rest with women. In the eyes of many community members, the Pandora's box of female sexuality that has been carefully crafted, guarded and managed through centuries of Zulu tradition and custom, had not simply been pried opened through time, but has been blasted apart in very recent years. The contaminated 'fall-out' was perceived to be not only teenage pregnancy and HIV/AIDS, but increased misfortune of all kinds. Who was to blame for all of this? Woman; the conceptually 'dirty' and dangerous creature whose sexual behavior is now seen as 'out of control'. Helping to substantiate the common theme of the unbridled nature of contemporary women's sexuality are new associations made in St Wendolin's today between female sexuality and witchcraft. The shared view of the community in this regard is that women are increasingly using love medicines to ensure the fulfillment of their sexual

desires. Traditionally the use of love medicines was considered to be the special preserve of men. As will be argued, transgressing accepted norms of sexual behavior by using love medicines contributes to the conceptualization of contemporary women as 'out-of-control'. It also serves to reinforce the symbolic construction of women as 'dirty' and dangerous. This is the topic of the next chapter.

Notes

1. Intracrural sex refers to the practice of non-penetrative sex, an accepted part of pre-marital relations traditionally. Also referred to as *hlobonga* (Bryant 1929, Krige 1950) or *ukusoma* (Vilakazi 1965 and Van der Vliet 1974). Vilakazi (1965) argued that this practice was strongly discouraged by the Christian missionaries and was no longer practiced in many parts of KwaZulu-Natal by the 1950s. Today young people in St Wendolin's refer to this practice as 'out-dated', associated with a time when the forefathers were 'ignorant', before there was such a thing as contraceptives. Abdool-Karim and Morar (1994), Hadden (1997), Varga (1997b) reported similar perspectives among other Zulu-speaking informants in the province. Some AIDS educators in the area are trying to revive this practice as a way to arrest the spread of HIV.
2. In July of 1997 a Colloquium was held at the University of Natal in Durban entitled 'Masculinities in Southern Africa'. This Colloquium represented the first organized attempt by academics in KwaZulu-Natal to address gender theories of masculinity in relation to the local context. The aforementioned work by Morrell (1998) originated from this colloquium along with other papers such as those by Xaba (1997) and Hemson (1997) that focussed on the impact of political struggle on the construction of masculinity among African men in KwaZulu-Natal. These authors noted how the display of violence and aggression was a crucial

component in the construction of the 'comrade' identity of young men during the fight against apartheid forces in the 1980s.

3. Efforts to resusitate virginity testing for girls have been embraced in some quarters as a way to acknowledge and promote positive African values that are perceived to be under threat of extinction in the face of pressures towards westernization. In October 1999 the Deputy President Jacob Zuma, a well-respected Zulu-speaking leader from KwaZulu-Natal province, fully endorsed the current revival of virginity testing by publicly stating that it was a 'cultural right of the Zulus'. However, the 'champions of chastity' (as the public media has referred to these exponents of virginity testing), are not without an opposition. In November 1999 a special parliamentary hearing was held to debate the 'Promotion of Equality and Prevention of Unfair Discrimination Bill', which is due to be passed into legislation by February 2000. During these hearings a strong call was made by researchers from the University of Western Cape's Gender Project to outlaw virginity testing on the basis that it was a clear-cut example of discrimination based on gender.

CHAPTER 7

THE KISS OF DEATH: WOMEN AND LOVE MEDICINES

> "It's terrible now because women are using all this strong stuff ... this medicine. Before it was us men, and we knew we had to be careful with such things. But women these days ... I don't know. I think they love sex too much!"..... *(40-year-old male informant)*

Related to, and often spoken of as an adjunct to contemporary women's transgressions of culturally-defined moral rules of sexual conduct, is the perception that women are increasingly using witchcraft 'love medicines' once almost exclusively used by men. This perception, shared by the self-proclaimed *isoka* quoted above, combines and joins with the notion of increased female sexual promiscuity to further reinforce and promote the ideology of women as 'out-of-control'. That women in Zulu society have long been regarded with suspicion, often being accused of witchcraft, is evident throughout the accounts of previous writers on the Zulu, as discussed in Chapter 5. Indeed, patterns of witchcraft accusations are similar among the Nguni, with most accusations being made against women (Hammond-Tooke 1974:338). Research conducted in the early 1950s in the current Eastern Cape province revealed that over 80% of witchcraft cases recorded among the Mfengu, involved women (most especially a wife) as the accused (Wilson et al 1952: 170-86). Writing on African belief systems more generally, Mbiti (1969:201) stated: "It is mainly women who get blamed for experiences of an evil kind and many a woman can expect to suffer under such accusations sooner or later."

The notion of women making use of mystical powers to do harm to fellow members in the community, as discussed in Chapter 5, is certainly nothing new in Zulu society. Today, informants in St Wendolin's say that the primary method associated with women practicing witchcraft is the technique of adding harmful substances (*umuthi* or medicines) to the victim's food. Because she is

the one who prepares and dishes out food to others, people say a woman can easily add *umuthi* to food in order to harm her enemies. That women are suspected of doing this often was obvious through the way in which children were constantly implored not to accept food or drink from just anyone. Poisoning of children (the English term 'poison' being used when referring to any harm-intended substance put into food or drink) was said to be a popular way in which *abathakathi* (people who use witchcraft) struck at the family of an enemy. The same precautions applied to accepting drink. The rule was that one must never accept a drink of any kind, which had already been poured into a glass. Rather, the bottle should be opened and poured directly in front of the person for whom it is intended. In this way the drinker was able to see that nothing of a harmful nature had been added.

Harming people by adding *umuthi* to their food and drink was not just the work of women (although they are primarily associated with it), but men could be and were also suspected of 'poisoning' others in this way. Informants were adamant that no intelligent Zulu man would leave a drink unguarded and unattended in a shebeen or other public place for fear that an enemy, even one who was unknown to the drinker, may slip something harmful into his drink. What appeared to be a paranoia about the poisoning of food and drink surely represented a dilemma for the people. Norms of hospitality required that visitors be offered some form of sustenance after being welcomed into a home. If the visitor had traveled from afar, the host was expected to show his deep appreciation by offering a full plate of food. The quantity and quality of the food is used as an index to measure how happy and appreciative is the host with his/her visitor. Not accepting the food offered by the host would be interpreted as suspicion on the part of the guest that the host was a 'witch', intent on doing the guest harm. To demonstrate an open mind free of suspicion, a guest had little choice but to eat the offered food, and take a chance in the process. Indeed, food represented a contrasting symbolic

equation of good (hospitality and nourishment) on the one hand, and bad (suspicion and poisoning)on the other. In trying to explain pervasive associations made between women and witchcraft among the Nguni, writers such as Gluckman (1940, 1956), Wilson (1951), Berglund (1976) and Ngubane (1977) have previously argued that the ambigious position held by women in patrilineal society and the 'uncertainty' that it represented, lay at the root of associations between women and witchcraft. I would suggest that notions linking food and witchcraft among the people of St Wendolin's today probably owe much to similar dubious associations and ambiguous meanings that people attach to food.

What was perceived as new in the community, was not the idea that a woman makes use of mystical powers, often through poisoning, but that she was making more use of these powers today, and in ways that were previously associated with men. As discussed in Chapter 5, there is a broad area of overlap in Zulu society between what many ethnographers, following Evans-Pritchard (1937), have tried to distinguish as witchcraft and sorcery. According to Evans-Pritchard (1937) witchcraft and witches are terms especially associated with women throughout Africa, and refer to both supernatural character and mystical powers that are often inherited from mothers. Witchcraft is said to be especially (though not exclusively) practiced at night through the agency of familiars – animal or humanoid 'helpers'. Sorcery on the other hand is primarily associated with men and refers to the manipulation of the powers inherent in medicines (*umuthi*). In sorcery, no supernatural character of the sorcerer himself is assumed; the power for 'evil' is in the medicines used. In his study of magical thought patterns among the Lobedu, Krige (1944) elaborated on these differences, while Schapera (1952) in a study of the Tswana, usefully applied the terms 'day witches' and 'night witches' to draw out these distinctions. While the Zulu idiom *ubuthakathi* implies both fields of evil geared towards harm and destruction, nevertheless the distinction

is recognized. Berglund (1976) observed that the use of medicines for evil ends and the manipulators of those medicinal powers were most often thought to be men, while those people who practiced 'evil from afar', through the use of familiars or otherwise, were often thought of as women. Berglund stated that medicinal use "goes with men who know the powers of *umuthi* . Witchcraft goes with the anger of women"(1976:268) . For the people of St Wendolin's, both manipulators of *ubuthakathi* (evil power) are termed umthakathi (witches). Nevertheless, informants claimed that use of special *umuthi* that resulted in serious harm and destruction including death were most especially associated with men. Today, I argue,they are being associated with women as well.

There is a strong perception in the community that women have ventured into this 'evil' preserve of men by way of using love medicines previously reserved for male use. Most informants shared the perception that there had been an upsurge in the use of these *umuthi* by women in recent years. Many claimed that this was unheard of a decade ago. Not only are women said to be demanding and using these preparations, but also people say men are increasingly demanding these 'love potions'. The fact that most informants justify the increased use of these *umuthi* by men by referring to *women's* increased infidelities, has significance for the process of 'gendering' AIDS *and* demonizing women. As one local *nyanga* described it, women are causing more 'worry' in their men: "Our men are very jealous, they can't stand to think of their women going around with other men. But women today don't seem to care about that. That's why a man uses these things. He has no choice."

NO CHOICE: THE POLITICS OF LOVE

Basically there are two broad types of love medicines which are identified by the people of St Wendolin's and need to be distinguished for discussion purposes. The first category includes the use of medicinal preparations, which are believed to act more generally in making a person likeable and lucky in all

his/her endeavors. These may be used in order to win over a prospective employer, a girlfriend, a future mother-in-law, to attract more customers to one's shop, or win the sympathies of a teacher or a judge in a court case. These good-luck charms (*iziphonso*) or herbal preparations (*ubulawu*) as they are referred to generically, may for the sake of argument, be viewed as types of 'broad spectrum' good luck medicines. Success in love affairs is but one application of these *umuthi* . The use of these preparations usually involves a combination of steam baths and vomiting aimed at cleansing the system of 'dirt' and then promoting a lovable personality. People in general do not view the use of these *iziphonso* and *ubulawu* preparations as witchcraft. Their use, by men at least, is considered legitimate.

The generally accepted view in St Wendolin's was that women should not use <u>any</u> type of preparation aimed at affecting their personal relationships with men. While the use of *iziphonzo* and *ubulawu* was always considered as right and natural for a man, its use by a woman was sometimes regarded as selfish and an indication of a possessive personality. "Why do women need this? If they are married, what more do they want? They're just selfish and silly." This was a comment made by a married woman who insisted that a woman had no justification for dabbling with these good-luck preparations, whatever their intended purpose. No doubt, the lack of consensus on the matter of women and these medicines reflected the overall suspicions which enshroud women; suspicions which assume evil intent and what Wilson (1951:313) referred to as a pervasive notion associated with women's perceived 'natural proclivity for witchcraft'. While some women informants, especially young women, did not see anything wrong with using *iziphonso* or *ubulawu*, they did concur with the general view of the community that there was a marked difference between *umuthi* used to cleanse oneself and promote good fortune, and love potions which are seen as witchcraft. Use of the former is legitimate and morally acceptable to a degree, while use of the latter is always considered immoral.

LOVE MEDICINES

Medicines used for love-related purposes are regarded as witchcraft and carry a bad reputation. These preparations go by various names which are associated with the effect that they are said to have on the victim. Three of the most popular love medicines reported to be in use in St Wendolin's and said to be most sought-after by Zulu men (and more recently women) are the following:

1) *Iqondo/umsizi* – said to be the most powerful of medicines used traditionally by a man to insure the fidelity of his wife or lover. After the man obtains the preparation from a *nyanga*, he may place it on the ground where his wife/lover will walk over it and absorb it 'into her blood'. However, the more popular method of administration is for a man to have the medicines rubbed into razor incisions made on his body. Then, without his partner's knowledge, he passes the protective medicine to her through sexual intercourse. The woman is said not to have any symptoms herself and is most often unaware that she has been 'protected' in this way. However, any lover other than the man who treated her will absorb this medicine and become sick. The main symptoms identified as *iqondo*-related include persistent headaches, blood or pus from the nose, mouth or penis, impotence, kidney pains, and general urinary complaints (1). Most especially, all informants agreed that men can and do die from *iqondo*. Using a condom is said not to offer any protection whatsoever. As one young woman put it. "His medicine goes through her skin and directly into her blood. Even if the man does not ejaculate, he will still get *iqondo* if the woman has been treated. A condom makes no difference." Schimlek (1950), Vilakazi (1965), Bryant (1970) and Ngubane (1977) referred to this type of 'love potion' and its illnesses as *iqondo*, while Krige (1950) and Hammond-Tooke (1974) used the term *umsizi*. Green (1994:66) referred to the use of similar 'fidelity-protection' medicines among the Swazi, another related Nguni-speaking people. According to informants these terms refer to the same class of 'fidelity-protection' medicines that cause sickness in unsuspecting partners and may even result in death.

Generally speaking *iqondo* or *umsizi* are considered to be the most potent of witchcraft love medicines and therefore are the most feared. However, informants say that its use is often justified in order toensure a good marriage or to 'teach women a lesson', as one elderly *nyanga* put it. One of the most notorious of the *iqondo* illnesses is when the illicit couple is said to become stuck together while copulating. While no informants claimed to have had first hand experience with this illness, they all attest to its existence and claim that it happens most often in rural areas, or 'up in Zululand'. Northern parts of KwaZulu-Natal are generally associated with strong *umuthi* .

2) *Isidliso* – said to be used traditionally by a man initially to capture and secure the love of a woman. *Isidliso* differs from the previously mentioned preparations said to produce likeability primarily due to the fact that *isidliso* is said to force a woman to fall in love with a man against her will, and is therefore considered to be witchcraft. To *dliso* a woman is considered wrong but effective, and said to make the woman foolishly subservient forever after. Again, as in the case of *iqondo,* there is a double standard that informs the use of *isidliso.* In some cases a man is said to be justified in his use of *isidliso,* especially in cases where a woman is either 'stupid about love', or plays the game of hard-to-get. One young man who said he would consider using *isidliso* if 'he had to', used a hypothetical example of a woman who might consider becoming a nun: "What if the girl you want thinks of joining a convent! Oh no, it's up to you to do something. If you're a man, you've got to do something." For him, becoming a nun and living a life of chastity was viewed as an unfortunate way to live one's life. Even in a Catholic community such as St Wendolin's many people, especially the young, viewed a life of religious devotion and chastity as simply abnormal. According to some informants a man had a certain duty to rescue a woman from such a fate. Desperate times require desperate measures. In such a case the use of *isidliso* would be legitimate. Its use by a woman however, was not considered appropriate under <u>any</u>

circumstances. In any case, informants in St Wendolin's said that women had other methods that they used to secure and maintain the attentions of a man, which did not require a special visit to the *nyanga*. For this a woman could always 'doctor' the food which she served to a man by using her own 'substances'. This would entail preparing food with the bath water that she previously used to wash her private parts. This 'home recipe' as it were, is said to make a man 'stupid' and subservient 'like a donkey', but it is believed less powerful and offers no guarantee as does the proper *umuthi* obtainable only from the *nyanga*. "The problem with using *isidliso* is that it has side effects. You can even die from it if it's not caught early and cured." This was the reason given by one woman who maintained that she would never *dliso* a man. The health implications of being a victim of *isidliso* were believed to center around chronic chest ailments, persistent cough and loss of weight. One traditional healer explained its effect as 'corroding and decaying the area between the lungs and the heart.' If left untreated (by a traditional healer), death was said to follow.

3) *Isichitho* – said to be used by someone who wants to provoke the breakup of a marriage or relationship by causing the couple to quarrel. The symptoms here are constant quarreling, verbal and physical abuse, 'cold heartedness', and lack of sexual interest which inevitably leads to separation. *Isichitho* is more commonly associated with women as it is said that she is most often the one who is 'jealous' of other couples' happiness. For this reason men say it is good practice to cleanse oneself routinely through the use of enemas and emetics prepared with good-luck preparations which dispel *isichitho*, and to fortify oneself with *iqondo* mentioned above which helps to maintain love and good marital relations. Beyond this, ensuring that your wife/lover is 'protected' by *iqondo* medicines is said to help negate the effects of *isichito*.

SUPPLY AND DEMAND

The three love medicines described above represent the most popular types of love medicines said to be currently in use locally. Apparently, these major love-related medicines have long been known and used by Zulu people and others. Previous writers have identified a vast range of similar 'magico-materia' used by most African groups in South Africa to secure and maintain love (see Hammond-Tooke 1974, for other examples). Writing on the Lobedu in 1943, the Kriges claimed that love medicines were unknown in the area in which they conducted their research, but were said to be gaining popularity amongst young men who "had come into contact with Zulus and Xhosas in town" (1943:258).

Whether the use of witchcraft love medicines has indeed increased in recent years is difficult to discern. In St Wendolin's there is a widely disseminated perception that there has been a marked increase in its usage which is largely due to women having become new consumers of these medicines, or these 'dirty things', as many people refer to them. The views of traditional healers on this matter were solicited in order to discern any basis to this current perception, insomuch as they are the ones from whom people obtain these medicines. One *sangoma* with a practice in a neighboring settlement, felt there was no doubt about the increased demand for her love medicines. She proudly boasted a new room for her 'surgery', which she said was built by money gained from selling love medicines – particularly *isichitho.* "This one (*isichitho*) is very famous with our people. Especially now. I don't like to sell it so much, but sometimes if a man takes another woman, of course his wife must try something. *Isichitho* will break the husband from that woman." For this *sangoma,* a woman 'throwing' *isichitho* at another woman who had stolen her husband's or her boyfriend's attentions, was considered better than the woman

resorting to physically fighting. Many of the traditional healers interviewed considered the use of *isichitho* not so much as 'bad' because it caused couples to quarrel and separate, but as 'good' because it prevented people from resorting to more drastic means of causing break-ups, such as beating or poisoning the offending rival. Mr Shangase, an elderly *nyanga*, who also claimed high sales of *isichitho*, clearly drew the connection between recent demand for the medicine and increasing promiscuity (and assertiveness) of women in general. "Women today are not shy to do anything they want. If they choose this man, or that one, or the other one, they will go for him. Before, our women were very shy about all this."

Unlike most other forms of love medicines, the use of *isichitho* was more readily admitted on the part of some women informants. Women associated the use of this medicine, which caused quarrelling and separation, with being civilized and more sophisticated when compared to their mothers and grandmothers or women from the rural areas. Most women considered it shameful and vulgar for two women to shout and fight over a man. One young woman commented: "Imagine rolling in the dirt, and pulling skirts, like those women on the farms. It's better to use the medicines to solve your problem today." Other women claimed that using *isichitho* achieved the results without fail, while 'rolling in dirt' with one's rival might anger your male partner and push him further into the arms of the rival. "With things like *isichitho*, you don't have to worry. It works." Such were the words of one middle-aged mother of seven children.

Use of *iqondo* and *isidliso,* love medicines believed to be capable of killing a person or at least making them ill with a range of somatic symptoms, was also said to be on the rise according to traditional healers. But unlike *isichitho,* some healers claimed that they would not agree to make these medicines for a woman unless she beseeched them repeatedly. They might even ask for evidence that her spouse or partner was neglecting his duties, such as not

buying food for his children, or spending all his money on a girlfriend. As use of these medicines was considered to be limited to the realm of legitimate masculine activity, healers always explained their use from the point of view of the male user. The healers claimed that the idea was to make the man's rivals sick, and that this sickness should serve to give the illicit lover the message so that he would end the affair. In this way, the faithfulness of one's lover is said to be assured, with men fearing physical harm should they have intercourse with her. The actual strength of the medicine is said to be determined by the degree of jealousy or anger felt by the client who used the medicine. If the client's anger was 'too deep' or 'too hot' healers say that death could indeed be the fate of the man who slept with the client's 'protected' partner.

THE DOUBLE STANDARD

According to many traditional healers men have long been consumers of the purportedly lethal fidelity-protection medicines, and they continue to buy them today. One traditional healer said that Zulu men buy these medicines 'cash and carry' meaning regularly and frequently. He added: "If he's married or not, a man doesn't want his woman to be with other men." Some healers showed concern for the ethics involved in selling people substances that have the potential to kill, but most say that because people are demanding it, they must give them what they want. "If their heart is so full of anger, it's them who know what will happen. We try to calm their worries but they still want these things, so we give it." The issue of women demanding medicines like *iqondo*, made clear that a double standard of morality applied. The assumption was that while a man has a right to ensure faithfulness on the part of his women, a woman had no such right. Healers shared this view, and showed a general disdain for women using *iqondo*. "This was not made for women to use. Before, it was none of her business. She was happy with one man, but not these days!" The opinion of this young trainee *nyanga* was shared by many traditional healers. The cultural expectation was that a woman should be

happy with one man, whether or not he is faithful to her. But as for a man, it would seem that no such expectation applied, neither in the past nor in the present.

From the point of view of many traditional healers, women's expectations in marriage and in love relationships with men in general had changed. Many traditional healers shared the community's opinion that women's changing expectations were introducing more stresses in male-female relationships and that women's sexual behavior today represented a decline in morality. Nevertheless, these changes obviously had financial implications for those in the business of selling traditional love medicines. Many traditional healers agreed that there had been a real increase in recent years in the sale of fidelity-protection medicines to female clients. Some associated this with the AIDS epidemic, claiming women were more concerned today about their partner's sexual transgressions. The *sangoma* who claimed *isichitho* as her number one best selling medicine, also confessed to selling *igondo.* "Even young women use this. I tell them its dangerous, but I can see that they are serious. If I don't sell it, they'll just go elsewhere. But first I make sure they know what they want."

Some women readily admit that they use love medicines, and some, like Nokwazi, seem to be proud of the fact. Nokwazi, a mother of three children by two former liaisons, said she used medicines to make sure her boyfriend stayed at home. So far, she said it was working, and indeed one of her suspected rivals was 'looking funny' as if she were sick. Nokwazi claimed that this was as a result of the medicines with which she treated her boyfriend. She supported the view of traditional healers that women were using these medicines more today than in the past. "Today if you have children, you need someone to help you. A man who is wasting time with other girlfriends is also wasting the

money. Yes, women today know about using such *umuthi*. We're not stupid anymore." Women in the Catholic Church formations were also aware of what they saw as a new and morally reprehensible trend amongst young women. For them, women using love medicine was akin to women wanting 'to be more like men', even if it meant copying their bad habits. One woman said it was further evidence of girls 'feeling free to poke around like chickens'. She added: "In my days a woman would never *dliso* a man. No such thing. This is witchcraft. Imagine now they even do this'. What has happened to our girls?"

Across the spectrum of men, women, young and old, people in St Wendolin's perceive an increase in fidelity-protection medicines by both sexes which is viewed as a bad and unhealthy trend. It is after all, witchcraft. Nevertheless, there is a marked double standard in its use applied along gender lines. Whereas circumstances may justify their use by men, women's use of love medicines is further evidence of their loss of self-respect and general loss of morality. Using love medicines reinforced perceptions that women were 'out-of-control'. In the eyes of the community it further substantiated the woman-as-witch ideology, and gave new reason to regard her with suspicion.

MALE VICTIMS

General sympathies lie on the side of the man who falls ill if his illness is believed to result from love medicines. The woman who is said to have "done this to him" is the one upon whom the community turns a wary eye. The man's illness would be construed in one of two ways. Either it resulted from what people described as a "desperate woman" using witchcraft, or it resulted from a man who 'protected' his wife/partner with the love medicine, and the victim fell ill as a result of sleeping with that woman. In the first case sympathies go naturally with the man. A woman resorting to witchcraft confirms and validates the cultural symbolism of treachery and danger that a woman embodies. Of all behaviors associated with women, none are more

strongly scorned and condemned as are suspected witchcraft activity. In the latter case, where his illness is thought to result from sleeping with a woman who was secretly 'protected' by a jealous husband or lover, again, the sympathies still lie with the man. The fact that he could be considered as having trespassed on another man's property as it were, especially if the woman was married, or that his behavior might be considered shameful in some other way, was only a minor issue, if an issue at all. The case of young Thoko is illustrative of the general line of argument. Thoko's friends said he was suffering from *iqondo*, an 'infection' he acquired from some 'silly woman' who was not trusted by her new husband. For these boys, Thoko was just a poor victim rather than a fornicator, and the husband who 'treated' his bride was seen as acting judiciously. Time and again through numerous conversations, the point was made that men today were using love medicines because they <u>had</u> to. The shared view of men was that women were promiscuous, and so men had no choice. "This woman's husband was clever to do this. You can't trust women even when they're married. What else could he do?"

The notion that men today had no choice but to resort to love medicines to ensure faithfulness was very pervasive and, I suggest, fundamental to the perceived overall increase in love medicines in the community. Almost everyone (except young women) attributed the increased demand for love medicines to promiscuity on the part of women, with a corresponding increase of worry and insecurity on the part of men. These newfound fears and worries served to justify men's use of love medicines, even those renowned to be 'too strong' and so capable of causing death. As noted earlier in this chapter, even traditional healers represented the whole love medicine issue in this light. Traditional institutions, which many informants said once served to regulate sexual activity, particularly the sexual activity of young women, were

no longer functioning in the urban environment. In St Wendolin's women were asserting their sexual preferences and trying to influence the direction of their love relationships by using *isidiso* and *iqondo*, something that was not done in the past. Only men were supposed to use these things. Women's behavior today was resulting in increased insecurity on the part of men, and his best recourse was, justifiably, to use love medicines himself. Whichever way it was looked at, men were the innocents while women were the guilty culprits. It was *women* who had gone astray. Illness and death due to the use of love medicines was always attributable to the actions of an 'evil' woman.

LOVE MEDICINES AND HIV/AIDS

From the point of view of young women, using love medicines was viewed as part of being less shy and modern, and indeed doing things more like men. As one young school-leaver put it, using love medicines is only considered bad because "men are jealous". In her words, "Why shouldn't we use them? Men have used them all along. They had their way with us, even before marriage. Now they're jealous because they see we can have our way too. It's their problem."

The fact that women today were demanding strong medicines such as *iqondo,* was a subject for discussion at an AIDS training workshop held in 1997 for traditional healers from the Pinetown area. This workshop was part of a series of workshops organized by the AIDS Foundation of South Africa and intended to teach traditional healers about HIV/AIDS. The AIDS Foundation's AIDS Training Program for Traditional Medical Practitioners was established with international funds several years previously, and has since become recognized as the foremost training program for traditional healers in the country (but mostly in KwaZulu-Natal) in AIDS awareness and prevention. The AIDS Foundation's Program originated after a successful pilot project to train South African traditional healers was held in 1992, during which the

anthropologist Edward Green (see Green 1988, 1993, 1994) served as a consultant and workshop facilitator. From his experiences in training traditional healers, Green (1994) argued that there must be much greater effort made to enlist the help of African healers in the fight against AIDS. Green's argument was based upon his observations that traditional healers were widely consulted by people presenting symptoms of sexually transmitted disease. Since then, Green has been involved in establishing AIDS prevention programs for traditional healers throughout Africa. The AIDS Foundation of South Africa took up the challenge of AIDS training for traditional healers from their base in Durban. Their programs consist of a 5-day workshop held at various venues, especially in rural areas, facilitated by a trained staff member. Drama, audio-visuals (where possible) and informal group discussions are used in addition to formal lectures and condom demonstrations. At this particular Pinetown workshop, the opportunity presented itself for discussing the issue of love medicines. The workshop facilitator happened to be a *sangoma* herself, as well as a trained nurse.

In a pre-training session, efforts had been made to assess the healers' knowledge about AIDS, its symptoms, its causes and its treatment. The group of largely female *sangoma* stated that they were very concerned by what they said was an increase in demand for love medicines in the past several years. Many were convinced that the AIDS epidemic and people dying from this 'new disease' was related to the increased use of strong love medicines. These healers claimed that somatic symptoms associated with *iqondo* or *umsizi* were widely used by their clients to describe symptoms that the healers said were actually sexually transmitted diseases. According to many healers, these diseases have been around for a long time and they have always been a common complaint of a large percentage of their clientele, both in the past and today. As witchcraft-related diseases, traditional healers said they knew how to treat them. While cautious not to reveal their exact treatments, the general

method of therapy would include using herbal mixtures to 'cleanse' the blood through emetics or enemas, followed by a regimen of drinking bitter infusions in order to stimulate appetite and 'strengthen' the blood.

While many claimed to know that AIDS was transmitted primarily through sexual activity, many stressed the fact that *their clients* believed otherwise. They claimed that their clients were applying the same causal explanations to HIV/AIDS and STDs, both were caused by witchcraft. Healers claimed that many of their clients whom they suspected of having this new disease of AIDS, believed that their symptoms were a result of being 'infected' by witchcraft, mostly witchcraft love medicines. If persistent coughing was a symptom along with general bodily weakness, a person was likely to claim that he/she had been the victim of *isidliso*. Skin rashes or lesions, especially in the pubic area, along with general urinary complaints or sexual dysfunction, were said to be attributed to *iqondo*. With an ever-increasing number of clients who were suspected to be AIDS patients, the healers consistently emphasized the 'strength' of the AIDS virus which they said made it difficult to treat. In the pre-training session healers made comments such as: "This AIDS is too strong, too much power." "It just sticks in your blood." Another said: "It never really comes out, but it can become weaker." "AIDS is the most powerful disease yet. It's stubborn." There was a general belief amongst many of the healers before training that they could cure AIDS. After the training workshop not a single one was willing to make the claim again. All of them said at this time that their prescribed therapies could help to strengthen an AIDS patient, and therefore help prolong his life. It is apparent that what the healers are doing is <u>treating</u> HIV/AIDS and managing the symptoms. After the AIDS training workshops, in the post-training sessions, healers seemed to have gained a better appreciation of the distinction made in English between *treating* an illness and *curing* an illness, a distinction not made in Zulu.

I would suggest that the problem of language translation plays an important part in sustaining widely-held beliefs regarding traditional healers and their ability to cure AIDS (2). In Zulu there is one term that refers both to the treatment and curing of a disease. This term, *ukwelapha,* makes no distinction between treatment and cure. It is better equated to the English term 'therapy'. That traditional healers do offer therapy for AIDS, and these therapies may indeed alleviate some of the symptoms (at least for a length of time), probably lies behind widely disseminated beliefs that traditional healers can cure AIDS. Traditional healers can and do offer palliative care in this AIDS epidemic (see Appendix 9, page 224). As more and more people start to see more deaths occurring in spite of prescribed treatments by traditional healers, their beliefs in the ability of traditional healers to cure AIDS may or may not weaken. To support their claims and retain their reputations (and guard against loss of clientele), healers could claim that their failure to cure AIDS was a result of the patients not following through with prescribed therapies. As the HIV epidemic matures into an AIDS epidemic of increased morbidity and mortality, much remains to be seen in terms of healers' responses to the changing and worsening physical and social impact of the epidemic.

THE KISS OF DEATH

As discussed in Chapter 4, people believed to be dying or have died of AIDS is a recent phenomenon for the community of St Wendolin's. The fact that the majority thus far has been young people mostly under the age of 40, is taken as 'proof' that witchcraft is involved. When people are young, in their prime, and dying, witchcraft is always suspected. As previous writers on the Zulu such as Krige (1944, 1950), Bryant (1949, 1970), Berglund (1976) and Ngubane (1977) all observed, apart from death from extreme age, all death, particularly death of young people in their prime is always believed to be caused ('sent') by witchcraft. For the people of St Wendolin's, this seems as true today as in the past. When faced with such a great misfortune as the death of a young person

who has had little chance to establish him/herself as an adult member of society, such an event is always suspected to be the work of witchcraft. While angry ancestors may cause illness and other misfortunes, they are not thought to kill. Only an agent of evil intent, an *abathakathi,* would cause a person's death. AIDS-related death, then, is the work of witchcraft.

Exploring African traditional thought, Gluckman (1956) made the observation that thoughts on misfortune involved two questions: how it happened, and why it occurred at all. Previous writers such as Callaway (1870), Bryant (1929, 1949, 1970), Krige (1950), Schimlek (1950), Vilakazi (1965), Berglund (1976) and Ngubane (1977) concur that this same pattern of thought applied among the groups of Zulu-speaking people whom they studied. I would add that it is still applicable today. The immediate 'how' question of disease causation may be answered by common-sense empirical observation. A man is bitten by a snake, so he falls ill, for example. A child falls in a river, so he drowns. People do not dispute these immediate causes of a mishap. In the case of new illness conditions such as HIV infection or AIDS-related illness or death, people in St Wendolin's are, for the most part, prepared to accept the media health campaign notion that it is caused by sexual contact with an infected individual. Many diseases and debilitating conditions, as discussed earlier in this chapter and in Chapter 5, are believed to be caused by sexual contact or intercourse with a woman. This immediate causal explanation is self-evident. However, answers to the 'why' questions; why me? why now? why here? for example, are more elusive.

Causal explanations used in the case of the death of Nomusa's sister are illustrative of the common genre of ethno-explanatory models used for HIV/AIDS in St Wendolin's. Nomusa, a trained nurse, became the guardian of her sister's two small children when her sister, an unmarried woman, recently died from what Nomusa herself said was AIDS. Nomusa, who has been

involved in AIDS education and the counseling of HIV infected persons, confessed that her sister had many boyfriends, 'just to help her with the bills and food for the children.' Nevertheless, from Nomusa's point of view unsafe-sex with an infected partner did not provide all the answers needed to explain her sister's death at age thirty-two. Three days after the funeral, Nomusa sought answers from a local *sangoma*. The *sangoma* revealed that her sister had never properly informed the ancestors about the birth of her two children. Moreover, according to Nomusa's account of the *sangoma's* revelation, one of her sister's boyfriends had a jealous wife who 'did something' which, in Nomusa's words, 'brought out that AIDS'. With the sister dead and buried it was too late to do anything that could possibly help mediate against the effects of witchcraft used by the jealous wife. However Nomusa quickly arranged to have beer brewed and a goat slaughtered in order to inform the ancestors of the birth of the two children living with her, now aged four and six. By doing this Nomusa was helping to ensure that they did not fall sick, or reap the misfortunes that their mother had reaped. While the general belief was that the ancestors would never cause one to die of AIDS, they could, if not given proper attention, take away their protection and leave one vulnerable to all sorts of misfortunes, including HIV/AIDS infection. For the people of St Wendolin's, one way to help guard against HIV infection, was to 'boost the spiritual immune system', so to speak, by maintaining good relations with and hence ensure the protection of one's ancestors during this time of AIDS.

Informants were often quick to point out that even Western science provided no sure answers for the ultimate explanation of AIDS. AIDS educators are still unable to say where AIDS came from or how it originated. Why some people get infected while others do not, still cannot be adequately explained. Witchcraft, from the point of view of informants <u>can</u> provide the theory of ultimate causation. It can explain the 'whys' of this current epidemic. Sex with an infected person may transmit HIV, but for many people in St Wendolin's,

notions of ancestral protection and witchcraft can help fill in the blanks regarding illness and death related to AIDS.

The distinction drawn between the immediate and ultimate causes of AIDS featured in peoples' conceptualizations of the difference between HIV infection and AIDS illness. Informants often referred to what they called the 'problem' of HIV infection – that it had no physical symptoms. Such an invisible state of infection was reinterpreted through the people's understanding of *umnyama*, the 'darkness' an invisible pollution associated most especially with women. Only with a *umnyama* condition can one be simultaneously 'infected' and yet not show any somatic symptoms. As sleeping with a woman in an *umnyama* state can 'weaken one's blood', predisposing one to illness and misfortune, so too is HIV infection said to predispose one to illness. "We hear them on the radio. HIV is the baby, AIDS is the mother. HIV just sits there waiting. But the mother .... she can kill you." This is how one informant saw the relationship between HIV and AIDS. Both HIV and AIDS were conceived as 'germs' or 'dirt' that could get into one's blood. HIV is said to be weak while AIDS is strong. But while some people saw a direct relationship between HIV and AIDS, others saw them as separate and distinct 'germs'. Among those who saw HIV and AIDS as related, the common view was that witchcraft caused the HIV 'germ' to 'come alive' or 'grow' and produce AIDS. In general there seemed to be no certainty amongst informants about the exact nature of the relationship between HIV and AIDS. What could be considered as a general understanding of how HIV, a weakening condition, relates to AIDS, a witchcraft killer, was difficult to discern. For some, HIV infection represented a witchcraft-induced condition as well as a 'darkness' *umyama* condition at the same time. For others HIV was simply 'darkness' that predisposed one to become easily affected by witchcraft that caused AIDS.

What became obvious to me in the course of persistent questions to gain insight into the relational process of HIV and AIDS, and to understand it as the

What became obvious to me in the course of persistent questions to gain insight into the relational process of HIV and AIDS, and to understand it as the people themselves understood it, was that people simply do not have any clear or consistent understanding on this matter. More importantly, it did not really seem to matter to anyone except the person asking the questions. Nobody (except me) showed concern with understanding the logical sequence and mechanistic functional detail. For the most part the people of St Wendolin's showed no real interest in unraveling the etiological details of HIV and AIDS. The nature of the precise conceptual relationship between HIV, the predisposition, and AIDS, the illness, is unclear, but one thing is very clear, they both involve the agency of women. HIV infection, the latent, mysterious condition which 'hides in the blood,' is construed as 'something you get from women', and 'something that lives in women'. It is a feminine condition that women transmit to men, and they then pass it on to other women. AIDS-related illnesses leading to death are commonly attributed to witchcraft, and much of it is traced to the use of powerful love medicines, either *by* women or *because* of women.

Interpretations of HIV and AIDS among the people of St Wendolin's may reflect a large degree of logical inconsistencies and incomplete understandings, but they share an important unambiguous causal element: the violation of patriarchally-inspired and still voiced rules and norms governing female sexual behavior. Current discourse on AIDS in St Wendolin's points in common conceptualization to a problem in the social control of women's sexuality. The ancient symbolic construction of woman-danger-disease-and-death that writers such as Patton (1985 and 1994), Treichler (1988), and Wilson (1997) have argued has informed the sexual politics of AIDS in the West, I believe is deeply embedded in the metaphoric thinking that signifies the current HIV/AIDS epidemic in St Wendolin's. How these 'gendered' notions of HIV/AIDS extend

Notes

1. This list of symptoms is by no means inclusive. Bryant (1970:55-59) refers to all matter of lower pelvic complaints held to be the result of illicit intercourse with the wife of a man who has previously 'treated' her. Different terms including *izembhe*, *iqondo*, and *umsizi* refer to this category of illnesses and the charms or medicines believed to have caused them. Schimlek (1950), a Mariannhill missionary who wrote on witchcraft-related beliefs among the Zulu in the St Wendolin's area during the first half of this century, went so far as to say that *iqondo* was in fact the most frequent illness complaint of Zulu men. The ailments believed to be traced to *iqondo* included bilhazia, hernia, sore back, tuberculosis, syphilis and most probably 'any disease known to science' (Schimlek 1950:287). Schimlek quoted an *sangoma* who claimed that *iqondo* was really venereal disease, while a certain Dr Kohler of the medical mission interpreted iqondo as 'the neurosis of the Native male' (Schimlek 1950:283).

2. There is much popular debate in St Wendolin's and amongst Africans more generally on whether or not traditional healers can cure AIDS. Local newspapers such as *Ilanga* or *City Press,* which target an African readership regularly contain advertisements by traditional healers who offer cures for AIDS. Such adverts, I believe, serve to reinforce the widely held belief amongst many people in the province that traditional healers can cure HIV/AIDS, in spite of the fact that modern medical practitioners say there is no cure for this new disease (See Appendix 9, page 257).

CHAPTER 8
MYTHS, METAPHORS AND GENDERED BODIES

> "Women who have AIDS must just go to the *nyangas* who have herbs to cure this sickness. They mustn't do like Gugu... going around advertising how dirty they are to all the neighbors. Sis!" .... (26-*year-old female informant commenting on the recent killing of a local woman AIDS activist in a near-by township)*

Clatts and Mutchler (1989), two of the first anthropologists to have studied the metaphors attached to HIV/AIDS and the implications which metaphorical thinking holds in relation to peoples' response to the disease, have argued that metaphor focuses our attention by crystallizing specific constellations of meaning and orientating our thought in particular directions. This chapter analyzes some of the metaphors attached to the idea of AIDS in St Wendolin's that are viewed as significant for understanding how the disease has been gendered, and how women have been 'demonized' through the gendered meaning-making process.

Gender as a construction is often linked in peoples' thinking with biology, but, as feminist writers of the past few decades have argued, it is neither caused by nor simply a response to biological differences. From a feminist constructionist perspective, notions of gender are socioculturally constituted. In a very literal way notions of gender are 'man-made' constructions, in the sense that they have been shaped and are still being shaped in a male-dominated world. Most writers of the past decade who have focussed on issues of gender in relation to AIDS, including Fee and Fox (1988), Berer and Ray (1993), Squire (1993), Patton (1985, 1990, 1994) and Wilton (1992, 1996, 1997) have worked

within a constructionist paradigm (see Chapter 2, Literature Review for more discussion on the works of these authors). As previously mentioned, Foucault (1976) was one of the first writers to draw out the sociocultural forces that act upon the human body and firmly locate it in a 'political field'. He stated:

> The body is directly involved in a political field; power relations have an immediate hold upon it; they invest it, train it, torture it, force it to carry out tasks, to perform ceremonies and to emit signs. (Foucault 1976:25)

In exploring the 'body politic' of AIDS in St Wendolin's, special attention needs to be paid to the discourses that deal with bodies and their functions, and the metaphors that signify them. Wilton (1997) argues that bodily differences between women and men play a key part in maintaining what she calls 'reproductive heteropolarity'. I shall argue that bodily differences not only help to maintain 'reproductive heteropolarity' in St Wendolin's but they also play a significant role in the symbolic representation of HIV/AIDS as a 'female' disease.

'DIRTY' BODIES

Jewkes and Wood (1999) have recently argued that previous South African medical ethnographies (i.e. Krige 1944, Bryant 1949, Krige 1963, Ngubane 1977, Hammond-Tooke 1970, 1981) have generally failed to problematize sufficiently the notions of pollution and 'dirt' while generally consigning them to the causal category of 'ritual pollution'. An analysis of women's reproductive health discourse in the Eastern Cape have led Jewkes and Wood (1999) to suggest that notions of 'dirty wombs', which appeared to be widespread among their informants, may represent a category of disease used as an idiom to express illness. My research would support this suggestion. In St Wendolin's notions of 'dirtiness' form part of the popular representation of illness generally. I would argue that ideas of bodily 'dirt' and 'dirtiness' among the Zulu represent a *broad ethnopathological explanatory model for disease that extends beyond*

the narrow category of 'ritual' pollution. While some South African ethnographers such as Hammond-Tooke (1981) have explicitly striven to keep various etiological categories of disease 'analytically separate' (for example ritual pollution and witchcraft/sorcerer), I would argue that such an academic exercise serves to limit our understanding of local disease etiology because it ignores the context of the human experience of illness. 'Dirtiness' as a form of non-ritual pollution is, I suggest, a central concept of disease among the Zulu though which other causal factors (such as witchcraft/sorcerer, the ancestors, etc.) work. Rather than being an alternative causal typology, 'dirtiness' should be understood as an explanatory model for illness. The state of being 'dirty' is an idiom through which illness and illness symptoms, whatever the cause are discursively represented. Thus, an understanding of the meanings attached to notions of bodily 'dirt' and its relation to the illness process is central to any attempt at understanding the meanings attached to specific disease among the Zulu. In addition, an understanding of what medical anthropologists often refer to as 'folk models' of the human body is crucial when trying to understand indigenous explanatory models for disease. My argument that HIV/AIDS is primarily construed as a 'female' disease draws upon these 'folk models' of illness processes and human (in this case female) bodies.

Conceptualizations of women's bodies in St Wendolins are similar to those reported from Botswana (Ingstadt 1990), Kenya (Udvardy 1995) and Tanzania (Haram 1997), whereby they are perceived as places which hide and harbor disease. The notion of women's bodies as suitcases which conceal and transport disease to others (see Ingstadt 1990) resonated in the descriptions of female anatomy by my informants. One young man, a newly qualified school teacher, claimed that germs 'like all those folds and curves inside a woman' because they can 'hide and grow'. Along with notions that women's bodies, as opposed to men's bodies, are believed to have more and better hiding places for disease-causing agents, informants often made reference to women's 'wetness' as a characteristic associated with disease. A woman's vagina and

womb were the two places most often identified by informants as places where HIV/AIDS 'hides' or 'sticks' and 'grows'. The HIV/AIDS virus is discursively represented as a strong 'germ' or 'dirt' that 'easily enters the blood'. According to the local 'folk model' of the human body there is a general notion that any 'dirt' or 'germs' that are responsible for causing illness anywhere in the body, whether from a 'dirty' stomach (causing stomach-ache, diarrhea, constipation, etc.) or 'dirt' from a 'dirty' chest, (causing persistent cough or other bronchial symptoms), or 'dirt' from 'dirty' kidneys (causing painful urination, lower backache, etc.), has the ability to 'mix with the blood'. When 'dirt' mixes with blood the result is said to be more generalized illness symptoms than those associated with specific organs. Related to this idea is the notion that all organs in the body are believed to be inter-connected. Thus 'dirt' causing illness in one part of the body may be conveyed to other parts of the body, via the blood, and cause illness symptoms in those other parts. Women have several unique anatomical features that are closely associated with disease processes. For one, there is a notion that the vagina is not a closed organ, but rather a 'passage' that opens into the womb and into the rest of the body. According to informants menstrual blood may consist of many different kinds of 'dirt' that may have accumulated in any region or organ in the body and then 'mixed with the blood'. From an ethnomedical perspective, menstruation is a process by which the body cleanses itself. Women's menstruation then, I suggest, is polluting not only in a metaphorical sense because it represents something 'out of place' in the natural order of things, (i.e. displaced nourishment for a growing fetus, a point of discussion in Chapter 5), but it is polluting in a very 'real' sense because it mixes with and conveys 'dirt' from other parts of the body. As menstrual blood passes through the vagina, informants say that some of this bodily 'dirt' will 'stick' to the inside of the vagina (because it is said to be 'wet'), and mix with secretions there.

Like other 'germs' that are being expelled or 'cleansed' from the body during menstruation, HIV/AIDS 'germs' are also believed to be expelled during menstruation. However menstruation is not seen as a way to 'cleanse' all HIV/AIDS from the body since it is believed that those 'germs' can, like other forms of bodily 'dirt', mix with the blood. One woman put is this way: "When a woman bleeds, the dirt all comes out down there. But with AIDS, most of it stays in your blood because it is strong. But of course the rest that comes out .... I think most of that just sticks inside. You really only know with a blood test." The idea of a blood test featured prominently in people's discourse on AIDS. Having a blood test was said to be the only way that one could 'prove' HIV/AIDS infection. As mentioned in the previous chapter informants often referred to the so-called 'problem' of AIDS – that it had no physical symptoms.

The theme of a 'wet' vagina and its ability to cause 'germs' or 'dirt' to 'stick' to its walls featured prominently in informants' discourse on sexually transmitted diseases and HIV/AIDS. One young nursing student described HIV infection in this way: "Women are wet down there. When they have an infection the germs just stick inside and smell. You can smell these infections like HIV or whatever. With men you can't." One young man expressed his sexual anxieties with reference to similar beliefs about the vagina. "Inside there it is dark, wet, not nice. AIDS can live there, waiting, and you don't know. Maybe the woman herself doesn't know because it just sticks. She really needs a blood test to know for sure". His friend added that today many men are afraid to touch 'down there', because HIV or AIDS can 'stick to your fingers and might pass to your blood if you have a scratch.'

As discussed in Chapter 1, the idea of latent disease is not a well-developed notion in the ethnomedical beliefs of the Zulu. Previous writers such as Krige (1950:331) and Bryant (1970:315) have noted that disease is usually defined by its somatic symptoms. This is still largely the case in St Wendolin's today.

With no symptoms, there is often believed to be no disease. With the 'new disease' of HIV/AIDS, popular media and professional medical discourse on the disease emphasize the long a-symptomatic period of HIV infection. For the people of St Wendolin's, the idea that a blood test can reveal HIV/AIDS infection – a disease that can have no symptoms – seems to hold a special significance. For one thing, it represents the uniqueness and the mystery of Western scientific medicine. The all-telling blood test is what stands between a person and confirmation of HIV infection. Informants concur that blood tests cannot discern general *umnyama* ('ritual' pollution) arising from birth, menstruation or death. This was often attributed to the fact that modern medicine simply does not have the right tools or abilities necessary for such a diagnosis. Only traditional healers had the necessary means for diagnosing such *umnyama*. HIV infection is a new and different kind of pollution. Some people say that only modern doctors can diagnose AIDS, while traditional healers cannot diagnose it. Healers themselves often say that western doctors are better at diagnosing HIV/AIDS than they themselves are. Nevertheless, most people believe that traditional healers can 'cure' AIDS, after a modern blood test has confirmed its presence. It is the blood test that gives modern doctors the edge, the final say in the matter of HIV/AIDS diagnosis.

As noted above, while many informants think that some HIV and other 'germs' in the blood can be expelled through menstruation, menstruation alone is not believed to be a completely effective way to rid the body of illness. This is especially true of HIV infection, as it is said to be a type of 'germ' that is exceptionally 'strong'. Along with its positive associations with fertility, I would suggest that menstruation has a positive dimension as a kind of innate curative process available to women to guard against disease or, ethnomedically speaking, the build-up of too much bodily 'dirt'. Nevertheless I suggest that it is exactly from this ability, the fact that she menstruates, that a woman largely derives her characterization as 'dirty'.

From the point of view of the people of St Wendolin's, women menstruate as a way to expel bodily 'dirt'. To say a woman is menstruating is to say that she is 'cleansing'. A man must avoid intercourse with a woman who is 'cleansing' or he can expect to be 'infected' by any manner of bodily 'dirt' that may have mixed with her blood and is being conveyed out of her body through her vagina. The regularity of menstruation has meaning as evidence that the accumulation of bodily impurities is a natural property and process of women. With the continual functioning of what informants describe as an automatic cleansing system, the physical proof is there of a woman's natural 'dirtiness', a 'dirtiness' that is simultaneously proof of her very real power, her fertility. This would support Douglas' (1972) theory that both positive and negative valences are reflected in the particular substances that a culture codifies as 'dirt'. Informants, both male and female, say that nature has provided women with the natural ability to expel 'dirt' through menstruation because she <u>needs</u> such an ability. In the eyes of the community women are 'dirty' then, not only in a ritual or metaphorical sense, but their 'dirtiness' has meaning in a very real physical sense.

Notions of women's 'dirtiness' are echoed in descriptions of anatomical differences between male and female sexual organs. A women's vagina is 'inside' and 'open at top' while a man's penis is 'outside' with only a smallish opening often described as a 'tube' leading inside the body. Like menstruation, men can expel any manner of bodily 'dirt' through their semen or urine, but their particular reproductive anatomy is generally not associated with 'germs' or 'dirt' that 'hide away', 'sticking' or 'waiting' or 'sitting nicely like a baby' as one male informant described 'dirt' in the womb that causes STDs. Images of a wet vagina that is believed to open into a dark nest-like womb (that is discursively represented as attached to or part of the stomach and interconnected in a complex way with other internal organs that convey blood and 'dirt' between

them), is reflected in informants' descriptions of female reproductive anatomy. A man who has intercourse with a woman who is 'cleansing' (menstruating), is said to run the risk of having his own blood contaminated with his partner's 'dirt' (whatever kinds of impurities she is harboring and which are 'mixed' with her own blood). While some of her bodily 'dirt' will be dispelled along with the menstrual flow, informants say that some of it can be expected to 'stick' to the walls of the vagina. If one of the impurities or kinds of 'dirt' found in a woman's blood or sticking to vaginal walls happens to be an HIV/AIDS 'germ', then that is what informants say will be conveyed to her sexual partner. Some young women believe that toothpaste used to clean the vaginal area after menstruation can help to 'kill' some of the 'germs' left lingering. Many confess to being unsure whether HIV/AIDS 'germs' can be destroyed by this method because HIV/AIDS is 'too strong'. One 16-year-old girl said that most infections 'down there' can be cured by applying toothpaste regularly on the sores or inside the vagina for two to three days. Like many other young women, this girl believed that HIV/AIDS was 'too strong' to respond to the use of toothpaste alone. Most informants concurred that HIV/AIDS required additional treatment with traditional medicines.

In spite of AIDS education and media messages which emphasize the opposite, people in St Wendolin's believe that HIV/AIDS can be passed through sex with a menstruating woman, but so too are many other diseases believed to be potentially sexually transmittable by menstruation. Even when she is not menstruating people say that any 'germs' that a woman may be infected with are still likely to be lingering in the vagina after menstruation. One woman said that if a man wanted to avoid HIV or any other infection, one of the best things he could do was to wear a condom at all times. "Germs are always there. It's where they come out. A woman knows she must clean there often." Green (1997) found similar ethnomedical beliefs regarding the sexual transmittability of a wide variety of illness conditions in other Nguni groups in both Swaziland

and Mozambique. Some of those identified by informants in St Wendolin's included TB, conjunctivitis, urinary complaints, biliousness, and skin rashes. "If she is sick with these 'germs' then a man can get them if he sleeps with her." Such was the claim of one young man who pointed out that because 'germs' can 'stick' to vaginal walls, a man may get an infection even when a woman is not menstruating. Like many others, this young man referred to HIV as an example of a particularly 'stubborn'germ' and for this reason it was believed to 'hang about' inside a woman's vagina between menstrual periods. "The HIV is always there," said one young nursing student, "it doesn't leave the body easily."

Along with the idea that things like bodily 'dirt' can come down into the vagina, so too it is believed that things can 'go up' the vagina, but need not necessarily come back down. The idea that a condom may remain and 'get lost' in the vagina is widespread, and was noted by Abdool-Karim et al (1995) in a study of sex-workers who plied their trade between Durban and Johannesburg. Not only is this fear commonly expressed by the women in St Wendolin's, but so too is there an expressed fear that the condom might break or slip off and 'float around inside' eventually finding its way up into the body and causing grave illness. One woman explained the problem thus: "What if it goes up to the heart or even the throat? It can choke you and then you'll die." Another suggested that a lost condom could get 'twisted inside', thus obstructing blood flow and causing high blood pressure.

From an analysis of people's discourse on 'dirt' and 'germs', menstruation and the 'sticking' quality of vaginal walls, I would suggest that people's beliefs about the sexual transmission of disease are being 'reinterpreted' (at least discursively) through their understanding of western germ theory. Sleeping with a woman (menstruating or not) can 'weaken a man', according to popular beliefs. How this is possible, through what biological agency or function, is

often explained with reference to notions of 'dirtiness' and bodily 'dirt'. Others make use of western biomedical terminology and notions of 'germs' identified as the invisible agents that 'weaken a man' and cause disease. As much as *umnyama* is 'ritual' pollution in the form of an invisible pollutant that can be passed to others in a mysterious way, so too are 'germs' and 'dirt' conceived as being invisible pollutants that can be passed onto others in a mysterious way. Behavior reflects competing notions of pollution in St Wendolin's as well as the 'reinterpretation' of traditional ideas of ritual impurity using the idioms of 'dirt' and germ theory. Traditionally people returning from a funeral would dip their hands into a special liquid consisting of bile juices from a slaughtered beast, in order to cleanse themselves of death *umnyama* (see Vilakazi 1965, Reader 1966, Berglund 1976). In St Wendolins today, in Catholic homes at least, a bucket of plain water and soap is sometimes provided for returning funeral attendants. Said one man whose son was buried in the morning: "They can use soap to take off whatever germs come from the graveyard. Why not? It does the job." One of the Catholic Church 'mothers' who commented on the use of soap and water in place of the traditional bile mixture to clean death-*umnyama* said: "Our people are afraid of nonsense. Today you can kill germs. They're just worried about old things that don't exist."

VAGINAL ANOMALIES

As discussed, images of a naturally 'dirty' woman are strongly reflected in informants' descriptions of female sexual anatomy. Discursively, it was not uncommon for both men and women to represent vaginas and vaginal fluids by using the same idioms as those used when describing illness symptoms. One middle-aged woman described the whole female crotch area as a large festering sore, occasionally bleeding, often oozing and sometimes painful and itchy. It is a moot point whether these depictions reflect deep-seated cultural constructions of females below-the-waist, or whether they reflect current realities of the very high incidence of sexually transmitted diseases and vaginal

infections said to be rife in this province and thought to be a primary co-factor in the high rates of HIV infection (1). One female traditional healer from the St Wendolin's area offered the view that Zulu men generally find vaginal fluids to be foul smelling, 'dirty' and even evidence that a woman is promiscuous. Secretions of any kind or quantity were also said to be associated with the presence of sexually transmitted diseases. Young women attest to the association between promiscuity and vaginal wetness. Many of them stressed the importance of being 'dry and clean' when sleeping with a man for the first time. This was considered necessary in order for a man to believe that you were 'like a girl' and not 'someone with many boyfriends'. The ability to give the illusion of virginity by having a 'tight and dry' vagina was considered part of a woman's sexual repertoire (2).

As part of their sexual knowledge, women in St Wendolin's are familiar with methods and substances which are said to 'dry' and 'clean' the vagina and hence make it more sexually acceptable to men. In a study of commercial sex-workers, Abdool-Karim et al (1995) noted the use of a douche made with Jik (bleach), Dettol or Savlon (topical antiseptics) as forms of contraceptives. Women in St Wendolin's say that these substances not only 'kill sperm' and other 'germs' but cause the vagina to 'tighten up'. Women say they 'feel fresh' after such a douche. Other vaginal substances identified by informants include snuff, bicarbonate of soda, toothpaste, or plain salt. The most popular substance seems to be coarse salt (the brand name 'LION' is often referred to) which is put into the vagina before intercourse. Women say it must be introduced not less than half an hour before intercourse so as to allow it to 'do its work', that is dissolve and supposedly make the vagina more arid and clean.

Women claimed that a dry vagina was more pleasurable for men, causing them to ejaculate more quickly, and assisting those with a small penis or one, which is 'too soft to do the work'. I would suggest that beyond the pleasure principle

lies a psychological principle; the dry vagina may help to allay male fears of entering the potentially dangerous 'passage' where female 'wetness' is perceived as and associated with contamination and 'germs' of all kinds that have 'descended' from other parts of the body. One woman who confessed to using LION salt 'just sometimes' because the juices were 'too much and you needed a pad', said simply that 'vaginal juices contain dirt that has to be removed from the body.' She added that men prefer a woman who is 'tight', and 'clean' because they (the men) 'didn't have to work so hard.' The use of similar substances to dry and tighten the vagina have been reported from other African countries (see Arnfred 1989, Runganga et al 1992, Brown et al 1993 and Green 1994).

Conceptualization of the vagina as a diseased passage lined with an unhealthy/undesirable contaminating female wetness, has implications for what is considered as normative or acceptable sexual behavior. According to female informants, any sexual activity that involves contact with a woman's genitalia, other than by rubbing or penetration with a penis, would be perceived by male partners as unnatural and 'unAfrican'. Female informants said that manual stimulation of a woman was never done by a man using his fingers. Rather, he would rub his penis against her vagina. Touching a woman 'down there' was considered 'unhealthy' and generally taboo. One elderly woman who assisted with AIDS awareness efforts in the community maintained that from a Zulu man's perspective, the proper place for a man's sex organ was in contact with a woman's sex organ. Women were adamant that cunnilingus was not a normal part of a man's sexual repertoire. "He would call me a witch if I even suggested such a thing! Why would I want to make him sick? This thing is just too dirty." "That's like saying go dig in the rubbish. Do I want him to be a dog?" With the loss of traditional activities such as intracrural sex, sexual activities other than penile penetration do not appear to be very common (See Chapter 9 for more discussion on this matter).

For the most part, it would seem that sexual relations among the Zulu are largely synonymous with coitus. The association of sexual activity with coitus even extends to the arena of commercial sex. Abdool-Karim et al (1995) and Varga (1997a) have noted that sex workers refused requests for oral and anal sex as these practices were considered totally unacceptable. According to Abdool-Karim et al (1995:1522), such attitudes were a reflection of 'strong cultural taboos against these forms of sexual activity.' The previously discussed study by Hadden (1997) on sexual attitudes and behaviors in a large KwaZulu-Natal township, also attests to a general reluctance towards engaging in forms of sexual expression other than peno-vaginal sex. These findings would tend to support other studies in sub-Saharan Africa that strongly suggest that vaginal intercourse is the dominant sexual behavior (see Mann et al. 1988, Pellow 1990 and Hunter 1993). Other forms of sexual activity are commonly associated with prisoners or even 'whites' and are said to be abnormal or at least 'not the Zulu way' of doing things. As one young man put it: "We Zulus are simple people when it comes to those things. We don't need all these fancy methods like whites. We do the thing and that is enough."

VIRGIN CURES

In her ethnographic study of medical notions among the Zulu, Ngubane (1977) made the point that compared to other bodily emissions, female sexual fluids were a class apart. That author attributed the unique status of these fluids to the fact that they represented a woman's power in the form of reproduction. It is within the context of patriarchally structured and dominated Zulu society that the dank-and-diseased model of female sexual anatomy must be considered. Douglas (1966) argued that polluting substances (read vaginal secretions) symbolize threatening forces that pose a danger to the very symbolic order that produce them. The vagina is the primary site of male pleasure along with being the site or 'avenue' of birth. It is a potent symbol of a woman's sexual and reproductive power, both seen as necessary ingredients of life. Patriarchal

fears of female power all coalesce in the symbolism of the vagina; the dark, wet, mysterious passage fraught with hazards in the form of disease and filled with delights in the form of bringing sexual pleasure and new babies into the world. I would suggest that the strong condemnation of the vagina and its secretions can be seen as essentially an expression of culturally-defined patriarchal fears and insecurities vis-à-vis a woman's inherent power - a power which is at variance with her social inequality and lack of power in society.

The ambiguous nature of the vagina is also articulated and manifested in local mythologies regarding techniques believed to cure AIDS; techniques that draw upon symbolic representations of the contaminating 'wetness' of women. In St Wendolin's there is a widespread notion that sexual intercourse with a virgin can cure a man of HIV infection and AIDS. While most women informants say they do not subscribe to such a belief, they did however think that this myth was widespread among Zulu men, particularly those from rural areas. My experience in St Wendolin's, as well as my participation in AIDS education programs throughout the province have led me to conclude that this belief is more prevalent than local authorities and HIV/AIDS educators care (or want) to acknowledge. I would suggest that this belief may be a significant factor in the reported rapid rise in the past few years of sexual abuse and HIV infection among young girls in the province (see Appendix 10 page 258).

According to this 'virgin cure' myth, a man can 'clean' his blood of HIV/AIDS 'germs' through intercourse with a virgin but the girl herself will not be infected with the 'germs' in the process. Questions put to informants about the 'virgin cure' revealed that there was no concensus as to what qualities associated with virginity gave the girl a special 'immunity' against acquiring HIV infection from the 'infected' male sexual partner. Basically there are two competing arguments used to explain the process. Some say a virgin avoids infection by nature of being 'closed up there'. The vaginal passage into the body is seen as

being 'sealed off' by the intact hymen. The intact hymen is viewed as a barrier that prevents the HIV 'germ' from getting into and settling in the girls' womb and into her 'blood'. This belief is somewhat akin to beliefs found in West Africa whereby certain sexually transmitted diseases are thought to be transmitted in the form of a worm entering through a man's urethra after sex with an infected woman (Green 1994:88). The worm is said to be killed when it comes up forcibly against an intact hymen. An alternative view offered by informants to explain why a virgin girl is believed to have a special immunity against HIV infection (and other afflictions believed to be sexually transmitted), has to do with her 'dry' vaginal tract. Generally speaking a pre-pubescent girl is not seen as having the vaginal secretions of the adult woman. Her vaginal tract, yet undeveloped, is perceived as 'clean', 'dry', 'uncontaminated', as she herself is considered morally 'clean'. Not being 'wet inside', informants say that 'germs' cannot 'stick' easily. One woman used the analogy of taste: "You can only taste something on your tongue because it's wet, the taste can stick there. You can't taste things on your hand. It's dry". Another referred to the case of nurses in a rural Zululand hospital who were reported a few years ago to have shown their displeasure over working conditions by throwing vials of HIV-infected blood around hospital wards. "You see, patients could get that infection if it touched their eyes or lips or bleeding wounds. Not if it fell on their skin. It can only stick on those wet places". Moist anatomical surfaces in general seem to be associated with disease as places where 'germs' can 'stick'. These related qualities of wetness and disease are also qualities associated with adult, post-pubescent women.

PRIMORDIAL HOMEOPATHY

Perhaps the underlying thought pattern being reflected in the discourse on 'virgin cures' may be found in the homeopathic principle which previous writers such as McCord (1919), Schimlek (1950), Bryant (1970) and Berglund (1976) have all described as a fundamental central tenet of Zulu traditional magico-

medical ideology; namely sympathetic magic. Sumpathetic magic draws upon ethnopathological notions of homeopathy whereby 'like produces like'. Medical conditions are believed treatable by substances that are symbolically associated with the conditions. For example, a bald man will be treated with herbs from gardens with a profuse growth; cowardice is treatable by consuming pieces of a lion's heart; talkative aggressive women may be treated for this 'illness' with parts from a timid sheep, etc. These are just a few examples of some ethno-therapeutic processes that involve the manipulation of symbols as well as material substances, and that may be relevant to an understanding of some contemporary responses to HIV/AIDS.

Like things and similar behaviors, as well as similar sounds and colors are thought to produce the same effect. Berglund (1976:354) referred to these notions as 'sympathetic associations'. Along with sympathetic associations used in medical treatments are "antagonistic associations". Here, things associated with each other are thought to act against each other (Berglund 1976:352). They are antagonistic *because* they are similar. Perhaps the young pre-menstruating girls are sufficiently similar to the adult woman (from whom men have obtained their HIV infection) but are considered uncontaminated and 'antagonistic' insofar as their effect on HIV is concerned. Beliefs about the curative capacities of young girls are probably closely linked to ideas that the potential 'sticking place' of the HIV 'germ', the vagina, is clean, dry and therefore clear of those contaminated and contaminating metaphors of women, - her vaginal secretions and the disease potential which they represent. Adult woman gives AIDS, girl child takes it away.

The City Press, (15 September 1998) a South African newspaper which specifically targets an urban African readership, has recently published an article claiming that the 'virgin cure' is also widespread among Xhosa-speaking people in the present-day Eastern Cape province. Although there is a lack of

clear figures upon which to base such a suggestion, my fieldwork experience and the persistence of rumors in the community about men coercing young girls into sex in an effort to 'cleanse their blood' leads me to conclude that the activity is more widespread than is thought.

It is worth noting that there are some interesting parallels with techniques formerly used in European societies, which were once believed to cure men of venereal diseases. Smith (1979) tells us that English men of the last century believed that intercourse with a child virgin would cure VD. Quack doctors kept special brothels in Liverpool, since 1827 at least, to provide this cure. The girls used were often imbeciles. Smith described a court case in 1884 whereby a man with 'bad syphilis ulcers' raped a girl of fourteen years. His defense was that he had not intended to harm her, but only to cure himself (Smith 1979:303). Such ways of dealing with STDs in Europe during the last century have disturbing similarities with ways of dealing with AIDS in some parts of Africa today.

CONTAMININATING BABIES

Pregnancy and motherhood were traditionally a Zulu woman's central duties and responsibilities as a wife, and both are still profoundly burdened with significance on a psychological and sociocultural level. Mature status is accorded a woman who bears a child. Fertility was and is all-important. A barren woman is still a much pitied person. But a mother who gives her baby a fatal disease along with giving life is, in the eyes of the people in St Wendolin's, the opposite of a mother. The peri-natal spread of HIV infection further compounds and reinforces the woman-disease-death imagery. It also lends support to the shared notion of HIV/AIDS being a particularly strong and stubborn 'germ'. As discussed throughout this thesis the 'dirty' woman and her foul fluids have long represented a danger to men. Now, through her 'new' capacity to give birth to babies born with weak blood 'dirtied by AIDS' (as

informants say), a woman is further demonized. With an HIV/AIDS infection, a woman becomes a threat to the health and safety of both men and children.

Women are blamed for the birth of HIV-infected babies in St Wendolin's, a problem that is just starting to make itself known in the community. "How can a woman do this? This is so sad. What can you do with such a child?" These remarks by an elderly woman portray the woman as if she had some kind of choice in the matter. According to many people in St Wendolin's, a pregnant woman does have a choice, to the extent that it is up to her to make sure that her womb is 'clean' before and during pregnancy. A 'dirty womb' (*isibelethu singcolile*) is an emically constructed disease category that is associated in St Wendolin's with a wide range of reproductive health problems, from sexually transmitted disease to infertility and cervical cancers. A woman, especially a married woman of reproductive age, is expected to keep her womb 'clean' at all times in order to conceive, carry, and give birth to healthy children in as unproblematic a manner as possible. For this, a woman is expected to make use of traditional methods (mostly in the form of herbal infusions taken orally) that are believed to 'clean' the womb of any 'dirt'. Etiologies of 'dirty wombs' among the women of St Wendolin's appear to be similar to notions found amongst women of the Eastern Cape, as reported by Jewkes and Wood (1999), who suggest that processes of womb 'cleaning' may be extremely common reproductive health interventions in both traditional and biomedical sectors. My research would support this suggestion.

At the very first sign of pregnancy a woman in St Wendolin's will be encouraged to make use of herbs that are said to cause the fetus to 'sit nicely inside'. At about 4 to 5 months, or when 'the tummy is starting to grow', a woman will be encouraged to take another herb to ensure that the baby 'moves nicely inside'. With the first signs of labor, she will often be advised to take yet another preparation said to 'clear' the vagina and thus ensure that everything 'comes

out' in the right way. When a child is born sickly then, in the eyes of the community, the mother is guilty of having neglected these necessary duties, duties that, if she is married, she holds in relation to her husband's family. Discussions with women around the topic of babies being born with HIV infections elicited similar responses, that such an event would be considered a 'shame and disgrace' and that the mother would be made to feel guilty and 'dirty'. For this reason, some young women claimed that if they bore such a child they would try their best to keep his/her illness secret. Others suggested that such a child would be better off if given to welfare. The case of a baby left on the doorstep of the convent at Mariannhill in late 1997 was rumored to have been HIV-infected and abandoned because the mother was afraid that her in-laws would learn about the baby's condition. While it is difficult to ascertain the extent to which babies or children are abandoned by mothers in St Wendolin's, including babies with a confirmed HIV diagnosis, recurrent rumors of newborns found at the bottom of pit-latrines, dug-up from shallow graves by dogs, or left at the convent or hospital at Mariannhill, attest to such events not being uncommon occurrences.

One could say that a woman who passes such strong 'dirt' to a child so as to cause its death is the antithesis of a mother; she is a witch, she is evil personified. The whole process of demonizing women in this era of AIDS further coagulates with her 'new' propensity to pass HIV/AIDS infection to her own children. Currently there does not appear to be much awareness amongst the people of St Wendolin's of the possibility of women passing HIV to babies through breastfeeding and neither are there statistics available on this form of vertical transmission through the local clinic. Should HIV infection acquired through breastfeeding start to become a noticeable and acknowledged cause of infant and child morbidity and death in the community, no doubt this will further compound woman-disease-and-death symbolism.

MEN AND THEIR FLUIDS

In contrast to female sexual fluids, male fluids are associated with all that is good, clean, strong and desirable. Informants often used the word *amandla* (power, strength) when referring to seminal fluids. These emissions are construed as the source and proof of a man's virility. According to Berglund (1976) semen and potency are closely linked in Zulu cosmology. For this reason men traditionally abstained from sexual intercourse before undertaking any enterprise which required all his power, whether physical, mental or spiritual. A man did not want to risk losing power through orgasm, and neither did he want to risk any debility that came through sexual contact with a woman. Ngubane (1977:93) stated that the fact that men have control over their reproductive fluids while women do not, is an important fact underlying the *amandla* associations of semen that exist among the Zulu (3). Power and control are themes that are still associated with semen today. Informants described semen as the significant reproductive substance, while the female simply provided the 'nest' (in the form of the womb) and the 'food' (in the form of blood) for the baby to eat and grow. It is the ancestors who are said to make the baby grow. One teenaged schoolgirl in St Wendolin's explained the reproductive process as starting with the ancestors: "They enter the womb from the man and make the baby by mixing with the woman's blood. Then her blood will feed the baby until it is strong. She can also get pills from the clinic (presumably iron supplements) to help make her blood stronger, but first she needs the ancestors from the man's stuff."

Thus male sexual emissions, the substance of the ancestors, is the real power source that starts the reproductive process. With such a high cultural value placed on reproduction, semen represents that which is good and worthwhile in life, as well as representing the future. For this reason men must guard their semen from evildoers. The sexual act and the expected pregnancy, birth and

growth of the child is an assertion of life, life which according to Berglund (1976) witchcraft and sorcery strive to annihilate. Berglund suggested three symbols of resistance to *abathakathi;* medicines, purity and fertility. In common to all of these is the expulsion of fluid, "the blowing out of pure medicated water, vomiting or emission of semen" (Berglund 1976:336). All of these symbols are predominantly associated with men. In its symbolic and moral sense, then, male emission is a resisting of evil. Male informants in St Wendolin's were emphatic that male orgasm, the symbol of purification, must occur regularly as a precautionary measure against potential contamination caused by witchcraft. In any case, the common view in St Wendolin's was that men had to have sex regularly or they would 'go insane'.

MONOGAMY AS HIGH-RISK BEHAVIOR

The general perception, as described in Chapter 7, that women are increasingly using witchcraft love medicines to get and keep their men, has certain implications for therapy from a magico-medical perspective. Suspicions that women are using these substances will cause men to use medicines or apply techniques to counter the effects of this witchcraft. One way for a man to 'cleanse' himself of certain infections suspected to be caused by love medicines is to expel the semen believed to be 'infected' or 'dirty'. For example, if a man fears that he has been treated against his knowledge with witchcraft medicines aimed at harming his wife or a particular lover, some informants say that the onus will be on the man to expel his semen elsewhere, i.e. NOT in the woman intended for harm. Traditional healers confirm that a man can 'cleanse' himself in this way. Only after having purified himself thus would he feel able to return to his wife or lover, free from worry. For these purposes, a child virgin was said to provide the best option for cleansing oneself of 'infected' semen. However, a virgin was not believed to be a necessity. Intercourse with any woman other than the one intended for harm, or even masturbation, would be appropriate as means for expelling this form of contamination.

However, one had to be careful that the woman chosen for this purpose had not herself been secretly treated with medicines by one of her lovers or husband. Considering the alleged high usage of love medicines today, I would suggest that 'untreated' women are likely to be perceived as being in short supply. For this reason, it is possible that choosing a young girl for sex may be perceived by men as providing a margin of safety and reassurance.

Similarly, Berglund (1976:333) stated that in traditional polygynous homes, seniors who held positions of authority would have one wife, neither the first nor the main wife, who was known as *umsizi* (the defender) or *umsulamithi* (the remover of evil). With her the senior man would cohabit when suspicious of *abathakathi* and 'expel the dark of evil medicines' into her. Not being the intended target (aimed at harming the mother of the heirs), the medical powers were believed not to affect her. After this, the husband assumed himself cleansed and could resume normal relations with all his wives. Kuper (1947) in her work among the Swazi, a closely related Nguni group, made reference to a similar belief. She suggested that men who were isolated from their wives due to the effects of the migrant labor system believed that through masturbation they could expel venereal disease, which they thought, was caused by witchcraft love medicines. Kuper (1947:84) quoted one informant who stated: "If we cast out the semen in this way the sickness of that place (i.e. VD) is thrown out. It comes out with the water. That is the cure we know".

The belief that intercourse with a woman can remove a man's defilement caused by witchcraft, is still held by some men in St Wendolin's today. With traditional polygyny having largely given way to Christian monogamous marriages in the KwaZulu-Natal urban areas at least, some men still insist that women can play the culturally sanctioned role of *umsulamithi*, remover of defilement. According to one elderly male healer, a *nyanga*, 'throwing out the dirt' that caused STDs by having intercourse with a 'clean' woman was the

traditional method of curing these diseases. This same *nyanga* claimed that although today there are 'tablets' for treating STDs and that he himself advised patients to get these tablets at the local clinic, he believed that some men still sought sex with women as a way to 'clean their blood'. "You know us Zulus, sometimes we are stubborn and we believe the old ways are right. We like to do the things of our forefathers." While this informant believed that it was mostly older men and those from rural areas that sought *umsulamithi* cures through intercourse, my experiences lead me to conclude otherwise. Judging from the number of times that young men in the community have asked me about *umsulamithi* cures and whether or not I believed that HIV could be 'cured' through this method, it seems that such ideas extend far beyond associations with old, illiterate men and rural environments. Whether or not young men have sought an *umsulamithi* cure for a STD or HIV infection, they have certainly heard about and thought about this method of therapy.

In an environment perceived to be rife with witchcraft-related sexually transmitted diseases including HIV/AIDS, it is likely that some men still feel a need to seek sex with women for 'blood-cleansing' purposes. Against such a system of beliefs, I would offer what is admittedly a highly speculative and tentative suggestion that monogamy itself, or the 'being faithful to one partner' of current AIDS education discourse, may, for some Zulu men, be considered to be more or less a 'high-risk' sexual activity. In a world of witchcraft illnesses and antidotes, it may be better that one maintains some choice in sexual matters, with options available when seeking a partner for sexual activities. Viewed from an ethnomedical point of view, perhaps having concurrent sexual partnerships makes good adaptive sense. Whatever the precise relationship (if any exist at all) between the perceived upsurge in the use of love medicines, therapies for 'cleansing the blood' of witchcraft-induced 'germs', increase in sexual abuse of pre-pubescent girls, and a rise in HIV infection rates in that age group, it may be that for some men at least,

faithfulness to one sexual partner is consciously or unconsciously perceived as the real form of 'high-risk' sexual behavior.

MALE CENTRALITY/MALE INNOCENCE

As discussed in Chapter 3, much academic research on HIV/AIDS in the province has focussed on the specific 'high-risk' groups of commercial sex workers and truck drivers (see studies by Posel 1993, Abdool-Karim 1995, Marcus et al 1995, Varga 1996, Varga and Blose 1997, Preston-Whyte et al 1997). For better or worse the impression was made early in the epidemic that HIV infection and AIDS was a disease associated almost exclusively with these 'extra-dirty' women and the men who used their services. Some local health workers today claim that this persistent myth still hampers their efforts to promote safer sex practices, as no man or woman wants to associate themselves in any way with the image of fast and crude commercial sex. But even in the early days at the start of the decade, apportioning blame for the spread of AIDS was clearly weighted on the side of innocence for men.

During the course of discussions on AIDS held in the community during that time, I was initially impressed by how the truck-driver client of the sex worker was constantly construed as the victim of infection. Sympathies were always on his side as he was portrayed in people's discourse as innocently carrying a deadly cargo only to pass it on to other women along the way who passed it to other men. During AIDS awareness workshops held in St Wendolin's in the early 1990s, noticeable disgust was often voiced in relation to commercial sex workers and their servicing of long-distance truck drivers. Many of the youth knew women who waited for truck drivers at the near-by Mariannhill toll plaza. In the eyes of many young people, both men and women, these women who sold sex to truck drivers were seen as thieves who took money and gave disease in exchange. One woman commented: "Imagine, these poor guys. They're tired....lonely. These woman just go for them. Take the money,

goodbye. Sometimes they have a disease and they don't tell them. It's not nice." Such a comment was typical of many that portrayed HIV infection amongst male truck drivers as a result of contact with 'dirty' infected women. One young man simply said that it was 'unfair' that these men became infected with HIV/AIDS. One middle-aged man offered the opinion that if these sex workers left men alone, there wouldn't be any AIDS epidemic in the first place.

Although most women participants in these AIDS awareness workshops were prepared to accept the idea that HIV infection might be passed to them through intercourse with an infected man, their views often reflected the dominant cultural construction of male centrality and innocence. Also reflected in women's discourse was the role that they themselves play in sustaining the mythologies that codify their subordination. One girl of twenty-two years whose boyfriend and father of her child died from AIDS simply said that he 'could do nothing' because his other girlfriend 'had this thing' and he 'didn't know'. While she herself had not been tested for HIV and her child of three years appeared healthy, she would feel compelled to seek her revenge on this other woman if she were to learn that she too had become infected: "I know what I'll do, she'll see. She can't kill us all like that." Her ideas reflected the general view that HIV/AIDS was a disease that women passed to men. According to the local mythology of AIDS, women stand accused. The spread of the disease follows one direction; <u>from</u> woman <u>to</u> man. The HIV-infected man is privileged with culturally sanctioned absolution for any wrongdoing, guilt or even complicity in the spread of AIDS.

The sad irony of this mythical assumption is that women are more likely to be the <u>real</u> victims in this epidemic, a point made in almost all studies of women and AIDS, including Preston-Whyte et al (1991), Schoepf (1992a and b), Berer and Ray (1993) Doyal et al (1994), Bury (1994) Butcher (1994), Doyal (1995), Gupta and Weiss (1995) and Wilton (1997). Too often women are coerced,

forced or beaten into sex by male partners who control sexual encounters and refuse to wear condoms (see Wood et al 1996 and Varga & Makubalo 1996, for discussion of violence and female powerlessness in the local context of AIDS). The practice of apportioning blame for HIV/AIDS on the more socially marginal 'other' is well documented in the literature, particularly in the body of literature focusing on AIDS and its symbols. The works of Sontag (1988), Clatts and Mutchler (1989), Douglas and Calvez (1990) and Farmer (1992), all attest to a propensity for associating HIV/AIDS with an already stigmatized 'other'. One example is that of some American gay writers in the late 1980s who were quick to disavow the stigma of AIDS-genesis by blaming Haitians for the disease. Wilton (1997:67) described how those writers had constructed AIDS as some type of illegal immigrant which "had slipped in from outside some mythically uncontaminated social space through the agency of already stigmatized others to infect the 'naturally' uncontaminated". As Farmer (1992) demonstrates in his study of the 'geography of blame' in Haite, the construct of AIDS presents the leakage of infection from social outsider to social insider as 'unfair', primarily because it is the natural property of the not-other to be clean, healthy and safe.

I would suggest that the position of women in St Wendolin's or more generally in Zulu-speaking or Nguni society, is essentially that of social outsiders. As in-marrying 'stranger-women' in the idealized patrilineal, patriarchal social system, women are the socially marginal 'others'. The association of AIDS with women in St Wendolin's is consistent with symbolic representations of AIDS as the property of what previous writers have referred to as the 'stigmatized other'. Women in Zulu society are the 'strangers' in the agnatically-joined group, the 'others', the non-men of patriarchal society. In the next chapter I consider dominant gender scripts and sexual cultures in the context of this gendered patterning of HIV/AIDS and argue that there is a 'problem' with the discourses that accrue from a gendered understanding of AIDS.

Notes

1. A recent study by Hoosen, Moodley, Maitin and Sturn entitled "Bacterial vaginosis in symptomatic women attending a gynaecology outpatient clinic" (South African Journal of Epidemiology and Infection 1997:12(4), makes the point that syphilis is endemic in KwaZulu-Natal, as are other vaginal infections that are probably all acting to facilitate the transmission of HIV in this province.
2. A recent article in the Mail and Guardian (Oct. 2-8, 1998:9), a widely read local newspaper with a nationwide circulation, reported that very similar attitudes regarding female genital fluids prevail in Zimbabwe among the Shona people, another Nguni-speaking group. This article quoted an ethnobotanist who claimed that Zimbabwean men liked women to be 'dry' with as little vaginal fluids as possible, because it 'gave the illusion of virginity'. Statements by informants in St Wendolin's attest to the existence of a similar complex of beliefs regarding the negative associations attached to vaginal fluids.
3. Associations of semen with masculine strength are certainly not unique to Zulu-speaking people. Like notions of female impurity, associations of male power and semen have been documented in a variety of cultural settings. For example Kelly (1976) reported that young boys in New Guinea were injected with semen in a ritual intended to make them strong and turn them into 'real men'. In Morroco, it has been reported that a man can be easily influenced and made to behave in accordance with someone else's will if his semen is found and manipulated in a culturally-defined manner (Dwyer 1978). Whitehead (1997) suggested that similar beliefs linking masculinity and semen are still evident today with some athletic coaches in the United States for example, who imply that athletes should not have sex the night prior to a big athletic event.

CHAPTER 9

GENDER SCRIPTS, SEXUAL CULTURES AND AIDS DISCOURSE

> "Men say they can't eat Kentucky (fried chicken) when still in the box. It must be out of the box, flesh to flesh ... you know. Men are just like that. They take what they want." (*25-year-old female AIDS counsellor*)

As discussed in the opening chapters of this thesis, much of the early research on HIV/AIDS focused heavily on quantitative studies aimed at documenting sexual attitudes and behaviors in different settings. Characterizing many of the early AIDS-related studies of the 1980s and early 1990s was a general understanding of sexuality as a universal physiological drive, rooted in the shared biology of human beings, and hence measurable and analyzable in accordance with the basic precepts of a positivist science of human behavior (Parker and Gagnon 1995). In more recent years, writers such as Boulton (1994), Parker (1994), Altman (1995), Gupta and Weiss (1995), Setel (1996), Herdt (1997), Whitehead (1997), Wilton (1997), Hostetler and Herdt (1998), have argued in favor of a constructionist approach whereby human sexual behavior is viewed as a sociocultural phenomenon rather than a universal consequence of shared biology (see Chapter 2, Literature Review).

While the biomedical understanding of sexuality continues to inform much AIDS-related research today, there is a growing awareness in social science circles and increasingly to some extent in medical circles, that the biomedical model of sexual response has only limited usefulness for our understanding of human sexuality and our efforts to reduce the transmission of HIV. This thesis represents an attempt to go beyond a study of sex-related attitudes and practices among people in St Wendolin's and focus on the inter-subjective

symbols and meanings associated with gender, sexuality and HIV/AIDS. My intention was to gain some insight into the sociocultural system that not only shape gender relations and (hetero) sexual activity, but also the ways in which people interpret and understand the AIDS epidemic in their midst. Thus this thesis represents a contribution to social science research on HIV/AIDS that places special emphasis on the sociocultural context through which behavior becomes meaningful and through which the subjective experience of sexuality is understood.

A main proposition of this thesis is that the common frame of reference that defines the contours of the cultural construction of HIV/AIDS has at its core, the idea of women as 'dirty' and dangerous. Coalescing around and giving renewed credence to what I suggest is an old, well-established patriarchal equation of woman-pollution-and-peril, are contemporary negative perceptions of women associated with their sexual behavior. Two of these perceptions that I have discussed as being especially significant to the current cultural construction and experience of HIV/AIDS in St Wendolins are (1) the perception of increased female promiscuity, and (2) notions of this increased promiscuity being aided (and abetted) by women's socially reprehensive use of witchcraft love medicines.

Based on a study of the words, images, beliefs and metaphors that some people in one small Zulu-speaking community of KwaZulu-Natal associate with AIDS, I have argued that women and their sexuality are construed as the 'natural' source and location of HIV/AIDS. By way of what is perceived to be an increase in women's sexual activity facilitated by witchcraft, (both representing moral transgressions), contemporary female sexuality is linked in common conceptualization to the cause and spread of the new disease HIV/AIDS. Further, I have argued that the cultural construction of femaleness itself has shaped the way in which people in St Wendolin's currently interpret and

experience HIV/AIDS. Notions of pollution and 'dirtiness' are closely associated with women; both at the level of shared knowledge regarding physical bodily processes, and at the level of cultural symbolism. This gendered meaning-making process demonizes women through its construction of AIDS as a 'female' disease that affects men. The use of Helen Ivy Vilakazi (see page 102) as a nickname for HIV/AIDS clearly reflects, I believe, the female nature of the disease. Thus, in a dynamic and synergic way, the sociocultural construction of women and the sociocultural construction of AIDS are informing and giving meaning to each other.

THE 'WOMEN' OF AIDS DISCOURSE

In her seminal works on the metaphors of cancer (1978) and AIDS (1988) Susan Sontag makes the point that for diseases that are not fully understood and difficult to treat, the process of 'meaning making' emerges as profoundly significant, with very real social implications. To an extent, the community of St Wendolin's has worked AIDS (a disease largely unknown to the people ten years ago) into pre-existing and probably much older interpretive frameworks, a process described by Mogenson (1995) in her study of AIDS among the Tonga in Zambia. Like the Tonga, a key symbol of HIV/AIDS among the Zulu is the notion of a naturally 'dirty' woman that is articulated by and connected to the theme of contaminated and contaminating sexual fluids. According to Mogenson (1995) the contaminating 'femaleness' the Tonga associated with HIV/AIDS was pollution related to miscarriage. For the people of St Wendolin's, I argue that the contaminated/contaminating 'femaleness' associated with HIV/AIDS is not specific to any singular reproductive-related type of pollution. Rather, it is the understanding of 'femaleness' as a whole, characterized by a unique biology and sexuality, which effectuates the essential linkage between women and AIDS.

Although pre-existing frameworks of understanding in the form of 'folk models' of human bodies, ethnopathological processes, and disease, explanatory models clearly play a considerable role in the local 'meaning making' process, they are not the only forces acting in the production of AIDS symbolism. The contemporary social context contributes its own substance to the cluster of metaphors that signify the disease. I suggest that perceptions of women's sexual conduct and use of love medicines which give rise to notions of women being 'out of control', are ways of articulating the shared perception that women have overstepped patriarchally-defined moral boundaries. These conceptualizations play an important part in the symbolic representation of AIDS as a gendered illness. Further, biomedical constructions of disease and its associated terminology such as 'germs', and germ theory, join and combine with ethnomedical constructions in the meaning-making process. In a study of chronic disease in Israel, Weiss (1997) described a similar process whereby her informants mixed and matched biomedical and popular ethnomedical metaphors to depict specific diseases. Sontag (1988) made the point that AIDS, wherever it occurred, implied a moral judgement. Thus, the metaphors of AIDS can be expected to reflect powerfully the particular notions of morality which exist in a given AIDS-context. Haram's studies (1996 and 1997) of the 'gendering' of AIDS in Tanzania clearly reflect the link between local meanings of morality and AIDS. In the community of St Wendolin's, morality, or more correctly the breach of morality, is clearly depicted in the images of AIDS. The breach of course, is caused by women. The possible association between men and HIV/AIDS remains, metaphorically, inconceivable.

The foundational assertion of AIDS symbolism is that women are both the source of HIV infection and the disseminators of AIDS illness and death. I would suggest that this symbolic assertion reflects the imperative of male control in the shape of patriarchal society. Women and their contaminating 'wetness' needs to be contained within the patriarchally defined and guarded

boundaries of health, order, law and decency. The local discourse that represents women as being 'out of control' , reflects a larger conceptualization that women are increasingly slipping out of patriarchal control. This represents the real menace to men and society, and the basis of male insecurities that are reflected in statements such as that by the young man quoted in Chapter 6 who claimed that women's liberation would 'destroy Africa'. Women today, in St Wendolin's at least, are clearly seen as challenging the patriarchally-defined social order. The metaphoric contaminated/contaminating female 'wetness' is, in the eyes of the community, overflowing prescribed borders.

The idea of HIV/AIDS as a 'strong' germ, a 'stubborn' dirt that is not easily (if ever) removed by medicine, whether traditional or western, is a symbolic representation of woman herself. She is the strong 'germ', the increasingly 'stubborn' problem. Women's changed and changing expectations, attitudes, roles and desire for assertiveness will not be easily 'removed'. As women are perceived to be increasingly acting 'like men', being sexually promiscuous and using witchcraft to assert their sexuality, so too are their 'dirty' and dangerous qualities perceived to be getting stronger. The insecurities of patriarchal society vis-à-vis the changing role of women are the pivotal notions being reflected in the metaphors that signify AIDS in St Wendolin's. With their well-known debilitating powers to 'weaken blood' and predispose men (and now babies) to fatal illness, as they once 'caused crops to die and udders to go dry' (Krige 1950), women are the embodiment of an immuno-compromiser. The familiar model of woman-as-risk-to-man has been updated and reinforced as the premier symbol signifying the AIDS epidemic among the Zulu people in KwaZuluNatal. Metaphorically women and AIDS are not simply linked constructions, they are really one construction. As strong, stubborn, polluted and polluting entities currently disturbing the social order and threatening to 'destroy Africa' the sociocultural construction of women and AIDS are minor images of the same disorder-dirt-disease-and death symbolism.

As the final draft of this thesis was being prepared, the media reported the killing of a woman in KwaMashu, the largest of Durban's surrounding townships, by men who were alleged to have been angered by her 'coming out' as an HIV-positive person. Among the allegations made against this woman was that she was intentionally spreading HIV and bringing the good name of the community into disrepute (see Appendix 11 page 259). Following this murder other women living with HIV/AIDS who had been encouraging HIV-positive people in the province to speak out about their condition, went into hiding for fear of their lives. Many of these women claimed that they had been verbally abused, chased from their communities, or assaulted by people who were angered by their 'coming out'. In some cases it has been former boyfriends of these women who have instigated the harassment and accused the women of intentionally spreading the AIDS virus (See Appendix 12, page 260). According to one middle-aged man in St Wendolin's who once worked to prevent violence in the community during the 1980s, harassing women who go public with their HIV status will increase as more women come forward. In his words, "Just wait, there'll be a general clean-up in all the communities. Who will stand these women telling us how dirty they are? What about their boyfriends? Their reputations get ruined by this. They don't care about that? Of course people will hit back." Another said: "If you're sick it's your business. Why must you shout around about it? It means you're mad too, so people must chase you." With the killing and terrorizing of women who disclose their HIV-positive status, the 'demonizing' of women through the common conceptualization that they are directly responsible for this latest of grave misfortunes befalling communities, becomes more than an academic exercise in interpreting the sociocultural construction of HIV/AIDS. It becomes a serious human rights issue, of life or death concern.

I would suggest that it is not coincidental that the victims of this intimidation of people living with HIV/AIDS have thus far all been women. Rather, I argue that

it is directly linked to the common conceptualization of women as both the cause and the transmitters of HIV/AIDS. Granted, there have been HIV-positive men who have publicly 'come out', and some of them have been railed against. None however, to the best of my knowledge, have experienced such dramatic and lethal responses from their communities as has women who have gone public with their HIV status. According to informants involved in the counseling of HIV-positive people, men are much more reluctant to acknowledge an HIV infection and go public in order to assist the AIDS effort. In my view there is a serious need for more men in this province to come forward with their HIV status in order to 'disrupt' and challenge the hegemonic gendered discourse on AIDS that is having such serious consequences for women living with the disease. Until more men come forward and speak publicly about their HIV/AIDS status, thereby contributing to the process of militating against the association of AIDS with women, it is likely that women infected with HIV and AIDS in this province will continue to live under threat of violence and intimidation.

DISCORDANT GENDER SCRIPTS

Metaphorically, the idea of 'woman' in St Wendolin's is associated with notions of pollution, marginality, sexual excess, treachery, wetness and the power to debilitate, all representing danger to men. Within this paradigm, 'man' is assigned attributes of purity, centrality, power, order and control. Disparities in the metaphoric representations of gender express and contribute to a way of seeing and knowing women as 'naturally' different to men, and invariably lead to notions of men being 'better' and thus more deserving of power and privilege in society. The traditional ideal of Zulu manhood whereby a man's behavior must demonstrate that he is able to control his 'female resources' (a major point of discussion in Chapter 6), is still an important hallmark of masculinity in St Wendolin's. The imperative of male dominance and control over women has implications for the shaping of what Simon and Gagnon (1984) might term the

'gender scripts' existing in St Wendolin's today. By demonstrating that they are 'in charge', men in St Wendolin's could be said to be acting in accordance with a socioculturally prescribed and approved gender script, a script that they view as natural and good.

The situation for many women in St Wendolin's is, however, different. Today many women, especially younger women are questioning and increasingly rejecting age-old gender scripts assigned to them as women in a patriarchal society. For the most part women informants viewed existing 'gender scripts' as oppressive and not at all good. As discussed in Chapters 6 and 7, young women especially express disdain for what might be called the normative attitudes and behaviors expected of them as women, both married and unmarried. Many are questioning the 'naturalness' of the socioculturally-sanctioned power differential between the sexes and the cultural ideal of male control. Increasingly, women are choosing to obtain an education in preference to early marriage, with many young women in St Wendolin's having had children but choosing not to marry until later in life. It was not unusual for young women to even question the necessity of marriage altogether. As discussed in Chapter 6, many young women see marriage as a way to bring frustration and misery into their lives. As one thirty-three year old unmarried mother of three children put it: "Why do we need men at all? They're worse than children with their demands, yet they expect us to treat them like a father at the same time. Ha!" According to this woman, it was more important for a woman today to seek an education and a career rather than seek a man for marriage.

Recent statistics compiled by the Development Bank of Southern Africa (see Appendix 13 page 261) reveal that in contrast to other population groups in South Africa, black women with tertiary level educational qualifications

outnumber black men. Of all Africans who hold a tertiary qualification, approximately 60% are women. This figure is likely to increase in the future, judging from how strongly many young women in St Wendolin's feel about the necessity to secure a good education today. It is not unusual for young women who are choosing education over marriage to claim that they have been dissuaded from marrying by observing the unhappy lives of their own mothers who were married. Some say that their mothers were the ones who actively encouraged them to seek an education above all else, and not to entertain false hopes that a man would provide for them and keep them happy as wives. It was not unusual to hear mothers in St Wendolin's say that it was more important for a daughter as opposed to a son to get educated today. They argued that women are often the ones to shoulder the financial burden of children, so they must prepare to become breadwinners.

Similarly, it was common to hear women claim that they would have to rely on their daughters to take care of them in old age, unlike in the past. The patrilineal ideal of the elderly mother being looked after by her son and daughter-in-law seemed not to hold much attraction for women in St Wendolin's. According to many women informants, both young and old, this traditional living arrangement was less than ideal in the urban environment. Most related this to the high rate of unemployment. Almost all women know of cases where mothers who live with grown sons are constantly besieged by request or demands for money. Women feared being assaulted by adult sons for not complying with their demands, and many knew of cases where elderly women were beaten or made to sleep in the bush because they refused their son's request for money. One woman recounted a story where a mother was raped by her 30-year-old son for refusing to give him money. Others claimed that such scenarios were becoming increasingly common. One way to escape such family terror was to take up residence in a home for the elderly.

According to many women informants demand is high for rooms in 'old age homes' in Durban's urban townships. Most would like to see more such homes being built, and some said they should even be segregated according to gender, not unlike contemporary men's hostels. One elderly woman's comments were most revealing when she said that old men could always find a woman to care for them. "Either a daughter, a *makoti* (daughter-in-law), a granddaughter, or a new wife. We old ladies don't get attention at all. The young ones just abuse us. We would prefer a home away from them."

In an increasingly deteriorating economic environment, it would seem that women are looking for alternatives, with many preferring to remain with their daughters in their old age, as opposed to living with possibly unemployed, frustrated and violence-prone sons. For this, it would be clearly in a woman's best interest (consciously or unconsciously) to encourage her daughter not only to get educated with the hope of obtaining a financially secure job, but also to remain unmarried, as a son-in-law may be loath to accept a living arrangement with a mother-in-law. As mentioned in Chapter 6, it is considered shameful for a man to live with a mother-in-law. Not only does this go against cultural prescriptions of the patrilineal extended family, but may well make it more difficult for a man to 'rule the roost' in true *umnumzane*/patriarchal style.

What might be described as a growing discordance between male and female gender scripts and expectations in St Wendolin's, combined with women's desire to modify the gender equation, is in fact part of much wider social change processes in South Africa. These processes are being assisted by policies intended to foster greater gender equity in the country. With the installation of a new democratic government in 1994, much has changed in terms of putting women and women's advancement firmly on the political agenda. Along with the establishment of a national Commission on Gender Equity and the creation of a number of 'Gender Desks' in the various

government departments to ensure that women's concerns are addressed, there have been several major pieces of legislation passed in recent years that have been hailed as victories for women. Included in these would be the rewriting of tax tables in 1995 specifically to benefit women, legalization of abortion in 1996, the Customary Marriage Bill passed in 1998 to recognize traditional forms of marriage and give equal power in marriage to rural woman, the Domestic Violence Bill of 1998 whereby women can now get expeditious interdicts against abusing husbands or partners, and a host of new labor legislation that makes maternity leave mandatory and includes codes to allow breast-feeding and to guard against sexual harassment in the workplace.

Indeed, 'women's laws' have kept government printers very busy in the past several years, sending out a message to the South African people that the ANC government is serious (at the level of legislation at least) about advancing the cause of women. With the seventh-highest number of women members of Parliament in the world, and black women increasingly being seen on corporate boards, there has been a proliferation in recent years of women being visibly 'in charge' and 'in control'. Whether or not these women have any real control is questionable. Many of these female board members are there as non-executive members, appointed to make the boards more representative in terms of gender and racial composition. Nevertheless I would suggest that these visible changes are all very threatening to men and to the social ideals of patriarchal society.

As AIDS increasingly continues to make its presence felt in the community, women are simultaneously continuing to challenge (both at the local and national levels) the patriarchal prescriptions and gender scripts that have structured the parameters of their social and sexual experience. These changes are giving rise, I believe, to fears and insecurities on the part of men, and these fears and insecurities are being reflected in the sociocultural construction of

AIDS. Failing to act within the patriarchally prescribed boundaries of acceptable behavior, including sexual behavior, women and their well-known power to bring misfortune to those around them and weaken men through their contaminating 'femaleness', are intimately linked to the new scourge in the land called AIDS. What has emerged most clearly from my field experience of researching HIV/AIDS in St Wendolin's is that people's understanding and experiences of the disease are intricately bounded by, interfaced with and acting to inform notions of gender and sexuality. Ultimately, it is the *complex relations between meaning and power in the sociocultural construction of gender and sexual experience* that is being expressed (and contested) through the sociocultural construction of HIV/AIDS in the community of St Wendolins.

SEXUAL CULTURE AND AIDS TRANSMISSION

Concurrent with the growth of a social science perspective that views sexuality as a product of a sociocultural system that shapes our experience and interpretation of that experience, there has emerged the notion of 'sexual culture', the matrix that informs and in turn is informed by people's sexual activity. Essentially, the notion of 'sexual culture' encompasses the context in which sexual interactions take place, including the indigenous cultural categories and systems of classification that structure, define, and give meaning to sexual experience (see works by Simon and Gagnon 1989, Parker, Herdt and Carballo 1991, and Parker 1994 as examples of studies of diverse 'sexual cultures'). From an intervention point of view, having a grasp of the sexual culture of a community is, according to many social scientists researching AIDS including Bolton (1992), Boulton (1994) and Herdt (1997) among others, more useful than knowledge of mere sexual acts and behavior. The idea of distinct and discernable sexual cultures has been much used by queer theorists such as King (1993), Abelove (1994) and Herdt (1997), who contested the universal character of notions such as sexual identity and accepted gender binaries (see the Literature Review of Chapter 2). Likewise, queer theorists argue that an

understanding of a people's sexual culture is fundamental to the development of effective AIDS interventions. The author of this thesis agrees with the queer theorists on this point, and offers this current thesis in an effort to begin the process of addressing sexual culture (which includes a growing discord in gender scripts) as a fundamental in our fight against AIDS in South Africa.

Viewing the problem of HIV/AIDS from the perspective of a 'sexual culture' that organizes sexual inequality in specific ways and provides rules and regulations on the potential for negotiation in sexual interactions, may provide us with a way forward as we ponder past failures to develop effective and sustainable AIDS prevention strategies in this province. I argue that we must view the heterosexual transmission of HIV/AIDS as part of *a whole sexual culture complex,* characterized by (in St Wendolin's for example), gender inequality, transactional sex, the sociocultural *isoka* ideal of multiple sexual partnerships, lack of discussion on matters of sexuality in the home and between sexual partners, the conditioning of both men and women to accept sexual violence as 'normal' masculine behavior along with the 'right' of men to maintain concurrent sexual partnerships and control sexual encounters, and the existence of increasingly discordant and contested gender scripts. In South Africa as indeed elsewhere, developing a sound foundational understanding of men's and women's different sexual cultures and designing interventions aimed at modifying those cultures in order to reduce the risk of HIV transmission, will necessarily entail a challenge to hegemonic ideologies and constructs of gender. As writers such as Berer and Ray (1993), Doyal et al (1994) and Wilton (1997) have argued, hegemonic gender ideologies have profound consequences for the epidemiology of HIV infection and the fight against AIDS. Considering the local and 'gendered' context of the AIDS epidemic, such a task will require nothing less than a radical paradigm shift, one that would disturb the deepest roots of embedded cultural mythologies which inform and structure gender relations and sexual relations.

THE SPACE TO SPEAK

The necessary first step in addressing sexual culture and challenging gender constructs that inform and shape sexual activity, is to develop a dialogue and discussion on sex. Considering the community of St Wendolin's as one example representing the local context of the HIV/AIDS epidemic, creating the 'space' to talk about sex is of no minor import. Innumerable times in the course of my field experience in that community, people have commented that with modernization, traditional structures in the form of older relatives to instruct youth on sexual matters, have been destroyed (see Chapter 6). In its wake has been left a vacuum, where nobody seems to be providing guidance in matters of sexuality, and with little if any discussion about such things in the home. Similar observations were made by Vilakazi (1965), Ngubane (1977) and more recently by Varga (1997b) in their studies of other Zulu-speaking semi-urban populations in the province. Previous writers such as Wilson (1936), Pauw (1962), Wilson and Mafeje (1963), Hellman (1948) and Brandel-Syrier(1971), made similar observations regarding the lack of communication on matters of sexuality in the homes of urbanized African families in other parts of the country.

For the young people in St Wendolin's popular magazines and peers have become the primary source of information on sex. Compounding the loss of traditional institutions to guide and regulate the sexual behavior of young people is, as discussed in Chapter 5, the propensity of many people to avoid discussion of 'bad things'. Such discussion is believed to 'open the way' for a repeat of that 'bad thing'. This propensity to avoid discussion also extends into sex talk. Open, direct discussion is mostly avoided in St Wendolin's on issues related to teen pregnancy, abortion, miscarriage, sexual abuse, incest, sexually transmitted diseases and any other situation that involves the transgression of norms and rules regulating sex. These topics are largely left to be considered

through whispers, gossip and rumors that circulate through the community. Discussion on matters of sex is usually reserved for peers, rather than one's sexual partner. Most women, young and old, say that it is a rare couple who talk to each other about sex or discuss sexuality.

During the course of my stay in St Wendolin's, it was not unusual to be told that such-and-such a girl from a certain family had recently given birth, much to the surprise of other members in the household. As these girls were living at home, I was often baffled as to how the girl's parents could not have noticed her pregnancy. Yet, parents insisted on total ignorance. One mother described how she was cooking when she heard a baby crying from her daughter's room. Sure enough, she opened the door to find her daughter had just given birth. Several others related how their daughters cried for help from the pit latrine toilets, because a surprise baby was 'falling out'. I came to interpret what was to me incredible stories of 'mysterious' births, as mothers' attempts to keep problems and potential conflicts 'out of sight/out-of-mind'. To recognize a daughter as pregnant was to recognize one's own failure as a mother. Besides that, deferring acknowledgement of the 'problem' until the birth of the child, implies a type of 'virgin birth' where no particular man is held responsible. In this way accusations of paternity and wrangles over financial responsibilities could all be avoided. After all, it was often too late anyway to do anything. It is difficult to assess whether such a response constituted 'denial' in the classic psychological sense, or whether these mothers were consciously choosing to ignore a reality that they felt helpless to change. In any event most mothers shared a common sense of resignation. For them, it seemed better just to accept the new arrival and carry on without much fuss.

Cultural prescriptions against talking about sex also extend into the arena of behavior. As discussed in Chapter 6, public displays of sexuality or affection

between men and women are frowned upon. Hand holding, hugging or kissing in public goes against culturally prescribed rules regulating sexual activity. Drawing from descriptions provided by female informants in St Wendolin's, it would seem that even in the private arena, cultural prescriptions dictate against most forms of sexual expression other than peno-vaginal intercourse. Many young women say that their sexual encounters involve a minimum of touching or caressing, with male partners moving quickly to intercourse. As Hadden (1997) has suggested in her previously discussed study of an HIV/AIDS prevention program (see Chapter 2) in a much larger urban settlement in the province, the people's use of the term 'private parts' in reference to male and female genitalia is significant. One's genitalia are essentially 'off-limits' to others, including one's sexual partners, for anything other than peno-vaginal contact. Women in St Wendolin's concur that most men would object if their lovers touched or fondled their sexual organs, as those organs are after all, his 'private parts'. Comments by women like those quoted in Chapter 8, such as: "This thing (the vagina) is just too dirty', or (in reference to oral sex) "That's like saying go dig in the rubbish", or men who say: "We Zulus are simple people, we do the thing and that is enough," not only allude to limited sexual repertoires and the predominance of peno-vaginal sex, but also reflect the multiple layers of silence that surround sexual expression as a whole.

For many researchers, including this author, the AIDS epidemic is bringing with it the stark realization that there is a desperate need for people to talk about sex. It can only be through talking about sex and sex-related issues and concerns that any possibility for the negotiation of safe sex practices between sexual partners can exist. Not only is sex-related communication viewed as an essential for halting the spread of HIV, but may indeed open the way for other, more far-reaching social changes. By simply giving men and women permission to speak about sex, Boffin (1990) has argued that the AIDS epidemic has

brought with it the very real opportunity to transform dominant relations of gender and sex.

Quoting Ardill and O'Sullivan:

> AIDS has opened up space and legitimized a feminist discussion on sexuality. AIDS gives us permission to talk sex, talk desire, talk 'dirty', talk fear, talk confusion, talk fantasy. It gives us a chance to talk about how we feel about men, how we feel about pressures to be sexual, pressures not to be sexual. (Boffin 1990:161)

Evasion, secrecy, indirect inference and pretense – all hallmarks of the expression of sexuality in St Wendolin's and probably many other African communities, is today in the era of HIV/AIDS, potentially lethal.

'DISRUPTING' CURRENT AIDS DISCOURSE

It will not be nearly enough simply to talk about sex. Implicit in the responsibility to 'talk sex' is the imperative to eradicate, not to reproduce, the various oppressions that enable the virus to spread unchecked. The AIDS epidemic demands that a new discourse be developed those challenges, above all, patriarchal hegemonic ideologies. In this regard there needs to be a re-examination and re-orientation of the content of health promotional materials used locally in AIDS prevention/awareness campaigns. Rather than challenging constructs of gender and sexual identity, current approaches to AIDS prevention education actively collude with and reinforce them. The underlying assumption in most AIDS prevention campaigns and materials used in AIDS education, in South Africa as elsewhere, is that men are sexually irresponsible, resistant to using condoms, and therefore need to be cajoled and manipulated into doing so. By assuming that women will have problems in persuading their partners to use condoms, by suggesting and providing assertiveness training for women in order to give them skills to have men comply with their wishes, we

are, I believe, accepting uncaring and unbridled masculinity as the norm. Writing on sexuality and identity, Weeks (1991) referred to this pervasive depiction of masculinity as the 'hydraulic model' of male sexuality, whereby the male is conceptualized as "uncontrollable, susceptible not to rationality or responsibility but only to covert manipulation" (Weeks 1991:128). Noting the growing sub-field of 'women and AIDS' research early in the decade Reid (1992) rightfully argued that a whole half of the equation was being overlooked, that is the role of men in HIVS/AIDS transmission. At the close of the decade, writers on AIDS (including this author) are still arguing this point.

As discussed in Chapter 2, much of the AIDS research of the 1990s focused specifically on the problems encountered by women in the face of the continued growth of the AIDS epidemic. (See for example Patton 1985, Panos Institute 1990, Preston-Whyte et al 1991, Berer and Ray 1993, Bury 1994, Butcher 1994, Doyal et al 1994). While such attention is to be lauded, as indeed women are still suffering the consequences of this disease disproportionately (see WHO 1995), we may legitimately ask ourselves, what about the men? The increasing awareness worldwide of the importance of gender in HIV/AIDS risk and transmission has, as yet, resulted in little focus on men. With the notable exception of a recent study by Campbell (1997) on masculine identity in relation to AIDS, there is a dearth of research on men and AIDS in South Africa. We must ask ourselves <u>why</u> this has been the case, and set ourselves the task of filling this research gap.

AIDS prevention campaigns in South Africa have largely failed to treat men like responsible adults, and have thus reproduced age-old constructs of gender. Even the AIDS discourse of political rhetoric reflects the normative assumption of male irresponsibility. Issuing a warning on the expected drop in life expectancy due to the current high rate of HIV infection in the country, Minister of Welfare and Population, Geraldine Frazer-Moloketi issued a statement in

1998 emphasizing that '*women should make choices about their sexual needs in order to protect themselves*' (see Appendix 14, page 262). Why is it women who need to make choices about their sexual needs? How are these choices supposed to protect them when it is the men who are in control of the sexual encounter? The Minister's statement clearly reflects the dominant discourse of male sexual irresponsibility, with the onus to adopt safer sex practices falling squarely on the shoulders of women, adding yet another burden to her multiple responsibilities. In her studies of women's discourses on AIDS and gender, Stebel (1996) and Stebel and Lindegger (1998) found that South African women's perspectives largely reflect the dominant discourses of male sexual irresponsibility. Strebel and Lindegger (1998) suggested that women's assumption that men did not and would not take responsibility for safe sex provided the 'starting point' in gendered notions of responsibility.

Far from challenging the meaning-making process in this epidemic that locates 'dirty' and dangerous women at the metaphoric epicenter of AIDS, and men as the innocent victims of infections (who are just acting 'naturally' in accordance with their gender scripts) AIDS prevention education and AIDS discourse has reproduced and reasserted the validity of oppressive and disempowering gendered paradigms. Almost a decade ago, Gordon made the point:
"Unless men are treated as responsible, caring human beings, rather than irresponsible children who have to be seduced into good behavior, the promotion of safer sex is unlikely to make much impact" (cited in Panos Institute, 1990:80).

It is time to rethink mainstream (one might say male-stream) AIDS education that has so obediently recycled and reinforced hegemonic gender narratives. The very fact that it is *only women* who are being asked to undergo virginity testing and make protestations to *Nomkhubulwane* to stop teenage pregnancy,

rape and the spread of HIV/AIDS (as discussed in Chapter 6), reflects not only the notion that women are responsible for these problems, but also the notion that men are not responsible. The organizers of these events, mostly conservative women and men who hold highly idealized views on Zulu tradition, accept the model of uncaring masculinity as the norm. As one of them plainly articulated in the course of an interview, there was no point in asking young men to attend these events as 'they wouldn't come anyway.' The up-dated version of *Nomkhubulwane* ceremonies may help to bolster cultural pride and convince girls of the value and benefits of remaining virgins until marriage, but, as currently conceived, they do little to change the sexual culture which makes virginity-until-marriage practically impossible and continues to affect women's reproductive health so negatively.

I would suggest that unless the complexities of gender power relations and sexual oppression that lie at the root of on-going violence towards women (which helps to maintain the high incidence of rape, unwanted pregnancy and the spread of HIV/AIDS), are properly addressed by both men and women, the problems that *Nomkhubulwane* is being asked to solve will never be solved. Anthropologists have consistently argued that AIDS interventions need to be based upon a clear understanding of the multiplicity of sociocultural factors shaping people's responses to the epidemic. Once understood, efforts should be made to create the space needed for both men and women to engage with and reflect upon those deeply embedded images, values, myths, metaphors and associations. How such efforts could be initiated locally within the context of a future AIDS education strategy is the topic of the next chapter.

CHAPTER 10
PROSPECTS FOR TRANSFORMATIVE AIDS INTERVENTIONS

> "It is critically important that we not allow the revolutionary energies built up in the struggle against apartheid to dissipate, with the masses of people disempowered and demobilized to a situation where they become passive recipients of the good things of life from their rulers – objects rather than subjects of change" (.... President Thabo Mbeki, 1999)

In the Introduction to the thesis I stated my goals and objectives in pursuing this research. Foremost amongst these was the desire to engage research participants in a participatory learning process that would serve the shared interests of both the researcher and researched. In the formal settings of AIDS training workshops, through formal and informal interviews, conversations and discussions on topics related to HIV/AIDS with a wide cross-section of people from the St Wendolin's community, a conscious effort was made to provide the space needed for people to reflect and ponder upon the issues being raised. With the knowledge and insight that I hoped to gain as a researcher, I intended to write a thesis that would illuminate some of the more salient commonly-held ideas related to HIV/AIDS and sexuality, and to suggest ways for creating more culturally competent and potentially more effective AIDS interventions. Thus this thesis was conceived as an exercise in exploring and developing linkages between research and action.

In the opening paragraph of her essay on illness as metaphor, Susan Sontag made the point that although people have historically tended to metaphorize

serious illness, illness is not a metaphor, and that "the most truthful way of regarding illness – and the healthiest way of being ill – is one most purified of, most resistant to, metaphoric thinking" (Sontag 1978:1). I believe Sontag's point is especially relevant in the context of HIV/AIDS in KwaZulu-Natal today, whereby the epidemic is steeped in metaphoric thinking. An unhealthy way of being ill promises to be the fate of millions of HIV infected people in this province if current trends continue. It is my opinion that nothing could be a more unhealthy way of experiencing illness than fearing that disclosure of one's disease will result in verbal abuse, assault, social excommunication, being left to die without food and water, or being beaten to death, all of which are very real fears of many people (especially women) currently living with HIV/AIDS in KwaZulu-Natal (see Chapter 3). The metaphoric thinking and patriarchal fantasies associating women with AIDS that, as I have argued, underpin people's experiences with and understandings of the local HIV/AIDS epidemic, must be challenged. In the light of the current AIDS crisis in KwaZulu-Natal and in South Africa more generally, it will not be enough simply to understand internalized images that inform the meanings people attach to HIV/AIDS. I strongly believe that these understandings must be incorporated into an intervention strategy where they can be addressed and challenged in the course of AIDS education.

In the opening chapters of this thesis I discussed how previous health researchers have argued that Paulo Freire's (1972) pedagogy of learning, reflection and action has much to offer the health promotion effort worldwide (see works by Dalrymple and Preston-Whyte 1992, Rifkin 1994 and de Koning 1994 and 1996 among others). In this concluding chapter I argue that this is the kind of education that is needed in our fight against HIV/AIDS in South Africa. Only an 'education for liberation' offers the possibility of debunking the

gendered myths of AIDS and exposing 'Helen Ivy Vilakazi' for what she is – a deadly disease that thrives on, among other things, ingrained notions of gender inequality. My intention here is not to produce a template for the future design and structure of AIDS education, but rather to 'point the way' by arguing that we need to re-conceive our current educational objectives and methodologies for creating more culturally sensitive, effective and sustainable AIDS interventions.

AIDS EDUCATION FOR LIBERATION

The anthropologists Clatts and Mutchler (1989) have previously argued that while metaphor focuses our attention and orients our thoughts in particular directions, it simultaneously obscures or blocks our orientation to other possible avenues of seeing and knowing. I would argue that new ways of seeing and knowing HIV/AIDS in KwaZulu-Natal are desperately needed. Current orientations of thoughts coalese into a collective demonization of women, which, among other things, obscures our thinking about men's complicity and men's responsibility for the spread of HIV/AIDS. New ways of thinking are needed that challenge assumptions regarding the sexual irresponsibility of men. In order for this to happen we must first expose and address the multiplicity of metaphors that currently orient people's thoughts. Only then shall the way be cleared for a creative re-orientation of thought patterns that shape the way people see and know AIDS; ways that might help slow its current rate of transmission and mitigate against its strong social stigma. To effectuate such a 'paradigm shift', I argue that a particular type of AIDS education is needed, one that engages with and challenges metaphoric thinking and the many gendered myths of AIDS. As I have briefly discussed in Chapter 1 and as I further argue in this chapter, an AIDS education that draws upon Paulo Freire's 'education for liberation' offers us the best possibility, I believe, for peeling back the layers of patriarchally-framed metaphoric thinking that impedes our fight against HIV/AIDS.

Freire identified three stages of consciousness that I suggest are of particular relevance to the challenge of AIDS education in this country. These include: the naïve, the mythological and the critical. According to that author the first two stages of consciousness embody basic distortions in the form of fantasies and unrealities; distortions from which people need to be 'liberated' in order to participate fully as critically conscious members of society. The central notion of Freire's 'liberation theory' is the idea that a shift in consciousness and a move away from naïve/mythological thinking towards 'critical consciousness' is possible through an education that incorporates critical reflection on the part of learners. The process would entail having social roles and prevailing role-related ideologies presented to the participants or learners for reflection and analysis. The aim is to have people not only reflect, but to de-codify actively or deconstruct accepted roles and ways of thinking. Once having done this participants could be expected to then act out of this new reflection. The result, as Freire maintained, would be a ceaseless rhythm of reflection and action that would eventually change the prevailing social order. Refining Freire's theories further, Shor (1993) indicated that critical consciousness could be described as having four qualities: power awareness, critical literacy, de-socialization, and self-organisation/self-education. Critical thinking means analytical habits of thinking which go beneath surface impressions and mere opinions and cliches; understanding of the social contexts, and discovering the deeper meaning of any subject matter, process or situation. De-socialization means recognizing and challenging the myths, the dominant cultural scripts, the language learned, and critically examining values operating in society. Shor (1993:32) argued that from this process should arise action to re-socialize oneself through self-education and organization as critically aware members of society.

Significantly, the growing feminist movement in the West during the 1960s and 70s drew heavily upon Freire's philosophy and methodologies for fostering

critical consciousness. Freire's perspective of viewing intra and interpersonal changes and collective action as interwoven aspects of the development of self and social change, became a cornerstone of the early feminist movement. Notions of power awareness, critical literacy, de-socialization and self-education were incorporated as critical components in feminism's 'consciousness raising' programs which emphasized critical reflection and discussion. Women and men, especially those attending western universities in the 1970s, were encouraged to participate in consciousness raising programs led by feminists whose aims were to stimulate debate and critical reflection on socially-constructed notions of gender. Following Freire who argued that such an education was necessary to achieve 'liberation', the early feminists believed that a similar critical awakening would foster women's 'liberation' and help bring an end to gender inequalities.

To assess properly the extent to which consciousness raising and the feminist movement as a whole was successful in fostering gender equality in the west would require an entire thesis on its own. Nonetheless few people would argue that most western societies have been profoundly affected by the 'reverse discourse' on gender which the women's liberation movement helped to bring forth. Notions of gender in the West have been subjected to much analysis, debate and change over the past thirty years, with the result that today there is little in terms of gender roles and expectations that is taken for granted as 'natural' or pre-determined. With western scientists claiming that it may soon be possible to alter men's bodies surgically and hormonally so as to enable them to bear children, even the basic biological 'fact' that a woman can bear a child while a man cannot, becomes questionable.

Starting in the 1990s writers such as Doyal et al (1994) began to argue that consciousness raising and a 'feminist agenda' were critical to the fight against AIDS. I would support Doyal et al's argument and suggest that liberation

theory and the associated educational methodologies and objectives have much to offer the struggle for more effective AIDS intervention strategies in South Africa. Characterizing the local context of the AIDS epidemic are a fair amount of false images, myths and regressive values that have been internalized into consciousness. Inasmuch as these distortions inform, structure and reflect gender inequalities (among other things) that make the practice of safer sex a near impossibility, and ultimately obstruct the fight against AIDS, they must be challenged. In my view there is an urgent need for AIDS education in South Africa to move beyond the erstwhile message of AIDS awareness and move in the direction of AIDS 'education for liberation'. A process needs to be initiated whereby people are enabled to become conscious of their internalized images, norms of behavior, and value systems which are taken for granted. AIDS educators should become facilitators of a learning/reflection and action process, rather than being simple messengers for the delivery of scientific medical information.

By re-defining AIDS education as a consciousness-raising endeavor, AIDS interventions could be used as the primary site for people to develop an awareness of where the images, ideas, positions and opinions they have of maleness, femaleness, sexuality and HIV/AIDS come from. Once explored and critically reflected upon, learners could be assisted to develop the necessary skills to initiate action that offers the possibility of giving different meanings and directions to their lives. Shor (1993) used the terms 'de-socialization' and 're-socialization' to describe this process. I would argue that de-socialization and re-socialization needs to become part of future AIDS interventions in South Africa, and that this could best be effected through a community-based peer education strategy.

CONSCIENTIZATION AND PEER EDUCATION

For the most part AIDS training has followed the traditional approach of information-based health education, evaluated through the use of a range of biomedical and behavioral 'outcomes' at the individual level of analysis. Such outcomes have included changes in the prevalence and incidence of sexually transmitted diseases or HIV over the course of time, a variety of individual behavioral indications (most especially changes in knowledge, attitudes and reported practices), or indirect measures of behavior such as the number of condoms distributed in the target population. There is currently a growing body of literature (see for example Campbell 1998, Gillies 1998 and MacPhail 1998) revealing the limitations of such individualistic approaches to AIDS management. As discussed previously in this thesis, it has become increasingly apparent to many involved in the AIDS effort, that sociocultural factors play key roles in the spread and growth of the AIDS epidemic. Awareness of this fact has prompted several writers such as Tawil et al (1995) to argue that the development of an 'enabling' sociocultural environment is vital for any desired behavior change to take place.

Dube and Wilson (1996) have argued that community-based peer education used in the fight against AIDS could provide the type of 'enabling' environment for people to critically reflect upon and renegotiate sexual cultures collectively, thus firmly establishing the AIDS 'problem' as a community problem. Writers such as Gillies (1998) and Ray et al (1998) maintain that health promotion should include a peer education and community development thrust in order to take into account some of the broader dynamics shaping and constraining sexual behavior. I would support such arguments. In the course of my research, I interviewed many people who shared the view that AIDS educators and the organizations involved in AIDS awareness training seemed to care more about AIDS than about the people themselves. This was evident, they claimed, by the way AIDS educators showed little or no interest in the many other

problems plaguing participants' lives. Peer education focusing on AIDS as part of a broader community development strategy could be a way to address this problem. Evidence is starting to emerge from other parts of Africa suggesting that peer education programs have been successful in reshaping sexual behavior (see works by Ng'weshemi et al 1997, Campbell and Williams 1998, Gregson et al 1998, discussed in Chapter 2). What these studies suggest is that such programmes have been more successful in fostering behavioral change because peer educators from the communities have a more intimate grasp of the dynamics and meanings attached to people's health-related behaviors, including sexual health. In addition they argue that the re-negotiation of sexual culture can best be explored and achieved collectively. AIDS interventions that make use of peer educators could provide the ideal setting for discussing sexual culture and developing a transformative 'reverse discourse' on gender aimed at promoting a 'liberation' from mythical thinking. By viewing the problem of HIV transmission reduction as part and parcel of the problem of modifying sexual culture (as opposed to sexual behavior per se), and by moving AIDS education in the direction of consciousness raising, internalized images and metaphorical thinking that is being brought to bear in this epidemic could be exposed, discussed and then subjected to critical reflection. A site must be created for people to not only talk about sex, but to *reflect critically upon mythical ways of thinking about such things as the idea of AIDS being unidirectional <u>from</u> woman <u>to</u> man, the notion that women are a natural source of 'infection', beliefs that witchcraft causes AIDS, that sex with particular women or girls can 'cleanse' the blood of HIV, and assumptions regarding the abilities of traditional healers to 'cure' AIDS, for example.* To create the possibility of other ways of seeing and knowing HIV/AIDS, the current mythical discourse on AIDS needs to be interrupted and challenged.

A community-based peer education approach to AIDS could provide the site and space for not only critical reflection on mythical thinking, but also the space

for raising questions around certain concepts, such as that of 'informed choice' for example. Moore (1994) in her discussions on gender identity and subjectivity draws our attention to two key questions that are most relevant to AIDS intervention:

> ... the questions are, can people actively recognize and choose the subject positions they take up, and to what degree are they able to resist the terms of the dominant discourse? (Moore 1994:4)

These questions could be taken up during a peer education AIDS intervention aimed at initiating a process of critical reflection. For example, how helpful is it for a young woman to be informed that having sex can put her at risk for HIV/AIDS without giving her the space to reflect and analyze all the factors that influence her 'decision' to have sex? She needs to become conscious, as far as possible, of the factors which influence her decision before she can start calling it a decision. Women need the opportunity to reflect upon such questions as: How much do they desire sex? What are the meanings they and their peers associate with condom use, with intercourse, with concurrent sexual partnerships, with sexual violence, with the use of love medicines? What are their fantasies about men, marriage or women who exchange sexual favors for clothes, outings or rides in luxury automobiles? As de Koning (1996:10) rightfully argues, an AIDS education that aims for empowerment and self-determination needs seriously to provide the space for analysis and reflection on the "congruent and conflicting ideas, self-images, self-representations, fantasies and desires which underlie a person's position in relation to dominant discourses on sexuality".

Ultimately, if we are serious in our efforts to slow the growth of HIV infection and assist those who are living with the virus or dying with AIDS, and those who are currently under threat of being killed because they have publicly acknowledged their condition, we have to find the courage to address some

deep-seated, culturally-sanctioned, long-existent and emotionally-charged ways of thinking about *what it means to be a man or a woman, and the implications that those meanings have for the continued growth of the HIV/AIDS epidemic.*

ENGAGING WITH CULTURE

A forward-looking AIDS education that draws upon Freire's (1972) liberation theories would mean actively engaging with and critically examining internalized images, myths and values associated with notions of African culture. It would mean taking a progressive view of culture, whereby culture is understood as something dynamic that changes and should change to meet the demands of an ever-changing environment. So-called 'traditional' ways of thinking about and doing things would then be subjected to a critical assessment as to whether such ways of thinking and doing are helping or hindering the fight against HIV/AIDS. In the course of my research for example, promiscuous behavior and unsafe sexual practices were often rationalized by informants in such a manner as to appeal to their own interpretation of 'tradition'. The pursuit of *isoka* status by young men which entails the sexual conquest of many women, was most often regarded as normative behavior and accepted as a type of 'traditional' birth-right of African men. Likewise men often referred to the 'tradition' of polygamy to justify their 'need' for multiple sexual partnerships. In the era of AIDS, such 'traditions' are considered by many involved in the AIDS effort to be 'traditions' that help to facilitate rather than halt the growth of the HIV/AIDS epidemic. The consequences of such 'traditions' in the midst of an as-yet incurable disease that is spread primarily through heterosexual activity, in conjunction with men's reluctance to use the condom (condom use often being viewed as something 'untraditional' and therefore to be avoided),are nothing less than lethal. As South African anthropologists Spiegel and Boonzaier (1991) previously argued, the normative prescriptions implied by the idea of 'tradition' derive from the ways in which "people appeal to an image of their past to gives legitimacy to presently preferred beliefs and practices"

(cited in Van de Vliet 1991:231). For many people in St Wendolin's, and especially young men, the preferred beliefs and practices of multiple sexual partnering and unsafe sex that propel the spread of HIV/AIDS are currently given legitimacy by way of being 'traditional'. Clearly then, ideas of 'tradition' need to be challenged.

An AIDS 'education for liberation' that deconstructs present-day notions of 'tradition' would mean addressing, in a critical way, the culturally-constructed complexities, including symbolic representations, that give meaning to and justify people's behavior in this epidemic. Such a project would necessarily mean going beyond the dredging up of old customs such as virginity testing that are, in my view, another way of controlling and disempowering women. Such rituals may have been a meaningful and appropriate way of addressing problems associated with a rural, agrarian past, but the modern realities of a largely urbanized South Africa today (which include frighteningly high levels of STDs, teenage pregnancies and the 'new' disease HIV/AIDS), demand that new strategies and new problem-solving rituals be developed. Given current legitimacy once again by way of being 'traditional', virginity testing is essentially a way of placing women's bodies and sexualities under greater patriarchal control. It denies women the opportunity to develop the necessary skills and confidences to take control over their own bodies. New rituals are needed that aim to empower women to have greater control over their own bodies and sexuality, not less. A 'reverse discourse' needs to develop, one that challenges dominant sociocultural constructions of femininity and masculinity and arises from critical reflection on internalized images that give meaning to these constructions. At issue then is the examination of much that is considered 'traditional' or 'customary' and often 'sacred' in the sense that for some, it is not even open for questioning or debate. Nevertheless, refusal to address what many might prefer to remain as 'un-addressable' because it means challenging male privilege and preferred interpretations of 'tradition', will only ensure that

current high rates of HIV transmission continue. AIDS impels us to be bold because AIDS itself is bold. Nothing and nobody in its wake is 'sacred', and nothing and nobody will be left unaffected. Together with a renewed government commitment to address the growing HIV/AIDS epidemic (as represented by the aforementioned launching of the 1998 Partnership Against AIDS), a new pedagogy for AIDS education could help to move people in a new direction, away from outdated and oppressive patriarchal mental frameworks that structure people's ideas and experiences of gender, sexuality and HIV/AIDS.

I believe the time is ripe to negotiate a new AIDS education/consciousness raising program, one that is firmly grounded in South Africa's new 'tradition' of social justice and human rights. By transforming the business of AIDS education into the site for a most radical change in gender/social relations, something positive may come out of this epidemic. Left unchecked, the AIDS epidemic promises to negate much of the progress already made and still to be made in building a new South Africa. In terms of life expectancy and socio-economic development, some researchers say that the AIDS epidemic will set South Africa back fifty years (Michaels 1998). As the opportunity and the reason to initiate social transformation that might help to militate against this depressing scenario, the AIDS epidemic offers an opportunity that we can ill afford to miss.

LOOKING FORWARD

By suggesting a focus on culture that brings gender constructions and metaphoric thinking into stark relief, I am in no way denying the importance of other forces shaping the AIDS epidemic. Interventions to promote changes in sexual culture must be firmly based on the understanding that, as Campbell (1998) correctly argues, sexual behavior is 'nested within a complex range of psycho-social processes'. These would include the collective negotiation of

sexual identities, self-efficacy or empowerment at the personal, small group, community, cultural, economic and social levels of analysis. As Farmer (1997) makes clear, fine-grained psychological portraits and rich ethnography are important, but they tell only part of the story. Large-scale economic forces are also at work, as Webb (1997) so forcefully argues, which result in factors such as poverty, migration, racism and historical/political heritage being embodied as increased risk. Along with the culturally specific such as local styles of sexuality, gender equalities and shifting representations of disease, large-scale factors constitute important shaping forces in the AIDS epidemic. These factors must also be addressed, and will require long-term and major financial commitments on the part of the government.

Clearly, the study of AIDS demands broad bio-sociocultural approaches. When considering education/prevention strategies, Bolton and Singer (1992) drew upon the lessons learned from the first decade of AIDS, the 1980s, and concluded the following:

> Prevention works best when it promotes change through individual and community empowerment strategies informed by holistic understandings of the local context, when it acknowledges the positive contributions of local cultural values to the process of change, and when it incorporates an array of options that permit individuals to transform their lives in ways that enhance their physical, emotional, and material well-being. Prevention efforts fail when they victimize and stigmatize those who do not accept messages incompatible with their basic needs, when they blame those whose behavior suggests recalcitrance or relapse from risk standards established by health 'experts', when they are based on top-down rather than community-designed and implemented approaches, and when they are shaped by the moralistic and authoritarian models advocated by political, religious, and medical leaders whose agendas

> may be inimical to the best interests of the clients of many prevention programs. (Bolton and Singer 1992:142)

I conclude this thesis in the hope that AIDS policy planners in the new century will grasp what anthropologists have known all along; that far from being a simple biomedical phenomenon, AIDS, like sexuality and gender, is a sociocultural construction. To be maximally effective, AIDS education programs must be based upon a thorough comprehension and acknowledgement of the sociocultural systems of thought and behavior, including the symbolic meanings that underpin those thoughts and behaviors, of the people for whom the programs are intended. Qualitative and participatory research methodologies could help facilitate the process of gaining the knowledge needed to grasp the complex webs of understanding in which the meaning of HIV/AIDS is enmeshed. Once understood, the space must be provided for people to reflect critically upon those images, thoughts, values and behaviors which impede not only our fight against AIDS, but our struggle for a more democratic society where guaranteed human rights and gender equity are more than empty promises on paper.

A truly transformative AIDS education could be 'the donkey that pulls the cart' of South Africa's continuing efforts at social transformation in the post-apartheid era. The profound reality of AIDS on our 'stoep' (a colloquial for 'doorstep') gives us little choice but to be bold in our responses to the ever-growing epidemic. Engaging with and questioning the myriad of mythical and metaphoric thinking that surrounds the AIDS epidemic will help clear the way for new ways of not only seeing and knowing about AIDS, but seeing and knowing about women in South Africa. An AIDS 'education for liberation' would mean a strong gendered response to an epidemic that is powerfully gendered in the minds of many peoples. Without such a response, the demonizing of

women in this era of AIDS will go unchallenged, bringing with it more justifications for control, discrimination and the further oppression of women.

The opportunity that AIDS brings in its deadly wake to explore and speak about notions of gender and sexuality (and the multiplicity of symbols and meanings attached to these notions) is an opportunity that we should not allow to slip away. The repercussions for women and society more generally could be profound. Ultimately then, the real challenge of AIDS is the challenge of seizing an opportunity through which to create and express a culture of renewal; an opportunity to foster an African renaissance that has real meaning for millions of people living and dying in the midst of the world's fastest growing AIDS epidemic.

APPENDIX 1

MEDIA REPORT OF FINDINGS OF THE KWAZULU-NATAL DEPARTMENT OF DEMOGRAPHICS PREDICTING NEGATIVE POPULATION GROWTH AND DROP IN LIFE EXPECTANCY

KZN faces wipe-out

Death rate set to rocket

Child mortality rates are predicted to increase from 48% to 99% in the year 2010 as a direct consequence of Aids

SAYS THE FINDINGS OF A PROVINCIAL GOVERNMENT RESEARCH

Stark predictions of a population decimated by Aids will soon become a reality. **SHARDA NAIDOO** reports

FOR the first time in history, deaths have exceeded births in KwaZulu-Natal. Already reeling with the highest HIV-positive infection rate in the country, this devastating news has confirmed the fears of Aids researchers who for years have been releasing grim statistics to a seemingly unresponsive public.

But while KZN is worst affected, deaths will soon outstrip births throughout South Africa, with young mothers perishing as a direct consequence of Aids.

Ms Karen Michaels, a researcher for the KZN Department of Demographics, found that KZN was starting to experience negative population growth, ahead of the other provinces, as the Aids and HIV epidemic reached alarming levels.

The 1998 Human Development Report (HDR) stated that the hardest hit sector was men aged between 20 and 40 and women aged between 15 and 35.

The report predicted that just 13% of South Africa's population would reach the age of 40 by 2005.

"South Africa is experiencing one of the most rapidly progressing HIV and Aids epidemics in the world, with KZN being the worst," said Michaels.

If trends continued, Michaels said, about five million adults will be HIV-infected by 2005. This will result in a steep rise in the adult and infant mortality rate, of which KZN also has the highest in the country.

Child mortality rates are predicted to increase from 48% to 99% in 2010 as a direct consequence of Aids.

This meant that almost 100% of the children born 10 years from now would die because the HIV-positive mother would infect her child either during pregnancy or breastfeeding, explained Michaels.

She said in Durban, where breastfeeding was the predominant infant feeding practice, the rate of HIV transmission from an infected mother to child was estimated at 50% in 1992. As a result, about 900 000 babies would be orphaned in five years, she said.

Deprivations

"There will be a significant reduction in life expectancy levels not experienced in recent decades.

"Increasing numbers of children will watch their parents die and they will face social and economic problems. The epidemic will replicate itself in the children of the next generation which are likely to experience social and personal deprivations that expose them in turn to HIV infection," she said.

Models projecting the future size of the population show that by 2010 about half of the general population will be HIV-infected.

Last year the life expectancy dropped from 65 years to 55 years and the growth rate declined from four percent to two percent, revealed Michaels.

In 10 years, she said, life expectancy was projected to fall from 68 years, in the absence of Aids, to 48 years.

This had devastating implications for both the social structure of households and for their quality of life, stated the report.

Professor Alan Smith, head of the virology department at the University of Natal Medical School, said the mortality rate had overtaken the birth rate because of the severity of the Aids epidemic in the province.

Negative growth

"Eventually the entire country will go into negative growth, but it is happening sooner in KwaZulu-Natal."

He said stakeholders and the public needed to realise these figures were reality and not released for shock value.

"The mothers of our nation are dying. The increase in the death rate of younger women is the reason for our country's population declining by the year 2010."

He said the Aids epidemic was killing younger mothers, who were a vital component of the population as they were responsible for producing future generations.

He said even after a war, when thousands were killed, there was a chance for population growth as there was usually a baby boom afterwards.

Although the report suggests that all stakeholders should work together to contain the epidemic, "it seems we are moving in a vicious circle, as even the health workers, who are supposed to help the sick and dying will soon become infected".

However, the health ministry is positive its campaign against Aids will prevent a drastic decrease in the South African population.

Health Minister Nkosazana Zuma's spokesman, Mr Khangelani Hlongwane, said the ministry viewed the situation as a priority.

He said the figures were shocking and the Government saw it as a serious problem.

But he said Zuma believed that its Aids awareness campaign, aimed at improving the quality of people's living conditions, would reduce the predicted number of people infected by the virus.

Source: The Saturday Independent, 8 May 1999

APPENDIX 2

NEWSPAPER ARTICLE HIGHLIGHTING THE WORK OF A NON-GOVERNMENT ORGANIZATION HELPING AIDS PATIENTS IN THE VALLEY OF A THOUSAND HILLS

Prejudice against Aids victims

Community workers have an uphill battle to help Aids sufferers, writes a DAILY NEWS REPORTER.

ILLNESS – and now hunger and violent death – threaten to overwhelm the cash-strapped Hillcrest Aids Centre, near Durban.

The centre provides for people with Aids from Field's Hill to Camperdown.

Centre director Neil Oosthuizen said there were 28 000 people terminally ill in the area. The population was estimated at 80 000.

In any given family in the area, at least one in five had the HIV virus, he said.

"Apart from counselling people with Aids and their families, we are getting an ever-growing number of them who are also facing starvation.

"We are now forced to arrange food parcels. Even that is not without its problems. Our helpers know that if they are caught handing over food parcels to people with Aids, they could be attacked and perhaps killed by a hostile community."

The head of the centre's feeding scheme, Moira Cooke, said she and her co-workers had to meet people with Aids secretly to give them food.

"We dare not do it openly. There is great prejudice in the region against people who have Aids. Employers will not keep them, schools will not admit their children, their homes are often burned down and they are either killed or chased into the wilds."

FOOD PARCELS: Neil Oosthuizen and Linda Knox pack food for delivery to families suffering from Aids.

She said what was perceived to be a "simple act of kindness" could result in gruesome death.

The centre's counsellor, Linda Knox, said there was a distinct pattern when a family wa struck by Aids.

"Usually it is the father of th household who gets sick first. is only when he is taken to ho pital and examined, that he found to have Aids. Natural we ask the wife to take a te and often she, too, is infected.

"We then ask for tests for th children. Invariably they eith have Aids or are HIV-positiv In some cases some of the ch dren are not affected."

"The problem for them star after the death of their parent They are left with their gran parents whose only income an old-age pension. The elder then have to take care of tho children. Soon, the kids drift and could easily end up on t streets."

The centre has drawn up staple diet and has appealed the public to make contrib tions. Mealie-meal, mealie-ri samp, soya mince, pilchar peanut butter, washing so sugar, toilet soap, margari and powdered milk are need

The situation is getting wo and recently a nearby an natal clinic found half of young woman between the a or 15 and 20 that came for h were either HIV-positive already had Aids.

At a Durban government h pital, 31% of all women v come to the ante-natal cli are either HIV-positive or h Aids.

Anyone wanting to make c tributions of food should t phone Ms Knox at 031-7655

Source: The Daily News, 26 November 1998

APPENDIX 3

MEDIA REPORTS OF CURRENT DEBATES ON AIDS AND GOVERNMENT POLICY

IT IS up to politicians to decide on the treatment of AIDS. However, it is the responsibility of those involved with health policies to be well informed about the wide range of treatments available and to be extensively briefed on all possible cures.

Most research into AIDS has been done in the field of allopathic medicine in an attempt to curb the virus itself, but since AIDS is a disease that suppresses the immune system, we need to investigate ways of stimulating immunity, if not to cure the disease, at least to delay the onset of full-blown AIDS.

In view of the interest in holistic health care and the multitude of claims for cures, research into the use of alternative medicine must be handled scientifically. Otherwise, politicians will use AIDS cures as political footballs. Health Minister Nkosazana Zuma has done so with Virodene and Winnie Madikizela Mandela is being asked to do this with ozone, exposing patients to considerable harm.

All potential AIDS treatments must be subjected to ethical trials conducted by universities and research institutes. Only once they are registered by an independent authority should they be made available to the public. The procedure followed by a Stellenbosch team researching the African potato has fulfilled the required criteria. Their treatment is based on refined bits from the hypoxis plant that boost immunity to infections. Tested on patients with TB, AIDS and chronic fatigue syndrome, the substance has produced favourable results. If used in government clinics and hospitals, it would cost a mere R20 a month per patient, improve people's response to TB drugs and delay the onset of full-blown AIDS. The research team wrote to the minister, but she has shown little interest in this indigenous plant.

The Health Department appears to have shown an equal lack of enthusiasm for treatment of HIV in pregnant women. A short course of conventional drugs, taken in combination, can prevent infected mothers giving birth to HIV-positive babies.

The department's failure to respond in these instances shows the lack of coherence in its AIDS strategy.

At present, women routinely tested at antenatal clinics are not tested on an individual basis. They are tested anonymously for statistical purposes. Many do not know they have AIDS. The condition is not notifiable, therefore even women who do know that they are HIV-positive, will not be followed up for treatment after they have left a clinic or hospital.

Our attitude towards AIDS has been largely defined by the West, where AIDS is regarded as a human rights issue rather than a public health crisis. Notifiability is rejected on the grounds that the spread of AIDS is mostly by sexual intercourse, therefore individuals can exercise some control. Contracting AIDS is a death sentence and the sufferer becomes a potentially lethal sex partner. Therefore, it is not surprising that the disease carries a stigma.

But the special status given to AIDS, requiring pre-test counselling, permitting people to choose not to know their AIDS status, and conducting anonymous testing are factors contributing to the rapid spread of the epidemic. In addition, easy abortions have not encouraged young women, the most vulnerable sector of the population, to insist on safe sex.

Measures to educate people to treat everyone as if they have AIDS and to protect themselves through preventive measures have largely failed. Spending another R8-million on a campaign to provide youth with lifestyle skills, promote condom use, improve education and counselling, and promote human rights is unlikely to impact on the spread of the disease.

A more effective AIDS strategy balances the rights of sufferers with those of the uninfected public. It combines the efforts of government and the private sector within clear guidelines and it ensures that everyone is well informed about all aspects of the disease. Schoolchildren ought to know which classmates have AIDS and how to cope with their injuries or nose bleeds. Knowledge, not persuasion, will end fear and rejection.

Communities need to organise to provide home-based care for the terminally ill and to take care of orphaned children. Universities and businesses should provide free condoms in toilets. The media should revert to role models who encourage teenagers to exercise restraint and protect their lives.

The ideal government policy protects sufferers from unfair discrimination and demands confidentiality of health workers. But against this background it cultivates openness and responsibility.

Testing for AIDS and HIV should be routinely done if indicated and patients or their families told the results. AIDS education should be taught extensively at schools, and counselling performed routinely at hospital outpatients departments and clinics, by NGOs cooperating with medical staff. HIV and AIDS should be notifiable, not at death demographically, but by name while patients are alive. This would facilitate monitoring of the illness, avoidance of further pregnancies and treatment to prevent the birth of infected infants. It should also be a criminal offence for people with HIV not to disclose this to sexual partners. A policy combining these features is coherent, humane and cost-effective, and works to limit the epidemic.

Those who oppose these measures on the grounds that people will hide their AIDS status are unaware of the extent of the disease. Some 1 500 South Africans are infected every day, we will have a million AIDS orphans by 2005 and 60 percent of AIDS cases are in sub-Saharan Africa. The disease is already too widespread to stigmatise sufferers. Our only hope of curbing it lies in openness.

Many of us now have HIV. Let us acknowledge it, accept it and deal with it, not ostrich-like facilitate a national disaster.

● *Dr Ruth Rabinowitz is the Inkatha Freedom Party health spokesman*

second opinion

RUTH RABINOWITZ

The AIDS epidemic can be controlled by protecting the public

Source: The Sunday Tribune, 28 July 1998

Making Aids notifiable a 'retrogressive' step

VIV BRADLEY
PIETERMARITZBURG BUREAU

SOUTH Africa is about to make AIDS a notifiable disease but, according to Durban academic Professor Alan Whiteside, the move might be a retrogressive one.

Addressing delegates to the Pietermaritzburg conference on Aids orphans, Prof Whiteside said there was very little data on Aids cases in this country, and therefore making the disease notifiable would not help in getting the information in.

"It is a credit to the KwaZulu-Natal Cabinet that they have started to respond to the Aids crisis without having all the data in front of them."

The Professor, who is with the Health Economics and HIV/Aids Research Division at the University of Natal in Durban, said the three-day conference was crucial because South Africa had failed to stop the epidemic and now had to deal with the consequences.

He said KwaZulu-Natal "led the pack" in terms of HIV prevalence throughout the country, but it was likely the other provinces would soon catch up "unless the province got its act together - and I don't see them doing much about it".

Prof Whiteside said Aids was the major cause of death among people between the ages of about 15 to 40 in many African countries – and this was the age-group which was most economically active.

Intervention

He said it was possible that, through intervention, the current infection rate among women at ante-natal clinics in KZN could be brought down from 30% to 10% – but this would have a significant effect on the social implications for children.

"We would simply be increasing the number of orphans," he said.

"There is no point in protecting them from mother-to-child transmission of the disease if society cannot protect them when they are orphaned."

He said despite the "horrific demographic consequences" of the epidemic, populations continued to grow, which increased the demand and reduced the resources with which to deal with victims of the disease.

Prof Whiteside said one of the primary causes of the ... demic in Southern Africa ... sexual behaviour wh... exposed people to infecti...

Little would change, ... pointed out, unless So... Africa succeeded in de... oping a "civil society"; ... which would create an e... ronment in which sex... values adopted by the p... lation did not put ther... risk.

He said that the tidal w... of Aids orphans had reac... a stage where we had to... urgently or be overwhelm...

Source: The Daily News, 11 June 1998

APPENDIX 4

REPORT OF INTERNATIONAL COLLABORATION ON LATEST EFFORTS TO DEVELOP A VACCINE AGAINST THE SUB-TYPE OF HIV MOST PREVALENT IN SOUTH AFRICA

SA's role in developing Aids vaccine

ISHANI BECHOO
MEDICAL REPORTER

SOUTH Africa is playing a key role in the development of an Aids vaccine.

While the Aids virus taken from a Durban person has been used as the basis of an HIV vaccine being developed in the United States in collaboration with experts from South Africa, a second initiative is under way in this country.

Still in the very early stages of development, the phase one human trials of the vaccine developed in North Carolina are expected to take place early in the year 2001.

Quarraisha Abdool Karim, from the Medical Research Council (MRC) Durban, said the vaccine development project was an initiative of the University of North Carolina, scientists from the MRC in South Africa, the University of Cape Town, and the National Institute of Virology, and was funded by the International Aids Vaccine Initiative (IAVI) – an organisation based in New York.

Meanwhile, in South Africa, a "novel and exciting idea" is unfolding – the South African Vaccine Initiative (SAAVI), a joint effort between the Department of Health, the Department of Arts, Culture, Science and Technology, Eskom and the MRC.

"While we are nearly two decades into the HIV pandemic, efforts towards the development of an HIV vaccine have lagged behind. The HIV vaccine development agenda has progressed rapidly in the last two years, largely catalysed by the IAVI and by US President Bill Clinton calling for an Aids vaccine by 2007."

Mrs Abdool Karim said there were about 10 sub-types of the HIV virus. In Southern Africa the dominant sub-type of HIV was Clade C which accounted for about 50% of all HIV circulating in the world today.

Clade C was mainly found where HIV was transmitted between heterosexuals. Clade B was found where HIV was spread through sexual contact between homosexual men as well as through blood transfusions done before 1985.

Infants born to infected mothers were Clade C while the first cases of HIV reported in North America were reported to be the Clade B type.

"While we do not know the implications of the different HIV clades, given the state of HIV vaccine development, it makes a lot of sense for countries to direct their efforts towards the dominant one. Efforts to date have primarily focused on vaccines towards Clade B HIV."

A Clade B product was being tested in Uganda while India had also made a commitment to developing its own vaccine.

"Historically vaccines have been developed in the north and bought by countries in the south.

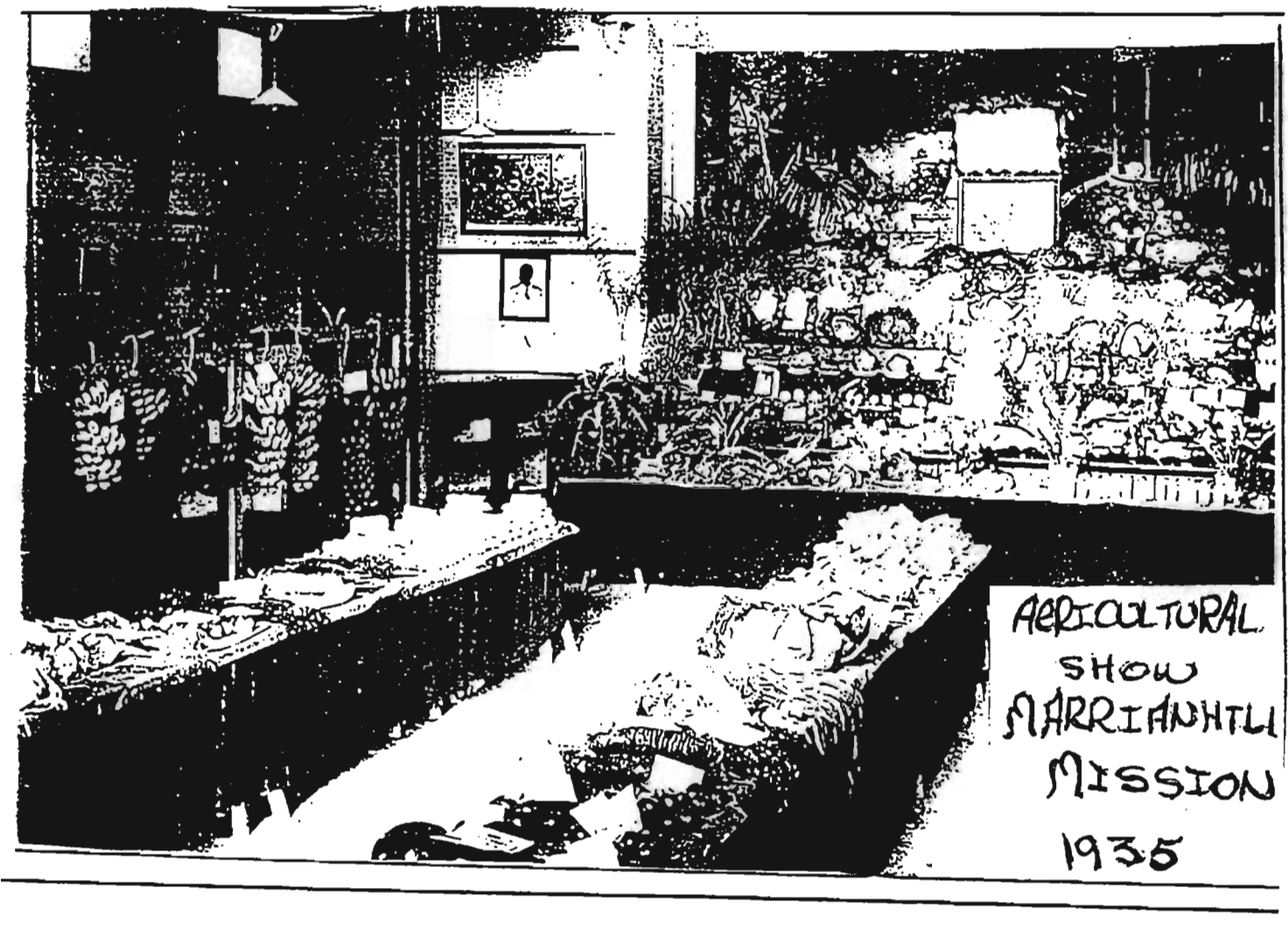
"Access in the south is largely influenced by economics. Hepatitis B is a good example. We have a vaccine that works, but many countries cannot afford to buy it."

The South African Vaccine Initiative was an effort to fast-track the development of a Clade C HIV vaccine for South Africa in collaboration with the international community.

Source: The Daily News 26 May 1999

APPENDIX 5

POSTER ADVERTISING UP-COMING AGRICULTURAL SHOW AT MARIANNHILL FOR THE AWARDING OF PRIZES TO LOCAL 'NATIVE' FARMERS.



Source: History of St Wendolin's (H.England, 1966)

APPENDIX 6

ARTICLE HIGHLIGHTING PILE-UP OF AIDS CORPSES AT ST MARY'S HOSPITAL

Grisly scenes as unclaimed bodies stack up in overcrowded hospital mortuary

Aids corpses piling up

It's a house of horrors at a Durban mortuary, with bodies littering the floor. ERIC NDIYANE reports.

IN what looks like a battlefield scene, piles of unclaimed Aids-infected bodies are lying on top of each other in a Durban hospital mortuary.

And with the soaring death rate, St Mary's Hospital mortuary in Mariannhill is faced with the problem of where to store the bodies until they are claimed by relatives.

Matron of the hospital Miriam Ndaba said the mortuary was built to accommodate 18 bodies and could not cope with the daily death rate.

At least three people died in the hospital each day, and that was causing the problem.

The missionary hospital did not charge for storing bodies, but it was costing the hospital lots of money to get a government undertaker to collect some of the bodies.

More deaths were likely due to the expected heat over the festive season when diseases spread quickly, she said.

Mrs Ndaba said the situation was forcing the hospital to "rotate" the bodies between the freezers and the trolleys, leading to grim scenes when they had to take out the "old" bodies and put them on trollies or on the floor to allow the "fresh" ones to be frozen.

Mrs Ndaba said last Thursday they registered four deaths and their freezer trays were already full – so they had to take out four bodies which had been frozen to put in new ones.

"The situation is getting out of hand. We have run out of space to put in more bodies. Our hospital is paying a fortune to get 'outside' undertakers to collect the bodies."

> **"In many cases I put five children on a single tray to create more space for adults. My job is a nightmare.**
> *NGIZWILE MKIZE*
> *Mortuary Attendant*

She appealed to people to take responsibility for their relatives' bodies as the problem was snowballing.

"I do not know why people do not come and collect the bodies of their relatives.

"We used to ask for the government morgue to come and take some of the bodies if they remained unclaimed more than a week or so, but even that is costly as we pay them R295 to remove an adult body and R195 for a child."

Mrs Ndaba said it was difficult to trace relatives of the deceased as many of them were from outside KwaZulu-Natal; others were from rural areas and it was difficult to trace their families; and others had been admitted in a serious condition, making it difficult to get their details.

The hospital's mortuary attendant, Ngizwile Mkize, said the lack of space had turned his job into a nightmare.

"In many cases I put five children on a single tray to create more space for adults; also, if adults are thin enough I squeeze two bodies on a tray.

"Sometimes the situation forces me to put other bodies on the floor. I become angry when I have to unpack and re-pack back bodies when relatives finally come to claim them."

HIV lives on after death

THE head of the Department of Virology at the University of Natal medical school, Professor Alan Smith, said HIV would remain active in a corpse for at least two weeks – but only if it had been refrigerated.

He said one study revealed that HIV had been found alive in a corpse that had been refrigerated for 13 days.

"Nobody has done research into whether the virus will remain active for longer."

When virologists wanted to keep a virus alive they refrigerated it.

"A body that is not kept cold begins to putrefy and when this happens the virus is destroyed by enzymes." – Medical Reporter

PICTURE: ERIC NDIYANE

A TIGHT SQUEEZE: The hospital's mortuary attendant, Ngizwile Mkize, who is battling to find space to store bodies.

Source: The Daily News, 25 November 1998

APPENDIX 7

MEDIA REPORT HIGHLIGHTING THE RAPID INCREASE IN NUMBERS OF FULL-BLOWN AIDS CASES IN KWAZULU-NATAL

PATIENTS MAY HAVE TO BE TURNED AWAY AND SENT HOME

Aids flooding KZN hospitals

THE "silent" disease is taking its toll on hospitals in KwaZulu-Natal which are battling to cope with the huge flood of people who have developed full-blown Aids.

And an ever-increasing number of children are being admitted to paediatric wards with Aids-related diseases.

At Pietermaritzburg's Edendale Hospital up to 60% of children are suffering from Aids.

A paediatrician said: "Children with Aids probably take up the highest number of patient days than any other illness."

At Grey's Hospital 70% to 75% of the children, who were all under the age of six, were admitted with Aids-related problems, said paediatrician Neil McKerrow.

In October, 80% of child-deaths were from Aids, he said. These diseases can include tuberculosis, skin diseases and other infections.

The number of adult patients suffering from Aids is also increasing dramatically.

"At present 30% to 40% of patients in hospitals are HIV-positive while 80% to 90% of the bodies passing through hospital mortuaries are HIV positive," said health spokesman Dave McGlew.

At some rural hospitals the figures are even higher.

"We are seeing about 50% of admissions to medical wards with Aids-related disease," said Ixopo Hospital superintendent Andrew Atuhaire.

The time is fast approaching when Aids patients will be turned away from hospitals and sent home where communities and families will be expected to take care of them, health authorities have warned.

In antenatal clinics an estimated 30% of pregnant mothers are HIV-positive and about 20% of patients have Aids-related diseases, according to the professor of virology at King Edward VIII Hospital, Prof Alan Smith.

"At the province's TB hospitals an estimated 60% of patients are suffering from Aids.

"The problem is that this has been a silent disease and we are still waiting to see the end results of it.

"About six years ago, when the HIV infection rate was about 9%, people did not think it was that bad," he said.

"But now we are starting to see the results.

"A recent survey showed that 52% of patients in medical wards are HIV-positive. Three years ago the figure stood at 19%," he said.

"In five years', we will probably have about 60% of hospital patients admitted with Aids-related diseases.

"It is getting to the stage where organised home care is going to be the only solution," said Prof Smith.

Mr McGlew said training was now being offered to people who could return to their communities and assist families who were looking after dying Aids patients.

Special kits, containing drugs such as painkillers, are also being given to Aids patients so that family members can treat them.

"We think that once a person has been identified with an Aids-related disease it is better for them to go home and die in the community rather than in the hospital.

"It is far more compassionate and they can die in peace and with dignity."

Source: The Mercury, 11 December 1998

APPENDIX 8

MAGAZINE ARTICLE ON REVIVAL OF NOMKHUBUWANE FESTIVAL AND VIRGINITY TESTING

Rain Queen Festival Tackles Premarital Sex

Virgins sow seed on Nomkhubulwane's sacred

With thousands of girls trying their virginity hoping to qualify for the annual festival of Nomkhubulwane, the Rain Queen, it was inevitable that some would fall short of the mark. THEMBA NTSHINGILA and NOTIANE report on the annual festival of Nomkhubulwane held in the KwaZulu-Natal Midlands recently. Photos by THEMBA NTSHINGILA

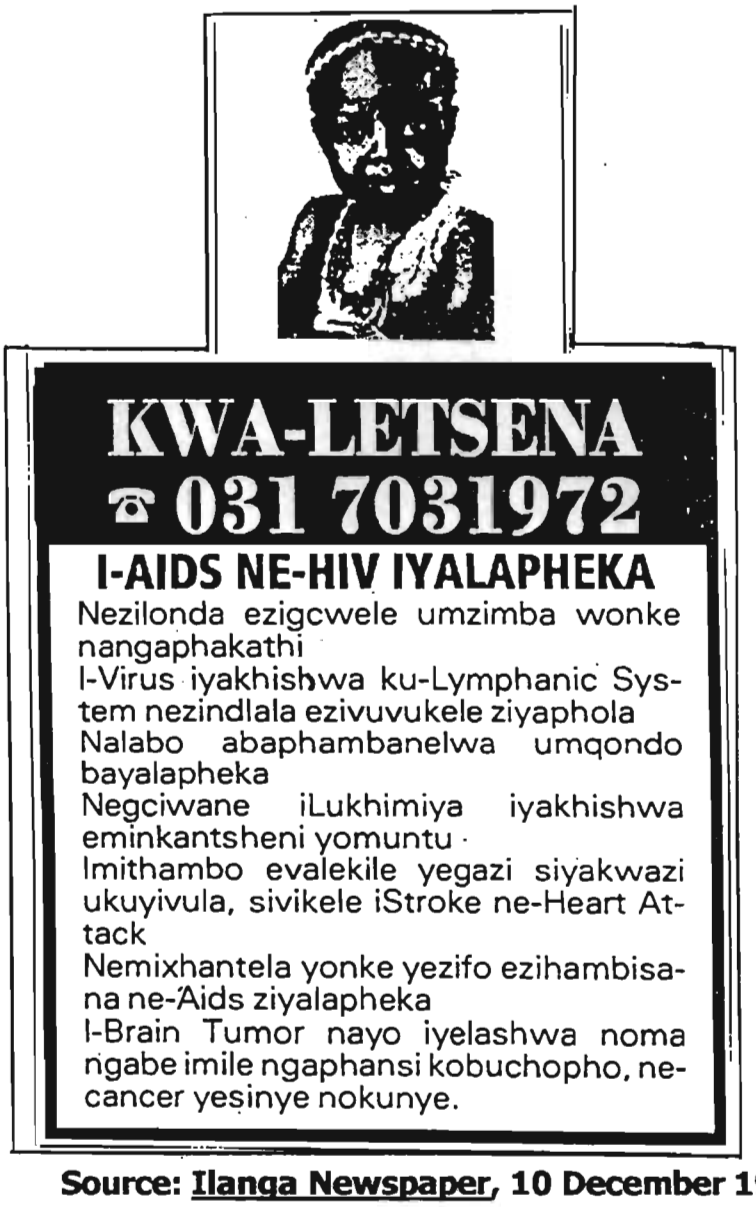
When some of the girls participating in this year's festival of Nomkhubulwane failed the virginity test, they were sent home in disgrace. Their chiefs will decide whether they will be fined in money or cattle.

Nomagugu Ngobese, head of the Cultural Organisation, said those who

Source: Bona Magazine, November 1998

APPENDIX 9

CLASSIFIED ADVERTISEMENT BY LOCAL TRADITIONAL HEALER OFFERING TREATMENT FOR HIV/AIDS, AS WELL AS BODILY-SORES, STROKES, HEART ATTACKS AND BRAIN TUMOURS



Source: Ilanga Newspaper, 10 December 1998

APPENDIX 10

MEDIA REPORT SUGGESTING A CORRELATION BETWEEN RISING INCIDENCES OF HIV INFECTIONS AND CHILD RAPE

Alarming increase in reported cases of rape and HIV infection

Child rape is on the increase – and so is the number of victims who are infected with the HIV virus, writes Crime Reporter JANI MEYER.

THE rape of children has increased alarmingly over the last four years with as many as 42 being raped each day. Child rape has rocketed from 7 559 reported cases during 1994 to a staggering 15 336 last year, an increase of 103%, the police child protection unit has disclosed.

And the increase in crimes against children over the last three years was 62%.

For example: six-months-old Lesley's stepfather used lighted cigarettes to punish him when he was naughty; 12-year-old Jenny was raped by her next-door neighbour; and Bongani was abandoned by his mother when he was barely two days old.

These youngsters are only three examples of the 40 634 children who suffered abuse last year.

Childline director Joan van Niekerk said another alarming fact was that the age of rape victims was dropping. "A few years ago we hardly ever dealt with rape cases involving children under five, but now we see them almost on a daily basis," said Ms van Niekerk.

There was also an alarming increase in the number of victims who were infected with the HIV virus after being raped.

Ms van Niekerk said: "Abuse is not restricted to poor communities. It happens in all walks of life."

She said the number of telephone calls to the help-line had increased from about 850 calls a month two years ago to more than 2 000.

According to figures released by the child protection unit more than 4 000 children were indecently assaulted last year and 853 were sodomised.

Provincial child protection unit co-ordinator Lynette Prinsloo said the unit dealt with at least one rape case each day.

She said that seven children under 12 were raped during the Easter weekend alone.

During the first week of April the unit arrested 42 people in connection with crimes against children including rape, attempted rape, indecent assault and sodomy.

The national director of the SA National Council for Child Welfare, André Kalis, said that despite efforts by the police and specialised child welfare staff, children were still having to endure horrific acts of abuse – "abuse that is way out of control and severely affecting our very vulnerable generation"

Source: The Daily News, 28 April 1998

APPENDIX 11

NEWSPAPER REPORT HIGHLIGHTING RECENT PLIGHT OF WOMEN WHO DISCLOSE THEIR HIV STATUS, FOLLOWING THE MURDER OF A TOWNSHIP ACTIVIST

HIV girl on the run after death threats

Deputy President Thabo Mbeki recently called on HIV-positive people to disclose their status in a bid to educate their communities, but as **Fidel Mbhele** reports, there is a high price to be paid for disclosure

Clarice Xaba, a mother of two from Newlands East in Durban, fears her daughter may be killed for admitting to be HIV positive.

Her daughter, Sinenhlanhla, received numerous death threats and has gone into hiding after armed men visited the family home looking for her.

The threats came soon after the murder of Gugu Dlamini of KwaMashu, who was brutally beaten by a mob that accused her of tainting the community's name by admitting to be HIV positive. Her murder, which sent shock waves throughout South Africa, was condemned by Thabo Mbeki and President Mandela.

Epidemic

The murder followed Mbeki's acknowledgement that the rate of HIV infection had reached epidemic proportions. The United Nations in New York added its voice of protest against Dlamini's murder, saying "silence surrounding the Aids epidemic in South Africa needed to be broken to prevent the spread of the disease".

Clarice Xaba hopes that Sinenhlanhla will be safe where she is now after the visit by the armed men who wanted to know why she had disgraced the community by admitting to her HIV status.

In the spirit of Mbeki's appeal for disclosure, Sinenhlanhla approached a newspaper on World Aids Day (December 1 1998) for her story to be told. She said her coming forward was to show her peers that Aids was a reality and they had to protect themselves.

"It is an uphill battle as one is ostracised by every community that is supposed to be helping," she told the newspaper.

The boyfriend, who infected her, had known of his HIV status, but did not disclose this.

Said Clarice Xaba: "What is painful is that we receive no support from our community. We thought that Sinenhlanhla's coming forward would have helped people, but it seems they do not want to know or they pretend that this (Aids) does not exist – as we have seen in Gugu Dlamini's case. Instead of acknowledging the problem people want to kill my daughter now."

> **Our citizens should stop killing HIV-positive people**
>
> *Dr Zweli Mkhize, Minister of Health*

Upset

She said that two days after the newspaper article had appeared she was visited by a young man, who said he was her daughter's lover. "This man showed me the newspaper cutting and said he had been upset by Sinenhlanhla having come out as he had slept with her previously," she said.

The stranger said he feared he was also HIV positive and would have to tell his parents.

A few days after the incident a person telephoned the house and said to the daughter: "I hope you enjoy your Christmas, if you will still be alive by then," and then slammed the phone down. The family received further calls, asking why the daughter had gone public with the information.

"A few days after we attended Gugu Dlamini's funeral nearby, my daughter saw several men who were going around the community asking where the Xaba house was. They asked her and she pretended not to know. These heavily armed men later found the house, but she was not there. They told the occupants that they were looking for Sinenhlanhla and would 'teach her a few things when they found her'," said Xaba.

Safer place

The men returned on another evening and, claiming to be policemen, wanted to speak to her. Sinenhlanhla had left the previous day for a safer place.

Xaba has since also moved out of the house.

"I do not care what happens now. Come what may, I am not moving now," she says.

Pat Hlongwane, spokesman for the National Association of People Living with Aids/HIV, said the situation should not be tolerated. Police, he said, were not doing enough to make sure that such attacks did not happen.

"It is coming close to a time now that communities will start 'necklacing' people who 'disgrace communities', as was previously done.

"Communities need to understand that HIV is a reality and they cannot be in denial forever," he said.

The Minister of Health, Zweli Mkhize, also condemned attacks on HIV positive people.

"I want to send a clear message to those criminals that the government will not tolerate such inhumane behaviour. Citizens should stop killing and terrorising HIV-positive people," he said.

Source: Sunday Tribune, 24 January 1999

APPENDIX 12

MEDIA REPORT OF HARRASSMENT OF LOCAL HIV-POSITIVE AIDS ACTIVISTS AMID ALLEGATIONS THAT THEY ARE DELIBERATELY SPREADING THE DISEASE

Smear campaign against young Aids awareness worker found to be false

ERIC NDIYANE
DAILY NEWS REPORTER

THE National Youth Commission has dismissed as a "smear campaign" allegations that one of its Aids awareness activists was responsible for spreading the deadly disease in Empangeni on the KwaZulu-Natal North Coast.

The top brass of the Pretoria-based commission arrived in Durban last week to investigate claims that the 19-year-old HIV-positive campaigner was spreading the disease deliberately on the North Coast where she was deployed to run the local awareness campaign.

Sinenhlanhla Xaba, the youngest person from KwaZulu-Natal to publicly disclose that she is HIV-positive, was temporarily suspended from any public functions of the Young Positive Living Ambassadors Project – a commission-backed project to educate people with Aids about the disease.

The furore erupted after she went public about her status and a series of allegations were levelled against her. Her accusers included her ex-boyfriend who said Ms Xaba had deliberately infected him with the disease by allowing unprotected intercourse.

But the commission yesterday told a media conference that its investigation had proved the allegations to be unfounded.

Project director Thembinkosi Ngcobo said: "We think the allegations were made to discredit the efforts of our members in fighting this deadly disease. We are not going to tolerate people harassing our members for personal reasons".

The KwaZulu-Natal chairman of the Youth Commission, Pinky Kunene, said their project was not going to be disrupted by a "smear campaign" against its members who had swallowed their pride, admitted to having Aids and committed themselves to educating communities about the disease.

"We found the allegations very unfair, especially against a young person like Sinenhlanhla. We will continue encouraging her and other youngsters who want to go public with their status to do so," said Ms Kunene.

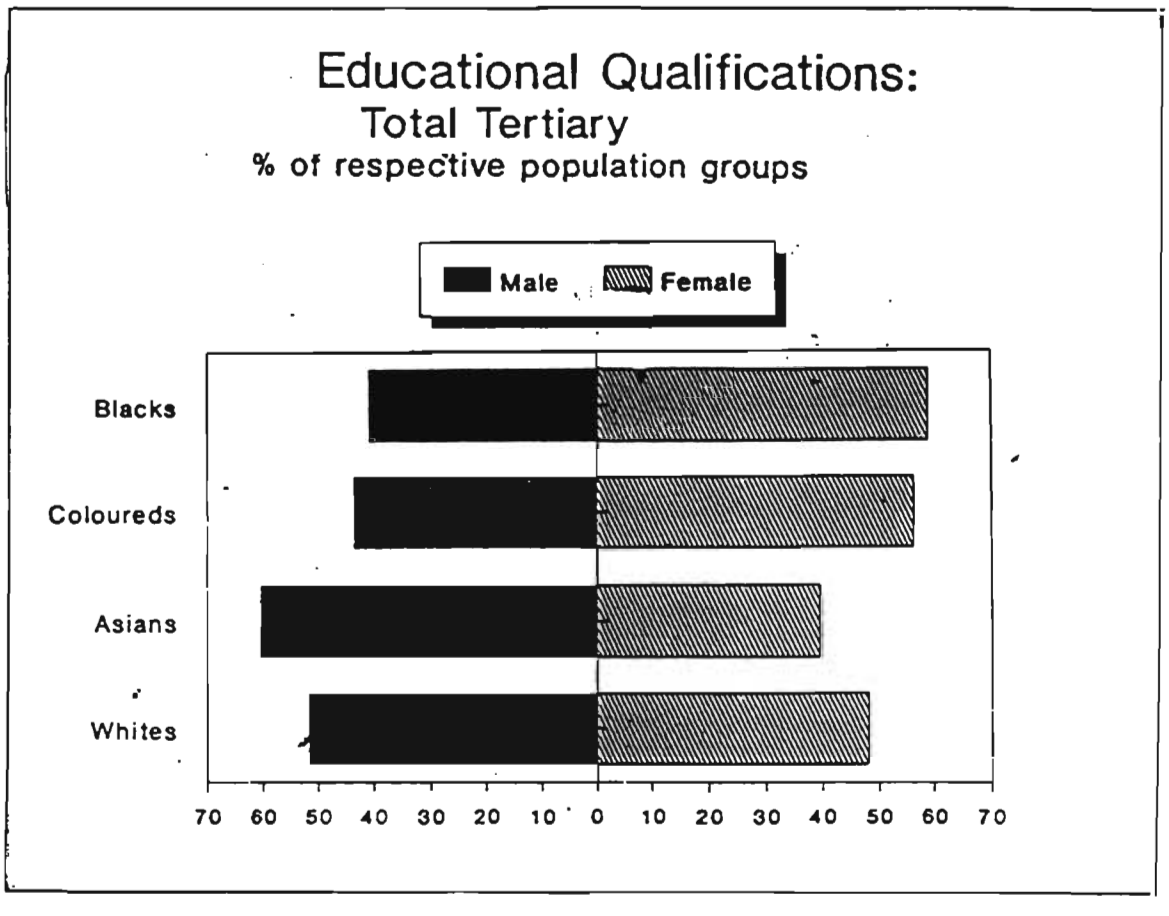
She said it was important for people to respect the private lives of volunteer workers and be supportive rather than discouraging them.

Aids campaigners countrywide have fallen victim to intimidation and assault in recent months, several dying in the attacks.

Source: The Daily News, 17 November 1999

APPENDIX 13

DISTRIBUTION OF TERTIARY EDUCATION QUALIFICATION ACCORDING TO GENDER AND % OF RESPECTIVE POPULATION GROUPS IN SOUTH AFRICA



Source: Development Bank of Southern Africa, Briefing Paper No.2. 1992. Halfway House: Information Clearing House

APPENDIX 14

MEDIA REPORT OF COMMENTS BY MINISTER OF WELFARE AND POPULATION DEVELOPMENT AFTER RELEASE OF U.N. REPORT ON AIDS, NOVEMBER 1998

Minister warns on Aids

PRETORIA: Welfare and Population Development Minister Geraldine Fraser-Moloketi has issued a shocking warning that South Africans' life expectancy could drop to only 40 years if the HIV/Aids epidemic continues growing at the current rate.

South Africa is rated as having the fastest growing HIV/Aids epidemic in the world, with 1 500 new infections every day.

Mrs Fraser-Moloketi described the HIV infection-rate as incredibly high, and emphasised that women should make choices about their sexual needs in order to protect themselves.

She said there were thousands of children who were orphans because their parents died of Aids.

Political parties were also urged to recognise the mounting HIV/Aids epidemic and to highlight the matter when campaigning for next year's elections.

Businesses, trade unions, religious communities and the media were also asked to play an active role in highlighting the epidemic.

Six women were yesterday chosen to co-ordinate a partnership among women's organisations in the fight against HIV/Aids.

This reference group is aimed at ensuring that proposals for dealing with the epidemic were implemented.

Mrs Fraser-Moloketi advised everyone to ensure that they used condoms to reduce the risk of infection.

Source: The Daily News, 26 November 1998

REFERENCES

Abdool-Karim S., Abdool-Karim, Q. Preston-Whyte, E. and Sanker, N. 1992 "Reasons for lack of Condom Use Among High School Students," South African Journal of Medicine 82: 107-110

Abdool-Karim, Q. 1998"Women and Aids: The Imperative for a Gendered Prognosis and Prevention Policy,"Agenda 39: 15-25

Abdool-Karim, Q. and Morar, N. 1994 "Women and AIDS in Natal/KwaZulu, South Africa: Determinants to the Adoption of HIV-Protective Behavior," Women and AIDS Research Program, Report Series No.7. Washington, DC:ICRW

Abdool-Karim, Q., Abdool Karim, S., Soldan, K. and Zondi, M. 1995 "Reducing the Risk of HIV Infection Among South African Sex-Workers: Socio-Economic and Gender Barriers," Amer. Jrl. Of Public Health 85(11): 1521-1525

Abelove, H. 1994 "The Politics of the 'Gay Plague': AIDS as a U.S. Ideology" in M. Ryan and A. Gordon (eds.) Body Politics: Desire and the Family. Boulder: Westview Press

Ackeroyd, A. 1990 "Sociocultural Aspects of AIDS in Africa: Topics, Methods and Some Lacunae," AIDS in Africa and the Caribbean: The Documentation of an Epidemic. New York: Institute of African Studies and the HIV Centre, Columbia University.

Adelgiza, Sr. M. 1983 100 years Mariannhill Province. Mariannhill: Mission Press

_____ 1984 History of the Congregation of the Missionaries of Mariannhill. Mariannhill: Mission Press

Agyei, W. and Epema, E. 1994 "Sexual Behavior and Contraceptive Use Among 15-24 year olds in Uganga," International Journal of Family Planning Perspectives 18 (1): 13-17

AIDS Consortium 1993 "The Government and AIDS: A Negligent Response," Critical Health 44: 11-16

Akande, A. 1997 "Black South African Adolescents' Attitudes Towards AIDS Precautions," School of Psychology International 18 (4): 325-341

REFERENCES

Abdool-Karim S., Abdool-Karim, Q. Preston-Whyte, E. and Sanker, N. 1992 "Reasons for lack of Condom Use Among High School Students," South African Journal of Medicine 82: 107-110

Abdool-Karim, Q. 1998"Women and Aids: The Imperative for a Gendered Prognosis and Prevention Policy,"Agenda 39: 15-25

Abdool-Karim, Q. and Morar, N. 1994 "Women and AIDS in Natal/KwaZulu, South Africa: Determinants to the Adoption of HIV-Protective Behavior," Women and AIDS Research Program, Report Series No.7. Washington, DC:ICRW

Abdool-Karim, Q., Abdool Karim, S., Soldan, K. and Zondi, M. 1995 "Reducing the Risk of HIV Infection Among South African Sex-Workers: Socio-Economic and Gender Barriers," Amer. Jrl. Of Public Health 85(11): 1521-1525

Abelove, H. 1994 "The Politics of the 'Gay Plague': AIDS as a U.S. Ideology" in M. Ryan and A. Gordon (eds.) Body Politics: Desire and the Family. Boulder: Westview Press

Ackeroyd, A. 1990 "Sociocultural Aspects of AIDS in Africa: Topics, Methods and Some Lacunae," AIDS in Africa and the Caribbean: The Documentation of an Epidemic. New York: Institute of African Studies and the HIV Centre, Columbia University.

Adelgiza, Sr. M. 1983 100 years Mariannhill Province. Mariannhill: Mission Press

_____ 1984 History of the Congregation of the Missionaries of Mariannhill. Mariannhill: Mission Press

Agyei, W. and Epema, E. 1994 "Sexual Behavior and Contraceptive Use Among 15-24 year olds in Uganga," International Journal of Family Planning Perspectives 18 (1): 13-17

AIDS Consortium 1993 "The Government and AIDS: A Negligent Response," Critical Health 44: 11-16

Akande, A. 1997 "Black South African Adolescents' Attitudes Towards AIDS Precautions," School of Psychology International 18 (4): 325-341

Altman, D. 1995 "Political Sexualities: Meanings and Identities in the Time of AIDS," in R Parker and H Gagnon (eds.) Conceiving Sexuality: Approaches to Sex Research in a Postmodern World. London: Routledge

Ankomah, A. 1992 "Premarital Sexual Relationships in Ghana in the Era of AIDS," Health Policy and Planning 7(2): 135-143

Arnfied, S. 1989 Initiation Rites in Mozambique.Copenhagen: New Science Monographs.

Asad, T. (ed.) 1973 Anthropology and the Colonial Encounter. London: Ithaca Press

Balmer, D. et al. 1995 "The Negotiating Strategies Determining Coitus in Stable Heterosexual Relationships," Health Transition Review 5: 85-95

Balzer, M. 1981 "Rituals of Gender Identity: Markers of Siberian Khanty Ethnicity Status and Belief," American Anthropologist 83: 851-867

Barnett, T. and Blaikie, P. 1992 AIDS in Africa – Its Present and Future Impact. London: Belraven Press

Barnett, T. and Whiteside, A. 1996 "Social and Economic Factors Crucial in Defining the Spread and Effect of HIV," AIDS Analysis, Vol. 2 (4) : July

Barton, T. 1988 "Sexually Related Health and Disease in Africa: A Brief Overview." Unpublished Paper, Southwestern Anthropological Association, 59th Meeting, Monterey, Ca.

Bassett, M and Sherman, J. 1994 "Female Sexual Behavioral and the Risk of HIV Infection: An Ethnographic Study in Harare, Zimbabwe," Women and AIDS Research Program, Report Series No.9. Washingington, D.C.: ICRW

Beeker, C., Guenther-Grey, C. and Raj, A. 1998 "Community Empowerment Paradigm Drift and the Primary Prevention of HIV/AIDS," Social Science and Medicine 46(7): 831-842

Benoist, J. and Desclaux, A. (eds) Sida et Anthrolopologie: Bilan et Perspectives. Paris: Karthala

Berer, M. and Ray, S. (eds.) 1993 Women and HIV/AIDS: An International Resource Book. London: Pandora

Berglund, A. 1976 Zulu Thought-Patterns and Symbolism. London: Hurst & Co.

Bhigjee, A., Vinsen, C., Windsor, I, Gouws, E., Bill, P. and Tait, D. 1993 "Prevalence and Transmission of HTLV-1 Infection in Natal/KwaZulu," South African Journal of Medicine. 83:665-667

Bird, J. 1880 Annals of Natal : 1495 – 1845 (No.8 and No.10, The Amatuli and The Amanganga). Cape Town: C. Struik Pbl.

Bledsoe, C. 1990 "the Politics of AIDS, Condoms and Heterosexual Relations in Africa: Recent Evidence from the Local Print Media" in P Handwerker (ed.) Births and Power : Social Change and the Politics of Reproduction. Boulder: Westview Press

Boffin, T. 1990 "Angelic Rebels: Lesbians and Safer Sex" in T Boffin and S Gupta (eds.) Ecstatic Antibodies: Resisting the AIDS Mythology. London: Rivers Oram

Bolton, R. (ed.) 1989 The Aids Pandemic – A Global Emergency. New York: Gordon and Breach

_____ 1992 "Mapping Terra Incognita: Sex Research for AIDS Prevention – An Urgent Agenda for the 1990s," in G. Herdt and S.Lindenbaum (eds) The Time of AIDS: Social Analysis, Theory and Method. Newbury Park: Sage Publ.

Bolton, R. and Singer, M. (eds.) 1992 Rethinking AIDS Prevention: Cultural Approaches. Philadelphia: Gordon and Breach

Boulogne, G. 1995 AIDS: "A Social Science Perspective with Special Reference to Anthropology," South African Journal of Sociology 26(2): 39-46

Boulton, M. (ed.) 1994 Challenge and Innovation: Methodological Advances in Social Research on HIV/AIDS. London: Taylor and Francis

Brandel-Syrier M. 1962 Black Woman In Search of God. London: Lutterworth

_____ 1971 Reeftown Elite. London: Routledge and Kegan Paul

Brookes, E. and Hurwitz, N. 1957 The Native Reserves of Natal. Vol. 7; Natal Regional Survey. Cape Town: Oxford University Press

Brown, J., Ayowa, O. and Brown, R. 1993 "Dry and Tight: Sexual Practices and Potential AIDS Risk in Zaire," Social Science and Medicine 37(8):989-994

Bryant, AT. 1929 Older Times in Zululand. London: Longmans, Green and Co.

_____ 1949 The Zulu People. Pietermaritzburg: Shuter and Shooter

_____ 1970 Zulu Medicine and Medicine Man. Cape Town: C. Struik Publ

Buckley,T. and Gottlieb, A. 1988 Blood Magic. Berkeley: Univ of California

Buga, G., Amoko, D. and Ncayiyana, D. 1996 "Sexual Behaviour, Contraceptive Practice and Reproductive Health Among School Adolescents in Rural Transkei," South African Journal of Medicine 86 (5): 523-527

Bury, J. 1994 "Women and HIV/AIDS: Medical Issues" in L. Doyal, J. Naidoo and T.Wilton (eds.) AIDS: Setting a Feminist Agenda. London: Taylor and Francis

Butcher, K. 1994 "Feminists, Prostitutes and HIV" in L. Doyal, J. Naidoo and T. Wilton (eds.) AIDS: Setting a Feminist Agenda. London" Taylor and Francis

Butler, J. 1990 Gender Trouble: Feminism and the Subversion of Identity. London: Routledge

_____ 1994 "Critically Queer" in GLQ: A Journal of Lesbian and Gay Studies.1(1):17-32

Caldwell, J. Caldwell, P and Quiggin P, 1989 "The Sexual Context of AIDS in Sub-Saharan Africa," Population and Development Review 15(2): 185-234

Caldwell, J., Caldwell, P., Ankrah, E. Agyeman, D., Awusabo-Asare, K. and I. Orubuloye, 1993 "African Families and AIDS: Context, Reactions and Potential Interventions," Health Transition Review 3: 1-16

Caldwell, J. 1995 "Understanding the AIDS Epidemic and Reacting Sensibly to It," Social Science and Medicine 41: 299-302

Callaway, H. 1870 The Religious System of the AmaZulu. Springvale: Blair

Campbell, C. 1991 "Prostitution, AIDS, and Prevention Health Behavior," Social Science and Medicine 32(12) 1367-1378

Campbell, C. 1992 "Learning to Kill: Masculinity, the Family and Violence in Natal," Journal of Southern African Studies 18: 614-628

_____ 1995 "Male Gender Roles and Sexuality: Implications for Women's AIDS Risk and Prevention," Social Science and Medicine 41 (2)

_____1997 "Migrancy, Masculine Identities and AIDS: the Psychosocial Context of HIV Transmission on the South African Gold Mines," Social Science and Medicine 45 (2): 273-282

_____ 1998 "Peer Education and Safe Sexual Behaviour Amongst Adolescents" in H. Moore (ed.) Report of the Expert Group on Health and Well-being of Children and Young People in the Context of Health Promotion. London: Health Education Authority

Campbell, C. and Williams, B. 1995 Epidemiologists and Social Scientists in HIV Research in South Africa: Working Together or Working Apart? Johannesburg: Epidemiology Research Unit

_____1996 "Academic Research and HIV/AIDS in South Africa," South African Medical Journal 86: 55-60

_____1998 "Evaluating HIV-Prevention Programmes: Conceptual Challenges," Psychology In Society 24:57-69

Cash, K. and Busayawong, W. 1997 "AIDS Prevention Through Peer Education for Northern Thai Single Female and Male Migratory Factory Workers," Women and AIDS Research Program, Report Series No.9. Washington, D.C.: ICRW

Center for Health and Social Studies 1996 An Analysis of HIV/AIDS Programmes in KwaZulu-Natal. Durban: CHESS Research Report.

Chambers, R. 1983 Rural Development: Putting the Last First. London: Longman Group

Clatts, M. and Mutchler, K. 1989 "AIDS and the Dangerous Other: Metaphors of Sex and Deviance in the Representation of Disease" in R. Bolton (ed.) The AIDS Pandemic: A Global Emergency. New York: Gordon and Breach

Cohen, D. 1998 Poverty and HIV/AIDS in Sub-Saharan Africa. UNDP Report: April

Connell, R. and Dowsett, G. (eds) 1992 Rethinking Sex : Social Theory and Sexuality Research. Carlton : Melbourne Univ. Press

Constantinides, P. 1985 "Women Heal Women: Spirit Possession and Sexual Segregation in a Muslim Society," Social Science and Medicine 21: 685-692

Cornwall, A. 1994 "Sharing Ideas: Bridging the Gap Between Medical Messages and Local Understandings" in K. de Koning (ed.) Proceedings of the International Symposium on Participatory Research in Health Promotion. Liverpool: Education Resource Group School of Tropical Medicine

_____ 1996 "Participatory Research Methods: First Steps in a Participatory Process" in K de Koning and M. Martin (eds.) Participatory Research In Health. London: Zed Book

Crewe, M. 1997 "Reflections on the Introduction of a Comprehensive HIV/AIDS and Life-Skills Program for South African Youth," AIDS BULLETIN 6(4): 8-10

Cross, C. Bekker, S., Clark, C. and Wilson, C. 1992 Searching for Stability: Residential Migration and Community Control in Mariannhill. Rural-Urban Working Paper no 23, Durban : Centre for Social and Development Studies, University of Natal

Dalrymple, L. and Preston-whyte, E. 1992 "A Drama Approach to AIDS Education: An Experiment in 'Action' Research," AIDS Bulletin 1 (1):9-11

De Koning, K. 1994 Proceedings of the International Symposium on Participatory Research in Health Promotion. Liverpool: Education Resource Group, School of Tropical Medicine

De Koning, K. and Martin, M. 1996 Participatory Research in Health: Issues and Experiences. London: Zed Books

Department of Health, 1998 "AIDS in South Africa," Epidemiological Comments: 25

Devisch, R. 1985 "Polluting and Healing Among the Northern Yaka of Zaire," Social Science and Medicine 21: 685-692

Dinan, C. 1983 "Sugar Daddies and Gold Diggers: The White-Collar Single Women in Accra" in C. Oppong (ed.) Female and Male in West Africa. London: G. Allen and Unwin

Doane, M. 1985 The Female Body in Western Culture; Contemporary Perspectives. Cambridge: Harvard Univ Press

Dominy, A. and Guest, B. 1989 Natal and Zululand – A New History. Pietermaritzburg: Shuter and Shooter

Douglas, M. 1966 Purity and Danger. London: Routledge

Douglas, M. and Calvez, M. 1990 "The Self as Risk Taker: A Cultural Theory of Contagion in Relations to AIDS," The Sociological Review 38 (3): 445-463

Doyal, L. 1995 What Makes Women Sick? Gender and the Political Economy of Health. London: Macmillan

Doyal, L. Naidoo, J. and Wilton, T. (eds.) 1994 AIDS: Setting a Feminist Agenda. London: Taylor and Francis

Dozon, J.P. and Vidal, L. (eds.) 1995 Les Sciences Sociales Face au Sida: Cas Africains autour de l'Example Ivorien. Paris: Orstom

Drew, E. 1995 Poverty – A Major Constraint in the Community Care of Orphans: A Study from North Nyanga District of Zimbabwe. Harare : Family AIDS Caring Trust

Dube, N. and Wilson, D. 1996 "Peer Education Programmes among HIV-vulnerable Communities in Southern Africa" in B. Williams and C. Campbell (eds.) HIV/AIDS in the Southern African Mining Industry. Johannesburg: Epidemiology Research Unit.

Dwyer, D., 1978 Images and Self Images: Male and Female in Morocco. New York: Columbia Univ. Press

Eaton, L., Flisher, A., Cruz, C. and Mathambo, V. 1999 "Report on the State of Health of Youth in South Africa," Unpublished Report: South African Youth Commission

Edwards, T. 1994 Erotics and Politics: Gay Male Sexuality, Masculinity and Feminism. London: Routledge

England, H. 1996 History of St. Wendolin's. Inner West City Council: Pinetown Museum Pbl.

Evans-Pritchard, E. 1937 Witchcraft, Oracles and Magic among the Azande. London: Oxford University Press

Farmer, P. 1992 AIDS and Accusation – Haiti and the Geography of Blame. Berkeley: Univ of California Press

_____1997 "AIDS and Anthropologists: Ten Years Later," Medical Anthropology Quarterly 11 (4): 516-525

Foucault, M. 1976 A History of Sexuality, Vol.1 : An Introduction. Hammondsworth: Penguin

Fayorsey, C. 1996 "Gender and Reproductive Health Problems in Ghana," Unpublished Conference Paper. PAAA Conference on Anthropology and the Social Transformation of Africa. Pretoria: Sept.

Fee, E. and Fox, D. (eds.) 1988 AIDS: The Burden of History. Berkeley: University of California Press

Fortes, M. 1970 Time and Social Structure. London: Athlone Press

Foster, G. 1992 Home Based Care – The Patient's Family and Community Involvement. Harare: Family AIDS Caring Trust

Frankenberg, R. 1994 "Learning from AIDS: The Future of Anthropology," in C. Akhbar and C. Shore (eds.) The Future of Anthropology. London: Athlone Press

Freire, P. 1972 Pedagogy of the Oppressed. New York: Seabury Press

Friedland, R., Jankelowitz, S. and De Beer, M. 1991 "Perceptions and Knowledge about the Acquired Immunodeficiency Syndrome Among Students in University Residences," South African Medical Journal 79: 149-154

Fullilove, M. 1990 "Black Women and AIDS Prevention: A View Towards Understanding the Gender Rules," The Journal of Sex Research 27 (1):47-64

Giddens, A. 1992 The Transformation of Intimacy: Sexuality, Love and Eroticism in Modern Society. Cambridge: Polity Press

Giffin, K. 1998 "Beyond Empowerment: Heterosexualities and the Prevention of AIDS," Social Science and Medicine 46 (2): 151-156

Gillies, P. and Parker, G. 1994 "Cross-cultural Perspectives on Sexual Behaviour and Prostitution," Health Transition Review 4: 257-271

Gillies, P. Tolley, K. and Wolstenholme, J. 1996 "Is AIDS a Disease of Poverty?" AIDS CARE 8(3): 351-363

Gillies, P. 1998 "The Effectiveness of Alliances and Partnerships for Health Promotion," Health Promotion International 13(1):1-21

Gilman, S, 1988 "Aids and Syphilis: The Iconography of Disease" in D. Crimp (ed.) AIDS: Cultural Analysis, Cultural Activism. Cambridge: M.I.T. Press

Gluckman, M. 1935 "Zulu Women in Hoe Cultural Ritual," Bantu Studies 9:355-356

_____1940 "The Kingdom of the Zulu in South Africa" in M. Fortes and E. Evans-Pritchard, (eds.) African Political Systems. London: Oxford University Press

_____1954 Rituals of Rebellion in South-East Africa. Manchester: Manchester Univ Press

_____ 1956 Custom and Conflict in Africa. New York: Barnes and Noble

Goldstein, D. 1995, "The Cultural, Class and Gender Politics of a Modern Disease: Women and AIDS in Brazil," Women and AIDS Research Program, Report Series No 4. Washington, D.C.: ICRW.

Graham, H. 1993 Hardship and Health in Women's Lives. Hempstead: Harvester Wheatsheaf

Green, E. 1988"AIDS in Africa: An Agenda for Behavioral Scientists" in N. Miller and R. Rockwell (eds.) AIDS in Africa: The Social and Policy Impact. New York: Mellen Press

_____ 1994 AIDS and STDS in Africa. Pietermaritzburg: Univ of Natal Press

Green, E., Jung, A. and Dgedge, A. 1993 "Sexually Transmitted Diseases, AIDS and Traditional Healers in Mozambique," Medical Anthropology 15 (3):261-281

Gregson, S., Zhuwau, T., Anderson, R. and Chandiwana, S. 1998 "Is There Evidence for Behavior Change in Response to AIDS in Rural Zimbabwe?" Social Science and Medicine (46) 3:321-330

Gupta, G. and Weiss, E. 1995 "Women's Lives and Sex: Implications for AIDS Prevention," in R. Parker and J. Gagnon (eds.) Conceiving Sexuality: Approaches to Sex Research in a Postmodern World. London: Routledge

Hadden, B. 1997 "An HIV/AIDS Prevention Intervention with Female and Male STD Patients in a Peri-Urban Settlement in KwaZulu-Natal, South Africa," Women and AIDS Research Program Report Series No 7. Washington, DC: ICRW

Hammond-Tooke, W.D. (ed) 1974 The Bantu-Speaking Peoples of Southern Africa. Johannesburg: Routledge & Kegan Paul

_____ 1970_ "Urbanisation and the Interpretation of Misfortune: a Quantitative Analysis", Africa 40: 25-28

_____ 1981 Boundaries and Belief: The Structure of a Sotho Worldview. Johannesburg: Wits University Press

Haram, L. 1995 "Negotiating Sexuality in Times of Economic Want: Young Meru Women at Risk." in K, Klepp, P. Biswalo and A. Talle (eds.) Young People at Risk: Fighting AIDS in Northern Tanzania. Oslo: Scandanavian Univ Press

_____ 1996 "The Gendered Epidemic: Sexually Transmitted Diseases and AIDS Among the Meru People of Northern Tanzania" in S. Bergstrom and G. Holmbee – Otlesen (eds.) Reproductive Health Research in Developing Countries (Sum. Report No 4.) Oslo: Centre for Development and Environment

_____ 1997 "In Sexual Life Women are Hunters: AIDS and Women who Drain Men's Bodies – The Case of the Meru of Northern Tanzania." Conference Paper, 'Health in Transition: Opportunities and Challenges'. Arusha, Tanzania: October

Harrison, F. 1997 "Gender, Sexuality, and Health in a Turn-of-the-Century Black Metropolis," Medical Anthropology Quarterly 11 (4): 448-453

Heise, L. 1995 "Violence, Sexuality and Women's Lives," in R. Parker and J. Gagnon (eds.) Conceiving Sexuality : Approaches to Sex Research in a Postmodern World. London: Routledge

Hellmann, E. 1948 Rooiyard: A Sociological Study of an Urban Native Slum Yard. Cape Town: Oxford Univ. Press

_____1967 "The African Family Today" in Collected Papers for Conference on African Family Life. Johannesburg: South African Institute of Race Relations

Hemson, D. 1997 "The Embrace of Comradeship: Masculinity and Resistance in KwaZulu-Natal." Colloqium Paper, 'Masculinities in Southern Africa'. University of Natal, Durban: July

Herdt, G. 1997 Same Sex, Different Cultures: Gays and Lesbians across Cultures. Boulder: Westview Press

Hlatshwayo, Z. and Stein, J. 1997 "Why HIV/AIDS Brings The Need For Gender Equality Into Focus," AIDS Bulletin 6(4) 17-18

Hostetler, A. and Herdt, G. 1998 "Culture, Sexual Lifeways and Developmental Subjectivities: Rethinking Sexual Taxonomies," Social Research 65 (2): 249-290

Hunter, D. 1993 "AIDS in Sub-Saharan Africa:The Epidemiology of Heterosexual Transmission and the Prospects for Prevention," Epidemiology 4(1):63-72

Ingstadt, B. 1990 "The Cultural Construction of AIDS and Its Consequences for Prevention in Botswana," Medical Anthropology Quarterly 4 (1): 28-40

Jackson, H., Karkhoven, R. and Woelk, G. 1996 Home Care – Where to Now? A Southern Africa Perspective. Harare : Southern Africa AIDS Information Dissemination Service

Jentsch, V. 1997 "A Review of Opportunistic Infections in Africa", The Southern African Journal of Epidemiology and Infection 12(1) 28-32

Jewkes, R. and Murcott, A. 1998 "Community Representatives: Representing The "Community?" Social Science and Medicine 46 (7) 843-858

Jewkes, R. and Wood, K. 1999 "Problematizing Pollution: Dirty Wombs, Ritual Pollution and Pathological Processes," Medical Anthropology 18: 163-186

Kaplan, J. 1990 "Umhlatuzana Rock Shelter Sequence : 100 000 years of Stone Age History in Natal," Museum Journal of Humanities Vol. 2

Kayal, P. 1993 Bearing Witness: Gay Men's Health Crisis and the Politics of AIDS. Boulder: Westview Press

Keesing, R. 1987 "Ta'a geni: Women's Perspectives on Kwaio Society" in M Strathern (ed.) Dealing with Inequality: Analysing Gender Relations in Melanesia and Beyond. Cambridge: Cambridge Univ. Press

Kelly, R. 1976 "Witchcraft and Sexual Relations: Exploration in the Social and Semantic Implications of a Structure of Belief" in P. Brown and G. Buckbinder (eds.) Man and Woman in the New Guinea Highlands. Washington D.C.: American Anthropological Assoc.

Kessler, E. 1976 Women – An Anthropological View. New York: Holt Rinehart and Winston

King, E. 1993 Safety in Numbers: Safer Sex and Gay Men. London: Cassell

Killewo, J., Lwihula, G., Sandstrom, A. and Dahlgren, L. (eds.) 1989 Behavioural and Epidemiological Aspects of AIDS Research in Tanzania, Dar es Salaam: Workshop Report, Dec. 6-8

Kirmayer, L. 1992 "The Body's Insistence on Meaning: Metaphor as Presentation and Representation in Illness Experience," Medical Anthropology Quarterly 6:323-346

Koornhof, H. 1995 "The Management of South Africa's HIV Infected: What are the Challenges?" The Southern African Journal of Epidemiology and Infection 10:34

Korten, D. 1980 "Community Organization and Rural Development – a Learning Process Approach," Public Administration Review 40 (5): 480-511

Kreuter, M. 1997 National Level Assessment of Community Health Promotion Using Indicators of Social Capital. Atlanta: WHO/EURO Working Group Report

Krige, E.J. 1950 The Social System of the Zulu (2nd ed) London: Longmans, Green and Co.

_____1968 "Girls' Puberty Songs and Their Relation to Fertility, Health, Morality and Religion Among the Zulu," Africa 38: 173-198.

Krige, J.D. 1944 "The Magical Thought-Pattern of the Bantu in Relation to Health Services," Africa 6:59-89

Krige, E.J. and Krige J.D. 1943 The Realm of a Rain Queen. London : International African Institute

Kroeber, A. 1925 Handbook of the Indians of California. New York: Collier Books

Kuper, H. 1963 The Swazi: A South African Kingdom. New York: Holt, Rinehart and Winston

Lambert, J. and Morrell, R. 1996 "Domination and Subordination in Natal 1890-1920" in R Morrell (ed.) Political Economy and Identity in KwaZulu-Natal: Historical and Social Perspectives. Durban:Indicator Press

Lindemann, S. and Olivier, E. 1982 "Consciousness, Liberation, and Health Delivery Systems," Journal of Medicine and Philosophy Vol. 7: 135-152

Leclerc-Madlala, S. 1997 "Infect One, Infect All : Zulu Youth Response to the AIDS Epidemic in South Africa," Medical Anthropology Vol. 17: 363-380

Longmore, L. 1959 The Dispossessed – A Study of the Sex Life of Bantu Women In and Around Johannesburg. London: Johnathan Cape

Lugg, H. 1929 "Agricultural Ceremonies in Natal and Zululand," Bantu Studies 3:357-383

Luthuli, H. 1983 "The First History of St. Wendolin's Mission", Unpublished Paper : Mariannhill Centenary – 1982

Lye, W. 1969 "The Ndebele Kingdom South of the Limpopo," Journal of African History 10(1): 87-104

MacPhail, C. 1998a Evaluating Behaviour Change Programmes in the Context of HIV in Developing Countries: a Methodological Review. Johannesburg: Epidemiology Research Unit

_____1998b "Adolescents and HIV in Developing Countries: New Research Directions," Psychology in Society 24: 69-87

Maguire, P. 1987 Doing Participatory Research: A Feminist Approach. Amherst: Center for International Research, Univ of Massachusetts.

Malinowski, B. 1929 The Sexual Life of Savages. New York: Scribners

Manji, A. 1996 Studying the Impact of AIDS in Africa using Participatory Research Methods. Occasional Papers, Centre of African Studies, Edinburgh University: University Press

Mann, J, Chin, J, Pirot, P, and Quinn, T. 1988 "The International Epidemiology of AIDS," Scientific American, October

Marcus, T. 1997 "Interpreting the Risk of AIDS: A Case Study of Long-Distance Truck Drivers," Development Southern Africa 14 (3):425-445

_____1999 "Community Responses to Caregivers in the AIDS Context." Unpublished Conference Paper. First Annual HIV/AIDS Conference: Positive Developments. Univ of Natal, Pietermaritzburg, April.

Marcus, T., Oellermann, K. and Levin, N. 1995 "AIDS and the Highways: Sex Workers and Truck drivers in KwaZulu-Natal," Indicator South Africa:13(1)

Marshall, P., O'Keefe, P. and Fisher,S. 1990 "Touch and Contamination: Patient's Fear of AIDS," Medical Anthropology Quarterly 4: 129-144

Mathews, C., Everett, K., Binedell, J and Steinberg, M. 1993 "Learning to Listen: Formative Research in the Development of AIDS Education for Secondary School Pupils," National AIDS Research Programme, Medical Research Programme. Cape Town : Medical Research Council.

Mayer, P. 1971 Townsmen or Tribesmen (Xhosa in Town). Cape Town: Oxford Univ. Press

Mbeki, T. 1998 Africa – The Time Has Come. Cape Town: Tafelberg Press

_____1999 "Prologue" in M W MaKgoba (ed.) African Renaissance. Cape Town: Mafube-Tafelberg

Mbiti, J. 1969 African Religions and Philosophy. London: Heinemann Ltd.

McGrath, J. 1992 "The Biological Impact of Social Responses to the AIDS Epidemic," Medical Anthropology 15: 63-79

_____ et al 1993 "Anthropology and AIDS: The Cultural Context of Sexual Risk Behavior Among Urban Women in Kampala, Uganda," Social Science and Medicine 36 (4): 429-439

Mead, M. 1940 "The Mountain Arapesh," Anthropological Papers: American Museum of Natural History, Vol 37

Meggitt, M. 1964 "Male-female relationships in the highlands of Australian New Guinea," American Anthropologist 66 (4)

Meyer-Weitz, A., Reddy, P., Weijts, W., van den Borne, B. and Kok, G. 1998 "The Socio-cultural Contexts of Sexually Transmitted Diseases in South Africa: Implications for Health Education Programs," AIDS case: 10

Michaels, K. 1998 "Human Development Report," South African Department of Demographics. Pretoria: Government Printing Press

Middleton, J. and Winter, E. (eds) 1963 Witchcraft and Sorcery in East Africa. London: Routledge and Kegan Paul

Mies, M. 1983 "Towards a Methodology for Feminist Research" in G. Bowles and R. Klein (eds.) Theories of Women's Studies. Boston: Routledge and Kegan Paul.

Miles, A. 1991 Women, Health and Medicine. Buckingham: Open University Press

Miles, L. 1992 "Women, AIDS, Power and Heterosexual Negotiations," Agenda 15: 14-48

Mogenson, H. 1995 AIDS is a Kind of Kahungo that Kills. Oslo: Scandinavian Press

Mohoebi, E. 1997 "Empowering the Youth with Skills to Protect Themselves Against HIV/AIDS," AIDS Bullletin 6(4):7-8

Moore, H. 1994 A Passion for Difference. Indianapolis: Indiana Univ Press

Morrell, R. 1998 "Of Boys and Men: Masculinity and Gender in Southern African Studies," Journal of Southern African Studies 24 (4): 605-630

Naidoo, L., Williams, P. and Knight, S. 1991 "A Survey of Knowledge about AIDS and Sexual Behaviour Among Students at the University of Natal, Durban Campus," AIDS Committee Project Report Durban: Univ of Natal

Nash, E. 1990 "Teenage Pregnancy – Need a Child Bear a Child?" South African Medical Journal 77: 147-151

Ngubane, H. 1977 Body and Mind in Zulu Medicine London: Academic Press

Ng'weshemi, T., Boerma, T., Bennet, J. and Schapink, D. 1997 HIV Prevention and AIDS Care in Africa: a District Level Approach. Amsterdam: Royal Tropical Institute

Niang, C. 1995 "Sociocultural Factors Favoring HIV Infection and the Integration of Traditional Women's Associations in AIDS Prevention in Kolda, Senegal, "Women and AIDS Research Program, Report Series No. 8. Washington, DC: ICRW

Nicholas, L. 1992 "AIDS Knowledge and Attitudes of Black South African First-Year Students 1990-1992", Student Counselling Report. Cape Town: University of the Western Cape

Ninth National HIV Survey Amongst Women Attending Antenatal Clinics in South Africa. Department of Health. November 1998

Nnko, S. and Pool, R. 1997 "Sexual Discourse in the Context of AIDS: Dominant Themes on Sexual Relations Among School Children in Mwanza, Tanzania." Unpublished Conference Paper, Workshop on Multi-partners Sexuality and Sexual Networking, Durban: February 7-8

Nossiter, A. 1997 "Man Knowingly Exposed 62 Women to AIDS Virus," New York Times April 19:7

Novicki, M. 1998 "Mixed Progress Against AIDS Epidemic," Africa Recovery. February: 16-18

Nzovu, G. and Lwanga, C. 1997 "Child, Adolescent, and Youth Multi-partnered Sexuality and Sexual Networking in Zambia." Unpublished Conference Paper, Workshop on Multi-partnered Sexuality and Sexual Networking, Durban: February 7-8

Obbo, C. 1993 "HIV Transmission .... Men are the Solution" in S.James and A. Busia (eds) Theorizing Black Feminisms: The Visionary Pragmatism of Black Woman. London: Routledge

_____1995 "Gender, Age and Class: Discourses on HIV Transmission and Control in Uganda", in H. Brummelhuise and G. Herdt (eds.) Culture and Sexual Risk : Anthropological Perspectives on AIDS. Chicago: Gordon and Breach

Orubuloye, I., Caldwell, J., and Caldwell, P. 1993 "African Women's Control Over their Sexuality in an Era of AIDS," Social Science and Medicine 37 (7): 859-875

Panos Institute 1990 Triple Jeopardy: Women and AIDS. London: Panos Institute

Parker, R. 1992a "Sexual Diversity, Cultural Analysis, and AIDS Education in Urban Brazil," in G. Herdt and S. Lindenbaum (eds) In the Time of Aids: Social Analysis, Theory and Methods . London : Sage

_____1992b "Male Prostitution, Bisexual Behaviour, and HIV Transmission in Urban Brazil," in T. Dyson (ed.) Sexual Behaviour and Networking: Anthropological and Socio-cultural Studies on the Transmission of HIV. IVSSP: 109-122

_____1994 "Sexual Cultures, HIV Transmission, and AIDS Prevention," AIDS 8: 309-314

Parker, R., Herdt, G and Carballo, M. 1991 "Sexual Culture, HIV Transmission and AIDS Research," The Journal of Sex Research 28: 77-98

Parker, R., and Gagnon, J. (eds.) 1995 Conceiving Sexualities: Approaches to Sex Research in a Postmodern World. New York: Routledge.

Patton, C. 1985 Sex and Germs: The Politics of AIDS. Boston: South End Press

_____ 1990 Inventing AIDS. London: Routledge

_____ 1994 Last Served? Gendering the HIV Pandemic. London: Taylor and Francis Pbl

Pauw, B. 1962 The Second Generation. Cape Town : Oxford Univ. Press

Pauw, I. and Brener, L. 1997 "Naming the Dangers of Working on the Streets," Agenda 36:80-84

Pellow, D. 1990 "Sexuality in Africa", Trends in History, 4(4): 71-96

Pelto, P. and Pelto, G. 1997 "Studying Knowledge, Culture, and Behavior in Applied Medical Anthropology," Medical Anthropology Quarterly 11 (2): 147-163

Perkel, A., Strebel, A. and Joubert, G. 1991 "The Psychology of AIDS Transmission: Issues for Intervention," South African Journal of Psychology 21 (3): 148-152

Posel, D. 1993 "The Sex Market in the Inner City of Durban," Economic Research Unit Occasional Papers No 28: Durban: Univ of Natal

Pratt, B. and Loizos, P. 1992 "Choosing Research Methods & Data Collection for Development Workers," Development Guidelines (7): Oxfam

Preston-Whyte, E. 1974 "Kinship and Marriages" in W.D. Hammond-Tooke (ed.) The Bantu-Speaking Peoples of Southern Africa. London: Routledge & Kegan Paul

_____1993a "Half-Way There: Perspectives on the Use of Qualitative Methods in Intervention Oriented AIDS research in South Africa" in H. Brummelhuis and G Herdt (eds.) Anthropological Perspectives on AIDS. London: Oxford Univ.Press.

_____ 1993b "Participation and Action: Reflections on Community Based AIDS Intervention in South Africa," Unpublished paper. Johannesburg, Association for Anthropology in Southern Africa Conference, Univ of Witwatersrand

_____1993c "Women Who are not Married: Fertility, 'Illegitimacy', and the Nature of Households and Domestic Groups Among Single African Women in Durban," South African Journal of Sociology 24(3): 63-71

Preston-Whyte, E., Abdool-Karim, Q. and Zondi, M. 1991 "Women and AIDS – the Triple Imperative," Critical Health 34:42-47

Preston-Whyte, E. and Zondi, M. 1989 "To Control Their Own Reproduction: The Agenda of Black Teenaged Mothers in Durban," Agenda 4:47-67

_____1992 "African Teenage Pregnancy: Whose Problem?" in Questionable Issues - Illegitimacy in South Africa. Cape Town: Oxford University Press

Preston-Whyte, E. and Dalrymple, L. 1996 "Participation and Action: Reflections on Community-based AIDS Intervention in South Africa" in K. de Koning (ed.) Participatory Research in Health. London: Zed Books.

Preston-Whyte, E., Varga, C. and Blose, F. (1997) "Sexual Networks, Race, Gender and Prostitution: Cross-Cultural Perspectives from South Africa." Conference Paper; Reconceiving Sexuality: International Perspecitives on Gender, Sexuality and Sexual Health. Rio de Janiero, March.

Quinn, T., Mann, J. Curran, J. and Piot, P. 1986 "AIDS in Africa: An Epidemiologic Paradigm," Science 234: 955-63

Rasmussen, S. 1990 "Lack of Prayer: Ritual Restrictions, Social Experiences and the Anthropology of Menstruation Among the Tuareg," American Ethnologist 751-769

Ray, S., Latif, A., Machekano, R. and Katzenstein, D. 1998 "Sexual Behavior and Risk Assessment of HIV Seroconvertors Among Urban Male Factory Workers in Zimbabwe," Social Science and Medicine 47 (10) 1431-1443.

Raymond, J. 1996 "A Vision of Lesbian Sexuality" in L. Harne and E. Miller (eds.) All the Rage: Reassessing Radical Lesbian Feminism. London: The Women's Press

Reader, D. 1966 Zulu Tribe in Transition. Manchester: Manchester Univ Press

Reid, E. 1992 "Why Women and HIV? It Takes Two to Tango Safely," AIDS Health Promotion Exchange 3: 1-3

Richards, A. 1956 Chisungu. A Girls' Initiation Ceremony Among the Bemba of Zambia. London: Tavistock Publ

Richter, L. 1997 "Street Children and HIV/AIDS," AIDS Bulletin 6(4): 4-6

Richter, L., Swart-Kruger, J. and Barnes, J. 1994 "Street Children and Youth in South Africa: AIDS-related Knowledged, Attitudes and Behavior" in B. Gannon (ed.) Children and Youth at Risk: HIV/AIDS Issues, Residential Care and Community Perspectives. Cape Town: National Association of Child Care Workers

Richter, L. and Swart-Kruger, J. 1995 "AIDS-risk and Street Children and Youth in South Africa: Implications for Interventions," South African Journal of Psychology 25: 31-38

Rifkin, S. 1994 "Participation and Research in Health" in K de Koning (ed.) Proceedings of the International Symposium on Particpatory Research in Health Promotion. Liverpool: Education Resource Group, School of Tropical Medicine

Roos, J., Pretorius H., and Visser M., 1995. "A Proposed Strategy for Changing High-Risk Sexual Behaviour Among Students at Tertiary Institutions: A Qualitative Investigation with a View to Developing a Preventative Programme. Part I and II," Journal of Comprehensive Health 6(2):81-89

Runganga, A., Pitts, M. and McMaster, J. 1992 "The Use of Herbal and Other Agents to Enhance Sexual Experience," Social Science and Medicine 35(8)

Sato, P., Chin, J. and Mann, J. 1989 "Review of AIDS and HIV Infection: Global Epidemiology and Statistics," AIDS 3(1): 301-307

Schapera, I. 1933 "Premarital Pregnancy and Native Opinion : a Note on Social Change,"Africa 6 59-89

_____1940 Married Life in an African Tribe. London: Faber & Faber

_____1952 "Sorcery and Witchcraft in Bechuanaland," Africa 51:41-52

Schimlek, F. 1950 Medicine Versus Witchcraft. Mariannhill: Mission Press

_____ 1953 Mariannhill: A Study of Bantu Life and Missionary Effort. Mariannhill: Mission Press

Schoepf, B. 1992(a) "AIDS, Sex and Condoms: African Healers and the Reinvention of Tradition in Zaire," Medical Anthropology 14:225-242

_____ 1992(b) "Women at Risk: Case Studies from Zaire" in G. Herdt and S. Lindenbaum (eds.) In the Time of AIDS – Social Analysis, Theory, and Method. London: Sage

Scrimshaw, S. and Hurtado, E. 1987 Rapid Assessment Procedures: For Nutrition and Primary Health Care. Tokyo: United Nations University

Seidel, G. and Ntuli, N. 1996 "HIV, Confidentiality, Gender and Support in Rural South Africa," The Lancet 347 (17) 464.

Setel, P. 1996 "AIDS as a Paradox of Manhood and Development in Kilimanjaro, Tanzania," Social Science and Medicine 43 (8) 1168-1178

Sharp, J. 1988 "Introduction: Constructing Social Reality" in J. Sharp and E. Boonzaier (eds.) South African Key Words-The Uses and Abuses of Political Concepts. Cape Town: David Philip

Shooter, J. 1857 The Kaffirs of Natal and the Zulu Country. London: Stanford

Shor, I. 1993 "Education is Politics" in P. McLaren and P. Leonard (eds.) Paulo Freire: A Critique Encounter. London: Routledge

Silva, K., Schensul, S., Nastasi, B., de Silva, M., Sivayoganathan, C., and Ratnayake, P. 1997 Youthand Sexual Risk in Sri Lanka," Women and AIDS Research Program, Report Series No 9. Washington, D.C. ICRW

Simon, W. and Gagnon, J. 1984 "Sexual Scripts," Society 22: 53-60

Sitas, A. 1992 "The Making of the Comrades' Movement in Natal, 1985-91," Journal of Southern African Studies 18(3):629-641

Smart, R. 1995 "Report of Workshop on Children Affected by HIV/AIDS (Orphans)." Unpublished Conference Report: Durban

Smith, B. 1979 The People's Health 1830 – 1910. NewYork: Holmes and Meier

Sobo, E., 1993 "Inner-City Women and AIDS: The Psychosocial Benefits of Unsafe Sex," Culture, Medicine, and Psychiatry 17: 455-85

_____ 1995 Choosing Unsafe Sex: AIDS-Risk Denial Among Disadvantaged Women. Philadelphia: Univ of Pennsylvania Press

Sontag S. 1978 Illness as Metaphor. London: Penquin

_____1988 Aids and Its Metaphors. New York: Farrar, Strauss and Giroux

Squire, C. 1993 Women and AIDS: Psychological Perspectives. London: Sage

Stall, R. 1986 "The Behavioral Epidemiology of AIDS: A Call for Anthropological Contributions," Medical Anthropology Quarterly 17: 36-37

Steward, J. and Malcolm D. (eds.) 1986 The Diary of Henry Francis Fynn. Pietermaritzburg : Shuter and Shooter

Strebel, A. 1992 "There is Absolutely Nothing I Can Do, Just Believe in God: South African Women with AIDS," Agenda 12:50-62

_____ 1996 "Prevention Implications of AIDS Discourses Among South African Women," AIDS Education and Prevention 8 (4): 352-374

Strebel, A. and Lindegger, G. 1998 "Power and Responsibility: Shifting Discourses of Gender and HIV/AIDS," Psychology In Society 24:4-21

Surveillance Bulletin 1998 "HIV Positive Results Reported since August 1998 Bulletin," South African Virus Laboratories Report: September

Swanewelder, R. 1994 "Fourth National HIV Survey of Women Attending Antenatal Clinics in South Africa," Epidemiological Comments: 21

Tawil, O., Verster, A. and O'Reilly, K. 1995 "Enabling Approaches for HIV/AIDS Promotion: Can We Modify the Environment and Minimize the Risk?" AIDS 9: 1299-1306

Taylor, C. 1990 "Condoms and Cosmology: the 'Fractal' Person and Sexual Risk in Rwanda," Social Science and Medicine 31 (9): 1023-1028

Thompson, C. 1985 "The Power to Pollute and the Power to Preserve: Perceptions of Female Power in a Hindu Village," Social Science and Medicine 21:701-711

Topouzis, D. and Hemrich, G. 1996 The Socio-Economic Impact of HIV/AIDS on Rural Families in Uganda: An Emphasis on Youth. UNDP Discussion Paper No 2: Geneva

Topouzis, D. 1998 The Implications of HIV/AIDS for Rural Development Policy and Programming: Focus on Sub-Saharan Africa. HIV and Development Programme: UNDP Report, June

Treichler, P. 1988 (a) "AIDS, Gender and Biomedical Discourse: Current Contests for Meaning" in E. Fee and M. Fox, (eds.) AIDS: The Burdens of History. Berkeley: University of California Press

_____ 1988 (b) "AIDS, Homophobia and Biomedical Discourse: An Epidemic of Significations" in D. Crimp (ed.) AIDS: Cultural Analysis, Cultural Activism. Cambridge (MA.): MIT Press

_____ 1992 "AIDS, HIV, and the Cultural Construction of Reality" in G.Herdt and S. Lindenbaum (eds.) The Time of AIDS: Social Analysis, Theory, and Method. Newbury Park: Sage

Udvardy, M. 1995 "The Lifecourse of Property and Personhood: Provisional Women and Enduring Men Among the Giriama of Kenya," Research in Economic Anthropology 16:325-348

Ulin, P. 1992 "African Women and AIDS: Negotiating Behavioural Change," Social Science and Medicine 34 (1) : 63 - 73

U.N. AIDS 1999 Global Report on AIDS. United Nations AIDS Programme. Geneva: May Update.

U.S. Bureau of Census 1996 Life Expectancy Rate with and without AIDS in Africa: 1996 and 2010. Washington D.C.: Population Division, U.S. Bureau of Census

Ussher, J. 1991 Woman's Madness: Misogyny or Mental Illness? London: Harvester Wheatsheaf Press

Vance, C. 1991 "Anthropology Rediscovers Sexuality: A Theoretical Comment," Social Science and Medicine 33: 875-884

Van de Vliet, V. 1974 "Growing Up in Traditional Society" in W.D. Hammond-Tooke (ed.) The Bantu Speaking Peoples of Southern Africa. London: Routledge & Kegan Paul

_____ 1991 "Traditional Husbands, Modern Wives? Constructing Marriages in a South African Township" in A Speigel and P MacAllister (eds.) Tradition and Transition in Southern Africa: African Studies Vol.50

Varga, C. 1996 "Commercial Sex Workers in Durban – Towards a Participatory Intervention Approach to AIDS/HIV Prevention," Final Project Report: Medical Research Council of South Africa.

_____1997a "The Condom Conundrum: Barriers to Condom Use Among Commercial Sex Workers in Durban, South Africa," African Journal of Reproductive Health 1(11):74-88

_____ 1997b "Sexual Decision Making and Negotiations in the midst of AIDS: Youth in KwaZuluNatal", Health Transition Review 7(2): 13-40

Varga, C. and Makubalo, L, 1996 "Sexual non-Negotiation," Agenda 28: 31-38

Varga, C. and Blose, F. 1997 "The Symbolism and Dynamics of Condom Use Among Commercial Sex Workers in Durban, South Africa," African Anthropology. February

Vasconcelos, A., Garcia, V., Mendonca, M., Pachero, M., Pires, M.,Tassitano, C. and Garcia, C. 1997 "Sexuality and AIDS Prevention Among Adolescents in Recife, Brazil," Women and AIDS Research Program, Report Series No 11 Washington, D.C.: ICRW

Venier, J., Ross, M. and Akande, A. 1998 "HIV/AIDS-Related Social Anxieties in Adolescents In Three African Countries," Social Science and Medicine 46(3) 313-320

Vilakazi, A. 1965 Zulu Transformations. Pietermaritzburg: University of Natal Press

Vlassoff, C. and Tanner, M. 1992 "The Relevance of Rapid Assessment to Health Research and Interventions," Health Policy and Planning 7:1-9

Webb, D. 1997 HIV and AIDS in Africa. Claremont: David Phillip

Weeks, J. 1991 Against Nature: Essays on History, Sexuality and Identity. London: Rivers Oram

Weiss, B. 1993 "Buying Her Grave: Money, Movement and the AIDS Epidemic in North-West Tanzania," Africa 63: 19-36

Weiss M. 1997 "Signifying the Pandemics: Metaphors of AIDS, Cancer, and Heart Disease," Medical Anthropology Quarterly Vol. 4:456-476

Welbourne, A. 1991 "Rapid Rural Appraisal and the Analysis of Difference," Rapid Rural Appraisal Notes 14: 14-23

_____ 1992 "Rapid Rural Appraisal, Gender and Health – Alternative Ways of Listening to Needs," Institute of Development Studies Bulletin 23: 8-18

West, M. 1988 "Confusing Categories: Population Groups, National States and Citizenship" in J. Sharp and E. Boonzaier (eds) South African Keywords- The Uses and Abuses of Political Concepts. Cape Town: David Philip

Whitehead, T., Peterson, J. and Kaljee, L. 1994 "The 'Hustle': Socioeconomic Deprivation, Urban Drug Trafficking, and Low Income, African-American Male Gender Identity," Pediatrics 93 (6): 1050-1054

Whitehead, T. 1997 "Urban Low-Income African American Men, HIV/AIDS, And Gender Identity," Medical Anthropology Quarterly 11 (4): 454-455

Whiteside, A. 1990 AIDS in Southern Africa. Durban: University of Natal

_____ 1996 "Briefing Paper on HIV and AIDS in KwaZulu-Natal", Provincial Leadership Forum Action Sheet: Durban

Whiteside, A. et al. 1995 The Impact of HIV/AIDS on Planning Issues in KwaZulu-Natal. Pietermaritzburg: Town and Regional Planning Commission

Wilson, C. 1964 "On the Origin of Menstrual Taboos," American Anthropologist 66: (3)

_____ 1995 Hidden in Blood: A Personal Investigation of AIDS in the Yucatan. New York: Columbia

Wilson (Hunter), M. 1936 Reaction to Conquest – Effects of Contact with Europeans on the Pondo of South Africa. London: Oxford Univ.

_____ 1951 "Witch Beliefs and Social Structure," American Jrl of Sociology 56:307-313

Wilson, M., Kaplan, S., Walton, E. and Maki, T. 1952 Social Structure Vol.3. Pietermaritzburg: Keiskammahoek Rural Survey

Wilson, M. and Mafeje, A. 1963 Langa: A Study of Social Groups in an African Township. Cape Town: Oxford Univ Press

Wilton, T. 1992 Antibody Politic: AIDS and Society. Cheltenham: New Clarion Press

_____ 1996 "Genital Identities: An Idiosyncratic Foray into the Gendering of Sexualities" in L. Adkins and V. Merchant (eds.) Power and the Organisation of Sexuality. London: MacMillan

_____ 1997 Engendering AIDS: Deconstructing Sex, Text and Epidemic. London: Sage Publ

Wood, K. 1998 "He Forced Me to Love Him : Putting Violence on Adolescent Sexual Health Agendas," Social Science and Medicine 47 (2): 223-242

Wood, K., Maforeh F. and Jewkes R. 1996 Sex, Violence and Constructions of Love Among Xhosa Adolescents: Putting Violence on the Sexuality Agenda. Johannesburg:CERSA/Women's Health, Medical Research Council

Wood, K., and Jewkes, R., 1997 "Violence, Rape and Sexual Coercion: Everyday Love in a South African Township," Gender and Development 5 (2)

_____ 1998 Love is a Dangerous Thing: Micro-dynamics of Violence in Sexual Relationships of Young People in Umtata. Pretoria: Center for Epidemiological Research in South Africa

World Bank 1997 Confronting AIDS: Public Priorities in a Global Epidemic. London: Oxford Univ Press

World Health Organization/GPA/SSB 1993 Social and Countextual Factors Affecting Risk-Related Sexual Activity Amongst Young People in Developing Countries: General Protocol. GENEVA WHO/GPA/SSB

World Health Organization 1995 International Consultation for Policy Makers on Women and AIDS in Preparation for the Beijing Conference. Geneva: WHO

Wright, J. 1993 "African-American Male Sexual Behavior and the Risk for HIV Infection," Human Organization 52: 421-431

_____1997 "African-American Males and HIV: The Challenge of the AIDS Epidemic," Medical Anthropology Quarterly 11 (4): 454-455

Xaba, T. 1997 "Masculinity in a Transitional Society: The Rise and Fall of the Young Lions." Colloquium Paper, 'Masculinities in Southern Africa. University of Natal, Durban: July

Yalman, N. 1963 "The Purity of Women in Ceylon and Southern India," Journal of the Royal Anthropological Institute. 2:10-19

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