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On the Pedagogy of HIV and AIDS: Conversations with Indigenes

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INTRODUCTION
This chapter is part of a broader study about the understandings of HIV and AIDS among migrant mine workers in a South African gold mining town that, for purposes of anonymity, I call ‘Goldtown.’ It draws on in-depth interviews that sought to establish how the men understand HIV and AIDS, that is, how they articulate its aetiology, its causes and ways in which people can protect themselves and others from contracting HIV.

Analysis of the interviews I held with the men yielded four categories into which to place them, which I respectively call, ‘progressives,’ ‘chance-takers,’ ‘indigenes’ and ‘radicals.’ They constitute the pillars of equipoising, a concept of embodied human responses to a difficult and complex circumstance, event or issue within spatio-temporality. I explain equipoising and its relationship to these pillars in substantial detail elsewhere (Molapo 2011). I use these categories as analytical tools aimed at examining the messages about HIV and AIDS propagated by the AIDS programme of the business unit in which they work.

In this framework, ‘progressives’ refers to those men for whom the symbols and narratives of HIV and AIDS science construct risk within a spatio-temporality. ‘Chance-takers’ depict men with a similar outlook to ‘progressives,’ with the difference that they acknowledge occasional conscious engagement in sex without the use of condoms. ‘Indigenes’ are men who employ symbols and narratives of risk in relation to HIV/AIDS that emanate from indigenous beliefs and practices, questioning risk as a construction of HIV and AIDS science. ‘Radicals’ denotes men who question and problematise risk as a construction of the symbols and narratives of HIV and AIDS science and do so in relation to their experiences of South Africa after apartheid. These categories are in essence positionings rather than positions, as they are dynamic and fluid and allow for shifts and movement.

My aim is to provide a phenomenological account of the understandings of HIV and AIDS among ‘indigenes.’ I thus make no judgements about their self-understanding or its implications but hold...
to their own accounts as the basic data. The study is based on in-depth interviews with 34 men from Lesotho, Mozambique and the Eastern Cape province of South Africa. The men I interviewed in this category were all heterosexual; I was not able to find ‘indigenes’ with a homosexual orientation, although other studies have shown that homosexual practices exist among mineworkers (Niehaus 2002; Moodie 1994).

I focus here on ‘indigenes’ because ‘tradition’—which includes what we might refer to as a religious orientation—is often seen by some as encouraging the proliferation of HIV and AIDS (Malungo 2001; Caldwell, Caldwell & Quiggin 1989). Of all the categories, it is ‘indigenes’—men who while accommodating the technologies meant for HIV and AIDS, also question the accompanying etiological claims—who allow for an examination of ‘tradition’ in the context of HIV and AIDS. Following Freire (1968), I refer to this message as ‘the dominant pedagogy of HIV and AIDS.’ This pedagogy is, however, a silencing one because the knowledge base is not located from below, that is, it is not framed by questions posed by the mineworkers themselves, but is framed from above, that is, by medical experts; it is also a pedagogy that seeks to produce compliance among the men. As a silencing pedagogy, its intention may be seen as trying to produce docile minds. I will show, nonetheless, that deep underlying structures and mechanisms constituting the behaviour of the mineworkers offer a challenge to the silencing effects of this dominant pedagogy of HIV and AIDS.

In exploring the understandings of HIV and AIDS among the indigenes, I attempt to make a case for the notion of embodied human experience in matters of health. I argue that HIV and AIDS intervention programmes, in fact, health interventions in general, ought to take practice seriously, as it is within the realm of practice that the deep underlying structures and mechanisms constituting behaviour reside. Here, borrowing from Bourdieu’s (1986) notion of habitus and Archer’s (2000) exposition of the human being, I mean by practice their daily or common practice, derived from their culture and customs, work place experience and linguistic or language experience and use. Interventions that overlook this reality gravitate into little less than a form of romanticism regarding health. Attempts to address the pressing issue of HIV and AIDS have to take seriously the critical issue of embodied human knowledge.

**On the Pedagogy of HIV and AIDS: A Brief Overview**

The dominant pedagogy of HIV and AIDS, which serves as a backdrop against which I explore understandings of HIV and AIDS among the indigenes, emerged in South Africa prior to 1994. However, it was only after 1994, within the post-apartheid dispensation, that its operations became pronounced. In the attempts to curb the proliferation of HIV and AIDS this pedagogy entailed and continues to entail mass education.
concerning HIV and AIDS—biomedical information on what it is, how it is contracted, and how people can protect themselves against contracting the virus (using condoms, for example) or slow its progress (immune-boosting nutrition and avoidance of alcohol, for example). The category of men that I call ‘indigenes’ emerges from my engagement with this pedagogy. Since their understandings of HIV and AIDS cannot be comprehended without it, this section provides a brief overview of the emergence of this dominant pedagogy of HIV and AIDS in South Africa.

The dominant pedagogy of HIV and AIDS emerged in South Africa out of a context of conflict between civil society organisations and the post-Apartheid government over public access to antiretroviral drugs. The confrontation was sparked by the government’s refusal to make antiretroviral drugs available to people living with HIV (PLWH), many of whom constituted the country’s poorest. (See Nattrass 2007 for a detailed account.) Among other things, the government’s refusal resulted in a lack of a clear national AIDS policy. Certain stakeholders, motivated by the belief in the right of all to health care and to life, viewed it the government’s obligation to make antiretroviral drugs available to PLWH and their own obligation to advance this. One is mindful here, for example, of the work done by Médecins Sans Frontières in Lusikisiki in the Eastern Cape Province of South Africa (Steinberg 2008).

Faced with a crisis of HIV and AIDS among its workforce, the mining industry quickly joined the frontline as a stakeholder. Convinced that the government was unable to produce an appropriate response to the pandemic, the mining industry formulated its own model for intervention among its workforce. The response within the mining industry itself was not uniform as some mining companies were reluctant to join the fight against HIV and AIDS. According to a medical practitioner on the mine studied, KrielkopGold (a pseudonym) was the first mining company to formulate an intervention programme for its workforce. It did so by adopting the World Bank sponsored model that Brazil, in the early 1990s, had put in place to deal with the proliferation of PLWH among that country’s citizens (Interview with Dr Brown, head of HIV and AIDS intervention programmes at KrielkopGold, 04/04/07). The Brazilian model, which combined prevention with the free distribution of antiretroviral therapies, was a strategy intended for replication by other developing countries faced with the similar challenge of HIV and AIDS (Biehl 2004).

Whereas KrielkopGold adopted the World Bank sponsored Brazilian model for implementation in a number of its business units, I will focus on just one, Monyakeng (also a pseudonym). At the time of this study, Monyakeng was viewed as representing the best mining industrial response to HIV and AIDS because the highest number of mineworkers testing for HIV and AIDS was reported there. From the very beginning of the intervention programme until 2008 when fieldwork for this study had neared completion, Monyakeng reported the highest percentage of
workers testing for HIV. Monyakeng appears to have developed a vibrant culture of testing for HIV and AIDS. Consequently, until 2007, it was in this business unit that most mineworkers who tested HIV positive were enrolled for antiretroviral therapy.

At Monyakeng, a workforce of about 4 000, mainly men and a handful of women, periodically engaged with the dominant pedagogy. My focus has been on the men since I wished to attain a regional feel for the phenomenon of the migrant mineworkers being examined in this study. The significant numbers of men allowed for such an enterprise as opposed to the handful of women, who were also mainly South African.

ON DEFINITIONS OF HIV AND AIDS: INDIGENES AS ADHERENTS OF THE DOMINANT HIV AND AIDS PEDAGOGY

I begin this section by showing that indigenes know about or are aware of the message of HIV and AIDS. I do so to argue that their subsequent questioning of the dominant pedagogy of HIV and AIDS is not due to ignorance on their part, but rather to claims about health emanating from epistemologies of practice in competition with the dominant HIV and AIDS pedagogy. The examples that follow are characteristic of the views expressed by men in my study sample. I commence with the answer to a question I had posed to Mr. TT concerning what he understood by HIV and AIDS:

According to my own understanding, HIV/AIDS is kokoana-hloko [a virus] that attacks the soldiers of the blood [the immune system] thereby rendering the body incapable of defending itself from diseases. Now, once the body is no longer able to defend itself from diseases a person eventually dies.

Consider, as well, this response from Mr. YL:

My understanding is dependent on what is being said here in the mine that HIV/AIDS is a disease that attacks the soldiers of the blood [the immune system] and that once the soldiers of the blood are weakened a person then becomes susceptible to contract diseases that will ultimately kill him or her. When a person is in this state, any disease can kill him or her.

An examination of the above two extracts from the interviews suggests that in talking about what they understand by HIV and AIDS, indigenes borrow directly from the explanations of the dominant HIV and AIDS pedagogy. However, these explanations are shown to translate into emerging localised understandings, caught up in a regional grammar via which these working class men indigenise the pedagogy of HIV and AIDS. Even though the language informing this grammar emanates from the company’s AIDS programme, I argue that in interacting with this
programme, the indigenes bring their own novelty into the process, thus shaping and expanding the process of the localisation of the pedagogy of HIV and AIDS.

Furthermore, even though it would appear from these two extracts that the men collapse the distinction between HIV and AIDS, treating them as the same thing, there are some indigenes who are quite aware of both the distinction and the relation between HIV and AIDS. Consider, for example, the following extract from a conversation with Mr. LM:

This thing called HIV/AIDS, is essentially a disease of the blankets [sex] and is caused by the infection of a virus called HIV. Now, this virus spreads across the body and destroys the soldiers of the blood [the immune system] thereby rendering the body incapable of defending itself from attacks by diseases. In other words, HIV is a virus that leads to the condition of AIDS. Even though we like to place an emphasis on the blankets, it is well known that a person can get it [HIV/AIDS] through many other ways.

Clearly, Mr. LM is among those indigenes possessing an awareness that HIV and AIDS are two separate but related stages in a progression from health to ill health. Thus, unlike some of his colleagues, he does not use HIV and AIDS interchangeably, talking instead, about HIV/AIDS in a way that appears to recognise these distinct but related stages in the progression of the disease. Deeper probing uncovered that a significant number of the men interviewed, rather than lacking a knowledge of a distinction, are aware of this distinction and relation but are simply accustomed to referring to this particular disease as one thing, HIV/AIDS, a linguistic short form.

In providing this brief account of understandings of HIV/AIDS among indigenes, I suggest that at face value indigenes could be seen as adherents of the dominant HIV and AIDS pedagogy. This is an important point to note because it shows that the claims of the pedagogy of HIV and AIDS already constitute the habitus (knowledge as embodied experience; Bourdieu 1986) of indigenes, as one part of the complex ways in which these men relate to their immediate environment.

**ON DEFEATED AND CONTAMINATED BLOOD: UNDERSTANDING THE CAUSES OF HIV AND AIDS AMONG INDIGENES**

Although indigenes accommodate and appropriate the explanations of the dominant HIV and AIDS pedagogy concerning what HIV and AIDS are, when it comes to explicating the causes of the disease, it appears that they subscribe to a counter aetiology related to their daily practice that ultimately undermines the explanations of the dominant pedagogy regarding the disease. In other words, at the level of explicating the causes of HIV and AIDS these men begin to elude the
grasp of the dominant pedagogy. Consider, for example, the following communication by Mr. MZ, in which he describes his understanding of what causes HIV and AIDS:

You see *mmate* [friend, in Shangaan], when we were born we were told that we were not supposed to have sex with older women or even to start sex with women prematurely and we, in fact, complied with such teachings. Now, young men have sex with older women. We were told that older women would *defeat* us because they have strong blood in comparison to the young blood of younger people. That is what used to happen. Now, these days, the problem is that young people do not listen. We were also told not to have sex with a woman who had just lost her husband because it may happen that a doctor may be able to .....; let’s say I had sex with a woman who had had an abortion, so if I happen to survive this sickness, the doctor may realise that I had sex with a woman who had had an abortion recently. But it is the blood of this woman that contaminated my blood. The doctor may not be able to see the real cause of the problem and I am telling you that this thing really kills ... This thing kills like AIDS. When you have sex with a woman who has lost a loved one without knowing, we call this disease that results from contaminated blood, *izinyama* [ritual uncleanness].

Clearly, according to Mr. MZ, two things are central to an understanding of the causes of HIV and AIDS. These are, respectively, the *defeated* blood of young people as well as ritual uncleanness or, what he calls, *izinyama*. As may be seen from the above extract, the former is a result of changes in the blood content of young people due to sexual engagement with persons culturally designated as older. In the conversation I had with Mr. MZ, he seemed to consider as older persons those women physically old enough to qualify as mothers to any potential male sexual partner. A cultural framing of motherhood rather than age as such is at work.

The latter cause, that is, *izinyama*, seems to be a result of two separate but related issues. (*Izinyama* is a word used to designate someone who is ritually unclean because they have not been through the cleansing processes following a death; a ritual practice present in many cultures of southern Africa; *tshila* and *intsila* are the respective Sesotho and *Izixhosa* equivalents.) The first issue concerns having sex with a woman who has had an abortion; the second relates to having sex with a woman who has recently lost her husband to death. Though these two causes may be seen as distinct, the common feature they share, one that generates a relationship between them, is that they both locate these women within an experience of death. They both symbolise loss due to death. It is the location of these women within a context of death that is paramount to an understanding of why sex with them is taboo.

According to Mr. MZ, as well as the testimony of a number of other indigenes, the experience of death of a husband or a wife places one in
a period of seclusion, during which time one is supposed to mourn the death of the beloved. During this mourning period, the living spouse is considered ritually unclean and must avoid sexual intercourse. The men in this study use various words to describe this form of uncleanness. They refer to the living spouse as having *sesila*, *izinyama* or *intsila*. *Sesila* is a form of culturally constituted dirt and, as such, is understood as having the power to contaminate those who come into contact with it. However, this is not a mere abstraction—the very person of the living spouse is seen to embody this contaminating agency. Contact of a sexual nature with such a person is altogether forbidden and considered dangerous because, as Mr. MZ points out, contact contaminates the blood of the sexual partner of the living spouse. Thus, in essence, sexual intercourse with a person considered ritually unclean radically transforms the content of the blood of his or her sexual partner.

As I learned from other indigenes, contaminated blood can also be the result of the mixing of the blood of strong and weak men via multiple sexual partners. The example below explicates this phenomenon. According to Mr. LL:

> As a person, you go about meeting different people [having sex with multiple sexual partners]. You sleep with them without any protection. Because as people our blood content is not the same and so are our sicknesses. When a man like myself shares the same sexual partner with, say a man like you, without any form of protection, once our blood meet [in the womb of the sexual partner concerned] it will cause sickness. If this blood goes to the same person [the same woman] you will find that there is one for whom this blood will be too heavy because his blood is too slow while others may go in and escape without any form of infection. A person with slow blood is the one who is most likely to contract such infections with ease.

So, according to Mr. LL, sharing a sexual partner is fraught with risk because of the potential it has of giving rise to conditions of ill health resulting from a mixing of blood from different people. Of course, the emphasis seems to be on the blood of different men who have sex with the same female partner. This mixing of blood, it would appear, essentially, gives rise to contamination since it is a mixing of differences of personality that reside in the blood. However, prospective sexual partners of the woman (that is, male sexual partners) have different chances of having their blood contaminated; those with *slow* blood stand a greater chance of contracting infections that reside in the person of the woman who is the carrier of contaminated blood. Thus, persons with *slow* blood are the ones most likely to spread sexual infections and not their strong-blooded counterparts. This idea emanates from the notion that fortune and misfortune are informed by the content of one’s blood. Consequently, a person with *slow*, and therefore, weak blood is more likely to attract misfortune. It is through this reasoning that Mr.
LL sees multiple sexual partnerships as providing a conduit through which HIV is transmitted.

While on the surface it may appear as though Mr. LL is making an argument about differences of personality, when asked to explain this issue further, he had this to say:

Yes, ntate [father], our blood [as people] is not the same. And as people there are lipitsa [herbal remedies] that we use. When these lipitsa cleanse bofeili [dirt] from me, I take that dirt and transmit it to you; that is why you will find that this dirt will cause you a lot of diseases.

The source of this contamination, which is generated when different men have sex with the same female sexual partner, is tshila (that is, contaminating dirt carrying the potential to generate disease). According to Mr. LL, this dirt emanates from the blood and is a result of cleansing processes that aim at purifying the blood. What emerges here, therefore, is that, like anything else, the blood is understood to acquire dirt and needs to be cleansed. From the extract above, it appears as though there are special herbal remedies that are used as detergents of the blood. These remove dirt from the blood that can then be passed from one person to another during sexual intercourse, thereby causing contamination that then gives rise to sexually transmitted disease; this, according to indigenes, is the same thing that medical experts call HIV and AIDS.

What emerges from these interviews is the existence of a counter aetiology to the aetiology of the dominant HIV and AIDS pedagogy, an aetiology that underscores how indigenes articulate their understandings of the causes of HIV and AIDS. More importantly, this aetiology seems to suggest that indigenes conceive of social relations, and therefore of life, in terms of an otherness that resides beyond the boundaries of the dominant HIV and AIDS pedagogy. The causes of HIV and AIDS, the indigenes appear to argue, ought to be placed within a context of the relationship between the utility of HIV and AIDS interventions and the excessive phenomena that lie beyond, that is, the ideas about reality that are found within epistemologies of practice. In the process, these men remind one of the primacy that Durkheim attributes to the ‘social fact, over and above the behaviour of individuals’ (Durkheim 1964, quoted in Pawlett 1997:98). The dominant pedagogy misses this relationship.

**What about Safe Sex? Indigenes on Sex that Involves the Use of Condoms**

In this section, I attempt to investigate the attitude of indigenes towards safe sex or sex that involves the use of a condom. I do so as a way of ascertaining the significance of condoms as technologies of sexual pleasure *vis-a-vis* a worldview that appears to emerge from an aetiology that challenges the aetiology of the dominant HIV and AIDS pedagogy.
In other words, I try to explore the relevance of condoms to indigenes, who seem to reflect a worldview on the issue that transgresses the boundaries of the dominant pedagogy.

In interviews with the indigenes, it appears that the language of protection and safe sex plays a critical role in how they conceive of sex in a time of HIV and AIDS. That is, condoms constitute a central component of the manner in which they negotiate safe sex. The following extract, in which Mr. TY responds to a question about the relevance of condoms to safe sex, illustrates this point:

> By protection, I am referring to the use of condoms. Condoms are very important because as you might understand it would be a terrible mistake to go to battle [a polite way of saying sex] without taking your likhohlopo [literally gumboots worn by mineworkers to protect themselves from water underground; the word has been appropriated in HIV and AIDS discourse to mean condoms]. I do keep them with me here [where he stays in the mine] just in case I find myself in an unfortunate day. Personally, I do not run around with anyone here but it is important just to have them all the time just in case you find yourself in a rainy day.

When I asked Mr. TY whether condoms could protect against the contamination of the blood that he and other indigenes were talking about, he responded as follows:

> They do. It is the only way of staying safe. And if you are not a person who likes using them the only suggestion I can give you is to stay away from women [from sex].

As can be seen from the above response, while with regard to the causes of HIV and AIDS indigenes transcend the boundaries of the dominant HIV and AIDS pedagogy, they gravitate back to its dictates when it comes to the issues of safe sex. While they provide counter-explanations about the causes of HIV and AIDS, they nonetheless imbue the technologies that the dominant pedagogy provides, such as condoms, with significance. This may be because indigenes agree in principle with the dominant pedagogy in the existence of a sexually transmitted disease phenomenon called HIV and AIDS, which is considered incurable. In the absence of a cure, these men argue, it is important to use what is perceived to work, that is, condoms. Thus, their counter-explanations concerning the causes of HIV and AIDS notwithstanding, when it comes to safe sex, indigenes approach condom use with the same attitude as men who subscribe to the dominant HIV and AIDS pedagogy.

As evidence of the seriousness with which they view condoms, indigenes dismiss the common perception of some of their colleagues that condoms have worms that eventually generate what medical experts call HIV and AIDS. Indigenes often view these men as extremists who lack proper understanding of how condoms should be used. For indigenes, condoms, like any other technology, have specifications that
need to be understood and followed if their efficacy is to be realised. Mr. HN illustrated this point:

You see some people do not understand. Everything that has been designed has a particular way in which it is supposed to function. You can see even here in the mine that there are many machines and each one of them works in a particular way that needs to be understood before it can be operated. And if you do not understand the instructions then you will not be able to operate that machine. The same thing applies to condoms. One has to understand how a condom works because it has *specification*. Now, some people say that they put water into condoms and then they see worms. Sure, they are supposed to see worms because they do not use condoms according their specifications. One is not supposed to put water inside condoms; that is not how they work. [Author’s emphasis]

I have italicised the word ‘specification’ in the above extract because it is the exact word that Mr. HN, who hails from a country in which English is not an official language and who does not himself speak it, used. His use of the word ‘specification’ is significant in two ways. First, it shows that there exists a counter-explanation to the one offered by the dominant HIV and AIDS pedagogy concerning condoms that many mineworkers have to engage; that is, indigenes, as well as other men, talk about condoms in contestation with other interlocutors who dismiss conventional understandings of condoms; in doing so, they draw insights from fellow workers who possess specific expertise. The use of the word ‘specification’ suggests conversation with fellow workers who possess ‘expertise’ or special knowledge of some sorts.

Secondly, it speaks of the embedded nature of the conversation they have with mineworkers who possess expert knowledge within an industrial mining context that is already inscribed within a language of technology. In other words, what essentially gives meaning to expert terminology is the familiarity that these men have with technological equipment that is a feature of mining contexts. I argue that this industrial context, characterised by technological equipment, enables a significant number of indigenes to appropriate this language and locate it in their own work experiences, thus enabling them in turn to develop a meaning about condoms independently of the dominant health experts.

Indigenes raised the safety aspects of condoms as one of their main concerns. Although they argue that condoms do offer protection from possible contamination of blood, they also point out that condoms are not 100% safe. Consequently, they communicate that they are aware that the use of condoms is not without problems, but contest that the use of condoms far outweighs what they refer to as ‘reckless conduct’ when condoms are not used at all.

However, among indigenes some men believe that condoms ought to be used as a last resort, because, according to them, condoms do
not cultivate a conduct of disciplined and responsible behaviour. They contend that condoms can actually encourage ill-discipline and irresponsibility among those who possess them, causing some to believe that they can indulge in sex without any consequence. Thus, a number of indigenes believe that abstinence should be the primary means of practising safe sex and that condoms should only be used in those instances when a person finds the life of discipline and responsibility very difficult to maintain. Mr. FP pointed this out:

You see, I recognise the value of condoms and I understand that it is important for us to use them. However, what is sad is that condoms make people who run around. They encourage men to chase after women because they know that they are safe. Now, although condoms are good they encourage irresponsibility and I only say they should be used only because people are hard-hearted.

Mr. FP’s response suggests that he ideally does not support the use of condoms because they encourage reckless sexual conduct—they ‘make’ people ‘who run around.’ Implied in this statement is the assertion that they encourage multiple sexual relationships. For Mr. FP, as well as a handful of other indigenes, easy access to condoms leads to the failure to cultivate responsible sexual lives, as it gives people the impression that they can indulge in sex without consequences. In other words, easy access to condoms gives people the license to have sex, which leads to an erosion of culturally constituted norms and values that are meant to regulate and cultivate responsible sexual conduct. What is at stake here is primarily the perceived negative impact of condoms on cultural norms and values rather than the issue of protection.

This tension between the practical concern to save lives and cultural ideals seems to be indicative of the usual conflict that emanates from the provision of technologies that seek to expand human freedom through the conquest of the arbitrary character of nature and the friction this generates among worldviews in which the body is lived as a total social fact. The adoption of these practical life-saving technologies, however, seems indicative of how counter-health epistemologies continue to propagate themselves in the face of values that, in essence, seek their eradication. I contend that the adoption of these technologies by indigenes gives rise to new and complex worldviews that defy the limited binaries of modernity and tradition often informing talk about HIV and AIDS in Africa (Caldwell et al. 1989; Rushing 1995, quoted in Oppong & Kalipeni 2004). Among other things, such talk lacks a substantive theory of agency.

CONCLUDING REMARKS

In studying the understandings of HIV and AIDS among the men that I have called indigenes, I am attempting to bring the body and,
therefore, embodiment, back into sociological theorising about health. I have done this by grounding my exploration in a concrete context of the crisis of HIV and AIDS in an industrial mine in South Africa. At a meta-theoretical level, I am seeking to overcome the divide between objectivists and subjectivists, as far as it expresses itself in the study of HIV and AIDS. In a nutshell, I am trying to place my inquiry beyond a preoccupation with studies that seek either to provide social explanations of the causes of HIV and AIDS (Hunt 1989; Jochelsen, Leger & Mothibeli 1991; Campbell 2003) or those that place emphasis on the significance of the meaning people have of HIV and AIDS (Walker, Reid & Cornell 2004). I am, instead, focusing on the deep underlying structures and mechanisms that constitute behaviour and reflecting on the dynamics that result from this relationship in relation to HIV and AIDS. By so doing, I seek to foreground the primacy of embodied agency in an exploration not only of HIV and AIDS but also of health.

By foregrounding the primacy of practice, I attempt to give purchase to agency and do so in a way that considers the social world in which the men I interviewed live out their lives as the basis for the production of their agency, as well as the outcome of that agency. This understanding is borrowed from Bhaskar’s (1979:43) definition of society as ‘the ever-present condition (material cause) and the continually reproduced outcome of agency.’ In so far as it is important to understand material, social and political realities that may act as causal factors for the proliferation of HIV and AIDS, it is equally important to think about ways in which actors make sense of such realities and how they do so from a point of view of life as an embodied experience. Such an inquiry enables us to see how actors negotiate the socially mediated meanings that are inscribed on the body. This provides us with variation in understandings of HIV and AIDS that is crucial and that requires understanding by those who formulate intervention strategies.

The case of indigenes, for instance, provides us with a model of men who appear to legitimise the claims of the dominant HIV and AIDS pedagogy. This is irrespective of the fact that they essentially question its aetiology claims. What this means, however, is that given a crisis in which they may experience HIV and AIDS themselves, they are likely to mobilise resources beyond those prescribed by the dominant HIV and AIDS pedagogy. As mirrored in the now well-known story of Khabzela (McGregor 2005), they are likely to go beyond the boundaries of the dominant HIV and AIDS pedagogy in their search for health.

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