The copyright of this thesis vests in the author. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

Published by the University of Cape Town (UCT) in terms of the non-exclusive license granted to UCT by the author.
EXAMINING RELIGIOUS LEADERS AND TRADITIONAL HEALERS’ EXPERIENCES AND RESPONSES TO HIV/AIDS IN A MODERN COMMUNITY

A minor dissertation submitted in partial fulfillment of the requirements for the Degree of

MASTER OF EDUCATION

by

AYSHA ABRAHAMS

MARCH 2006

(Supervisor: Ms M.J. Baxen)
Plagiarism Declaration

I hereby declare that the whole of this thesis, unless specifically indicated to the contrary in the text, is my own original work and that it has not been submitted for any degree in any other university.

Signature: Abrahams

Aysha Abrahams

Date: 31 March 2006
ABSTRACT

With the rampant onslaught of the HIV/AIDS pandemic, concern from various sectors of South Africa has led to the disease receiving much publicity in more than one way. Despite the vast amount of exposure and availability of HIV/AIDS information, infection rates are still souring throughout communities.

Therefore this study embarks on examining key individuals in communities that may be able to contribute to curtailing further infection rates. The study focuses specifically on ‘examining the experiences and responses to HIV/AIDS, of religious leaders and traditional healers, in a modern community. The study acknowledges that these individuals are not only influential individuals, but are also educators in their respective communities and thus the study is situated within the education sector.

The study is located in the qualitative paradigm because it seeks to achieve a deeper understanding of how religious leaders and traditional healers are positioned, how they interpret religious principles in relation to a disease that is primarily transmitted through sexual intercourse, and how they respond to, and deliberate about private issues such as sex and sexuality.

Data was collected from religious groups that included 4 Christian leaders, 3 Muslims leaders, 2 Jewish leaders, 6 Rastafarians leaders and 3 Traditional healers. Data collected from five communities in the Southern suburbs of the Western Cape. Methods of data collection included observations, semi-structured interviews and two focus group discussions.

The results revealed that examining religious leaders and traditional healers’ responses and experiences, is a complex process that has to consider the contexts in which religious leaders and traditional healers operate. It was also found that they are indeed influential individuals that can influence how people perceive and manage daily challenges such as HIV/AIDS.
ACKNOWLEDGMENTS

This thesis forms part of a project called Schooling Cultural Values and HIV/AIDS and therefore much appreciation goes to the National Research Council and Norway Research Foundation for the funding provided.

Since the study sought to examine religious leaders and traditional healers’ experiences and responses to HIV/AIDS in a modern community, the study acknowledges that without the participation of all the religious leaders and traditional healers, this study would not have been possible. Thus sincere thanks go to all my respondents.

I wish to thank my supervisor, Ms M.J. Baxen for her guidance, expertise and time offered especially in the last leg of completing this arduous task.

A special thanks to Professor Crain Soudien of UCT who assisted me in the absence of my supervisor and especially in advising me on Chapter 2. Also Professor Andes Breidlid of Norway who guided me with chapter 5.

I acknowledge my dear friend and colleague, Associate Professor Aslam Fataar, for expertise offered and sound advice. Thank you for always being there for me, your words of encouragement will always be appreciated.

Many thanks to the staff at the document centre, namely Nuroo Ismail, Dianne Steele and Nadessen Paliann who assisted me with the layout and referencing of this dissertation. Many thanks to Faranaaz Arnold and Neil Rolls for editing done. Also Cathy Hutchings at CHED for checking my references.

My friends and colleagues: Hilda Rolls, Joy Alexander, Bernice Adonis, Mamatsoso Matsoso-Makhathe and Ronald Zamanjah. It was an immense learning experience having worked with you on this project and indeed an honour for me to be associated with individuals of your calibre. Thank you for sharing unselfishly of yourselves, your time and your knowledge with me.
Special thanks to my colleague and friend Christelle Eckron for reading my work, providing constructive criticism and checking up on my state of health. My friends Shoekerie and Rholda Andrews, thank you for regularly checking on me and my progress. You valuable comments contributed to the way I interpreted and thought about my study.

To my parents Dawood and Gabiba Hattas: Thank you for believing in me, for all the love shown, prayers, support and caring for my family during my busy periods. It is much appreciated.

To my husband, Yagya Abrahams, thank you for accompanying me to sites where respondents requested that my spouse be present and for video recordings done in the sites. Many thanks for your generous financial assistance, unconditional love, patience, continuous support and encouragement. Without your help and guidance this would not have materialized. My beloved daughters Ilhaam and Sakeenah thank you for loving a nose-in-the-book mom! Thanks for doing some of my chores and for the midnight cups of coffee.

To my brother M.Thabiet Hattas and his wife Nawaal Hattas-Toefy, for taking care of my children while I was writing. My sister Yumnah Hattas-Schloss for listening and offering advice and her husband Yazeed Schloss for always reassuring me that I ‘shouldn’t worry all will be fine’. To my in-laws Yusooof and Abeda Abrahams, thank you for being there for me and my family and for caring about us unconditionally.

To my dear friend Zayd Abrahams, thank you for regularly calling to see if I am ok, for your prayers, reassurance and confidence that you displayed to my work. Also Ibtisaam Peck, thank you for your support and patience. Sedick Gamieldien for your continuous prayers said for me. You are indeed valuable friends.

Last but not least, I thank God for gracing me with the above.
Table of Contents

PLAGIARISM DECLARATION ........................................................................................................... I

ABSTRACT ........................................................................................................................................ II

ACKNOWLEDGMENTS ................................................................................................................... III

TABLE OF CONTENTS ................................................................................................................... V

LIST OF APPENDICES .................................................................................................................. VII

LIST OF ABBREVIATIONS ............................................................................................................ VIII

CHAPTER 1: INTRODUCTION TO THE STUDY ............................................................................... 1

1.1 INTRODUCTION AND BACKGROUND ................................................................................ 1
1.2 ORIGIN AND STATEMENT OF THE PROBLEM .................................................................. 2
1.3 AIM OF THE STUDY .............................................................................................................. 3
1.4 RESEARCH QUESTION ......................................................................................................... 3
1.5 SUPPORT QUESTIONS .......................................................................................................... 3
1.6 OVERVIEW OF THE STUDY ................................................................................................ 4

CHAPTER 2: LITERATURE REVIEW ............................................................................................. 6

2.1 INTRODUCTION .................................................................................................................... 6
2.2 SOCIOLOGICAL CONSTRUCTIONS OF RELIGION .......................................................... 7
  2.2.1 Traditional Perspectives on Religion ................................................................................ 7
  2.2.2 Modern Perspectives on Religion .................................................................................. 11
  2.2.2.1 From Religion to Science and Globalization ............................................................... 11
  2.2.2.2 From Religious Membership to Secularism ............................................................... 13
  2.2.3 Modern African Perspectives on Religion ....................................................................... 15
  2.3 RELIGION AND DISEASE ............................................................................................... 17
    2.3.1 A Brief Historical Overview of Religion and Disease ................................................ 17
    2.3.2 Religion and Disease in Modern Times ........................................................................ 19
    2.3.3 Constructions of Sexuality and Sexual Behaviour in Religion .................................... 24
    2.3.4 Sexuality Shifts within Modern Contexts .................................................................... 28
    2.3.5 Religious Leaders, Traditional Healers and HIV/AIDS ................................................ 29
    2.3.6 Studies on Religious Leaders and Traditional Healers responses to HIV/AIDS ........ 31

CHAPTER 3: RESEARCH DESIGN ................................................................................................. 37

3.1 INTRODUCTION .................................................................................................................... 37
3.2 METHODOLOGICAL OVERVIEW ...................................................................................... 37
  3.3 Site and sample: selection processes .................................................................................. 39
  3.3.1 Site ................................................................................................................................. 39
  3.3.2 The sample ................................................................................................................... 40
  3.3.2.1 Accessing the sample ............................................................................................... 41
3.4 METHOD OF DATA COLLECTION ..................................................................................... 42
  3.4.1 Process of data collection ............................................................................................. 42
  3.4.2 Observations ............................................................................................................... 43
  3.4.3 Focus group discussion ................................................................................................. 44
  3.4.4 Semi-structured interviews ......................................................................................... 45
3.5 CHALLENGES AND ACCOUNTING FOR MYSELF ........................................................ 47
3.6 DATA ANALYSIS PROCESS ............................................................................................... 48
  3.6.1 Physical tools of analysis ............................................................................................. 50
3.7 Ethics and Confidentiality ............................................................................................................... 50
3.8 Limitations of the Study .................................................................................................................. 51

CHAPTER 4: PRESENTATION OF RESULTS ......................................................................................... 53

4.1 Introduction ........................................................................................................................................... 53
   Table Two: Pseudonyms of Respondents ................................................................................................. 53
4.2 Religion and the Place and Purpose of Sex .......................................................................................... 54
4.3 Views, Knowledge and Conceptions of HIV/AIDS, Disease and Sexuality .............................. 56
   4.3.1 Views on Transmission, Sexual Behaviour and Risk .................................................................... 56
   4.3.2 Vulnerability and Risk .................................................................................................................. 60
4.4 Disease Prevention Strategies and Religious Beliefs .......................................................................... 65
   4.4.1 Testing: Assisting prevention or highlighting inequalities of who tests ...................................... 69
   4.4.2 Curing HIV/AIDS: spiritual or physical healing ......................................................................... 70
4.5 Care and Support ................................................................................................................................ 73
   4.5.1 Pastoral care .................................................................................................................................. 74
   4.5.2 Experiences with caring for HIV/AIDS sufferers ......................................................................... 75

CHAPTER 5: ANALYSIS, DISCUSSION AND RECOMMENDATIONS ..................................................... 80

5.1 Introduction ......................................................................................................................................... 80
5.2 Analysis and Discussion ...................................................................................................................... 80
5.2 Conclusion .......................................................................................................................................... 88
5.3 Recommendations .............................................................................................................................. 89
5.4 Recommendations ................................................................................................................................ 89

REFERENCES ............................................................................................................................................ I

APPENDICES ........................................................................................................................................... IX

   INTERVIEW ONE ................................................................................................................................. xxvii
   INTERVIEW TWO ................................................................................................................................. xxix
   INTERVIEW TWO ................................................................................................................................. xxxi

LIST OF TABLES

   Table 1: Respondents as per Religion ...................................................................................................... 41
   Table 2: Pseudonyms of Respondents ..................................................................................................... 53
LIST OF APPENDICES

APPENDIX A: CONTEXTS OF RESPONDENTS

APPENDIX B: FOCUS GROUP SCHEDULE

APPENDIX C: OBSERVATION SCHEDULE

APPENDIX D: SEMI-STRUCTURED INTERVIEW SCHEDULES

APPENDIX E: CONSENT FORM OF RESPONDENTS
LIST OF ABBREVIATIONS

HIV: Human Immunodeficiency Virus
HI virus: Human Immunodeficiency Virus
AIDS: Acquired Immune Deficiency Syndrome
STDs: Sexually transmitted diseases
UCC: United Christian Church
UNAIDS: United Nations Aids
CHAPTER 1: INTRODUCTION TO THE STUDY

1.1 Introduction and Background

It can be argued that certain individuals such as teachers, sports personalities, religious leaders and the like are influential persons that have the ability to encourage the general population to reflect on and change behaviour on pertinent issues such as prevention of new infections, sexuality, care and supporting the infected, etc. Religious leaders and traditional healers are particularly influential in that they often act as the moral conscience of society (Ahmed 1999). They hold persuasive positions and are associated with having direct links to the divine or Supreme Being. They act as moral guides, specifying what religious norms societies should adhere to. They are often called upon to render counseling or advice on everyday issues and challenges. In some instances they use holy scripts to give advice and in other instances, offer healing through the use of traditional medicines or prayer. As people in leading positions, and unlike personalities such as those in sports, they are in direct communication with their respective communities on a more regular basis. As such, it is often assumed that they have knowledge of and understand the complexities of daily life in ways that other leaders might not. Thus, they have the ability to persuade and influence individual and collective identities of societies (Hewson 1998).

Religious leaders and traditional healers are also viewed as those who provide solace to people during periods of vulnerability. This often occurs when societies experience natural disasters, threats of disease or when scientific answers to problems are not accessible, as in the case of HIV/AIDS today. Sometimes though, their advice and responses to issues can be contradictory and misleading and out of touch with the realities and experiences of members within their society. This notwithstanding, they do have some influence on the collective psyche of members in society.
Religious leaders are often called upon by governments to assist in the promotion of healthy lifestyles. In South Africa, and with regard to the HIV/AIDS pandemic, such a request was made to leaders due to the high rates of infection. Even though HIV/AIDS information and messages are disseminated through schools, medical, corporate and communication sectors, rates of infection continue to rise, affecting different contexts and influencing the lived experiences of people at home, in schools, places of recreation, in different sites of worship. In 2005, UNAIDS reported that globally, there were 4.2 million new infections in adults and 0.70 million in children.

In an attempt to combat new HIV/AIDS infections in South Africa, the Department of National Education, through its National Education Policy for HIV/AIDS (1999), proposed that all learners, teachers, and communities be educated about HIV/AIDS. This policy proposed collaboration between HIV/AIDS units in Departments of Education and faith-based organizations.

1.2 Origin and statement of the problem

The results of a study conducted in 2003 within a Muslim community, illustrated that the responses to the HIV-positive community by religious leaders was problematic and that their interpretations of the disease held implications for the lives of PWAs (Hattas Abrahams 2003). The results of this study indicated that religious leaders were in powerful positions to influence and interpret messages and responses to HIV/AIDS. They influenced beliefs, attitudes and responses in communities, and in this case, contributed to the marginalization and stigmatization of those infected.

Within the South African context both religious leaders and tradition healers exist. They play the role of primary disseminators of knowledge, whether it relates to marriage, disease, abortion or even condom use. With regards to understanding and interpreting HIV/AIDS, religious leaders and traditional healers play a unique role in that they not only provide advice about disease, but some also provide medication.

---

1 PWA- Person/s living with HIV/AIDS
As a pandemic that is transmitted primarily through sexual contact, HIV/AIDS forces religious leaders and traditional healers to confront the deeply private issues of sex and sexuality. However, they ascribe to their own personal belief systems of sex, disease, morality, religion, while at the same time, are required to make ‘professional’ judgments using religion as a frame of reference. What are their attitudes, responses and experiences of a disease that foregrounds sex and sexuality? How do they understand their roles in response to HIV/AIDS? It was such questions that led to the focus of this study. These centre on questions about their knowledge of and responses to HIV/AIDS in the contexts where modern and traditional beliefs find expression, in complex and sometimes conflictual ways.

1.3 Aim of the study

The study aims to examine religious leaders and traditional healers’ experiences and responses to HIV/AIDS in a modern community.²

1.4 Research question

In the context of HIV/AIDS, what are the experiences and responses of religious leaders and traditional healers in a modern community?

1.5 Support questions

- What are religious leaders’ and traditional healers’ knowledge and conceptions of HIV/AIDS?
- What are religious leaders and traditional healers’ responses to the pandemic?
- What are their positions on care and support of infected people?

² A modern community is defined by Iverson (2005:1) as “a community with a relatively complex division of labour, whose inhabitants tend to welcome change, use sophisticated technology, have well-developed mass media, and rely more on formal, secondary relationships than on primary or informal relationships.”
o How do they understand their roles as religious leaders in the face of the pandemic?

o With regards to HIV/AIDS, what are some of the challenges that religious leaders and traditional healers encounter?

It should be noted that the study uses the terms ‘spiritual healers’ synonymous to ‘Sangoma’ or ‘traditional healers’, and refers to whichever terms in no specific order and with no preference. On occasion respondents are referred to as ‘leaders and healers’, or simply as leaders, as the writer sees fit.

1.6 Overview of the Study

Chapter 1 provided the background, context, and aim of the study. In this chapter I set out the argument for the questions the study sought to address. I provided the rationale for a focus on religious leaders and traditional healers and their responses to HIV/AIDS. I outlined the key and supporting questions and offered the methodological and theoretical orientations of the study.

Chapter 2 provided a theoretical and analytical framework. I do two things in developing the argument. Firstly, I begin by locating HIV/AIDS within the broad historical discourses on disease. Rather than a general overview of disease and as opposed to a health perspective, the stance I take is one that examines disease from a religious perspective. Secondly, I use Durkheim, Weber and Giddens to gain perspectives on the role of religion in making societies. In order to locate this study in the current literature, I end this section with a brief examination of recent studies that have examined disease and religion. This framework formed the undergird for the analysis in Chapter 4.

In Chapter 3 I provide the research orientation for the study. Here I outline the research design where I explain the methodological approach, methods of data collection, site and sample from which the respondents were drawn and the ethical considerations. I also give a brief account of how I overcame the sensitivities inherent in such a research topic. I
give an in-depth overview of how I accounted for myself as the researcher. I end this section with a brief description of the limitations in this study.

Chapter 4 presents empirical data derived from in-depth interviews and observations that addresses the question posed in this study. This data is presented in four broad themes each covering categories. I give an overview of the broad trends that emerged and follow this with specific areas of differentiation amongst groups and individuals.

In Chapter 5, I set up a discussion by analyzing the empirical evidence against the theoretical framework offered in Chapter 2.

The final section offers some recommendations and makes suggestions for further research.
CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This study sought to examine religious leaders and traditional healers’ experiences and responses to HIV/AIDS in a modern community. The literature review that follows, therefore, provides a conceptual framework for the study. Using the work of Weber (in Giddens 1997) and Durkheim (in Cosman 2001), this discussion begins with a review of the sociological construction of religion and its role in structuring society. It includes descriptions of ways in which people in general and religious leaders in particular have traditionally used religion as a filtering lens to understand their roles in societies. With the onset of modernity, major shifts have occurred in societies in general and religious orientations and practices in particular. The discussion above is, therefore, followed by a brief description of shifts that have been brought about through modernity and how within these contexts people understand the role of religion.

Since I was interested in experiences and responses to HIV/AIDS as a disease, I continue this chapter with a description of the historical accounts of disease. I link this discussion to the previous one by highlighting religious interpretations of disease and demonstrate how people make meaning of their lives through such interpretations. This discussion is important in that it locates the study within the broad discourses of religion and disease and provides a framework for situating and examining the roles of religious leaders, and thus their experiences and responses to the pandemic. As a disease that is transmitted primarily through sexual contact, HIV/AIDS is as much a disease as it is about people’s sexual behaviour. It was important for this study, therefore, to include a discussion on sexuality and the role that religion plays in constructions and interpretations of sex and sexuality in many communities.

I end this chapter by highlighting the nexus between religion and disease and how a complex social context presents new challenges for religious leaders, thus making the
examination of their roles, experiences and responses to a disease such as HIV/AIDS important.

2.2 Sociological constructions of religion

Religion exists in all societies and can be understood as a social phenomenon. While practices may differ from community to community or culture to culture, each society has some belief system and these have particular rules and values, symbolic markings and ritual practices. Religion has traditionally assumed the role of unifying and aligning people to a consistent way of thinking. Religion as an institution, therefore, has often functioned as a structure that influences peoples’ understanding of their role in society. Like other institutions (e.g. schools, family, etc.), it too acts as an interpretive lens through which people make sense of their daily lives. But, what is the role that religion assumes within a society? Giddens is helpful as he questions how religion functions as a sociological phenomenon. He asks, “under what conditions does religion unite communities, and under what conditions does it divide them?” (Giddens 1997: 435).

2.2.1 Traditional Perspectives on Religion

Religious beliefs and practices play a significant role in how people understand collective relations and everyday practices. Traditionally and common amongst most religions of the world, is the belief in a Supreme Being or God, who controls all life forms and who is commonly accepted as the creator. It is generally accepted that this Being determines the period of life on earth for all living beings/creatures. Often, in many religions, people supplicate and engage in various forms of prayer, ritual practices and religious ceremonies as a means of gratitude or servitude to the Supreme Being (Giddens 1997). Adherence to such rituals and practices provide people with feelings of reverence and emotional fulfillment (Giddens 1997). This state of fulfillment is sustained through not only a belief, but also through fundamental practices, rituals and ceremonies. Religious laws are maintained in peoples’ daily practices because often, they fear the wrath of God,
or they are in awe of their religion. Woodward (2002) explains that people often hold onto traditionally accepted behaviours as these serve as a frame of reference in formulating present identities. This means that people construct their religious identities around common religious prescriptions that are traditionally bound. In this way religion provides the basis and lens through which decisions about daily life are made. As a lens, it influences ways in which people understand and respond to life issues (e.g. relationships, disease, economic choices) within their communities.

Perspectives on the role of religion in society though, do not always cohere. Weber and Durkheim (in Giddens 1997) shed light on varying perspectives on the role of religion. It should be noted that while Christianity is primarily referred to, the principles are applicable to other religions.

Weber suggests that religion is political in nature and has economic benefits for those in power. It has the ability to bring about social change through influencing the development of western capitalism (Giddens 1997). According to him, religion has the ability to cause historical shifts and create capitalist foundations that result in the expansion and/or reduction of capitalism. For example, the European Protestant community believed that their ability to work, think and produce goods were blessings from God. Since their destiny was determined by God, and as a way of showing gratitude towards God for the gifts He provided, they needed to use these gifts to work and consequently fulfill their destiny. According to Weber (in Giddens 1997), such motivation fuelled the growth and expansion of “Western economic development” (in Giddens 1997: 444). Weber suggests that religion in this instance contributed to capitalist foundations as well as changing the nature of society, thus creating a modern industrialized Western society. For Weber, therefore, the primary role of religion in society is economic in nature. Religion plays the role of enabling or disenabling communities to gain or lose economically and thus creates historical shifts or alters peoples’ actions.
Weber acknowledges that religion also has the ability to influence people’s actions beyond the economic sphere (in Giddens 1997). He developed a fourfold categorization system to explain social action (Marshall 1998). Firstly, he suggests that people respond through traditional action. By this he means that people’s responses are filtered through an understanding that, traditionally, things were always done in a particular way. Secondly, affectual action occurs due to people having emotional attachments to the actions. In using traditional and affective lenses as a frame of reference, people do not necessarily take responsibility or rationalize about their actions. To them, their actions are externally shaped by predetermined rules and regulations. Weber suggests that rational behaviour is common in the third and fourth categories, value-rational action and end rational or instrumental action, in that people take some responsibility for their actions. This is particularly evident in modern communities (fully explained later in the chapter).

Durkheim, on the other hand, understands religion as the nucleus of society. Unlike Weber who views religion as the facilitator of social change and economic gain or loss, Durkheim views it as the important constituent that holds communities together. He defines religion as a “unified system of beliefs and practices relative to sacred things, things set apart and surrounded by prohibitions- beliefs and practices that unite its adherents in a single moral community called a church” (in Cosman 2001: 46). Durkheim places religion at the core of all social life and as such, its ultimate role is to act as a guide for people (Binsbergen 2003). He explains that religion is important for communities because of its cohesive function. According to him, religion is “not divinely or supernaturally inspired” but rather a creation of society that is “eminently social… [and consists of] collective representations” (Durkeim in Cosman 2001: 46). To him, religion conveys shared aspects and truths, which belong to the community. The role of religion therefore is to stimulate, sustain or recreate peoples’ way of thinking within a particular society and, as such, maintain cohesion. Any issues to be dealt with in the community, are approached in a way common to all, as “religious facts, as social affairs and the product of collective thought” (Durkheim in Cosman 2001: 46).
According to Durkheim, religious life is divided into different spheres, which he refers to as the “sacred and profane” (Durkheim 1973: 159). Sacred, on the one hand, refers to all the spiritual aspects of life and include rituals, symbols and places of worship. In adherence to these, people draw strength and obtain direction in both the physical and moral aspects of their lives. Profane, on the other hand, indicates anything else that does not hold religious significance. This includes routine behaviour, daily work and domestic duties and is essentially that which occurs outside ritualized periods of religious adherence.

These two perspectives demonstrate the way in which religion, particularly in Western societies, shaped peoples' collective and individual identities and acted as a script for making meaning of their social life. Fundamentally, within a Weberian perspective, the use of religion in creating the hierarchies prevalent in Western economies was evident. This, he argues, caused historical shifts thus altering peoples' everyday actions. Within a Durheimian perspective, the role of religion was simply to maintain collective cohesion.

The discussion above is important to this study, as it makes evident the position religious leaders held within traditional societies. In both perspectives, people looked at leaders as oracles of God, echoing the voice of God on earth. Their position was both powerful and influential. Religion was always the stable and secure hub to which people turned to in times when science offered no explanations to occurrences, such as natural disasters and disease. In more traditional societies people listened attentively to leaders as they explained and interpreted what Holy Scriptures had to offer about the various issues occurring in their communities.

However, major shifts in perspectives occurred in the role of religion. These shifts have come about as the result of modernity. Modernity is understood as the commencement of the Enlightenment Era. This era was the onset of the scientific revolution during the 17th century. As Berger (1977: 70) says, modernity is a “historical phenomenon” that is characterized by “rejecting traditional and conventional forms” in the quest to foster innovation and new empirical foundations (Rohmann 2002: 265). Modernity was
perceived as being “intrinsically superior to whatever preceded it” including concepts of religion and tradition (Berger 1977: 70).

2.2.2 Modern Perspectives on Religion

Societies around the world have experienced shifts as a result of the influence of scientific thought and globalization. These shifts are believed to be a move “from ignorance to truth” or from a dark period to a period of ‘Enlightenment’ (Rohmann 2002: 115). The onset of modernity saw a focus on “human progress through rationality and technological advances” (Berger 1977: 70), evidenced also through adoption of arts and culture and the rejection of conservative and traditional values and practices. Changes from tradition to modernity that occurred, therefore, resulted in changes in all spheres of social life. These shifts were especially evident in the movement from religion to science. From a religious perspective, shifts occurred from collectivism to individuation and reflexivity and from religious membership to secularism.

2.2.2.1 From Religion to Science and Globalization

Religion has traditionally been the anchor for many communities and in the individual lives of people described in the discussion above. However, with the onset of modernity that emphasized a scientific, rational approach to social life, questions were posed about the nature of things. The modernist scientific approach was premised on assumptions that beliefs and values should be based on evidence and rationality. Within such a stance, religious beliefs and values were not accepted as unquestionable and beyond doubt. Barbour (1997: 86) offers insight into the differences in science and religion and gives a perspective of the shift from religion to a more rational scientific approach to everyday life. He suggests that science offers logical explanations to people that religious scriptures do not necessarily supply. To him, science is about enquiry through evidence-based investigations and is committed to uncovering “truth and faith in rationality of nature” (Barbour 1997: 86) whereas religion, he says, seeks a transcendentdal Supreme
Being: God. Science seeks to explain to people “objective, public, repeatable data”, while religion encompasses the “existences of order, beauty of the world and the experiences of the inner selves” (Barbour 1997: 86). According to Barbour, religion produces feelings of guilt and anxiety when practices are not adhered to. Non-compliance to practices is understood as sin that needs forgiveness and redemption. Science on the other hand responds to objective “how questions”, while religion seeks to answer “personal why questions” about people’s past, present and future (Barbour 1997: 86). The foundation of supremacy in science is “logical coherence and experimental adequacy” whereas in religion, it is a Supreme Being. Science produces quantitative specifications that can be assessed empirically, while religion has to use “symbolic and analogical language because God is transcendent” (Barbour 1997: 86). Science uses scientific statements as the rule for all discourses and has discarded all that has not been experientially confirmed (Barbour 1997). While science poses pertinent questions about natural phenomenon, it cannot provide, what Barbour calls “a philosophy of life or a set of ethical norms” (1997: 87). Religion, on the other hand, gives direction and purpose to life as well as provides people with sets of guidelines that enable them to make meaning of their individual and collectives selves. Religion also promotes commitment to specific values and moral principles.

Global trends, occurring through the migration, urbanization, and industrialization of communities (Smelser and Munch 1992), further exacerbated shifts from religion to scientific orientations and from collective to individual responses to religion. Globalization caused an integration of cultures and a disintegration of more traditional forms of religion and religious life. Such shifts caused not only a shift away from more traditional adherences to rituals and practices, but also a move from collective to individual interpretations of religion. Individuals no longer adhered to collective forms of religious identity, as was the case in traditional societies.
2.2.2.2 From Religious Membership to Secularism

With the onset of modernity, religious membership, attendance at religious worship, and the financial state of the church was at an all time low. Secularist theological movements arose, seeking to dissociate the church from its traditional trappings in an attempt to make religion more accessible in a modern context. The “death-of-God” movements became the dominant trend of the day. Such movements attempted to substitute dogma with various modern “secular gospels [such as] existentialism, psychoanalysis, revolutionary liberation, etc” (Berger 1977: 157). This resulted in many religions aligning themselves with “cultural or political” organizations in an attempt to promote the church as a relevant structure to the concerns of modern society. Traditional religious leaders, holding on to their traditional ways, were disorientated, while those enticed by secular initiatives felt that “commodities such as personal growth and raised consciousness” could be found inexpensively outside the church (Berger 1977: 157). With modernity and concomitant secularism, many people turned away from formal religion to more informal, less fixed forms of religious practice. This new orientation resulted in people clinging to traditional religious beliefs but not necessarily engaging in their practices. Binsbergen (2003: 4) agrees with Giddens and says that “believing without belonging” became evident in modern communities. The upshot is that people exercised the choice of visiting places of worship as and when they deemed necessary rather than as a form of religious obligation. This new era saw a significant reduction in external manifestations of religion through rituals and practices (Giddens 1997: 466).

The consequences of such a shift meant a new positioning in the role of religious leaders. In this regard, and unlike their position in traditional religious settings (where their roles seemed stable and secure), religious leaders in modern environments were no longer perceived as influential, powerful or as speaking on behalf of God (Giddens 1997). People had the freedom of choice and gained access to other forms of believing, thus

3 Secular / secularization – a process whereby religion loses its influence over the various spheres of social life (Giddens, 1997: 465)
situating religion and the religious leader outside of the decision making sphere of their lives. In other words, religion no longer held the grip in people’s moral psyche, since they were now able to navigate their way outside the rigid parameters of religion. The consequence for religious leaders is that they no longer had rituals and practices they could invoke in stabilizing their position. People seemed less reliant on religious advice, thus threatening the influential role and position of religious leaders.

This notwithstanding, Giddens explains that while this may be the case in modern society today, few individuals can say that they have not been “touch[ed] by religious sentiments” in some way or the other (1997: 466). Greeley (in Berger 1977: 149) also adds that through the years “basic human religious needs and basic religious functions” have not transformed much. Religion is still traditionally guided by people’s sense of God’s will, despite the choice offered in modernity. The argument is made that religion has not adopted scientific laws and that leaders continue to preach and teach according to their holy scriptures (Greeley in Berger 1977). Barbour (1997: 8) agrees that religious devotion rejects modernity, and continues to regard God as “the Supreme Being on the hierarchy of beings”. Reynolds (in Allott 1999: 3) also asserts that religion remains the decider of right and wrong on issues [faced in modern societies] such as adolescent sexuality, marriage, divorce, widowhood, but to name a few. The decision of what is right or wrong is still deeply rooted in the traditional religious guidance of morality and as such still holds relevance since, as Allott (1999: 2) states, religion has a “particularly important link with morality”.

So while modern responses to religion include people shifting from traditional adherences to secular, scientific notions of religion, Giddens makes the point that modernity has still not caused major shifts in religion as an institution, even though it may have influenced many of its practices. Instead, religion remains the point of affirmation in modern communities about what is acceptable and unacceptable on pertinent modern day issues such as abortion.
The next section briefly examines perspectives of religion in Africa since this study is located in South Africa and bears the resemblances of ways in which people on this continent understand themselves religiously.

2.2.3 Modern African Perspectives on Religion

Binsbergen argues that a Weberian transformation has occurred in Africa in the 20th century, shifting lifestyles, social orders and patterns. He explains that shifts have occurred at various levels of the political and economic strata of society including “the state, education, health care and religion” (2003: 10). Global political trends have also influenced the nature of religious adherence in Africa (Binsbergen 2003). These have included religion playing a calming role (in the individual and collectives lives of people) given the unstable or insecure political situations faced in the various countries of Africa. For instance, traditionally local and global religious identities did not necessarily have an influence on the success of trade in Nigeria. However, in modern times and for many Igbo immigrants in Nigeria, successful trade now depends on whether or not traders are following or are sympathizers of the Muslim faith. In this region, Binsbergen (2003: 7) states that the “Islamic identity now incriminates” the African person wanting to trade since they are perceived to be posing a threat to American-British hegemony”.

The influence of religion from a Weberian perspective is further evident where economic shifts have occurred in Africa. Here Binsbergen shows that religion also has the potential to divide people economically. He refers to the “stereotyping⁴” of Islam in North Africa after the 9/11 bombings in the USA (Binsbergen 2003: 10). Since Muslims carried out the attacks, many traders suffered financially as a result of stigmatizing. Potential buyers, who support the USA, would not purchase from Muslim traders because they were affiliated to the religious group that was regarded as being the terrorist that executed the bombings. Religion here plays two roles; one of encouraging ostracization and

⁴ Stereotyping – A generalization, usually exaggerated or oversimplified and often offensive, that is used to describe or distinguish a group
segregation amongst traders, and two, altering the economic status of North African trade. It also fragments parts of the African economy and the world (Binsbergen 2003).

On the whole and with regards to the individual, Binsbergen illustrates that in Africa globalization has introduced “new boundaries and new identities” (2003: 4). The religious field is now “an unstructured, diffused social field” where individual identities are being shaped through global trends and not only traditional structures such as religion and family. Berger and Binsbergen propose that people have gained self-confidence in their new ability through the process of reason and operate “outside [of the] boundaries” of traditional religion. Berger (1977: 70) coined the term “individuation”, which emphasizes the individuality of people and places them into self-reflective positions. This, he suggests, results in personal growth for individuals, where a shift from communal perspectives and adherences to individual preferences is evident (Berger 1977). He further maintains that this has placed the individual in a “historically unprecedented counter position” to his or her traditional religious community (Berger 1977: 70). The above indicates areas in modernity where religion looses its grip on people.

However, although individuality is evident in this era, as an example of a religion, Christianity has held onto communal religious beliefs and has rejected the idea of “anomie” where moral accord and tradition were discarded (Durkheim 1952). The consequence this holds for individuals is that often they are torn between what the familiarity religion has to offer and the logical empirical facts of science. Despite the strong sense of communal religious beliefs and guidance, religion offers no solace and comfort for such individuals. Sometimes tension is created when individuals try to maintain traditional religious values and beliefs while living in a modern community.

In the main, different African religions follow either a Weberian or a Durkheimian perspective or both. Each religion has its own set of outcomes. In some, the Weberian influence is greater whereas in others the Durkheim notion of role religion is prominent.

---

5 Anomie –introduced by Emile Durkheim in his book ‘Suicide’ 1952
Common amongst all religions, irrespective of whether they subscribe to Durkheim or Weberian perspectives, is the transference of religious beliefs and values to its people by potentially influential individuals, namely religious leaders and traditional healers. These leaders and healers have specific roles that they portray and embody. Constructions of religion as described above are only important in situating the key concern in this study, namely understanding religious leaders and their responses and experiences to disease. The discussion above is therefore important in that it describes ways in which people understand themselves in society and the role of religion in people making meaning of their individual and collective identities. So the study now asks: How do religious leaders facilitate such understandings? And how are they positioned as mediators in constructions and interpretations of disease?

As such the next section gives a brief overview of religion and disease as it has occurred through the ages.

2.3 Religion and Disease

In order to understand responses to disease historically, the works of Foucault (in Cousins and Hussain 1985); Allen (2000; 2001); and Sontag (1989) was useful as they offer perspectives on different diseases through the ages. This, discussion is important for two reasons. Firstly, it serves as the basis for examining the role of religion in constructions and interpretations of disease and secondly, it provides a framework for situating the religious leaders’ roles and responses to disease, particularly HIV/AIDS.

2.3.1 A Brief Historical Overview of Religion and Disease

Foucault (in Cousins and Hussain 1985) is helpful as he examines disease processes from a historical perspective from the 17th century. He explains that the way in which people, especially religious leaders, interpreted diseases led to particular responses. Foucault (in Cousins and Hussain 1985) and Allen (2001) argue that when people were unsure about the reasons why diseases occurred, they turned to religion for answers. Allen, (2001)
however, explains that while people were unsure, so too were religious leaders especially in the absence of medical scientific evidence. This he suggests, led to speculation. People, including religious leaders, speculated about the origin of the disease as well as the reasons for its occurrences. Speculation, Allen says, forms an essential part of the history of disease as it was this point of enquiry that afforded us the biomedical knowledge that we have of diseases today. (Allen 2001). But, on the other hand, and while there were no immediate cures available, peoples’ speculations had devastating effects on patients.

Allen explains that traditionally diseases were classified as being either “endemic or epidemic” (2001: 1). However, while endemic illnesses, such as common fevers, were not interpreted as fatal, epidemics infected people over longer periods of time and often caused death. This instilled fear in communities and people developed an understanding that disease was strongly linked to divine intervention (Allen 2001). Thus God was seen as the Being that was ultimately able to spare people from diseases. Consequently, in order to access God, people communicated via religious leaders who were seen as chosen ones who could be directly connected with God on a spiritual level. People turned to them for support and guidance. However, Allen (2001) and Foucault (in Cousins and Hussain 1985) indicate that the interpretations given by leaders often held negative connotations that saw disease as the result of people engaging in immoral and irreligious behaviours. For example, people interpreted mental illness, Black Death and tuberculosis as diseases that occurred as a result of people behaving in impure, sinful and immoral ways. They believed that God bestowed this disease on people as a form of punishment. Another set of diseases interpreted in a similar way was Cholera and Small Pox. These diseases, however, were not perceived as punishment for immoral behaviour. Instead the punishment was seen as God cleansing the world of the unclean and poverty stricken areas in society (Allen 2001). A disease such as Cancer was understood to have come into being as a result of punishment for the weakness of people. It was believed that people who were unable to control their urges of wanting to indulge their desires, faced the consequences of becoming infected with cancer. For example the inability to
discontinue a smoking habit resulted in such a person becoming infected with lung cancer (Sontag 1989).

Syphilis sufferers understood their disease also existed as a form of punishment from God. However, specific to syphilis was the notion that people became diseased as a result of indulging in deviant sexual behaviour, irrespective of whether this was true or not. When people developed syphilis, they kept it a secret for fear of being ostracized by their religion and community (Quetel in Brandt and Rozin 1997). Religious leaders believed that syphilis sufferers were being punished in the same way that they became infected, through sin and via their genitals (Allen 2000) Allen concludes that where disease occurred in unpopular social groups or within disease prone individuals, such as homosexuals and prostitutes, it was seen as “manifestation of the will of God against those who have sinned” (Allen 2001: 1).

It is evident from the above that historically interpretations of diseases focused on the reasons why people became infected and the meanings attributed to disease. Foucault (in Cousins and Hussain 1985) highlights that this focus fore-grounded moral interpretations in which peoples behaviour came under scrutiny rather than an emphasis on the need for physical healing. Since leaders were in commanding positions, they often made pronouncements on the moral integrity of individuals by interpreting disease as sin and punishment was inevitable.

2.3.2 Religion and Disease in Modern Times

Like Allen (2000; 2001), Ahmed (1999) also explains that diseases, for which causes have not been found, result in their sufferers being stigmatized and ostracized. As had happened in the past when science offered no explanations and solutions for the occurrence of some diseases, people today also turn to religion in the wake of unexplainable disease conditions (Ahmed 1999:1). Religion, however, also follows the ‘history-repeats-itself’ scenario in that it does not objectively view the sick person’s position and status in the community (how they are viewed). As an example, Hattas-
Abrahams (2003) highlights how two Muslim women of the Western Cape of South Africa were stigmatized and ostracized for being HIV positive. Muslim religious leaders’ speculation about ways in which they had contracted the HI-virus had serious implications for these women. One leader even suggested that appropriate punishment for this condition would be death by stoning because, according to him, they had performed immoral acts of behaviour (Hattas-Abrahams 2003: 48). While many such responses seem common, what follows is a brief discussion on the dominant religions of South Africa with a view to examining responses to disease, particularly HIV/AIDS (Giddens 1997). The example illustrates ways in which religious leaders make pronouncements that influence communities in their response to disease and often has consequences for the experiences and living conditions of the diseased. What follows below is a brief discussion on ways in which dogma in other religions offer perspectives on HIV/AIDS, with a particular emphasis on how religious leaders and traditional healers are positioned in relation to disease.

Judaism, for example, puts forward the idea that “HIV/AIDS prevention and treatment” is a fundamental religious responsibility (Paasche-Orlow and Rosenn in Smith 2001: 403). To illustrate this, the authors quote Psalms 41:4 and Babylonian Talmud Nedarim 40b that suggests disease as an opportunity for ill Jews to retrospectively examine their character in relation to the religion. It is believed that a patient repenting draws nearer to God as God is always in the presence of the sick (Paasche-Orlow and Rosenn in Smith 2001). The authors explain that Jewish leaders understand that HIV/AIDS may be transmitted through intravenous drug consumption, and homosexuality, including lesbianism. They add that such behaviour is traditionally prohibited by the Jewish faith. However, they assure that even though Jewish people should not engage in immoral sexual behaviour, those who are diseased would still receive fair treatment from Jewish leaders. The pastoral responsibility to preserve life, in spite of moral integrity is profoundly important in Judaism (Paasche-Orlow and Rosenn in Smith 2001). Paasche-Orlow and Rosenn assert that Rabbis should demonstrate the role of caring for “physical, social and spiritual needs of the sick” irrespective of the nature or origin of the illness. They must show understanding that a healing process is not only God’s responsibility or
that of the medical fraternity. It is a shared responsibility and a partnership with God to save lives and preserve health (Paasche-Orlow and Rosenn in Smith 2001: 402).

The Muslim faith interprets HIV/AIDS as an indication of God’s ability to single-handedly own all of “creation” (Abdul-Wahhab in Smith 2001: 932). Abdul-Wahhab explains that Muslims understand that God creates disease “for human correction” if they’ve sinned (in Smith 2001: 932). Disease, he says, is also a means of cleansing and reparation. The author quotes from the Quraan 17: 82 in support of this position that God orders Muslims to eat and drink moderately, observe personal hygiene, make compulsory prayer and offer regular supplication to maintain a healthy life-style (Abdul-Wahhab in Smith 2001). He adds that leaders and Muslims are aware that God created HIV/AIDS and therefore, they believe that the cure to HIV/AIDS will come from God. However, God will decide on the time of healing (Abdul-Wahhab in Smith 2001). Thus Muslim’s who are ill are taught to accept their condition and seek help both medically and through prayer because it is the belief that the diseased are closer to God, as God chooses those whom He wishes to be ill (Thanvi 1992).

Muslims leaders believe that drug abuse, immoral sexual behaviour such as premarital sex, fornication, extramarital sex, adultery and prostitution are in defiance of Islamic Law and contributes to the transmission of HIV/AIDS (Abdul-Wahhab in Smith 2001). He explains that leaders are in a position to call for “corporal punishment ... including capital punishment” in cases where immoral sexual behaviour have been proven (Abdul-Wahhab in Smith 2001: 392). It is the duty of the leaders to care for those that are diseased, unless the disease possesses a threat to those providing care. They have a moral obligation to care for the sick through visitations and prayer. The comfort, confidentiality and well-being of the sick are of importance to the leaders (Thanvi 1992).

Goss (in Smith 2001) explains that Christianity understands that HIV/AIDS is transmitted through homosexuality, premarital and extramarital sex. These sexual behaviours, the author states, are forbidden within Christianity. He reports that Protestant churches
challenge the homosexual community about following God’s path and adhering to the
destiny ordained for mankind, which is heterosexuality and marriage.

This, Goss says, is a means of protecting the church from being perceived as an
institution that promotes immorality. However, the church is clear that it will care for
those that are diseased with HIV/AIDS irrespective of the manner in which they became
infected (Goss in Smith 2001).

Recently, the Christian Catholic denomination indicated that while they too are
concerned about all PWAs, they however certainly do not condone “immoral” sexual
behaviour (Goss in Smith 2001: 543). Other denominations of the Christian faith, agree
that HIV/AIDS is not punishment from God. However, they warn that it can be a result of
sin such as homosexual behaviour, as well as engaging in sexual activity outside of the
sacred institution of marriage (Goss in Smith 2001). Despite the disagreements that the
churches have with homosexuals, Christian leaders have to show kindness towards all
fellow beings. Leaders are expected to bear skills of advocacy, reconciliation, pastoral
caring that encompasses counseling, religious, spiritual, emotional, and physical health of
the nation’s people (Almond 1996). With regards to sexuality, diseases and HIV/AIDS,
UCC\(^6\) reports that some religious leaders are preaching infection - curbing notions by
encouraging people to learn about their sexuality from their parents, religious institutions,
and schools because here the "biological, psychological, cultural, ethical, and spiritual
dimensions of sexuality" are dealt with (UCC 2005). UCC explains that religions play the
cherished role of sustaining curing, health promotion and care as well as disease
prevention. In their attempt to curb sexually transmitted diseases, many churches have
opted to creating opportunities to discuss issues around sexuality (Almond 1996).

With regards to Rastafarianism, there is a belief that leaders should assist those who are
diseased through caring for them and providing medicine. Pettiford (2000) explains that
religious leaders believe they have the ability to heal HIV/AIDS and other diseases. Their
beliefs are based in the biblical texts of Psalms 104:14 that state “He causeth the grass for

\(^6\) UCC – United Christian Church
the cattle and herb for the services of man... thou shalt eat the herb of the field”. Rastafarians therefore use the plants accordingly. From these quotes leaders believe that God has provided for them a holy herb “Ghanja”7 (Pettiford: 2000: 2). Thus leaders use Ghanja and encourage followers of the religion to do similar. It is used for spiritual meditation and medicinal purposes and since God provided it, it is seen as the means by which people are protected from becoming infected with diseases (Pettiford 2000).

Makhubu (1978) explains that Traditional healers are regarded as honoured individuals in their communities. This is so because they possess special powers that allow them to communicate with their ancestral and spiritual world. These spiritual dialogues are crucial to the healers’ work, as the spirits direct healers to the omen or problem and in this way they are able to heal people (Makhubu 1978).

The role of traditional healers’ is to practice medicine and heal people psychologically, physically and emotionally (Kenan 1997). They are expected to provide counseling, medicine, sex education, promoting condoms, etc to their patients (Green 1994). Often they function as both doctor and pastor in their communities (Kenan 1997). They have personal experiences with infectious symptoms, suffering and pain, and have skills in preparing herbal remedies (Sobiecki 2001). Traditional healers are able to “influence” the sexual behaviour of patients in their communities (Green 1994: 191). As will be discussed further on in the chapter, Green highlights that in South Africa traditional healers are aware of the dangers of HIV/AIDS and they are of the opinion that they are able to heal HIV/AIDS. They do not discriminate against those that are infected. Instead they treat all types of sexually transmitted diseases, including HIV/AIDS, and warn people that immoral sexual behaviour can lead to infection.

The discussion above highlights differences and similarities in the way religions understand and interpret disease. A striking feature amongst all religions is their emphasis on the relationship between disease and immoral behaviour. All the religions under discussion view disease as a form of punishment and interpret disease from a moral

---

7 Ghanja, also known as Marijuana, is illegal in most parts of the world (Pettiford 2000)
base. Often, the ‘infected’ is stigmatized as having committed immoral behaviour and as such deserves the punishment meted out. Religious leaders and healers across religions act as the moral voice through authorizing the pronouncements. The literature shows that leaders and healers in all the religions demonstrate a sense of obligation to the sick because of their belief (Kenan 1997: 57). However, while they express such a responsibility, the moral pronouncements made by them more likely than not becomes the frame of reference from which others view and respond to the ‘infected’.

Despite the move from collectivism to individualism and from traditional religious orientations to secularism, Giddens (1997) alludes to the fact that religion remains the binding force of many modern communities. Opinions, beliefs and responses by authoritative voices such as religious leaders, still hold sway. This notwithstanding, religions are faced with modern day challenges especially since people make choices that do not align with religious principles, in cases such as abortion, teenage pregnancy, homosexuality, premarital sex as well as extramarital sex. HIV/AIDS brings together a host of conflictual issues in which the position, role, authority and responses of religious leaders is brought under the spotlight as this study will show later.

HIV/AIDS is a disease that is transmitted primarily through sexual contact, and as such any discussion on religion and HIV/AIDS requires a comment on ways in which sex and sexual behaviour is positioned, constructed and interpreted within religious discourses. What follows below is a brief discussion on the ways in which sexual behaviour is understood and constructed within the context of religion. In this discussion I highlight the inter-connectivity between views on sexuality and sexual behaviour and how these are shaped by religious affiliations.

2.3.3 Constructions of Sexuality and Sexual Behaviour in Religion

This modern era disease, HIV/AIDS, presents an explosion of new knowledge especially evident in modern medicine, modern preventative methods, and modern ways of living and modern open ways of talking (Allott 1999). Directly relevant to our discussion is the
growth of knowledge about the physical act of procreation. This is an enormous challenge to leaders and healers who would traditionally have preferred to discuss sex generally and confine it to the private sphere, where what is considered to be right and good, is projected as a moral discussion.

Russell (1972: 56) however, highlights that Christian moralists have bestowed a filthy connotation to sex, since it is associated with natural “excretory” functioning and thus people have became uncomfortable to talk about sex freely. Instead it has become a taboo topic.

Slowinski (1994) adds that Biblical Hebrew and Greek texts had no word to talk about sex. The purpose of the Bible was not to be a guide for sexual morals. Instead it understood sex as being “part of life” that was situated in a community context as a natural and good part of life (Slowinski 1994 in Bullough and Bullough 1994: 520). The main function of sex was for procreation. Self-constraint, denial of sexual passions, celibacy and virginity were regarded as virtuous features. Straying from these Slowinski (1994 in Bullough and Bullough 1994) explains, leads to sin and shame especially when congregants express desires. This interpretation was especially evident in Christianity and resulted in feelings of guilt and shame. The guilt, Slowinski (1994) says, arose from the pleasure experienced because religion specified that the purpose of sex was not to fulfill pleasurable desires but primarily for procreation (Slowinski 1994 in Bullough and Bullough 1994). This interpretation of virtuous deeds complicated the understanding of sex as natural and pleasurable (Debien 2003). Furthermore, the interpretation created the understanding that sex was not a natural part of religion but was confined to private spaces in communities (Slowinski 1994 in Bullough and Bullough 1994). The interpretation of shame, Debien (2003: 2) explains, originated with the first loss of innocence in the Garden of Eden where Adam and Eve became aware of their “nakedness” and with the exposure of their “genitals” (Debien 2003: 2). This shame is inherent in constructions of Christianity, thus offering little alternative but a moral, silenced and closed interpretation of sex by leader.
Allott (1999: 3) says that sexual behaviour in most communities is strongly influenced by “religious beliefs and prescriptions”. The above beliefs ensure that the community remains organized and informed about what and how their sexual behaviour should be. Beliefs also give the community a particular definition and thus different communities have different “sexual morals” that define the communities’ identity and sexual practices.

Bullough and Bullough (1994: 514) go deeper and explain that religion’s understanding of sex is governed by “sacred texts”, and as Allott (1999: 3) alluded to, these texts embody a set of laws for sexual conduct making the rules clear for when, who and how the sexual act might be engaged. Often, these texts are interpreted and taught to people by “male priests, rabbis, imams, shamans” and individuals that are in immediate contact with divine supremacy. Bullough and Bullough (1994: 514) explain that leaders preach a “formal value” which is embedded in what they call a “fixed world view”. They explain two world views, namely the fixed and the process world views. In terms of the first, the fixed world view, God created people in a fixed way with defined roles for men and women. Marriage and heterosexuality is predetermined in Hebraic religions such as Judaism, Christianity and Islam, where human life originates in the Garden of Eden with “Adam and Eve”, in their perfect, unblemished human state. Male dominance and monogamy was established here as well as, the sole purpose of sex (Bullough and Bullough 1994: 514). This view provided an accepted sexual code for people to follow. Within the fixed worldview, there are prohibitions such as the use of “contraception, punishment for masturbation, frowning on oral sex, premarital sex, divorce, extramarital sex, homosexuality and women in positions of authority” (Bullough and Bullough 1994: 515). The authors add that some religions may be lenient with individuals indulging in prohibitions. However, such individuals are warned about the possibility of punishment on earth and in the “hereafter” for sinful behaviour. Such sin can only be redeemed by self-restraint and the prevention of “indulgence of pleasure”, specifically sexual pleasure (Bullough and Bullough 1994: 515).

In terms of the second, the “process world view”, Bullough and Bullough argue that people are constantly in the process of developing and in a continuous process of
struggling to reach their full potential (1994: 514). The idea of "physical and moral evil" is regarded as a part of this process of growing and becoming. While common principles govern individuals, they ultimately have the choice to apply these principles when deciding what acceptable behaviour is or not especially with regards to their sexuality. What is important in this view is the nature of relationships that people develop with each other and that people interact with universally ethical principles that allow them to be socially accepted (Bullough and Bullough 1994: 514).

Bullough and Bullough (1994) explain that people may adhere to one worldview or the other and that some may even shift between the two views. However, religiously orthodox individuals adhere to one view only and would base their sexual behaviour on the principles of that view.

What was common amongst religions is that the purpose of sex is primarily for procreation and that it occurs within the confines of a heterosexual marriage. Allott (1999: 3) argues, that traditionally religion continues to contain people's insecurities about "not understanding" issues such as why pleasure is experienced naturally during sexual intercourse but is forbidden in religion. Religion in this sense became unquestionable and influenced the way people understood and made sense of sexuality (Allott 1999). This unquestionable state of religion was compounded by the lack of openness and the inability to talk about sex and created anxiety not only for people but for leaders as well. Thus the guidance received from leaders was morally laden (Brandt and Rozin 1997). These morals, the authors argue, have warped and distorted the views of the medical fraternity, which is objective and scientifically based.

Outlined above are constructions of sexuality and sexual behaviour within dominant traditional religious discourses. Modernity and the pressure brought upon by scientific knowledge, globalization, technology, individuation and secularism have impacted such traditional constructions, highlighting contradictions and sometimes conflicting positions between religious discourse and lived experiences in communities as the next section briefly illuminates.
2.3.4 Sexuality Shifts within Modern Contexts

Science and globalization have inevitably affected perceptions of sex. Allott (1999) explains that science and modernity have restructured sex sociologically. Sex is no longer situated within the confines of the family. Many sexually active individuals choose to be unmarried and this, he says, reduces the religious cohesion that is reinforced by the familial organization. In addition, the inception of and use of different methods of contraception, sterilization, including “artificial fertilization” continues to separate sex from its religious reproductive purpose (Allott 1999: 3) as was the case in more traditional religiously constituted environments.

Some contraceptives, also invoke conflictual responses. For example while condoms are a scientific initiative that intends to save lives and prevent infection, if correctly used (Brandt and Rozin 1997), many religions are against its use because from a moral perspective, it is understood as an immoral initiative that encourages infection and prevents procreation.

Slowinski (1994 in Bullough and Bullough 1994: 514) concludes that when people comply with the religious perceptions and practices of sex, often these traditional understandings of sex interfere with the “natural” explanation of sex. This means that from a natural perspective, people may engage in sexual acts as their natural desire arises and not solely for the purposes of procreation. These people accept that pleasure is a part of the natural process of sex and that they may simultaneously be fulfilling its biological process of procreation (Slowinski 1994 in Bullough and Bullough 1994: 521, Allott 1999:3 and Giddens 1997: 466).

Tensions arise in modern communities where individuals make choices that are not often aligned to religious expectations. Religious leaders do not necessarily hold positions of power in the way they might have in more traditional times and as such people do not always take counsel from them placing them in precarious positions. Adhering to the
dominant script of sex in marriage for the purposes of procreation, is often an individual choice today rather than solely a condition enforced by religion dogma. People today have the choice to operate from various frames of references and do not only rely on religion to prescribe behaviour practices. Such shifts in practices challenge the fundamental religious foundations and as such pose a threat to the role and positions of leaders.

While the above may hold true, religion places distance between itself and more modern deliberations on sex. However, Brandt and Rozin (1997) explain that there are definite links between modern medical initiatives and religious moral foundations. The authors argue that “health is powerfully associated with morality, just as immorality is powerfully associated with illness” (Brandt and Rozin 1997: 2). In the wake of this, they explain that HIV/AIDS as a disease that highlights this interrelation between religious morality, disease and sexuality in significant ways and provides a vehicle for examining the intertextuality of the three components through what this study seeks to do, namely examining responses and experiences of HIV/AIDS by religious leaders and traditional healers (Brandt and Rozin 1997). Since an understanding was given about religion and HIV/AIDS, sex and sexuality, the next section will discuss how religious leader and traditional healers are sometimes in suitable positions to combat further infections, however, because of their religious beliefs, they would prefer to refrain from such encouragements.

2.3.5 Religious Leaders, Traditional Healers and HIV/AIDS

Rezende explains that the key entities namely religious groups and scientists are aware that HIV/AIDS is a serious problem (in De Young 2001). However, he says that the manner in which the problem is being addressed varies from group to group. Rezende says that the religious community offers assistance to the infected from a religious perspective and science encourages the use of condoms, while he adds, that debates globally are continuously aimed at merging religious orientations with modern perspectives on sex that argue for protection against disease or unwanted pregnancies.
Menka (2005) argues that religious prevention messages are meaningless in a modern society because sexual activity is rife and often occurs outside the confines of marriage as religious leaders continually propose. He believes that religious leaders are in suitable positions to assist in encouraging people to become informed about health and safety measures. However, he says, that leaders are instead developing antagonistic relations with people once they show inclination to engage in premarital sex or extramarital sex and contact with such persons is minimal. Menka (2005: 1) adds that religion needs to shift its understanding that in certain instances people, especially women, does not have the choice to “abstain”. Instead their survival sometimes depends on providing sex services. In this debate science situates religion in a position of practicing double standards. Such religious responses he says, not only go against nationalized policy, but also refute religious beginnings that expect leaders to be compassionate to the social welfare of women (Menka 2005).

Local African debates are expanded upon by Kalipeni, Craddock, Oppong, and Ghosh (2004). The authors note that while conversations around sex do not display problematic attitudes towards protection, the problem remains entrenched in the various religious and cultural groups that may be privileging religious practices such as polygamy, procreation and the like. For example, within the African traditional religion, the sexual act is primarily about maintaining the “lineage” of the tribe (Phillips 2000: 25 in Kalipeni et al 2004: 161). Patriarchy and polygamy are important features highlighted by traditional leaders. This is especially the case with the act of receiving “lobola”8. Here girls are pressurized into early pregnancy before marriage to confirm their procreative capacities and strengthen the lineage (Machido 2004 in Kalipeni et al 2004: 161). Machido (2004) emphasizes that traditional healers, in this instance, are in positions to encourage and teach about prevention methods as well as promote healthy living. However, they experience conflict in their quest to support procreation because, in many instances the risk of transmission of HIV/AIDS becomes high. So while on the one hand leaders are encouraging prevention of the disease, at the same time religious beliefs encourage sex for procreation.

8 Lobola – ‘bridewealth’ or dowry paid by a bridegroom to a brides parents
The above discussion shows instances where religious leaders and traditional healers are in positions to encourage the combating of new HIV/AIDS infections in modern communities. However, the discussion also shows the tensions experienced by religious leaders and traditional healers as they seek to adhere and promote their religious beliefs.

Not much research exists in examining the tensions inherent in the views and responses of religious leaders to disease. In particular there is a dearth in the literature that talks about religious leaders and traditional healers’ immediate responses such as mentioned above and of their experiences with HIV/AIDS. What I have found though were the following empirical studies, which consist of a case study, and a conference review, that shed light on leader’s immediate responses.

2.3.6 Studies on Religious Leaders and Traditional Healers responses to HIV/AIDS

In this section I review studies by Green (1994) and Easom (2005) that investigate the immediate responses and experiences of religious leaders and traditional healers to HIV/AIDS. While Green’s study focuses on views regarding condoms, premarital sex, abstinence and providing messages of HIV, Easom’s review of a conference focuses on denial and fear associated with HIV/AIDS (Easom 2005: 1).

Green (1994), a Washington DC-based medical anthropologist, worked in Africa, Caribbean and South Asia. What follows is a brief report on his research conducted in Southern, East and West Africa. The sample included Liberian, Mozambique, Nigerian and South African traditional healers. His sample comprises 1,292 traditional healers in peri-urban areas and 4,150 healers in rural areas. Green’s focus was on examining the role of traditional healers as they provide primary health care with a focus on AIDS/STDs and family planning (Green 1994). He also sought to obtain views on abstinence, promiscuity and marriage. Primarily Greens’ literature examines views of traditional healers because religious leaders have not been the focus of his study. His data collected was “solely from traditional healers” and was set in a qualitative paradigm (Green 1994: 126). His methods of data collection included interviews prior to selecting
the sample group. This group eventually comprised a balance between gender, age and location of the traditional healers. Further data collection techniques were now implemented which included semi-structured interviews which allowed for modification of the open-ended interview schedule as information emerged. In addition five rounds of focus group discussions were held of which two focused on STDs and had males and females separated to ascertain if male knowledge, attitudes and practices were different to that of females.

Green’s findings served as a framework for further biomedical planning in a unit of the Mozambique Ministry of Health and for the development of an educational strategy for the Department of Traditional Medicine. This formed part of the country’s policy regarding traditional healers and served as recommendation for legislative amendments (Green 1994).

Green’s findings indicated the following:

- That male and female knowledge, attitudes and practices had no significant differences.
- The healers identified three types of sexually transmitted diseases, namely Siki and Nyoka. HIV/AIDS however fell into another category.
- Healers reported that Siki, identified with Western medicine as Sexually transmitted diseases, is found in adults not children but is common in men. It was not associated with promiscuity, instead it is believed that it is spread through genital discharges. The healers reported that treatment of Siki included drinking of herbs and application of ointments. Prevention of Siki they indicated will involve the consumption of medicine just prior to intercourse. This medicine has different prescriptions for men and women. Alternatively, healing will occur with abstinence completely, abstaining while on treatment or engaging sexually with uninfected partners.
- Nyoka was identified by healers as with being a ‘guardian’ that exists in the body and that indicates when illnesses are present in the body. This explains why patients may suffer of cramps if they have consumed intoxicants. In Western
medicine Nyoka is symbolic of valuing and appreciating the individual’s body. It is evident in all people and found in the area of the heart in the body. A moral view of transmission was reported.

- Healers reported that this disease can affect menstrual cycles in women, miscarriages and create infertility.
- HIV/AIDS was reported by most healers as a disease that they know or heard from on radio. With the exception of a few, all healers said that in Mozambique it was a new disease. Some healers confused HIV/AIDS with Siki disease. Most healers reported that HIV/AIDS is found in Africa, that it is an incurable deadly disease and that it is sexually transmitted. No healers indicated that HIV/AIDS is transmitted through blood. However they did mention extramarital sexual transmission as a possible means of contraction. Healers reported that a cure and prevention for this disease is found in the herbs in Africa. Some healers claimed that they “can cure- and have cured” HIV/AIDS (Green 1994:126).
- There seemed to be much resistance to the use of condoms especially amongst the African healers. Traditional medicines and advice was regarded as the preferred preventative means with advice on abstinence being advocated means of prevention.

As previously mentioned, Easom (2005) also focuses on immediate responses by religious leaders. Similar to Green (1994) she reviews a HIV/AIDS Conference that was held for Medical and Religious Professionals. The conference occurred in Chicago on 5 February 2005 and in Easom’s opinion it was the first of its kind ever to be held. The focus of the conference was to build a stronger link between religion and the medical fraternity in the combating of HIV/AIDS. The conference focused on understanding responses of religious leaders with regards to denial and fear (Easom 2005: 1). Focus group discussions were the main form of data collection. Paired-groups were also used. Partners were not selected according to any criteria, instead they were randomly placed and paired off with someone regardless of profession or denomination. The task set to the pair was that they should converse about the anxieties that HIV/AIDS present. An important consideration that all participants had to bear in mind throughout the discussion.
was that they wanted to provide criteria for the “wholeness of life” (Easom 2005: 1). From amongst the responses of participants the following was reported:

- That despite the vast amounts of information filtering through communities about HIV/AIDS, people are still apprehensive about being in the same environment as infected people (Echols quoted by Easom 2005).
- That HIV positive homosexuals and HIV negative care givers are similarly stigmatized. Edelheit add that there are still many groups that do not have adequate knowledge of the disease that will eliminate existing “ignorance, denial, shame and stigma” (Edelheit quoted by in Easom 2005: 2)
- That some Rabbis perform “commitment ceremonies” for homosexual couples and marriage in heterosexual couples because in their opinion monogamy in both sexual types is a useful preventative measure (Edelheit quoted by Easom 2005),
- Moswin (quoted by Easom 2005) saw condoms as the basic means of prevention that is 98% effective. He emphasizes that the youth who receive all-encompassing sex education are more eager to condomise than youth who are cultured into abstaining. He added that the youth were more concerned about preventing pregnancies than HIV infection and in this instance he says, condoms are not preventing HIV/AIDS.
- Traditional healing methods were reported by Wright (quoted by Easom 2005) as being problematic in the church, because in his opinion the church focuses on the disease from a theological perspective and not from a biological view. In this regard Gray (quoted by Easom 2005) reminded the assembly that HIV/AIDS is a disease and that it has nothing to do with sin or evil wrong doings
- That church leaders feel uncomfortable with talking about sex and sexuality issues. Also, since HIV/AIDS is a disease transmitted through sex, the leaders find it difficult to deal with. This was reported as being one of the reasons why leaders do not enter into discussions with homosexual. (Wright and Ware quoted by Easom 2005). Ware elaborated that communities will talk about HIV/AIDS but it depends on whether or not the religious leaders are willing to engage in such conversations. She adds that in her opinion the majority of leaders do not talk
about the disease because they are not educated enough about the disease and thus they are not comfortable with informing their communities (quoted by Easom 2005).

- Fear was reported to be the main reasons that emerged because, as the respondents indicate, people do not address the issues of HIV/AIDS. Specifically fear of homosexuals.

In conclusion, Ware cautioned the group that there is no one best way of approaching the problem of talking about a sexually transmitted disease in religious institutions. Ware explains that because all institutions differ in various ways, no specific model could be used to educate religious leaders, their contexts should be considered (reported by Easom 2005). However, as the main findings indicate, religious leaders are still uncomfortable with talking and discussing sexuality. As a consequence, therefore misunderstandings and stigmas may still exist in communities despite numerous publicity drives and information that is disseminated about the disease.

From this conference and from Green’s case study it is evident that religious leaders and traditional healers are in influential positions that can create either a change in sexual behaviour or retain the status quo.

Chan (2002) explained that Science may be able to speak about its obligation to promote various ways of prevention; however, for religion, prevention is largely still about faithful relationships and marriage as the ultimate preventative method. And thus while Moswin (quoted by Easom 2005: 8) argues that condomising is at present, the most effective way of preventing new infections, De Young (2001: 1) reports that in a meeting held in Pretoria South Africa where Roman Catholic Bishops announced that condoms are an “immoral and misguided weapon” used in the fight against HIV/AIDS. The Bishops felt that condoms may instead be the prime transmitter of HIV/AIDS. De Young further adds that Pakistani and Evangelical Protestants also showed similar sentiments and further warned that “AIDS related sex education and condom promotion will undermine individual responsibility and morality leading to social degradation (2001: 1). Moswin
reiterates that because leaders are uncomfortable about talking about sex, and because they view condoms as “misguided weapons” in the battle against HIV/AIDS, the issue becomes complicated because HIV/AIDS is a disease that is primarily transmitted sexually. He asserts that this is the same reason why religious leaders are unable to deal with the issue of homosexuality. Both issues require that leaders speak about sex and at the moment “they can’t deal with sexuality” in a modern scientific way (Wright reported by Easom 2005: 8). Ware confirms that if the pastor is uncomfortable talk about homosexuality, then his congregation will also be uncomfortable (reported by Easom 2005).

It is suggested by Kirby (2004: 6) that in the battle to curb further infections, a “change in attitudes of religions [towards] sex, sexuality, drug use”, should first occur before lives will be saved. If these changes do not occur soon, Kirby warns that “hypocrisy and moralizing” will prevail, while millions will be dying (Kirby 2004: 5).

2.4 Conclusion

In this chapter, and with the aid of theorists Weber and Durkheim, I have reviewed literature that shows the sociological constructions of religion both traditionally and in modern communities. Within modern communities I have explored religion in relation to science and globalization as well as the shifts from religious membership to secularism. At this point I looked at how religion operates in the African context. Hereafter, I outlined how disease played out historically so that I could better understand how disease functions in modern communities. Then I viewed sexuality traditionally, with specific emphasis on the role that religion plays in its construction, as well as the way modernity has altered sexuality. I concluded this chapter with empirical studies that indicate how religious leaders and traditional healers are situated and respond to HIV/AIDS within a modern community. Throughout the last part of the chapter it is evident how HIV/AIDS as a disease brings together the three discourses namely religion, sexuality and disease in distinct ways, as the results highlights in chapter four.


CHAPTER 3: RESEARCH DESIGN

3.1 Introduction

This study sought to examine the responses and experiences of religious leaders and traditional healers to HIV/AIDS in a modern community. What follows is a description of research design. I begin with an overview of the methodological approach used. Here I briefly offer reasons for the methodological stance and highlight the approach taken in the study. I follow this section with a description of the site and sample of respondents. In this description, I highlight the challenges of access to sites and respondents. Following this, I explain the methods of data collection. Since my study dealt with a sensitive topic that required sensitivity to context and respondents, the section that follows is one in which I explain how, as a researcher, I overcame these challenges and as such, account for my position as insider/outsider. I include a brief description of the way in which I managed and analyzed the data. This section is followed by a description of the ethical dilemmas and how they were addressed in the study. I end this chapter by highlighting the limitations of the study.

3.2 Methodological Overview

In the literature review chapter, Weber (in Giddens 1997) devised a fourfold categorization system that explained the complex process of social action. While this categorization is helpful in explaining people’s behaviour, it is insufficient for analyzing data in this study, since the study aimed at examining and understanding more than explaining the responses and experiences of religious leaders and traditional healers in a modern community. In this respect, Babbie and Mouton (2001) are helpful in that they suggest the use of the qualitative paradigm. According to them, this paradigm allows the researcher to do an in-depth investigation from an “insider perspective on social action” (Babbie and Mouton 2001: 270). This means that human action can be examined from the perspective of the social actors themselves, who in this case are the religious leaders and traditional healers.
The qualitative paradigm is particularly important to this study because it’s focus is on the opinions of the actors, on describing, understanding and gaining insight into the individual contexts. This focus eliminates generalizations and specifically allows for detailed descriptions of the realities of respondents to come to the fore, as opposed to providing a theoretical base against which respondents are understood (Babbie and Mouton 2001).

The authors explain that this paradigm provides a wide methodological approach from which social action could be studied. It provides various methods and techniques that could be employed. But since this study was primarily interested in understanding rather than explaining social action, and since the study sought to foreground responses and experiences of a phenomenon, an appropriate approach was taken. This study therefore utilized the phenomenological and narrative approaches.

The phenomenological approach was used because, according to Babbie and Mouton (2001), the approach focuses on the human consciousness and not necessarily on the physical aspects of people. It recognizes that people are constantly in the process of “constructing, developing” and shifting their daily lived patterns which in turn alters their experiences. This is particularly relevant to this study, since the study traces how people have constructed and reconstructed their responses, not only to disease but also on a personal level with the onset of modernity. Within this process, the author comprehends that people are “conscious self-directing and symbolic” individuals that can decide when and how they wish to engage in various aspect of daily life. Therefore, this approach was appropriate in examining religious leaders and traditional healers, as it made evident the extent to which they self-directed and how this self directedness positioned them in their respective communities.

The second approach that the study used was a narrative approach. In accordance with Connelly & Clandinin, narratives have a particular purpose, which is to provide a script. The script in this study relates to a particular type of discourse, a story (1990 cited in Hatch and Wisniewski 1995). This story narrates experiences both from a personal and
professional context. It also indicates how people make meaning of themselves. Thus, in telling their stories, religious leaders and traditional healers record their expressions in a “linguistic form” within a narrative (Ricoeur in Hatch and Wisniewski 1995:7). In relating their stories, religious leaders and traditional healers also made available rich data that is thick in descriptions. These descriptions provide the study with insight into the contexts in which they operate on a daily basis, sketching for the researcher the scene of their lives. Furthermore, this approach allowed the study to view respondents’ responses to deeply personal issues such as sexuality and sexual behaviour. The construction of narratives encompass occurrence, experiences, opinions and actions or responses all woven together into a structured oneness (Polkinghorne cited in Hatch and Wisniewski 1995: 7) that serves as a “conceptual scheme by which contextual meaning” of single events is presented (Kathard 2001: 1). Time is of importance in narrative constructions and of relevance to this study. By this, I mean that from narratives, researchers are able to gauge and compare time frames. For example, since modernity, globalization and technology has occurred throughout communities, this study examines whether respondents have shifted their behavioural patterns and opinions in response to that.

3.3 Site and sample: selection processes

This study formed part of a project that investigated ‘Schooling, Cultural Values and HIV/AIDS in South Africa’. While the project researched learners, teachers, heads of departments and principals as well as pre-service teachers, the project conceded that religious leaders and traditional healers are equally influential individuals, contributing to the educative processes of schooling and culture. Thus, my study recognizes religious leaders and traditional healers as educators of the community, which comprised of parents, learners and on occasion teachers that reside in the vicinity.

This study aligned to purposive sampling as Babbie and Mouton (2001: 166) explains that is “Sometimes it is appropriate for you to select your sample on the basis of your own knowledge of the population, its elements and the nature of your research aims”. Fraenkel and Wallen (2000: 114) echo this idea that researchers may use their “judgment
to select a sample that they believe, based on prior information, will provide the data need[ed]”.

3.3.1 Site

The selection of sites and associated schools was executed by the primary researcher and the research assistant of the project. All the primary schools in the Cape Metropole area were clustered according to the ex-department categories that were used during the apartheid era, prior to 1994. The schools within each category were numbered and these numbered schools were placed in one of five boxes. One school from each box was selected using random sampling. This was done to ensure that the sampling process allowed for each school of a region to have had a fair chance and probability of being selected (Babbie and Mouton 1996). A final selection included five schools.

Hereafter a letter was written to the Western Cape Education Department for permission to conduct research in the schools. The research was also approved by the Ethics Committee of the University of Cape Town. The administration office (secretary and principal) of each school was contacted and initial introductory meetings were set up for schools to meet the project team. At these meetings information of the project was presented, with each student highlighting particular areas of interest. Since my study was not specifically located within the school parameters, I used the five schools as a base to access respondents. The principals provided insight into the various religious communities represented in the respective schools and also directed me to religious sites such as mosques, churches, synagogues, etc. nearest to the school.

I had no formal introductions (by school personnel) to the relevant religious institutions, I personally visited the sites and introduced myself to caretakers, neighbours and on occasion, the leaders themselves. Upon meeting leaders, I exchanged contact details and secured appointments for further visitations and observations. Details of the process of

9 White Schools-House of Assembly, Indian Schools- House of Delegates, Coloured Schools- House of Representatives, Black Schools- Department of Education and Training
data collection will be provided further on. I was also able to visit respondents alone. However, in cases where language and/or other barriers were indicated, I was accompanied by an appropriately selected research assistant (see details later).

3.3.2 The sample

The sample comprises 18 religious leaders. Table one below indicates the sample and religious groupings that were used.

Table One: Respondents and Religious Group

<table>
<thead>
<tr>
<th>Traditional Healers</th>
<th>Jewish leaders</th>
<th>Christian Leaders</th>
<th>Muslim Leaders</th>
<th>Rastafarian Leaders</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>6</td>
</tr>
</tbody>
</table>

Respondents were selected through purposive sampling. Purposive sampling was used because, according to Babbie and Mouton (2001), it allows the researcher to choose a sample relevant to his or her study. In this study the relevant group was the leaders who stemmed from various religions. These leaders formed part of the sample schools’ population of the research sites.

I was aware that some leaders lived in the vicinity of the school, while others commuted in to the sample area. In this instance I did not have a choice in handpicking one respondent over another. I instead, research those who existed and worked in the sample community and hence the number of respondents as shown in table one.

3.3.2.1 Accessing the sample

Gaining access to the sample areas was done through making prior appointments with respondents. On two occasions, access became a point of concern. In one instance, a leader requested that I only visit him if I was accompanied by my spouse, since his religion did not permit strange women and men to be in a private space alone. This could
have barrired the data collection process if I did not have a spouse or brother that was
eager to accompany me. So I conceded to the request and my husband accompanied me
in the capacity of a detached observer and in this way data was collected.

On another occasion, Rastafarian leaders felt that I was not wearing their traditional
garments and thus I would insult their God by entering their temple in ordinary
clothes. Thus, access was limited to interviews occurring in a separate room next to the
temple. This restricted my observations of these specific leaders’ interacting with their
congregants. The personal and professional data of these respondents was however
collected through interviews.

3.4 Method of data collection

According to Shipman (1992), a study becomes vulnerable when a researcher uses only
one data collecting method. Therefore, to avoid such vulnerability, this study used
triangulation in its research. Triangulation was also used to allow the researcher of this
study to view the same aspect, but from different perspectives. In this way it increases the
scope of information of the study. By viewing aspects from various perspectives, it also
allows for in-depth and precise analysis of data. Given the above, the study’s data
collection methods included observations, semi-structured interviews and in 2 instances,
focus group discussion. By using triangulation, it ensured that any errors in reliability and
subjectivity were minimized.

3.4.1 Process of data collection

This process took place over a period of time and followed the following pattern.

---

10 Rastafarian dress: White linen clothing consisting of long skirts and long plain tops with head scarf
twisted high on the head
11 I wore a navy skirt, lengthed well below the knees, long sleeved white blouse and a head scarf.
1. After informal visits to sites, contact details were exchanged and formal initial meetings occurred. These initial meetings served as introduction sessions where the project set up and processes were explained. The focus and purpose of the project was clarified, details of who the researcher is and her purpose in the process was explained and ethics of the study was emphasized.

2. The next visit to the sites was for observations of the respondents. The observations will be elaborated on in the next section.

3. After observations occurred, the respondents were visited for two rounds of interviews. The first set of interviews was for the personal accounts of respondents and the second for their professional accounts. This too will be elaborated on in the following section.

4. In two instances focus groups discussions were used.

3.4.2 Observations

Initial visits to sites were made for observing the respondent in his or her natural surroundings. According to Shipman (1992: 70), observations are the basic method that could be used to sustain “personal, professional” information of respondents and he suggests two ways of executing observations, that of “participant” or “detached” observer (Shipman 1992: 70). In this study, the status that I held was that of a detached observer.

Observations occurred while leaders were teaching either in their places of worship or at the sample schools where they taught. This method allowed me to examine the leaders in their domain and in relation to their congregants or learners.

In the case of traditional healers, healing is a personal encounter between patient and healer. Thus confidentiality constraints did not allow me to do entire observations of the healers interacting with their patients (Shipman 1992). On one occasion I observed the end portion of an interactive session between a healer and a client.
To enhance the reliability of the data collected, an observation schedule\textsuperscript{12} was prepared to keep focus of what needed to be observed and a “systematic recording system” was used (Black\textsuperscript{1999}: 235).

These observations allowed me to obtain an overview and to familiarize myself with the scenario being investigated prior to doing further work in the community (Denzin in Babbie and Mouton 2001). Specifically, the physical settings of the community was observed, whether they depicted a poorer community or comfortable and more affluent community of Cape Town. The hypothesis was that the economic state of communities could have bearing on the data collected. Also, that the ways in which individuals conduct themselves in observations may provide more details in addition to their interviews. This made the observations invaluable when set against the semi-structured interviews (Babbie and Mouton 2001).

3.4.3 Focus group discussion

On two occasions, I administered a focus group discussion with Rastafarian elders and Christian leaders. This was done because the Rastafarians congregate once a year to celebrate ‘Marcus Garvey’\textsuperscript{13} Day at the sample site. On this day all the Rastafarian elders are together from all over Cape Town. Having interviewed my main elder from the sample area, I took the opportunity to have a focus group discussion with 5 different elders that visited the site. While my main elder, Bianca was not a part of the discussion, it provided me with a means to verify some of the data that I collected from her earlier.

With regards to the Christian group, my main leader was accompanied by a support leader from the same church. The support leader was only available for one sitting with me. Thus, I had a focus group discussion with them and a second interview with the main leader. This proved to be beneficial to my study because I soon discovered that the

\textsuperscript{12} See Appendix C for copy of Observation Schedule
\textsuperscript{13} Marcus Garvey – A prophet of the Rastafarian People
accompanying leader (Priest Ted) had first hand experiences with HIV/AIDS. His father had died of HIV/AIDS and this occurrence impacted on the way he teaches.

These sessions encompassed a conversation within a group of respondents concerning a particular aspect of this research. The aim of the discussion was to create interaction between respondents, where views were debated, agreed upon and questioning of opinions were entertained. Ultimately, the sole purpose was still to solicit data (Barbour & Kitzinger 1999).

These sessions occurred in familiar surroundings and thus respondents were comfortable to interact freely expressing the personal opinions (Barbour & Kitzinger 1999). In these discussions the respondents received validation for what they said and received immediate responses to their opinions. From these discussions I acquired information about their experiences, thoughts and knowledge that they possessed about HIV/AIDS and how they operated within their communities.

To initiate the discussion each group was provided with a scenario as stimuli. This vignette revolved around a son abandoned by his family because he was HIV positive. Further probing and discussions were enhanced in the focus group discussions using questions from the interview schedule placed. A focus groups schedule is provided14. My role was merely to facilitate discussion and constructive interaction (Greig & Tailor 1999).

3.4.4 Semi-structured interviews

As previously mentioned, semi-structured interviews were used because it allowed for an intimate “interaction” with my respondents (Babbie and Mouton 2001: 289). Interviews were conducted on a one-to-one basis, where respondents were doing most of the talking.

---

14 See Appendix B for copy of Focus Group Schedule
(Kumar 1999). I portrayed the part of a digger probing for information, without biasing any questions or answers (Babbie and Mouton 2001).

Prior to entering the field, I prepared two sets of semi-structured interview schedules (Kumar 1999). The questions for interview schedule one\(^{15}\) questioned the personal lives of respondents. The second interview schedule\(^{16}\) questioned the professional lives of respondents. This broad questioning pattern was done with the intention to gain insight into respondent’s perceptions and responses when they were in a personal capacity and to see what their perceptions and responses were like when they were in a professional capacity.

Since I envisaged constructing narratives of my respondents, semi-structured interviews supported me in setting a relaxed tone where the respondents were telling their stories. These interviews were set in a conversational and flexible tone. Semi-structured interviews afforded me the autonomy to create questions as they came to mind during interviews, around the topic being investigated (Kumar 1999), and thus I was able to hone in on specific issues that were mentioned spontaneously by the respondents (Babbie and Mouton 2001). This legitimized the opportunity to further probe into the notion of how the leaders and healers created understandings of HIV/AIDS. Furthermore, I latched onto contradictions that arose in their conversations. This made evident how the respondent’s opinion came into being, rather than what their opinions were (Babbie and Mouton 2001).

While I aimed at completing my questions on the schedule, I still managed to set an anxiety-free atmosphere, where my respondents had the freedom to answer my questions in their preferred language, using their own words and expressions, and in their own time. Because of this consideration, I had to enter into second and in some cases third interviews.

\(^{15}\)See Appendix D for copy of Interview Schedule one
\(^{16}\)See Appendix D for copy of Interview Schedule two
Having used this method, I was able to probe using the occasional question ‘why’ as oppose to responding in a manner that would limit or close the conversation (Babbie and Mouton 2001).

3.5 Challenges and accounting for myself

Since religion is the key focus of my study, accounting for myself is necessary, as I am embedded in a religion on a personal level. This being my context, I wish the reader to bear it in mind, as I have constructed narratives of my respondent’s lives. The way in which I constructed these narratives could have been constructed and presented differently by another researcher living a different life context. Therefore, I wish readers to know the following of me at the time of data collection.

I am a practicing Muslim, embracing the pillars of Islam. I do not always exercise all the traditions and find it essential to express my opinions of religions, be they in agreement or disagreement with religious customs. This, I believe, is my right and that of the rest of South African citizens. Through the process of my research, I often questioned my own perceptions about HIV/AIDS, with the hope to understand my leaders and healers better. I was of the impression that this will enable me to interact at a personal level with my respondents. Thus, I kept a diary in which I noted how I felt after each session with respondents. The key idea of this exercise was for me to self-reflect and in this way remove biases from my work. While in my opinion I may appear as not being bias, I do however account for any biases that may occur within my work. Such biases, I acknowledge, could have surfaced when working with Jewish leaders. Being Muslim and given the political situations17 in the East at the time of data collection, I was concerned about how Jewish leaders would accept me. However, the leaders accepted me as a researcher researching HIV/AIDS. The disease remained the focus of interviews and not once did either of the leaders hint at the East situation. One leader did mention though

---

17 The war between Muslims and Jews in Palestine and Israel.
that it was the first time that he engaged with a female researcher on the question of HIV/AIDS.

Throughout the process I tried to place myself in the respondent’s position and in this way I hoped to apply the appropriate questions and responses, so that leader and healer would trust me to examine their responses and experiences to sensitive and personal issues, such as sex and sexuality. Being a woman in the research field was never an apprehensive experience for me. However most of my respondents were men and I did have a concern about gaining access to their responses to sensitive issues of sexuality. For example, during first rounds of interviews my respondents were apprehensive and words such as “homosexual” were not used freely. Instead they would say “when a man is using a man”. In such cases I would ask “homosexually?” And they would reply “yes”. This hampered my initial data collected, especially during first interviews. Not all my respondents were comfortable with my probing. Specifically, one Muslim leader preferred to provide one word answers and even at a second interview his responses were minimal. Often the word “sex” would be referred to as “it”. This probing session was longer than usual with very little data collected. However, perseverance and another round of interviews elicited the important data. His response, I assumed, was because I was a woman trying to discuss very pertinent, private and sensitive topics such as sexuality. This leader and many of the others admitted that this was the first time that they were interviewed by a woman on such a sensitive topic. In most cases they became more relaxed at further conversations during second interviews.

3.6 Data analysis Process

This process intended to highlight patterns in the data that would lead to theoretical insight of religious leaders and traditional healers’ responses and experiences, and how they engage with HIV/AIDS in a modern community (Kumar 1999). It intended to highlight the contexts, processes of social life and rich details of the lives lived by the respondents.
This process commenced with all collected data being manually analyzed (Kumar 1999). Video recordings and observation notes were scrutinized and were then used to create the context of each respondent. In total five community contexts were constructed with descriptions of their locations and surroundings.

Hereafter, recording of interviews were listened to, transcribed and typed up. From the interviews, I first did coding with the aid of reading and re-reading the interviews, colouring and labeling items of data collected. Coding was implemented by using the open coding method, specifically as per paragraph. This gave rise to many place holders for example, their thoughts on ‘sex’ were placed together and ‘HIV/AIDS’ related data was placed in another place holder. Each place holder was highlighted with a different colour as they formed various categories (Polkinghorne cited in Hatch and Wisniewski 1995).

Focus group details were recorded on video tapes that captured the atmosphere of a Rastafarian event. Part of this information was used for constructing contexts and other information was used for further analysis. The video taped data was transferred onto audio tape, transcribed and typed up. This was now ready to be analyzed. Once again, I used place holders to highlight emerging categories from the focus group discussion. From the categories of the two sets of interviews, the information of focus group sessions and the respondents’ respective contexts, I construct narratives of each respondent. Contexts of the respondents are attached in Appendix A.

From the narratives, I distilled related information that formed the emerging themes that are evident in chapter four (findings) and that are analyzed and discussed in chapter five.

Since narratives were too cumbersome, these themes and categories were arranged accordingly and presented in chapter 4 as results.
3.6.1 Physical tools of analysis

Permission was requested from the interviewees prior to the use of a tape recorder and video recorder. A tape recorder was used as it allowed me to engage and remain focused in conversation without having to take notes (Bauer and Gaskell 2000). This saved time. Using the tape recorder allowed me to have a “record of the [actual] conversation”. This meant that I could analyze this conversation at a later stage and that I had not lost relevant information. Furthermore, the tape recorder afforded me the opportunity to “double check” my transcriptions. (Bauer and Gaskell 2000: 52). For similar reasons I used the video recorder. This tool allowed me to view the setting of the respondent again, reiterating the contexts and capturing physical movements of the respondents in their domains, while they were interacting with their congregation.

3.7 Ethics and confidentiality

The research was conducted in an ethically transparent manner, in accordance with the University of Cape Town. Confidentiality of respondents was of prime importance. Thus, pseudonyms were used for respondents to protect their identities. The UCT code of ethics expects that researchers consider the safety of respondents be it social, physical or psychological. This study adhered to all considerations stipulated. Information of respondents was limited to the researcher and the supervisor. I was also aware that my respondents disclosed issues of a personal nature. In these cases I was prepared to advise respondents to seek professional help.

Furthermore, consent was obtained from the Department of Education, school heads and principals. While my data was not collected in schools but in the community, I still formed a part of the project and the consenting process applied. In my case, I received permission from the leaders and healers themselves telephonically, to allow me to interview them. Observations were done only after respondents informed their congregants that I was going to join them. If congregants were not happy with me being there, they were free to attend another session or I would choose another session to
observe the respondents. On most occasions, congregants were pleasant about my visitations. A copy of the consent form used is attached in appendix E.

3.8 Limitations of the study

Since my sample was purposively selected, no generalizations were made, as the respondents are not representative of all leaders and healers of the Western Province.

Due to my Xhosa language barrier, an interpreter was used, making the data collection in these instances second handed information. This was the most challenging limitation for me as I feared cultural laden verbal gestures or expressions may have been lost because of my language barrier. Furthermore, this barrier made probing difficult as I could not latch onto issues arising conversationally (Kumar 1999).

A second limitation that I considered was that narratives encompass story telling and story telling could be fictitious or it may carry “misconceptions” (Polkinghorne cited in Hatch and Wisniewski 1995: 7). The fear existed that happenings related to me could have been alleged to have happened. Thus, thorough investigations had to be done, with the aid of triangulation to eliminate such misconceptions.

Shipman (1992: 87) assumes that individuals who allow themselves to be interviewed often do so “reluctantly”. This I experienced with one of my respondents who at the end of the second interview became rather irritated. This caused restrained responses. Fortunately, I was at the end of the second interview and I had already covered the essential questions for data collection (Shipman 1992).

Often respondents assumed that I am married, that I am in a heterosexual relationship and that I adhered to traditional Muslim Customs. So often I needed to ask respondents to explain what they meant when they would say “you know what I mean”. Sometimes this was time consuming, but it indicated to me that they were becoming comfortable with my
presence and probing because they were beginning to include me in their discussions of ‘sex within marriage’.
CHAPTER 4: PRESENTATION OF RESULTS

4.1 Introduction

In this chapter I present data derived from in-depth interviews and observations that addresses the question posed in this study, namely, examining religious leaders and traditional healers’ responses and experiences to HIV/AIDS, in a modern community. What follows, therefore, is a presentation of findings on eighteen religious leaders and traditional healers’ views, experiences and responses to disease and sexuality in general and HIV/AIDS in particular.

Important to note is that from here on traditional healers and religious leaders will be referred to as religious leaders, respondents or simply leaders. I use pseudonyms to identify different leaders. These are linked to terms of references used in respective communities to identify religious leaders. The table below depicts the respondents’ pseudonyms.

Table Two: Pseudonyms of Respondents

<table>
<thead>
<tr>
<th>Traditional Healers</th>
<th>Jewish leaders</th>
<th>Christian Leaders</th>
<th>Muslim Leaders</th>
<th>Rastafarian Leaders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mamela</td>
<td>Rabbi P</td>
<td>Pastor Allen</td>
<td>Imama Fatima</td>
<td>Elder Job</td>
</tr>
<tr>
<td>Tando</td>
<td>Rabbi O</td>
<td>Priest Brian</td>
<td>Moulana Omar</td>
<td>Elder Aaron</td>
</tr>
<tr>
<td>Chiko</td>
<td></td>
<td>Pastor Jeff</td>
<td>Imam Ali</td>
<td>Elder Solomon</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Priest Ted</td>
<td></td>
<td>Elder David</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Elder Ezra</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Elder Bianca</td>
</tr>
</tbody>
</table>

In order to gain insight into the contexts of this cohort of respondents, I began each interview with life history narratives. These provided me with an overview of dominant influences in their respective lives. It also shaped the decisions they made as regards becoming religious leaders. This contextual overview also enabled me to gain insight into
ways in which situated contexts influence and are influenced by social actors as already described in chapter 2 (Literature Review). While this information was important to my understanding, it did not form part of the main study and is therefore presented in Appendix A. It is suggested that the reader first read these contexts prior to reading the data presented.

In an attempt to present the main findings in a coherent way, various strategies were employed. The first included a process whereby narrative descriptions of each religious leader and traditional healers were developed. What emerged though were comprehensive narratives that, while rich in description, proved to be too cumbersome to include in this chapter. I thereafter, considered presenting the data in a form that highlighted similarities and differences within and between individual religious leaders and groups. In so doing, I used the narrative descriptions to develop themes and categories that finally formed the main findings presented in this chapter.

Presented below, therefore, are the findings in four interrelated parts. While I describe these separately, I am aware of their interrelatedness. The four parts include Religion and the Place and Purpose of Sex; Views, Knowledge and Conceptions of HIV/AIDS; Disease Prevention Strategies and Religious Beliefs, and Care and Support for the Diseased

4.2. Religion and the place and purpose of sex

Responses to HIV/AIDS cannot be separated from the views that show the connection between religion, disease, infection and sex. Importantly, amongst this group of religious leaders, responses could not be de-linked from the place and purpose of sex in social life. What follows therefore are leaders responses to the sex and its purpose.

All leaders, with the exception of the Sangomas, specify that the primary purpose of sex is for procreation and also sanctity of life. Procreation according to these leaders was functional and not necessarily always associated with pleasure or sexual acceptable
indulgence. For the most part sex is perceived only in the context of marriage or long-term-stable relationship. For example Rabbi O said “It [sex] is a very important aspect of marriage, to have children, many children. According to Jewish law religious people have many children… family is the core”. This view was echoed by Rabbi P who explained that sex is the means through which “God’s wishes” are sustained because “Life belongs to God, it is a blessing”. He referred to the biblical figure “Father Abraham had many sons … You want to make more babies; you want to increase the life on earth”.

Christian leaders agreed with their Jewish counterparts. Pastor Allen put it this way “When you get married what is the initial idea of having sex? It’s having children, wanting a family, carrying on my name, that’s why I’ve got boys, carrying on my name”. While Priest Brian and Priest Ted did not make reference to sex in relation to procreation, they however believed that sex should be saved for marriage and should therefore not be considered outside of the institution.

Muslim leaders agreed that sex is for procreation and importantly, should occur within the context of marriage. Imam Ali, for example, emphasized that “sex is for marriage and to have children”. Muslim leader, Moulana Omar, perceived sex as either for the purposes of procreation or saving the human species. He explained that sex should hold a place within the context of “marriage or a long term stable relationship”.

While Rastafarians do not believe in conventional marriages, they believe in long-term-stable relationships. It is in this context that they believe sex occurs. Bianca explained that when “you leave your parents, now is the time to move on with your life you feel ready to take a man and you choose one more fitting, this is the man I think should take my family”.

Two responses seem evident, one that sex is for procreation and two that sex occurs within the context of marriage. It is important to gain a sense of how leaders viewed sex, because these views directly influence the way leaders develop conceptions about a sexually transmitted disease such as HIV/AIDS. Also how they interpret transmission of
the disease and who they regard as being most vulnerable, as will be discussed in the next section.

4.3 Views, Knowledge and Conceptions of HIV/AIDS, Disease and Sexuality

In this theme, the knowledge of respondents with regards to transmission of HI-virus, sexual behaviour and risk, and their views on who is vulnerable and why, is presented in two categories. The first is a discussion on transmission and highlights religious leaders views that integrate conceptions of disease, sexuality and HIV/AIDS and the second category is a description of who is presumed vulnerable.

4.3.1. Views on Transmission, Sexual Behaviour and Risk

Amongst the 18 respondents, there was general consensus on ways in which HIV was contracted. All respondents agreed that HIV was transmitted primarily through sexual contact, be it deviant or not. All were aware that there are other forms of transmission that included amongst others, blood transfusions.

While all 18 respondents agreed that sex was one way of becoming infected, responses amongst the religious groups and leaders varied. All three Muslim respondents agreed that contraction of the virus was primarily as a result of promiscuity and extra-marital relationships, but also as a result of ‘going against nature’ through deviant sexual practices. Moulana Omar and Imam Ali highlighted that transmission was mainly the result of immoral sex which, he suggested, went “against nature”. For him, transmission was mainly through “illicit sex, [and] homosexual sex”. Imam Fatima was of the opinion that transmission was primarily due adults “sleeping around”. She emphasized that it was specifically “married men and women”. Interestingly, this cohort of three respondents situates transmission as a result of sexual behaviour that goes against traditional religious beliefs.
Similar to views held by the Muslim group, Sangomas also agreed that immoral and deviant sexual behaviour was a prime contributor to new HIV-infections. While Mamela was of the opinion that HIV is spread “mainly through sexual immorality”, she was very aware of infidelity in the communities and its contribution to the spread of the pandemic. The following excerpt illustrates the point she makes:

She’s got a husband and maybe her husband goes and sleeps somewhere else without her knowing and then he come back and sleeps with her. In such cases it becomes difficult for a married person to ask their partner to use a condom because it is supposed to be open amongst the two of them. And it would be difficult for her to advise a certain system of prevention to use, because you cannot prescribe the use of condoms [in marriage]. So she thinks it is just the way people are treating themselves and behaving. That’s what causes the spread of the virus.

The compromised position of woman and the lack in negotiation about safe sex practices in marriages is what Mamela highlights as a difficulty in the above excerpt. Tando, a male Sangoma, also agrees and views susceptibility to transmission as resulting from the connection between sexual behaviour and venereal diseases. To him these three work in ways that make the individual susceptible to infection. In this regard he stated:

Sometimes patients come back with a recurrence, for venereal diseases. There was a patient last year because sometimes some people they go back again, mess around on different partners and then get the same diseases, so he knows where to go back to check what he gave them then. Sometimes he heals a disease and then it comes back.

While Christian leaders also agreed that the most common way of contracting the virus is through sex, they held expanded views on different forms of transmission. Priest Brian, for example, suggested that “HIV is transmitted through blood, and there’s a number of ways be it through sex, through homosexual sex, through cuts that other people, blood mixture, rape, I think most probably sex is the most common transmitter of HIV and AIDS”.

Pastor Allen, while having medical knowledge of transmission, did not confine transmission as occurring solely amongst adults and homosexuals. He was of the view that young people are also potentially at risk. He said:
Firstly blood transfusions. It can happen also if you are working with someone who’s got AIDS and you’ve got a cut if somehow blood gets in by accident your blood mix that is how. Also through different sexual partners, and when it comes to young people before marriage, they become so intimate with that person, holding hands, feelings are aroused, so they become sexually involved and then they break up and they go to the next one and I think that is how it can happen

Priest Ted agreed with Pastor Allen and said, “The youth had current pressure and loneliness and sexuality education is to promote that they don’t sleep around and get AIDS”. While three Christian responses indicated scientific knowledge of transmission and agreed that youth as well as adults can become infected, one of the four leaders seemed more closely aligned with views held by the Sangomas and Muslim leaders above. Pastor Allen indicated that deviant behaviour or sex outside of marriage is key contributors to the spread of the pandemic.

The two Jewish leaders also held expansive views like their Christian counterpart by suggesting that HIV may be contracted in multiple ways. They too showed a vast scientific knowledge of transmission. Rabbi O explained that transmission occurs in a “sexual way and there’s blood, blood transfusions, sharing of needles and there’s mother to child, I think that those are the main areas, I’m not an expert”. Rabbi P agreed and explained that people “get infected from sexual intimacy, from intravenous, from needles, that’s how they get infected”. To him “there are doctors that can get infected. There are accidental ways of getting infected through cutting and blood. It’s got to be through the blood ultimately through the transmission of fluids is how HIV is transmitted”. While this Rabbi agreed that sex was a means of transmission, his emphasis, however, was on blood spilling and the consequences if one had cuts or an open wound. An interesting observation amongst the Jewish religious group therefore, was their emphasis on blood transfusion and the dangers of contracting HIV within the workplace. Rabbi O suggested that this posed a greater risk for Jews than them contracting the virus through sexual encounters. He states

I think the main area in which it affects us is the people that we come into contact with, especially the workers. There are many Jewish people in factories and of course they are loosing workers and the domestic workers and I think that those are the type of people who we come into contact with you know, on a large scale, of and with HIV

58
Implicit in the view above is an understanding that Jews are less promiscuous in their sexual practices and are, therefore, less vulnerable to contraction of the pandemic as a religious group as will be discussed in more depth in the next section.

The Rastafarian leaders, however, held very different views on transmission to the rest of the religious groups and individual leaders in the study. This was primarily due to their understanding of the role of religion in preventing contraction. This cohort of six respondents denied that contraction was ever possible in their religious community. Bianca stated that as a religious group, they have never experienced anyone who has contracted the disease. According to her, “Amongst us HIV is never something that I have seen amongst us. It is very scarce; I don’t know any Rasta amongst us that has that disease”. She explained that HIV/AIDS does not exist in her community because, as a religious group, they are protected by the religious practice of smoke a holy herb called Ghanja. She said

Ghanja is playing a big role amongst the Rastafarians, because it seems that our blood is already full of Ghanja. Ghanja is protecting us from getting any disease because if you’ve got Ghanja in your blood, it’s not easy for any disease to attack you. It warms your blood and therefore kills other things before it gets in

This view of protection through the use of Ghanja was also held by all the elders interviewed. Elder Solomon’s response below encapsulates what was a common sentiment

It’s true, especially if you’ve got flu and you smoke a lot, tomorrow it’s gone. You can taken seven days when you are sleeping, lying on your bed with your flu. If you smoke a lot, it’s gone. It warms your blood. If your blood pressure is low, it can take it high. It depends how you smoke. It stays a while in your body. Cause you smoke it spiritually. But it comes physically in your urine it turns green

What emerges, therefore, is a consistency in views that suggest a link between transmission and sexual behaviour. Interestingly, two groups do not consider HIV/AIDS as a threat in their respective communities, but for very different reasons. The Jewish religious leaders’ view is that HIV does not pose a threat because community members are not necessarily promiscuous and don’t always deviate from the dominant religious
practices that promote abstinence and sex within the confines of marriage. The Rastafarians on the other hand, do not believe members in their community are at risk. This they propose is because of a religious practice that includes the use of a holy herb as a form of protection. For these two groups, risk of infection and sexual behaviour are disconnected even though they agree that sexual transmission occurs. As the following section highlights, risk is associated with factors that do not always include sexual behaviour and risky practices.

4.3.2 Vulnerability and Risk

While the Rastafarian respondents dispute that they do not contract the virus they, however, do give reasons why HIV/AIDS is prevalent. Reasons amongst this religious group did not always cohere. All six respondents agreed that poverty was the main reason for the escalation in HIV-prevalence. Bianca, for example, suggested a link between poverty and vulnerability. According to her, “When you are poor you are at a disadvantage”. While she agreed to the link between contraction and risky sexual behaviour, she emphasized poverty as the key reason for the increase in rates of infection, particularly amongst Blacks. She also described woman’s vulnerability because, as a means of survival, they may engage in sexual behaviour that puts them at risk of infection. She said, “For a woman, it is easier than for a man to catch. If I am a woman with children… they don’t have anything to eat. I will have sex with him, I will deal with him, I give my life away. Poverty is what cause”.

Elder Aaron agreed with Bianca in his perception about the link between poverty and women’s vulnerability. To him, women are forced to use their bodies for economic gain because they are poor. He said

The problem is poverty. I don’t believe there’s no disease that cannot be cured. This disease can be cured but people sell their bodies because of poverty. Right now a 14 year old, nine year old daughter, ten year old has a child already. And the father of the child is an old man. It’s the big problem in South Africa
Elder David confirmed that “nine, ten and 14-year old daughters [are engaging sexually] to earn money because they are poor”.

Elder Ezra offers a similar perspective to that of his counterparts in that he too sees the link between poverty, vulnerability and infection. To him though, economic conditions play a role in differentiating communities in their access to condoms. He suggests that some condoms are manufactured cheaply and others are more durable but expensive. The former, he suggests, is less reliable and are mostly used by those in poor communities. He therefore proposes a class differentiation in the use of condoms which puts poor people at risk. He says

Condoms got something to do with HIV because the condom you get it in different class, different grades, a local one and an expensive one. So it means only the rich man can survive by that expensive one and what about the poor? The poor will never survive because he’s always with the cheap one. I find that it’s the cheap one who spread the AIDS amongst the poor. How come AIDS is among poor? Because of these cheap condoms which they distribute.

While poverty was an important indicator in contractions of HIV/AIDS, one respondent amongst the Rastafarian group offered reasons that had little to do with socio-economic conditions. Instead, he emphasized reasons that were more consistent with the other religious groups in the study who proposed that promiscuity, incestuous behaviour and sex outside the confines of marriage are the key causes of new infections, he also linked increases in infections to the use of condoms. In Elder Aarons’ perspective, condoms encourage promiscuous behaviour, particularly amongst ‘married’ women. He stated that, “We are saying no you don’t need condoms, condoms say yes you can do adulteress”.

Similar views on the link between condom use and risky sexual behaviour were expressed by Christian leader Pastor Jeff who explained that “They [society] talk about safe sex, use condoms, you are not helping them, and you are encouraging them to have sex”. Besides this view, Pastor Jeff alluded to a similar view to that of Bianca as he felt that “the non white society is at risk”. This he says is because government is providing condoms free of charge and in his opinion “you give anything for nothing, everybody
grabs. But who is grabbing? 99% is the non white society” and therefore he felt that the HIV/AIDS infection rates would be higher in the non white communities.

This notwithstanding, the three Christian leaders linked contraction and vulnerability more directly to sin and punishment. According to them, infections are the result of choices people make to sin, rather than the result of external influences like poverty. The consequences therefore, are infection which is interpreted as punishment for sinful ‘deviant’ sexual behaviour such as homosexuality or extra-marital relationships. Pastor Allen, for example, suggested the following explanation. He said:

...in Bible times in the Old Testament Solomon had 700 wives but there was nothing like AIDS then. Somewhere along God has made up His mind and said enough is enough and allowed this [HIV]. He allows it because people wouldn’t listen. Jesus said that you shall love the Lord your God, and love your own wife. You shouldn’t have a love affair. A father’s love to his daughter they started mixing it and now he’s having sex with his daughter and this is where God has just had it, and that is sin

Christians were, however, not the only group that made the link between sin and infection. Imam Ali, a Muslim religious leader, alluded to sex occurring outside of marriage as sinful. He suggests that if “you follow the religion properly, there won’t be any AIDS. It means our religion teaches no intercourse before marriage”. Imamama Fatima places the responsibility on the religious leader to teach about adhering to religious principles that include abstaining from premarital sex since it is sinful. In this regard she state, “Muslim leaders [are answerable, because] they should have been strict from the start and taught our young children that sex before marriage garaam [sin]”. Interestingly, while he too agreed on infection as punishment for ‘deviant’ sexual behaviour, Moulana Omar explained that infection may be a test from God, particularly in the case of infected new born babies. He said

A person who has been born with HIV, its not a punishment, it’s like a person born blind, that person is being tested by the creator. But when a person is going in for things which, brings these things upon himself. Like when a man is using a man [homosexually]. That is against nature and it can bring disease because it disturbs nature. It is a punishment
As a group, the Jewish leaders had conflicting views on vulnerability and risk. Contraction was not a concern for Rabbi O because, while he says that contraction could be linked to “premarital sex, which is sin”, he did not view Jews as being promiscuous and, therefore, they are not vulnerable to infection. He said, “One doesn’t want to close your eyes to it [people having sex outside of marriage]. It is a problem, but it doesn’t seem to me to be an enormous problem in the Jewish community”. Rabbi P on the other hand differentiated between promiscuity and risky sexual behaviour. To him, contraction depended on how responsibly people behaved rather than on whether or not they were promiscuous. According to him, “promiscuity of the age, that’s ridiculous, you can blame whatever you want it’s not going to address the situation because every human being is responsible”.

While the Rastafarians linked poverty and infection as well as condom use and infection, they too believed contraction of HIV is connected to sinning. Interestingly sin was connected to sexual behaviour outside of religion rather than sex outside of marriage as indicated in descriptions by the previous religious groups. Elder Solomon highlights the point in this excerpt

Young girls are falling into these traps of having sexual intercourses with some follower [of a] religion which is dead. Those people going to church on a Sunday. When you look again to them, it is the same people who come with this sickness and pollution. All the diseases happen because of all this sin. It’s not what our God want us to be, because we’ve got a God, the creator, who loves us

The Traditional healers (Sangomas) also concur that infection is related to sinful practices. However, unlike the Jews, Christians and Muslims religious groups, ‘sinful’ was perceived as the consequences of a sexual act rather than the act itself. Mamela suggested that infection is “mainly due to sexual immorality and infidelity”. She offered people condoms as a means of protection because she “didn’t want sins with God”. To her, sins with God meant that she did not want to participate in abortions and deaths occurring due to the disease. Having sex, therefore, was not necessarily sinful, hence the provision and encouragement in the use of condoms.
Chiko’s explanation for contraction was based on a cultural practice that proposes that “there’s no way you can sleep with a women with a condom because traditional men will not condomise”. The belief is that procreation is more important than protection against disease. According to him, men who use condoms will be ‘stereotyped’ as ‘not real men’ even though he personally recognizes the efficacy of condom use as a preventive measure.

Interestingly, this cohort of three traditional healers specified that they advocate condom use because people engage in sex at younger ages and that they fear many youth will loose their lives due to HIV/AIDS. In this regard Tando said “Before they would do those things [sex] when they were older, but today these guys do sex at young ages and that is why they are suffering more from venereal disease, female and male alike”. Mamela agreed with her counterparts that people are sexually active at younger ages, but she emphasized that previously youth would experiment with sex, however, what is different today is that youth experience “direct intercourse”. She said “before there was a way boys were doing it [sex] with girls…they sleep wearing their underwear… these days the youth are having real intercourse”, and therefore she encourages condom use as a barrier to becoming infected. Imama Fatima, a Muslim leader had similar view because she had lost a friend to HIV/AIDS. She explained “She was only 14. She was so young and yes, sexually active at that age”. She added that she has a learner of the same age who was sexually active at the time of interviewing. Priest Brian has the same opinion as the previous respondents, where the youth is more sexually active. However, he explained youth sexual activity along racial lines. He said “white learners [are] more sheltered about sex issues. The coloured and black communities, they’re a lot more outgoing, they’re sleeping around in grade eight and nine, but the whites start having sex in matric, grade 11 and at varsity, which is a bit later than their peers”. Despite the age of sexual activeness, Priest Brian feels that the youth should be preserved and, therefore, he encourages them to condomise.

Evident above is that conceptions of vulnerability and risk varied across and within religions. In the main, leaders and healers indicated that women and youth are the most
vulnerable groups in the communities, with the exception of the Rastafarian and the Orthodox Rabbi who says that his community is not promiscuous, making them less vulnerable. Some identified groups within communities while others identified communities as more or less at risk. Whichever way, the majority of leaders were aware that HIV/AIDS is a life threatening disease and curbing its infection rates was seen as important. However, the ways in which prevention strategies were implemented varied from leader to leader as could be seen in the next section.

4.4 Disease Prevention Strategies and Religious Beliefs

All leaders, with the exception of the orthodox rabbi, indicated that they have vulnerable groups in their communities and that they employ various strategies of disease preventions. Inevitable in the discussions was the use of condoms as a protection strategy, and as was previously mentioned, 11 respondents perceived condom use as a mechanism that prevents procreation which goes against the primary religious function of sex. Others responses included the perception that condoms were a means of discarding of lives and also as interfering with the natural processes of people “meeting and cohabitating”.

In this section leaders either offered alternative strategies or explained why condom use was not encouraged by their respective religions. Rastafarians believed that if the South African government alleviated poverty, then HIV will be prevented. In this regard Elder Job said “This disease can be cured but the problem is people go and sell their bodies because of poverty. It’s the big problem in South Africa. If the government of South Africa can just come truly [in alleviating poverty]”.

Other elders felt that a strategy to prevent new HIV infections would be to eliminate the promotion and use of condoms. As previously quoted, in the previous section, Elder Ezra highlighted that condoms are provided by suppliers at different price ranges that he proposes is linked to quality and safety. Thus the poor will use the less safe and cheaper condom which places them at higher risk of infection. Elder Aaron agreed and confirmed
that "the condom is not safe, because the very same persons that use the condom, they get AIDS". Elder Ezra explained why condoms are unsafe. He said

Government needs to look in terms of why they approve different grades of condoms. I find the use of a chemical, I really would like to know, what kind of chemical is on there. That chemical is supposed to leave something behind. Whether it’s going to be on the man, or on the female you’ve got to deal with. Somehow, one of you two needs to take some of that stuff with you

Elder Jobs agreed that condoms should be discarded but his reasoning centred round abuse. He said “These things [condoms] leads to other crime because when a daughter not agree to have sex with you, you’re not supposed to force, and once you get this condom now you force, because you’ve got protection”.

While Rastafarians were of the opinion that the quality of condoms was related increase infections, and agreed that discarding of condoms was a strategy for disease prevention, Rabbi O, a conservative, was qualifying why perhaps he may agree to condom use. He said that “I do realize that to prevent the transfer of AIDS it’s an important thing, if it [condomising] would save his life, then maybe [I]would say that. It’s not a question I have been faced with, I must be honest”. As an alternative, he said that he would rather advocated abstinence. In this regard he said

If somebody came to me and said ‘Rabbi I am going to be promiscuous what should I do?’ The first thing I would try to do is convince him not to be promiscuous, I wouldn’t say use a condom I would try to stop him from being promiscuous, abstain, because [using] a condom is problematic. We believe the semen must be deposited into a woman’s vagina and cannot be spilt

This notion of saving sperm was echoed by Rabbi P who said “There was a belief that the seed of man was limited so you didn’t want to waste seed, in that point of view, condom use is prohibited, and you’re sending a message that you don’t want life. However while Rabbi P agrees with Rabbi O on the saving of sperm and lives, he says that life is complex and therefore in certain instances he would advocate the use of condoms. Rabbi P said

Life is complicated and therefore there are a lot of considerations. If the consideration happens to be the life of the person you’re loving and the risks of AIDS for our whole society, we’re making policy for an entire society, you want to do the moral thing, and you have to protect
everybody against the danger, the loss of their life and health. Therefore we have to be positive about condoms in this society, regardless of the Jewish traditions that see this to be an affront to God, because of the sanctity of life

This view of saving life and using condoms as a prevention strategy was echoed by Imama Fatima who said “Getting married the moment you have feelings for a person. That’s the way you are going to prevent it [HIV/AIDS]. Try to abstain from it [sex] until then. But if you do come across it [sex] and you can’t help yourself then try using some protection, condom.”

While Imama Fatima suggested the use of condoms as a last resort, her counterpart disagreed with her. They felt that abstinence is the strategy that would prevent HIV/AIDS. Imam Ali said “yes condoms might help, but in my class I tell them no sex before marriage… I don’t tell them about condoms. It’s strict, our religious principles”. Moulana Omar agreed and explained that condoms are not a strategy for prevention of HIV/AIDS, instead he was of the opinion that it is encouraging youth to have premarital sex, prevent unwanted pregnancies and despite its existence, more people are becoming infected. So therefore he feels that condoms should be eradicated. In this regard he said

Condoms, is not the method to give the youth to protect themselves against HIV, but it’s to prevent pregnancy. Let them experience [sex] and this is detrimental, they must abstain. People think it’s no problem, let’s just get a condom, then you can sleep with anyone, whoever, wherever, a prostitute. The percentage infected with the disease, is there. Condoms are not helping. It must be eradicated. There must be no things that give encouragement that you can continue as long as you don’t fall pregnant

Priests’ Brian and Ted also agreed that people should abstain from sexual intercourse until they are married. However, as Imama Fatima they felt that condoms can act as a preventative measure. Priest Brian said

We wouldn’t be dealing with a crisis of HIV/AIDS if people choose [not] to have sex outside of the covenant of marriage. [Therefore] dating couple may well kiss but there is other physical area, when people have sex that they wouldn’t want to go into. As for condoms, as far as I am aware there’s no reference to the use of condoms [in the bible], but there are a lot of principles in the bible that we can use and it’s really a measure of safety. I don’t have a problem with the use of condoms
Pastor Allen and Pastor Jeff, while agreeing with the cohort that advocates abstinence, however they disagreed with those who promote condom use. Pastor Allen said:

There’s this saying prevent AIDS and condomise. We had people come here to talk about AIDS and then they brought across, ‘you young people if you can’t withhold yourself from sex, use condoms’. That we don’t allow, so we had to speak to the young people again and say the things that lady said were excellent but condomising is wrong, condomising gives you an alternative to sin. We are against condomising. They must abstain.

Pastor Jeff agreed that as protection from infection, people should abstain from having sex outside of marriage. He said “They talk about safe sex, use condoms, condoms are not helping them. It is encouraging them to have sex outside. It’s not right”.

While Bianca agreed with the Rabbis’ about not spilling sperm, she disagreed with the cohort that suggested abstinence. She was of the belief that she was not in a position to dictate the time of intercourse to people. She said “It is not the right to put your sperm into a bubble and throw it into the garbage, and it’s not right for me, we cannot tell people not to have sex, it’s natural”. Therefore condoms were not an option for her and neither was abstinence a prevention strategy.

As for the three Sangoma’s, and as previously mentioned, they all consented to advocating the use of condoms as a prevention strategy, as Chiko explained “If they don’t understand. I sit down with them and advise them if you use a condom this is going to save your life and it’s going to prevent pregnancy and sexually transmitted diseases”.

Mamela also promoted condoms and said “I would be glad to have condoms because sometimes people who have venereal disease, even though I advised them not to have sex, and they go back to square one, then they think the treatment I give doesn’t work”.

In the main condoms were regarded as an inappropriate means of prevention. However there were respondents within religions that thought of it as a last resort to save life. Such contentions appeared within the respective religion, as in the case of the Muslims, two Christian leaders and a Rabbi. Further probing into prevention strategies presented
findings about how respondents felt about encouraging HIV/AIDS testing as a means to assist prevention.

4.4.1 Testing: Assisting prevention or highlighting inequalities of who tests

HIV/AIDS Testing was predominantly mentioned by the Rastafarian and Muslim respondents as a means of prevention. This was so because both these religions allowed their males to engage in polygamous relationships. The second wives or partners were expected to take the HIV/AIDS test. Both the first wife and the husband were not mentioned as having to be tested as well.

With regards to this Bianca explained that “My king can take another queen, but he must see to it that that queen be tested. Otherwise I cannot go have sex relation with him because then he come and has sex relation with me... Once you become of a sexy age and you find somebody who you want to have sex, I say go get tested”.

All three Muslims agreed that the husband should ask his second wife to have herself tested for HIV/AIDS, and in Imam Ali’s case he specified a time for testing, “before marriage”. Moulana Omar concurs that “In today’s times it is essential for her to test. I mean the second wife, to see if she is HIV positive”. Imama Fatima agreed and adds that she also encourages her learners that are sexually active “to go for a HIV/AIDS test”.

As for the Christians, they too regarded testing as an important means to prevent further infections. However in their cases it was not to facilitate polygamous relationships, it was simply for openness before entering into marriage. For example Priest Brian explained that testing for HIV “Is an important thing. I would encourage people, so that there’s clarity of what they are getting themselves into, before marriage”.

While the leaders above encouraged testing, two leaders felt different about encouraging HIV/AIDS testing. The first was a Rastafarian Elder David who raised a different concern that HIV/AIDS testing may encourage people to continue engaging in illicit sex.
He said: “If the people have to pay for the testing, and he can afford to take tests every time because if you can afford, he’ll just keep on doing it [sex] all the time, outside [of a long-term-stable relationship]”.

The second was Rabbi O who felt that testing wasn’t necessary in his community.

Testing is not something which we are that concerned about. I don’t think that I would need to do that because even though I do know that in many cases the couple has had premarital sex, the reality is that generally with people that are much more trustworthy, I wouldn’t do it. There might come a time when I might have to do it and I can see the wisdom in it. If it was necessary, as I said I do think that Jews are not a terribly promiscuous community

With the exception of the last two leaders, the rest of the cohort was not averse to encouraging HIV/AIDS testing and saw the exercise as a means to assist in preventing and protecting people from infections. Further probing for prevention strategies will now be presented in the last section of this theme with regards to medicines is investigated. Specifically, the investigation centres on whether or not leaders choose to encourage the use of medicine for infection. Furthermore, if they do promote the use of medicines the study explores what alternatives they promote for people as a means of prevention.

4.4.2 Curing HIV/AIDS: spiritual or physical healing

Different leaders respond differently to the use of Western Medicines. Interestingly, the only religious group that was confident in curing HIV/AIDS was that of the Rastafarians. The rest of religious groups either promoted western medicines, a combination of traditional and western medicine, or in the absence of a medical cure, offered spiritual healing through repentance.

All six Rastafarian respondents were confident that they had a cure for all diseases. The cure though was related to a particular ‘religious practice’. They were also of the opinion that modern medicine was not an adequate means to cure HIV/AIDS or other diseases. For example, and as previously alluded to, Bianca explained why, according to her, Rastafarians are not infected with HIV/AIDS or other illnesses. She said
Amongst us HIV is never something that I have seen, very scarce. I don’t know any Rasta that has that disease. We heard that there is HIV but I feel Ghanja is in our blood, it’s already full of Ghanja. Ghanja is protecting us from getting any disease. It warms your blood and therefore kills other things before it gets in. It’s the herb that we use for healing of the nation, not just the Rasta, but the whole population of the world use Ghanja

She also explains why she does not promote the use of anti-retroviral drugs and why in her opinion, it is not a useful prevention measure. She said “Anti-retroviral, the thing has gone through the gate. Why not try to curb this thing before it happens. These drugs are not going to get you better. It’s like you have a toothache and you take tooth medicine to ease the pain. When the medicine has gone the pain comes”

The Sangomas’ have a different view to that of the Rastafarians. While they are using traditional medicines to cure various illnesses, they seem to be treating the symptoms of HIV and not necessarily the HI-virus. Mamela explained: “I know about HIV”. However she says that “it’s not enough for me to say yes I treat HIV, when anyone comes with HIV, I try to mix this and that to see if it can help”.

Tando also indicated this sentiment and said that

I treat venereal diseases like gonorrhoea, syphilis, herpes, I see frequently. I use medicines, herbs and animal products. One way or the other, I will give them something to wash with, to inhale in, to steam, to smoke or to drink. If there are some sores on the sex organs, so they [people] will come in summer in October to December. But not HIV, I send [them] to test at clinic

Chiko shared his counterparts’ views and explained “I know of HIV but I treat TB, cancer, asthma and if you have syphilis, I give you something like an ointment. If it’s gonorrhea I will give you something to drink or an enema. For sexually transmitted disease, most of the times, I tell patients that they must also always use the condoms”.

Both Chiko and Tando preferred to refer patients to the nearest health clinic or hospital if they saw that the patients were “terminal cases or if matters are beyond our control” as in the case of HIV/AIDS, so that these patients can receive “western medication”.
While the Sangomas treated the symptoms of HIV/AIDS with traditional medicines, it remained their preference to refer patients who are in their final stages of HIV/AIDS or who are terminally ill to the nearest health clinics. Rastafarians on the other hand attempted physical healing with the aid of their traditional holy herb (Ghanja). The rest of the cohort sees curing as a process whereby it is not only healing the physical body, but curing the person spiritually. Religion, sin, obedience to God, forgiveness and repentance were element of this curing process and did not have direct bearing on the question of implementing actual medical prevention strategies. For example
Pastor Jeff was of the opinion that healing can take place if the patients rid themselves of all hatred. He said

"Aids can be healed. But in the name of Jesus, we’re not talking about a religion now, but in that name Jesus. So I say to the person, you need the healing, he can be healed of his AIDS, that person must come 100%, but that person also, have to search their lives and all the hatred with all the family, he must be released of"

Healing for Priest Brian will occur with sacrifice. He explained that “In the Old Testament they use to sacrifice lambs to receive forgiveness of sins and healing. Jesus then was sent as the ultimate lamb, which was slain. His sacrifice then became enough for our sins and healing”. Pastor Allen’s way of curing included an explanation of where sin started because in his opinion, illness occurs when people sin. He explained that

"He is a God of love, He will forgive you, He can heal you or He can restore, sickness started with Adam and Eve sinning. Sin is disobedience to God. We pray for sick people, that is not God [making them sick], but Satan that has touched that sick and afflicted the person. God’s intention is to heal. Sin sticks like glue and to get rid of it, you need to say Lord, I sacrifice this, I give this up, like illicit sex"

The Muslims also believed that, in the absence of a medical cure for HIV/AIDS, spiritual caring should be encouraged. They suggested that patients should beg for forgiveness because, and as previously mentioned, sin in their opinion was resultant from people behaving and indulging in irreligious sexual behaviour. HIV/AIDS is thus seen as the punishment for such behaviour. For example Imam Ali said that “there is a chance for them [PWAs], to repent for their sin before they die, because God is most forgiving”. Moulana Omar concurs with Imam Ali and referred to his friend that died of HIV/AIDS
and said that “there’s no cure, God will decide on the cures time. My friend, the creator will forgive him for that sin, because as time went by he had repented”

While Imama Fatima agreed with her counterparts to beg for forgiveness for curing of sins, she also advised her HIV positive friend to take her medication that doctors prescribed. She said

Just prepare yourself for your death, now that you are ill, first God has mercy on a sick person so ask for forgiveness. I told her how to live now, because she has a short period to live. She did mistakes in her past and she told me, so I advice her to live a better life now, caring for herself and taking her medicines. Just speaking to her I could see that she knew what she did was wrong and if she could rectify it she would have

Imama Fatima and the Sangomas were not the only that encouraged the use of Western medicines, the Jewish leaders’ also encouraged the use of Anti-retroviral drugs. Rabbi P explained “there are scientists that have uncovered a range of phenomenon that can be treated by some medication and sick people’s lives can be improved, they can be enhanced although it’s not a complete cure form HIV”. Rabbi O felt that while many “Jewish people are involved in the Treatment Action Campaign who promote Anti-retroviral drugs, Government should be more helpful” in providing these drugs to people that are HIV positive.

Having gained insight into the various responses to disease prevention strategies, the study will now explore whether or not leaders offer care and support to sick persons and their families. If respondents were involved in offering care and support to the diseased community, the study presented findings that indicate to which extend they offered support.

4.5 Care and Support

This theme relates to respondents responses in relation to their role regarding care and support of diseased people. The first part of the theme looks at a category of pastoral caring generally. The second category looks at specifically experiences with caring for
HIV/AIDS sufferers. In this way the study not only gains insight into how respondent respond to disease on the whole and to HIV/AIDS, but it looks at evidence that shows if respondents have experiences with HIV/AIDS and to what extent they actually get involved with the sufferers.

4.5.1 Pastoral care

An important obligation that all religions demonstrate is that of pastoral care. Amongst the Muslims, pastoral caring is a religious obligation irrespective of the type of illness or the reason for its occurrence. As such, Imama Fatima explained that “As Muslims we must care for all religions, not only for ourselves and I do worry about others that are ill”. Imam Ali added that “Whenever anyone is sick…. We must be there for them…we go to their houses and we see to their needs”. Moulana Omar agreed and said “In the Quraan we are taught that the elderly and sick…you have to see to their needs, look after them. We’ll be punished if we’re no looking after them”.

A similar view was held by Christian leaders. Pastor Allen explained that his churches “ancestors were missionaries, they were people that go to hospitals, visit children who got AIDS. We encourage people to visit, be it AIDS, cancer, whatever we go out there, try and reassure people”. Priest Ted learnt about pastoral caring when his dad died. He said “Before he [dad] died a catholic priest came around and said that my dad had asked him to tell us the news that dad had AIDS and he [the priest] counselled us to draw close to my dad because this was our last patch of time with him” and therefore he believes in the importance of pastoral caring. Pastor Jeff’s was of a similar opinion and said that “my church is in the health ministry… open to any denomination …the bible says pray and care for the sick then they will be healed”.

The Jews agreed with their counterparts that pastoral caring is a religious obligation. For example, Rabbi P said that their “responsibility of Jews is to help them [the sick] as much as possible… show honour, respect and you have a duty to them”.  

74
Similar care and support was demonstrated by Sangoma’s. For example, Mamela explained that besides supplying medicine, she also “advise patients about personal health, that during treatment they should not have sexual exchange or I advise [them to] go to the chemist and take medicine to be cured”. Chiko explained that “I usually get a vision whether the patient is going to be healed or not, and even though I knows that the person is going to die I’Il give them this concoction or that, go home and take a cup or two” to soothe the person. Tando added that “sometimes people come to him at a later stage of their health deterioration and I think of them and gives them the medication free of charge and I send them to hospital. Some of them refuse to go, and then I do what he can for them but obviously [those] people pass away”.

The Rastafarian respondents also indicated a high commitment to care and support of the sick. Bianca said that “if somebody is sick, we take that person to the doctor … then we give those herbs and lots of caring”.

It is evident that all respondents do provide pastoral care to those that are diseased since they perceive it as a religious obligation. While this is the general trend, the following section highlights tensions in caring for HIV infected persons. The section highlights the degree to which respondents provide caring and also what experiences respondents have with specifically HIV/AIDS.

4.5.2 Experiences with caring for HIV/AIDS sufferers

While caring for the sick was a priority for all leaders, some leaders indicated that they do have experiences with caring for HIV positive persons and others indicated that they do not have any experiences with caring for HIV positive patients.

Reasons for the latter responses varied. Some explained that they had experiences with caring for people that suffered of diseases such as cancer, but that they had no experiences with caring for people that suffered of HIV/AIDS. Others explained that their
lack of experience in this area was because, as they believe, the disease was non existent in their communities while another leader felt that their duty was time bound.

The Rastafarians for example, reiterated that they are not infected with HIV/AIDS and thus they were of the belief that they are not in contact with infected persons and do not have to care for HIV infected people. However they do indicate that previous Rastafarians have had experiences with the disease because the disease is evident in their traditional songs. Within these songs earlier Rastafarians warned the next generation about the dangers of HIV/AIDS. As Elder Solomon said

AIDS amongst us Rastas, there has never been a Rasta which was HIV Positive. We try our best to make people alert of HIV, because it was there before. Rastafarian singers from 1980, 1985, 78 they used to sing about this AIDS long time. It is said that if you get AIDS your life is gone, if you get sick don’t go to the doctor because the doctor himself looking for a cure. So watch yourselves

While the Rastafrians felt that they do not have experiences with caring for HIV positive people in their community, because they have been forewarned, this notion of not having to counsel an infected community was also echoed by Rabbi O who reiterated “As I mentioned before, I don’t think it’s an enormous problem because I don’t think that in general that we are a terribly promiscuous community, generally we’re not. I was never faced with it[ having to care for an HIV positive person]”. His counterpart Rabbi P however felt that caring for HIV positive persons is the responsibility of the family and not the rabbi. He explained that “yes” he knows HIV positive people in his community and “yes” he works with them, but when it comes to visiting them regularly, he said

No. Basically I encourage the families to do what they’re supposed to do as families because it is the family that has to cope with the situation. So the Rabbi is like an angel. He pops in at the right time, sees the family at the right time, at some critical time at critical surgery, if this happens It’s all a matter of timing and being there at critical moments like just before death

As for the Christians, Pastor Jeff said that he had no encounters with HIV positive persons. However the rest of the three Christian leaders have had first hand experiences with HIV sufferers. Priest Brian explained that “we deal with it at the Red Cross Children’s Hospital and [at] an AIDS Orphanage Centre. We work with AIDS babies”.
Pastor Allen’s experiences with HIV/AIDS were similar to that of Priest Brian’s. He explained that “some of us went to the Red Cross and prayed for a child there. When we came out we said we need to get our youth involved. So we are implementing ways to help. Our thinking is not changing about condoms but we need to balance out and we, say, what about the people with cancer, what about people who say I’ve got AIDS, what about these little babies lying in hospital. So we started to formulate groups”.

Similar to Priest Brian and Pastor Allen, Priest Ted had experiences with HIV/AIDS as he assists Priest Brian with Red Cross Children’s Hospital and an HIV/AIDS orphanage for HIV positive babies. However Priest Ted’s experiences with HIV/AIDS were also of a personal nature. He explained:

My father had a homosexual affair and my mother was devastated. He tried to change but her trust had been betrayed. He died due to a homosexual life. I discovered this later in my life. It was a secret that my dad was gay and that he died of AIDS, it was a heavy secret. Two guys at the church discipled me, counselled me, and told me to write a letter to my father, just to help me deal with it. I remember crying while I wrote and then for weeks just being sad and he explained that this is a normal grieving process. I said – Dad, I told him the good stuff, how much I loved him, how much I missed him, how amazing he was. Then I said dad, why were you gay? Why did you do that? Dad, didn’t you love us. I basically expressed all the irrational emotions that were very real to me. I gave myself space to feel and not to try and rationalise everything. I struggled with his relationship with W. I told him that I was angry that he had left us. It was because of his irresponsibility, his selfish living that he had died prematurely and he had left us. I expressed some of my disappointment too.

Similar to Pastor Jeff, Imam Ali has not had experiences with HIV positive persons but he explained that he has had experiences with death caused by disease. The two remaining Muslim leaders both had first hand personal experiences with HIV positive sufferers who have died.

Imama Fatima’s experiences were similar to that of Priest Ted. She was still saddened when she said:

I had a friend, she got infected through sexual intercourse. She never knew. After she discovered about a month after she passed away because she wasn’t on any medication. It was a really emotional period for me because I was in shock but it opened my eyes. She was so young if I
should get the opportunity to work with somebody again or to speak to the person I will definitely do so because in my opinion it does and did make a difference. I would tell her that you should allow that yourself to be sick because you know you are sick, just try and do everything better, eat healthily, and take care of yourself, even though she wasn’t a Muslim. She didn’t want to go on to any medication. Personally I felt bad because I was thinking that I was giving her advice, but at that time I didn’t know much of HIV. So I didn’t really have good advice for her. But now that it has happened I speak to many people who know about the disease. I just had a guilty conscience because it was my friend and I could have helped her in some way. I have learnt a lot from the experience of talking to her, caring for her and listening to her. Advising her to pray and allow herself to be sick is ok and accepts her illness.

Moulana Omar’s experience was similar to Priest Ted and Imama Fatima. He said

It’s a friend of me, I didn’t know this he’s HIV but this was a personal situation. I didn’t recognize him first because he became thin. He was a fat guy and became skinny. But I didn’t know really what his problem was. I would give him inspiring talks from our Quran. The advice which I was suppose to have given him if only I had known his problem I had to be patient. I told him that it’s a test from our creator. And this is not a lasting life, all people in this world... leave this world. So we were preparing for his eternal life after death. He is drawing the help of the creator. And the creator is 100% with you. Have patients and just look forward to your life after death, just focus and pray. And pray for us also because his prayer is more accepted. And he died.

All the Sangomas indicated they have had experiences with HIV/AIDS because they are regarded as the healers in the community of any disease. Mamela explained her recent experience with an infected person was “last year, a girl 16 years came over to be treated and said, ‘please use gloves because I am HIV positive’, so I used gloves. In some cases they don’t know that they have HIV, until it’s too late. But I help them”.

Chiko explained that his has experiences with the disease because

Some of them infected ones come here and I refer them to the clinic first for testing because it goes back to the visions. I might see that this guy shows AIDS related symptoms because AIDS is not a new disease. I don’t want to repeat President Mbeki’s because for sure people here do die of TB, die of pneumonia but also AIDS. I see

Tando explained how he goes about treating people that are HIV positive.

Somebody is positive, sit down with them; tell them that being HIV positive doesn’t mean that you’re going to die tomorrow. All you need to do is to accept it, come to us and we’ll give you
treatment. That’s to keep it stable, I calm them down. I tell them I not necessarily going to get rid of it. Some Sangomas say they are able to get rid of it but there’s always a dispute.

It is evident that while pastoral caring was exercised by all the respondents, there were some of them that had little or no direct experiences with HIV/AIDS as a disease or with victims. Here it is also evident that some respondents choose not to become involve, while others are offer time with HIV positive persons. A last group that is evident is the respondents that have had personal encounters with the disease and in all cases offered caring and support.

This chapter has presented data collected that expounds on religious leaders and traditional healers’ Knowledge and Conceptions of HIV/AIDS, their perceptions on disease prevention strategies in relation to their respective religious belief systems, and their views and involvement with care and support for the diseased. This presented data will now be analyzed and discussed in the following chapter. The literature reviewed in chapter two will also form a part of this discussion.
CHAPTER 5: ANALYSIS, DISCUSSION AND RECOMMENDATIONS

5.1 Introduction

The findings in chapter four suggest that there is no single response to the way in which religious leaders understand and respond to HIV/AIDS. Responses showed agreement and disagreement both within and across religions and highlighted the inherent tensions that resulted from trying to maintain the traditional religious practices on the one hand, and responding to specific contexts on the other.

In this chapter I shall frame my discussion within the parameters of ‘open’ and ‘close’ discourses. I use this framing because it best describes the findings, it acts as an indicator situating where the HIV/AIDS dilemmas stem from and shows where attempts are made to combat the disease.

5.2 Analysis and Discussion

This discussion centres on two religious discourses that emerge from the findings, namely ‘close’ and ‘open’ religious discourses. The discussion is broadened by the tensions that arise within these discourses.

The ‘closed’ religious discourse is characterized by being scripture-based conservative, moral, traditional and resistant to transformation. While the second religious discourse still adheres to basic religious principles, it is more open to discuss and view specific issues that arise in the context of HIV/AIDS. Before the study discusses the two discourses it is evident from the literature review and from the findings that religious leaders and traditional healers are in key positions to disseminate messages about various issues such as sex, sexuality, disease, etc (Machido (2004) in Kalipeni et al 2004 and
Menka 2005). Their positions, as chosen individuals, who are able to connect with the spiritual world provide an authoritative stance and an authoritative voice in their communities. Thus they are in positions to create and provide the script that prescribes, for example abstinence, non-compliance to condom use and abortion, to name only a few. Of importance to this script and specific to this study, is leaders and healers’ historical embeddedness. Leaders’ historical embeddedness, especially with regards to sex, disease and religion, contributes to their authoritative voice (Makhuba 1978, Giddens 1997 and Allen 2001).

The study will now discuss the first conservative religious discourse in relation to the findings. According to Giddens (1997) the onset of modernity created change in various institutions, but religion remained to a large extent unaffected. This is evident in the data where most religious leaders continue to encourage people to adhere to traditional religious principles whenever they encounter issues in their daily lives. Scientific initiatives such as condom use, HIV/AIDS testing and using Western medicines, produced various responses, but the majority holds onto a conservative discourse. These leaders claimed that religions forbid people to use condoms because it interfered with the primary religious purpose of sex which is procreation. This is in keeping with the literature reviewed. Allott (1999), for example emphasized that religion not only has the ability to influence peoples’ sexual choices but provide guidance from a religious perspective if people feel unsure about the purpose and context of sex. The findings are also synonymous with authors Bullough and Bullough (1994: 514) who highlights that the religious leaders’ positions sex in a “fixed world view”. This view correlates with a closed religious discourse where collective identities guide people and presents a ‘traditional religious leader’ to direct the process (Durkheim in Cosman 2001). However, this traditional discourse seems however, isolated from modernity and reality. This means that leaders respond the way they do because their frame of reference is a traditional religious perspective, that encourages adherence to a literal reading of religious scriptures despite the fact that people are living in a modern society that gives rise to modern challenges such as HIV/AIDS. According to Menka (2005) and Allott (1999) the encouragement of traditional adherence does not account for the reality that
people do engage sexually outside of the fold of marriage without regard to procreation and familial arrangements (Menka 2005). So ultimately the discouragement of religious leaders to use condom protection allows, inadvertently for further HIV infections to occur.

The literature review and the data indicate that not only was procreation perceived as a priority over condom use, but condom use was also seen as encouraging people to engage in illicit sex outside of the fold of marriage (Slowinski 1994 in Bullough and Bullough 1994). This was especially the case with the two Muslims, all the Rastafarians and two Christian leaders. The orthodox Rabbi also felt that condoms were not necessary in the Jewish religion because, in his opinion, Jews are not a promiscuous community. What does create tensions here is the fact that people have experienced “individuation” (Berger 1997:70) where they exercise their choice of, for example, wanting to procreate at every sexual encounter or wanting to engage sexually for pleasure and using condoms, remain the person’s decision. Such choices have resulted in tensions for religious leaders who have to oversee the execution of rigid religious principles within communities that are making choices outside of the religious boundaries.

The anomaly to this was religious leaders who present the study’s second religious discourse. As previously mentioned, the second religious discourse adheres to the basic religious principles, but modernity has filtered through and has opened up this discourse. Therefore this discourse takes into account the reality of communities and the anxieties created by modern life where, for example, as the data indicates, more people are engaging in sexual activity at younger ages than in traditional times. This, together with the understanding that religion intends to preserve life, is important to these leaders. Therefore, their responses were different from the previous cohort in that the latter cohort encouraged people to use condoms as a means of protection. These leaders emerge in this study as ‘traditionally modern leaders’.

It should be noted that these traditionally modern leaders were a minority group in the study. They were the Sangomas, two Christians, one Muslim and one Jew, that
contributed to the opening of this religious discourse. These open and closed discourses will continue to form a part of the discussion as the chapter progresses because this indicates where the problem lies. The closed religious discourse, does not contribute to the combating of new HIV infections. It is the open religious discourse that allows for transformations of perceptions of HIV/AIDS and thus is open for discussions and debates since the leaders are comfortable in discussing a contentious disease such as HIV/AIDS and takes into account modern reality (Moswin quoted by Easom 2005).

The literature indicates that from a scientific-medical perspective, there is no cure available for HIV/AIDS and that the infection rate is soaring (UNAIDS 2005). However, the data and the literature indicate that the Rastafarianism religion is one religion that claims to be able to cure HIV/AIDS through the use of a holy healing herb called “Ghanja” (Pettiford 2000). These leaders are of the belief that their God expects of them to use the healing herb that He provided for them. Therefore, they are guided by their religion to discourage HIV positive people from using antiretroviral drugs. Instead, they encourage the use of “Ghanja”, which is historically and globally seen as an illegal intoxicant and has not been scientifically proven to be a cure for HIV/AIDS. Once again the closed traditional religious discourse surfaces, where the authoritative voice disallows the questioning of a traditional practice and further prohibits the use of modern medicines that has been scientifically proven to support HIV positive person’s lives. Moreover the study considers the possibilities that HIV infections can penetrate Rastafarian communities because their men are allowed to enter into polygamous relationships as part of their traditional practices and given that condomising in all sexual relationships is not allowed the possibility of infection is high. While the data indicates that Rastafarian leaders can cure HIV/AIDS, the literature shows in Green’s study that a group of traditional healers also indicated that they are able to and have already cured HIV/AIDS. Contrary to this, the data indicates that all three Sangomas researched in this study were aware of HIV/AIDS, but were unable to cure the disease. Instead, they specify eagerness to obtaining more information of the disease. Evident here is an open religious discourse where, while leaders provide traditional herbal remedies for symptoms of the diseases, they acknowledge that they have limited knowledge of the disease. They are not opposed
to using western medical technology and western medicines to compliment their
traditional remedies. They further open the discourse when they encourage the use of
scientific initiatives such as condomising and encouraging their patients to have
HIV/AIDS testing done. Their approach may assist in combating the disease especially
given the traditional practices of polygamy, where the purpose of sex is to sustain the
descent of tribes and where women have to prove their fertility (Phillips in Kalipeni et al
2004).

In addition to the preventative measures mentioned above, the management and
interpretation of knowledge strongly impacts on the responses to the disease. According
to Quetel (in Brandt and Rozin 1997) sexually transmitted diseases were traditionally
perceived as having occurred as a means to punish the victim for having indulged in
immoral sexual behaviour. Immoral sexual behaviour was regarded as an irreligious and
sinful act, and is punishable by God (Allen 2001). The data indicates a similar belief
where all the Muslims, all the Sangomas, one Rastafarian and two Christian leaders’
perceived the occurrence of HIV/AIDS as being linked immoral sexual behaviour and in
some cases it was regarded as also sinful and punishable by God. Once again it is evident
that such responses are based on a literal reading of the scripture which emerges as the
authoritative discourse. Within this discourse the interpretation of disease is based in a
closed religious discourse where scientific diagnosis is not considered. The emphasis of
diseases remains focused on how infection occurred and not necessarily what the cause
is. These findings suggest that an authoritative discourse is also a closed discourse since it
does not allow for change and transformation. The responses of the Rastafarians were
interesting as they reiterated that because they use Ghanja, HIV infections do not exist in
their religion. However, they mentioned that should such infections occur in their
communities, it would be because of poverty. Their explanations centred on women who
would engage sexually with men in order to obtain financial assistance to support their
families. Another consistent response was that of the Jewish leaders who emphasized
blood as the key transmitter of the virus. The leaders mentioned sex as a possible means
of transmission, but their knowledge of blood as a means of transmission remained their
focus.
With regards to their knowledge of contraction and vulnerability of HIV/AIDS, responses varied. For example, the Rastafarians persisted that HIV/AIDS do not exist in their community because they smoke Ghanja. The HIV/AIDS denial notion of Rastafarians is also evident in the orthodox Rabbis response that his community is traditionally not promiscuous and he offers the explanation that Jewish people become vulnerable to contracting the virus accidentally especially in their workplaces. Denial, as could be seen above is not consistent with what statistics shows that irrespective of religion, race or sex, HIV/AIDS infects any community (UNAIDS 2005). The study perceives such denial as a ‘tension coping mechanism’ or as a means to avoid confrontations with tensions that arise from the shift in communities traditional practices. This means that people no longer conform to traditional practices, instead they are informed by their individual choices that may not be necessarily aligned to traditional patterns.

Furthermore, the study is of the opinion that the above denial stems from an authoritative religious voice that leads their communities to the belief that HIV/AIDS is not occurring within their communities. However, the consequence of such a belief is that people in these communities will not battle against the disease or even attempt to employ preventative measures. The concern remains that such an authoritative voice is in an influential authoritative space can assist in combating new HIV infections. However, it would seem that the authoritative voice, in this instance, instead may contribute to the increasing infection rates.

The discussion around vulnerability of HIV/AIDS in the Rastafarian community was limited to, poverty that cause women to prostitute and poor black people disadvantaged by government. The discussion omits the reality that Rastafarian men are allowed to engage in polygamous relationships and that condom use is not permitted because the religious prescription that procreation cannot be restricted. Similarly, to the Rastafarian religion, Muslim leaders’ based vulnerability and contraction of HIV on people that engage in deviant and immoral sexual behaviours. However, within the latter religion men are allowed to enter into polygamist marriages, which present possibilities for further infections. This is said in light of the adherence to the Muslim religious law that
prohibits the use of condoms. One Muslim leader however indicated that she advocates the use of condoms to her congregation. Within both these religious groups a concern arises that women are more vulnerable than their counterparts because they may become infected in a polygamous relationship or because they are the ones that prostitute for a living, especially young Rastafarian girls. The responses of Muslim leaders was very interesting when they suggested that in a polygamous marriage the second wife ought to be tested for HIV/AIDS, but no mention was made that the husband should take the HIV/AIDS tested. This emphasizes a close religious discourse that perpetuates male dominance and ignores the reality of female vulnerability.

While three Christian leaders thought that people who engage in immoral and deviant sexual behaviour are vulnerable to HIV infections, dissenting views arose from a Christian leader who was of the opinion that non-white people and medical staff are also vulnerable. Another dissenting view came from the Progressive Jewish leader who specified that vulnerability and contraction do not occur due to promiscuity, but emphasized that irresponsible behaviour of people does occur. This Rabbis’ view is regarded as being part of an open religious discourse because he suggests that people should be educated about their responsibility in sexual behaviour. Similarly, the two Sangomas indicated that people in their communities are vulnerable and are at risk of contracting HIV/AIDS because of a lack of knowledge of the virus and because an ignorance exists about condom usage. The latter responses are from traditionally modern religious leaders that form part of an open religious discourse. According to UCC (2005), religion can play an important role in encouraging prevention of HIV/AIDS and implementing health strategies because of the authoritative position that they hold. The literature shows that traditionally people do turn to the authoritative religious voice if there is no cure provided for an illness (Ahmed 1999) and therefore this study agrees that religion should use such opportunities to emphasize the dangers of the disease and offer advice that is based on community realities and not on traditional challenges that have no bearing to modern challenges as have previously been discussed.
Having viewed that data that emerged in chapter 4 in relation to the literature reviewed in chapter 2, a conclusion could be drawn that religion is situated in an authoritative discourse, which is traditional, conservative and resistant to change. Traditionally this authoritative discourse was sought to deliberate on various issues. However, this authoritative discourse does not take into account that communities have been exposed to modernity and its challenges that are different to past challenges. This authoritative discourse is unable to offer realistic solutions to the combating of an overwhelming challenge such as HIV/AIDS. Therefore the study proposes that, and as could be seen emerging already in some religions, that the new open religious discourse, that was precluded, should be allowed to filter through religions. This open religious discourse may adhere to religious beliefs, however it does consider the rhetoric and realities of modern communities. This is said in lieu of the fact that ultimately the aim of all studies in this field is to contribute to combating any further HIV infections.

As for the positions of both the traditional leaders and the traditionally modern leaders, it is apparent that they are situated in a complex position where they are wedged between their traditional religious beliefs and practices, and modern-day challenges such as the implications of HIV/AIDS. However, it would seem that the traditionally modern leader is working a way to manage disease prevention through encouraging for example, condom use.

The traditional religious leader, on the other hand remains inert and in denial of the existence of HIV/AIDS in his or her communities or that condoms use is an immoral initiative. Thus this leader abides strictly to religious principles, while the second leaders’ shifts between discourses and occupies different spaces with different rules. These rules are applied where and when relevant and takes into account the realistic challenges that people face in a modern community in the wake of HIV/AIDS.

It should be borne in mind that this cohort of religious leaders does not represent the entire religious community of South Africa, and that similar or different opinions and findings could emerge from data collected in the same religious types.
5.2 Conclusion

It is evident that within a modern community religious leaders are still able to influence the way people think about religion and contentious issues such as HIV/AIDS. The study has set out to examine the responses and experiences of religious leaders and traditional healers to HIV/AIDS within a modern community. What emerged were two discourses, a traditionally ‘closed’ religious discourse and ‘open’ religious discourse. The former being distinguished by its adherence to tradition, moral and religious scriptures, epitomizes the close religious discourse that does not allow for change or adjustment of lifestyles. The latter discourse, while still adhering to basic religious principles, allows for modern initiatives, such as condom use, to filter through in order to prevent contraction. The study hinges on the differences of the two discourses and how, when the two are implemented, they can either contribute to combating new HIV infections or encourage further infections. This study though proposes reasons why the open discourse should be encouraged and implemented.

In response to the aim of the study: examining religious leaders and traditional healers’ experiences and responses to HIV/AIDS in a modern community, this study has presented two discourses in which leaders and healers find themselves in a modern society. The study suggests that leaders and healers are either operating in an ‘open’ discourse allowing for intervention of modern preventative methods, or they are situated in a ‘close’ discourse, where religious laws prevent the permeation of modern preventative measures. The study further suggests that the open discourse contributes to the efforts of curtailing new HIV/AIDS infections.
5.3 Recommendations

The following recommendations have been foregrounded through the investigation with regards to religious leaders and traditional healers:

- Religious leaders and Traditional healers’ education and training should include elements of modern medicine. The training should not be limited to traditional aspects only.
- A module of their training curriculum should include the considerations for the contexts of communities.
- Some religious training institutions do include counseling in their curriculum documents. However, this study recommends these documents specifically include training religious leaders to counsel HIV positive persons. HIV/AIDS counseling is already a part of Traditional healers training.
- Religious leaders and Traditional healers should be educated about the legal implication of working with people that are HIV positive and what their legal obligations are as counselors.
- The South African Government should dispense condoms free of charge to Traditional healers as they are in a sense primary caregivers because they provide medicine and assistance in communities where medical infrastructure is lacking.
- Should Religious leaders request for condoms to be dispensed from their institutions, the South African Government should provide for them too.

5.4 Recommendations

These recommendations serve as suggestions for a further study in this field.

While my debate has centred on the issue of religious leaders and traditional healers in relation to HIV/AIDS, my debate followed the trajectory of disease through the ages and more importantly through modernity. All the relevant features of modernity, that impact religious leaders and traditional healers have been dealt with. In other words, I present a leader and healer, who traditionally prefer to talk about sex in a private space. However,
these leaders and healers are situated within a modern society and are faced with the challenge of dealing with a disease that is primarily transmitted through sexual intercourse.

The late 20th century had produced what we have come to call post modernity (Rohmann 2002). It is suggested that these leaders and healers be further researched, still within a sociological sphere, but that the study be set against the backdrop of post modernity and its featured. One such a feature that would be interesting to see emerge is that of the embrace of “ambiguity”. While stemming from modernity, post modernity questions the notions of “meta or grand narratives”, and produces the idea of human multiplicity, in all respects, identity, relationships, culture and lifestyles and so on. Postmodernity further encourages a shift from “traditional narrative mode of knowledge” and encourages that the unspokenness of a patient be embrace and be regarded as normal (Rohmann 2002: 310).
REFERENCES


De Young, K. 2001. *Aids challenges religious leaders*. Washington Post. (Date: 13 August; p.1)


Lipner, P. 2002. *Who are those most fit to serve as Jewish Leaders?* San Francisco: Jewish Community Publications Inc.


APPENDICES

Appendix A: Contexts of respondents

This section talks about the space that the respondents find themselves in. Observation sessions were helpful in obtaining this information and in describing their spaces.

MUSLIM DELIVERANCE
In this section I dealt with 3 leaders. They were Imama Fatima, Imam Ali and Moulana Omar.

Imama Fatima is a female religious leader, who taught Life Orientation at a school in the Southern Suburbs of Cape Town. The school where she taught had a Wednesday period when religious instruction was taught. I first met her in a parking lot in the school grounds. I noticed that she wore a pardah, the traditional Islamic garb, for women that cover all parts of the body including her face. She was friendly and invited me to her classroom. Her room was large with tables and chairs facing a chalkboard. Her table was situated in front of the class. When her learners arrived I noticed that some of them were wearing headscarves and when she greeted them she revealed her face. She explained that she only did this because the class compliment was all girls.

During her teaching she engaged all her learners, however she remained seated throughout the lesson with no unnecessary body movements. The girls responded freely to her. Her lesson focused on HIV/AIDS education and it was evident that she had covered the topic HIV with her learners prior to my visit. Specific to the lesson that I observed: she was revising what they had done in their assignments. Imama Fatima was unambiguous in reiterating correct biomedical facts and allowed learners to talk about their personal situations that they found themselves in while doing their assignments. She ventured slightly into how the disease affects women socially at the learners level, which
was grade 4. On enquiry I found that she was neither employed by the WCED or governing body, instead she worked voluntarily every Wednesday at this school. She indicated that she has been working in this community for two years.

She was born and raised in Mitchell’s Plain, in the Southern Suburbs of Cape Town. All her life and at the time of her interviews she lived in a place called Strandfontein. She explains that her youth was “wonderful, with very different experiences”. She regards her parents’ divorce as being one of the difficult experiences in her life. Despite this Imama Fatima was grateful to her God for “providing me the strength to endure this at the tender age of ten”. She has two older brother and two younger sisters, and her family has always followed the Muslim religion.

She attended three different schools in the area. Imama Fatima says that she has completed courses in counseling and formal Islamic studies but has no formal training as a teacher. However she has always wanted to be “an Islamic teacher”. She described her role as a teacher as providing “advice” and educating the community about Islam and issues that surface within the community.

For the past five years she has been counseling people in her home community for various problems. Imama Fatima separated her work and home communities. She explained that the communities differed vastly in that her work community was rather ‘close’ and that they do not talk to their children about sexuality issues or HIV/AIDS. In her home community people were more interested and eager to assist her.

During her interviews she remained candid, confident and comfortable in her responses to questions about HIV and sexuality. She had no problem in being interviewed more that twice. At that time, Imama Fatima was not married but intended to do so soon.

Imam Ali, a male religious leader, taught Life Orientation at a school in the Southern Suburbs of Cape Town. He taught at the same school as the previous Muslim religious leader. While Imama Fatima took the girls for Life Orientation, Imam Ali took the boys.
A week after I observed Imama Fatima I observed him. On meeting with him I noticed that he was wearing traditional Islamic garb for men. He had a stern look on his face when I first met him, he instructed me to follow him to his classroom. His room was large with windows lining the sides. Tables and chairs were neatly placed in rows facing a chalk board. The teacher’s desk was placed at the side of the room. When his learners arrived they were lined up in rows and they moved quickly to their seats. Some of them were wearing their traditional Islamic headgear. Imam Ali explained that he only teaches the boys at the school and that that lesson was specifically for a grade 4 class.

During his teaching he engaged all his learners, and moved around the classroom all the time. The boys were less responsive than the girls. His lesson had the same focus as that of Imama Fatima’s, with revision of HIV/AIDS and handing in of assignments. Ali was clear in revising the biomedical facts of the disease. He however did not ask the learners how they felt about doing their assignments. As Imama Fatima, Ali was not employed by the WDED or the school governing body. He too worked voluntarily at the school.

Imam Ali was not very responsive during his initial interviews that focused on his personal life. He did however mention that he had formal training as a Muslim religious leader and that he resided with his parents on a farm in the Southern Suburbs. He was unmarried at the time. During his interviews he initially appeared nervous but soon warmed up to my discussion and did not hesitate to provide details of his work. Imam Ali indicated that he travels in to work and that the community at home was different to his community at work.

Moulana Omar, a second male Muslim leader was also from the Southern Suburbs of Cape Town. He taught in an all Muslim school where male learners learnt to memorize the Qur’an. This school was attached to the mosque and Moulana Omar resided in the immediate vicinity. This leader serviced the community surrounding the sample school as well. On visiting with Moulana Omar it was imperative for me to be accompanied by my spouse, since his religious rules did not allow for him to mix freely with unfamiliar women such as I was. The location wherein the interviews were conducted was an
upstairs room of the mosque building, away from the immediate view of other staff members. Moulana Omar emphasised his fear of “fitnah” or local gossip that he was seen with a strange women. For these reason, I asked my spouse to accompany me as a passive observer. Moulana Omar’s workspace consisted of a wide open space that was carpeted with no furniture. He and his learners sat on the floor while they engaged the teaching.

On my arrival I was greeted by a humming sound of boys reciting and memorizing their verses from the Qur’an. He shared this carpeted space with other teachers. Every one, including Moulana Omar wore traditional Islamic garb. At the time of the interview Moulana Omar was working in his community as a Muslim leader for about 3 years.

Moulana Omar was born in an area called Mitchell’s Plain in the Southern Suburbs of the Western Cape. He has three brothers and two sisters. He was the second youngest. He adds that they all follow the Islamic faith. He lived in and was reared in Mitchell’s Plain and attended schools in the vicinity. As a youth Moulana Omar experienced traditions from both the Muslim and Christian faith because his father had converted from Christianity to Islam. He attended church schools as well as Muslim schools and he never felt any “rift” between the families’ religions. After completing matric he left to study the Muslim religion in Newcastle. At the end of his second year, he felt the “need to marry and settle” into family life. He remembered a girl in his class. He was familiar with her and she fulfilled the criteria, according to Islamic Law, for being chosen as a wife. He proposed to her father. Since courtship is not allowed in Islam, Moulana Omar only returned home twice a year to visit his family and his wife-to-be. He never “dated” her, as it was “not allow”. Her father accepted his proposal and in his third year of studies they got married. He carried on studying for another 3 years. Moulana Omars’ sponsors suggested that he should reside in and be part of the community he cared for so much. At the time of the interview he was married for 7 years and had seven children of which two sets were twins.

THE JEWISH JOURNAL
In this section I worked with 2 leaders. They were Rabbi O (the orthodox) and Rabbi P (the progressive) and they were so named by choice of the rabbis’.

The contexts of the Rabbis’ are discussed together so that differences and similarities within their contexts become evident.

I visited both Rabbis at their respective synagogues. Both synagogues were situated in the more ‘affluent’ areas of Cape Town. I first visited with Rabbi P. Upon my arrival he met me at the high security remote controlled gate the enclosed the synagogue. As we entered the synagogue Rabbi P introduced me to the reception staff and led the way to his office.

My arrival at Rabbi O’s synagogue was more formal. I had to announce myself at high security remote controlled gates and having been let in, I had to re-announce myself at another set of security doors. Hereafter I presented myself to a reception desk where the secretary checked to see for my appointment. She telephoned Rabbi O to say that I had arrived. I was asked to be seated on a shiny wooden bench, in a partially lit passage across the secretary’s office. After about five minutes Rabbi O arrived and greeted me with a handshake and led the way to his office.

Both rabbis’ had neat offices, the one more meticulous than the other. The progressive rabbi had odds and ends on his desk with a large window behind his seat overlooking a garden. The orthodox rabbi had a smaller office with wood paneled walls, a less cluttered well polished desk, and small rectangular windows lining the upper sections of the outside wall. Rows of neatly shelved books lined the inner walls of his office. Prior to our interviews Rabbi O informed his secretary that we were busy and that he would prefer not to be disturbed. I was offered a cup of tea/ coffee and we commenced uninterrupted.

With the progressive rabbi interruptions occur during interviewing with telephone calls of a personal and professional nature. He didn’t mind me being there while he took his calls. Both rabbis’ were patient and focused throughout interviews. In the orthodox synagogue I was given a brief tour of the synagogue where lectures occurred and the rabbi explained that men sit separately from women. Video taping was however not allowed.
Rabbi P was born in Los Angeles California in 1954. His parents were Jewish and very “hard working in the field of education”. They co-coordinated day camps for the youth. This was their business in the United States of America. Summer vacations for the Rabbi were long and he compared his youth with that of “clergy children where the clergy is always there for the congregation and not for their own children”.

Rabbi O on the other hand was born in Johannesburg, South Africa and was almost 30 at the time of the interview. He grew up in the Northern Suburbs of Johannesburg, where he attended a Jewish school from grade one to matric. The majority of his friends were Jewish and they were “quite affluent, we were privilege”. Apartheid at that time was nearing its end. Unlike Rabbi P’s upbringing, Rabbi O’s family was rather close and they spent “much family time together at Friday night dinners”. He rememberered three important occurrences in his happy life. One, when he turned thirteen and he accepted his Jewish obligations, two his wedding day and the third, the day when he officiated his brothers wedding. He explained that an honour that his parents bestowed on him was when they circumcised him when he was only eight days old.

Both Rabbis’ met their wives while they were studying. Rabbi P met his wife in Jerusalem where he was working in a local bookstore while studying in Graduate School of the Hebrew University in Jerusalem. His wife was working as a pharmacist and he pretended to be Israeli when he invited her out for coffee. She was South African. They were both ordained at the Jewish Theological Seminary of America “which is understood to be the conservative branch of Judaism”.

Rabbi P came to South Africa when a progressive congregation in South Africa needed a Rabbi in 1989. Since then thus he has been in South Africa for 14 years. Rabbi P is married and has 4 children. He said that he is “a liberal and therefore [his children] were free to choose” which religion they prefer to follow. As for his own family ties, he had one brother who lived in Los Angeles, California with his father. As for his brother, Rabbi P explained that they “do not agree on things”.

xiv
Rabbi O studied in Israel and returned to Johannesburg to an academy where he specialized in Jewish Tumultic learning. He stayed there for seven and a half years, and in his last year of study he met his wife and they got married before he finished. Rabbi O held his first position in Cape Town where he worked for two years. Thereafter he held a post in another “affluent” community where, at the time of interviewing, the couple was still employed. At the time of interviewing Rabbi O was married for five years and did not have any children.

THE SANGOMA’S SALVATION

In this section I dealt with 3 healers. They were Mamela, Tando and Chiko. While the Sangoma’s do not teach or preach as the religious leaders do, their contexts are based on more physical aspects. Since healing sessions were regarded as confidential, I was not allowed to observe these sessions at all. The physical contexts of the Sangoma’s were very similar and therefore it will be presented together with differences highlighted as it occurred. Since I am not au fait with the African language spoken by the Sangomas, I made use of 2 different interpreters who accompanied me on meetings. Therefore, throughout these descriptions I shall refer to ‘we’ in my explanations.

Interviews were conducted with all Sangoma’s. These interviews were held in the living spaces of the Sangomas. In all cases these living spaces doubled up as consulting rooms. No strict security measures were evident. These consulting rooms were located in the poorer areas of the Western Cape known as ‘townships’. Since I collected data during winter, the atmosphere in the townships was cold and walking through puddles of water necessitated the wearing of winter boots. Bon fires burnt throughout the day from various yards and people sat huddled together round the fires under scrap metal or wooden-roof coverings. At the location in Langa the consulting area was a very dark room. Mesh wire separated the front area from the private consulting backroom where patients stayed overnight. The floor was covered with snake and crocodile skins, ostrich egg-shells lined the side of the floor while tails of various African animals were suspended from the roof. A variety of herbs were piled in basket-like containers covering the centre of the floor.
The darkness made it difficult to see the differences in herbs, an often the Sangoma would smell to be sure what they are. Incense burners partially lit up a corner of the dark room. The distinct smell of herbs brewing over a fire, filled the air. Tando, sat on his wooden chair and invited us to be seated on animal skinned stools next to his.

Tando was working as a healer and herbalist for twenty years. He was originally from the Eastern Cape where his father was a herbalist too. Much of Tando’s education occurred from what his father taught him prior to his death. He explained that even after his father’s death. His father still communicated with him through his dreams, especially when he advised Tando about which plants to use for preparing medicines. Tando arrived in Cape Town in 1981 and he has since been practicing here.

A second Sangoma was interviewed in Langa Township, over a weekend. The outside location was still wet from the winter rains. Smoke that was heavily laden with the aroma of chicken and meat BBQ filled the air of every backyard. Children played in the stagnant puddles of water. Walking through lines of damp washing we arrived at the Sangoma’s home. The door was ajar and we had a view of a partially furnished front area. Two wooden benches lined the bare walls of the small room that facilitated a waiting room for patients. A bedroom and kitchen diverted from this main entrance area. We were greeted by a bewildered teenage girl, who led us down a short passage. We were then welcomed by a deep brown lion printed African blanket that embraced a bed standing against a wall of another small bedroom. Mamela sat contentedly on the bed, at her window and smiled as we entered the room. In the corner of her tiny room I noticed a shower area that was cornered off with a turquoise shower curtain. Later on we discovered that this was not a shower, instead it was a store where she kept her herbs and already mixed medicines. Interestingly enough, during my second interview with Mamela I had to quit the interview because the ancestors were making contact with her. In her state of closed eyes and head swaying, she politely asked us to leave. And so we did.
Mamela was a married Sangoma and was based in “the house” so that the ancestors may communicate with her freely. Initially she was a Christian but she explained that it was too complicated for her in that she had a conflict of beliefs. Her calling started in 1992 when she became ill due to infections caused by waste programmes that were implemented near her home. She sought assistance from a “western practitioner”, but with no avail. She visited yet another medical practitioner who also could not diagnose her illness. She then decided to call on her Traditional Healer who explained to her that her illness indicated that she should seek training as a Sangoma. That was her initiation into healing.

She explained that for as long as the ancestors preferred to communicate with, she would continue to practice as a Sangoma. She says that the ancestors will indicate to her when she should quit, for example if her marriage should be in jeopardy.

At the time of interviewing she belongs to a traditional healers’ association. She had graduated in Cape Town in 1998 and proudly displayed her graduation ceremony photographs.

My interview with the Khayelitsha Sangoma took place on a slightly warmer day. Here we found an extended room at the front of Chiko’s home that was specifically used as an office and consulting area. A desk filled with papers, a telephone and a fax machine formed part of the consulting area. The cement floor was cold, despite the grey-blue plastic Coverlon tiles. A wooden bench became my seat directly opposite the desk, where Chiko sat. A metre sized window covered with a floral curtain, lit up the white painted walls that were lined with certificates validating the healers qualification as a registered Sangoma and as a trained HIV/AIDS counselor. During our visit people popped in and out to be consulted. As such, since we were occupying his time with interviews, the Sangoma was loosing out financially as his patients left to go somewhere else. Thus at the end of our visits with him, he asked that we compensate him with one consultation fee which he offered to us at a reduced rate of R40. This I paid him.
Chikumbutso is a male Traditional healer that grew up in Transkei. As Mamela he too became ill beyond the help of western doctors. His elders recommended that he seek the help of a spiritual healer “Umtandazi”. At the time could not hear or see properly, but on consulting with the healer it became evident that: “it’s a calling for him to become a traditional healer”. His mother did not approve of him pursuing his calling and sent him back to school “to study”. Chiko tried his best to please his mother but unfortunately each time he returned to school he would fall ill with impaired hearing and partial blindness which made it difficult for him to continue attending school. So he quit school.

Chiko’s mom was knowledgeable of the medicinal properties of various herbs. As they walked through the bush to collect herbs, she would educate him about these herbs. On one of their walks Chiko wondered far off to the other side of the bush and decided to rest under a tree where he eventually fell into a deep slumber. In his dreams his grandfather explained to him why he was ill and he recalls hugging the old man. A loud firing sound shook him from his dreams. He heard people talking, the wind in the trees and birds chirping.

Meanwhile, his mother could not find him and had informed the police, who by that time was searching for him in the bush. They called him using loud hailers. When she eventually found him she yelled at him with anger but soon realized that he was deaf and ceased her yelling. She was astounded to hear him say that she should lower her voice as he could hear her. He related his experience with his grandfather in his dream to her and that his grandfather suggested that he should honour this calling by entering into Sangoma training. She had no option but to accept his calling and she arranged for him to study the Sangoma tradition.

At that time he was sixteen. His dreams continued to guide him. It showed him where aught to be studying, as well as where his long lost father was, whom he had never met. Eventually he left his mother’s home and moved in with his father who secured his studies as a healer in 1992. In 1996 he graduated as a traditional healer. Initially he
practiced in Mozambique, Port Elizabeth, Oudtshoorn and now he owns his own practice in Cape Town.

THE CHRISTIAN CONVICTION

In this section I interviewed four leaders. They were Priest Brian, Priest Ted, Pastor Allen and Pastor Jeff

When I visited Pastor Allen, we met at his community church in Mitchell’s Plain in the Southern Suburbs of Cape Town. Pastor Allen belongs to the Immanuel Apostolic Church. He met me at the gate and escorted me to a back entrance of the church. We entered into an empty room with an open area that extended into a kitchen section next to piled up plastic orange chairs. He offered me a chair and we moved towards a table near a window. Here we sat across the window flaunting a view of a downtrodden fence, unkempt lawns with sandy patches here and there, a dilapidated children’s park and a modest residential area. Occasionally youth would enter through the same door, greet the pastor and I, before making their way through huge double-swining doors that led into the main church hall. Throughout our interviews choir practices occurred and the church band played.

Pastor Allen was born in Athlone in the Western Cape. His mother bought a home in Mitchell’s Plain and this was where he was reared. Pastor Allen had two younger brothers and an older sister. All of them were serving the Christian faith, however they belong to different churches. His father worked for a docking company. Pastor Allen explained that his father was a “stern person” and he did not “really have a talking relationship” with his dad. Their family was a typical patriarchal family.

Pastor Allen got involved as a bass-guitarist in the church band that played “inter-denominationally”. He was then 16 years old. His parents were originally from Assemblies of God and this was the Christian church he was reared with.
When he was 18, Pastor Allen met his wife at a band function. Her grand father was a pastor and the band played at his church. Pastor Allen said that his wife became pregnant out of wedlock. Soon after they discovered the pregnancy, they were married. At the time of interviewing, they were married for fourteen years and had two sons aged thirteen and ten years old.

The second context described is that of Priest Brian and Priest Ted. Since these leaders engaged in a focus group discussion, because Priest Ted was only available for one interview, and because they worked together, their context is presented together.

Priest Brian and Priest Ted’s working contexts differed vastly from that of Pastor Allen’s. On arriving at their location, which was their community church, it was requested of me to announce my presence at a safety gate and then again at the receptionist’s desk. I waited for the leaders in a well polished wooden floored room, dressed up in ‘Biggie Best’ brightly yellow bowed décor. A yellow and blue couch with matching scatter cushions added warmth to the nippy day. We sat adjacent to slide-up windows that displayed a majestic garden with neatly trimmed lawns edging fitted garden furniture and gargoyles that enhanced an already spectacular water feature. As they entered the room Priest Brian introduced himself and welcomed me to their church. He sat on a chair in front of one of the windows, while Priest Ted explained that he preferred to lie down on the floor, since he was suffering of backache.

The two explained that their church was about six years in existence and that it related to the Ministry called the “New Covenant Ministries International”. The churches perspectives centred on “what we believe church is” and “this is how we believe church should be run” and thus Priest Brian says that their church is people centred.

Priest Brian was born in Port Elizabeth and resided in U.S.A. as his father was studying education and missions. He has an adopted sister eight years older than him. Priest Brian was the eldest of his parent’s biological children, followed by his sister just eighteen months younger than him. He also had a younger brother aged fifteen who, at the time
resided with his parents in America. At the time of the interview Priest Brian was engaged to be married. He met his partner through church. He explained that he was reared in a Christian home. While his parents had a huge influence on his Christian belief system, his religion was no longer about what his parents were saying, but what he was experiencing and more about him taking ownership of his religion.

When his family returned to South Africa he attended a boarding school in Wellington. Here he studied for another ten years. Then he worked for a “Christian outdoor adventure organization”. This organization supported schools, leadership programmes and camps. He formed part of the field team that worked in primary and high schools. This team taught life skills education, sexuality and spiritually based programmes. This he has been doing for the past two years.

Unlike Priest Brian and Pastor Allen, Priest Ted explained that he was reared in a “totally irreligious family”. Priest Ted’s parents filled for divorce when he was five years old. This divorce occurred after his mother discovered that his father was engaging in a homosexual relationship. Thus during the week he and his brother had to stay with his mother and over weekends they lived with his father. At the age of ten they moved to Cape Town and resided with his grandparents. When he was thirteen, his father also moved to Cape Town. Priest Ted and his brother then had to move in with his father. Here they stayed until Priest Ted turned sixteen. It was during this time that Priest Ted discovered that his father was homosexual. At the time of interviewing Ted said that he was engaged to be married in November.

The fourth Christian leader interviewed was Pastor Jeff’s. His work context was similar to that of Imama Fatima and Ali because he taught at the same school as they did. The difference in his case was that unlike the Muslim leaders, he did not commute into the area of the school. He was a resident of the area. Pastor Jeff taught religious education and focused specifically on Christianity. When the Muslim learners attended Imama Fatima and Imam Ali’s lessons, the Christian learners attend Pastor Jeff’s classes.
Pastor Jeff requested that his interview take place at his home. He lived a few roads from the school. On arriving at Pastor Jeff’s home, I walked along a neat path lined with Fynbos shrubs that formed part of a well kept garden. The path led to a miniature wooden garden feature that stood flanking a burglar gate safe guarding the front door. The pastor opened the door for me and politely offered me a seat in his small, neat front room. The area was warm and a radio or television could be heard in the background. It was early and the rest of his family was still asleep. A wooden and floral upholstered two-seater couch and chair accompanied a wooden coffee table that displayed blue knitted doilies and an ornamented ashtray. Matching blue curtains were still drawn and the pastor turned on the light. I took my seat on a wooden chair that stood opposite the coffee table. Aged black and white photos in glossed wooden frames hugged the walls to which he later explained were his “grandparents”. I was offered coffee and we commenced. Since the pastor was aware of my interview, he prepared notes which he referred when he answered some of my questions. He explained that he feared forgetting the key points and his notes allowed him to remain focused through our interviews.

THE RASTAFARIAN TALE

In this section I dealt with 1+5 Elders. They were Bianca, Elder Job, Elder Aaron, Elder Solomon, Elder David and Elder Ezra. Since three interviews were conducted with Bianca, she became the focus respondent. It was perchance that the other 5 Elders came together from other parts of Cape Town to celebrate Marcus Garvey Day in Bianca’s community. Therefore, the approach here will be: providing contexts of interviews, but Bianca’s context will be the focus.

All the interviews were held in the poorer locality, or as the local police officer explained and directed me to “there where the squatter camp is and shacks are”. At the onset of my first meeting with Bianca, she immediately informed me that Rastafarian leaders are called elders and much respect is given to the elders and the decisions that they propose. There were no significant differences in the roles played by male and female leaders. They were all equally respected by the followers, and decision making occurred in the
presence of all elders. Elders meet and decide and various issues. One such an issue arose when I met with the group of male Rastafarian elders. The issue was whether or not I should be allowed to view their temple. The elders met and only after consensus was reached, an hour later, did they respond to me. They decided that in the interest of their community, they would meet with me collectively but outside of the temple, since I was, according to them, inappropriately dressed.

The location in which this interview and video observation occurred was in a wooden structure outside of the temple. It had a scrap metal door entrance that led into a small square vicinity where a Rastafarian follower were preparing food and crushing Ghanja leaves. My camera person and I had to squeeze pass, into a second room that had dilapidated chairs lining a sandy floored room and a square window-type opening from where I could view the inside of the church. The wall facing me held a striking mural of the map of Africa decorated in the bright red and green traditional Rastafarian colours. The throb of the African drums filled the air with Reggae beats harmonizing with the smoke from incense burners. As we entered the small room, the elders were waiting and invited us take a seat and share fresh oranges with us. All the elders wore traditional Rastafarian garb and their most striking features were their dreadlocked hairstyles.

Bianca was 60 years old at the time of the interviews. Her interviews occurred in her home a few metres from the temple. I noticed that her home was made of wood while others were made of a scrap metal material. No strict security measures were evident. Our meetings occurred in the local “spaza”or shop. The spaza was a wooden structure that had a first floor which extended into Bianca’s bedroom. The kitchen area was neat, and I was given a tour of the yard that comprised of a wired and wooden fence enclosing a fully-grown vegetable garden about six metres on. A train passed by ever so often and passengers would wave to Bianca as they greeted her by name. Interviews in the spaza occurred in a square lobby space at a table and a male elder, who explained that I got the area name incorrectly, accompanied us. The crooked walls were lined with portraits of their Prophet Marcus Garvey and King Solomon. As we talked locals would pop in to purchase small amounts of soap, sugar and other grocery items.
Bianca explained that she had little formal education, and that she was “self-educated” through traveling across England, America, Bahamas, and the smaller islands of the Caribbean. Slave children she suggests were educated on the plantations. The “Rastafaray da Nayabingi order” was her roots of religion, the “real isocracy … that ruled the earth in righteousness”.

A part of family survival in the Rastafarian community includes being a “farmer, healer, working with children in the street, young women, elderly people, teaching them handicrafts and self-reliance by making a home garden, preparing and preserving food”. Bianca explained that she loved to share and that she was gregarious by nature. However, when she visit stores in “Mitchells Plain,… people watch you …like you come to steal something. They look on you like derogatory…they see you as people that smoke Ghanja and we are dirty… Rasta, sorry to say, is one of the cleanest people on earth”

Bianca explained that traditionally Rastafarian couples do not marry, they have a long-term-stable relationship. She explained that she had a good “king” or man in her relationship. She said that she had children only from him. Bianca was worried about her children, as they were still not allowed to leave the Jamaican islands to come home to Africa, but she said that she had “faith in God” that will make a way for them to come home. The only communication she had with them was by telephone, if she could afford to buy airtime. Otherwise they wrote letters to one another. Her eldest son was 37 years old and the youngest daughter was 24 years old at the time of the interview. In total, she has 31 grandchildren. She encouraged all her children to follow the Rastafarian lifestyle.

Bianca’s partner died of “old [age] of 77 years”. He died at home in the islands and her son took his body to the “hospital morgue”. Hereafter his body was taken into the mountains to be buried. She explained that the mountain had a “conscience side and they buried him in centre mass”. The belief existed that the “dead should bury the dead” and therefore their corpses were collected by the undertaker because old Rastafarians don’t carry or bury their dead.
Appendix B: Focus Group Discussion

While I only used this twice, the schedule was used to get a conversation going around which leaders interacted with me guiding the conversation. The scenarios that I used were: The following scenario was used for the two Christian leaders Brian and Ted, as well as for the Rastafarian Elders.

“In a recent local newspaper I read that a teenage boy was asked to leave his parents home because he was HIV positive. The boy left and moved into a home that cares for people that are HIV positive. The carers at the home tried to contact the parents’ of the boy just prior to his death. However, the parents refuse to respond and said that they had “nothing to say to him”. The boy died and on his request, his body was cremated. When his parents fetched his ashes, they would not pay for the urn in which the ashes were placed. Thus, his parents carried his ashes home in a brown paper bag. As leaders of your religion, how does this true story make you feel? Please explain to me your response?”
Appendix C: Observation Schedule

This schedule served as a reminder to me of what I was looking for when I observed some of my respondents. I used the following as a guide to gain a sense of the leaders and healers contexts. On most occasions many other details emerged as could be seen in the contexts of leaders and healers:

THINGS TO OBSERVE: PHYSICAL SIGNS

- Clothing/ dress – traditional garb and other
- Responses of leader/ healer – ways of talking, language used, types of words used, stuttering or repeated. Body movements e.g. pacing up and down, folded arms, eye and facial expressions
- Area :- Size of room, colours schemes of rooms, decorations eg, photos on walls, private spaces, surroundings
- Entrances to places, e.g. gardens, access - security measures.
- Smells – coffee, smoke, etc
- Atmosphere on the whole
Appendix D: Semi-structured interview schedule

The interview schedules were divided into three: Personal data of respondents, Professional data of respondents and since Sangoma’s Job description differed from that of religious leaders, in that they also administer traditional medicine, a different schedule was prepared for them.

INTERVIEW ONE

PERSONAL LIVES OF RELIGIOUS LEADERS AND SPIRITUAL HEALERS

Where were you born?
Where did you grow up?
Which schools have you attended?
What religion do you follow?
Have you always followed this religion?
Tell me about your siblings (brothers and sisters)
What was it like growing up in your family?
Tell me about the special occasions that you celebrated in your family
Were these occasions related to your religion or to your culture?
Tell me about these relations
Are you married?
Tell me about the way you met your partner
Tell me about your relationship prior to your marriage e.g. did you date?
Tell me about your wedding preparations
And your wedding day, tell me about that
How long are you married now?
How has your life changed after your marriage?
Do you have any children? Tell me about them
How do you rear them?
Would you encourage them to follow the same religious and cultural practices that you followed as a child? Explain your response.

Are your parents still alive?

How old are they?

And do they enjoy good health?

*(if not alive) were they ill prior to their death?

*Tell me about their funerals / burial procedures.

*Does this procedure apply irrespective of the cause of death, eg. What about the case of suicide, murder or HIV?

What if the person was homosexual?

(If parents are alive) If they should fall ill, tell me about the role that you, as their child would play.

Tell me what you religion expects of you in this situation.

What does your religion say about those that are sick?

How do you feel about diseases such as Cancer?

What does your religion say about Cancer and HIV?

Tell me what you do during spare time? (Hobbies, favourite TV programmes etc)

What do you enjoy reading and why?
INTERVIEW TWO

PROFESSIONAL LIVES OF RELIGIOUS LEADERS

What areas do your church/mosque/synagogue/temple services?
Does this include schools in the neighbourhood?
What is the relationship between the church/mosque/synagogue/temple and the schools?

I've read an article where a family disowned their son because he was HIV positive. How does this make you feel?
How do you think your community here would respond if they must hear this?
How did you first get to know about HIV/AIDS?
Tell me, how does the community in this vicinity respond to illnesses or diseases?
Do the people in your community talk about their illnesses, for example if they should be HIV positive?
How do you think they would respond to somebody that is HIV positive?
Tell me about the advice that you offer those that are ill
Would this advice differ from the advice that you'd give to someone that is HIV positive?
Please will you explain you previous response.
So how do you think this disease, HIV/AIDS is transmitted
Tell me, who do you think is most vulnerable to becoming infected?
Please explain you previous answer.
Tell me, how do you feel talking to me about HIV/AIDS?
Tell me would you encourage your people to go for HIV/AIDS testing?
Please explain your previous answers
When do you think people should have themselves tested for HIV/AIDS?
Tell me, if you were to have someone in your community who has had an HIV test done and the results were positive, how would you respond to the person?
Tell me, if you were to have someone in your family have an HIV test done and the results were positive, how would you respond to the person?
Are you aware that HIV positive people can use anti-retroviral drugs? Would you encourage people to use these?
Do you know of any alternate measures of medication or healing that sick people could use?

Tell me, in your opinion how do you think illnesses such as HIV/AIDS could be prevented?

Tell me about your community around here.

What do you enjoy most when working in this community?

Tell me about some of the difficulties that you have experienced here in the community.

Do people regularly attend the church/mosque/synagogue/temple?

On which days do you have huge attendances?

Tell me about the services that your church/mosque/synagogue/temple offer people

(Probe on counseling)

Do you have key speakers visiting your church/mosque/synagogue/temple?

Tell me, how long have you been working here in this community?

Tell me, does the community here speak about HIV/AIDS at all?

Tell me about the youth, do you work with them?

Tell me, what is it like for you to work with them?

Tell me about their ideas around the issue of teenage pregnancies

Do the church offer programmes to the youth? (If so) What these programmes about?
INTERVIEW TWO

PROFESSIONAL LIVES OF TRADITIONAL HEALERS

(Since traditional healers job description differs to that of religious leaders, I devised a separate semi-structured interview schedule for them)

What areas do you services?
Have you had any formal training as a Sangoma?
Where have you trained?

(Diagnosis) How can you tell which illness people are suffering from?
Do you ask questions?
Or do you examine them?
Do you use trances or call on spirits?
Are there many different diseases that you see? Can you name some for me?
Do you treat Arthritis the same as you would treat T.B.
Tell me, have you ever dealt with HIV/AIDS?
How can you tell if a patient has HIV/AIDS and not another disease?

Tell me, do you have any referrals from other Sangomas?
Do you refer patients to clinics or hospitals?
Tell me who do you treat the most, mostly men or women? Are they young or old?
What about the youth, do you often see them?
What treatments do they come for?
How old do you think they could be?
Tell me do a girl and a boy come together perhaps as a couple?

Tell me about your treatments, what do you administer?
Do you provide advice too?
Tell me about the patients that come back with the same illness?
How long does treatment take to heal?
How do patients pay for their treatment?
Tell me about the challenges that face you.
Where do you get your information about illnesses and diseases?
Are you busier in winter or in summer?
Please could you explain your response.

Are you a member of a traditional healers’ association?
Has it been a good thing to have an association?
Does the association meet regularly to discuss issues in the community?
What do they discuss at their meetings and how often do they meet?
Are there women serving on the association?
Have you ever had patients die after you have treated them?
IF YES, then what is the procedure that follows?
Do people blame the healer?
What do people die of often in this community?
How old are these people that die?
Do the families come back to you after somebody has passed away and what advice he gives them?
Appendix E: Consent form for respondents

I ............................................................... (Full name and surname) belonging to the ......................................................... (Name of church/ synagogue/ mosque) do hereby consent to being a part of the research process to be exercised by Aysha Abrahams, a Masters student at UCT, student no HTTAYS 001. The student has explained the ethical issues as prescribed by the University of Cape Town. Furthermore the student has agreed to do research within my capacities and on my conditions. I am aware of the topic that is being research.

............................................... ............................................... ........................................
(Signature of respondent) (date) (place)