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A Shock to the System: HIV among Older African Women in Zimbabwe

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Abstract HIV remains a threat to the ordinary everyday life of older woman in African society. In what can be called “a reality shock,” HIV challenges most of the ordinary everyday endeavors in conservative African societies as it imposes new Western prevention, treatment, and health-management methods over long-held African traditions. The reality of the “Western” HIV epidemic, and its impact on the “African” ordinary everyday life, demands that the infected undergo a paradigm shift in order for them to live harmoniously within their society. This calls for a re-examination of traditional values and a strong sense of responsibility, courage, and determination to remain relevant and not be considered odd in one’s community, especially as one grows old with the virus. The study, which focuses on the experiences of women from the Manicaland Province in Zimbabwe who are aging with HIV, observes that growing old with an HIV infection fosters forms of inner strength and wisdom that enable the infected to disregard some of the unquestioned traditions and employ effective ways of living well with the life-threatening condition.

Keywords HIV; Lifeworld; Older Women; Reality Shock; Paradigm Shift; Zimbabwe

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An HIV-positive diagnosis unleashes all sorts of emotions as the person struggles to take in the reality of living with an incurable condition. It most certainly triggers a sense of disbelief and shock. More so, it is a huge cultural shock for Africans in predominantly conservative African societies because it is widely assumed that HIV is a direct threat to African traditions, and is a foreign, modern, Western epidemic. Still persisting in traditional, conservative African thinking are the perceptions and images of the first publicly reported cases of HIV and AIDS in America where homosexual males were dying from compromised immune functioning. The result of these perceptions and images is that HIV penetrated large parts of the public

thinking in Zimbabwe as a “repugnant” epidemic that affects men who engage in “illicit” homosexual activities. For a long time, many heterosexuals, and especially women, lived under this misunderstanding and got infected with HIV unsuspectingly. Many died as a result and cases were often regarded as misfortunes related to practices such as witchcraft. A common assumption in most African societies is that untimely death can be attributed to witchcraft or unhappy ancestors or retribution from God. This builds on the belief that any natural occurrence such as sickness can be effectively combated by traditional and spiritual means relevant to African ways of being (Mbona 2012). In this context, HIV has been thriving and destroying silently.

In the case of a society holding onto norms, practices, and cultural beliefs without feeling a need to generate alternative reasons for why things happen the way they do (Kain 1994), it becomes common practice to apply meanings to conditions such as sickness that are consistent with age-old practices that are “tried and true” in that particular society. However, in the face of a “foreign” infection such as HIV, it is likely to be more acceptable to incorporate “foreign” factors to deal with the impact of an exposure. In such a situation, common meanings of sickness and ways of dealing with it are likely to be reformed, and borrowed meanings from other cultures are likely to be deployed. Kain (1994) calls this process cultural diffusion. Thus, Western ways of healing, prevention, and management of HIV were implemented within an African context to deal with a problem which is seriously disturbing the traditional lifeworld.

The appearance of a “foreign” infection such as HIV rattles the known reality. The willingness to allow in the strategies, management, and preventative actions coming from the *origins* of the infection does not occur without disruptions. This results in what Holzner (1972) calls a reality shock. Everyday thinking and acting is confronted by feelings of limitations and of looming crisis that create anxiety and uncertainties. Schütz and Luckmann’s (1973) view is that, in the lifeworld, actions can be oriented and rationally motivated to suit the demands of a situation. Experiences then cease to be ordinary and obvious. They now become subjectively analyzed and understood to have a self-fulfilling and meaningful life of their own. At this point a person’s consciousness is awakened and directed towards an object

that disturbs the ordinariness of the everyday. He/she now thinks and acts with a rational motive or intention to create and maintain order.

Plummer (1994) discusses this notion of creating social order as reordering the ordinariness of the everyday through a change of values, beliefs, and experiences arising from new exposures. He mentions that, for people to adapt to change—current and future—there must be a shift where the usual way of doing things has to be re-appraised and re-examined because new exposures demand new meanings. Thus, when confronted with new realities or challenges, rationality becomes focused more on preserving life than on satisfying the demands of the status quo at the expense of life and good living. In this article, we interpret the narratives of the group of older African women living with HIV in the context of their attempts to understand their new situation and adapt to the demands of the changes brought to their lifeworlds.

Methodological Account

For social scientists interested in human behavior, meaning in context (Merriam 2014) is at the core of the exploration of the research participants’ experiences. So, we opted for a qualitative exploration of research participants’ experiences, and situated this exploration in their own environment. This study gathered narratives on the experiences of growing old with HIV from eight purposely selected HIV-positive women aged between fifty and sixty-one years who are living in the province of Manicaland in Zimbabwe. The study focuses on a sensitive issue, namely, HIV, as well as a hard-to-

reach population, namely, *older* women living with HIV. For these reasons, we decided to work with a small set of participants in order to get a deep understanding of the different meanings and contexts that influence their experiences. As Brinkmann and Kvale (2015) note, rich data are more likely to be gathered when one engages in-depth with a small number of participants.

We subscribe to all the ethical considerations requiring researchers to act ethically during the engagement with the research participants. The study was formally approved by the University of the Free State's Humanities Faculty Ethics Committee (approval number UFS-HSD2015/0345) and by the Zimbabwean Medical Research Council (approval number MRCZ/B/931). Ethical protocols included acquiring written informed consent from the research participants prior to their participation. All interviews were audio-recorded. Appropriate measures were taken to mitigate any kind of harm and risk to participants related to this sensitive study. All interviews were conducted without any incidences of emotional breakdowns or withdrawals.

Data were collected using semi-structured conversational interviews with open-ended questions. As a phenomenological study interested in the experiences of their lifeworlds as narrated by research participants, interview questions started with general questions aimed at gathering background information and moved gradually to questions probing more personal and subjective experiences. In this way, the interviews managed to access progressively deeper levels of the participants' lived experiences and their struggle with the reality of

growing old with HIV. They were encouraged to express themselves freely and give voice to their own points of view. The data were analyzed thematically; some codes were deduced from the data and literature, while others emerged more inductively from the data.

Philosophical Reflections

The Schützian definition of the lifeworld proclaims that everyday ordinary experiences are central to the constitution of human thought and behavior in a society (Gurwitsch 1962; Schütz and Luckmann 1973). This suggests that ordinary people's experiences of reality and their taken-for-granted interactions in the lifeworld occur naturally and shape their reality quite fluidly. But, in addition to this, every society has its own and sanctioned ways of doing things—a lifeworld that people fit into without thinking or questioning its validity (Overgaard and Zahavi 2009). The everyday is also considered as the unnoticed (Jacobsen 2009) because its activities are mainly obvious and not much attention or reflection is given to these actions. Following this, the way in which sickness is perceived, treated, and managed in a particular society becomes part of reality to the extent that remedies for certain ailments are not interrogated: they are simply known and implemented. If, in a traditional society, a certain sickness is perceived as being caused by witchcraft—as was the case with most research participants in this study when they started to experience HIV-related symptoms—part of the common practice will be to consult a traditional doctor or herbalist for treatment and/or for removing the root cause of events.

The research participants' experience of everyday life, their constitution of meaning, and their social interaction with other members of their society will actively contribute to the way in which they live their everyday life and to the way they perform in their society according to what is expected of them as women. Firstly, this points to the fact that a person's ordinary reality or immediate experience is subject to, and influenced by, his/her interaction with others. Secondly, it indicates that everyday experiences involve shared meanings, as well as a shared consciousness underlying the collective understanding of phenomena (Sokolowski 2000). This connectedness is termed intersubjectivity. These women—the participants in this study—are to a large extent, bound to meet and satisfy the demands and expectations of societal norms in order to fit in and be accepted as an authentic part of a whole. Their experiencing of social reality takes place within a socially delineated collective identity. Thus, we contextualize the narratives of female research participants within their larger social environment.

Their gender determines their conduct, persona, relations, and thoughts—all of which are intersubjectively constituted and confirming the “commonness” of their lifeworld. Reality in this lifeworld—which we can call a gendered lifeworld—is imposed and accepted as natural (Schütz 1962). An assessment of the research participants' narratives indeed finds that they feel largely disempowered to act individually and to engage in other forms of agency against HIV infection. This is because the social reality in which they find themselves expects them as married women to be subservient. The research participants' societally imposed

inferior status as women means that they could not question husbands if they suspected them of risky sexual behavior, nor were they able to impose preventive methods to avoid an HIV infection or re-infection. These women's powerlessness with regard to sexual matters and their ultimate inability to influence their husbands' risky sexual behavior is embedded in a shared reality that they have internalized through socialization as part of their everyday experiences. This is confirmed in the following statement by one of the participants:

There was nothing you could do. But, you will know that when he comes, you will know that he is my husband. You will just meet [have sex] like that. We did not have an opportunity to say: “No-no-no, let us use a condom...” NO, it was not something that was expected to be done because a man cannot be challenged by a woman and a woman cannot tell a man what to do. It is still happening even today. So, when it comes to prevention, we never had that chance to do anything. Sometimes you would know that my husband has a girlfriend, called this. You could even clearly see and know that this is what my husband is doing. Even sex, we never enjoyed it when it was like that because you would know that here I am being given a disease, but there was nothing that we could do. So, as a woman you would just keep quiet.
[Grandma Mecky]

The acceptance of socially constructed ways of doing things leads to normative behaviors becoming embedded in human understandings and being considered as natural. In phenomenological terms, this is called typification (Overgaard and Zahavi 2009). So, there are typical actions that are governed

by typical motives and deployed in typical situations with typical consequences (Flick, Kardorff, and Steinke 2004; Overgaard and Zahavi 2009). But, typifications are never entirely rigid and unchangeable; an actor can adapt certain ways of doing things in order to resolve a problematic situation. Alfred Schütz argues that typifications are indeed prone to revision, especially where expectations and needs are not met (Overgaard and Zahavi 2009:105). People can be exposed to situations/conditions that are out of the ordinary, and in these situations, they can also act with rationality in an effort to deal with social reality. So, in response to the familiar and the less familiar, as Alfred Schütz points out in his analysis of the lifeworld (Overgaard and Zahavi 2009:105), typifications are driven by “because” and “in order to” motives.

When applied to this study, we argue that a woman living and growing old with HIV in a traditional African society does not typify the common actions of others. She adapts an attitude that makes it possible for her to deal with her situation and to live meaningfully with HIV. Most of the narratives indicate that the ultimate aim of participants is to manage their condition and to preserve their lives. The narratives indicate that when a woman with HIV is on anti-retroviral (ARV) treatment, she adapts her motive: “I am not using traditional herbs to treat HIV ‘because’ ARVs are proven to manage the virus effectively and they are working well for me.” Or, she can argue: “I use ARVs ‘in order to’ live longer and healthily with HIV.” In both cases, rationality takes center stage over the shared traditional meanings surrounding sickness and its connection to spiritual and traditional heal-

ing. This study’s participants are taking ARVs “because” this treatment restored their health, which had deteriorated:

Myself, to tell the truth, from the beginning I was not well. I was sick before taking the pills [ARVs]. So, when I started taking the pills, I don’t get sick anymore. But, previously my hair used to fall off [and I had] ringworms all over my body. [Grandma Jessy]

That time I was not even able to walk on my own, people would lift me up. Then I started to take the ARVs and started to get myself up and walk. And then I realized that the tablets are helping me, up to now. [Grandma Vicky]

I can say in the first days—those first days, that is, when I say I got so thin. Ehm, the first days before I knew that it’s the disease [HIV]. But, when I started to take the ARVs, I gained weight, getting really fit and strong. [Grandma Shelly]

A further dimension of the philosophical framework for this article can be found in existential phenomenological thinking, which assists us in unpacking the research participants’ experiences of living with an “uncommon” condition. Living with HIV is a deeply existential issue that impacts the self and how an individual responds to changes in his/her everyday experience. It has to do with how our HIV-positive, older women live, feel, and respond to situations that confront them: how they experience changes to their bodies, challenge cultural norms, and interpret new social signals from their environments. From the narratives of participants it is clear that all these changes and challenges contribute

to a reality shock. Existential phenomenological thinking, therefore, assists our analysis in that it highlights the individualistic nature of existential aspects in its relationship to acquired expertise, conformity, and the broad cultural reality of society (Kotarba and Johnson 2002).

From this study's findings it is clear that most of the women were emotionally affected by their HIV-positive diagnosis. Their first thoughts were—in line with common perceptions in their society—that HIV is so destructive that nothing meaningful can come out of it. Their narrations capture the feelings of shock, hurt, and death-related ideation that most of them experienced after being diagnosed with HIV:

To tell you that I did not say anything when I got home [from the HIV testing center]. I was very angry and confused at the same time...I was thinking that it is better to die than to live a life of a sick person. Because it was being said everywhere that this disease cannot be cured. Once you get it, you have it for life. So, I thought of suicide... [Grandma Maybe]

I was hurt and I said: "How am I going to support these children that were left to me." I was hurt and I cried...I even wrote a will... [Grandma Mecky]

Later, they all altered their perceptions and tried to counter their negative assumptions by seeking life-saving treatment and support. They achieved this by existentially engaging with the collective myths, beliefs, and misconceptions surrounding HIV in their society. By taking up this position, they allowed their existential self to act outside their socially constructed cultural context.

Creating New Meanings

Their HIV-positive diagnoses clearly caused great trauma to the research participants. This reality shock, in the view of Holzner (1972:11), coincides with an unexpected change or occurrence in the everyday reality of a person where traumatic feelings are experienced as a result of extreme disappointment and disbelief. Holzner (1972:11) argues that the feelings take on an unreal character because these experiences are completely unrelated to their shared natural attitude. From the narratives it is clear that an HIV-positive diagnosis was not only traumatic but also entirely unanticipated. With the exception of one, all the research participants claim that they never engaged in sexually risky encounters that might have exposed them to an HIV infection. This following quote is broadly representative of what all the other participants say about finding out that they are HIV-positive:

Ehm, I was hurt. I felt hurt because I never imagined that situation to happen to me. Because I was married to my husband when I was a virgin, and I was very honest. That is the truth. There was nothing [risky sexual behavior] that I did, yes. So, it was hurtful to me that today I am now told that I have HIV. I did not go around looking for other friends [sexual partners]. [Grandma Jessy]

A reality shock of this magnitude clearly heralds a turning point in life where the everyday must be re-evaluated and new ways found to deal with the situation in order to save one's life (Baars and Philipson 2014). Holzner (1972) further points out that a reality shock creates doubts about the ordinary

ways of doing things and often calls for a reconsideration of reality, causing most of the natural and existing reality to collapse. New meanings must be found to readjust priorities in order to live a meaningful life. From the narratives we can see that participants renegotiated their notions of reality. Initially, they tend to blame the deaths of their spouses on witchcraft, and thought of themselves as healthy and not infected by the virus. They later changed their views and took steps to manage HIV:

...myself, before I got treated, I also thought that I was bewitched. Even when my husband passed away, I also thought that he was bewitched, yes. But, now I know that it is HIV. [Grandma Rose]

After confirmation of their HIV statuses, by means of clinical testing, the research participants adapted new perspectives enabling them to deal with the disruptions caused by HIV and their lifeworlds. The ways in which they deal with the hurt and humiliation accompanying their HIV status reveal a shift in the participants' identities. They become more directed inwards and strive to value self-fulfillment, inner satisfaction, and better quality of life. Although often despised and labeled—and even isolated and discriminated against—it seems these women do not allow these issues to get in the way of them managing their HIV status:

Ah, they call us...There is someone who once gave me this name, calling me *Zhing Zhong* [laughs] [*Zhing Zhong* is a nickname most people in Zimbabwe give to cheap Chinese products that are not durable]. Ha-a-a the *Zhing Zhongs*, you see...But, we never put that into our minds because you can see that it is better

because there is treatment for us. Even if we are the HIV people like this, we actually see that we are the same with those people who have sugar [diabetes] those with what, Asthma. [Grandma Shelly]

Ehm, people would talk, even today they still say many things—names, nicknames we are given. *Masofa panze* [sofas outside—to signify a funeral; meaning that the HIV-positive people are destined for death] or *vari kunojusa* [they are going for a re-charge—collecting ARVs at the clinic]...Ah, these days I no longer care. I am now well; what can trouble me? Let them say what they want, but myself I know that I am taking my medicine and I am living. [Grandma Vicky]

The narratives also indicate that some of these women began advocating for condom use—something that they never did before they got infected with HIV. Grandma Tamar, who is living with an HIV-negative husband, discloses that they started using condoms after learning that she is HIV-positive and she encourages other women to talk about condom use with their husbands:

...then you must use that condom. You then agree on that. When you are going to Sissy Grace's place, go with it in a pocket so that you don't do what? Take Sissy Grace's disease and bring it here to me. [Grandma Tamar]

New meanings and actions are constructed in the face of a phenomenon such as HIV that is understood and experienced as coming from outside of the normal cultural life and demands new ways of dealing with reality.

Rationality in the Face of HIV

Calls for rational action are by no means confined to our times. Rationality is rooted in enlightenment philosophy where reason and empirical knowledge are presented as superseding traditional beliefs. A significant part of this study pivots on issues related to individual reasoning versus collective culture. For most participants, it appears to be a matter of inner compulsion responding to internal health needs, as well as external social judgments, that drive the impulse to re-fashion their views and experience of reality (Gellner 1992). The research participants are handling HIV in what can be considered as reasonable ways. They shifted their mindset from believing that the sickness and the resulting deaths of their husbands were a result of witchcraft, towards viewing HIV as a medical condition that needs to be managed with clinically-proven Western treatment and not by only consulting traditional healers and diviners.

Living with an HIV-positive status, trying to come to terms with it, and striving towards a better life knowing that you must grow old with this condition require a rational approach and a fair share of level-headedness. In this regard, Western medical intervention is a given. But, this realization—that a future life will coincide with disciplined taking of medication—does not come naturally. Realizing the full impact of living with HIV and making rational choices goes hand-in-hand with having access to knowledge about the disease and its effects. The research participants in this study went beyond common sense to acquire knowledge of the problem (HIV) at local clinics and at HIV/AIDS support

groups: they decided not to follow blindly the common assumption that HIV equals death. They did not give up on life but chose to enroll in HIV programs, even though some already displayed symptoms associated with AIDS—the more advanced stages of HIV infection—and realized that they might die as a result of HIV. Their decisions to start with anti-retroviral treatment went together with the rational acceptance that this particular treatment regime is the best option available to them.

Other noted rational actions taken by these women—besides seeking effective treatment—include embarking on a healthy diet and refraining from any actions that might fuel the spread of HIV. In many cases, the research participants—supposedly because they believe that they got infected by their husbands and now prefer celibacy—indicate that it is important for them to take care of their psychological well-being.

I control myself [being faithful to one sexual partner]. Even the food that I eat: I do not eat things that are too sweet plus I do not eat food that is too oily. I eat traditional vegetables like pumpkin leaves and black jerk leaves. [Grandma Tamar]

Ehm! [Laughs] What for? [Getting a sexual partner]. Ah, not again. NO, I cannot start again. What for? [Laughs] I only want to focus on living now. I have my children and they now have their own children, what else do I need? [Grandma Shelly]

To just live without thinking about it. Yeah! Not to think too much about it every time; that everywhere you are you think about it, no-no. Don't get concerned

by it—that this AIDS; when is it going to end? [Grandma Tamar]

Although each one of the eight participants has her own subjective experience, there are similarities in the way they manage their condition. It seems that they create a modified lifeworld characterized by the everyday experiences that revolve around HIV and managing it. Even their relationship experiences are shaped by HIV:

I don't have a friend that I can say I talk to, but for these friends of mine in the [support] group that I am with. Like these ones that I take tablets [ARVs] with. We can talk to each other without any problems because we are all the same. And it is easy for me to talk to them because what they have [HIV] is the same as what I have. So, there is no one who says: "I don't have the disease" [HIV]. [Grandma Vicky]

Yes, someone [sexual partner] who is also in the program [ART] because your [social] network is not, not a problem. Partner, let's take a condom. You are now: What now? Using a condom. Partner, today it's like this. He understands because he is living in it. [Grandma Tamar]

A New Openness

The narratives of the research participants reveal that some of these women consider themselves as experts in HIV issues and are even conducting HIV counseling and advocacy activities with little shame. They believe that they will be listened to because of their age. They give their personal testimonies to encourage others to know their HIV status

and to get the necessary help—though they realize that many in their society despise people with HIV. HIV is often associated with younger people in their society and HIV related issues (especially when discussed with members of the opposite sex) are seldom discussed because of the sensitive link between HIV, sexual activity, and the body. In the case of one of the participants, a son noticed that his mother was infected with HIV, but could not tell her. He waited to broach the subject when the mother later disclosed her HIV status to him:

...he told me that: "Mother, I saw it long ago that you are now sick [HIV-positive]. But, as a child it was not possible for me to tell you first"...It was not possible for him to tell me that this is what is there. So, he talked to his father when I was away in South Africa: that he must go and get tested. [Grandma Maybe]

This poignant story is a testimony to the need to break through cultural, gender, and age barriers to health. Participants' boldness in going against the socially accepted norms and advocating for rational choices in terms of lifestyle and treatment are doing just that. Their advocacy can be partially attributed to the maturity and social status that age brings, but it is mainly due to the fact that they have lived long with HIV and are exposed to positive HIV discourse through their involvement in support groups.

New Everyday Practices

It is documented that the older a person gets, the more self-control and care he/she exercises in as far as his/her health (Emlet, Tozay, and Ravies 2010). The older women in our study decided to embrace

life by choosing to treat themselves with the recommended and prescribed medication for HIV and AIDS, namely, ARVs. They even chose a specific time to take their pills to ensure strict adherence as reflected in this narrative:

I take them [ARVs] at 7 [o'clock] before I go to bed. 7 [o'clock] everyday, that's enough. Then the next day I do the same as usual. Why did I choose that time? Because I am a person who goes to [work in] the fields. I might forget [to take the pills] at times when I am in a hurry to get there... [Grandma Tamar]

Their ARV treatment ensures that they are ageing well with HIV. As members of a society with socially defined ways of handling sickness they report that they initially sought healing from herbs and traditional alternatives. But, when this trusted ally failed, they embraced a new solution:

Myself, I no longer use such things other than ARVs. I once used that stuff. What do we call it? Moringa [plant consumed for its nutritional medical value]. I would eat it...I later realized that: "Hey! Even the doctor told me that you are mixing things and you are damaging your body." [Grandma Kate]

Myself, no-no-no! I do not use those things [traditional herbs] and I do not encourage it. That is why I feel sorry for those people who refuse to take ARVs and prefer to drink traditional medicines. [Grandma Jessy]

Ehm, herbs, a-a-h no! We just use ARVs; just eat our food. The food we are encouraged to eat—black jerk, pumpkin leaves, dried vegetables, what-what...Yes, AND FISH, yes! This beef is the one that we are not

encouraged to eat. It's [the] red meat that has problems. But, if you want to eat it, make sure it is well cooked...Those herbs N-O-O. [Grandma Shelly]

Driven by their own motives, preferences, and interests—all related to survival—these women act in the face of a threat to their everyday reality. This leads to a re-evaluation of traditional meanings regarding everyday life experiences. One such re-evaluation relates to the notion and practice of hospitality in their society. The custom of visiting others and of sharing a meal with the host is highly valued in most African societies. In the Zimbabwean context, desirable social connectedness involves checking upon one another and sharing whatever food is available with visitors to one's homestead. There is even a Shona proverb: *Hukama igasva hunozadziswa nekudya*. It translates literally to: "Relations are half fulfilled unless one has eaten the food offered by the host." The participants—who now follow a healthy diet—actively defend their health rather than compromise it with practices that may be detrimental to their condition:

Don't let other people force you to eat things that are not good for you [as an HIV+ person]. Because when I visit, those spices, we are not allowed to eat them. But, others will eat spiced food because they are shy. Don't be shy. [With] these things [HIV] you cannot be shy. You need to be open. That personally, ehm, things with spices, I do not eat...And if you see that it is difficult for you, don't go there. Stay at your place because you know that this is what I am [HIV+]. [Grandma Tamar]

In a remarkable turnaround from traditional *collective* cultural norms to a much more individual-

istic approach, participants decide not to jeopardize their health by eating the food of kinsmen. Interestingly, cultural norms also support this new brand of individualism: the boldness shown by these women is enabled by the fact that older people are often better positioned to stand their ground and live life in terms of their own needs—no matter how out-of-the-ordinary their actions might appear to others.

From Collective to Individual Orientation

Clearly participants get to a point where they become less bothered by what the collective says or does. Another example is participation in traditional beer-drinking ceremonies common in Zimbabwean society and where traditional beer is used as a medium to contact the ancestors in times of need. Women prepare traditional beer at sacred places in mountains, mainly at the beginning of the rainy season. When the beer matures, people in the community gather and share it amidst the singing of traditional songs and dances. During these ceremonies a portion of the beer is spilled on the ground in request to the ancestors for rain. Attendance and participation are traditionally mandatory, but some of the research participants—who stay connected to their rural roots—claim that they now abstain from these ceremonies. They are—as people who are living with HIV and who are on anti-viral treatment—aware of the adverse effects of alcohol on their health. As a result of their age and maturity they also feel more inclined to challenge the previously unquestioned ordinary everyday norms. Some of these sentiments are reflected in the following:

Even beer, that beer that is brewed in rural areas for traditional purposes, I don't do such things. At times you are told that everyone must drink it and if you refuse, they say: "H-e-e, she is refusing to drink the traditional beer. Who does she think she is? H-e-e, she must be punished." [Grandma Kate]

There are also challenges to traditional practices that fuel the spread of HIV. Some research participants discourage the tradition of "wife inheritance" and refused to get inherited by their husbands' brothers. This practice is part of the culture in Zimbabwean society: to meet the needs of the widow and to have a "provider" for the deceased's family:

Myself, when my husband died, I was still very young [28 years old]. But, some relatives did not know what had caused the death of my husband. They wanted me to be inherited by someone else, but I am the one who said it is not possible that I get inherited because the way my husband died. The way he was sick and then his death certificate [I suspected that] there is something related to this modern disease [HIV and AIDS]. So, I did not agree to be inherited because of that. [Grandma Mecky]

...our views are different, but myself I saw that, ehm, I did not like wife inheritance. H-a-a! Inheritance! I refused it...That's how the disease [HIV] spreads, that's how the disease spreads. You will be spreading it to another man together with his wife. It's a big sin to do. When you know that you have the disease, just stay like that. What else do you want? Just live on your own. [Grandma Shelly]

Ehm, I can say that inheritance is not a good thing. Yes, because you can spread the virus to that person

who inherits you. But, if it was possible for the man who inherits you to understand, you would just say: "Let us use condoms." [Grandma Vicky]

A prominent part of the research participants' lifeworld is the high value placed on the role of a grandparent in taking care of grandchildren—even when the child's parents are still alive and capable of taking care of the child. The custom of being an engaged grandparent stems partly from the need to combat loneliness in old age and it also enables grandparents to pass traditional knowledge on to younger generations. The grandparents introduce grandchildren to traditional values, practices, and the overall culture of their society. The increase of orphans due to AIDS-related deaths of parents has also brought about a condition where grandparents are forced to become primary caregivers of orphaned children. This situation poses challenges to grandparents who are themselves living with HIV because of the expanded roles and duties that come their way. One of the research participants narrates how she had to send away a grandchild who was staying with her because of her HIV-positive condition. She says that the child's behavior caused her constant stress. Knowing the requirements related to her condition—that stress is not good for her immune system as an older person with HIV—she acted against the ordinary and everyday practice in her society and refused to take care of her grandchild. This grandmother was not prepared to risk compromising her immune system:

I once stayed with one of them [grandchildren]. So, she started to get very mischievous. So, as a grandmother I saw that my CD4 [cells] will decrease. [Grandma Rose]

Another example of research participants changing their behavior and actions relates to the way they limit their roles as grandmothers owing to their HIV infections. Traditionally, a grandmother prepares solid food for babies sometimes by way of masticating it before feeding the baby. But, with HIV, they cannot do this because of their fear that the child can get infected with the virus:

When it comes to food, I know that I am sick [HIV-positive]...It is no longer possible for me to bite and spit for my grandchildren. [Grandma Maybe]

I now know that it is no longer safe to do that. Or that I suck a *freesit* [ice lolly packed in a plastic sachet] and spit it into her [small child] mouth. Or even a sweet, a lollipop that I am sucking. If she asks me for it, I cannot give her. [Grandma Kate]

In their culture, mothers are expected to be carers and overseers in the family to ensure that the family is well cared for. Some realize that overworking their bodies to meet their socially defined roles can be detrimental to their health as older women living with HIV, hence:

Some of the work that I used to do, big jobs, I have left them. I saw that I cannot carry those heavy bags anymore to go and sell in South Africa. I cannot do it anymore. I am old now. It was possible before then. [Grandma Vicky]

...if it was possible to find things to work with that go hand in hand with our status. Things that do not make us overwork, yes. In life, ehm, those pills need us to rest. We sometimes overwork ourselves because

we are seeing that, ehm, especially myself a widow, ehm, I am straining myself. [Grandma Rose]

Concluding Remarks

The findings show how participants' lifeworlds are challenged and disturbed in the context of HIV infection, which necessitates many changes to everyday life. The ordinary and the traditional way of life is exposed to several reality shocks, which call for flexibility and innovation to maintain meaningful engagements. Many of the clinical issues related to HIV treatment and care constitute disruptions in as far as traditional culture and meanings that surround sickness in many conservative African societies. HIV entered African spaces in the context where sickness is commonly perceived as a punishment from God or from the ancestors, or from witchcraft. The traditional way to deal with sickness, therefore, often involves spiritual and divine healing combined with traditional medicine.

As in many other African contexts, in traditional Zimbabwean society, HIV is perceived as foreign and coming from the outside, and more specifically, from the West. Prevention and treatment options from the

West are thus also seen as "foreign tools" and similarly under suspicion having followed the virus from the outside. The illness, its prevention, and its treatment can all be regarded as countering traditional indigenous medicines and challenge the way traditional people from Africa normally exercise their health, familial, community, and even conjugal rights.

To survive and live meaningfully with such a threat to life and living requires several paradigm shifts involving re-assessments of circumstances and options, as well as the adaption of new ways of doing things. This study found that the overwhelming desire is to live healthily and to grow old with HIV. Rationality, intentionality, and motivation take center stage and life saving steps are employed. All participants took uncommon steps and employed rational means to manage their condition. As older women who are living with HIV, they constantly have to weigh up the requirements of a healthy lifestyle against the demands of everyday life and injunctions to adhere to cultural norms several of which go against health needs. A norm that works in their favor is that age is revered in Zimbabwean society: some use this to move beyond personal coping into the realm of advocacy.

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