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BEYOND BIOMEDICINE: CULTURAL CONSTRUCTIONS OF MEMORY LOSS IN RURAL SOUTH AFRICA

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Abstract

Memory loss among elderly populations represents a growing public health challenge in sub-Saharan Africa yet remains poorly understood within local cultural contexts. This study explores community perceptions of memory loss in the Eastern Cape's rural KwaNyathi community through the lens of Max Weber's social action theory. Using a quantitative approach with 90 respondents, the research reveals a complex interplay between biomedical and traditional belief systems in understanding cognitive decline. Findings indicate that while 93.3% of respondents acknowledge a relationship between memory loss and aging, significant proportions attribute behavioral changes in elderly people to witchcraft (8.9%) and cruelty. The study uncovers substantial knowledge gaps regarding memory dysfunction, with diabetes most identified (22.7%) as a memory-related illness, while only 14.3% correctly identified amnesia. These perceptions lead to stigmatization, social exclusion, and inadequate caregiving for memory loss patients. The research demonstrates how socialization processes, shaped by cultural beliefs and limited formal education (52.2% below Grade 12), perpetuate misconceptions that conflate normal aging with supernatural causation. This study contributes to sociology of health by illuminating how cultural constructions of illness affect vulnerable populations and argues for culturally sensitive interventions that bridge traditional and biomedical knowledge systems in resource-limited settings.

Keywords: memory loss, cultural perceptions, rural South Africa, stigmatization, socialization, traditional beliefs, dementia care

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Introduction

The global burden of dementia and memory loss is shifting dramatically toward low- and middle-income countries, with sub-Saharan Africa projected to experience the most significant increases in affected populations over the coming decades (Prince et al., 2016). Yet this epidemiological reality stands in stark contrast to the limited research attention devoted to understanding how African communities conceptualize, respond to, and care for individuals experiencing cognitive decline. This gap is particularly acute in rural areas where biomedical healthcare infrastructure remains minimal and where traditional belief systems continue to shape interpretations of health and illness.

Memory loss, broadly defined as deterioration in cognitive function beyond expected biological aging consequences, affecting memory, reasoning, and daily functioning (WHO, 2019) presents unique challenges in cultural contexts where its symptoms may be interpreted through non-biomedical frameworks. In South Africa, where the legacy of apartheid has created stark healthcare inequalities and where diverse cultural systems coexist, the experience of memory loss among elderly people is mediated by complex social, cultural, and economic factors that remain inadequately documented.

This study examines community perceptions of memory loss in KwaNyathi, a rural community in Port St Johns Local Municipality, Eastern Cape Province, South Africa. The research addresses a critical gap in the literature by focusing not on healthcare providers' perspectives or clinical presentations, but on how ordinary community members, family caregivers, neighbors, and potential support networks understand and respond to cognitive decline in their midst. Given that most elderly South Africans with memory loss receive care at home from family members who often lack formal healthcare training (Lloyd-Sherlock, 2019), understanding community perceptions becomes essential for developing effective, culturally appropriate interventions.

The significance of this research extends beyond academic inquiry. Misunderstandings about memory loss can lead to profound consequences: stigmatization, social isolation, accusations of witchcraft, inadequate care, and even violence against elderly people (Mavundla & Mphelane, 2009; Hanssen, 2017). When cognitive decline is interpreted as moral failing, supernatural malevolence, or deliberate misbehavior rather than illness, the social fabric that might otherwise support vulnerable elderly individuals instead becomes a

source of harm. This study therefore seeks not only to document perceptions but to illuminate the sociological mechanisms through which cultural beliefs translate into social action or inaction toward people experiencing memory loss.

The South African Context

South Africa's unique history creates a distinctive context for understanding health beliefs and practices. The country's racial segregation under apartheid created profound disparities in access to education and healthcare that persist today, particularly in rural areas like KwaNyathi. Port St Johns Local Municipality, located in the OR Tambo District, exemplifies these challenges: characterized by high unemployment (Phiwani, 2025), limited infrastructure, and populations that rely heavily on traditional healing systems alongside or instead of biomedical healthcare.

In Xhosa-speaking communities like KwaNyathi, traditional belief systems include concepts of ancestral influence, witchcraft, and supernatural causation of illness that coexist with varying degrees of biomedical knowledge. The term ukutwela confessing to witchcraft activities and concepts like isimilo (respectful behavior) shape how communities interpret behavioral changes in elderly people. When an elderly person displays unusual behavior, community interpretation filters through these cultural lenses, potentially overriding biomedical explanations.

Previous research suggests that memory loss in South Africa is often normalized as an inevitable consequence of aging rather than recognized as a medical condition (Kalula et al., 2010; Gurayah, 2015; De Jager et al., 2017). This normalization has contradictory effects which may reduce stigma by making cognitive decline seem natural, but it simultaneously prevents recognition of memory loss as a condition requiring intervention and support. The present study seeks to untangle these contradictions by examining what residents of a rural community actually believe about memory loss and how these beliefs shape their responses to affected individuals.

Theoretical Framework: Social Action Theory

This research is grounded in Max Weber's social action theory, which posits that individuals' actions are shaped by the meanings they attach to social phenomena within specific cultural and historical contexts (Weber, 1922/1978). Unlike structural approaches that emphasize how social forces determine behavior, social action theory focuses on subjective meanings and interpretations that

individuals construct through social interaction. People do not simply respond to objective reality; they respond to reality as they perceive and interpret it through culturally mediated frameworks.

Applied to perceptions of memory loss, social action theory illuminates how community members' responses to elderly people displaying cognitive decline are shaped not by the biomedical reality of neurological deterioration but by culturally constructed interpretations of what those symptoms mean. If cognitive changes are interpreted as witchcraft, responses will differ fundamentally from interpretations of illness or normal aging. These interpretations are not individual idiosyncrasies but are socially constructed through processes of socialization the transmission of cultural knowledge, values, and beliefs across generations and through social institutions.

Social action theory is particularly appropriate for this study because it directs attention to the mechanisms through which cultural beliefs become embodied in individual perceptions and actions. It helps explain why community members with similar observable experiences (elderly relatives displaying memory problems) may interpret those experiences differently based on their socialization histories, educational backgrounds, and positions within community networks. The theory also suggests that changing responses to memory loss requires not just providing biomedical information but addressing the deeper cultural frameworks through which that information is interpreted.

Structural functionalism, the broader theoretical tradition from which Weber's work emerged, views society as an integrated system of interdependent parts, each serving essential functions for social stability. Applied to health beliefs, this perspective reveals how community perceptions of memory loss even seemingly problematic ones may serve social functions such as maintaining moral boundaries, explaining misfortune, or preserving traditional authority structures. Understanding these functions is crucial for developing interventions that don't simply dismiss traditional beliefs as ignorance but recognize their social embeddedness.

Research Objectives and Questions

The primary objective of this study is to explore the attitudes, perceptions, and beliefs held by residents of KwaNyathi community regarding memory loss among elderly people. Secondary objectives include:

1.Identifying existing beliefs and attitudes associated with memory loss in this rural African community
2.Unpacking the knowledge base that informs community understandings of cognitive decline
3.Examining how socialization processes and its agents influence perceptions and responses to memory loss

These objectives are addressed through the following research questions:

- •What views, perceptions, and beliefs do KwaNyathi residents hold about memory loss?
    - What knowledge exists within the community regarding memory loss as a medical condition?
- •How do socialization processes influence community perceptions, attitudes, and responses toward individuals with memory loss?.

Literature Review: Cultural Perceptions and Knowledge of Memory Loss

Defining Memory Loss Across Cultural Contexts

The terminology used to describe cognitive decline reveals fundamental differences in how societies conceptualize this condition. While biomedical literature employs standardized terms like "dementia," "Alzheimer's disease," and "cognitive impairment," many African communities lack direct linguistic equivalents, instead using local terms that embed different causal assumptions and social meanings (Duke, 2013; Brook, 2018). This linguistic diversity is not merely semantic but reflects genuine differences in how cognitive decline is understood as disease, as punishment, as natural aging, or as supernatural influence.

The World Health Organization (2019) defines dementia as "a syndrome in which there is deterioration in cognitive function beyond what might be expected from the usual consequences of biological aging." This definition emphasizes the pathological nature of cognitive decline, distinguishing it from normal aging. However, this distinction may not be recognized in communities where substantial cognitive impairment in elderly people is viewed as expected and normal. Kwok et al. (2011) describe memory loss as a "degenerative and non-communicable condition commonly experienced by people at late adulthood stages," while emphasizing its progressive deterioration of memory capacity and moral reasoning.

These biomedical definitions contrast sharply with local conceptualizations documented in African contexts. Duke (2013) found that many African societies construct their own local terms for memory-related symptoms, with some communities not recognizing memory loss as a distinct illness category at all. Sahin et al. (2006) similarly reported that many elderly individuals and their families consider memory loss occurrences in old age to be normal phenomena rather than medical conditions. This normalization has important implications: if memory loss is seen as normal aging, it may not prompt help-seeking or be considered worthy of medical attention or social support.

Stigma, Misconceptions, and Social Exclusion

Poor public understanding of memory loss has led to widespread stigmatization across many cultural contexts (Alzheimer's Disease International, 2012). In sub-Saharan Africa specifically, research consistently documents inadequate knowledge about memory loss and dementia (Adebiyi et al., 2016; Khonje et al., 2015). This knowledge deficit combines with cultural beliefs to create environments where people with memory loss face not only the challenges of their condition but also social rejection and discrimination.

Putman (2008) notes that people with memory loss are often stigmatized and experience social exclusion from their communities. This stigmatization is not limited to any particular social class but pervades society, making it difficult for affected individuals and their families to disclose their condition or seek medical treatment (Adebiyi et al., 2016). The consequences of this stigma extend beyond hurt feelings to material deprivation of social support, economic resources, and healthcare access.

In South African contexts, particularly within Xhosa-speaking communities, research reveals specific patterns of stigmatization linked to supernatural beliefs. Ekoh et al. (2020) found that people with memory loss are sometimes seen as dangerous, leading families to avoid having them in the household. Hossain et al. (2018) documented beliefs connecting memory loss with supernatural forces in some South African societies. Mavundla and Mphelane (2009) reported that behaviors associated with memory loss may be attributed to evil spirits or witchcraft, fundamentally altering how affected individuals are treated.

Hanssen (2017) provides particularly disturbing evidence of consequences when memory loss is interpreted through witchcraft

frameworks. In some cases, elderly people displaying cognitive decline have been accused of practicing witchcraft, leading to social ostracism, abandonment, violence, and even death. The concept of ukutwela or public confession to witchcraft may be applied to elderly people whose behavioral changes (wandering, accusations, paranoia) are interpreted as evidence of malevolent supernatural activity. This represents an extreme case of how cultural interpretations can transform vulnerability into culpability.

These findings underscore that stigmatization of memory loss is not merely a matter of ignorance or lack of education, though these factors play roles. Rather, stigma emerges from coherent cultural systems that provide alternative explanations for cognitive and behavioral changes. Addressing stigma therefore requires engaging with these explanatory systems rather than simply opposing them with biomedical information.

Knowledge Deficits and Educational Disparities

Research consistently identifies major gaps in public knowledge about memory loss, particularly in low-resource settings. Khonje et al. (2015) found that in South Africa, memory loss is generally perceived as a normal aging process rather than a medical condition. This perception reflects broader patterns across sub-Saharan Africa where dementia awareness remains low (Adebiyi et al., 2016).

However, knowledge deficits are not uniform across populations. Educational level appears to influence understanding, though not always in straightforward ways. Some studies find that higher education correlates with greater recognition of memory loss as a medical condition, while others suggest that traditional belief systems persist across educational levels when dealing with unexplained phenomena like cognitive decline. Martin et al. (2013) observed that while some individuals are adequately knowledgeable about dementia and can identify specific symptoms like memory loss, this knowledge does not necessarily translate into rejecting traditional explanations or reducing stigma.

The relationship between knowledge and beliefs is further complicated by the coexistence of multiple explanatory frameworks. Individuals may simultaneously acknowledge biomedical explanations of memory loss while also entertaining supernatural interpretations, particularly when symptoms are severe or when individuals are seeking to make sense of distressing situations. Amuyunzu-Nyamongo (2013) argues that mental illnesses including memory loss are socially constructed concepts, with societies

employing diverse frameworks for conceptualizing both the nature and causation of these conditions.

Socialization and the Transmission of Health Beliefs

The process through which individuals learn cultural frameworks for interpreting illness is socialization the mechanisms by which societies transmit knowledge, values, norms, and beliefs across generations and through social institutions (Haralambos & Holborn, 2008). Understanding socialization is crucial for understanding health perceptions because it reveals how beliefs about memory loss are learned, maintained, and changed.

Socialization occurs through multiple agents: families, peer groups, educational institutions, religious organizations, media, and healthcare systems. In rural African contexts where formal healthcare infrastructure is limited, family and community-based socialization may predominate in shaping health beliefs. The Mental Health Foundation (2015) notes that misconceptions about memory loss are shared generationally through enculturation the gradual acquisition of cultural norms and characteristics. This intergenerational transmission helps explain the persistence of traditional beliefs even as biomedical information becomes more accessible.

Religious socialization also plays a significant role. Ekoh et al. (2020) found that religious perspectives can adversely affect care and treatment of people with memory loss, particularly when cognitive changes are interpreted as spiritual punishment or demonic influence. In Christian and African traditional religious contexts, unexplained suffering may prompt searches for spiritual causes, potentially overriding medical explanations.

The concept of socialization helps explain why providing biomedical information alone often fails to change health beliefs and practices. If individuals have been socialized into frameworks where supernatural causation is a valid explanation for illness, and where community authorities (elders, traditional healers, religious leaders) validate these frameworks, biomedical information may be incorporated into but not replace existing belief systems. Changing perceptions therefore requires engaging with socialization processes and recognizing the social functions that existing beliefs serve within communities.

Methodology

Research Design and Approach

This study employed an exploratory quantitative research design to investigate perceptions of memory loss in KwaNyathi community. The exploratory approach was appropriate given the limited existing research on community perceptions (as opposed to clinical presentations) of memory loss in rural South African contexts. The quantitative methodology enabled systematic documentation of beliefs, attitudes, and knowledge across a representative sample, generating data that could reveal patterns and relationships between demographic variables and perceptions.

A structured questionnaire was developed based on variables identified in the literature review, focusing on: (1) demographic characteristics, (2) perceptions and attitudes toward elderly people's behavior, (3) knowledge of memory dysfunction and associated illnesses, and (4) beliefs about relationships between aging, memory loss, and behavior. The questionnaire employed primarily closed-ended questions with categorical response options, facilitating statistical analysis while incorporating open-ended follow-up questions to capture qualitative nuances (Phiwani Athi, 2024).

Study Area and Population

The research was conducted in KwaNyathi community, located in Port St Johns Local Municipality within the OR Tambo District Municipality of Eastern Cape Province, South Africa. KwaNyathi consists of four sub-villages (Mbokazi, Mkhuzaza, Mkhumbane, and Nqezu) with a total population of approximately 5,437 persons according to 2011 census data. The location covers 21.17 km² and represents a typical rural, low-income community characterized by limited infrastructure, high unemployment, and predominantly Xhosa-speaking residents.

Port St Johns Local Municipality encompasses 1,291 km² across 20 wards, with KwaNyathi representing one of the more remote areas. The community's remoteness and economic challenges create conditions typical of many rural South African settings where healthcare access is limited and traditional belief systems remain influential. These characteristics made KwaNyathi an appropriate site for examining how rural communities with limited exposure to formal healthcare systems conceptualize memory loss.

The target population comprised all adult residents of KwaNyathi aged 18 years and older. This age criterion ensured that participants possessed sufficient maturity and life experience to have observed

elderly people and formed opinions about their behavior. Excluding individuals under 18 also addressed ethical considerations regarding consent and vulnerability. The study specifically excluded individuals currently experiencing memory loss to focus on community perceptions rather than self-perceptions of affected individuals.

Sampling

Simple random sampling was employed to select participants from the target population. This probabilistic sampling method ensured that all eligible adults in KwaNyathi had equal opportunity for selection, enhancing the generalizability of findings to the broader community. A sample size of 90 respondents was determined based on: (1) the community's total population, (2) resource constraints, (3) the need for adequate statistical power for planned analyses, and (4) practical feasibility for data collection within the study timeframe.

The sampling process involved several steps. First, a sampling frame was constructed by identifying households across the four sub-villages with assistance from community leaders. Second, households were randomly selected from this frame. Third, within selected households, one eligible adult was randomly selected for participation. This multi-stage process helped ensure demographic diversity in the sample while maintaining randomness.

Prior to full data collection, a pilot study was conducted with 10 participants to test the questionnaire's clarity, identify potential ambiguities, and refine data collection procedures. The pilot revealed some terminology challenges, particularly with older participants who were unfamiliar with formal terms for memory loss. Based on pilot findings, question wording was simplified and Xhosa translations were refined to enhance comprehension while maintaining conceptual validity.

Data Collection

Data collection occurred over three weeks in August 2023 following ethical approval from Walter Sisulu University's Research Ethics Committee and permission from the KwaNyathi chief's office. The researcher personally administered questionnaires through face-to-face interviews conducted in participants' homes or other private, comfortable locations of their choosing. This approach was necessary given variable literacy levels and to ensure comprehension and clarification of questions.

Each interview began with a detailed informed consent process in which the researcher explained the study's purpose, procedures, risks, benefits, and participants' rights including voluntary

participation and right to withdraw. Participants provided written or thumbprint consent before proceeding. Interviews lasted approximately 30-45 minutes, with duration depending on participants' elaborations on open-ended questions.

Several challenges emerged during data collection. Language barriers required careful translation and back-translation of terminology, particularly regarding medical concepts. Some participants expressed initial suspicion about the research purpose, requiring the researcher to explain connections between the study and community benefit. Older participants sometimes needed repeated explanations of questions. The researcher addressed these challenges through patience, cultural sensitivity, and flexibility in communication approaches while maintaining standardization in question content.

Data Analysis

Quantitative data were analyzed using SPSS (Statistical Package for Social Sciences), version 28. Analysis proceeded in several stages. First, data were cleaned and checked for completeness and consistency. Second, descriptive statistics (frequencies, percentages, means) were calculated for all variables to characterize the sample and identify response patterns. Third, cross-tabulations were generated to examine relationships between demographic variables (age, gender, education, employment) and key perception and knowledge variables.

Chi-square tests of independence were employed to assess statistical significance of relationships between categorical variables. A significance level of $\alpha = .05$ was established for all inferential tests. Given the study's exploratory nature and multiple comparisons, results were interpreted cautiously, with attention to practical significance and patterns alongside statistical significance.

For open-ended questions, responses were categorized thematically, with themes derived from the data itself rather than predetermined. Response frequencies for each theme were calculated and incorporated into the quantitative analysis. This approach enabled quantification of qualitative data while preserving nuance and unexpected findings.

Ethical Considerations

The study received ethical clearance from Walter Sisulu University Faculty of Humanities, Social Sciences and Law Research Ethics Committee (Protocol Number: REC/12(xxviii)/2022). All research procedures adhered to ethical principles outlined in the Declaration of Helsinki and South African research ethics guidelines.

Informed consent procedures ensured participants understood the study and voluntarily agreed to participate without coercion. Participants were explicitly informed of their right to withdraw at any time without consequences. Confidentiality was maintained by separating identifying information from research data, storing consent forms separately from questionnaires, and using identification numbers rather than names in datasets. Anonymity was ensured in all reporting, with no information published that could identify individual participants.

Fidelity maintaining promises to participants was upheld through transparency about study procedures and limitations. When participants expressed distress during interviews, the researcher provided emotional support and offered referrals to available counseling services. Given the potential for the topic to evoke memories of family members with memory loss or experiences of stigmatization, sensitivity and respect were paramount throughout the research process.

Findings

Demographic Characteristics of the Sample

The final sample comprised 90 participants (n=90) from KwaNyathi community. The gender distribution was nearly balanced, with 51.1% male (n=46) and 48.9% female (n=44) participants. All participants identified as Black African, reflecting the community's demographic composition.

The age distribution revealed a relatively young sample: 41.1% were aged 18-30 years (n=37), 25.6% were 31-42 years (n=23), 12.2% were 43-54 years (n=11), 15.6% were 55-66 years (n=14), and only 5.6% were over 66 years (n=5). This distribution reflects both the community's age structure and the greater accessibility of younger adults during data collection periods.

Educational attainment was generally low, consistent with rural South African patterns. The majority (52.2%, n=47) had not completed Grade 12, while 30.0% (n=27) had obtained matriculation (Grade 12 completion). Only 3.3% (n=3) had higher certificates, 8.9% (n=8) had undergraduate degrees or diplomas, and 5.6% (n=5) had

postgraduate qualifications. These figures indicate limited exposure to formal education about health and biology for most participants.

Most participants were single (70.0%, n=63), with smaller proportions married (15.6%, n=14), widowed (10.0%, n=9), or divorced (4.4%, n=4). Religious affiliation was predominantly Christian (83.3%, n=75), with 13.3% (n=12) identifying with African traditional religion and 3.3% (n=3) reporting no religious affiliation. Household sizes were generally moderate, with 62.2% (n=56) reporting 10 or fewer household members, though some households were considerably larger.

Employment status revealed severe economic constraints: 72.2% (n=65) were unemployed, with only 27.8% (n=25) reporting employment (including self-employment). This high unemployment reflects broader economic challenges in rural Eastern Cape and has implications for access to healthcare and exposure to diverse information sources about health conditions.

Cross-tabulation of gender by age groups showed interesting patterns. Among younger participants (18-30 years), females slightly predominated (51.4% vs. 48.6% male). However, among middle-aged groups (31-42 and 43-54 years), males were more represented. Among the oldest participants (55+ years), females again predominated, particularly in the 66+ category where 80% were female. This pattern likely reflects both demographic realities (female longevity) and gendered patterns of availability for interview participation.

Perceptions of Elderly People's Behavior

Participants were asked about which age groups demonstrate noticeable or uncommon behaviors in their community. Overwhelmingly, youth were identified as the age group with the most noticeable uncommon behavior (91.1%, n=82), followed by adults (5.6%, n=5) and elderly people (3.3%, n=3). This finding suggests that within this community, elderly people's behavior is not generally viewed as the most problematic or deviant, though subsequent questions revealed more nuanced views.

When asked specifically whether elderly people behave the same way as other age groups, 87.8% (n=79) responded "No," indicating recognition that elderly behavior differs from that of younger people. Only 12.2% (n=11) believed elderly people behave similarly to other age groups. Among those answering "No," follow-up questions revealed diverse explanations. The largest group (44.4%, n=35) believed elderly people behave well or better than other age groups,

attributing this to maturity, wisdom, and life experience. Another substantial group (46.7%, n=37) explained that elderly behavior differs due to personal experiences accumulated over their lifespans.

However, a notable minority (8.9%, n=7) associated elderly people's behavior with cruelty or witchcraft. This finding, though representing a small percentage, is significant given its implications for how individuals experiencing memory loss might be perceived and treated. The attribution of behavioral changes to supernatural malevolence rather than medical conditions can lead to stigmatization, social exclusion, and even violence.

Participants identified various factors influencing behavioral changes, with environmental factors most selected (47.8%, n=43), followed by age (44.4%, n=40) and illness (7.8%, n=7). The prominence of environmental factors suggests recognition that behavior is not solely determined by individual characteristics but shaped by social context—a perspective aligned with sociological understandings of behavior.

Regarding which age groups display most noticeable behavior, 71.1% (n=64) identified the 40-60 year age range, while 23.3% (n=21) selected 61-80 years, and only 5.6% (n=5) chose those over 80 years. This distribution is somewhat counterintuitive given that memory loss prevalence increases dramatically in the oldest age groups. The finding may reflect either that very elderly people are less visible in community life or that their behaviors have become normalized and thus less "noticeable."

When asked to describe the behavior of people over 80 years of age, 58.9% (n=53) described it as like that of children or toddlers, 26.7% (n=24) characterized it as strange or unexplainable, and 14.4% (n=13) described elderly people as stubborn and difficult to convince. The child-like characterization is particularly significant, as it suggests recognition of cognitive changes while simultaneously potentially infantilizing elderly people and failing to recognize their behavior as symptomatic of medical conditions.

A substantial majority (88.8%, n=80) agreed that elderly behavior is related to age, suggesting widespread recognition that aging affects behavior. However, when asked whether elderly behavior is acceptable in society, responses divided: 70.0% (n=63) considered it acceptable, while 30.0% (n=27) did not. Among those finding it unacceptable, 93.3% (n=25) explained this was because elderly behavior contradicts how they are supposed to behave, while 6.7% (n=2) attributed unacceptable behavior to witchcraft.

These findings reveal complex and sometimes contradictory perceptions. Most participants recognize that aging affects behavior and find age-related behavioral changes generally acceptable, yet substantial minorities attribute behavioral changes to supernatural causes or view them as violations of social norms. This complexity suggests coexistence of multiple interpretive frameworks within the community.

Knowledge of Memory Dysfunction

To assess community knowledge about memory loss as a medical condition, participants were asked if they had heard of "memory dysfunction." Surprisingly, 80.0% (n=72) reported having heard of it, while 20.0% (n=18) had not. This relatively high awareness rate was unexpected given the literature's emphasis on poor public knowledge about dementia and memory loss in rural African settings. However, further questions revealed that awareness of terminology did not necessarily correspond to accurate medical knowledge.

Chi-square analysis revealed no significant relationship between age and having heard of memory dysfunction ($\chi^2=6.043$, df=4, p=.20), suggesting that awareness of the term is distributed similarly across age groups rather than being concentrated among younger, potentially better-educated participants.

When asked to identify illnesses associated with memory dysfunction from a provided list, responses revealed substantial confusion. The most commonly selected option was diabetes (22.7%, n=20), followed by amnesia (14.3%, n=13) and dementia (12.9%, n=12). Other selections included stress, Alzheimer's disease, and high blood pressure (each 5.7%, n=5), with smaller percentages selecting depression, anxiety, trauma, schizophrenia, and other conditions.

The prominence of diabetes as the most commonly identified memory-related condition is noteworthy. While diabetes is indeed a risk factor for cognitive impairment and vascular dementia, it is not itself a form of memory loss. This confusion suggests participants may conflate risk factors with the conditions themselves or may observe that many elderly people with memory problems also have diabetes, leading to association without understanding causation.

Cross-tabulation of people's knowledge about memory dysfunction by age revealed no significant relationships ($\chi^2=6.043$, df=4, p=.20), indicating that knowledge gaps exist across all age groups rather than being concentrated in particular cohorts. Similarly, chi-square tests revealed no significant relationships between understanding of memory dysfunction and educational level ($\chi^2=1.039$, df=4, p=.90) or

employment status (χ^2=.396, df=1, p=.53). These null findings are somewhat surprising and may reflect either the limited variation in the sample (most participants had low education and were unemployed) or the possibility that knowledge about memory loss in this community is transmitted through informal channels rather than formal education.

However, a significant relationship emerged between gender and beliefs about memory loss and aging (χ^2=6.149, df=1, p=.01). Female participants were more likely to agree that memory loss is related to aging, possibly reflecting their predominant role as caregivers for elderly family members, providing them with more direct experience of cognitive decline.

When asked to describe memory loss, participants provided diverse definitions. The most common description (36.7%, n=33) characterized it as forgetfulness of basic activities or daily routines. The second most frequent (25.6%, n=23) described inability to store information long-term and recall past events. Other descriptions included forgetting information irregularly (12.2%, n=11), connecting memory loss to depression, stress, or anxiety (8.9%, n=8), and attributing it to past illness experiences (7.9%, n=7). Smaller percentages provided idiosyncratic definitions.

These descriptions reveal partial understanding of memory loss symptoms but often confuse symptoms (forgetfulness) with the underlying condition. Few participants demonstrated understanding of memory loss as a progressive neurological syndrome, instead describing it as a behavioral phenomenon or psychological state. This gap between symptom recognition and medical understanding has important implications for help-seeking and caregiving practices.

Beliefs About Memory Loss, Aging, and Normality

A central question addressed whether participants believed a relationship exists between memory loss and aging. An overwhelming 93.3% (n=84) answered "Yes," while only 6.7% (n=6) answered "No." This near-unanimous recognition suggests widespread acceptance that cognitive changes accompany aging, though as subsequent questions revealed, the nature of this relationship is understood differently by different individuals.

All participants (100%, n=90) identified elderly people as the age group most likely to suffer from memory loss, indicating consensus on this point. However, when asked whether memory loss is normal and inevitable among elderly people, while 95.6% (n=86) answered

"Yes," their explanations revealed important variations in understanding.

Among those agreeing memory loss is normal and inevitable, the most common explanation (38.4%, n=33) was that "everyone at elderly stage suffers from it" suggesting a view of memory loss as a universal feature of aging rather than a pathological condition affecting some but not all elderly people. The second most common explanation (37.2%, n=32) was that "as people grow, they forget frequently due to intellectual capacity deterioration" a more biomedically informed view acknowledging cognitive decline as a physiological process.

Other explanations included beliefs that elderly behavior regresses to childhood (14.0%, n=12), that elderly people act like children as memory deteriorates (5.8%, n=5), and that past traumatic experiences or illnesses affect memory functioning (2.3%, n=2). Smaller percentages provided unique explanations, including that memory loss has existed across generations (1.2%, n=1) and that elderly stress causes memory problems (1.2%, n=1).

Among the small minority (4.4%, n=4) who disagreed that memory loss is normal and inevitable, half (50%, n=2) explained their disagreement by stating that elderly people exhibiting unusual behaviors are motivated by cruelty and witchcraft rather than memory loss. The other half split between believing memory loss depends on personal experiences like lifestyle and environment (25%, n=1) and observing that some elderly people don't experience memory loss (25%, n=1).

The prominence of witchcraft attributions, even among this small group, is significant. It suggests that for some community members, cognitive and behavioral changes in elderly people are interpreted through supernatural frameworks that attribute moral agency and malevolent intent to affected individuals. This interpretation fundamentally alters the social meaning of memory loss from medical condition to moral failing or supernatural evil.

Chi-square tests revealed no significant relationships between description of memory loss as normal/inevitable and either educational level ($\chi^2=3.730$, df=8, p=.97) or age ($\chi^2=2.994$, df=8, p=.94). These null findings suggest that beliefs about the normality and inevitability of memory loss are widely distributed across demographic groups rather than concentrated among particular educational or age cohorts.

Personal Experience with Memory Loss

Participants were asked whether they had lived with someone suffering from memory loss. A substantial majority (74.4%, n=67) reported having this experience, while 25.6% (n=23) had not. This high proportion reflects both the prevalence of memory loss in elderly populations and the extended family structures common in rural South African communities where multiple generations often reside together.

Chi-square analyses revealed no significant relationships between having lived with someone with memory loss and either educational level (χ^2=2.506, df=4, p=.64) or age (χ^2=8.823, df=4, p=.075), suggesting that this experience is distributed relatively evenly across the community rather than concentrated in particular demographic groups.

Among those who had lived with memory loss patients, descriptions of their behavior revealed important patterns. The most common description (41.8%, n=28) was that affected individuals "forget frequently, forgetting basic things like their daily routines such as dressing themselves." This emphasis on functional impairment in activities of daily living aligns with clinical definitions of dementia but frames it as forgetfulness rather than neurological disease.

The second most frequent description (21.0%, n=14) characterized memory loss patients as forgetting "past events or incidences such as social encounters, or if someone has passed away." This captures the episodic memory deficits characteristic of Alzheimer's disease and other dementias. Other descriptions included: being short-tempered and controlling (15.0%, n=10), resistant to change (13.4%, n=9), both forgetful and short-tempered (10.0%, n=7), forgetting more when drunk (1.5%, n=1), and having strange, unjustifiable behavior (1.5%, n=1).

These behavioral descriptions emphasize the challenging aspects of memory loss not just cognitive impairment but personality changes, emotional dysregulation, and behavioral symptoms that strain caregiving relationships. The descriptions also reveal that community members recognize memory loss as affecting multiple domains of functioning, not just memory per se.

Among those who had not lived with memory loss patients, opinions about why it occurs revealed interesting patterns. The most common view (34.8%, n=8) was that "everyone at elderly stage forgets more when they are old"—again reflecting normalization of cognitive decline. However, 21.7% (n=5) acknowledged that "some individuals at elderly stage do not suffer from memory loss," recognizing

variability in aging outcomes. Other views included that memory loss depends on nutrition and external factors like alcohol (17.4%, n=4), that behavior corresponds to age (17.4%, n=4), and that some elderly people falsely claim memory loss to avoid accountability (8.7%, n=2).

This last perspective that elderly people feign memory loss to escape responsibility is particularly significant as it attributes intentionality and manipulation to what are actually symptoms of neurological disease. Such interpretations can lead to anger, resentment, and punitive responses toward affected individuals rather than compassionate care.

Discussion

The Coexistence of Multiple Explanatory Frameworks

The findings reveal that KwaZulu-Natal community members employ multiple, sometimes contradictory frameworks for understanding memory loss. While the overwhelming majority (93.3%) acknowledge a relationship between memory loss and aging, suggesting acceptance of a biological explanation, substantial minorities simultaneously entertain supernatural explanations involving witchcraft and cruelty. This coexistence of biomedical and traditional belief systems is not unique to this community but reflects broader patterns across African societies where multiple medical systems operate simultaneously (Amuyunzu-Nyamongo, 2013).

From a social action theory perspective, these multiple frameworks represent different lenses through which individuals interpret the same observable phenomena. An elderly person wandering at night, making accusations, or exhibiting personality changes can be understood as: (1) manifesting symptoms of neurodegenerative disease, (2) reverting to childlike behavior as a normal part of extreme aging, or (3) engaging in witchcraft activities. Each interpretation implies different social responses medical care, patient tolerance, or social sanction demonstrating how subjective meanings shape social action.

The persistence of witchcraft attributions, even among the minority holding these views, has serious implications. As Hanssen (2017) documented, elderly people accused of witchcraft in South African communities have faced violence and even death. When cognitive symptoms (paranoia, confusion, behavioral disinhibition) are interpreted as evidence of malevolent supernatural activity rather than illness, the vulnerable become culpable. The Xhosa concept of ukutwela confessing to witchcraft may be applied to elderly people

whose memory-related symptoms are misinterpreted as admissions of supernatural practice.

This finding suggests that efforts to improve care for people with memory loss cannot rely solely on disseminating biomedical information. Rather, interventions must engage with existing belief systems, acknowledging their cultural validity while creating space for complementary biomedical understandings. Respecting traditional beliefs while expanding explanatory frameworks represents a more promising approach than attempting to displace traditional knowledge with Western medical models.

Knowledge Gaps and Educational Implications

The finding that diabetes was most commonly identified (22.7%) as a memory-related illness, surpassing amnesia (14.3%) and dementia (12.9%), reveals significant gaps in medical knowledge about cognitive disorders. While diabetes is indeed a risk factor for vascular dementia and cognitive impairment (Malik et al., 2018), it is not itself a form of memory loss. This confusion likely stems from several sources: the high prevalence of diabetes in elderly populations, leading to observational association; the multisystem effects of diabetes including potential cognitive impacts; and limited formal education about the distinction between risk factors and disease outcomes.

More broadly, the finding that educational level showed no significant relationship with knowledge about memory dysfunction challenges assumptions that formal education straightforwardly translates into health literacy. This null finding may reflect several realities: the consistently low educational levels throughout the sample (limiting variation), the possibility that health knowledge is transmitted primarily through informal channels in this community, or the inadequacy of South African primary and secondary education in addressing health topics.

The descriptions of memory loss provided by participants reveal a focus on behavioral and functional symptoms rather than underlying pathophysiology. Memory loss is described as "forgetting basic things," "being unable to recall past events," or "acting like a child" all phenomenological descriptions of what memory loss looks like rather than explanations of what it is. This symptom-focused understanding, while practical for identifying affected individuals, may hinder recognition of memory loss as a medical condition requiring healthcare intervention.

From a public health perspective, these knowledge gaps suggest the need for community-based educational interventions. However, such interventions must be carefully designed to: (1) respect existing knowledge and beliefs, (2) use accessible language and concepts rather than medical terminology, (3) emphasize practical caregiving strategies alongside etiological information, and (4) address supernatural attributions directly rather than ignoring them as irrational.

Stigmatization and Its Consequences

The finding that 30% of participants consider elderly behavior unacceptable in society, with some attributing this to witchcraft, illuminates the stigmatization that people with memory loss may face. Even more telling is the description of memory loss patients as "stubborn," "resistant to change," "wanting to control everything," and engaging in "strange, unjustifiable behavior." These characterizations emphasize the challenging aspects of caregiving while potentially obscuring the medical nature of symptoms.

Stigmatization of memory loss operates through several mechanisms identified in this study. First, behavioral symptoms (aggression, disinhibition, wandering) may be interpreted as moral failings or intentional misbehavior rather than disease manifestations. Second, memory loss may be conflated with other stigmatized conditions, particularly mental illness and witchcraft. Third, the perception that some elderly people falsely claim memory loss to avoid accountability suggests suspicion and mistrust rather than compassion.

The consequences of this stigmatization are serious. As documented in the literature, stigma leads to social exclusion, family rejection, inadequate care, and violence (Putman, 2008; Adebiyi et al., 2016; Ekoh et al., 2020). When families believe an elderly member's cognitive changes reflect malevolence rather than illness, they may respond with punishment rather than support. When communities view people with memory loss as dangerous or morally compromised, social networks that might otherwise provide assistance instead withdraw.

Structural functionalism helps explain why stigmatization persists despite its harmful consequences. From this perspective, stigmatization serves social functions: maintaining moral boundaries, explaining misfortune, justifying resource allocation decisions, and reinforcing social norms. Challenging stigma therefore requires not just correcting misinformation but addressing the social needs that

stigmatization serves providing alternative explanations for misfortune, alternative mechanisms for maintaining social order, and alternative frameworks for distributing care responsibilities.

The Role of Socialization in Shaping Perceptions

The study's findings regarding socialization illuminate how perceptions of memory loss are transmitted and maintained. The lack of significant relationships between demographic variables (age, education, employment) and many beliefs suggests that perceptions are widely shared across the community rather than varying systematically by social position. This pattern indicates that socialization occurs primarily through informal, community-wide mechanisms rather than formal institutions.

Several socialization agents appear influential. Family-based socialization likely predominates, as the high proportion (74.4%) reporting experience living with memory loss patients suggests that direct family caregiving experience shapes perceptions. Religious socialization also appears important, given that 83.3% identify as Christian and previous research documents how religious frameworks influence health beliefs (Ekoh et al., 2020). The peer socialization evident in shared beliefs across age groups suggests community-wide cultural norms about aging and cognitive decline.

The intergenerational transmission of beliefs, noted by the Mental Health Foundation (2015), appears evident in this community. Views about memory loss being "normal" and "inevitable," about elderly people reverting to childlike behavior, and about supernatural causation are unlikely to be individually invented but rather learned through observation, storytelling, and explicit teaching across generations. This transmission ensures cultural continuity but also perpetuates misconceptions that may have been adaptive in the past but are problematic given current medical knowledge.

Educational socialization appears less influential, given the null findings regarding formal education levels and knowledge about memory loss. This suggests that the limited formal education most participants received did not adequately address health literacy or critical thinking about disease causation. It also suggests that brief educational interventions are unlikely to overcome deeply socialized beliefs without addressing the multiple socialization agents that maintain those beliefs.

Gender Dimensions of Memory Loss Perception

The significant relationship between gender and beliefs about memory loss and aging (p=.01) merits attention. Female participants were more likely to agree that memory loss is related to aging, possibly reflecting gendered caregiving roles. In South African societies, women disproportionately provide care for ill and elderly family members (Lloyd-Sherlock, 2019). This caregiving experience may increase women's awareness of cognitive decline's relationship to aging while also increasing their burden.

The predominance of females among older age groups in the sample (80% of 66+ respondents) reflects both demographic reality (female longevity) and potentially gendered patterns of availability for research participation. Older women's overrepresentation in the sample is appropriate given that they are both more likely to experience memory loss themselves and more likely to provide care for affected spouses or relatives.

However, gendered perceptions may also have negative dimensions. If women are viewed as primary caregivers, the burden of supporting people with memory loss may fall disproportionately on female family members without adequate support or recognition. If women are more likely to be accused of witchcraft (as suggested by some literature), elderly women experiencing memory loss may face particular vulnerability to stigmatization and violence.

Comparing Findings to Existing Literature

These findings align with and extend existing research on memory loss perceptions in African contexts. Like Khonje et al. (2015), this study found widespread normalization of memory loss as an expected part of aging. Like Duke (2013) and Sahin et al. (2006), it documented beliefs that cognitive decline is inevitable for elderly people. Like Adebiyi et al. (2016), it revealed knowledge gaps and confusion between memory loss and other conditions.

However, this study also reveals some unexpected findings. The relatively high proportion (80%) reporting awareness of "memory dysfunction" terminology contrasts with literature emphasizing poor public knowledge. This may reflect increasing awareness through media, healthcare campaigns, or other information sources, or may indicate that terminology awareness doesn't correspond to conceptual understanding. The specific identification of diabetes as the primary memory-related illness is not prominently featured in previous literature and may reflect this community's particular disease experience.

The witchcraft attributions documented here align with findings from Mavundla and Mphelane (2009), Hanssen (2017), and others studying South African contexts. However, the relatively small proportion (8.9%) explicitly attributing elderly behavior to witchcraft contrasts with some literature suggesting more widespread supernatural beliefs. This may reflect genuine community variation, effects of social desirability bias in responses, or the specific question wording used.

The coexistence of multiple explanatory frameworks documented here extends social action theory applications to health beliefs. While Weber emphasized subjective meanings, this study reveals that individuals may hold multiple, potentially contradictory meanings simultaneously, activating different frameworks in different contexts. This theoretical contribution suggests that health belief models emphasizing single causal attributions may oversimplify the cognitive complexity of how people actually understand illness.

Limitations and Strengths

Several limitations should be acknowledged. First, the study's cross-sectional design captures perceptions at a single time point, precluding analysis of how beliefs change over time or in response to experience. Second, the reliance on self-reported beliefs may be affected by social desirability bias, with participants potentially underreporting stigmatizing beliefs about witchcraft or overstating knowledge about medical concepts. Third, the sampling from a single community limits generalizability, though it enables depth of contextual understanding.

Fourth, the quantitative approach, while enabling systematic documentation of belief patterns, may miss nuances better captured through qualitative methods. Fifth, the study focused on community perceptions rather than the experiences of people with memory loss themselves, whose perspectives are crucial but beyond this study's scope. Sixth, translation between Xhosa and English, while carefully managed, may have introduced conceptual slippage.

Despite these limitations, the study has important strengths. The random sampling enhances representativeness within the community. The face-to-face interview approach enabled clarification and depth while maintaining standardization. The inclusion of both closed and open-ended questions balanced quantification with qualitative richness. The focus on an understudied population (rural, low-income, Xhosa-speaking) addresses a significant literature gap.

The grounding in social action theory provides theoretical depth often missing from atheoretical surveys.

Conclusion

Theoretical and Empirical Contributions

This study contributes to the sociology of health by illuminating how cultural constructions of illness shape social responses to vulnerable populations. Applying social action theory to memory loss perceptions reveals that community responses to cognitive decline are mediated by culturally specific interpretations that coexist with but are not reducible to biomedical understandings. The finding that multiple explanatory frameworks operate simultaneously biomedical, developmental, and supernatural advances theoretical understanding of health belief complexity.

Empirically, the study documents specific patterns of knowledge, beliefs, and attitudes in an understudied rural South African community, providing baseline data for future interventions. The identification of specific misconceptions (diabetes as memory loss, universal inevitability, witchcraft causation) provides targets for educational efforts. The documentation of stigmatization patterns illuminates mechanisms through which vulnerable elderly people experience social harm.

Policy and Practice Implications

Healthcare System Implications: The knowledge gaps documented here suggest that primary healthcare services in rural areas should incorporate dementia and memory loss screening, education, and support. Currently, most rural clinics lack specialized geriatric or psychiatric services. Training primary healthcare workers to recognize cognitive decline, provide basic counseling to families, and refer complex cases would improve care access.

Educational Interventions: Community-based awareness campaigns should address both knowledge gaps and stigmatizing beliefs. Effective interventions would: (1) use accessible language and concepts rather than medical jargon, (2) respect traditional beliefs while introducing complementary biomedical frameworks, (3) address witchcraft attributions directly and compassionately, (4) emphasize that memory loss is an illness, not moral failing, (5) provide practical caregiving strategies, and (6) utilize trusted community leaders and institutions for message delivery.

Academic Research: More research is needed on: (1) experiences of people with memory loss themselves in African contexts, (2) effective interventions for changing stigmatizing beliefs, (3) culturally appropriate caregiving models, (4) economic impacts of memory loss on households, and (5) comparative studies across different South African communities to assess generalizability.

Government Action: Policy responses should include: (1) legislation protecting elderly people from violence related to witchcraft accusations, (2) social support programs for families caring for memory loss patients, (3) integration of dementia care into primary healthcare, (4) public awareness campaigns, and (5) training for traditional healers about memory loss to create bridges between traditional and biomedical systems.

Community Engagement: Interventions should work with existing community structures chiefs, churches, traditional councils rather than imposing external models. Community dialogues exploring local understandings of memory loss, caregiving challenges, and resource needs would ground interventions in lived realities.

Memory loss in rural South Africa exists at the intersection of biology, culture, economics, and history. Understanding and addressing it requires moving beyond simple biomedical models to embrace the complexity of how communities make meaning of cognitive decline. This study reveals both concerning patterns stigmatization, knowledge gaps, supernatural attributions and hopeful ones widespread recognition of aging's effects, caregiving commitment, openness to discussion.

The challenge ahead is not to replace traditional beliefs with biomedical knowledge but to create spaces where multiple forms of knowledge can coexist productively. Elderly people experiencing memory loss deserve both the medical care that biomedicine can offer and the cultural respect that traditional systems emphasize. Achieving this requires humility from healthcare professionals, openness from communities, and sustained commitment from policymakers.

As South Africa's population ages and the prevalence of memory loss increases, the stakes of getting this right grow higher. The alternative continued misunderstanding, stigmatization, and inadequate care is unacceptable. This study provides a foundation for action, but action itself requires collective will, sustained resources, and genuine partnerships between diverse knowledge systems and stakeholders.

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