HIV/AIDS at a South African University: investigating the role of Walter Sisulu University's prevention role players and student behaviour at the Institute for Advanced Tooling

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Abstract

This thesis investigated perceptions of HIV/AIDS at the Walter Sisulu University (WSU), situated in the Eastern Cape, South Africa. The study focused on understanding opinions related to HIV/AIDS using data derived from interviews with twenty HIV/AIDS key role players from across the entire institution, and twenty students at the Institute for Advanced Tooling (IAT), a postgraduate section of the Mechanical Engineering Department in the Faculty of Science, Engineering and Technology (FSET) in Chiselhurst, East London. A key concern of the study was to examine the way in which local cultural beliefs and practices may shape understandings in relation to HIV/AIDS and to help inform more sensitive prevention campaigns in the future.

The study, methodologically utilising Denzin's concept of interpretative interactionism, and Giddens' structuration theory, found that there was no single 'cultural belief' regarding health or related issues, but that cultural beliefs were always expressed in personal and contextual ways. The investigation into nutrition, health and general well-being and perceived causes of HIV/AIDS revealed that research informants subscribed to cultural beliefs for different reasons in personal constructs, and the study concluded that cultural issues surrounding these factors would need to be socially debated in intervention efforts. Perceptions of gender, as the most significant factor, were highly contested, with differing beliefs expressed regarding female sexual agency. It was further stated by research informants that the ABC approach lacked contextual consideration of environmental factors. The thesis therefore argues that for effective preventative action, there is a necessity, firstly, for a health-enabling environment to be created that includes strategies for alleviating nutritional deficiencies in a culturally contextual fashion. Second, based on the data, it was established that in relation to respondents' orientation towards cultural beliefs, social HIV/AIDS debate programmes should be introduced in conjunction with health officials, the community and traditional healers in a peer-oriented approach. It was thirdly established that this approach should include addressing contextual factors from a 'lived experience' perspective, and that social positioning by the WSU should occur towards certain social issues (for example, constructions of gender) identified within this study.

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Author's declaration

I declare that this thesis is my own independent work, except where referenced and indicated in the text.

I also declare that this work has not been previously submitted to any other University for the purposes of obtaining a qualification.

Ian Saunderson
July 2013

Glossary of terms and abbreviations

Agency: The following description has been adopted for the study:

> …does not refer to a series of discrete acts, combined together, but a continuous flow of conduct. …involving a stream of actual or contemplated interventions of corporeal beings in the ongoing process of events in the real world. …it is a necessary feature of action that, in any point in time, 'the agent could have acted otherwise': either positively in terms of the attempted intervention in the process of 'the real world' or negatively in terms of forbearance (Giddens, 1979:56).

ABC approach: The following description has been adopted for the study:

> Abstinence, Be faithful and Condomise. This approach for HIV/AIDS prevention formed part of the US governments' 2003 PEPFAR (President's Emergency Plan for AIDS relief) plan focused on '15 countries that were home to 80% of all people requiring treatment' (Merson et al, 2007:7).

AIDS: Acquired Immune Deficiency Syndrome.

Amakanghata: (isiXhosa) Senior members within the Xhosa community. Males responsible for the initiation process.

ANC: African National Congress. Governing political party in South Africa.

ART: Anti-Retroviral Treatment. A combination of drugs, inclusive of ARVs, and other medical treatment to reduce the effect of the HIV virus.

ARV: Anti-Retro Viral (drug). Taken by HIV positive patients to reduce the effects of the HIV virus.

Bio-medicine: Promotion of 'Cartesian principles' in the treatment of illness associated with the human body, in opposition to 'variants' such as THPs (Wreford, 2005:57). Also explained, in relation to Africa, as a form of 'cultural imperialism with which Europe has bombarded Africa…' (Baronov, 2008:2) in relation to beliefs surrounding health and the human body.

BT: Border Technikon. Merger partner in forming WSU in 2005.

Butterworth: Town in the Eastern Cape, 120 kilometres north-east of East London. The WSU's Ibika campus is located here.

Contextual factors: The following description has been adopted for the study:

> Since early in the epidemic, enquiry into the factors influencing HIV-related vulnerability has been recognised as essential for prevention efforts. While much early work focused on the individual determinants of sexual and drug-related risk-taking, increasingly the contextual factors which render some groups more vulnerable than others have come to be recognized. Factors as diverse as age, gender, social position, economic status, cultural norms, beliefs and expectations determine the risks faced and enable and constrain individuals in their actions (Carael, 1999:4).

Culture: The following description has been adopted for the study:

> It denotes a historically transmitted pattern of meanings embodied in symbols, a system of inherited conceptions expressed in symbolic forms by means of which men communicate, perpetuate and develop their knowledge about their attitudes towards life (Geertz, 1973:89)**.**

DOHET: Department of Higher Education and Training.

Dual Universe Design: A research design where the universe of the study is two fold. The term is directly related to the chosen methodology, wherein Denzin (2002:3) states that 'researchers should use the approach advocated here only when they want to examine

the relationships between personal troubles (such as wife battering or alcoholism) and the public policies and public institutions created to address these troubles'. The implication is that the first universe would be those experiencing personal troubles, whilst the second would be the institution created to address these troubles. In this study, the first universe is the key role players in HIV/AIDS at the WSU, and the second, the students of the IAT. Since this study has a qualitative design and strives towards attaining transferability as opposed to generalisability, this design allows for conclusions to be made separately about each group and, furthermore, allows for comparison of views expressed by one group, responsible for HIV/AIDS prevention and the other, recipients of the preventative effort. This design is based on research previously done in this environment (Saunderson and De Wet, 2004:105), which revealed heterogeneity in views expressed by management and in those of students, partially due to the pressure on management to demonstrate performance, and the views of students, which reflected experiences of management performance at ground level.

ECT: Eastern Cape Technikon. Merger partner in WSU. Former headquarters in Butterworth.

FBML: Faculty of Business, Management Sciences and Law at WSU.

FSET: Faculty of Science, Engineering and Technology at WSU.

HIV: Human Immunodeficiency Virus.

Health-enabling environment: The following description has been adopted for the study:

> …we believe (there) are six key strategies for facilitating the development of 'AIDS-competent'

communities: building knowledge and basic skills; creating social spaces for dialogue and critical thinking; promoting a sense of local ownership of the problem and incentives for action; emphasising community strengths and resources; mobilising existing formal and informal local networks; and building partnerships between marginalized communities and more powerful outside actors and agencies, locally, nationally and internationally (Campbell et al, 2007:347).

Hlondipha: (isiXhosa) Word meaning respect. Commonly used as a result of gendered relationships.

IAT: The Institute for Advanced Tooling. A postgraduate division of the Mechanical Engineering Department, Faculty of Science, Engineering and Technology at the Walter Sisulu University. Based at the Chiselhurst Campus, East London.

IAT Students: The students of WSU's IAT were the second group to be interviewed, following the key role players, via typical case sampling. This was done during 2007. Since the IAT only had 11 students at the time (all isiXhosa-speaking males, with the exception of 1 student, a Shona male from Zimbabwe), 9 prospective male Xhosa IAT students, taken from the third year Mechanical Engineering group, were also interviewed.

IOP: Institutional Operating Plan. All national universities, affiliated to DOHET, are required to submit these plans to the Department from time to time.

Isiqwati: (isiXhosa) To remove. Associated in the context of this thesis with removal of evil spirits following initiation.

Ja: (Afrikaans) Word meaning yes. Commonly used by all interviewees.

Key Role Players: (Methodology) WSU staff at the institution identified as those who had an interest, or played a key role in the

development and delivery of education and training, as well as the provision of services in relation to HIV/AIDS.

Minister Manto Tshabalala Msimang: Minister of Health during the time data was collected for this study. Replaced first by Barbra Hogan, followed by Aaron Motsoaledi after the 2009 elections.

Mthatha: (Formerly Umtata). City in the Eastern Cape, approximately 250 km north-east of East London. WSU's main campus, Nelson Mandela Drive, is located here.

Muti: (isiXhosa) Word meaning medicine. Commonly used in most South African languages.

NSFAS: National Student Financial Aid Scheme. A government-supported study loan system specifically aimed at low-income families.

Nyanga: (isiXhosa) Word meaning herbalist.

PGDP: Provincial Growth and Development Plan, that sets strategic growth priorities of a province. Issued by the Office of the Premier.

Positioning: The following description has been adopted for the study:

> The positioning of agents in circumstances of co-presence is an elemental feature of the structuration of encounters. Positioning here involves many subtle modalities of bodily movement and gesture, as well as the more general motion of the body through the regional sectors of daily routines (Giddens, 1984:84).

President Thabo Mbeki: President of South Africa during the time data was collected for this study. Replaced first by President Kgalema Motlanthe, followed by President Jacob Zuma after the 2009 elections.

Queenstown: Small town in the Eastern Cape, 180 km north-west of East London. WSU had a campus here during data collection. The campus has been relocated to Whittlesea.

Sangoma: (isiXhosa) Word meaning witchdoctor. Authors suggest the term 'witchdoctor' is pejorative (c.f. Hewson et al, 2009:7), hence the term THP. *Also* referred to as *igqirha,* with similar meanings.

Social distancing: An observation whereby research informants, when describing beliefs, state 'they believe'. This was common, and the term infers that research informants were removing themselves from the beliefs that they were describing.

Social position: An approach that members of society have to take in order to address a specific problem. In this manner peer trainers take a 'social position' (or stance) to convince peers about the negative consequences of unprotected sex (in this study). In the same manner the WSU HIV/AIDS key role players would have to take a social position in relation to an indigenous, knowledge-integrative or bio-medical approach to intervention.

Structure: The following description has been adopted for the study:

> …refers, in social analysis, to the structuring properties allowing the 'binding' of time-space in social systems, the properties which make it possible for discernibly social practises to exist across varying spans of time and space which lend them 'systemic' form (Giddens, 1984:17).

TAC: Treatment Action Campaign. A non-governmental organisation under the leadership of Mr Zackie Achmat. The organisation opposes what it has termed 'AIDS denialism by the South African Government'.

THP:	Traditional healthcare practitioner.
Ukumetsha:	(isiXhosa) Word meaning ‘thigh sex’, and has historic origins in the promotion of abstinence through non-penetrative sexual engagement (Robins, 2009:31). Abandoned as a social practice due to influence of missionaries, *circa* 1930 (Cole and Thomas, 2009:38).
Ukuswama:	(isiXhosa) Word signifying a request to the ancestors to watch over an initiate during the initiation process, normally includes the ritual slaughtering of a goat (or other animal, such as an ox). The meat must first be eaten by the initiate, with no salt.
Umgidi:	(isiXhosa) Word signifying celebration, following successful initiation.
UNITRA:	University of the Transkei. Former merger partner in WSU.
WSU:	Walter Sisulu University.

1: Introduction

1.1 Overview of the chapter

In this chapter, I will seek to introduce the reader to the main tenets of the study and to provide background information about the nature and scope of the HIV/AIDS problem in South Africa. I shall present the reasoning behind the investigation and will explain why conducting a study of this nature seemed important. In the second section, I will provide general information about HIV/AIDS in South Africa, with the specific purpose of highlighting the seriousness of the disease through an examination of statistical data regarding HIV/AIDS epidemiological trends at higher educational institutions in the country, especially in the Eastern Cape and specifically at the Walter Sisulu University (WSU). This is followed by a description of the rationale for the study, an outline of the structure of the thesis, and a note on terminology.

1.1.1 General introduction to the study

The aim of this thesis was to examine how students from the Institute for Advanced Tooling (IAT), as well as key-role players in HIV/AIDS prevention at WSU, understood key factors related to HIV/AIDS. I was particularly concerned to investigate perceived causes of HIV/AIDS; nutrition; gender and the effectiveness of the government led 'ABC approach' to HIV prevention. In a more general sense the thesis examines HIV/AIDS beliefs from a cultural perspective. It is an assumption of this research that because everyone's practice and decision making is shaped by cultural beliefs, effective prevention campaigns need to be informed by a better understanding of how health, illness, transmission etc. are locally understood. In this manner, Liddell, et al (2006:218), argue that cultural beliefs has a significant impact on the way that health and health beliefs are constructed and understood in South African communities. This research thus examined how the culture of the students and the key-role players in HIV/AIDS at the University influenced their beliefs about HIV and AIDS.

The study was undertaken at the Walter Sisulu University in the Eastern Cape, South Africa, and included interviews with both staff and students. The staff were identified as those who had an interest or played a key role in the development and delivery of education and training and the provision of services to people with HIV/AIDS. The students were drawn from the IAT in East London. More than 95% of the research

informants in the study were isiXhosa-speaking, which broadly reflects the demographic make-up of the student body at WSU. Interviewing both groups allowed me to understand how local understandings shape both the delivery and the reception of existing prevention campaigns, as well as the detection and comparison of heterogeneity in beliefs between these two groups. The key role-players have the role of initiating and sustaining the prevention of HIV/AIDS at the institution, while students at the IAT may or may not accept the efforts of these key role-players.

Discussions with colleagues with greater length of tenure at WSU revealed that HIV/AIDS has been a major topic of discussion at the University for a number of years. HIV/AIDS research in the area has mostly examined the incidence of HIV/AIDS, its prevalence and its mortality rate, with findings that indicated that the Eastern Cape Province had a prevalence rate of 26% of the entire population in 2007 (AVERT, 2010). This percentage is 2% below the national average of 28%, and substantially below that of the Kwa-Zulu Natal Province, which exhibits the highest rate of 37%. In view of the apparent variety of opinions related to the incidence of the disease, I felt that a study such as this could provide a much needed account of understandings and beliefs relevant to HIV/AIDS but attentive to the local context. I considered myself well-placed to research the topic as the IAT was located at the campus where I lectured. The next section examines the current position in relation to HIV/AIDS at South African higher educational institutions, and will provide some insight into the extent of the problem.

1.1.2 HIV/AIDS epidemiology: South African higher educational institutions

South Africa has the highest HIV/AIDS prevalence rate in the world, based on 2007 figures (Pooe and Surujlal, 2009:265). The World Health Organisation's (WHO) HIV epidemiological fact sheet (2008:4) estimates that 5.7 million people in South Africa were HIV positive. As AVERT indicated in 2010, this translates to a national average of 28% of the population (AVERT, 2010). For comparative purposes, a 2004 HEAIDS study (HEAIDS, 2004:3) estimated that '25% of Technikon students and 20% of university students have contracted HIV'. The study anticipated that by 2005, these numbers would have increased by '10% across institutions'. These figures can be compared to those released in 2010 (HEAIDS, 2010), which revealed that the student prevalence rate was at 3,4% nationally and at 6.4% in the Eastern Cape. The Eastern Cape Youth Commission, in a study that examined HIV prevalence at the University of Fort Hare, Nelson Mandela Metropolitan University and WSU, estimated that 15% of the students were HIV positive

(Eastern Cape Youth Commission, 2010:18). From these figures it is clear that rates vary substantively across institutions, and that provincial HIV/AIDS prevalence is correlated with institutional HIV/AIDS prevalence. Also, and of concern for WSU, it was found that the highest prevalence rate was in the OR Tambo district with 22%. WSU was the only university of the three that had participated in the study with a presence in this area. It is important to note that this figure of 22%, compared with the 2004 estimate (HEAIDS, 2004:3), shows that, at the least, for WSU, the 2004 HEAIDS' estimate was very accurate, and that facts revealed in later reports mirror estimates in previous reports.

The Eastern Cape Youth Commission report concluded:

> …this finding seriously challenges the assumption that the current preventative measures influence behaviour and the subsequent lowering of the prevalence of HIV and AIDS among the youth. It is clear that in general the youth has a good understanding with regards to HIV and AIDS related matters, yet it has failed to influence their behaviour. The vast majority of the youth are sexually active and only about half reported that they use condoms. It is this researcher's opinion that it is of vital importance to reinvestigate current HIV prevention measures in place in order to adapt them in a manner that will bring about positive changes in the youth's behavioural patterns (Eastern Cape Youth Commission, 2010:XXI).

Both the HEAIDS report and the Youth Commission report revealed that the issue of concern was not basic knowledge regarding HIV transmission. There is a great deal of evidence to suggest that HIV/AIDS related behaviour both in South Africa and in the rest of the world is affected by cultural beliefs (Parker, 2001:163; Motzoi, 2006:2; Visser et al, 2009:197). There is also evidence to suggest that if HIV/AIDS prevention programmes are to be successful, they must reflect and be embedded in the cultural beliefs of those that they are aimed at (Rolston, 2010:2; Bartholomew et al, 2011:12). Against this background, this study aimed to investigate the intersection of local practices, personal beliefs and national campaigns, by talking to both WSU HIV/AIDS key role-players and IAT students about these questions.

1.2 Rationale for the study

In this section I firstly discuss my decision to adopt an approach aimed at understanding a range of different factors dealing with HIV/AIDS, as well as the relevance of each of the key themes which emerged form the first analysis of data. These include: perceptions related to the cause(s) of HIV/AIDS, nutrition, health and general well-being, gender and the ABC approach. This is followed by a discussion as to how each of these factors is

linked to cultural beliefs, and therefore the rationale behind adopting a culturally sensitive approach. The research question, aims and goals are provided, followed by a discussion on design considerations.

1.2.1 Factorial considerations

The study of HIV/AIDS and related concepts, such as sexual behaviour, has proven to be multi-disciplinary in nature, and the complexity of the issue is such that many authors grapple with the level and number of contextual factors that should be included for investigation in a study (Wekesa and Coast, 2007; Desmond, 2009; Van der Riet, 2009). For example, Campbell (1997:273) examined migrancy, identities, masculinity, health and sexuality, all within one study dealing with HIV/AIDS affecting South African mineworkers and their perceptions of the disease. Desmond (2009), in a study dealing with HIV and risk-taking behaviour in Tanzania, examined issues such as the social landscape, local administration, health and religion, social relations, agency and prevention efforts all within a study about risk factors and HIV/AIDS. In a similar manner Chisaka (2006) included factors such as poverty, emotions, selfhood, stigma, suicide and so forth, within a study of women living with HIV/AIDS. Guided by the experiences of such authors I have adopted an approach which tries to situate the question of HIV/AIDS within the context of a wider range of issues. In particular, the following factors emerged as relevant from the data: perceptions about the causes of HIV/AIDS; understandings about nutrition; practises and beliefs related to gender; and the effectiveness of the ABC campaign.

1.2.2 Key Themes

Within the context of this study, the most significant key themes relating to HIV/AIDS emerged as: perceptions related to the cause(s) of HIV/AIDS, nutrition, health and general well-being, gender and perceptions related to the ABC approach. Some background information in relation to these themes which are central to the thesis are discussed below:

- Perceptions related to the cause(s) of HIV/AIDS: Determination of beliefs related to the causes of HIV/AIDS could help us understand how existing belief systems that shape the basis of acceptance or non-acceptance of advocated preventative behaviour. HIV/AIDS prevention models of the past did not take into account ‘African belief systems’ (Airhihenbuwa and De Witt Webster, 2004:6), and consequently have not been successful (Setswe, 2007:5). In this manner, Van Dyk

(2008:201) stated that '…people can experience the world in a unique and very specific way that is different from the way Westerners experience it.' The author then continues with the contention that 'HIV/AIDS education and prevention programmes have mostly been based on Western principles, and no attempt has been made to understand and integrate the diverse cultural and belief systems of Africa into such programmes. Might this not be one of the reasons why HIV/AIDS education systems failed so dismally in Africa…?' In this sense, it is one of the aims of this thesis to establish to what extent attention needs to be given to local perceptions of HIV/AIDS when considering social issues surrounding HIV.

- Nutrition: The element of nutrition in this thesis is primarily concerned with two issues – one, the exploration of cultural beliefs related to, nutrition, health and general well-being and HIV/AIDS, and two, investigating the response to former President Thabo Mbeki's promotion of traditional foods in the fight against HIV/AIDS. The medical arguments for good nutrition, especially when someone is HIV positive, have been well documented (Liebenberg and Pillay, 2000:4; Loevinsohn and Gillespie, 2003:8), and a culturally sensitive approach in relation to nutrition could be useful in curbing the onset of AIDS, as indicated in studies conducted by Cocks and Moller (2002:387) and Jolly (2006:89). Some authors (c.f. Mare, 2009:4) are of the opinion that Thabo Mbeki, and former Minister of Health, Manto Tshabalala Msimang's views (which involved the promotion of a diet of garlic and beetroot as a cure to HIV/AIDS) were responsible for 'the death of many HIV positive South Africans' (Myburgh, 2005:2). I felt it was important to assess some of these views expressed in the media against those held by research informants.

- Gender: Sexual behaviour is gendered, entailing 'socio-culturally constructed behaviours' (Ragnarsson et al, 2008:740), which manifests in all world-view interpretations of sexuality (Pollis, 1985:286), and is clearly not unique to isiXhosa-speaking research informants. These behaviours have a direct bearing on HIV-prevalence, since it is argued that a lack of agency causes women to be more susceptible to contracting HIV (Ampofu et al, 2004:692). Some authors are of the opinion that isiXhosa-speaking males' beliefs regarding gender roles are formed at circumcision schools (Stinson, 2008:2), and also that the role of circumcision schools has changed (Vincent, 2008:431). Some authors describe it as a patriarchal society (Muller and Pienaar, 2004:1029; Motshekga, 2010:1). Others state that

violence against women is prevalent (Peltzer and Pengpid, 2008:1466), and the study of gender in this context therefore specifically relates to sexual agency and the extent to which this may have a bearing in relation to HIV/AIDS.

- The ABC approach: This approach is the primary HIV/AIDS prevention approach introduced by the South African Government (Mash, 2006:51). However, many authors have described it as a failure (Campbell and Williams, 1998:57, Obaid, 2004:2, Dworkin and Erhardt, 2007:14, Setswe, 2007:5) due to the fact that it does not take the context, environment, gender considerations, and elements of social power into consideration. Mash (2006:51), for example, stated that the ABC campaign in South Africa 'erroneously assumes that women are in control of sex, can control their partners faithfulness and can influence the decision to use a condom'.

1.2.3 Culture and health

The adopted definition for the term 'culture' in this thesis is that of Geertz:

> It denotes a historically transmitted pattern of meanings embodied in symbols, a system of inherited conceptions expressed in symbolic forms by means of which men communicate, perpetuate and develop their knowledge about their attitudes towards life (Geertz, 1973:89).

If we were to examine texts such as Kuper (2003:390), Robins (2001:239) and Saugestad (2001:203) various definitions of culture emerge. It needs to be emphasised that in this study these terms are examined from the perspective adopted by research informants in a South African setting. Kuper (2003:390) also explains that terms such as culture are 'romanticised' in a South African setting. This also occurred in this thesis - while interviewing research informants, they would often use the term 'in our culture' to explain their own beliefs, and were comfortable using this terminology. This is also reported in research conducted by Van der Vliet (1991:236), Tutani and Rankin (2000:8) and Chuene (2006:130).

In that respect, I use the term 'culture', reflecting the usage of my research participants. Reflecting terminology in this manner is also appropriate according to Gidden's double hermeneutic, also applied in this study. In a similar manner, Robins (2001:239) highlighted that terms such as 'indigenous' as defined by the UNWGIP (United Nations Working Group on Indigenous Populations), are not adopted by the South African Government, since 'South Africa has specific and unique circumstances'. In this way, the term

'indigenous' has even been described as 'an inconvenient concept in South Africa' (Saugestad, 2001:303), and will therefore be avoided within this thesis. There is thus a preference for use of the term culture as opposed to ethnicity in this thesis, not only to avoid conceptual confusion but to ensure consistency as well.

ARHAP (2006:15) maintains that in many cultures the understanding of the term 'health' encompasses far more than it does with the standard bio-medical view; i.e. that it involves 'a far richer description, one that encompasses the spiritual elements of health that the bio-medical model tends to ignore, and one that is linguistically embedded in a non-Cartesian unity of subject and object, of religion and health.' Evidence suggests that approximately 80% of people in the Eastern Cape depend on traditional healers for guidance on health-related issues (Mulaudzi, 2001:7). For the purposes of this study the term traditional healers (c.f. Kahn and Kelly, 2001:35), or traditional healthcare practitioners (THPs) (c.f. Glossary of terms and abbreviations), include diviners (*amagqira*), herbalists (*ixhwele*) and faith healers (*umtandazeli*).

Following an interpretative approach, Kahn and Kelly (2001:36) stated that 'being Xhosa means subscribing to a general culture of social practice, and a culture of health and healing'. Various authors (Venter, 2004:202; Chuene, 2006, Duku, 2007:4) suggest that heterogeneity in terms of identity should be a concern when conducting research within isiXhosa-speaking research populations. In this way Chuene (2006:13) highlighted that there are great differences between elderly people and urbanised youth in relation to perceptions surrounding health and HIV/AIDS. For instance, Duku (2007:4) stated: 'African identity is neither exclusively a matter of tradition and culture, nor exclusively a matter of modernity and citizenship, as Mamdani's (1996) approach on the face of it suggests, but a 'melting pot of multiple identities' (Nyamnjoh, 2002).

Faced with the concept of bio-medicine, Kahn and Kelly (2001:47) further describe conceptualisations of health amongst the Xhosa as 'they subscribe to a pluralistic system and draw on both cultural worlds in an adjunctive way without a single core set of principles'. For the purposes of this study, which acknowledges the need to be culturally sensitive in HIV/AIDS prevention programmes, I will also be investigating the manifestation of this pluralistic, heterogeneous, outlook with regards to health, HIV/AIDS and general well-being.

1.2.4 Culture, the research question, aims, goals and delimitations

The term 'culture' and its usage is heavily debated, to the extent that Geertz has commented that 'anthropology is a science whose progress is marked less by a perfection of consensus than by a refinement of debate' (Geertz, 1973:29). In this sense, I recognise the multiplicity of debates surrounding the use of terminology within the social sciences.

For me, nomenclature and debate surrounding whether the term 'culture' or 'ethnicity' is most appropriate, has only scholarly value. Death from AIDS does not concern itself with whether you are from a specific 'cultural' or 'ethnic' background, and what term you decide to use. So the point of departure for me could only be the views of research informants and the ways in which they use the term 'culture' to describe beliefs surrounding HIV/AIDS. Notably, a word search on the term 'ethni*'[1] through forty transcribed interviews reveals zero returns. So, this leaves us with the term 'culture', irrespective of criticisms against its usage, as criticisms against the use of the word 'ethnicity' are also numerous.

In this sense, my concern is not to make contributions towards cultural theory, but to understand how a culturally sensitive approach might help us make pertinent recommendations towards HIV/AIDS prevention. These recommendations will be made to the IAT and the key role players in HIV/AIDS at the WSU – which could lead to saving lives. This, to me, has more value than any theoretical contribution. By taking the position of my research informants and their use of nomenclature immediately places me within the interpretive approach to culture. Lystra (1983:43), in her analysis of Geertz, stated that 'to see cultural analysis clearly as interpretative, and to make no apology for it, is an important contribution to understanding the nature of method in culture studies'. I think that this quote clearly reflects my view, and is appropriate here.

The research question in this study explores some of the local beliefs of the key role-players in HIV/AIDS prevention at the WSU, as well as students from the IAT, surrounding their perceptions of HIV/AIDS, and more specifically, in the areas of the cause(s) of HIV/AIDS, nutrition, gender and the ABC approach. The study furthermore asks what the implications for HIV/AIDS prevention are, and attempts to make pertinent

[1] The '*' is commonly used as a search tool – in this case it would find any word that starts with the term 'ethni' – such as ethnicity or ethnic.

recommendations in this regard. Thus, the study is a concern to understand how we can better implement HIV/AIDS intervention programs that are culturally sensitive, which take into account the implications of the existence of a dual system of traditional healing and bio-medicine, and which are peer-driven.

The research aims were formulated as follows:

1. To better understand the response to previous prevention campaigns by WSU key role players in the field of HIV/AIDS and students of the IAT in relation to local beliefs regarding health and HIV in the areas of: the causes of HIV/AIDS, nutrition, gender, and the ABC campaign.
2. To gain an understanding of local practises related to HIV/AIDS prevalence and to make pertinent recommendations in relation to the main approach that the key role players in HIV/AIDS at the WSU have to take to in order to address the spread of HIV/AIDS at the IAT and WSU.
3. To understand to what extent research informants are critical of understandings of cultural prescriptions in relation to HIV/AIDS when considering issues surrounding HIV.

The research goals were formulated as follows:

1. Determine the extent to which subscription to local beliefs regarding health and HIV/AIDS ultimately affects the manner in which the problem of HIV/AIDS should be addressed. Ultimately this study wishes to demonstrate to the research community the importance of cultural and local considerations in approaching issues concerning HIV/AIDS, and
2. Provide, through the findings of this research, guidance to the IAT about the way in which HIV/AIDS should be approached at a postgraduate centre within WSU, and possibly inform future strategies at the WSU to curb the proliferation of the disease.

While the study limits itself to these factors, as identified earlier for investigation, it remains difficult not to mention other factors, such as poverty, for they are closely related. In this respect the contention from a UNAIDS publication concerning the spread of

HIV/AIDS in developing countries is pertinent:

> Social and economic development are essential elements in the battle against AIDS. As the history of other devastating epidemics has shown, vulnerability is magnified by poverty, discrimination and despair. And people's capacity to deal with the threat of disease is fundamentally shaped by the social and economic conditions in which they live (Collins and Rau, 2000:3).

In view of the above, it should be accepted that issues concerning social and economic development in a setting of extreme poverty (Rampedi, 2005:320) are major aspects of the HIV/AIDS situation in South Africa and especially the Eastern Cape. These factors are however considered *ceteris paribus* although some reference is made to these conditions in Chapter 2, which is concerned with the research setting. The poverty factor is obviously related to factors such as 'nutrition and well-being'. Other issues such as HIV/AIDS in relation to homosexuality, intravenous drug infection and religion have proven to be negligible factors in these contexts (Alma, 2007:20) and were also, therefore, not central concerns of this study.

1.2.5 Design considerations

This study clearly outlines two distinct research groups in what I have called a dual universe design: WSU key role-players in the field of HIV/AIDS, who consisted of 20 key role-players in HIV/AIDS for the entire institution, and 20 students from the IAT of WSU, a small postgraduate section of the Mechanical Engineering Department in Chiselhurst, East London. Key role-players included 20 major and prominent role players in the field of HIV/AIDS prevention at WSU, including people such as the Chairperson of the HIV/AIDS Committee, some of the HIV/AIDS counsellors, HIV/AIDS workers, and HIV/AIDS activists. This group of people were interviewed during the course of 2006. The students of WSU's IAT were the second group to be interviewed. This was done during 2007. Since the IAT only had 11 students at the time (all isiXhosa-speaking males, with the exception of 1 student, a Shona male from Zimbabwe), 9 prospective male Xhosa IAT students, taken from the third year Mechanical Engineering group, were also interviewed.

The reasoning behind this design was the fact that it allowed for interviews with both those involved in the implementation of prevention campaigns and practices, and those who are the 'recipients' of such practices. By dividing the two research groups into 'students' and 'WSU role-players' it is perceived that this design would allow for

highlighting differences between the management of the institution in relation to HIV/AIDS related issues, on the one hand and the views of the students on the other. Research previously done in this environment (Saunderson and De Wet, 2004:105) revealed differences in views expressed by management and amongst students, partially due to the pressure on management to demonstrate performance.

1.3 Structure of the thesis

Chapter 2 has as its purpose to provide background information, and first situates the study in its specific context in time. The chapter then discusses the geographical area of the Eastern Cape, citing research findings from various studies which were conducted within the research area, which are considered as background information to the more theoretical discussion in Chapter 3. The chapter further introduces the reader to the Walter Sisulu University and the Institute for Advanced Tooling, and also examines Higher Education South Africa (HESA) initiatives in HIV/AIDS management.

Chapter 3 focuses on explaining the major theoretical underpinnings of the study. The chapter consists of three sections, with the first examining the major theories utilised in the study (including Gidden's theory of structuration, his focus on the unintended consequences of action as well as his conceptualisations of the double hermeneutic). The second section examines key terms in relation to the research problem, which amounts to a discussion about culture and related terms. The third section combines the discussion about the identified contextual factors (of which the background was discussed in Chapter 2), with the idea of culturally sensitive intervention programmes in a peer oriented approach.

Chapter 4 examines the research methodology utilised in the study. This chapter describes the methodological approach that underpins this study and the methods adopted in carrying out the research. On the basis of other South African studies, and the nature of the research problem, it argues for a qualitative approach, within the interpretative tradition, utilising Denzin's method of interpretative interaction (Denzin, 2002). The chapter layout is structured around a discussion of Denzin's six steps in the interpretative process (Denzin, 2002:70), whilst the last two sections address issues relating to data integrity and ethics.

Chapter 5, the first data analysis chapter, specifically addresses two thematic questions; (1) the perceived causes of HIV/AIDS and (2) nutrition and perceptions regarding health. This chapter provides an exploration of knowledge about HIV/AIDS grounded in the cultural

beliefs of the research participants, their social position in relation to cultural beliefs, as well as nutritional beliefs that the HIV/AIDS key role-players at WSU and the students of the IAT described in relation to HIV/AIDS. Based on the findings the chapter argues, as suggested by Campbell et al (2005:471) and Campbell et al (2007:347), that a health-enabling environment is required before embarking upon any HIV/AIDS-preventative measures.

Chapter 6 is the second data analysis chapter and specifically addresses two further issues; (3) gender and (4) the ABC approach. This chapter argues that gender equality, with consideration of sexual agency, should receive special priority in HIV/AIDS prevention campaigns in the research context area due to the fact that this factor was most commonly cited by research informants as a perceived cause of HIV/AIDS. This chapter also shows that the ABC approach was largely rejected by research informants.

Chapter 7 is the third data analysis chapter and based on the findings from the previous data chapters, suggests a multi-step approach to HIV/AIDS prevention for the IAT and discusses considerations for key role players in HIV/AIDS at WSU. The chapter first discusses the interpretative conflicts identified during the study to highlight the differences between 'personal troubles' and 'institutional troubles' (c.f. Denzin, 2002:3). This analysis then argues, drawing on all the elements of the thesis, for a multi-step approach for addressing problems associated with HIV/AIDS at the IAT.

Chapter 8 offers a concluding synthesis. A research summary is provided with highlights from each chapter. This is followed by sections that detail the research implications for future practice.

1.4 Nomenclature and writing style

Specific nomenclature issues need to be addressed in relation to the manner presented:

- Writing style and subjectivity: I frequently employ the 'I', as with first person writing. Where necessary, third person writing is also employed. I felt it was important that I should not 'erase' myself from the study as I am aware of the influence that I am likely to have on my research respondents (c.f. Clifford and Markus, 2005). It also demonstrates a need for objectivity, thus the use of the third person where necessary.

- 'The Xhosa culture/Xhosa ethnicity': I am fully aware that, as per explanations in various texts[2], such as Glaser (2001:143), that culture cannot be viewed as 'singular' and am aware of academic discussion of the dangers of reifying the concept of culture.

[2] The Xhosa consists of many groups all with different beliefs and practices. For instance, 'not all Xhosa speaking group circumcise. It is not practised amongst the Bhaca, Mpondo, Xesibe or Ntlangwini' (Stinston, 2008). To conclude that circumcision is a 'Xhosa practise', would therefore be incorrect.

2: Background and research setting

2.1 Introduction

In this chapter, I firstly seek to situate the study in its context and in the time of research, since there were some very important social issues surrounding the debate on HIV/AIDS during the period of data collection. The elapsed time between data collection and finalisation of the study has seen some issues disappear and others emerge, and this section will attempt to show how this problem was controlled in order to make the findings of the study relevant.

Secondly, I present an overview of the findings of selected existing studies which are relevant to the core concerns of this study, particularly as these issues manifest themselves within the Eastern Cape. This allows the reader to gain a preliminary insight into how some aspects of these factors were viewed within the region during the time of research. It should be noted that these factors are discussed in more detail in Chapter 3.

Thirdly, I introduce the reader to the existing situation in relation to HIV/AIDS preventative efforts at Higher Education Institutions of Learning (HEIs) in South Africa. This allows for comparison between other HEIs' efforts in relation to HIV/AIDS prevention, and those undertaken at WSU. It also allows for a comparative benchmark in relation to student views of WSU HIV/AIDS prevention efforts which are discussed in more detail in later chapters.

Lastly, I briefly describe the Walter Sisulu University as an institution through examining its major operations, and then briefly discuss the background of the two groups of research participants: the key role players in HIV/AIDS at WSU and the students from the Institute for Advanced Tooling.

2.2 Situating the study in context and time

The need to situate research in context and time is important since it allows the reader to reconstruct what the major issues were during the time of research and the context of the social setting. Denzin (2002:85) reminds us of 'the problem of timing, history and mapping', whilst Giddens (1984:71) refers to the 'time-space' wherein events took place.

By 'context and time' I am specifically referring to the problem of history and context, and will attempt to situate the research in relation to some key public debates which took place in relation to South Africa during the time of research. It should be remembered that this study, in relation to its aims, also looks at 'social position'[3], implying that the study should give some consideration to wider social issues that affected HIV/AIDS proliferation and understandings about the disease, during the period of research.

This would make the inclusion of a discussion on the Government's position on HIV/AIDS prevention during the time of the study relevant not least due to its potential impact on local HIV/AIDS prevention strategies. These issues received ample media attention during the time of research (Mare, 2009:4). During the time of the study the President of the South Africa was Thabo Mbeki. He resigned as President in 2008. In relation to this study from a health perspective, he was supported by Health Minister Manto Tshabalala-Msimang, who passed away in 2009. During the presidency President Thabo Mbeki, Jacob Zuma, president of the country since 2009, was deputy president. Dr Aaron Motsoaledi was appointed as the Minister of Health following the election of Jacob Zuma as president. The change in the position adopted on HIV/AIDS by the South African Government following this change of presidency has been described as a positive step in the fight against HIV/AIDS (Karim et al, 2009:921).

There is therefore a considerable change between the way in which these issues are publically discussed now and the way in which they were being discussed during the time of research. In this respect I would note Janesick's (1994:218) description of relevance: 'qualitative research has an elastic quality, much like the elasticity of a dancer's spine'. In a later publication (Janesick, 2003:57) explains that a 'holistic picture' should be painted, which would include how instances of lived experience discovered in the field are made relevant to current settings. This research therefore continually attempts to include

[3] c.f. Glossary of Terms and Abbreviations

references relevant during the time of research and current references, and juxtaposes these separate references in time against one another to result in findings and recommendations that are relevant to the time of completion of the thesis.

2.3 Geographic area and research setting: The Eastern Cape

This section contains relevant general information regarding the population of the area in which the research was undertaken and examines research data related to the wider population in respect of perceived causes of HIV/AIDS, gender, nutrition and the ABC approach.

2.3.1 Geography, population and socio-economic conditions

Fig. 1: Map of South Africa (http://www.sa-venues.com)

The geographic area of South Africa is depicted in Fig. 1. The Eastern Cape forms a smaller section of South Africa (Figs. 2 and 3), and these figures show the geographical

research area wherein the WSU's multi-campus setting is located. Figure 2 provides some insight into the actual size of the various municipalities and Figure 3 indicates some of the major cities and towns within the Eastern Cape.

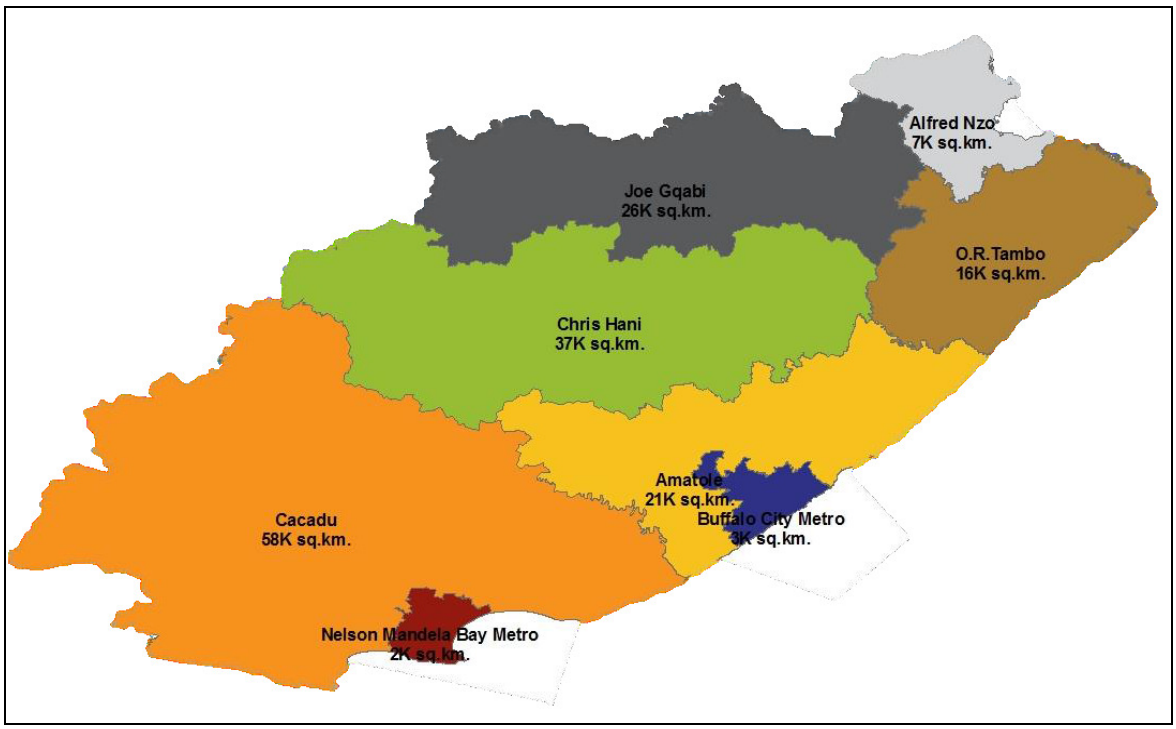

Fig. 2: Map of the Eastern Cape showing the municipal district areas
(Eastern Cape Socio – Economic Consultative Council, 2012)

Fig. 3: Map of the Eastern Cape: major centres (http://www.ectourism.co.za/)

It can be clearly seen from the maps that the Eastern Cape is a very large area, occupying 168 966 square kilometres (approximately 13,9% of the total surface area of South Africa) (South African Yearbook 2011:3). In terms of Figure 3, it should be noted that the WSU main campus is located in Mthatha (depicted as Umtata on the map[4]). In addition to Mthatha, the WSU also has campuses in Butterworth (halfway between East London and Mthatha, not on the map), East London and Whittlesea (close to Queenstown on the map).

	2003	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
Total	**6,517,540**	**6,554,681**	**6,591,952**	**6,627,460**	**6,669,749**	**6,703,452**	**6,728,955**	**6,743,823**
Black African	5,670,243	5,706,343	5,744,466	5,783,060	5,827,986	5,866,141	5,897,399	5,919,244
Coloured	493,928	499,600	503,912	506,399	509,046	509,915	509,513	507,962
Indian or Asian	17,717	17,762	17,798	17,822	17,864	17,903	17,951	17,970
White	335,651	330,975	325,777	320,179	314,854	309,493	304,092	298,648

Table 1: Population of the Eastern Cape by population group (Eastern Cape Socio – Economic Consultative Council, 2012)

	2003	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
Cacadu	395,829	395,848	394,386	391,496	388,481	384,872	383,872	383,410
Nelson Mandela Bay Metro	1,044,331	1,051,631	1,058,323	1,064,557	1,072,747	1,079,681	1,084,711	1,087,791
Amatole	1,713,021	1,717,492	1,720,312	1,721,621	1,724,414	1,726,031	1,731,838	1,737,265
Buffalo City Local Municipality	725,703	730,456	734,980	739,611	745,807	751,584	757,289	761,996
Chris Hani	831,926	832,300	831,653	829,646	827,491	824,545	824,346	824,383
O.R.Tambo	1,765,535	1,784,433	1,807,513	1,833,430	1,862,381	1,887,834	1,900,184	1,905,311
Alfred Nzo	419,072	426,943	436,878	448,327	460,834	472,304	477,403	479,591
Ukhahlamba / Joe Gqabi	347,826	346,035	342,887	338,384	333,401	328,185	326,602	326,072

Table 2: Population of the Eastern Cape by District Municipalities (Eastern Cape Socio – Economic Consultative Council, 2012)

Tables 1 and 2 depict data from the Eastern Cape Department of Population Development. These figures provide significant indicators relating to the population groups and distribution of the population by district municipalities. Noticeable from this data are, first

[4] Note that Umtata has recently been changed to Mthatha. The map does not reflect this change.

that the WSU campuses serves both extremely rural areas as well as very urbanised centres. The second noticeable element is the fact that the majority of the population is what was described by the Eastern Cape Socio – Economic Consultative Council, 2012, as 'Black African'. In the same way as the overall population distribution in the Eastern Cape, 95% of the students from the WSU are from this group.

2.3.2 Perceived causes of HIV/AIDS

Perceived causes of HIV/AIDS in the Eastern Cape seem to be heterogeneous. In the very rural areas, e.g. Ngqeleni in the OR Tambo district, Cocks and Moller (2002:387) found that perceptions existed that HIV/AIDS was a product of witchcraft and that it could spread through casual contact. In contrast to this, another study (HEAIDS, 2004:3), conducted in a more urban setting amongst university students, found that 'knowledge regarding HIV is at acceptable levels'. It should be noted that this statement was made in a bio-medical context: thus 'acceptable' refers to knowledge of the causes of HIV/AIDS as understood by medical science. In another study amongst isiXhosa speaking research respondents, Kalichman and Simbayi (2004:580) found that 'relationships between traditional beliefs about the cause of HIV-AIDS and AIDS stigmas are mediated by AIDS-related knowledge. AIDS education efforts are urgently needed to reach people who hold traditional beliefs about AIDS to remedy AIDS stigmas'. By this finding they were referring to knowledge not related to medical science, and were calling for more education to communities not commonly exposed to medical knowledge.

It would appear that discussion about sexuality amongst the isiXhosa speaking people is a taboo (Tutani and Rankin, 2000:8), making it much more difficult to discuss issues such as HIV/AIDS. It should be noted that there are a number of studies that describe respondents using the phrase 'in our culture' when referring to issues of cultural beliefs and HIV/AIDS (Tutani and Rankin, 2000:8; Van der Vliet,1991:236 and Chuene 2006:137). However, the majority of these studies also indicate that, although this expression is commonly used, in reality explanations regarding beliefs are not uniform, but largely heterogeneous, and there is evidence of change in beliefs over time (Magubane, 1973:1704). Of importance here is the fact that cultural beliefs and tradition cannot be changed by education or medical knowledge of HIV alone:

> Behaviour that sprouts from cultural beliefs and traditions is thus important to individuals within a community as well as to the community as a whole and can

> therefore not simply be changed by education or knowledge about HIV or other health issues (Joubert-Wallis and Fourie, 2009:107).

Of importance for this study is the fact that cultural issues need to be debated amongst participants in HIV/AIDS prevention programmes in relation to the HIV prevalence rate. Only once consensus on these issues are reached can HIV/AIDS prevention begin. One of these contested issues are perceptions surrounding gender.

2.3.3 Gender

The 2007 isiXhosa-speaking gender distribution in the Eastern Cape is depicted in Table 3. It should be noted that WSU has a presence in all of the areas mentioned with the exception of Cacadu and the Nelson Mandela Bay Metro. The following elements in the table were found applicable to this study:

- WSU's areas of most significant presence, Amathole and OR Tambo, accounts for 58% of Xhosa males with 42% of Xhosa females.
- From the male/female ratio distribution in the respective age groups, it is clear that the ratio remains rather similar up to the age of 30-34 (48% male, 51% female), whereafter there is a sudden and significant change in the distribution, with 44% males and 56% females in the 35-39 age group, followed by an average 40% male and 60% female distribution for all age groups between 35 to 59.

The explanation behind this gender anomaly largely lies with the legacy of apartheid and the emergence of the migrant worker population with men often leaving families behind in the former homelands while seeking work in the mines of Gauteng (part of the former Transvaal) (Akinsola and Mulaudzi, 2009:217). These authors also describe the migrant worker population and resultant sexual practices as another reason for a high HIV prevalence (Akinsola and Mulaudzi, 2009:217), whereby it is stated that men would have sexual liaisons with women in both Gauteng and their wives upon returning home. The situation is also exacerbated by the fact that the majority of the poor are located in the Eastern Cape, making them more susceptible to HIV, as explained by Burgoyne and Drummond, (2008:14), who state that 'the most vulnerable group is poorly educated women, those from rural backgrounds, and women who are economically dependent on men'.

Over and above the unequal gender distribution, the need for gender studies in relation to HIV/AIDS in the Eastern Cape and the promotion of gender equality required for sexual agency, has been described as follows:

> The Eastern Cape ranks sixth for male reports of forced sex but second for females and third overall. It is likely that males tend to under-report forced sex owing, to social acceptability bias in responses. These results suggest that gender violence could be an important determinant of HIV transmission in the Eastern Cape (Mafuya et al, 2009:40).

It can thus clearly be seen that in this study understanding related to HIV/AIDS prevalence in the Eastern Cape needs to be attentive to issues of gender.

Xhosa Male	**15 - 19**	**20 - 24**	**25 - 29**	**30 – 34**	**35 – 39**	**40 - 44**	**45 – 49**	**50 - 54**	**55 - 59**	**Sum**	**% of total male ratio 15-59**
DC10: Cacadu	8263	8035	7579	7123	6531	5036	3815	2867	2016	51265	0.035952
DC12: Amatole	95583	72481	55185	48358	37561	30772	25157	24204	20005	409306	0.287047
DC13: Chris Hani	53319	26152	18872	18822	14018	11649	10639	10796	9266	173533	0.121699
DC14: Ukhahlamba	19237	11368	9134	7962	5190	4340	3283	4067	4126	68707	0.048184
DC15: O.R.Tambo	125040	83530	51818	40446	30405	22967	22139	16639	16106	409090	0.286895
DC44: Alfred Nzo	32674	17226	12542	10137	7620	5343	4901	4299	4719	99461	0.069752
NMA: Nelson Mandela Bay Metro	35853	38199	31241	29480	24750	20997	13783	11595	8660	214558	0.15047
Sum	369969	256991	186371	162328	126075	101104	83717	74467	64898	1425920	1
% of total male ratio 15-59	0.2594599	0.180228	0.130702	0.113841	0.088417	0.070904	0.058711	0.052224	0.045513	1	
Xhosa Female	**15 - 19**	**20 - 24**	**25 - 29**	**30 – 34**	**35 – 39**	**40 - 44**	**45 – 49**	**50 - 54**	**55 - 59**	**Sum**	**% of total female ratio 15-59**
DC10: Cacadu	8733	8111	6932	7045	6662	5074	4393	4189	2840	53979	0.032922
DC12: Amatole	90892	74498	55097	50369	47679	44676	40472	32576	27532	463791	0.282872
DC13: Chris Hani	45148	31969	19931	19244	20050	18985	18950	15702	15576	205555	0.125371
DC14: Ukhahlamba	18630	11682	7807	7303	6903	6765	6392	5426	5217	76125	0.04643
DC15: O.R.Tambo	123519	93251	59000	51552	42593	37753	35798	27296	26414	497176	0.303234
DC44: Alfred Nzo	30124	19473	13619	14593	12033	10552	10003	9679	9324	129400	0.078923
NMA: Nelson Mandela Bay Metro	33177	36053	29202	25431	24049	22870	17010	15168	10592	213552	0.130248
Sum	350223	275037	191588	175537	159969	146675	133018	110036	97495	1639578	1
% of total female ratio 15-59	0.2136056	0.167749	0.116852	0.107062	0.097567	0.089459	0.081129	0.067112	0.059463	1	
Total Males and Females	720192	532028	377959	337865	286044	247779	216735	184503	162393		
Male Ratio	0.5137088	0.48304	0.493098	0.480452	0.440754	0.408041	0.386264	0.403609	0.399635		
Female Ratio	0.4862912	0.51696	0.506902	0.519548	0.559246	0.591959	0.613736	0.596391	0.600365		

Table 3: Xhosa Gender Distribution in the Eastern Cape (Stats SA, 2007)

2.3.4 Nutrition and HIV/AIDS

The public health sector of South Africa has been described as being in disarray, as a direct result of the apartheid era which post 1994 resulted in the amalgamation of fourteen departments of health (Witton et al, 2004:2). It is further accepted that within the country as a whole biomedical approaches co-exist with traditional approaches (Wood and Webb, 2008:111). At regional level a Primary Health Care Strategy (PHCS) has been adopted by the Department of Health in the Eastern Cape:

> Certain principles were to underpin the PHC approach (PHCA), namely, universal accessibility and coverage on the basis of need; comprehensive care with an emphasis on disease prevention and health promotion; community and individual involvement and self-reliance; inter-sectoral action for health; and appropriate technology and cost-effectiveness in relation to available resources (Witton et al, 2004:1).

But these and other researchers have argued that it remains imperative that special attention be given to the maintenance of both biomedical and traditional forms of treatment and care, where traditional methods seeming to fare better at meeting the psychosocial and spiritual needs, and bio-medicinal methods more effective in terms of the treatment of physical symptoms (Witton et al, 2004:1). It would appear that these two health sectors need to find linkages to ensure proper healthcare for the Eastern Cape community at large.

Another major problem directly affecting the Eastern Cape is malnutrition. Directly linked to poverty, malnutrition is a major problem in South Africa as a whole, with the Eastern Cape, Northern Cape and Kwa-Zulu Natal having the worst conditions (Witton et al, 2004:4). Malnutrition in these regions is related to Vitamin A deficiency, as well as to anaemia (Witton et al, 2004:4). The Integrated Nutritional Programme (INP) was launched in 1995 with the aims of promoting nutrition in general.

The importance of understanding cultural beliefs in relation to nutrition, as part of the fight against HIV/AIDS has been described as follows:

> There is also some evidence to suggest that micronutrient status has an important bearing on HIV infection, progression of HIV to AIDS and response of individuals to antiretroviral drug treatment. Consequently prevention of malnutrition becomes an essential primary step in establishing a global strategy for HIV/AIDS prevention and control. Appropriate indigenous food systems will form part of this strategy (Malaba, 2003:1).

The combination of a basic public health service, in conjunction with traditional methods, combined with proper nutrition, could contribute to increasing the general well-being of the isiXhosa-speaking people. This would allow for improved resistance against diseases, including HIV/AIDS, amongst the impoverished in the region. In cases where individuals are already infected with the HIV-virus, it has been proven that properly nourished individuals, in conjunction with a proper ART programme, have a better chance at survival than those who are not (Liebenberg and Pillay, 2000:4).

2.3.5 The ABC approach

The ABC approach attempts to change behaviour that is considered to be conducive for contracting HIV. It advocates that individuals should abstain from sex in order not to contract HIV. Failing abstinence, it provides for second and third choices of 'being faithful' and 'condomising' as alternatives to abstinence (Barnett and Parkhurst, 2005:590). Following initial success in Uganda (Cohen, 2004:132), this approach has been largely criticised for various reasons over a number of years (Parkhurst, 2012:17).

One of these criticisms included an international study that examined 192 programmes across all continents regarding the success of the ABC approach concluded that there is 'no conclusive proof' that this approach has been successful (Setswe, 2007:10). As the primary preventative message in the Eastern Cape (Wedin, 2007: 41; Jajula, 2007:10), the ABC approach has been described as 'unsuccessful' in the educational sector of the province (Wood and Webb, 2008:111). In a national survey, the Eastern Cape, as in all other provinces, showed that 'there was no significant difference' between communities that have been exposed to the ABC approach and those who were not (Pettifor et al, 2005:978).

Research with the intent of determining reasons for failure of the ABC approach at universities, conducted by Mulwo (2009:iv) demonstrated that the specificity of particular cultural contexts need to be investigated in order to understand the effectiveness (or otherwise) of prevention campaigns. Ntshebe et al (2006:466), in another study, also highlight this aspect as a major deficiency of the ABC campaign. Mulwo (2009:3) and Shapiro and Ray (2007:70) further criticise the United States President's Emergency Plan for AIDS Relief (PEPFAR) for insisting on subscription to an ABC approach, whilst stigmatising condom usage.

Mulwo (2009:3) specifically criticises the clauses in the PEPFAR funding document which state that 'funding may not be used for distributing condoms in school settings', 'may not be used in marketing efforts to promote condoms for the youth' and may not be used to 'encourage condom use as the primary method of HIV prevention'. Shapiro and Ray (2007:70), also state that 'while many young people, both HIV positive and negative, may welcome programmes that support not having sex, abstinence is hard to sustain as a "forever" or long-term option.'

From the studies listed above it can be seen that the ABC approach does not only lack a contextual approach, but also one that is culturally – sensitive, that takes into account strategies internally consistent with belief systems, as concluded in a paper dealing with the possibility of moving 'beyond' ABC strategies :

> …humans typically rely on mechanisms of interpretation and framing both to understand evidence and to construct strategies of action internally consistent with belief systems. This interpretive process has been shown by political scientists to be a common feature of policy making where deep divisions exist between opposed groups. As such, making this process explicit is critical to improve the use of evidence, as well as to overcome the seemingly intractable debates that arise around highly contested issues such as sexuality (Parkhurst, 2012:32).

This study therefore tries to respond to questions surrounding cultural belief systems and HIV/AIDS related behaviour and debate strategies, contextual factors and another successful HESA strategy: peer intervention programmes, that will be discussed in the next section.

2.4 Higher Education South Africa (HESA) and HIV/AIDS

HESA is a statutory body that was formed in May 2005 (HESA, 2011), following the amalgamation of the two bodies previously responsible for public education in the tertiary sector, the Committee for Technikon Principals (CTP) and the South African Universities Vice Chancellors' Association (SAUVCA). HESA now 'represents all 23 universities and universities of technology and is a Section 21 company' (HESA, 2011:1). Out of the growing concern regarding the HIV/AIDS problem within South Africa, HESA has over the years firmly established a position about the manner in which HEIs should address HIV/AIDS within Universities. In 2008 a policy framework on HIV/AIDS was adopted for all HEIs in South Africa.

The purpose and intention of the policy framework was described as follows:

> The purpose and intention of the Policy Framework is to guide and inform higher education institutions as they develop and operationalise their institutional strategies or refine existing initiatives to mitigate the impact of HIV and AIDS in the higher education sector (HESA, 2011).

Whilst numerous HIV/AIDS programmes are running at Higher Educational Institutions (HEIs) in South Africa, the most commonly recognised one stems from a national initiative known as HEAIDS. In its mandate as an HEI, the Walter Sisulu University also has a duty to implement HIV/AIDS education programmes as part of its service to the student community. HEAIDS is described as follows:

> HEAIDS is an initiative of the Department of Education and is undertaken on behalf of the Department by Higher Education South Africa (HESA), which represents the vice-chancellors of all 23 public higher education institutions. It is funded by the European Union under the European Programme for Reconstruction and Development in terms of a partnership agreement with the Department. The programme aims to enable institutions of higher education to address HIV/AIDS through their mandate to:
>
> - Undertake advanced teaching and prepare graduates for responsible roles in the world of work.
> - Perform research, share knowledge and provide intellectual leadership.
> - Develop campus communities as nurturing and enlightened environments for students and staff.
>
> (HEAIDS, 2010:1)

Key to HESA's strategy has been the promotion of HIV/AIDS peer intervention campaigns which promote social debate surrounding the problem whilst delivering a specific message. This approach therefore takes into consideration the social context whilst addressing the problem of HIV prevalence (Pearlman et al, 2002:38). It is therefore, by the nature of its design, sensitive to local factors. In this manner, Beeker et al (1998:832) classify this mode of delivery as part of an 'empowerment approach' whereby it focuses on 'the process by which people, organisations and communities gain mastery over their lives' (Beeker et al., 1998:833). It thus becomes a standard approach that institutions, individuals, as well as peer trainers have to take in order to change the manner in which an intervention is viewed for it to be effective.

UNESCO was also supportive of it as a HEI strategy in its 2006 report:

> Peer intervention programmes of HEIs have succeeded in expanding HIV preventive education and health promotion, and developing life skills and psychosocial competencies among members' (UNESCO, 2006:61).

Moreover in the HEAIDS report of 2010, reference is made to the success of peer-intervention programmes at other Universities in South Africa:

> The HIV and AIDS peer-education programmes at the University of Pretoria and the University of the Western Cape stood out as particularly successful, featuring a range of engaging student-led prevention activities including drama groups, residence workshops, media and marketing projects, marches, games, poetry slams, VCT counselling, community outreach and more. The peer educators at these institutions received extensive training and the programmes were structured in a way that presented a variety of opportunities for students to develop their leadership, grow within the organisation and participate in a variety of activities (HEAIDS, 2010:102).

A key concern of this research was to understand whether such approaches would be more effective. In McKee et al's (2004:87) approach, whereby peer educators can be used to design the programme of action provided that research is used to predetermine the issues that need to be addressed, research such as this study would allow for the IAT to determine what the issues are that need to be addressed in approaching student issues concerning HIV/AIDS.

2.5 The Walter Sisulu University, HIV/AIDS key role players and IAT students

In recognition of the socio-economic requirements of the region, Walter Sisulu University has as its slogan: 'a developmental university… technological, scientific, innovative and responsive'. The WSU claims that ' 24,000 students and 2,000 staff live and work across four campuses with eleven delivery sites in Mthatha, Butterworth, Buffalo City (East London) and Queenstown (WSU[1], 2011:2).

WSU came into existence on 1st January 2005. This was as a result of the merging of Border Technikon (BT), Eastern Cape Technikon (ECT) and the University of Transkei (UNITRA) through the terms of the Higher Education Act (Act 101 of 1997 as amended) (WSU[1], 2011:2). It should be noted that, within this research, key role players in the field

of HIV/AIDS from most of the campuses were interviewed. The list of interviewees and their geographical bases are depicted in Chapter 4. The key role players are regarded as those individuals within the institution who have the most significant impact on the manner in which HIV/AIDS is being addressed by the institution (as required by various national bodies), and are therefore of prime importance for this research. In line with the HESA and HEAIDS principles, with added input from other stakeholders, key role players in HIV/AIDS at WSU have since 2005 developed and implemented a comprehensive HIV/AIDS strategy[5]. The WSU HIV/AIDS strategy was put in place prior to the commencement of this study. These strategies have developed over the years into the following:

> The educational programmes include: Policy and Strategic Plan Development, Prevention, Care and Support Programmes, Integration of HIV/AIDS into the university curriculum, staff and student peer education, Scrutinize Campaign, support groups, Men in Action Programme, Voluntary Counselling and Testing, CD4 count tests which will be extended to all WSU clinics soon and HIV/AIDS Research. There is also a Student Counselling Unit under the Department of Student Affairs which conducts individual and group counselling for students. They also run peer helping programmes for students to educate them about psycho-social issues that include gender relations, self-esteem, self-confidence, assertiveness training among others (Twaise, 2010:1).

In a visit by the HEAIDS Programme Manager, Dr Ramneek Ahluwalia, in 2011, it was stated that an abstinence-only programme could not be successful due to the fact that '82% of the South African population are sexually active' (WSU[1], 2011:1). It was further highlighted that WSU can only be successful in tackling HIV/AIDS by taking into account socio-cultural factors and implementing HIV/AIDS strategies in conjunction with surrounding communities (WSU[1], 2001:1). Comments such as these by HEAIDS show a clear direction in the manner in which HIV/AIDS problems are expected to be addressed by SA HEIs. The question remains whether students experience intervention efforts in the way they were intended.

This research also selected students from the WSU's Institute for Advanced Tooling (IAT). These were postgraduate products of the National Diploma: Mechanical Engineering and were enrolled for a postgraduate qualification. The Department of Mechanical Engineering at the WSU offers programmes in various sites in East London and Butterworth. The IAT

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[5] As part of this research the author was a member of the institutional HIV/AIDS Committee during the years 2005/2006. This is elaborated upon in Chapter 4, Methodological Orientation.

itself was originally situated at the College Street Campus, but moved to the Chiselhurst campus in 2007, and has as its main aim the development of the tooling and design industry.

Based on the fact that master toolmakers are scarce (Van Reenen, 2005:1), the impact of HIV/AIDS needs to be investigated and, at the very least, the main factors explaining the success or otherwise of prevention programmes identified. Whilst it would be incorrect to state that the impact of this research is applicable to the entire South African population, in the case of tool-making industry, it could be particularly pertinent. If 250 jobs are created down the line in the South African manufacturing industry (Newey, 2004:10) for every one qualified toolmaker[6], the impact of the current HIV prevalence rate has a significant effect on the country's ability to produce manufactured goods. The question that clearly requires addressing is whether students at the IAT experienced HIV/AIDS preventative efforts promoted by HEAIDS and key role-players in HIV/AIDS at WSU to the extent that these efforts result in behavioural change.

2.6 Conclusion

The ABC's of HIV/AIDS prevention, Abstinence, Be Faithful and Condomise, are under scrutiny (Setswe, 2007:10), with criticisms from many different angles for different reasons (c.f. El-Sadr and Hoos, 2008:553). Applicable, firstly, to this study is research, internationally (El-Sadr and Hoos, 2008:553) and within the region of the Eastern Cape (Pettifor et al., 2005:978), that has suggested that the ABC strategy might be not as effective in its approach, although the cited research does not compare the ABC strategy to any other.

Secondly, there is the criticism on the focus on condoms in the campaign, as advocated by the PEPFAR funding agreements (Mulwo, 2009:3), with concern regarding this approach explained as follows:

> A number of PEPFAR-South Africa's positions (notably on condoms and on abortion) are in contradiction to South Africa's own laws, though the South African Government has not challenged this. The 2008 reauthorization of PEPFAR, however, which increases commitment to prevention, provides a critical

[6] For further detail on financial and economic considerations, refer to Appendix F.

> opportunity to address the HIV-GBV[7] link in its work, but PEPFAR will need to tackle the existing deficiencies identified in this study. PEPFAR-South Africa officials explained that addressing the GBV-HIV link does not form an explicit strategic goal, there are no indicators for it, and although some agencies receiving PEPFAR funding do address the links between GBV and HIV, this appeared incidental rather than being a proactive reason for PEPFAR funding (Ghanotakis, Mayhew and Watts, 2009:364).

Thirdly, further criticism against the ABC campaign emanates from the lack of sensitivity to local factors against a cultural backdrop within a given region (Joubert-Wallis and Fourie, 2009:107). Within the factors discussed in this chapter, it was seen that the geography of the Eastern Cape encompasses a large region (168 966 square kms) (South African Yearbook, 2011:3) with heterogeneous cultural beliefs not least because of the existence of different clans within the Xhosa (Roediger, 2009:2). Moreover, within any one set of beliefs elements of fluidity and opposition are also present (Tutani and Rankin, 2000:8; Van der Vliet,1991:236 and Chuene 2006:137). Age and the rural nature of the population also influence subscription to traditional beliefs, with the elderly and more rural less likely to fully accept bio-medical explanations for diseases such as HIV/AIDS (Chuene 2006:137). Perceived causes of HIV/AIDS range from perceptions related to witchcraft (Foster, 1976:777) through to full acceptance of bio-medical explanations (Molebatsi and Mulinge, 2004:135).

The necessity to understand cultural belief systems and their influence on HIV preventative efforts is therefore important; even for campaigns that are more 'culturally sensitive' we need to know how successful such efforts have been. This becomes especially true in the context of the link between nutrition, general well-being and HIV/AIDS, since it was established that there is a bio-medical link between nutrition and the body's' ability to fight the HIV virus (Loevinsohn and Gillespie, 2003:1). These cultural perceptions, as well as the perceived causes of HIV/AIDS, gender, the ABC approach and nutrition, and general well-being and HIV/AIDS, are examined in more detail in Chapter 3.

[7] Gender-based violence

3: Literature Review

3.1 Introduction

The literature review consists of three parts: a discussion of my theoretical framing, a discussion of some key concepts and a section that addresses the aim of the thesis as a whole, that is: a concern to understand how we can better implement HIV/AIDS intervention programs that are culturally sensitive, which take into account the implications of the existence of a dual system of traditional healing and bio-medicine, and which are peer-driven. In this respect, the thesis does not seek to be theoretical in nature, but aims to make pertinent recommendations towards improving HIV/AIDS prevention which draw on and are informed by some key theoretical concepts.

The theoretical approach for this thesis is based on an interpretative framework, and I argue that such an approach is ideally suited to this type of study due to the fact that it investigates a phenomenon from the perspective of 'lived experience' of a particular, relevant community. Section 3.2 considers various studies which have been conducted using interpretative frameworks. In addition to the interpretative framework, work from various authors (including Giddens, Geertz, Weber and Parsons) examining structure and agency are also examined, as a core concern of this research has been to investigate how individual understanding and action may be shaped by wider social and structural factors. The next section first examines culture, followed secondly by a discussion on knowledge and cultural beliefs, the relational approach to ideas of truth and belief, and attempts to show how these various discussions are relevant to the study. Thirdly, the concepts of imagined communities and Geertz's imaginative act are examined. This is followed by a discussion about double speak, double identity and myth, which are conceptual terms which I have used to define how identities are or were constructed in the field of study. The last section, entitled 'culturally sensitive intervention programs', consists of three main subsections. The first subsection provides background information regarding local health perceptions, health enabling environments and localised strategies for overcoming HIV/AIDS. The second subsection provides information regarding the key themes which emerged during the study, including perceptions regarding the causes of HIV/AIDS, gender, nutrition and the ABC approach. The third subsection examines the concept of a dual-healthcare system, peer education and culturally sensitive HIV/AIDS prevention programs.

3.2 Theoretical framing

My main reason for deciding on an interpretative framework for this study is that it allows for an investigation into how a particular phenomenon is understood from the viewpoint of the research informant: in other words it investigates their 'interpretative repertoires' of those individuals: how they make sense of the world (Campbell and Williams, 1998:61). This is of crucial importance because more effective prevention programmes need to be based on an awareness of how relevant issues are understood by those at whom the programmes are targeted.

3.2.1 Interpretivism and Interpretative Interactionism

Interpretative research has as its aim a focus on 'lived experience' and is concerned with the viewpoint of research participants. Denzin (2002:ix) states that 'the focus of interpretative research is on those life experiences that radically alter and shape the meanings persons give to themselves and their experiences'. Denzins' approach, which he termed interpretative interactionism, rests on three core conceptions: interaction, problematic interaction and interpretative interactionism. He described these terms as follows:

- Interaction: Interaction between individuals, the capability of mutual action that is emergent. For human beings, interaction is symbolic, involving the use of language – hence the term symbolic interaction.
- Problematic interaction: Interactional sequences that give primary meaning to subjects' lives. Such experiences alter how individuals define themselves and their relations with others. In these moments individuals reveal personal character.
- Interpretative interactionism: The point of view that confers meaning on problematic symbolic interaction.

(Denzin, 2002:32)

What Denzin termed 'the problematic' - epiphanies in peoples personal lives at the moment of making sense of intense personal problems - signifies for this study a problem arising from sexual relations and dealing with HIV/AIDS infection, which in turn relates to how power- relationships are perceived within a specific cultural setting. Denzin later states that interpretivism is ideal for investigation into 'personal troubles' and societal influences that may shape perceptions and understandings of such problems (Denzin, 2002:3). For the point of view of this study, in other words, my concern is to understand

how the 'problematic' of HIV/AIDS is perceived and how it is dealt with by those affected within a particular cultural context.

3.2.2 Interpretivist studies on HIV/AIDS

The approach of interpretative studies to questions of culture was of particular importance for my work. In many ways, I adopted an approach similar to Denzin's (2002:85) whereby reflexivity and a concern to understand conceptions of selfhood, as elements in culture, are stressed as important components. In a study conducted in Kenya by Nzioka, (2000:2), the reasoning for examining cultural beliefs was explained as entailing the fact that adequate understanding could not be obtained without examining local knowledge and behaviour. By local knowledge and behaviour, the author (Nzioka) was specifically referring to practises and beliefs that could contribute to the spread of HIV/AIDS. The author argued that the interpretative framework allowed him to understand narratives from respondents in a way that was removed from a concern with 'generic truth' (Nzioka, 2000:4), and thus he assumed that 'meanings were situationally located and required to be discovered'. In other words it can be seen that the approach of interpretivism assumes that understanding is always localised, and informed by local knowledge.

Similarly, Mogensen (1995:132) worked amongst the Tonga of Southern Zambia and refers to the fact that the Tonga utilise existing traditional interpretative frameworks for understanding concepts such as ill-health associated with HIV infection[8]. Mogensen's (1995:132) study emphasises the importance of listening to narratives and in her account a discourse analysis framework is of importance in understanding localised conceptions of the disease. What further emerged from this study was the manner in which this approach allowed her to tie the work to policy and the underachievement of policy-stated goals. A study conducted in Uganda (Mutonyi, 2007:190), also using an interpretative framework, has similarly highlighted the challenges related to HIV prevention that stem from a failure to properly consider cultural constructions of the disease.

From the above studies it can be seen that adopting an interpretative approach means recognizing that the interpretations and understandings of individuals are always

[8] Mogensen found that the discourse displayed strong ties with *kahungo*, a 'traditional disease' which is said to 'be caused by sexual intercourse with a woman who has miscarried, i.e. by sexual pollution'.

contextual, and always shaped by local situations, and that this therefore implies the need to unpack such local views and beliefs.

3.2.3 Structure and Agency

The question of structure and agency is linked to HIV/AIDS and interpretative studies through the interpretation of power relationships (Dowding, 2008:21). It should also be noted that the development of interpretivism has its origins in earlier structuralist orientations (Kuper, 1999). Hence, for example, Kuper (1999) dedicates an entire chapter to Parsons, Weber and the 'American Anthropologists' to show this development of interpretivism from structuralism. If we examine Weber's work, for example, it should be noted that it was commented on his work that: '[we are] cultural beings endowed with the capacity and will to take a deliberate stand toward the world and lend it meaning' (Kahlberg, 2005:8). In relation to culture, Parsons indicated that 'culture patterns have a dual relation to action, they may be objects of the situation or they may be internalised to become components of the actor's orientation pattern' (Parsons, 1951:30). The impression from reading Parsons and Weber together is that it is necessary to understand both the question of interpretation (meaning) and structure in order to adequately understand a social phenomenon. When referring to 'structure' I am thinking particularly of power relations, and therefore how they affect understanding (i.e. interpretation). As interpretative researchers we should not only be sensitive to how people interpret their worlds, but also the (quite often, unequal) structures that govern their worlds, which may affect their interpretative ability.

Combining these two viewpoints (interpretivism and structuralism) for the purposes of analysis would seem in that respect prudent. A significant writer who has sought to do this, and who has been of particular influence on this study, is Clifford Geertz. Whilst Geertz's work could be described as interpretivist in many ways, he also reminds us of the need to include structural analysis, which in this case refers to deeply held intellectual patterns:

> The job of the ethnologist is to describe the surface patterns as best he can, to reconstitute the deeper structures out of which they are built, and to classify those structures, once reconstituted, into an analytical scheme… After that 'all that would remain for us to do would be to recognise those [structures] which [particular] societies had in fact adopted' (Geertz, 1973:352).

The difficulty of the interrelatedness of the terms structure, agency and culture has also been discussed by Sewell (1992:1). Of interest in his discussion for this study is the use of the term 'cultural schemata' and how these are related to the culture/structure debate:

> Structures, I have argued, are constituted by mutually sustaining cultural schemas and sets of resources that empower and constrain social action and tend to be reproduced by that action. Agents are empowered by structures, both by the knowledge of cultural schemas that enables them to mobilize resources and by the access to resources that enables them to enact schemas (Sewell, 1992:27).

Hays (1994:58) was of the opinion that the interrelatedness of the terms culture, structure and agency lead to a 'quagmire of conceptual confusions'. She then argues that we can combine both terms: 'culture is a social structure with an underlying logic on its own' (Hays,1994:58). She further suggests that 'the allegedly rational actor maximising gain through constant single minded calculation of efficiency and potential advantage appears to me …, not as an agent at all, but as someone entirely controlled by an external structure of opportunities…' (Hays,1994:62). This brings us to the point that successful HIV/AIDS prevention lies with the provision of an external structure of opportunities. It is therefore logical to argue that the structure of opportunity provided must not be in conflict with any of the structures, agency or cultural conceptions that might exist.

So, whilst this thesis mostly accepts an interpretivist orientation, and therefore emphasises the importance of understanding the construction of meaning, structuralist viewpoints are also taken into account, and hence the inclusion of Anthony Giddens' structuration theory for the purpose of analysis. He specifically seeks, in structuration theory, to recognize both the constraints of structure and human capacity to change structures, in part through their ability to interpret, consciously, the situations in which they find themselves. A summary of Giddens' theory suggests that 'human agency and social structure are in a relationship with each other, and it is the repetition of the acts of individual agents which reproduces the structure' (Gauntlett, 2008:107). The social structure itself is, however, transient and fluid, '…this means that there is a social structure - traditions, institutions, moral codes, and established ways of doing things; but it also means that these can be changed when people start to ignore them, replace them, or reproduce them differently' (Gauntlett, 2008: 107).

Giddens defines the terms ‘agency’ and ‘structure’ as follows:

> Agency does not refer to a series of discrete acts, combined together, but a continuous flow of conduct …it is a necessary feature of action that, in any point in time, ‘the agent could have acted otherwise (Giddens, 1979:56).
>
> Structure refers, in social analysis, to the structuring properties allowing the ‘binding’ of time-space in social systems, the properties which make it possible for discernibly social practices to exist across varying spans of time and space (Giddens, 1984:17).

Of particular interest for this study is the manner in which Giddens deals with issues of agency, power, and the body. In relation to agency, Giddens provides for a diagram describing structuration in figure 4.

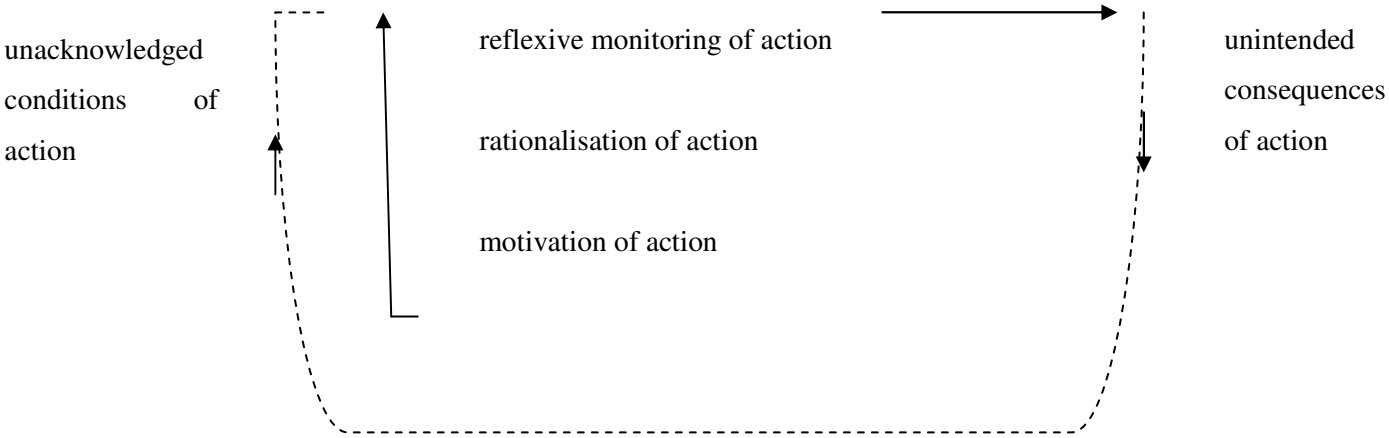

Fig. 4: The stratification model of the agent (Giddens, 1984:5)

Giddens explains the core terms here as follows:

- Reflexive monitoring of action: a feature of everyday action which does not only involve the conduct of the individual alone but also of others.
- Rationalisation of action: continuing theoretical understanding of the grounds of activity
- Motivation of action: the potential for action.
- Unacknowledged conditions: reasons why continued actions would take place
- Unintended consequences of action: the outcome in psycho-analytical theory, a slip intervening in a course of action in which the person is intending to do something different altogether.

Giddens (1984:5-9)

Giddens' central point, thus, to emphasise how action, intention, rationalisation and consequence are all related. The interrelatedness of all of these elements would have a role to play in the way in which culture is viewed. In other words, a member of a specific culture would on a day-to-day basis be thinking about the manner in which he or she conducts him/herself against the conduct of others. These actions are thus structured by both rationalisations and motivations, both of which can give rise to unacknowledged conditions for different forms of action – in other words, they don't simply reproduce the status quo – as well as to potentially unintended consequences. Importantly Giddens places the body in the middle of the agent-power relationship:

> The body is the locus of the active self, but the self is obviously not just an extension of the physical characteristics of the organism that is its carrier. Theorising the self means formulating a conception of motivation (or so I shall argue) and relating motivation to the connections between conscious and unconscious qualities of the agent (Giddens, 1984:36).

The importance of the above for this study relates to the fact that we should recognise how individuals reflect on issues that affect themselves in relation to social-power aspects that influences their ability to control how their own bodies are viewed by society. In this way people personally theorise about their own bodies and societal control, whilst social scientists also theorise about the body in a societal context.

The knowledge people have about their own lives and experiences is, however, different from knowledge and categories derived about society by sociologists, leaving us with a phenomenon termed the 'double hermeneutic' (Giddens, 1984:284). In his description of the double hermeneutic Giddens distinguishes between first and second order knowledge. First order knowledge refers to the knowledge belonging to, and explanations of, ordinary actors as part of everyday life. He refers to second order knowledge as the interpretations of sociologists after reflecting on first order knowledge as a direct result of interaction with research participants. Research therefore involves a double translation of knowledge, which allows for further and deeper analysis of a research problem. In relation to this study, the manifestation of the double hermeneutic is relevant, since a core focus of the research has been to begin from the interpretation of first order knowledge derived from the responses of research participants.

The approach that I tried to follow in this work therefore relates to first recognising 'cultural schemata' (Sewell, 1992:27), and the recognition that it might influence agency

and structure, although we should simultaneously recognise that beliefs are individually constructed and are not the result of 'culture'. Second the work of Giddens allows us to situate ourselves as researchers in relation to research informants through the double hermeneutic (Giddens, 1984:284), and allows us to recognise agency and structural elements, from their monitoring, rationalisation, motivation and intended and unintended consequences of action.

3.3 Key Concepts

In what follows, the first section examines some definitions and debates associated with the term 'culture' and describes its usage in this study. In the second section I briefly consider the concept of knowledge and argue that understanding this adequately may require us to think critically about a Cartesian duality between mind and body, or between consciousness and world. Therefore, after examining these various debates, this section argues for the need to adopt a relational approach in relation to HIV/AIDS prevention programmes, which is further discussed. Thirdly, this section is followed by an examination of the concept 'imagined communities', and the wider interest in use of the term 'imaginary' as developed by various scholars. This is done in order to provide a theoretical platform for analysing notions of 'cultural practise' as used by other authors investigating the Xhosa (c.f. Van der Vliet, 1991, Banks, 1996, Tutani and Rankin, 2000 and Chuene, 2006). The notion of 'cultural practises' is important in understanding behaviour surrounding the HIV/AIDS phenomenon, also addressed in Section 3.4. Lastly, this section includes a discussion of the terms double speak, double identity and myth as conceptual tools for analysing 'cultural practises'.

3.3.1 Culture, Myth and Double Speak

A classical definition of culture is provided by Tylor: 'culture or civilization, taken in its wide ethnographic sense, is that complex whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habits acquired by a man as a member of society' (Tylor, 1891:6). There is clearly a static implication in Tylor's approach that does not take into account the ability of societies to change and adapt. Giddens (1984:244), by contrast, emphasised change, referring to 'identifiable sequences of change affecting the main institutions within a societal totality, or involving transitions between types of societal totality'. This complexity of 'culture', has been clearly outlined by Geertz and, as we have seen, he particularly argues for an 'interpretative theory of culture'. For Geertz the

importance of an interpretivist approach lies in the fact that the very act of anthropology is in itself an interpretation (1973:15). For Geertz – cultural systems are above all about meaning, about how people understand and make sense of their lives, and because all peoples *already do this,* anthropology should be guided firstly by the attempts of those who live in a particular context to make sense of that context: 'cultural analysis is (or should be) guessing at the meanings, assessing the guesses, and drawing explanatory conclusions from the better guesses' (Geertz, 1973:20). This thesis accepts, therefore, Geertz' definition of the term culture:

> It denotes a historically transmitted pattern of meanings embodied in symbols, a system of inherited conceptions expressed in symbolic forms by means of which men communicate, perpetuate and develop their knowledge about their attitudes towards life (Geertz, 1973:89).

Kuper also defends the use of the term 'culture':

> The reason that we still need the notion of culture is a moral one, or a political one. The concept of culture provides us with the only way we know to speak about the differences between the peoples of the world, differences that persist in defiance of homogenization (Kuper, 1999:212).

In my own view, I prefer to use the term culture in this thesis because it allows me to emphasize change and fluidity in social practices, and not therefore to treat them as somehow fixed or simply belonging to one set of people (which the term ethnicity can imply). If we look at other criticisms of the term ethnicity, Banks (1996:4) stated that 'certainly, books and monographs are still published that contain key terms 'ethnicity' and 'ethnic' in their titles, but my impression is that they are less common than they were in the heyday of the 1970's', suggesting that it was a popular term during a specific era. He defines ethnicity as follows:

> …a collection of rather simplistic and obvious statements about boundaries, otherness, goals and achievements, being and identity, descent and classification, that has been constructed by as much the anthropologist as the subject… (Banks, 1996:190).

Blu (1980:23) criticised use of the term 'ethnicity' by stating that 'the term ethnicity should be dropped altogether as a cross-culturally useful analytic term … [and] restricted to describing and analysing what it does best, namely, an important form of social differentiation in the United States'. Williams (1989:417) also criticized Cohen's theory on ethnicity (1978) for 'trying to find ethnicity where it is not' (Banks, 1996:34).

It is important to recognise that anthropologists on both sides of the culture/ethnicity debate recognise that neither cultures nor ethnicities are static or given facts. Both, culture and ethnicity, are subject to change because both are historical and social reconstructions. Kuper (1999:xi) recognises change in culture by stating that 'the difficulties become most acute when culture shifts from something to be described, interpreted, even perhaps explained, and is treated as a source of explanation in itself'. Cohen (1978:383), arguing for the popular use of the term ethnicity, recognised the importance of change by stating that 'the ethnicity concept suggests that there is a problem here whose solution will take us toward an understanding of specific culture histories and general evolutionary processes of culture growth and change'. In recognising that one can understand culture as socially constructed, Geertz stated that cultures are imagined and not given (Geertz, 1973:13), whilst Kuper (1999:246) also supported this position: 'it is in the mind'.

We still need a term to talk about the differences in how people understand the world and act within it, and the best word we have for that is culture. Therefore this thesis recognises the various positions in the ethnicity/culture debate, but will use the term 'culture' as opposed to 'ethnicity'. Other terms, which have various historically problematic connotations (c.f. Cohen, 1978:384), such as tribe, will also be avoided.

The term myth in this thesis thus builds on the position that every culture is historically situated (Moodie,2003:7), that we have a duty to address 'fundamental issues of power and dispossession [of the] indigenous' (Kenrick and Lewis, 2004:9), and that, ultimately, 'their (the indigenous) role in the life of society – must always take a central place and provide a basis on which understanding may be built' (Winch, 1970:110). Taking the above into consideration, Bell (1997:10), highlights a rejection of Tylor's view that 'myth is a misguided explanation':

> Myth narrates a sacred history, it relates an event that took place in primordial Time, the fabled time of the 'beginnings'. In other words, myth tells us 'how, through the deeds of Supernatural Beings, a reality came into existence, be it the whole of reality, the Cosmos, or only a fragment of the reality – an island, a species of plant, a particular kind of human behaviour, an institution. Myth then, is always an account of 'a creation' … . Because myth relates the *gesta* of Supernatural Beings and the manifestations of their sacred powers, it becomes the exemplary model for all significant human activities (Bell, 1997:10).

Bell (1997:22) further reminds us of the fact that 'A myth - like a ritual – imposes an order, and accounts for the origin and nature of that order, and shapes people's

dispositions…'. The use of the word 'myth' in this thesis is therefore used as part of the understanding required in the relational approach, and assumes that myths provide us with a framework for understanding past events and interpreting future events (Kuper, 1999:177). The term 'double speak' has been defined by Kenrick and Lewis as follows:

> The extent to which many dominant groups of people define themselves as modern on the basis of an assumed superiority of their own culture and knowledge, whilst denying that their knowledge is socially constructed, is the hallmark of the cultural double-speak within which and against which indigenous peoples have to struggle. There is a tendency among such dominant groups to believe that they have moved beyond being defined by something called 'culture' and are thus able to organise society rationally in ways that those thought of as still defined by 'culture' are incapable of doing. The assumption that modern society is no longer defined by 'culture' obscures the influence the dominant groups' 'cultural' assumptions can have (Kenrick and Lewis, 2004:8).

The relevance of the term 'double speak' here relates to the need to be culturally sensitive in an approach relating to HIV/AIDS prevention. As it can be seen that myth and multiple identities can have an influence on an intervention effort, it would be important that the communicator of the intervention effort not to fall into a practice of double speak: for no researcher nor HIV/AIDS activist can raise themselves above their own 'culture'.

3.3.2 Knowledge and the Relational Approach

This section attempts to consider particularly the idea of knowledge and advocates, in approaching this question, the use of a relational approach in HIV/AIDS prevention as advocated by Saugestad (2001:307) as well as Kenrick and Lewis (2004:9). The need for incorporation of this approach here is based on the fact that many HIV/AIDS prevention programs to date do not adequately take into account the 'complex social relations' of the contextual environment (Campbell & Cornish, 2010:1570).

3.3.2.1 Bio Medicine

Reynar (1999:285) explains that the key to a modern understanding of knowledge 'was foretold in Descartes' statement, I think, therefore I am'. This so-called Cartesian duality, can also be understood as being in some respect the grounding of 'modern' bio-medicine[9]. Ryles' (1949:24) criticism of this conception is based on the fact that it assumes a

[9] c.f. with the definition of the term supplied in the Glossary of Terms and Abbreviations.

fundamental distinction between ‘body’ and ‘mind’. He, by contrast, argued against viewing the mind and the body as separate ‘categories’. He stated that ‘the reduction of the material world to mental states and processes, as well as the reduction of mental states and processes to physical states and processes, presupposes the legitimacy of the disjunction’. In a similar way, but more recently, Semali and Kincheloe (1999:28) in their criticism use the term Cartesian reductionism, which they use to describe a process associated with assumptions about the universal truth of this distinction regardless of its context, as long as its validation process falls within the principles of ‘western science’. Against such a view, Moodie (2003:7) is of the opinion that every culture has different historical origins, and therefore knowledge is particular to local culture, and therefore cannot be universal. In reaction to Moodie (2003:7), Horsthemke (2004:31) questioned the validity of use of the term ‘knowledge’ and provided a set of requirements for the ‘truth’ to be constituted as valid knowledge.

Considering these discussions I am of the opinion that human thought is shaped contextually, and that it therefore cannot be divided from the ‘world’ (or context) it is situated within. However, I do not take the extreme view that different contexts (or cultures) exist entirely separate to each other – since Reynar (1999:285) points out that various hegemonic power-play elements (referred to as modernity) have already ‘tragically and forcefully destroy(ed) cultures around the world’. Given the fact that modernity has already had this effect, the ‘perpetrators’ of modernity have a moral duty to attempt to ‘repair’ the damage that has been done – as Turnbull stated: ‘at the end of the twentieth century we can now perceive that there is a high cost to pay for science's hegemony’ (Turnbull, 1994:30).

Thus I agree with Winch’s (1970:110) position that ‘I am, from the outset, in specific relations to other people, from which obligations spring which cannot but be ethically fundamental’. My position in relation to truth in relation in this thesis is therefore that, as bio-medical interventions are most likely to be effective against HIV/AIDS, that medical interventions are important. Culturally – sensitive prevention programmes, advocating changes in practice, in support of cultural beliefs, should be the basis of HIV/AIDS prevention, as opposed to the ‘bulldozer approach’ that has been seen in the recent past. We need to understand that all ‘cultures’ are already involved in complicated negotiations with the effects of modern capitalism, modern nation states, changing social structures etc. An effective approach therefore involves rejecting a neat distinction between ‘traditional’ cultures and ‘modernity’.

3.3.2.2 Knowledge

In this thesis, therefore, it is accepted that beliefs that are local and have a 'cultural' origin, could play a role in decision-making, and affect decisions surrounding treatment of illnesses such as HIV/AIDS. It is these type of beliefs that may lead to consultation with a traditional healer as opposed to a bio-medical specialist for treatment of a specific ailment. We have already seen that numerous problems exist with the term 'indigenous knowledge' (c.f. Section 1.2.3), but some authors still prefer to use the term to describe certain local beliefs. Semali and Kincheloe state that:

> The term indigenous, and thus the concept of indigenous knowledge has often been associated in the Western context with the primitive, the wild, the natural … But for others, especially the millions of peoples of Africa, Latin America, Asia and Oceania, indigenous knowledge (or what others have called the native ways of knowing) is an everyday rationalisation that rewards individuals who live in a given locality. In part, these individuals, indigenous knowledge reflects the dynamic way in which the residents of an area have come to understand themselves in relationship to their natural environment and how they organise that folk knowledge of flora and fauna, cultural beliefs, and history to enhance their lives (Semali and Kincheloe, 1999:3).

Some authors (e.g. Brush, 1996:4) distinguish between a broad and narrow definition of such knowledge. A broad definition refers to 'the systematic information that remains in the informal sector, usually unwritten and preserved in oral tradition rather than texts' (Brush, 1996:4), while a narrow definition is seen as referring to the 'knowledge systems of indigenous groups rather than to local, popular (folk), or informal knowledge in general'. Brush (1996:5) further contends that knowledge systems are quite often under threat of extinction. Similarly some researchers (Hayden, 2003:7; Hoppers, 2002:12; Nader, 1996:10) emphasise that not enough attention has been given to local knowledge in efforts to overcome problems associated with sustainable development, such as widespread poverty. Maffi described these thought patterns as follows:

> Indigenous and local communities worldwide have commonly recognized (implicitly and often explicitly) the existence of an intimate link between cultural and linguistic identity, worldviews and knowledge systems, on the one hand, and on the other, the lands and territories they occupy and from which they derive material and non-material sustenance (Maffi, 2006:56).

Irrespective of the term used to describe local beliefs, this thesis recognises the importance of paying attention to local beliefs in HIV/AIDS prevention programs, and therefore argues for a 'relational approach' as discussed below.

3.3.2.3 The Relational Approach

Given the previous section, the relational approach discussed here provides us with an epistemological orientation towards approaching phenomena such as HIV/AIDS, where changing behaviour may play a significant role. Recognising that not enough attention has been given to issues such as local knowledge, Prakash suggests that 'the need for historians to hear African voices originates with the same impulse as the need to hear the voices silent within European history' (Prakash, 1995:60), thereby focussing on the 'historically deprived'. Prakash (1995:40) stated that 'the end of universal narratives' has just begun, and he makes this statement resting on an analysis of 'Africa in history'. The key point that he makes here is that as researchers we have to listen to local communities and not base our findings on our own preconceptions.

Similarly, Bell (1992:183) states that 'belief systems are understood to be a matter of cultural worldviews or communally constructed ideological systems, quite beyond what a particular person may or may not hold true'. Peter Winch, providing guidelines for the 'understanding of primitive society' states that:

> In any attempt to understand the life of another society, therefore, an investigation of the concepts – their role in the life of society – must always take a central place and provide a basis on which understanding maybe built (Winch, 1970:111).

Whilst Winch argues for a relativist approach to understanding cultures, he clearly thinks that there is a difference in various cultures. Geertz (1973:349) criticizes Claude Levi-Strauss for the term 'cerebral savage', as well as Peter Winchs' (1970:80) interpretation of 'primitive society', stating that 'He and I [the savage] are both thinking in patterns of thought provided for us by societies in which we live'. Whilst also advocating against a strongly relativist position, Kenrick and Lewis (2004:4) are more strategic in their orientation, and proposes an approach that addresses the 'imbalances of the past' (c.f. Turnbull):

> A relational understanding of the term [indigenous] focuses on the fundamental issues of power and dispossession that those calling themselves indigenous are concerned to address, and on the enduring social, economic and religious practices that constitute their relationships with land, resources and other peoples. From this perspective, indigenous describes one side in a relationship between certain unequally powerful groups of people. The indigenous side is the one which has been dispossessed, not the quintessential primitive… (Kenrick and Lewis, 2004:9).

Maffie (2001:267) defending the 'veritism' position of truth, reminding us that veritism is embraced by 'African' philosophies, states that Verus in Latin means 'not only to be true, but genuine, real and authentic'. In his criticism of Aristotelian logic and the polar orientation, Weinberg (1959:86) supports a multi or infinite - valued orientation and states that 'it is the steering apparatus that directs us to our destination'.

Overall this thesis therefore recognises that every culture is historically situated (Moodie, 2003:7), and that we have a duty to address 'fundamental issues of power and dispossession [of the] indigenous' (Kenrick and Lewis, 2004:9). This must take place within the confines of moral obligation (Winch, 1973:110) to the best possible solution – in the case of HIV/AIDS, a bio-medical approach advocated in a culturally-sensitive manner.

3.3.3 Geertz' imaginative act, imagined communities and the imaginary

This section examines how various authors have sought to understand how members of a community (e.g. a 'culture', a nation) understand concepts of inclusion and justification. Geertz construes the case for thinking of culture as an 'imaginative universe':

> What, in a place like Morocco, most prevents those of us who grew up winking other winks or attending other sheep from grasping what people are up to is not ignorance as to how cognition works (though, especially as, one assumes, it works the same among them as it does among us, it would greatly help to have less of that too) as a lack of familiarity with the imaginative universe within which their acts are signs (Geertz, 1973:13).

Geertz's argument here specifically relates to the idea of 'imaginative signs'- and the challenge for those of us who come from other imaginative universes to entirely understand the signs in question. There is a warning here: we should continue to ask ourselves how many signs we do not understand due to the fact that we are not insiders. With regards to insiders having 'imagined conceptualisations', in this sense, Anderson famously proposed the idea of nationalism as an imaginative act:

> In anthropological spirit, then, I propose the following definition of the nation: it is an imagined political community – and imagined as both inherently limited and sovereign. It is *imagined* because the members of even the smallest nation will never know most of their fellow members, meet them, or even hear of them, yet in the minds of each lives the image of their communion (Anderson, 1983:15).

Strictly speaking, Anderson's concept of nationalism removes us from the term 'culture'. He does however, in his chapter on 'cultural roots', tie the term 'nationalist imaginings' to 'religious imaginings' (Anderson, 1983:18) and then later to 'the dynastic realm'. There is an acknowledgement that nationalism was preceded by 'large cultural systems… out of which – as well as against which – it came into being'. The assumption is that it would not be incorrect to tie the term 'nationalist imaginary' to the term 'cultural imaginary'. Of importance here is the idea that an entire community of people, too large to know each other on a personal level, may subscribe to personalised beliefs or to a personal sense of identity which ties them to the entire group – identity is therefore 'imagined'.

The association of the term 'imagined' with various elements in society is also developed in Hobsbawm and Ranger, who defined the term 'invented tradition' as follows:

> 'Invented Tradition' is taken to mean a set of practises, normally governed by overtly or tacitly accepted rules of a ritual or symbolic nature, which seek to inculcate certain values and norms of behaviour by repetition, which automatically implies continuity with the past. In fact, where possible, they normally attempt to establish continuity with a suitable historic past (Hobsbawm and Ranger, 1983:1).

Within the 'three overlapping types' of invented tradition (Hobsbawm and Ranger, 1983:9) this study concerns itself with '(c) those whose main purpose was socialisation, the inculcation of beliefs, value systems and conventions of behaviour'. This study thus concerns itself with 'invented' tradition where individuals would use such traditions to justify their own behaviour. It should be clear that the term is not being used in quite the sense that Anderson nor Hobsbawm and Ranger intended it to be used, but then Mills reminds us of the following:

> What they [sociologists] need, and what they feel they need, is a quality of mind that will help them to use information and to develop reason in order to achieve lucid summations of what is going on in the world and of what may be happening within themselves (Mills, 1959:2).

My reading of this quotation is, as Denzin reminds us, that researchers are encouraged to formulate their own terms or propositions (Denzin, 2002:131) as he did utilising many of Geertz's conceptualisations of thick description. For this study concepts surrounding the imaginary are brought in relation to the fact that it is necessary to understand how people imagine the world (and community) of which they are part.

Later in Hobsbawm and Rangers' publication (1983:212) they deploy the term 'invented tradition' in relation to 'Africa'. They state that 'the invented traditions of African societies – whether invented by Europeans or Africans themselves in response – distorted the past but became themselves realities through which a good deal of colonial encounter was expressed'. In their conclusion on the invention of tradition in Africa, warn that historians have a double task:

> They have to free themselves from the illusion that the African custom recorded by officials or by many anthropologists is any sort of guide to the African past. But they also need to appreciate how much invented traditions of all kinds have to do with the history of Africa in the twentieth century (Hobsbawm and Ranger, 1983:262).

We have to ask ourselves the question whether claiming that a specific practice is part of '*my* culture', is referring to these invented traditions described by Hobsbawm and Ranger, which amounts to a quasi-postcolonial condition, a fragmented identity, forged from colonial underpinnings mixed with Xhosa traditional beliefs. In a similar manner, Omura (2003:396), in his criticism of an article by Kuper (2003:389) reminds us of the Inuit who have adopted a tradition of 'trapping and driving snowmobiles'. This new 'tradition' is clearly not based on what the Inuit of three hundred years ago would have understood as traditional, and it shows a new type of identity that is at least partly affected by the influence of colonialism.

In a similar manner both Hess (1995:181) and Silverstein (1995:136) discussed the concept of 'multiple religious identities'. In these two separate discussions, both dealing with 'Afro-Brazilian' conceptions of identity, the multiplicity of cultural and religious beliefs (including those which are Brazilian, Catholic and those from various 'African'[10] cultures), are considered and the relation of these conceptions to healing are described. Hess (1995:198) states that 'the only way in which the Umbanda encompasses the other healing systems is through a rhetoric of tolerance and ecumenism[11]' whilst Silverstein (1995:147) highlights the 'longstanding ideology of syncretism' in which the different religions 'appear not conflictive but conciliatory' (Silverstein, 1995:148). Hess (1995:204) concludes that 'I would hate to see any one religion as modernising force' whilst Silverstein states that 'these shifting, cultural symbols represent a multilayered struggle for

[10] Inclusive of, according to Silverstein (1995:135) as 'the Ancient African cultures of the Bantu of Southern Africa and the Yoruba and Ewe-Fon of West Africa'.

[11] "all of us"

cultural authenticity' (Silverstein, 1995:150). The key point to be drawn from the above is that this thesis does not assume that references to Xhosa 'culture' or 'tradition' – either by participants or any other figures talking about Xhosa people – refer to some stable set of traditional practices that have somehow remained static and unaltered. Albeit not from a distinguished author, is the term 'cultural imaginary', which is developed out of the concepts described by the authors above:

> …where people refer to culture to define and reinforce the familiar… it is, thus, important to recognise that consistent reference to 'culture' may be a strategy for creatively responding to challenges of personal and social life (Masenyama, 2004:19).

Overall, for this study, the concept of the imaginary relates to the fact that authors such as Van der Vliet (1991), Tutani and Rankin (2000) and Chuene (2006) have frequently encountered use of the term 'in my culture' by research informants. As with previous studies, I frequently encountered claims from respondents which justified their choices or behaviour by reference to what they understood to be done 'in their culture'. In that respect, what I take from the writers that I have discussed, is the idea that 'cultures' are always imagined; they are constructions whose imagined reality guides and shapes our choices.

3.4 Culturally sensitive intervention programmes

This section consist of three main subsections and it is important to understand how these subsections fit together. The following issues are addressed through reviewing current literature: (1) understanding of local health perceptions and localised strategies counteracting the effect of HIV/AIDS (2) that the identification and understanding of content-related issues needs to take place in a peer-driven environment, and (3) that issues pertaining to the presentation of a prevention program needs to be addressed. Thus, the main purpose of the first subsection is to consider, in light of the previous discussion, local health perceptions, health enabling environments and local strategies for overcoming HIV/AIDS. The second subsection, examines the key themes in relation to HIV/AIDS prevalence examined argued in this thesis and also examines the importance of peer-driven programmes. The third subsection examines an approach of dual (traditional healing and medical consultation) and culturally sensitive HIV/AIDS prevention programs.

3.4.1 Health perceptions, health enabling environments and localised strategies

Disease should not only be seen from a bio-medical perspective, but from a cultural and indigenous perspective as well (Molebatsi and Mulinge, 2004:135). English language mechanisms to explain illness, health and HIV have no immediate linguistic equals within the isiXhosa language (Price, 2009:12). Other studies (Molebatsi and Mulinge, 2004:135, Levin, 2006: 1083) have also established that difficulty is experienced between medical doctors and isiXhosa-speaking patients because of language barriers and because of the differences in conceptualisations of health and illness. Partially, these barriers exist due to the fact that, for the Xhosa, issues of health, religion and belief in the supernatural are inseparable (Foster, 1976:777 and Herselman, 2007:63). Consequently, it would be the practice of many patients to seek help from both medical professionals trained in the 'Western' tradition and traditional healers at the same time for the same illness, since these different treatments are understood to address different aspects of the problem. A medical doctor, for instance, cannot address issues pertaining to the ancestors, which might have 'sent' an illness because the patient has failed to honour a specific ritual. For Herselmann (2007:63) and others (Abrahams et al, 2002:79; Mlisa, 2009:193), the basis of the Xhosa conceptualisation of disease consists of various interrelated mechanisms, all inseparably tied together, inclusive of the natural and the supernatural.

On the basis of these differences in conceptualisation of health, Campbell et al suggest the following strategies are essential to health-enabling environments:

> …we believe (there) are six key strategies for facilitating the development of 'AIDS-competent' communities: building knowledge and basic skills; creating social spaces for dialogue and critical thinking; promoting a sense of local ownership of the problem and incentives for action; emphasising community strengths and resources; mobilising existing formal and informal local networks; and building partnerships between marginalized communities and more powerful outside actors and agencies, locally, nationally and internationally (Campbell et al, 2007:347).

These strategies would allow for the communities in question to think about problems presented by issues such as HIV/AIDS, bio-medicine and local conceptualisations of health, and to come forward with strategies, in conjunction with, for example, international funding agencies, medical doctors and traditional healers to address the situation, while fostering a sense of community ownership in the resulting schemes.

As another form of health-belief having an influence on HIV/AIDS prevalence, virginity testing could be viewed as a localised strategy to overcome HIV/AIDS. It is however a largely contested practise since it is considered an invasion of privacy, by some, and discriminatory by others due to the fact that it is gender-specific. Erika George describes the practice of virginity testing as follows:

> Virginity testing, as a prenuptial custom traditionally conducted just prior to marriage, refers to the examination of females to ascertain whether or not they are sexually chaste. Virginity testers, usually older women, conduct vaginal exams to determine if the female's hymen is intact and assess other physical features held to be indicative of the innocence and purity of the individual tested such as her muscle tone and the firmness of her breasts. Proponents of the practice advocate total abstinence from sexual intercourse as a way to prevent HIV/AIDS (George, 2008:1450).

The importance of the virginity of the female is related to the monetary amount or the number of cattle paid to the father of an unwed bride (Mntuyedwa, 2008:1). Van Der Riet (2009:127) stated that virginity testing and penalties for loss of virginity followed the 'established norms and rules' of the past. However, this assumption of a historical continuity in relation to this practice may be misleading; she also states that virginity testing has been re-introduced as a method of preventing the spreading of HIV/AIDS and in this respect it can be considered more as a form of invented tradition. Thus the process of virginity testing is a practice that, according to Le Roux (2006:13), ceased to exist but 'emerged with renewed vigour in the 1990s as a result of the increase in deaths due to HIV/AIDS' in the Xhosa and Zulu cultures. The author also explains that the test is unreliable since the hymen may or may not be present for reasons other than sex, such as physical activity, or the use of tampons or even its absence since birth. In terms of the debate regarding the invasion of privacy, George (2008:1451) paints a detailed picture of the practice and of associated responses to such testing, such as abuse of initiates who failed the test by family members. The fact that this practise was re-introduced under the auspices of 'tradition' and 'culture' is not only an example of an invented tradition, but also shows how claims about 'cultural' practice can be used in ways that justify inequalities within societies.

In relation to male rites of passage, it has been suggested that the biggest hurdle to overcome in the introduction of HIV/AIDS education in the context of traditional teachings is to be found at circumcision schools, and this is the belief that such schools are sacred (Mgqolozana, 2009:24). Whilst the practice of initiation is not of importance for this study

in itself, the basic problem of interpretation which is introduced here is important. The main elements of Groce et al.'s (2006:308) proposed framework in this regard include the fact that AIDS messages could be introduced at circumcision schools, but that beliefs surrounding tradition prevents this from happening, such as sceptical views about 'hospital men'[12] (Mhlahlo, 2009:100). From these above examples, it can be seen that it is necessary to think about how best to frame prevention efforts in terms of local understandings and practices.

3.4.2 Key themes

Whilst the elements discussed in this section were referred to as 'key themes' in Chapter 1 (c.f. Section 1.2.2), some authors refer to these localised problematic areas of investigation as 'contextual factors'. The term is thus defined as follows:

> While much early work focused on the individual determinants of sexual and drug-related risk-taking, increasingly the contextual factors which render some groups more vulnerable than others have come to be recognized. Factors as diverse as age, gender, social position, economic status, cultural norms, beliefs and expectations determine the risks faced and enable and constrain individuals in their actions (Carael, 1999:4).

The key themes (or contextual factors), are discussed here in relation to culturally sensitive peer education programs.

3.4.2.1 Perceptions surrounding the causes of HIV/AIDS

Mlisa's (2009:14) quoted Dr Matsibisa of the South African Medical Research Council's (South African Broadcasting Corporation, 2003) who suggested that '78% of the Xhosa used traditional medicine as a cure for HIV/AIDS'. I accept, in this context, Wreford's (2005:64) explanation of the meaning of the word 'cure' in relativistic terms, following her research with THPs:

> In traditional terms the interpretation of cure differs dramatically from that of biomedicine. *Amagqirha,* and their clients, assert that 'absence of symptoms' equates with a cure. Take Nikiwe, for instance. During the conversation in which she branded the dissident healer a liar, she confidently asserted that 'if there are no symptoms, the patient is cured.' This opinion was echoed by Khwezi, and is underlined in other South African research (for example Leclerc-Madlala, 2002b:13). It is an interpretation which has obvious and serious ramifications for

[12] Initiates who underwent circumcision in a hospital environment

> the treatment of HIV and AIDS; for while traditional healers recognise and have been shown to successfully treat symptoms of the opportunistic infections commonly accompanying HIV/AIDS, there is as yet no evidence that they can affect the virus. Arguably then, considered from the biomedical position, this was just a matter of misdiagnosis; since AIDS is often accompanied by recognised sexually connected diseases the *Sangoma* had misread the case and believed it cured once these symptoms had subsided (Wreford, 2005:64).

I therefore do acknowledge that it can be argued that recognizing and working through local accounts are important when dealing with issues of the disease, and that terms such as 'cure' should be understood contextually. I also entirely agree with Wreford that treating HIV/AIDS requires bio-medical intervention, and that the two systems, localised health care and bio-medical health care, can work together. In terms of witchcraft, an explanation of HIV provided by Ashforth (2002:121) pertains to a practice called *idliso*, or poisoning, the belief that an evil source could poison a person upon whom they wish ill-health. The symptoms, allegedly similar to those of HIV, include 'respiratory infections, the long absence of symptoms and inevitable death for infected people'. These symptoms 'have led people to interpret HIV and AIDS as *idliso*, and therefore as witchcraft' (Ashforth, 2002:121). What is thus required is the critical understanding of the role that cultural beliefs play in defining health and illness, and a critical engagement with these beliefs in terms of future prevention efforts.

3.4.2.2 Beliefs about nutrition and HIV/AIDS

In this section I shall primarily address two issues: beliefs relating to nutrition and HIV/AIDS and President Thabo Mbeki's approach to the promotion of traditional foods[13]

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[13] Some of the Xhosa traditional foods are listed below (quoted from Majova, 2011:16):

Amarhewu is maize meal that is cooked to make porridge.

Inkobe is boiled maize grain. Maize grain can be used either fresh or dry.

Ugume or *ukhothe* roasted maize powder.

Ujeqe is bread made by boiling crushed green maize or sorghum.

Umbaqanga is a thick porridge that is made from crushed maize or sorghum.

Umdokwe is porridge that is made from maize or sorghum flour and served warm.

Umngqusho is made from stamped dry maize cooked with or without beans.

Umqa is made from crushed maize mixed with pumpkin.

Umvubo is prepared from fermented milk (amasi) and maize or sorghum. Maize or sorghum is boiled, pounded and then mixed with fermented milk.

Umxhafele is a mixture of *inkobe*, cooked together with wild vegetables or pumpkin leaves.

in the fight against HIV/AIDS. I need to state that this section does not support the argument that nutrition is a miracle 'cure' against HIV/AIDS, but I do accept that it (nutrition) has a role to play in strengthening the body's immune system, whether individuals are HIV positive or not. Thus, proper nutrition is an essential element in the fight against HIV/AIDS since the body's ability to fight disease is directly linked to the quality of food consumed (Liebenberg and Pillay, 2000:4). The effect of poor nutrition on HIV positive patients leads to micronutrient deficiencies that increase the risk of mother to child transmission and susceptibility to other diseases (Loevinsohn and Gillespie, 2003:8). In response to this, the major argument according to a number of authors is the recognition that actions from a micro level (i.e. a community growing a crop farm) through to actions at a meso level all influence HIV/AIDS prevalence and that the world should be viewed 'through an HIV/AIDS lens'. In addition to this, they also stress the importance of proper nutrition, and encourage actions at the community level to improve the quality of food intake. Jolly's dissertation entitled 'Co-Engaged Learning: Xhosa women's narratives on traditional foods' (2006:89), draws from some of the arguments posed by Loevinsohn and Gillespie (2003:1), and highlights the correlation between proper nutrition, indigenous knowledge and HIV/AIDS. It asserts:

> …characterised by high rates of poverty, unemployment, poor nutrition and HIV/AIDS, individuals and households are pressed to make maximum use of their human, natural, social, physical and financial assets. As community members endeavour to make the best possible nutrition and health choices for themselves and their families, each draws on her own capital knowledge which reflects learning through a variety of methods and experiences. This study suggests that there are significant benefits in gathering a diverse group of voices together for reflexive co-engagement (Jolly, 2006:89).

From the above it can be seen that individuals are under pressure to make the right choices concerning nutrition, which in turn has an effect on outcomes such as HIV/AIDS. Many examples of traditional foods and their nutritional values are cited in Jolly's study, and it demonstrates the important aspect of making sure that the community shares with one another what they know. In this manner Jolly's study suggests 'that through the process of co-engagement and deliberation around indigenous ways of knowing, agency and cultural identity appears to be enabled and strengthened' (Jolly, 2006:1). Thus it appears that there is clearly a need to focus on elements of local understandings about proper nutrition in a study concerning HIV/AIDS, and that knowledge should be drawn from local sources as a base for departure, in an approach that integrates other forms of existing knowledge/beliefs to ensure that all individuals are less susceptible to contracting HIV. In the same manner

HIV positive individuals could be better equipped to fight opportunistic further infection since proper nutrition improves the body's immune system. Secondly, and directly related to nutrition and HIV/AIDS, during the course of this study, serious concerns were raised regarding the stance of the former Minister of Health, Dr Tshabalala Msimang, whose position was reported in the media as endorsing the effort 'to wean our people from antiretrovirals and present a diet of lemon, garlic, onion and olive oil as an alternative means of treatment' (Myburgh, 2005, Watson, 2006, Blandy, 2006). Whilst it is clear that it was the position of the South African Government to promote traditional nutrition in fighting the disease, the impression is gained that corrective steps have been taken with the establishment of the HSRC Centre for the Study of the Social and Environmental Determinants of Nutrition (HSRC, 2010:62) following widespread criticism. In an article entitled 'Discourses and Counter-Discourses in the fight against HIV/AIDS in South Africa' Mare (2009:4) highlights how the current government has been taking steps to correct misperceptions created by the Msimang statement surrounding issues of HIV/AIDS and nutrition. Mare (2009:4), describes the 'damage' done by the President Mbeki's government as follows:

> In a damning study published in 2008, Harvard researchers found that 330 000 South Africans died prematurely between 2000 and 2005 due to the lack of proper AIDS treatment. An estimated 35 000 babies born with HIV during that time also perished because 'a PMTCT programme was not implemented' (Mare, 2009:4).

3.4.2.3 Gender

The importance of gender, in a study conducted in the Eastern Cape, was highlighted as follows:

> Women are already marginalised by their gender in a patriarchal society. Specific gender roles for women are that they must be submissive to their husbands; they must never have authority over a man and must therefore keep silent. Women living with AIDS are marginalised even further, both as women and as human beings. Their illness can lead to additional marginalisation through poverty, especially when they themselves are not able to work and the family income is reduced or non-existent, leaving them entirely without material support. (Nieuwmeyer, 2002:23).

Mis-conceptualisations surrounding Xhosa gender and the construction of HIV/AIDS have been discussed by authors such as Delius and Glaser. In their work on polygamy (2004:84), they make it clear that views held by many South African researchers on

HIV/AIDS in respect of the interrelatedness between promiscuity and polygamy are 'simplistic'. They opposed two basic arguments; one, that historical polygamy creates an expectation of multiple sexual partnerships for men, and two, that historical polygamy therefore 'contained male sexual urges'. The core claim behind Delius and Glaser's paper was that marriage in the Xhosa context was not about sex, but entailed issues such as offspring, lobola[14] and the organisation of labour duties. Their paper further argues that 'a great deal of sex took place outside of marriage' (Delius and Glaser, 2004:84). Sex outside marriage and the way in which gender roles are viewed, inclusive of sexuality, is a determining factor of HIV/AIDS infection given the significance for infection rates of multiple sexual partnerships. By showing how assumptions about sexuality have changed over time, Delius and Glaser (2004:86) remind us that 'as far back as the early 1800s, the Xhosa reserved polygamy for kings and chiefs. They further report that in 1907, for instance, the belief existed that 'the man belonged to all women, but the woman only belonged to one husband'. The article further makes a distinction between rural and urban practices. Taking the history of polygamy and beliefs surrounding polygamy and extra-marital affairs into account, and that is wrongly believed to still exist, the article concludes as follows in relation to HIV/AIDS programmes:

> A more plausible starting point … is the recognition that there are long traditions of multi-partnership sexuality in this country … Evidence from elsewhere in Africa suggests that a significant reduction in levels of multi-partner sex can play an important part in reducing the rate of HIV/AIDS infection… this outcome cannot be achieved without a candid recognition and frank discussion of entrenched practices (Delius and Glaser, 2004:114).

Kuper (1999:19) argues that culture must not be viewed in a determinist way, and through Delius and Glaser's approach (above) we can see how important it is not to essentialise culture based on entrenched gender practises. It is therefore important to recognise the role of agency within conceptualisations about gender, to approach prevention programmes in a culturally sensitive manner, not to generalise, and make conclusions about past practises.

3.4.2.4 The context of the ABC programme

The main drive of the South African Government in the prevention of HIV/AIDS is the ABC approach (Mash, 2006:51). Mash also argues that the ABC approach does not take

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[14] lobola: bridewealth (or similar to) dowry (India). Mtuzi (1990:30) highlights, in a South African context, the term remains in the vernacular, due to the fact that there is no accurate translation.

into account 'local power relations' and 'contextual factors', and that consequently it (the ABC strategy) has not been successful. The ABC approach in South Africa (Mash, 2006:51) has been criticised for its tendency to 'erroneously assume that women are in control of sex, can control their partner's faithfulness and can influence the decision to use a condom'. In a review that examined, internationally, '192 sites' where ABC campaigns had been implemented, the following conclusion was drawn:

> There is no conclusive proof that abstinence-only[15] programmes have been successful in reducing HIV transmission. Evidence is also growing that abstinence-only programmes have failed to prevent the spread of sexually transmitted infections and teenage pregnancy (Setswe, 2007:5).

Setswe reviewed a number of studies which present a wide variety of reasons why abstinence-only programmes have not succeeded in different countries. Campbell and Williams (1998:57) have described the reasons for these failures as 'contextual' (not attentive to local understandings and contexts). It can be argued, therefore, that a global and universal 'formula' approach could not possibly be appropriately aligned with local, cultural, and individual constructs about identity and knowledge, especially in relation to understandings about gender-relationships. The argument against the ABC programme in this thesis is that it lacks the required cultural orientation towards its primary receivers. A generic message, although containing all of the required bio-medical information, cannot be effective if it is not placed within a sensitive understanding of the local cultural context.

3.4.3 Dual-system, peer orientated, culturally sensitive intervention programmes

In response to these problems, then, a number of alterative HIV/AIDS intervention programs have been proposed: 1) The specific involvement of THPs[16] in referral of patients to bio-medical professionals, 2) Peer education programmes and 3) 'Culturally' sensitive intervention programmes. This section discusses all of the above and overviews the contribution of these developments in the fight against HIV/AIDS.

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[15] The ABC is considered a 'abstinence based sex-education' program, a sub-category of abstinence programmes, where abstinence is promoted as first choice, but alternatives 'B' and 'C' are provided as well (Barnett and Parkhurst, 2005:590).

[16] Traditional Healthcare Professionals

3.4.3.1 Dual-system healthcare: THP's, the referral system and bio-medicine

The role of the traditional healthcare practitioner in the management of HIV/AIDS has been receiving some attention for a number of years in South Africa (Mufamadi, 2009; Wreford, 2009; Mulaudzi, 2005). In an evaluation of an approach where the role of THPs are engaged to provide information to HIV positive individuals, I highlight the following:

> Information sharing and educational programs in South Africa have resulted in THPs providing correct HIV/AIDS advice, as well as demonstrations of condom use. One such program trained 1 510 THPs and it was calculated that during the first 10 months of the program, some 845 600 of their clients may have been reached with AIDS/STD prevention messages (Bodeker et al, 2006:568).

Jo Wreford, an anthropologist from Cape Town, has received widespread recognition for her efforts through a project called HOPE[17]. HOPE has as its main aim the education and training of THPs about HIV/AIDS, and about existing management and referral systems, should individuals be identified as possibly being HIV positive (Bateman, 2010:80). The success of the project has been measured by the number of possible HIV positive referrals to medical professionals by THPs. This, according to Bateman (2010:81), had resulted in the referral of 250 patients from just three THPs over a period of six weeks. In a more detailed article by Wreford (2009:1) on the project, she states that 'the relationship between westernised and traditional medical paradigms is disjunctive, a binary opposition characterised by mistrust and disengagement'. She proceeds to consider this tension at the local level in South Africa drawing on the history of South Africa in demonstrating how this 'dual' approach had emerged. Although it is worth noting that in a query to Wreford's dual approach (2009:1), Abrahams et al. (2002:80) state that the country has indeed three systems of healthcare, which are referred to as 'biomedical', 'folk' and 'popular', of which the last category is a combination of self-medicating and lay treatment.

Wreford's article (2009:1), in any case, further describes how the 'country's diverse therapeutic environment is more accurately described as pluralist' with references to the interaction between local and 'westernised' health care. The main thrust in the article comes from the suggestion that many people 'use both systems, sequentially and even simultaneously' in their day-to-day health care, and that, subsequently, cross-training should be given to THPs about HIV/AIDS and referral to 'westernised' care, while the THP remains responsible for mental, spiritual and divine support. Dual consultation is also

[17] HOPE: HIV Outreach Program and Education

proposed by Mulaudzi (2001:7) who 'asserts that '80% of black patients visit traditional healers before or after they have consulted a bio-medical doctor'. Of importance for this study, then is the insight that it is necessary to inculcate the understanding that health beliefs refer not only to bio-medical issues, and that culturally sensitive HIV/AIDS prevention needs to take into account the cultural nuances associated with health beliefs.

3.4.3.2 Peer-orientated, culturally – sensitive studies in HIV/AIDS prevention

The concept of peer education and its success at Higher Educational Institutions in South Africa through HESA driven programmes were examined in Section 2.4. This section will discuss culturally centred approaches, and also examine a study in which peer-orientated and culturally sensitive approaches were combined to form a coherent whole.

The idea of 'culturally' - sensitive HIV/AIDS prevention programmes have been examined by a number of authors (e.g. Baldwin et al, 1996:322; Bayer, 1994:895; Dwairy, 2004:423; Kreuter et al, 2003:133; Osemene et al, 2001:481 and Thomas and Quinn, 1991:1498). All of these authors used the term 'culturally sensitive' to describe an approach that takes into account socio-cultural variables in HIV/AIDS prevention. Baldwin et al (1996:322), through what was termed 'integrative theory', stressed the necessity of ensuring that HIV/AIDS programmes must '(1) be relevant to developmental issues (2) address the values, beliefs and attitudes of the local inhabitants, and (3) promote relevant changes in their normal health behaviour of persons in their normal social-action contexts'. This 'integrative prevention model', involves the steps of 'local input, curriculum integration, field testing and evaluations' (Baldwin, 1996:323), and stresses the 'integration of theory and local culture' in a way that presupposes that cultural role models must play a important part in shaping cultural values that are aligned to HIV/AIDS preventative behavioural outcomes.

In relation to peer-education programmes, Campbell (1997:274) investigated perceptions of migrant mineworkers in South Africa, and based on the findings, proposed a peer-intervention strategy that was later implemented. Her basis for suggesting peer education programmes were simply that:

> …the argument that high-risk sexual behaviours (such as unprotected sex with multiple partners) are too complex to be changed by simply providing people with health-related information, as traditional health education programmes have sought to do (Campbell, 1997:274).

In terms of contested environments, Campbell, Foulis, Maimane and Sibiya (2005) examined 'social contexts' and showed how successful intervention strategies with sceptical youth in Ekhutuleni (Kwa-Zulu Natal, South Africa) took place. The level of contestation included some youth displaying (sexual) bravado with 'fatalistic notions' and complaining about 'information overload' (e.g. 'tell us something new').

Dwairy (2004:423) defined the term 'assertiveness training in peer education' as 'programs aimed at helping people not to give in when it comes to expressing their needs and feelings but to do so without becoming aggressive toward others'. The study examined Arab educational interventions in Israel, and criticised the Israeli Department of Education for imposing 'westernised educational programs' upon Israeli – Arab citizens. One of the criticisms was made in relation to the collective /individualist debate, claiming that Arab citizens were more 'collectivistic' than the intended target market. In a call for a more 'culturally sensitive' approach, the author examines 'assertiveness programs' in addressing matters of inequality, and recommends that solely working toward 'behavioural change is insufficient and that cognitive work on societal issues must be an integral part of any assertiveness training'. Dwairy's (2004:423) recommendations could be helpful in relation to current assertiveness training modules offered in relation to gender at the WSU (Twaise, 2010). Kreuter et al also attempted to devise 'culturally appropriate' programs utilising five strategies:

- Peripheral strategies give programs the appearance of cultural appropriateness
- Evidential strategies seek to enhance the perceived relevance of a health issue
- Linguistic strategies seek to provide them in the dominant or native language
- Constituent-involving strategies are those that draw directly on the experience of members of the target group. These strategies include hiring staff members who are indigenous to the population served.
- Socio-cultural strategies discuss issues in context of broader cultural values.

Kreuter et al (2003:185)

A programme that supports social debate would ensure that topics are included which aligns to all of Kreuters' strategies. It can be seen that the inclusion of a THP within the discussion would enhance the 'appearance of cultural appropriateness'. Providing evidence of success surrounding health issues could resolve debates, whilst conducting debates in the native tongue, Xhosa would address linguistic issues. Running debate programmes led by peers would contribute to constituent – involvement whilst issues for discussion would be situated within broader cultural values.

Osemene et al (2001:481) proposed that a culturally targeted intervention must include 'environmental, social, economic, and political issues of the group and would include ethnic pride, HIV/AIDS facts, and essential skills for communication, problem-solving, and coping'. Thomas and Quinn (1991:1498) highlighted the fact that 'strategies such as (1) the use of program staff indigenous to the community, (2) the use of incentives, and (3) the delivery of health services within the target community' should be utilised to promote culturally-sensitive health intervention programmes. In a combined, culturally - sensitive, peer education program Majumdar et al (2004:71) used 'peer-education with culturally sensitive material' to educate Aboriginal Canadian youth about HIV/AIDS. The findings of the study suggested that the transferability of the knowledge depended on how culturally sensitive the material and the programme was.

3.5 Conclusion

In this chapter I firstly reviewed the theoretical framing for the purpose of justifying my emphasis on an interpretative framework while also recognising the need to be attuned to the effect that structural questions can play on understandings and actions. This included an examination of Gidden's theory of structuration in conjunction with similar concepts offered by Weber, Parsons and Geertz, with further commentary from Hays (1994:62) and Sewell (1992:27). Based on the fact that the literature revealed that many of the beliefs with regards to HIV/AIDS prevention are said to be culturally based (Willims et al., 1996:9; Nzioka 2000:2; Mogensen, 1995:132; Mutonyi, 2007:190), a deeper understanding of the concept of 'culture' was required for the purposes of analysis, and therefore notions of 'culture' by various authors were examined. Cultural analysis currently addresses issues of power and dispossession through the relational approach. Taking this imbalance into account, as well as Giddens' concept of the double hermeneutic and Geertz's acknowledgement that ethnographers' accounts are of a 'second and third order', the interpretative approach allows for truly understanding social issues, such as beliefs surrounding HIV/AIDS that are culturally-based.

As a result of the above mentioned power-imbalance and 'the postcolonial condition', works by authors such as Geertz (1973:13); Hobsbawm and Ranger (1983:11) as well as Anderson (1983:15) introduces the concept of the 'imaginary'. The 'imaginary' is a useful concept that allows us find a manner of interpreting difficult statements by research informants relating to '*my* culture', which seem to commonly occur in research (c.f. Van

der Vliet, 1991:236; Tutani and Rankin, 2000:8; and Chuene, 2006:130). Further literature, allowing for analysis, are concepts such as ‘double speak’, double identity and myth.

Culturally sensitive intervention programmes would therefore have to take into account local health perceptions, the provision of health enabling environments, current local strategies related to HIV/AIDS prevention as well as key themes local to the context of the environment. The fact that the majority of the Xhosa population subscribes to a dual system of health care (bio-medicine and traditional health care practises) brings us to the conclusion that HIV/AIDS preventative action should take place in recognition of this fact, which also forms the basis of contextualisation. The major key themes were reviewed and revealed certain beliefs in relation to perceived causes of HIV/AIDS, nutrition, gender and the ABC programme of the isiXhosa speaking people. In light of these themes, the chapter examined a three-tier system that takes into account the fact that dual healthcare system exists, the success of peer education in South African Universities and what has been termed ‘culturally sensitive’ intervention programs’. The chapter finally examines various steps that could be considered in the implementation of such a proposed programme.

4: Methodology

4.1 Introduction

This chapter describes the methodological approach that underpins this study and the methods adopted to carry out the research. It also critically engages with previous research in the area and gives an overview of other methodological approaches used to research HIV/AIDS in South Africa. On the basis of other South African studies and the nature of the research problem, it argues for the appropriateness of a qualitative approach within the interpretative tradition, utilising Denzin's method of interpretative interactionism (Denzin, 2002). The method was found to be ideally suited for the study of debates around societal problems, such as HIV/AIDS (c.f. Nzioka, 2000:2; Mogensen, 1995:132; Mutonyi, 2007:90).

Denzin describes the steps in the interpretative process as framing, deconstructing, bracketing, constructing and contextualising (Denzin, 2002:70). The chapter is structured around these steps outlined by Denzin and first re-states the research aim as posed in Chapters 1 and 2. The discussion then demonstrates how interpretative interactionism as a method was chosen under the headings 'deconstruction' and 'analysing prior conceptions of the phenomenon'. This is done through discussing the quantitative/qualitative debate, and then arguing for a qualitative approach. The argument then moves on to explore the interpretative tradition in more detail. The next section examines issues surrounding the capturing of the data and demonstrates how the research brought me closer to the research sample (although 'insiderness' was not achieved, c.f. Geertz, 1973:85), and how the sampling and interviewing process took place. In the next section, I examine how I bracketed the data through the process of data analysis, which consisted of discussing the demographics, the software utilised for analysis and mapping. This is followed by a discussion of the data construction process wherein I explain how I utilised Geertz's conception of thick description (1973:9). The last two sections address issues relating to data integrity and ethical considerations.

4.2 Framing the study

The aim in this study, as explained in Chapters 1 and 2, relates to a concern to understand how we can best implement HIV/AIDS intervention programs that are culturally sensitive, which take into account the implications of the existence of a dual system of traditional healing and bio-medicine, and which are peer-driven.

For the purposes of the study a qualitative method, interpretative interactionism, was chosen. A sampling frame was constructed to include data from both those responsible for HIV/AIDS prevention in the institution, referred to as 'key role players', and the recipients of HIV/AIDS prevention programs, 'students'. Since the student body is extremely large[18], and given the fact that this study did not attempt to achieve a representative sample, a small unit of students was chosen from the Institute of Advanced Tooling (IAT – c.f. Chapters 1 and 2), referred to below as 'students'. A topic guide was constructed, which was refined after pilot interviews with both groups. A total of 40 interviews were then conducted (20 with key role players, and 20 with students) over a period of two years. The data was transcribed and thematically analysed. Themes were refined into categories and data from categories are discussed in the data chapters as constructs and conceptualisations from these two key groups.

The next sections will show in more detail how the above took place and include discussion on the decisions that was made to follow the described methodology, and show why these methods were appropriate to the research questions and concerns. The first of these research decisions required me to examine the qualitative/quantitative debate.

4.3 Deconstructing prior conceptions of the phenomenon

This section first examines the quantitative versus qualitative debate and discusses the reasons for opting for a qualitative approach. It then discusses the interpretative tradition in relation to this study and explains interpretative interactionism as a method most suited for this study.

[18] 22 000 students (WSU Institutional Plan, 2010)

4.3.1 The qualitative/quantitative debate

One of the major problems with HIV/AIDS research is that no specific method exist solely for the purpose of sexual behaviour research (Parker et al,1991:419), and that researchers have to draw from many of the research traditions in multidisciplinary fields in order to come to meaningful conclusions. A qualitative orientation was chosen, with an interpretative stance, and interpretative interactionism as a method, due to its ability to explain societal problems and help us investigate lay coping mechanisms (Denzin, 2002:2).

Quantitative studies which have looked at HIV/AIDS in South Africa include Mafuya et al (2009:1), who investigated the social determinants of HIV/AIDS in the Eastern Cape and the HEAIDS study of 2010 (HEAIDS, 2010:1), which investigated HIV/AIDS prevalence in South African universities. Shisana et al (2005:1) reported on a 2005 national HIV prevalence, incidence, behaviour and communication survey funded by the South African HSRC[19]. Quantitative findings do not allow for an adequate understanding of the contextual factors involved. It is with this theoretical concern in mind that it has been argued that qualitative research into HIV/AIDS 'has described the theory and practice of belief systems, the role, influence and potential of traditional healers and has been able to capture cultural and local variations' (Abdool-Karim, 1993:690).

The role of qualitative research in HIV/AIDS was explored in a paper by Power (1998:687). One of the central claims put forward by Power is that qualitative research can 'provide rich contextual data to forward our understanding of the phenomena' and 'is pivotal to our understanding of the socio-behavioural aspects of HIV transmission' (Power, 1988:687). Qualitative studies of significance that focus on either/or a combination of the contextual factors under investigation in this study, include works by Jolly (2006:29) (using an interpretative methodology in a study on indigenous knowledge and nutrition as an element of well-being), Wood et al (1998:233) (in a study on Xhosa gender issues), Kelly (2000:29) (on the failure of HIV/AIDS educational programmes to incorporate cultural conceptions of HIV/AIDS into the school curriculum) and Campbell et al. (2005:451) (who examined the social factors associated with peer-intervention programmes).

[19] Human Sciences Research Council

4.3.2 The interpretative tradition

In this study a qualitative orientation was sought that allows for interdisciplinary research within the social sciences. Interpretative methodologies allow for both 'interdisciplinary and cross-disciplinary research questions' (Yanow and Schwartz-Shea, 2006:xi). One of the major contributions from the interpretative tradition to HIV/AIDS research is described as follows:

> Because action has increasingly come to be understood as socially constructed and fundamentally collective in nature, earlier notions of behavioural intervention have given way to ethnographically grounded AIDS education and prevention programs that are community-based and culturally sensitive-programs aimed at transforming social norms and cultural values, and thus at reconstituting collective meanings in ways that will ultimately promote safer sexual practices (Parker, 2001:168).

Parker's quote above denotes the conceptualisation of social structures as governed by interaction and, ultimately, sexual interaction: 'Special emphasis has been given to analysing cultural categories and systems of classification that structure and define sexual experience in different social and cultural contexts' (Parker, 2001:167). In this manner the interpretivist tradition thus allows us to link structures within social settings with HIV/AIDS perceptions, and this could ultimately be used, as suggested here, in prevention campaigns.

Similar to Parker (above), Giddens also refers to social structures that govern social interaction (Giddens, 1984:5). The structures that Giddens refers to can be linked with health promotional theories through describing how the notion of action has similarities in the two approaches. If we examine various proposed and researched processes of taking preventative action in HIV/AIDS research, as described in numerous models of health promotion[20], the first step consists of access to information regarding prevention (an individual is required to know why the wearing of a condom would prevent the spreading

[20] The process of providing knowledge and ensuring that knowledge turns into action has been described in a range of models such as the Health Belief Model (Naidoo and Wills, 2000: 222), The Theory of Reasoned Action (Wright, 1998:271), the Stages of Change Model (Naidoo and Wills, 2000:231-232) and the AIDS Risk Reduction model (Lanier and Gates, 1996: 538). These processes have some sort of resemblance to Giddens' approach (c.f. Chapter 3) of interrelatedness of action, intention, rationalisation and consequence.

of HIV), followed by action amounting to a change in behaviour (i.e. the wearing of a condom during intercourse). These steps have similarities with Giddens' approach that discusses the interrelatedness of action, intention, rationalisation and consequence. Giddens' process would therefore translate into an interpretative 'step' in comparison to some health promotion theories, thus making the interpretative tradition ideally suited for this study.

4.3.3 Denzin's method of interpretative interactionism

Authors such as Whitehead, who researched HIV/AIDS and the contextual perceptions of African-American men, utilising interpretative action as a method, credited Denzin for his contribution for his work in HIV/AIDS research (Whitehead, 1997:411). Denzin also forces an author to take sides and therefore states that researchers should be careful to consider the following proposed steps:

1. Adopt their own value position.
2. Identify and analyse the values and claims to objective knowledge of positions that are contrary to their own.
3. Show how these appeals to ideology and objective knowledge reflect particular moral and historical standpoints.
4. Show how these standpoints disadvantage and disempower members of a specific group.
5. Make an appeal to the participatory, feminist, communitarian ethic.
6. Show how the ethic in (5) could produce social betterment by applying it to a concrete case.
7. In a call to action, engage in concrete steps that will change situations in the future.

(Denzin, 2002:4)

4.4 Capturing the phenomenon: entering and interviewing the field

This section will first demonstrate how my sampling frame developed, followed by my attempts to understand insider perspectives from the position of being an outsider. As an insider I could only relate to my interviewees through years of experience of lecturing at WSU, and from the more distinct outsider position, some of the perspectives shared with me were very different from my own beliefs and from the presuppositions of my social upbringing. The section lastly describes the interviewing process.

4.4.1 The sampling process

Overall, forty in-depth topic-guided interviews were conducted during two separate six month periods over a period of two years, with an analysis stage of the first year's interviews in between. The first set of twenty interviews was with key role-players in terms of HIV/AIDS at WSU, which allowed for a deeper understanding of policies and approaches to the problem taken by the University. After analysis of the first set of interviews, a second set of twenty interviews was conducted with students at the IAT. As the Centre did not have twenty students, some interviews were also conducted with third year mechanical engineering students who intended entering the IAT after completion of their undergraduate qualifications. As with the first set of interviews, the second set of interviews was analysed after completion.

In terms of sampling, the first set of interviewees was chosen utilising the 'snowball' method of sampling (also known as chain-referral), as described by Biernacki and Waldorf (1981:141), which allowed for interviewees to be chosen in terms of their association with the research problem. According to these authors (Biernacki and Waldorf, 1981:141) this sampling method is 'particularly applicable when the focus of the study is on a sensitive issue, possibly concerning a relatively private matter…', making it ideal for this study. In terms of this process, the first interview was conducted with a well-known HIV/AIDS counsellor at the institution. In the course of the interview, some key themes emerged, and the first interviewee was asked to advise the name of a second prospective interviewee, the second was asked similarly to help in the recruitment of a future interviewee, and so on. In terms of this process, the topic guide was updated after every interview as further themes emerged. The second set of interviewees was chosen utilising typical case sampling (Tashakkori and Teddlie, 2003:280). In terms of their explanation, typical case sampling involves finding cases 'that best illuminate the research question at hand'. The application of this method of sampling, in terms of the students at the IAT, consisted of choosing all willing students enrolled at the IAT, as well as prospective IAT students.

4.4.2 The outsider perspective

In this section I will demonstrate some of the complexities I had to grapple with as a researcher given my outsider status in relation to the researched population. It was indeed difficult to establish a position. A number of categories of 'insiderness' and 'outsiderness' had to be considered against a backdrop of complexity of debates in relation to the social

sciences, and the goal of position relative to research informants:

> We are now at a moment where contemporary social science inquiry has accepted that outsider status not only cannot be fully erased in the course of research, but that it also plays a role in the production of data. Some of these conversations have been about how respondents define themselves as outsiders to distinguish aspects of their identities and experiences, or how respondents' designation of the researcher as a outsider promotes conversation that informs the researcher about certain attitudes, opinions or world views maintained by these respondents. Despite these advances and transformations, an enduring value is still placed upon the insider status as the privileged position from which to converse with respondents. By this I mean that researchers ultimately aim to increase their insiderness even if they know that they must contend with the various issues concerning outsiderness. Consequently, there is a lack of more critical exploration of how insider status may, in fact, inhibit conversation during specific moments in fieldwork (Young, 2004:192).

There are difficult questions that emerge from the above quotation: one has to ask oneself what defines oneself as an outsider in relation to identities and experiences, and how these outsider qualities may promote or inhibit conversation. Hiebert (1999:49) states that 'anthropologists are to describe other cultures and worldviews using native categories and logic'. Coming back to the hermeneutic position, the same author acknowledges that this is difficult to achieve; 'the hermeneutical method requires a Hegelian type of dialogue that seeks synthesis, not a joint search for the truth' (Hiebert, 1999:48). It is accepted that this is the most that this process of seeking an insider/outsider position could achieve.

Sometimes it also occurs that a position of insiderness is assumed beforehand, but the researcher actually discovers that he/she is an outsider, as was the case with Duku (2007:7). She was a Xhosa female researching Xhosa females, and who first perceived herself as an insider, but highlighted the fact that she discovered, through the process of research, that she was actually an outsider, despite the fact that she was of the same gender and culture as her research participants. This is an indication that the inside/outside position is relative, and shifts during the process of conducting field interviews. In terms of my chosen methodological orientation, interpretivism, I am required to take the 'standpoint of those studied, to the best of my ability' (Denzin, 1974:269), albeit from the vantage point of an outsider.

If I examine categories of insiderness/outsiderness, first with the WSU key-role players in HIV/AIDS, I can then see that the majority of research respondents were all WSU professionally-employed with a majority being female (65%) (demographics depicted in

Section 4.5), of ages ranging from 24 to 55, with age majority peaks at 41, 42, 47 and 48, and majority Xhosa (65%). In relation to my own position, I am professionally employed by WSU (as are all of the key role-players), I share a common interest in HIV/AIDS prevention, and am of similar age as my colleagues. In relation to culture, I am an outsider. In terms of gender the majority were female (65%).

Secondly, we have to examine the position of the students at the IAT. Of importance here was the fact that I had to try to avoid any undue influence over the students due to the fact that I was involved in an existing lecturer-student relationship, which was partially overcome by the fact that we were from different faculties. The power position was, however, always present, with many students calling me 'Sir', as a sign of respect[21]. In terms of other demographics they were all male, as I am, and all 3rd year or postgraduate students, whilst I have been a university student since 1992, and then later employed by a university. Culture and age were very real demographic differences. Given the fact that many students had heard about the interviews from others and approached me as a matter of interest in the topic, with some inviting me to make presentations about HIV/AIDS to their whole group (a task that I handed over to the campus HIV/AIDS counsellor), given the openness of their responses, I certainly feel that I was able to achieve a good rapport with my participants during the course of the study, although I realise that insiderness was never attained. If we were to examine overlapping categories, it would be incorrect to state that I am an insider, but I also became less of an outsider as a result of the study, since understanding never achieved before, was obtained.

4.4.3 The interviewing process

In terms of language issues it should be noted that WSU is an English medium University. In accordance with the University's language policy, and my inability to converse in isiXhosa, all interviews were conducted in English. The use of English, however, implied the use of a second language for the research informants. Whilst the use of English was certainly adequate in terms of understanding and interpretation, I found it necessary to

[21] The term 'respect' was also examined in various sections within all of the data chapters. It emerged to be a very important element of the social structure influencing issues such as agency. I accept that in many ways, the respect I was receiving through use of the terms 'Sir' was similar to what Wood (2009:412) experienced. In Wood's description, she approached learners and enquired about which values they perceived as good in their culture. Their responses were (Wood, 2009:412) 'respect, ubuntu, and the willingness they have to care for those in their extended families.'

revisit certain Xhosa terms used by research informants (e.g. lobola) during analysis of the interviews. This was done through consulting a senior lecturer in the isiXhosa language. The lecturer was also a friend, which aided openness in explanation of cultural nuances associated with terms. The interviewing process was preceded by two pilot interviews, which I did to familiarise myself with the research setting and to identify possible problem areas in the topic guide. In the case of WSU key role players research informants went out of their way to explain cultural nuances pertaining to belief systems etc. Some terms and phrases such as 'in our culture', 'flesh on flesh', et cetera, seemed to become repetitive during the transcribing of interviews.

As previously discussed, I also had to ensure that I exerted no undue influence on interviewees due to my involvement with WSU. In terms of the first set of twenty interviews with key role-players, I had no professional association with the HIV/AIDS unit of the institution, and therefore no motive to exert any undue influence. It was found that professionals were keen and eager to participate in the research process because they themselves were in a process of trying to formulate an HIV/AIDS policy for the new institution at the time of writing. The impression was gained that the professionals wanted to see the outcomes of the study since it might provide meaningful information that could be used in the management of HIV/AIDS at WSU. In terms of the second set of research informants, students from the IAT, I had to take the position that I had no undue influence on the students as a lecturer. I therefore selected the IAT. Not only was this an important unit in the University, it was also from outside of my faculty and I had no previous contact with it. I form part of the faculty staff of Business, Management Sciences and Law (FBML), whilst the students from the IAT form part of the Faculty of Science, Engineering and Technology (FSET). In terms of interviewing the students, it was initiated in an entirely different manner to that of the key role-players.

The IAT Centre Director introduced me to various male students (some were employees as well as students), and the basic understanding and point of departure was that tooling was a scarce skill, at which point HIV/AIDS as an influencing factor was discussed. The interviewees quickly decided, despite discussions relating to privacy, to discuss my presence amongst them, and 'a label' was attached. It was a positive label, and I was viewed as knowledgeable in the field of HIV/AIDS and I found it necessary to have pamphlets and information pertaining to HIV/AIDS ready during interviews. Whilst it was explained that I had no medical background, the interviewees had clearly made up their mind about my knowledge pertaining to HIV/AIDS and this was seen as a welcome and

necessary part of their education. In some instances, it was also necessary to involve members of the WSU clinic, arising out of requests by students after the interviews. In some instances, students declared their positive status outright and early on in the interview, despite the fact that I explained that it wasn't necessary. Some males initially boasted about their sexual exploits but quickly changed the conversation to one of concern in relation to the possibility of STDs and HIV/AIDS.

The fact that the interviews were based on topic guides and in some instances were allowed to become unstructured, allowed me to delve deeper into some issues that would not have been possible if, for instance, rigidly structured interviews were used. Due to my aim of understanding claims made by the interviewees, I was able to discuss and dissect the various emergent themes explained in the later data chapters. During the interview process I was forced to travel extensively as WSU has numerous campuses. Interviews were conducted at the main Mthatha campus, the Butterworth (Ibika) campus, Potsdam (East London), College Street (East London) and Chiselhurst (East London) during the first phase of interviews. During the second phase all interviews were conducted at either the IAT or the Chiselhurst campus in East London. Interviewing in different settings allowed a broader understanding of the context. Other information was also collected and used during the process of interpretation, such as educational material and photographs. The interviews also paved the way for me to be introduced to the institutional HIV/AIDS Committee.

4.5 Bracketing, Constructing and Contextualising: Data analysis

This section examines the bracketing of the data, explains how constructing the data through thick description took place and contextualisation through Denzin's (2002:48) epiphany.

4.5.1 Bracketing: Demographics, Software and Temporal Mapping

Denzin (2002:75) states that during bracketing, 'the researcher confronts the subject matter, as much as possible, in its own terms'. In terms of this comment, we can see that it is the intention of this phase to organise the data in a meaningful manner for interpretation before the data is 'constructed and contextualised', which would imply that subjective interpretation and my own perspective on the data gets added after the bracketing process has been completed. This section therefore examines the 'hard data', the unchangeable

facts (i.e. demographics), sorting mechanisms (i.e. software used for analysis) and the mapping process.

4.5.1.1 Demographics

Age	24	26	32	33	37	38	41	42	44	45	46	47	48	50	55	Total
Frequency	1	1	1	1	1	1	3	2	1	1	1	2	2	1	1	20

Table 4: Age, Key Role Players

Region and Campus:

Region	Campus	Frequency
East London	Chiselhurst	5
East London	College Street	5
East London	Potsdam	5
East London	Vincent	1
Butterworth	Ibika	2
Mthatha	Nelson Mandela Drive	2

Table 5: Region and Campus, Key Role Players

Table 4 shows the average age of respondents in my first cohort as 41, of which 7 were white and 13 Xhosa. In relation to gender, 7 were male and 13 female. Table 5 shows the region and campus location of the key role players interviewed. One interviewee was based off-campus in a suburb of East London called Vincent, whilst the others were divided equally between Butterworth (called Ibika) and Mthatha, Nelson Mandela Drive (NMD).

Age	22	23	24	26	27	28	Total
Frequency	5	3	5	4	2	1	20

Table 6: Age, Students

Region	Campus	Frequency
East London	Chiselhurst	9
East London	College Street	11

Table 7: Region and Campus, Students

The average age of the students interviewed amounted to 24.5 years old, with the majority aged between 22 and 24, as indicated in Table 6. All the students were male and 19 were

Xhosa with only one Shona, with table 7 showing their campuses. The full list of research participants are depicted in Tables 8 and 9.

Region	Campus	Designation	Culture	Age	Gender
East London	Chiselhurst	Snr. Lecturer, Mechanical	White	55	M
East London	College Street	Director, IAT	White	42	M
East London	College Street	IAT Employee	Xhosa	26	M
East London	College Street	IAT Employee	Xhosa	24	F
Butterworth	Ibika	HIV/AIDS Project Manager (USAID)	Xhosa	42	F
East London	Chiselhurst	Lecturer, Com and Languages	Xhosa	37	F
Butterworth	Ibika	HIV/AIDS co-coordinator	Xhosa	46	F
East London	College Street	Health Promoter	Xhosa	41	F
East London	Potsdam	HIV/AIDS co-ordinator	Xhosa	44	F
East London	Potsdam	HIV/AIDS co-ordinator / male nurse	Xhosa	41	M
East London	Potsdam	Academic Development Officer	White	47	F
East London	Potsdam	Residence Officer /	Xhosa	48	M
East London	Potsdam	Psychologist – Student Councillor	Xhosa	41	F
Mthatha	NMD	Health Promoter	Xhosa	32	F
Mthatha	NMD	Health Promoter	Xhosa	33	F
East London	College Street	Junior Lecturer, Fine Arts	White	48	F
East London	Chiselhurst	VP: Student Affairs and Marketing.	Xhosa	50	M
East London	Chiselhurst	TABEISA Dev Officer	White	38	F
East London	Chiselhurst	Snr. Lecturer, Mechanical	White	45	M
East London	Vincent	Edunique AIDS	White	47	F

Table 8: List of key role players and their demographics

Region	Campus	Designation	Culture	Age	Gender
East London	College Street	Student: IAT	Xhosa	24	M
East London	College Street	Student: IAT	Xhosa	26	M
East London	College Street	Student: IAT	Xhosa	24	M
East London	College Street	Student: IAT	Xhosa	27	M
East London	College Street	Student: IAT	Xhosa	26	M
East London	College Street	Student: IAT	Xhosa	28	M
East London	College Street	Student: IAT	Xhosa	27	M
East London	College Street	Student: IAT	Xhosa	26	M
East London	College Street	Student: IAT	Xhosa	24	M
East London	College Street	Student: IAT	Xhosa	24	M
East London	College Street	Student: IAT	Xhosa	26	M
East London	Chiselhurst	Student: 3rd year, ND: Mech Eng	Xhosa	22	M
East London	Chiselhurst	Student: 3rd year, ND: Mech Eng	Xhosa	22	M
East London	Chiselhurst	Student: 3rd year, ND: Mech Eng	Xhosa	23	M
East London	Chiselhurst	Student: 3rd year, ND: Mech Eng	Xhosa	22	M
East London	Chiselhurst	Student: 3rd year, ND: Mech Eng	Xhosa	22	M
East London	Chiselhurst	Student: 3rd year, ND: Mech Eng	Xhosa	22	M
East London	Chiselhurst	Student: 3rd year, ND: Mech Eng	Shona	23	M
East London	Chiselhurst	Student: 3rd year, ND: Mech Eng	Xhosa	24	M
East London	Chiselhurst	Student: 3rd year, ND: Mech Eng	Xhosa	23	M

Table 9: List of students and their demographics

4.5.1.2 Software

NVivo version 2.0 was used during the process of analysing the data. The main advantage of using NVivo is that it allows for electronic sorting and categorisation of data, making the data far easier to access, manage and control. Whilst the program was considered particularly helpful in sorting and categorising the data, the trees and nodes developed were numerous (i.e. 134 branches) and sometimes the initial sorting was too complex for meaningful interpretation. On the first attempt of the first set of interviews, this difficulty led to a second attempt at re-sorting. Key categories were only clear once an initial sorting process was completed. The re-sorting attempt highlighted the emerging themes. Due to the fact that this process was done before the second set of interviews, sorting and categorisation of topics in the second set of interviews was far easier and less complex. The re-sorting of the data increased methodological rigour and forced me to a greater familiarity with the data than initially.

4.5.1.3 Temporal Mapping

Temporal mapping has been defined as:

> Connecting individuals to social situations. Includes determining temporal sequencing and the location of the situations where persons come together. Focuses on who does what with whom, when and where (Denzin, 2002:175).

Temporal mapping called for reflection on how I interacted with the research informants, how they opened up to me and for what reasons, which allowed me to gain access to information. The process, however, should be seen as the link between organising the data (through a programme such as NVivo) and the constructing process. Understanding how and why people open up to one paves the way for understanding through the next step, thick description, which allows for interpretation and separation of intentions.

First, the rationale behind the two groups were the fact that it allowed for comparison between comments from the two respective groups, who experienced HIV/AIDS at WSU from entirely different vantage points. Key role players experienced it as a management - communication issue at the institution, whilst students experienced it from a receiver of management communication issue. Secondly, as indicated in the sampling frame, it should be remembered that I chose to use snowball (or chain-referral) sampling, whereby my first interviewee was a known member of the group ‘WSU HIV/AIDS key role players’. The

interviewee then recommended the next person for interviewing, and so on. Whilst I found that this method was effective with the key role players, and they were keen and eager to open up to me because they supported the research (after intense questioning of my intentions), the matter of students opening up was an entirely different one. The sampling frame followed a case sampling method, whereby willing students were asked to come forward, following introduction to the students in a class setting. Students were requested to contact me should they be interested in participating.

I always knew how I could locate the group, and understood what they were talking about. Maybe I did not get to know the entire group well enough to graphically illustrate a social network, However, I had a fair idea of how the social setup worked and what I had to do to gain access to the group. This process aided thick descriptions which played a role in the biographies and other instruments which were used for interpretation and locating the epiphanies.

4.5.2 Constructing through thick description

Denzin describes 'thick description' in the analysis of qualitative data as follows:

> Description is the art of giving an account of something in words. In interpretative studies, thick description and inscriptions are deep, dense, detailed accounts of problematic experiences. These accounts often state the intentions and meanings that organize actions (Denzin, 2002:98).

Whilst the analysis was done through utilising Denzin's application of thick descriptions, it would however be incorrect not to trace the origin of thick descriptions in order to fully understand how the concept was applied to this research. Ponterotto (2006:539), acknowledging Geertz's (1973) popularisation of the term, traces it back to 'an Oxfordian', Ryle (1949), and states that the major purpose behind Ryle's thick description was the 'ascribing of intentionality to behaviour'. Geertz however took thick description a step further. He stated that:

> ...what we call our data are really our own constructions of other people's constructions of what they and their compatriots are up to – is obscured because most of what we need to comprehend a particular event, ritual, custom, event, idea, or whatever is insinuated as background information before the thing itself is directly examined (Geertz, 1973:9).

Through the above I found that interpretation of my own data was informed by several views. One was my own understanding, a second was that of my research informants, and a third was the objective inputs of third parties – scholars and commentators. These, together, enriched my understanding of the data and sharpened my analysis and interpretation thereof. So the construct was therefore balanced within the realms of the double hermeneutic referred to earlier. My interpretation, based on theory and the expression of experience and perception are reflected in the text. The interpretations of the research informants' inputs, and also other outsider ideas that emerged through discussion proved useful. This process of multiple interpretation, is, one could argue, in some way an improvement on some of the conceptions of the double hermeneutic, what Geertz (1973:9), through illustration, calls 'winks upon winks upon winks' – to the extent where it could be impossible to determine the actual intention behind the wink.

Geertz also introduces the notion that culture is a semiotic phenomenon (1973:5), and later (1973:9) compares it to 'signs' and 'codes' (c.f. Barthes, 1972), and ultimately describes the process of researching culture as follows:

> What the ethnographer is in fact faced with – except when (as, of course, he must do) he is pursuing the more automatised routines of data collection – is a multiplicity of complex conceptual structures, many of them superimposed upon or knotted into one another, which are at once strange, irregular and inexplicit, and which he must contrive somehow first to grasp and then to render. …Doing ethnography is like trying to read (in the sense of 'construct a reading of') a manuscript (Geertz, 1973:10).

The biggest challenge in relation to 'unknotting' the tied knots in relation to my own research was separating the structures of culture and belief systems in relation to health and HIV/AIDS from WSU as an institution itself, and on a more deeper level, separating the intentions of the WSU key role-players in HIV/AIDS from what was happening on the ground, compared to the intentions displayed by some of the students. Some of the intentions displayed by the WSU HIV/AIDS key role players were seen in the fact that they were trying to demonstrate their ability to run, and engage in, an effective HIV/AIDS Committee, whilst some of the students, as per the Student Representative Council (SRC) practice, were keen to display power through mass action and political involvement with the management of the institution.

Geertz (1973:412) illustrated in his work (e.g. the analysis on Balinese cockfighting), that cultural practices provide a context for reflection on social life itself. We have to ask

ourselves the question whether Geertz's construction of Ryle's (1949) 'thick description' was adequate and in line with what is required of the interpretative paradigm. Ponterotto (2006:540) is of the opinion that Denzin should be credited for popularising the term, and that this extended its use further than anthropological ethnography, into 'a wider audience of qualitative researchers (e.g., in sociology, psychology, education) and qualitative approaches (e.g., phenomenology, grounded theory)' (Ponterotto, 2006:540). Ponteretto further suggests that Denzin was the first to add the term 'thick interpretation' to 'thick description' – a seemingly necessary corollary. For Denzin, thick description must use multiple methods and include an examination of the lived experience, interactions, individualism and collectivities and meanings associated with vicarious experience, and not gloss over what is being described (Denzin, 2002:117).

4.5.3 Contextualising: interpretation and locating the epiphany

Denzin makes it clear that interpretation is a 'temporal' process:

> …first, it takes time for the researcher to learn the language…, second, the researcher must learn the biographies…, third, he must learn the relationships in a group. Fourth, the researcher must be able to call up in himself or herself the range of meanings that any word or phrase has for a group member… (Denzin, 2002:123).

Throughout the study, the significance of Denzin's temporal process in the research is attempted. By using thick description and immersing myself in the context I started to understand concepts in the isiXhosa language (e.g. 'muti', 'sangoma' and 'nyanga'), as well as other slang and idioms. Some of these terms include the use of words such as 'flesh on flesh' (depicting unprotected sex), 'sweet' or 'wrapper' (condom, depicting a wrapper around a sweet) and 'House In Vincent[22]' (HIV). The biography of each of the research participants, provided later in the study, is constructed in a form of thick description following the interviews. I also developed an understanding of a range of South African, Eastern Cape, WSU 'speak' (linguistic context), having entered the field as a South African living in the Eastern Cape. The theories that emerge in the following chapters are an interpretation of the formulation of social theories utilising Denzin's method. Of particular importance for Denzin was 'locating the epiphany' (Denzin, 2002:37).

[22] 'Vincent' is a suburb in East London, South Africa.

The term ties in with his explanation given in the beginning of the book (Denzin, 2002:ix) that interpretative interactionism is ideal for applying to 'problematic social situations':

> The epiphany occurs in those problematic interactional situations where the individual confronts and experiences a crisis. Often a personal trouble erupts into a public issue, as when a battered woman flees her home and calls the police, or an alcoholic enters a treatment centre for alcoholism (Denzin, 2002:37).

4.6 Credibility, transferability, dependability and confirmability

Many terms relating to the integrity of data have been defined, e.g.: measurement validity, internal validity, causality, external validity, reliability and replicability, interpretivist criteriology and constructivist criteria (Seale, 1999:32-49). Since this study utilises interpretative interactionism as a method, interpretivist criteria are utilised to discuss the integrity of the data.

Guba (1981:75) replaces the terms internal validity, external validity, reliability and objectivity (taken from 'conventional inquiry') with credibility, transferability, dependability and confirmability ('naturalistic inquiry'). Credibility, in Guba's scheme, is obtained by aligning the study to ethical procedures as outlined in Section 4.7 of this chapter. Furthermore, four research participants were chosen at random and handed their interview transcriptions as well as the analysis of the data for comment. None of the interviewees were critical of the transcriptions or the interpretation. Seale (1999:45) states that transferability relates to qualitative methods as external validity relates to quantitative methods.

He states that transferability is achieved 'by providing a detailed, rich description of the setting studied, so that readers are given sufficient information to be able to judge the applicability of findings to other settings which they know'. It should, furthermore, be noted that Denzin's requirement of 'thick descriptions' adds to the transferability of the study. Dependability is Gubas' (1981:75) alternative to external reliability in qualitative research. The process involves a procedure referred to by Seale as auditing: 'Peer auditors would be brought in at various stages to examine the transcripts… category cards (index cards) with referent index, list of units of information…' (Guba, 1981:79). Seale (1999:144) views this as 'a methodological consultancy'. All information presented in this study was made available to supervisors for purposes of checking (auditing) the information presented, not only from a methodological perspective, but also from a

theoretical and academic development perspective. The term confirmability, also linked to the process of auditing by Guba (1981:81), is described as 'an exercise in reflexivity, which involves a methodologically self-critical account on how the research was done'.

4.7 Ethical issues

HIV/AIDS is a sensitive issue that requires that all data be treated with utmost sensitivity. It was therefore important that the study received appropriate ethical scrutiny before I entered the field. This was done by first obtaining permission through the Glasgow University (GU) Ethics Committee. The application to the GU Ethics Committee was also strengthened by an application to the WSU HIV/AIDS Committee, who also approved the study. Permission was given to do two sets of twenty interviews. Before interviewing, all participants in this study were given a letter stating the purpose and intent of the research, as outlined in Appendix A. Furthermore, they all signed a consent form allowing me to use the data as provided, attached as Appendix B. The Glasgow University Ethics Committee, as per Appendix C, approved these forms and processes associated with ensuring confidentiality. Appendix D provides a copy of the topic guide used during the process of interviewing. Further consideration was given to obtaining consent during the analysis process through being co-opted as a member of the WSU's HIV/AIDS Committee. The Committee further required that I gave it constant feedback on the development of the research, on my attempts at finding HIV/AIDS funding for WSU, and required assurances that I did not join the Committee for the purposes of obtaining personal funding from it. It should be noted that research participants' names were not used in the analysis itself.

4.8 Conclusion

This chapter demonstrates how I utilised a qualitative research design following the interpretivist interactionist method of Denzin. The very basis of the design required me to reflect on personal issues such as the outsider perspective in terms of orientation to the research. Recognition was given to the fact that no qualitative research could be value free and reflection was required in terms of how I attempted to develop a sense of 'verstehen'. Due to an outsider perspective, I was able to discuss the various emergent themes that are explained in the later data chapters through dialogue and the use of in-depth interviewing. The ethical considerations of pre-approval through recognised approval systems were addressed in all phases of the research process.

Data integrity was addressed utilising interpretative criteriology in terms of the research design and the issue of credibility showed a causal link with the way in which ethical issues were addressed. Other data integrity issues included are transferability, dependability and conformability. Transferability was explained in relation to the theoretical constructs introduced in the earlier chapters. Dependability was achieved through the use of Guba's auditing process (1981:75), and confirmability was achieved through the incorporation of reflective methods that allowed for a critical assessment of how I constructed the analysis. The interviewing process and methods of analysis were explained in relation to the methodologies applied. It was important to recognise the fact that the analysis, as detailed in the following chapters, is a systematic process that depended on my ability to relate to my research informants. The next chapter will follow the method explained above. The chapter will focus on perceived causes of HIV/AIDS as well as nutrition and general well-being.

5: Perceived causes of HIV/AIDS, nutrition and perceptions regarding health

5.1 Introduction

This chapter specifically addresses (1) the perceived causes of HIV/AIDS and (2) perceptions regarding nutrition and health, as expressed by the research respondents. These themes are discussed first since they provide an overview of the problem, as opposed to the second data chapter, on gender and the ABC approach, which addresses a social structural factor, agency; followed by the third data chapter that discusses perceptions regarding a prevention approach.

The first question in this chapter, in relation to perceived causes of HIV/AIDS, asks whether research informants believe that the cause of HIV/AIDS is viral. Here I compare Herselman's (2007:64) conceptualisation of 'Xhosa perceptions of health' against beliefs expressed by research informants. The second theme examines research informants' perceptions surrounding the actions taken by the South African Government to ameliorate the situation. The third theme deals with conceptualisations of masculine identity, and explores positions expressed by research informants regarding condom usage (or lack thereof), as well as perceptions regarding gender and condom usage, and is contrasted against theoretical conceptualisations of gender as first discussed in Chapters 2 and 3.

The themes related to nutrition and perceptions regarding health, include a discussion on the contrast between attitudes towards traditional healers and bio-medical approaches to nutrition expressed by research informants, as theoretically discussed in Chapters 2 and 3. This is followed by a discussion of views expressed by research informants regarding the severity of HIV/AIDS in relation to malnutrition in the research area. Then follows an examination of views expressed about the WSU's HIV/AIDS Committee's approach of feeding schemes and their attempts towards the creation of a health-enabling environment.

This chapter, as a forerunner to more extended discussions of agency in the next chapter, utilises Giddens' definitions pertaining to agency (1979:56) in the analysis. This is done by an examination of the perceived causes of HIV/AIDS, which lays the foundation for a further analysis of the social structure later within the thesis. This is followed by examining perceptions regarding nutrition and health. In other words, I am asking research informants about the day-to-day beliefs surrounding health, which could be an indicator of

lack of agency, as explored in publications such as Benatar (2004:81), who reinforces the notion that social determinants of health affect HIV/AIDS prevalence. Based on the findings related to perceived causes of HIV/AIDS and nutritional health beliefs, the chapter will further argue, as suggested by Campbell et al (2007:347) that a health-enabling environment is required before embarking upon any HIV/AIDS-preventative measures. Based on the notion of respect for beliefs displayed, I contend that traditional healers should be incorporated as part of the health-enabling process, taking some of Wreford's (2009:173) suggestions on merging bio-medical and traditional healing practices into account.

5.2 Perceived causes of HIV/AIDS

In this section I intend to explore some of the central understandings of my research informants regarding the causes of HIV/AIDS. The section on beliefs related to causation also includes a discussion of the notion of 'respect' (hlondipha), since it is argued that the notion of respect (c.f. Wood, 2009:412) is an indicator of cultural beliefs, albeit contested. It is viewed as 'perceived causes' since some cultural practises may have an effect on beliefs responsible for the proliferation of HIV/AIDS.

The key finding from the first section was that, albeit a highly debated area, that research informants expressed contested views related to both traditional beliefs and bio-medicine and talked about the need for sensitivity towards cultural beliefs. The common understanding was however that the underlying cause of AIDS was viral.

The key finding from the second section, perceptions surrounding the South African Governments position on HIV/AIDS were that there was a distinct criticism of some of the views expressed by the South African Government during the time of research. Furthermore, research informants did not view these comments from the Government to be in line with local perceptions and beliefs.

The key finding from the third section, masculine identities, revealed evidence of an already existing critical attitude to gender roles and beliefs. Respondents were clearly highly critical of existing gender relations and the resultant effect on the HIV/AIDS prevalence rate. Respondents report on gender relations in a manner that seeks to detach themselves from them, or suggest that they are themselves in disagreement with manifested beliefs.

5.2.1 HIV/AIDS: bio-medical, supernatural, stigma and agency

Herselman (2007:64) described dominant conceptions of health amongst the Xhosa in relation to the term 'impilo' as follows:

> The Xhosa term impilo refers to physical health, but it also means 'fullness of life' with a religious connotation that implies harmonious relationships with the ancestor spirits. Destruction of impilo is caused by sickness, but also by some other misfortune such as losing a job, money or livestock. This understanding of misfortune explains why people consult an indigenous healer for medicine to strengthen and protect them against misfortune in general (Herselman, 2007: 63).

Herselman is reminding us in this quotation that health is not necessarily viewed from a bio-medical perspective, and that data from research informants should be viewed in the same light. This section examines research informants' comments and views on the perceived causes of HIV/AIDS. As for 'physical health', when asking about HIV as a cause for ill-health, it was described as 'viral' (38/40 responses). If we were to examine the separate cohorts, it was two key role players that did not subscribe to 'viral explanations'. In general it was clear that students and key role players in general accepted a bio-medical explanation of the disease, which has correlations with 'Cartesian principles'[23] in relation to causation:

Example 1 (IAT student[24]):

When you say HIV/AIDS for me it is like a virus that is circulating in South Africa. I think it is more in the young people, but I won't say it is not in the adults, but I think it the virus that is more in the young people. I think the young people get it by having unprotected sex, I think that is the virus that is being caused by that, or any other contact with blood with other people that has the virus.

Example 2 (Key role players[25]):

…and with preventative strategies you would have to embark on explaining it, especially to Xhosa people who do not have knowledge of bio-medicine and health promotion. Just simple prevention concepts: micro organisms, how they spread for example the virus, the HIV virus that is transmitted sexually and through blood, how ARV's work…

[23] c.f. Bio-medicine in the Glossary of Terms and Abbreviations

[24] East London, College Street, Student: IAT, Xhosa, 26,Male

[25] East London, Potsdam, Psychologist – Student Councillor, Xhosa, 41, Female

From the interviews conducted the impression was not gained that any misconception existed about the causality of HIV as understood from a bio-medical perspective. The student respondent clearly spoke about 'unprotected sex causing the virus', which was a frequently occurring phrase. It should be remembered that these are well-educated, mostly post-graduate students, who, given their age, had probably been exposed to HIV/AIDS awareness campaigns for most of their lives. In the same manner all of the key role players in HIV/AIDS at the institution had some form of bio-medical training as a requirement to their respective positions. One should, however, be careful of assuming that this interpretation cannot coexist with other understandings of health, as Wreford (2005:64) highlights an experience wherein a traditional healer explained how traditional medicines strengthened immune systems 'against the virus'. The conclusion that can be drawn here is that the reference to 'viral transmission' does not allow for the conclusion that research informants did/do not also subscribe to traditional beliefs surrounding health, since the term 'virus' also found itself into traditional health discourse, albeit carrying a completely different meaning. Wreford explains:

> …the stage between a positive HIV diagnosis and possible ARV treatment may be several years long. In this period, or treatment gap, traditional remedies can offer the support of immune - boosting herbs to render the virus less potent, and allow the patient to enjoy better health. On its side, biomedicine offers ARVs, which intervene to slow down or prevent the progression of the virus. The result is the same: a strengthening of the immune system, a body in better health, but no cure. Perhaps then, it is time for both traditional and biomedical systems to accept defeat (albeit a temporary one) in the face of HIV/AIDS (Wreford, 2005:62).

It can clearly be seen from the data in this study that research informants also subscribed to the coexistence of traditional and bio-medical understandings. One of the research informants, a medically qualified health promoter, contrasted his position with traditional medicine:

Example 1 (Key role players)[26]

I am a Health Promoter and at the same time I'm a Health Provider because we also prescribe medicines [medical] and we at the are educating students about health so it's health promotion. That's why I am saying they are both together, culturally even with

[26] East London, Potsdam, HIV/AIDS co-ordinator / male nurse, Xhosa, 41, Male

HIV/AIDS also they say that they can cure it with traditional medicine. They give you something that promotes diarrhoea and vomiting…

The use of the term ARV, and support for its use, was also given by both the IAT students and the key role players as follows:

Example 1 (IAT students[27]):

Through my general knowledge and hearing people talking and saying things I would say I'd go for the ARV because that is what is being circulated through the entire country … the beetroot and the garlic thing just came because some people just don't agree with Manto's approach to things, so I wont say that I'll go for the beetroot and garlic thing because I haven't heard anything that those things have actually gone for tests or something … but since there are some people who are taking ARV's I have seen the conditions of their lives after taking ARV's improve…

Example 2 (Key role players[28]):

Primary prevention behaviour you know, focussed more on the young people, especially the sexuality issues which are a difficult issue with them. We have to educate them more about it, to prevent it. ARV's will come later if the person is already infected with HIV and the CD4 count has dropped down usually below 200. You know it's many years now after the person has been infected...

In reference to the 'beetroot and garlic thing' (example 1) the student is questioning the alternative to ARVs, as posed by the (then) Minister of Health. The position put forward by the Minister was described in the following way: '…she stated in February 2004 that it was her intention to wean our people from antiretrovirals and presented a diet of lemon, garlic, onion and olive oil as an alternative means of treatment' (Myburg, 2005). The student is against it, and in response to the proposal of a choice between ARVs and the 'garlic and beetroot alternative', said that 'I would go for the ARV'. The majority of the informants (37/40) stated that they would use ARVs. As per the previous section, if we were to separate the cohorts, it was three key role players that indicated that they would not use ARV's, whilst all students said yes to its use.

[27] East London, Chiselhurst, Student: 3rd year, ND: Mech Eng, Xhosa, 22, Male

In the same manner, whilst discussing the process of treating students that have been diagnosed as HIV positive, one of the key role players quickly highlighted when it would be relevant to introduce a HIV positive student to ARVs. The general guidelines as laid down by the South African Department of Health for ARV treatment during the time of study was a CD4 count of below 200 (Wreford, 2005:66), and was comparable to then WHO standards[29]. Of importance here is the fact that the research informant presented it as a logical and foregone conclusion that a person would receive ARVs under these conditions if under the care of WSU HIV/AIDS key role players. This would allow for the conclusion to be made that, at the very least, that the WSU does recommend bio-medical treatment and presumably, that students were getting the message, given their responses. Generally students and key role players distanced themselves from suggestions that witchcraft is associated with HIV infection, but frequently research informants referred to it. This to say: they referred to it more in relation to the spiritual side of 'impilo', but always, notably, informants would preface such discussion with a phrase such as 'they say', so that in this, or a similar way they (the informants) always distanced themselves from these beliefs:

Example 1 (IAT students[30]):

Not actually the Sangomas, but the witchcraft they can do it. One of my other family members is a nurse in a hospital and she believes that they can actually put AIDS into you. She can describe it to you as saying the one you can get from sexual intercourse and the other you die immediately. She firmly believes that because the witchcraft is very strong especially with the Xhosas because they can take you away but leave the body that represents you.

Example 2 (Key role players[31]):

People go to nyanga's instead of medical doctors, and 8/10 people who are HIV positive they normally have meningitis as well. When they have that they think that someone bewitched them. So they go to the sangomas and of course the sangoma's does not want to tell them that they have HIV. So they tell them that their neighbour is bewitching them.

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[28] East London, College Street, Health Promoter, Xhosa, 41, Female

[29] WHO guidelines for ARV treatment in 2006 were at a CD4 count of below 200 (Wreford, 2005:66). This has however increased to 350 in 2010 (WHO, 2009).

[30] East London, Chiselhurst, Student: 3rd year, ND: Mech Eng, Xhosa, 22, Male

[31] East London, Chiselhurst, Lecturer: Dept. Communication and Languages, Xhosa, 37, Female

Then they pay R200 and then the sangomas give the strong medicine that is supposed to cleanse. They then drink that medicine and they are supposed to puke out whatever the witch has put inside them. The medicine is so strong that it causes your body to become very depleted of "juices", making you very weak. Then the weaker they become the more the sangoma's say the more the muti is working. In three or four week's time they will die.

The student in example 1 was explaining beliefs held by one of her 'other family members', a nurse, who is reported as believing that witchcraft is seen to be a cause of HIV/AIDS. Whilst the majority of informants referred to incidents of belief regarding witchcraft, none of them gave the impression that they actually believed in this themselves. It was always an aunt, a brother or a sister who was said to hold such beliefs. It is always someone else who experienced it (c.f. above: …she firmly believes…). Interestingly, Wreford (2005:73) refers to a similar incident also involving a HIV positive nurse, wherein it was stated that the nurse, from Cape Town, travelled to the Eastern Cape to consult with a THP about her HIV positive diagnosis. Wreford questioned why a bio-medically trained person would resort to witchcraft, and in the process described both Stein (2003) and Ashforth's (2005) experiences wherein research informants related witchcraft to stigma. The notion was that 'stigma acts as a deterrent to accepting a positive result' (Wreford, 2005:73) which explains why the agent might have travelled away from the area and stated that the problem is witchcraft-related. Doing this enables the 'victim' not only to avoid admitting to being HIV positive, but also gives them some agency in this situation:

> Whilst I accept Ashforth's finding as far as it goes, my research thus far with *amagqirha* and CHWs in the Western Cape Province suggest that there is more at work in this conflation of witchcraft and HIV*/*AIDS than mere denial. What is at stake here is the question of personal agency in the face of a death-bringing illness. In other words, the capacity of a person made ill to take action to become better. Let us reconsider the nurse's story with this in mind. Despite her biomedical education and training one can assume that she understood the implications of the positive HIV result. No matter that ARVs might later be available to her, the disease would still present itself more in terms of a death-sentence than of a controllable condition. Most importantly, she would have understood that there is as yet, no cure for HIV/AIDS. She would thus be rendered powerless to change the situation. An explanation of witchcraft, on the other hand, would have agency, for it would offer the possibility of an intervention aimed at healing (Wreford, 2005:74).

I agree with the notion that resorting to witchcraft is a manner of avoiding stigma, and am of the opinion that this a plausible explanation for the manner in which research informants referred to it. These are obviously things that they have experienced in society, and backed

up by the fact that Wreford's study had also revealed that students preferred not to be tested for HIV out of fear of being diagnosed as HIV positive, this explanation is accepted and also seen as relevant to this study. As for agency, it also provides yet another method for attempting to ameliorate the effects of the disease, which also seems plausible.

Added to the issues of stigma and agency described above, another question that emerged was why students would resort to references to witchcraft when discussing 'respect for the culture'. My understanding was that it would be 'disrespectful' not to refer to 'cultural' explanations of the disease as well, as also seen in Wood's (2009:412) description of the term 'respect' (hlondipha). It appears important for students to be respectful to the beliefs of 'others' (ancestors, the elderly, and the distinctly rural), and to refer to these beliefs in a respectful manner, to the extent that the uninformed might actually misconstrue their true core beliefs as being the same as those of the 'others'. Respondents themselves drew a deliberate distinction here, between what they believed and what they recognised as culturally significant, even if they were implicitly critical of the latter. Many of the research informants referred to the issue of respect, which was in agreement with Wood's (2009:412) findings. For instance, a nurse maintained that he did not believe that witchcraft could cause HIV/AIDS, although he continually had to make me aware of the fact that she had to respect the 'culture' when referring to it. He asserted that I was being disrespectful by posing a question on witchcraft beliefs:

Example 1 (Key role players[32]):

I:	*…but some people say that HIV can be caused by witchcraft?*
Nurse:	*Ha! Ha! No, it's not. It's cultural. You know we have to respect our culture. That I'm not against. But you know it is a very sensitive issue.*
I:	*I struggle to understand it. But do you not think it has anything to do with HIV/AIDS?*
Nurse:	*I don't want to be against it but medically speaking I really don't believe in it, but I respect the culture as I've said.*

He understood my ignorance at the time with regards to the 'correctness' of the manner in which I had posed the question. Only upon deeper reflection I understood (with the aid of researching articles such as that by Wood (2009), as above) why and how the notion of respect was conceived. I realised that, although the notion of the cause of HIV/AIDS is

[32] East London, Potsdam, HIV/AIDS coordinator/nurse, Xhosa, 41, Male

socially contested, one must always be respectful towards the cultural 'practice' in a social setting. While individuals may position themselves in all kinds of ways relative to the idea of local culture, they probably recognise that this culture is also vulnerable, under attack in a sense, from more powerful social forces. In that context they have to manage the difficult and even contradictory business of defending it in one sense, even as they may critique it in another. A number of the students also brought in this notion of respect when discussing issues such as witchcraft, although they were more vociferous in their opposition to it than the WSU key role players. However, they were also more vociferous in defending what they described as 'cultural practices' when talking about issues such as witchcraft:

Example 2 (IAT students[33]):

> *In the early days when cultural practices were created there wasn't restrictions like HIV/AIDS. This is no reason to stop them. Nothing was done culturally to promote sex whatsoever. You see. To call it cultural must be stopped. No one can say cultural practices can cause the spread of AIDS…*

By these 'cultural practices' the specific student in question was referring to a witchcraft issue which was included as part of the question posed. I was not suggesting that witchcraft was a cause of AIDS. I was merely asking about the belief and whether the belief shaped perceptions surrounding HIV/AIDS. Now that I understand the issue of respect from a cultural point of view and its importance, I now know that to question whether a specific 'cultural practice' is conducive to the spread of the disease would be disrespectful. It's a question of being sensitive to how even interpersonal discussions and conversations are shaped by an awareness of wider social and political contexts that tend to positions specific speakers as speaking on behalf of specific communities.

The impression was gained that research informants rejected cultural explanations of the causes of HIV/AIDS, and that they opted for a biomedical explanation. This correlates with the Eastern Cape Youth Commissions' findings that 'it is clear that in general the youth has a good understanding with regards to HIV and AIDS related matters' (Eastern Cape Youth Commission, 2010:XXI). However, the impression was created that the notion of respect is of extreme importance. It seemed acceptable to discuss views with an outsider in an interview setting opposing ideas suggesting witchcraft and HIV/AIDS. However, it

[33] East London, College Street, Student: IAT, Xhosa, 24, Male

would have been socially unacceptable to do so in a public setting, especially where elderly people were present.

The notion of the term respect (interpreted in terms of as a similar experience to that of Wood,2009:1) also signified to me that research informants did not totally abandon notions surrounding 'impilo', but rather that, under certain social situations, preferred bio-medicine for curing ailments, whilst always showing respect for traditional methods, which may augment the healing process, as also suggested by Wreford (2009:1). The male nurse referred to this dualistic approach and the need to 'educate', with sensitivity towards cultural issues:

Example 1 (Key role players[34]):

There is a danger when approaching cultural issues, that is why we use modules. For example you can try to apply a good prevention programme but the people will not accept it because the cultural aspects of the people were not considered. I am thinking of a module which is called Helping Module which has been used overseas when TB started during the Second World War and they used this module, which tells of the seriousness of the disease and all things like vulnerability and people although there were x-rays and medicine but they didn't go. There was also immunization available but they didn't go until they used this module and understood the perceptions and educated the people.

5.2.2 Perceptions of the South African Government's position on HIV/AIDS

The question of the South African Government's position on HIV/AIDS at the time of the research (with President Mbeki as president) and how this was understood by respondents is of importance. The Government is seen as the legislator, the policy maker and the custodian of goodwill in society. The South African Constitution states, 'everyone shall enjoy all universally accepted fundamental rights, freedoms and civil liberties, which shall be provided for and protected by entrenched and justiciable provisions in the Constitution' (South African Government, 1993: Sch 4 Subs2). It is therefore logical to assume that a particular, public stance from the government on the issue would be likely to affect preventative efforts regarding HIV/AIDS. Interviewees challenged President Thabo Mbeki's stance regarding HIV/AIDS during the course of the study, the government's

[34] East London, Potsdam, HIV/AIDS coordinator/nurse, Xhosa, 41, Male

public position did not affect the views of respondents; they rejected them. Respondents views regarding the disease were not affected by outcries in the media around the (then) Minister of Health, Dr Tsabalala Misimang, who at the time advocated garlic, lemon and olive oil as a cure for HIV/AIDS, and the position advocated by President Thabo Mbeki at the time, who was criticised as follows:

> The slow provision of antiretroviral drugs in South Africa has been influenced by the attitudes that certain politicians have taken to AIDS. In particular, President Mbeki has consistently refused to acknowledge that HIV is the cause of AIDS; he argues that HIV is just one factor amongst many that might contribute to deaths resulting from immunodeficiency, alongside others such as poverty and poor nutrition: 'Does HIV Cause AIDS? Can a virus cause a syndrome? How? It can't, because a syndrome is a group of diseases resulting from acquired immune deficiency. Indeed, HIV contributes, but other things contribute as well.' (AVERT, 2008).

Whilst the students gave full support to President Thabo Mbeki's leadership and respected his political ability, they did not endorse his views on HIV/AIDS. They all believed in the use of ARVs (as already seen in the previous section, although some expressed concern given their toxicity, thus showing some knowledge of current biomedical debates).

Furthermore, they all (both cohorts) believed in the importance of good nutrition for staying healthy (40/40). Both cohorts (40/40) did not believe that nutrition could possibly be construed as a magical 'cure'. In this way they rejected garlic, lemon and olive oil as a cure for HIV/AIDS. They did not believe in any of the views that are often popularised in the media in South Africa (what Denzin would term 'myths'). Again, according to these respondents it was 'others' who believed these 'myths'. These myths included having a shower after sex to wash the AIDS away[35], and that the ritual slaughtering of animals[36] would result in a cure.

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[35] This was commonly mentioned by research informants in a humorous way, referring to Jacob Zuma's (Deputy President at the time) court case, where this was purported as an act to avoid contracting HIV/AIDS. I do not consider any of these myths to be related to local beliefs due to jest displayed by research informants when referring to it.

[36] These are some beliefs to have been found in other studies in South Africa, c.f. Earl-Taylor (2002:1). Also compare with Wood's (2009:414) description on causality of myth-making.

Example 1 (Key role players[37]):

Research Informant: I still say that if the President of our country continues to bury his head in the sand about HIV/AIDS, the situation will not improve. Do you know that the President of Uganda took it upon himself to improve the situation?

I: So it starts at the top?

Research Informant: He made it a national priority and he took it upon himself to make sure that HIV decreased in Uganda. He was part of it and we can see how the situation has improved. As our leader in South Africa, as far as he is concerned, HIV is not going anywhere, because he is saying it is caused by poverty, he is travelling frequently and each and every time he gets a chance to talk, he remains silent about HIV. He will talk about gender, and how we are ready to have a female president (which I don't oppose), but he makes other people angry because he will not talk about HIV/AIDS.

Example 2 (IAT students[38]):

I: President Mbeki was heard to say that between HIV and AIDS there is no correlation between the two. Do you believe in that?

Research Informant: No, I don't believe that. I really don't believe that.

One of the interviewees, as a key role player, and a HIV/AIDS counsellor at a campus of WSU, strongly criticised the views of President Thabo Mbeki. She contrasted the successful HIV/AIDS strategies in Uganda with those in South Africa. She referred directly to his attitude towards malnutrition and HIV/AIDS, and criticised his silence in addressing HIV/AIDS issues in South Africa.

She indicated that South Africa should be leading the continent in the fight against HIV, i.e. 'We have so many resources in South Africa…'. She had high expectations of the South African Government at the time. In her claim that President Thabo Mbeki was 'putting his head in the sand', she stated that the President of South Africa was not coming forward and taking a definite position on HIV/AIDS. She furthermore stated that he was silent in the media failing to communicate an acceptable message related to HIV/AIDS alleviation. She regarded the fact that he supported dissident views about HIV/AIDS as

[37] Mthatha, Nelson Mandela Drive, Health Promoter, Xhosa, 32, Female

[38] East London, College Street, Student: IAT, Xhosa, 24, Male

problematic. She found it disturbing that countries like Uganda, which are not economically strong, have successfully reduced their HIV/AIDS infection rate, whilst South Africa's infection rate remains one of the highest in the world. She commended the Ugandan president for his efforts and distinctly expressed the view that 'he took it upon himself'. She expressed the need for personalised efforts from President Thabo Mbeki and accused him of spending too much time attending to foreign affairs outside the borders of South Africa. This created the perception that he did not take the same level of personal care associated with his predecessor, former President Nelson Mandela.

A student of the IAT, directly opposed President Mbeki's views about causation between HIV and AIDS, as explained in the Duesberg hypothesis (Duesberg and Rasnick, 1998:85). He stated that he did not support this position, thereby demonstrating that, as noted in the previous section, opposition was not inappropriate. But given the notion of respect, also displayed by this student, would he openly proclaim this in public? I did not ask this in the interview, but these types of questions seems to be underlying and important in understanding how various positions regarding HIV/AIDS are conceived and how people express their beliefs in social settings.

Overall, this analysis revealed to me, as the researcher utilising a qualitative methodology concerned with exploring understandings, that research informants were of the opinion that there was a distinct criticism of some of the views expressed by the South African Government during the time of research. There had, however, been a turnaround on the issue since the introduction of the successor to President Thabo Mbeki, President Kgalema Motlanthe, and now President Jacob Zuma, with a new minister of health, Dr Aaron Motsoaledi (Karim et al., 2009:921).

5.2.3 Masculine identities and perceptions regarding the use of condoms

This section examines perceptions expressed by research informants regarding the use of condoms and gender stereotypical perceptions that exist that, in their view, affect condom usage, and therefore have an effect on HIV transmission. Condom use is of long standing with some scholars estimating it to having been common practice since the 15th century (Feldblum and Rosenberg, 1987:89). PROMETRA[39] (2011) argued controversially that

[39] PROMETRA is an 'International Organization with its general objective the promotion and preservation of Traditional Medicine and the creation of links among cultures throughout the world' (Gbodossou, 2013).

condoms were not specifically designed for use against contracting HIV, and thus should be seen as an antiquated method used against a modern virus. The debate on the use of condoms to prevent HIV/AIDS is contentious, as also seen in the PEPFAR[40] position that forbids the promotion of condoms to prevent HIV/AIDS, based on the notion that it amounts to the promotion of sexual promiscuity (Ghanotakis et al, 2009:357). Research informants were of the opinion that condom usage was a problem with regards to HIV/AIDS prevention. Many views expressed a contrast between a male's expectation (i.e. their expectation not to be told to use a condom by a woman), and the woman's right to sexual agency. However, all research informants referred to lack of condom usage as a perceived cause of HIV/AIDS, and this warrants discussion.

Example 1 (Key role players[41]):

Ha! ha! I had a friend that slept with a girl he had just met at a party and I asked him how could he sleep with her you've only just met her. I asked him if he used a condom and his reply was, why must I use a condom if I'm eating a sweet why must I eat it with the wrapper on. I think I won't support this 'flesh to flesh' thing. It's about not wearing a condom.

Example 2 (IAT Students[42]):

Research Informant : Yes and this other thing that if you use a condom it's a waste of babies.

I: A waste of babies?

Research Informant: (laughs) Yes, they say it's a waste of babies

I: So you want to have many babies.

Research Informant: Ja I want to.

Example 3 (Key role players[43]):

Research Informant: I am a Pondo and I am coming from the Pondo culture… I think that another thing that causes the spread of HIV is that they do not believe in the condom.

I: They don't believe in the condom?

[40] United States President's Emergency Plan for AIDS Relief

[41] East London, Chiselhurst, Senior Management, Xhosa, 50, Male

[42] East London, College Street, Student: IAT, Xhosa, 26, Male

[43] Butterworth, Ibika, HIV/AIDS co-coordinator, Xhosa, 46, Female

Research Informant: No ways.

I: Why is that?

Research Informant: They are just stubborn people. They have a saying that says 'even my father never uses this, it is something that comes from the western culture, so it is not ours'. We used to be 'flesh to flesh' so why do we have to change now that we are old like this. So it doesn't work for them. At the same time, most of the old guys in my culture they do not go for initiation. It is something new that has been done by the young guys now, they don't do it of which that is another thing which causes the infection to spread fast. They say that the foreskin carries most of the infections and they pass it through.

Many contradictions regarding condom use emerged in research informants' views, even if they were from the same background – understanding what these differences were and what was regarded as disrespectful was, therefore, of importance. Regional differences served as a partial explanation for some contradictions. The reasons offered by research informants for not wearing condoms were heterogeneous and multiple, and related to the following:

- Lack of sensation, with references to '*sweet within a wrapper*' hence preferring '*flesh on flesh*'
- Making the sex act insignificant, e.g. a waste of *'babies'*
- Gender-related comments such as '*I have to show that I am a man*'
- Issues of trust in relationships, such as '*if a woman tells me to use a condom then I would tell her she doesn't trust me and then I would get angry*'
- Purity of the sex act, with comments such as *'sex must be as nature intended'*
- The notion that condoms promote promiscuity, with comments such as *'if you are handing out condoms at the bars and shebeens and high schools then you are actually promoting that people should have sex'*
- Cultural norms, *'it is something that comes from the western culture, so it is not ours'.*

These reasons for not wearing condoms could be compared to those cited by Krumeich et al (2001:125), which were divided into 'male' and 'female' reasons:

- For men, the use of condoms may arise the partners' suspicion, …sperm is 'wasted', men's inclination to have multiple partners, their preference for penetration during sex and their reluctance to use condoms put themselves at risk…
- For women, missing out on men's gifts…condom use is at odds with cultural norms, such as submissiveness and obedience … which in turn promotes violence… (Krumeich *et al,* 2001:125).

I have found that the reasons provided for not wearing condoms by Krumeich et al were similar to this disclosed in this study, with slightly different use of terms, although they refer to the same beliefs. The major findings of Krumeich et al's paper, which could be brought in relation to this study was that:

> This illustrates how social position (women's economic dependence) and constructions of gender (the importance of motherhood, women's submissiveness and reservedness towards sexuality and the men's responsibility towards the primary partner and the continuity of the clan) influence people's health behaviour (not using condoms) (Krumeich et al, 2001:126).

Krumeich et al's findings attempted to show how they 'can change the basic cultural and social structure such as gender roles' to improve the situation pertaining to HIV prevention – although it should be noted that in this study an already existing critical attitude to such things were already present. In this study it was found that most of the research informants were quite explicitly critical of the failure to use condoms or see it as the problem of those who are ignorant or stubborn. The evidence in this data is not of a need to change gender roles or beliefs, but of an already existing critical attitude to such things. In Chapter 7 of this study a strategy is proposed for both IAT students and key role players in HIV/AIDS at the WSU using this finding. The next section will briefly address perceptions regarding condom usage and gender inequality, which is further explored in Chapter 6 of this study.

The next section discusses how elementary comments about gender were made to suggest that the inequality of genders plays a role in sexual decision-making related to condom usage. In the first example attitudes towards polygamy and condom usage is discussed,

whilst in the second male attitudes towards condom negotiation is discussed. The majority of the research informants alluded to a male dominated environment[44].

Example 1 (Key role players[45]):

> *At the same time I cannot stop him from going there* (sic – implying to visit another woman)*, either he would just go off and marry the second woman. So, people are saying rather than let him have the second wife, rather let him sleep around before that happens. At least I don't have to see those women if he only sleeps around. You are however putting yourself at a very high risk of contracting the disease. That is the problem.*

Example 2 (IAT Students[46]):

> *We talk about it if you are a man you should do it. If you are a man should do that and you should not let a lady tell you what to do and once a lady tells you to use a condom say no and that is what is really destroying us.*

The research informant in the first example is critical of the idea that women are required to be submissive and not oppose, even in circumstances of multiple relationships where monogamy is expected, and a man's need to have relations with other women. In this specific circumstance it can be seen how the research informant is suggesting that women tend to accept their fate (with unfaithful husbands) rather than oppose it. This tendency is also described as follows:

> Xhosa and Zulu constructions of masculinity and femininity mirror norms regarding sexuality. Men are supposed to be always ready to have sex, to know all about it and take the initiative. Their status depends on the number of partners that they conquer. However, the Xhosa and Zulu people distinguish between the 'close' woman (primary partner) and the 'distant' ones (secondary partners) (Krumeich et al, 2001:125).

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[44] The impression might be gained that this section might have been better placed in the chapter on gender. However, it would be incorrect not to have listed this item as a perceived cause related to the spread of HIV/AIDS, since the term 'gender' emerged during all interviews as a perceived cause of HIV/AIDS. It was therefore decided that the section placed within this chapter will only serve as a brief introduction to the topic, whilst the topic would be explored in more detail in the following chapter.

[45] Mthatha, Nelson Mandela Drive, Health Promoter, Xhosa, 33, Female

[46] East London, College Street, Student: IAT, Xhosa, 24, Male

In the second example it can be seen how men, in turn, are expected to reinforce their beliefs regarding masculinity, and not accept female domination under any circumstances. This type of male domination where women are expected to remain submissive, was described by Krumeich et al.(2001:126) 'bringing up the subject of [men's] infidelity would violate norms of submissiveness and reservedness'. It is further clear from the second example that the young man in question is of the opinion that it is this male gendered relationship and its implied imbalance of agency that 'is really destroying us'.
Given the fact that 17/20 key role players, as seen in these two examples, were critical of beliefs related to male superiority and the culture of multiple sexual partnerships, the matter is clearly, socially, an issue of discussion and debate. Social debate programmes, as discussed later in this thesis, would therefore have to focus on these issues for which no social consensus exists.

Some key role players (3/20) suggested that females must support their male partners under all circumstances. Nobuntu, a female HIV/AIDS project manager, explained that males speak on behalf of the family and that the females are supposed to keep quiet. Females may not interrupt males during conversation[47]. She explained as follows, in separate comments:

Example 1 (Key role players[48]):

Yes, because in the Xhosa culture it is the man who is the head of the house; so the only person who speaks last in the house is the man, not the woman.

Example 2 (Key role players):

Ja, she does; [have a right to demand that the man wears a condom] but they don't do that, because they are scared about getting hurt; because if one was to ask the man to wear a condom, the man would turn round and ask her if she thinks he has AIDS and he'll start beating her up.

It is, of course, believed in many cultures that men are the head of the household. She was, however, referring to dishonouring the husband as an act of provocation and that it also dishonours tradition. The person speaking last, by implication, is the person who has control over the household and who makes the important decisions. Male research

[47] This has correlations with the findings of Suzman (2001:267)

[48] Butterworth, Ibika, HIV/AIDS Project Manager (USAID), Xhosa, 42, Female

informants argued that a woman was to be treated with suspicion and distrust if she raised the issue of condom usage, which is a stereotypical male portrayal of the situation[49]. According to the informants, females did not have the right to suggest (or imply) that the use of a condom was appropriate. The notion of 'trust' in both these cases seemed to apply, albeit based on the fact that the term 'trust' has a totally different connotation – it is not a reciprocal position of trust, it is a one-sided position. Based on comments made by research informants I can draw the conclusion that in certain cases it was unacceptable for women to demand that males wear condoms. In extreme cases, the demand may lead to physical violence. Ultimately, research informants expressed the idea that females' rights of condom use negotiation were limited, as in some instances, would be expected from people engaged in trusting relationships, such as marriage. The notions on womens' sexual agency gave rise to the next chapter, on gender, since female agency has been identified as a problem in relation to the prevention of HIV/AIDS (Wood, 2009:412; Wight, 1994:97; Holland et al, 1990:336).

The key finding from this section would be that respondents are clearly highly critical of existing gender relations and its resultant effect on the HIV/AIDS prevalence rate. Respondents report on gender relations in a manner that seeks detach themselves from them, or suggest that they are themselves in disagreement with manifested beliefs.

First, I wish to emphasise the question of respect manifested in interactions with research informants. They really did believe in the importance of respect towards existing cultural beliefs. The element seems to manifest in a double order of meaning: what you may say publically and what you may not say publically. These manifestations may, however, be totally different from one's own core beliefs, as seen in various interactions with research informants. It is also clear that it would not be inappropriate to say to an outsider, in a one-to-one interview setting, that one believes that the cause of HIV/AIDS is viral or even bio-medical. It would, however, be disrespectful to do so in a social setting, where, for instance, elders and traditional healers are present who may have alternative beliefs, some

[49] c.f. Wight (1994:97) who had similar findings of heterosexual young men in Glasgow, stating that 'the term safer sex was assimilated into (heterosexual young men's) construction of sexuality'. Also compare Holland et al (1990:336) who concluded that 'public health campaigns aimed at women cannot be effective unless they recognise that men and women begin their sexual encounters as unequal partners in the battle against sexual transmission of HIV.'

even believing that traditional healers have a cure for HIV/AIDS. This element of respect show deep-rooted respect for tradition, even amongst those opposing traditional practices.

Second, in examining the perceived causes of HIV/AIDS, two main issues emerged: the South African Government's position on HIV/AIDS and issues surrounding condoms and sexual agency. It was determined that within these categories research informants saw HIV as the causal factor for AIDS. In relation to the South African Governments' position on the HIV/AIDS crisis, all research informants described this as a major issue concerning the cause of HIV/AIDS, and they stated that they did not accept the Government's position at the time. The question has to be asked how this occurred. It can be stated that, in addition to the manifested 'us' and 'them' typology in the language, a form of social distancing also occurs, which allows research informants to remove themselves 'away' from the disease. This type of behaviour is also commonplace in studies that examined stigmatisation of HIV/AIDS in South Africa [(c.f. Kalichman and Simbayi (2004:572); Forsyth et al (2008:74); as well as Visser et al (2009:197)]. In this case however, over and above notions of stigma, research informants distanced themselves because, in certain social situations, they do not want their opposition to become public, purely as a form of respect. They do not generalise about cultural constructions about the disease, but individualise it. Research informants used the same type of language expression when talking about the South African Government's position on HIV/AIDS – they did not want to display their dissatisfaction with the government's position publically, since this may be construed as being disrespectful, but they certainly had their own views on the matter. This manner in which research informants find it respectful to not oppose social beliefs in social circumstances, manifest in the 'us' and 'them' typology.

5.3 Nutrition and perceptions regarding health

Molebatsi and Mulinge (2004:135) argue that if we are to understand HIV/AIDS in 'African societies' where there are high rates of infection, researchers need to move beyond a bio-medical approach to one that is informed by cultural knowledge and people's experiences. With this in mind, this section seeks to document what my research revealed about cultural understandings of HIV/AIDS as expressed by research informants. It starts by examining ideas regarding food, natural medicine and HIV, and then, more specifically, moves on to malnutrition. This discussion is further developed in Chapter 7, which addresses suggestions that local perceptions have a role to play in social debate

programmes that would stimulate cultural discussion surrounding the prevention of HIV/AIDS.

The key finding from this section is that recognition of local perceptions regarding traditional medicine and nutrition needs to be acknowledged, even though research informants' tended to be positively orientated towards bio-medicine. Role players such as THPs therefore have a crucial role to play in assisting the community in distinguishing between issues of bio-medicine and traditional healing, in an over-arching dualistic healing approach that creates awareness of HIV/AIDS at community level.

5.3.1 'If Sangomas can cure HIV/AIDS, why don't they cure us?'

This section attempts to show that research informants acknowledged that both bio-medical and traditional forms of healing are important, but that they supported bio-medical explanations of HIV/AIDS, and mostly supported bio-medical methods of preventing and treating HIV/AIDS. They thus agreed with a position such as stated by Mall (2005:119) 'that no traditional medicine has yet been shown, through scientific testing, to be an effective treatment for HIV/AIDS', and that the challenge remains to allow:

> …people to consult with Western doctors to prescribe bio-medical drugs and to consult traditional healers, such as Sangoma's, to address the spiritual aetiology of the disease. The challenge is thus to ensure that these parallel treatment strategies do not undermine the effectiveness of the ARV rollout treatment in South Africa (Mall, 2005:119).

In some instances we can see that research informants place a high value on traditional forms of healing (c.f. example 1 below), whereas others rejected traditional forms of healing outright:

Example 1 (Key role players[50]):

Even if you did chemistry you will find that they are not realising that you do something that is the same as what the medical people are doing. Most of the time we need to take natural medicine. So from that they mix them and from there they think something which maybe it is one which is the same as the ARVs.

[50] East London, College Street, IAT Employee, Xhosa, 26, Male

Example 2 (IAT Students[51]):

> *I think I can try to tell them because those herbalists can't cure them and as I said the HIV virus destroys the white blood cells and the herbalist will give them medicine you see and then you drink the medicine and then you die. So this is not going to work…*
> *Sangomas let us say that they make medicines for AIDS but there is no known cure and if someone did find a cure each and everyone would know about it. Especially with the blacks it would spread like crazy. If there is something that works for them then they really go for it. Like if there is something new like Mix-It* [a social networking platform] *if I could tell them I've got something better than Mix-It then everyone would stop Mix-It and go to what I've got.*

In example 1 the research informant is stating that there is some correlation between what herbalists 'prescribe' and what 'medical people are doing' - and might be implying that natural medicine may have the same chemical basis as modern pharmaceuticals. He is stating that, whilst bio-medical doctors prescribe pills for various ailments in most instances, traditional healers might refer patients to eat various leaves or roots of certain species of plants for the same ailment. There might be some correlation between medicines prescribed by traditional healers and those prescribed by medical doctors, i.e. many medical companies examine and analyse the healing properties of various plants which in the long run find their way into 'medical' prescriptions.

The question that emerges is whether it is possible from his choice of words to discern whether the research informant subscribes to beliefs related to traditional medicine. His words 'they mix them' might indicate that he does not entirely subscribe to these beliefs – it is a form of distancing, he could have stated 'we mix them', but chose not to. '*So from that they mix them and from there they think something which maybe it is one which is the same as the ARVs'*. One gets the impression that the research informant is describing a belief here, but that he is distancing himself from it '*they think…ARV'*.

In relation to example 2 the research informants showed some sort of understanding of bio-medicine in relation to the use of the terms associated with HIV/AIDS. Whilst the distinction of the different types of white blood cells are not provided, the suggestion that 'HIV destroys the white blood cells' shows understanding. The research informant clearly refutes the claim by sangomas that they can cure HIV/AIDS, and later states that a cure

[51] East London, College Street, Student: IAT, Xhosa, 27, Male

would spread like wildfire if proven to be effective. There is also notably his/her appeal to 'proof', which is associated with a rationalised process of western scientific procedure.

Not only did most research informants reject the idea of local medicine but some also pointed out some of the dangers associated with its use, as in example 2 where it is stated that the patient will die after drinking medicines prescribed by sangomas. Research informants alluded to the fact that an individual may become weaker after drinking a prescribed 'muti' administered by a sangoma, and that it is the belief that becoming weaker is a sign of the 'muti' actually working. Research informants explained that, should death actually follow 'the weakness', it is commonly believed that the individual in question angered the ancestors and in some way did not follow the prescribed associated rituals (such as the slaughtering of a goat).

Thus whilst it seemed important for all of the research informants to show that they had knowledge of local beliefs about HIV/AIDS (i.e. ancestors, goats being slaughtered, etc.) all of them seemed to question the efficacy of local medicine in some way, or to distance themselves from these accounts. If we separate the cohorts, 18/20 of the research informants from the IAT students group undeniably questioned local medicine, whilst 16/20 of the key role players also questioned local medicine. In some cases (9/20 IAT students and 7/20 key role players) it seemed important for them to provide arguments against the use of traditional medicine. The manner in which they spoke about bio-medicine and its theories showed that they were not ignorant about some of these debates and, furthermore, they often claimed to accept bio-medical explanations as opposed to traditional medicine beliefs and practices.

As suggested in Chapter 3, the opinion remains that sangomas can cause more medical damage than actually curing the patient, and that there are inherent dangers within this situation. Mall (2005:123) concluded that most medical doctors are aware of the fact that some of their patients consult with traditional healers, and 'will continue to do so', and therefore the only solution lies with recognising the dual care challenge. This would require medical doctors to collaborate with traditional healers and in order to ensure that THPs do not prescribe the consumption of any 'muti' that may affect the workings of the ARVs, and that THPs only provide support from a 'cultural, spiritual and psychological' point of view (Mall, 2005:123).

5.3.2 Severity of HIV/AIDS and malnutrition

The next section will explore data on perceptions regarding malnutrition: the focus of the discussion is on how research informants sought to understand the disease in a much wider socio-economic context. By investigating this link between HIV and malnutrition, this section will argue that HIV/AIDS prevention should not be seen as an isolated component in a free standing context. Instead, it should also be viewed in relation to other health related factors affecting general well-being. The purpose of this would be the creation of a health-enabling environment for both the WSU in general and IAT specifically.

Example 1 (Key role players[52]):

Most of the students that are studying here you find that their fees are paid by their grandmothers. Their mothers are not working or their mothers are not there; you will find that their mothers have already died from HIV/AIDS. So we are looking at orphans that are being looked after by their grandmothers. So you will find that even if the student is HIV positive that they still struggle to pay fees and get food on the table. So that is why we have decided to look at poverty in great levels as a component of HIV/AIDS.

Example 2 (IAT Students[53]):

Practitioners or nurses, whatever, they need to understand malnutrition and HIV/AIDS. You take ARVs and cultural lessons, and they must give you support to understand the conditions of using them. It is just that I would not be involved with people that don't know what they are doing… telling us that beetroot is a cure for HIV/AIDS! I think government must avail them some expertise in the choice between ARVs and nutrition.

In the first example an account is provided a HIV activist at the Ibika campus and who also served on the HIV/AIDS Committee. In this passage she describes the severity of HIV/AIDS and malnutrition at the institution. She was one of the forerunners when it came to dealing with HIV positive students on a daily basis at the Ibika campus. It can seen that she is advocating a position far more complex than the mere provision of ARVs to HIV positive students. If students are not in a position to adequately fend for themselves, pay

[52] Butterworth, Ibika, HIV/AIDS Project Manager (USAID), Xhosa, 42, Female

[53] East London, College Street, Student: IAT, Xhosa, 28, Male

their fees through NSFAS funding[54], or through their relative meagre funds, it can be stated that the creation of a health-enabling environment[55], seems to be more important on campus than merely addressing HIV/AIDS as a single health-related phenomenon in an isolated context. Her statement further reflected the effect of HIV/AIDS mortality combined with the effect of poverty. Ensuring that HIV/AIDS individuals are properly nurtured were motivated as follows:

> Issues related to ART in resource limited settings have become increasingly relevant to PLWHA[56], caregivers, service providers, and programmers. Interactions between ARVs and food and nutrition can significantly influence the success of ART by affecting drug efficacy, adherence to drug regimens, and the nutritional status of PLWHA. Managing the interactions between ART and food and nutrition is a critical factor in the extent to which the therapy is effective in slowing the progression of HIV/AIDS and improving the quality of life of PLWHA. In resource limited settings, many PLWHA lack access to sufficient quantities of nutritious foods, which poses additional challenges to the success of ART (Castleman et al, 2004:3).

She is suggesting that HIV/AIDS should not be viewed in isolation but that it is necessary to address the situation holistically – the creation of a health-enabling environment would allow for better nutrition and lead to the overall improvement of health. Only once this type of environment exists do HIV/AIDS prevention strategies (along with strategies addressing all of the other major problems, i.e. T.B) have a chance of being successful.

Another issue clearly addressed in her statement is HIV/AIDS related mortality. In this regard she stated, ‘So, you will find that even if the student is HIV positive that they still struggle to pay fees and get food on the table. So that is why we have decided to look at poverty in great levels as a component of HIV/AIDS’. This statement reflects the need for the WSU to look at the situation holistically. Even if the student is not HIV positive, sustenance remains an important issue. For those who are HIV positive, proper nutrition is important so as to increase the lifespan of the infected person. The statement explains why the WSU includes feeding schemes in their operational planning, as well as more specialised feeding schemes for those who are HIV positive.

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[54] NSFAS: National Student Financial Aid Scheme. A government supported study loan system specifically aimed at low-income families (c.f. glossary of terms and abbreviations).

[55] As discussed by Campbell et al (2007:347)

[56] People living with HIV/AIDS.

In the second example the student is questioning the ability of some HIV/AIDS workers to understand the correlation between HIV/AIDS and nutrition, and clearly disapproves of HIV/AIDS workers that support the garlic and beetroot argument. The student in question is asking for Government's intervention, and asking for 'expertise in the choice between ARVs and nutrition'. Castleman et al (2004:3) explain various combinations of different types of food and ARVs and their interactions. This might be the type of expertise that the student was referring to. The call is therefore far more than merely addressing malnutrition, but also addressing issues surrounding the creation of health-enabling environments.

5.3.3 Conclusion: Nutrition and perceptions regarding health

This section examines various manifestations of agency in relation to health and HIV/AIDS inferred from the previously discussed sections. It looks at access to bio-medical services as a problem and it examines how social distancing occurs from local health beliefs. It takes into account the manner in which the WSU takes the approach of creating a health-enabling environment in relation to health-related issues, as opposed to addressing HIV/AIDS in isolation. The first element present relates to access of bio-medical services. It is known from research surrounding malnutrition and poverty in the area that many individuals do not have a choice between local medical services and bio-medicine.

Apart from an unequal access to various types of health services in the area, another element emerges: the continued use of the term 'us' and 'them'. By the continued use of these terms we can see that there is a second-order of meaning that emerges here: subscription to local knowledge perceptions surrounding health under certain circumstances and social situations. Research informants, advocating for bio-medical explanations in interview settings, might not advocate the same message in different social situations. It has to be asked why, for instance, various research informants need to talk about 'them' believing that 'they are the ones who equate muti with ARV's', whilst the research informants clearly stated that they do not truly believe in these beliefs, although an element of sensitivity towards local beliefs seems to be present. It should be stated that these relatively educated respondents were capable of a considerable level of critical detachment regarding their 'own' culture. This is also indicative of a complex and fluid social structure wherein the requirement for messages related to HIV/AIDS prevention needs to be finely crafted with these differing levels of meaning clearly kept in mind. In

the understanding of these beliefs and the manifested levels of agency, the WSU's primary response to the HIV/AIDS epidemic showed that they do not view HIV/AIDS in isolation, but take the above elements of agency into consideration when discussing preventative measures. As a first building block, they embarked upon taking a health-enabling environment approach. This is seen in the attempt at establishing a feeding scheme and entrepreneurship with it. It was established that, due to social position, people cannot always determine their own outcomes and that there is recognition from the WSU that it has a role to play in this regard. It can even be stated, although delivery levels still need to be questioned, that the idea of the creation of a 'health-enabling environment' as described by Campbell et al. (2005:348), as a first step towards HIV/AIDS prevention, is present. This first step, in a multi-step approach as argued by this thesis, is a starting point for HIV/AIDS prevention schemes.

5.4 Conclusion

It was established early on in this study that contextual factors are important elements that need to be considered when examining platforms for HIV/AIDS – related prevention schemes, as supported by research by authors such as Adimora and Schoenbach, (2002:708); Pettifor et al. (2005:971); Desmond (2009), all of whom determined that wider social factors played a significant role in HIV prevalence. The basic findings from this chapter suggest that preventative measures have to be geared towards the environment where the preventative action is proposed. Factors such as understandings in relation to nutrition and perceptions regarding the causality of HIV/AIDS need to be taken into consideration from a local perspective. This is in contrast to the ABC approach as a mode of delivery that theoretically does not take these factors into consideration. The lack of consideration for local factors, such taking local access to nutrition into consideration, were criticised as follows:

> Because of the nature of HIV transmission in South Africa, prevention efforts tend to focus on changing sexual behaviour through the ABC of prevention: abstain, be faithful and use a condom… this approach assumes that sexual behaviour is a matter of rational individual choice. In reality, sexual behaviour is itself influenced by a range of factors, which include social, cultural, economic, political and technological factors…(Van Donk, 2002:1).

If then nutrition has a role to play as demonstrated above, and studies such as Jolly (2006) have proved that understanding local beliefs has a role to play in the alleviation of

nutritional problems, then surely the role players in HIV/AIDS at the WSU have to take this factor into consideration when considering HIV/AIDS prevention. The research revealed that various feeding schemes were proposed, in conjunction with entrepreneurial activities that fell within the ambit of WSU's institutional planning process, as well as the upgrading of sport facilities. These actions initiated by the WSU HIV/AIDS key role players have certain correlation with the research highlighted above, as well as other research:

> There is growing recognition that the implementation of discrete programs aimed at delivering services to vulnerable groupings is likely either to fail, or not be sustained in the long run, if the surrounding context and supporting systems do not shift in ways that support the goals of program efforts (Campbell et al, 2005:348).

While it is clear that strategies are in place, students reminded us of the fact that these strategies are yet to be fully realised, especially in a manner sensitive to local considerations. The data also showed that positioning should include local views, not because research informants believed in them, but because of the amount of respect that they showed towards traditional values. If Giddens' (c.f. Chapter 3) notion of action, intention, rationalisation and consequence is re-examined, it can be argued that the way in which research informants used and contextualised the term 'respect' would mean that they would on a day-to-day basis monitor the manner in which they conduct themselves against the conduct of others. In this way, it would be required that any intervention should be mindful of the social position of respect and the fact that respect stems from local pre-conceptions. Wreford's notion (2009:18) of having the traditional healers work hand-in-hand with health workers to ameliorate the problem would therefore be important in establishing an intervention effort for the IAT, and also possibly the WSU as a whole. Such a strategy could address true core-beliefs whilst, at the same time, maintain the correct social position of inclusion of all role players in social debate.

This allows for inclusion of the pre-determined position that students have displayed that HIV is viral, and the fact that they have a lot of respect for traditional healers. This approach would suggest that debate would have to occur surrounding these issues (between traditional healers and students), and also consider the fact that Campbell et al (2007:347) suggest that peer-intervention programmes are ideally suited for this type of environment wherein debate has to occur for community buy-in. It has to be emphasised, however, that respondents demonstrated a detached, critical view, without ever wanting to give up on

their cultural identity – hence the need to ensure that social debate programmes are peer driven and in consultation with community leaders and THP's. The recommendation is therefore made that this approach should be followed against a health-enabling background, because of the way in which they relate to it and the manner in which it has unintended consequences. This is a first step in a multi-step approach to HIV/AIDS prevention. In relation to WSU, this chapter also revealed that gender emerged as a strong issue, and it, alongside the data on the ABC approach, is discussed in the next chapter.

6: Gender and the ABC approach

6.1 Introduction

This chapter examines the role of gender and gendered relations and the way they impact on sexual behaviour in the context being researched. Gender was a key theme to emerge in all of the interviews and the data presented here shows that any approach that aims at changing sexual practices, as well as other HIV/AIDS prevention schemes, must take gender into account. This approach is supported by studies, such as Van der Riet (2009:209), examined in the literature review. The chapter also examines the ABC approach and, on the basis of the interviews, questions whether this approach is failing due to its failure to properly contextualise the intervention to local circumstances. I discuss gender and the ABC approach together, in this chapter, because both themes takes into considerations of sexual agency, its manifestation thereof and current efforts to address it.

In addressing the aims of this thesis, the section on gender specifically focuses on local beliefs which may affect the proliferation of the disease. It therefore determines what issues concerning gender equality should be addressed in HIV/AIDS prevention whilst considering the orientation towards localised beliefs. The section on the ABC approach addresses all of the thesis aims and asks whether the approach has made a difference by examining the views expressed by research informants and if it is sensitive towards local contexts and understandings.

The discussion on gender consists of three main sections. The first section examines perceptions regarding gender and asks how perceptions of gender comes into being in the context under consideration. It was found that circumcision school teachings had a significant role to play in the formation of gender perceptions. The following issues in relation to gender are discussed: local beliefs and masculine constructions thereof, myths surrounding gender such as ‘isiqwati’, and how women experience the circumcised male.

The second section asks how perceptions of gender manifest in relationships and discusses structural elements of gender in relation to the nature of relationships. Here the themes of infidelity and gender-based violence emerged and, as above, should become better understood in prevention campaigns that encourage social debate, such as peer intervention programmes.

The last section on gender utilises Giddens' notion of how individuals, through acquisition of agency, shape the social structure (Risman, 2004:432), and it subsequently analyses what lay-strategies women have been engaging in when using gender as a departure point for intervention campaigns in the research area. This section suggests that, in a prevention campaign encouraging social debate, separate strategies for women need to be engaged in to fight the spread of HIV/AIDS. These types of strategies would have to be included in an approach taken by the WSU and the IAT. This type of finding is important to the thesis since it provides direction for approaching prevention strategies. Overall, support for interventions sensitive to gendered understandings and practices on HIV/AIDS forms the basis of the multiple arguments for this chapter and is also supported by other authors, *inter alia* those cited below:

> …the socio-cultural construction of sexuality in specific social contexts is key to the interpretation of planned interventions, and gender is also an integral part of the analysis as it works in an interwoven theoretical and practical manner and is essential in HIV programme design and prevention efforts (Ragnarsson et al, 2010).

In terms of the ABC approach, perceptions expressed by research respondents in relation to the Government's response to HIV/AIDS are discussed in sections addressing the three elements of the ABC approach: Abstinence, Be Faithful and Condomise. Research informants were not of the opinion that the approach is sensitive to local needs, and rejected the approach in general. Seen in conjunction with the previous chapter, it can be seen how, in terms of this thesis, a multi-step approach is required to address the issue of HIV/AIDS, and needs to include elements of gender, and a new approach (other than the ABC) which includes greater sensitivity towards local beliefs.

6.2 Gender perceptions: initiation

This section, firstly, discusses male rites of passage and in particular the initiation process. The Xhosa initiation process is described by Vincent (2008[2]:10) 'as the instrument for the transition from boyhood to manhood' and she argues that 'Xhosa boys are aware from a young age that initiation is regarded as an inevitable part of male life' (Vincent, 2008[2]:11). In this section the first purpose is to describe the three different stages of initiation, and the process that a male has to undergo in the process of becoming a man, based on previous ethnographic studies. Secondly, the section asks research informants whether perceived perceptions surrounding circumcision school teachings may lead to a situation whereby

female sexual agency is curtailed, to what extent research informants believed in some of the myths surrounding initiation, and lastly whether research informants were of the opinion that the initiation process changes males' perceptions with regards to sexual agency over women. As already stated, it should be borne in mind that 'not all isiXhosa speaking groups circumcise. It is not practised amongst the Bhaca, Mpondo, Xesibe or Ntlangwini' (Vincent, 2008[2]:10; Stinston, 2008:1). It is known that some groups within the Xhosa circumcise, and that every group has a different set of beliefs associated with the practice. Since this study did not focus on a specific grouping, an aggregated view of research informants' perceptions is given.

The key finding from this section was that my interviews revealed a clear attempt to contest claims that masculine domination can be justified on cultural grounds. The lesson for future intervention schemes would seem to be that there is already a strong critical, reflexive consideration of 'culture' or 'tradition' which could be built upon – at least amongst students in this context – rather than treating them as the unthinking victims of culture.

6.2.1 Rites of passage and masculinity

This study did not set out to explore rites of passage or initiation in themselves. However, during the course of interviews it became apparent that this initiation process was an important one in terms of understandings of gender and sexual behaviour and was therefore of consequence for HIV/AIDS prevention. A further understanding of the different stages of the rites of passage was therefore required for purposes of analysing comments from research informants. A research challenge presented by some of the Xhosa groups who practise initiation, is the fact that the rituals are 'shrouded in secrecy' and that any public display of information pertaining to circumcision schools is seen to 'undermine the secrecy and symbolic meaning of the rite' (Ndangam, 2008:209).

Some authors, as described below, have attempted to provide some insight into the ritual, but are criticised for speaking publically (Ndangam, 2008:209). Therefore, some of the authors' information provided below is viewed in this context of controversy and possible questionable assumptions. Posel (2005:242) explains that the secrecy surrounding the initiation ritual 'is a source of power', 'rooted in power relations and the configuration of interests and norms shaping them…'. The power of secrecy has, therefore, been viewed as a means whereby 'male authority' (Ndangam, 2008:207) is stamped upon Xhosa society.

The associated rites of passage and initiation have been described in general as follows:

> Rites of transition involve the stages of separation, transition and incorporation. Although ceremonies differ across different groups, certain commonalities exist, these including ritual sacrifice, seclusion (entering the bush and building temporary lodge), circumcision, and the painting of the skin with white clay, followed by the burning of the lodge and belongings at the close of the seclusion. Celebrations of the change in status accompany the incorporation of these men into the community (Stinson, 2008:2).

There is a great deal of variety in this process in different contexts, with different groups emphasising different aspects of the process in different ways. The pre-initiation-stage includes preparation, during which the male has to undergo various family rituals to prepare him for the separation. This includes a ritual (*ukuswama*) whereby a goat is slaughtered. This is symbolic of a request to the ancestors to watch over the initiate during the process (Bogopa, 2007:57).

The transition stage is characterised by acquiring local knowledge. Hardship is endured during this stage, and initiates are expected to live from the land for long periods at a time. This often leads to initiates suffering dehydration, becoming malnourished and sometimes dying (Ntombana, 2009:74). Towards the end of this stage, the actual act of initiation takes place.

In terms of incorporation, certain views about society are discussed, including gendered knowledge about women, and the rite includes *umgidi* (celebration) by the family, with a goat being slaughtered to thank the ancestors and to celebrate the arrival of a new man in Xhosa society. A new name is also given to the successful initiate (Ntombana, 2009:75). This procedure was seen as one that defines manhood and masculinity by both the males and females who took part in this study. As a primary means of socialisation (Gwata, 2009:3), research participants described how there was a fundamental change in the way men behaved following circumcision school and also a change in the way females view just-circumcised men.

From examining data from the cohort, the key role players, the majority of respondents described boys as becoming ‘more arrogant’ (15/20) after initiation, whilst also describing the ‘requirement’ for females to be submissive (11/20), either assumed after initiation, or a general expectation of society, or both.

Example 1 (Key role players[57]):

the amakanghata, the people who are doing the classes, three weeks…believe me a boy that goes into the initiation ceremony comes out a much more worse person than what they were, they are taught to be arrogant, they are taught to be disrespectful, taught to assert themselves as men, so it is all negative things that they are taught about how to treat women. I see it as a place where they could be told to use a condom and why…

A female lecturer and HIV/AIDS activist described the situation in example 1. Her view was broadly supported by my respondents and all research informants described men who had just completed circumcision school as behaving differently to those who did not. From examining the data from the cohort of IAT students, the general description of 'boys being more arrogant' emerged more clearly amongst the responses (17/20), and *all* responses from this cohort confirmed the necessity for women to 'be submissive' in a male-dominated environment.

Example 2 (IAT Students[58]):

'because they are submissive and I don't know why they do that because they are hurting themselves and most of them are dying because of this because they get the HIV from us'.

In the second example the social power gained from the initiation process, thereby creating an image of masculinity, is said to have an effect on the transmission of HIV. In this way Ndangam describes how social power manifests as a result of initiation:

> The ontological importance given to initiation is such that many die in the process of attaining the cultural ideal of manhood. The black male body therefore becomes a site on which fears, insecurities and uncertainties about socio-political transformation are projected, negotiated and defended. The result is that a black African male body is not only a site of enculturation, but also a site of contestation over culture and masculine embodiment in post-apartheid South Africa (Ndangam, 2008:225).

In an article that reviews the construction of male identities in Africa, Ratele (2008:533) argues that such identities are 'produced at both the social and psychological levels' thereby reflecting not only societal and group pressures to behave in a certain way towards

[57] East London, College Street, IAT Employee, Xhosa, 24, Female

[58] East London, Chiselhurst, Student: 3rd year, ND: Mech Eng, Xhosa, 22, Male

females as 'a group' (Ratele, 2008:516), but are also constructed in the 'psychosocial realities of individual males' (Ratele, 2008:517). This view recognises that identity construction is fluid and therefore different for every male, but also recognises that, in this context, there is a common understanding of 'masculinity' which displays some consistency across individuals.

However, it was notable that research informants did not describe associated behaviours and beliefs surrounding initiation as 'cultural', but rather argued that these beliefs were not 'cultural'. What my interviews revealed, in other words, was some opposition to traditional beliefs surrounding initiation. Once again, as seen in the previous chapter, the distinct impression is gained that, although men are going through the physical ritual of initiation, belief systems described as 'traditional' are not beyond question.

Thus, in the examination of the data from the cohort, IAT students, the majority of research respondents showed an understanding that culture is not fixed (16/20), and typically provided responses such as these:

Example 1 (IAT Students[59]):

This thing starts as you get one guy trying it and his friend will try it and it then ends up being a cultural thing, like most of the Xhosa things that they are doing, like for example, having to control your wife. Another example of being cultural is that now they are using brandy and not mkomboti (beer) at their cultural ceremonies, but nowadays if you only have mkomboti at your ceremony the people won't come because you don't have brandy. This brandy thing is now like a cultural thing though it is new to the Xhosas, it changes them, but now it's like they were born with it. So now this thing is going to roll on and it is going to go on and on. It will look like it is part of the Xhosa culture, though it is not.

In this example it can be seen how the research informant demonstrated how various practises become 'cultural' due to the fact that everybody is engaging in such behaviour. It is noticeable that the element of 'to control your wife' was seen as such an example by this research informant. In this way the research informant is informing us that particular gendered constructions are seen as 'part of the Xhosa culture, though [they] is not'.

[59] East London, Chiselhurst, Student: 3rd year, ND: Mech Eng, Xhosa, 23, Male

In the examination of the data from the cohort, key role players, the majority of the research respondents showed an understanding that culture is socially constructed (17/20), and typically provided responses such as these:

Example 2 (Key role players[60]):

No, I think because you want to make them aware that some of these things that we are sticking to we are doing because we say it's our culture and it also encourages HIV/AIDS. Sexual violence as a form of respect is a practice really because most of the time it has nothing to do with the culture. It is something that is created by people.

In this second example above the research informant revealingly notes: 'we say it's our culture and it also encourages HIV/AIDS'. Of importance and far more noticeable from the second cohort was the fact that research informants displayed a deeper understanding of the connection between cultural constructions of masculinity and its effects on the HIV/AIDS prevalence rate, in ways suggested by this quote. Both of the research informants quoted reflected a wider pattern across both of examined cohorts; they are asking how far the term 'culture' could be used as justification for anything: the first, by insisting that cultures change over time; the second by explicitly claiming that one cannot defend oppression by referring back to culture. This profound critical scepticism towards cultural practice, and the claims of tradition, brings us back to terms such as 'invented tradition', and the realisation of research informants that people are responsible for changing behaviour and not 'culture'.

6.2.2 *Isiqwati* and experiencing the circumcised male

During one of the early interviews in the cohort undertaken amongst the key role players, a HIV/AIDS councillor described what she termed '*Isiqwati*'. Taking this topic forward to subsequent interviews, research informants (16/20) recognised it in some form, but they mostly rejected the idea that woman should succumb to it based on a 'cultural' argument:

Example 1 (Key role players[61]):

I don't know in isiXhosa it is called isiqwati…there is something that you must take out … if you had a steady girlfriend before the ceremony you are not supposed to sleep with that

[60] East London, Potsdam Residence Officer, Xhosa, 48, Male

[61] East London, Potsdam, HIV/AIDS co-ordinator, Xhosa, 44, Female

girlfriend of yours…once you sleep with that one it means that definitely your relationship is going to break. So for your relationship to work you must sleep with someone else so that you can take out that isiqwati to that person…so you go to your real girlfriend.. That I think can also exacerbate the spread of HIV.

Example 2 (Key role players[62]):

Ja, I have, but what it actually boils down to what you want to do. I mean I can take a girl out and have sex now without using a condom or I could go out and someone and I might prefer to use a condom. It is all your own choice of what you actually want to do. There is this stupid belief that when this whole process is done you must get rid of the dirt so why am I going to dump my dirt on some poor girl who doesn't know anything about it.

Example 3 (Key role players[63]):

For the Xhosas it's like he is respected for having so many girlfriends. He is like powerful he's the man. It's something like that. There is nothing cultural about it.

These descriptions refer to a belief held that men who have just completed initiation must have sex with a woman. The woman may not be romantically involved with the man at the time (such as a girlfriend). Following this, the man must then return to his girlfriend, and the relationship will last as a result of the above act. All of the research informants were of the opinion that this act is expected to be 'flesh on flesh', but also stated that in some cases the nature of the sex did not matter. The reasoning behind this practice, they explained, was that 'a man carries evil following initiation, and the evil has to be dumped' (disposed of). The 'evil' is stated to be bestowed upon the female in question. As per the example above, it can be seen that some of the research informants recognise the fact that the decision to engage in risky sexual behaviour should not be tied to local beliefs, and was understood to be 'a choice of your own'. The mere fact that this specific research informant described it as a 'stupid belief' suggests that realisation exists that such practices do not go unquestioned, and that beliefs cannot be held accountable for irresponsible sexual behaviour. Gwata also found evidence of this belief:

> Recent reports that new initiates are encouraged to have sex as soon as possible as part of the necessary 'cleansing' and that they should have it with women of

[62] East London, College Street, IAT Employee, Xhosa, 26, Male

[63] Mthatha, Nelson Mandela Drive, Health Promoter, Xhosa, 32, Female

> 'lesser value' (i.e. women known to have had many partners) has led to concerns about the spread of rape and HIV (Gwata, 2009:8).

Whilst most of the research informants from the cohort IAT students referred to 'sex after the initiation process' (15/20), in some form, students were more aware of the social impact it has upon women, and the likelihood that women would respond in a 'positive' manner. We should be reminded that this cohort consists only of young men of a certain age:

Example 1 (IAT students[64]):

…the young girls if you are coming from the initiation schools they think that you are just the guy so if they were to propose to one of the girls to sleep with him she will say yes just because you are the man coming from the initiation school, knowing that he is doing this to cleanse himself...

Example 2 (IAT Students[65]):

There is a belief that when you are coming back from the bush you can't sleep with your girlfriend because when you come from the bush the first person you sleep with you are taking the dirt from you and if you do you can't give it to your girlfriend and if you do sleep with your girlfriend it won't last so you have to find someone else.

Example 3 (IAT students[66]):

There are all these things that come along with manhood, at the expense of culture and our beliefs. I really think it is wrong to call it culture, especially ours, that would preach such things. No, we are not cultural when we do those things.

Whilst it was found that these research informants related to the description, they often distanced themselves from this practice when they described it to me. They often framed such beliefs as a question of 'they believe that…'. Bell (1992:18) highlights how 'ritual and belief are intertwined and yet separable, since it is conceivable that one might accept beliefs but not rituals associated with them'.

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[64] East London, College Street, Student: IAT, Xhosa, 26, Male

[65] East London, College Street, Student: IAT, Xhosa, 24, Male

[66] East London, College Street, Student: IAT, Xhosa, 24, Male

She also equates ritual with 'thoughtlessness' by stating that:

> Ritual is then described as a particularly thoughtless action – routinised, habitual, obsessive, or mimetic – and therefore the purely formal, secondary and mere physical expression of logically prior ideas (Bell, 1992:18).

The research informants were also quick to remind me that the practice was 'not cultural'. The distinction between what constitutes the 'ritual' would be the notion of the initiation ritual itself, whilst the notion of acceptance of manhood, and the required 'training', becomes Bells' 'logically prior ideas' – however – we must recognise the fact that these respondents demonstrate that they don't simply think of ritual as 'thoughtless action' in the way that Bell describes.

In relation to the above examples, females' interest in just-circumcised males was also found in studies such as Kepe (2010:729) who stated that the whole process of initiation 'enhances masculinity'. Other characteristics associated with circumcised males have been described as follows:

> It is where young men receive instruction in courtship and marriage practices. Cultural expectations regarding social responsibilities and their conduct as men in the community are transmitted and, following initiation, men are afforded numerous privileges associated with their status. Men who've been through initiation are distinguishable by their social behaviour and a particular vocabulary they learn during their time in the bush (Stinson, 2008:4).

The above statements in many ways summarise many of the issues discussed in this section surrounding initiation. Whilst it is clear that the above research respondents made the point that associated beliefs surrounding initiation are 'not cultural', they clearly did recognise that it was through initiation that a normative masculine identity emerges. This creates the impression that, given the background where females have been described as 'submissive', some males believe that having endured hardship in the bush they are now an entitled to become a decision-maker, a patriarch. This would include issues surrounding sexual decision-making which under certain circumstances could be conducive to the spread of HIV/AIDS. The fact that the majority of the research informants always distanced themselves from whatever they were describing, thus creating an 'us' and 'them' dichotomy, could be partially attributed to flux and change in beliefs, the recognition that these beliefs are socially constructed, as well as social distancing and stigma that occurs as a result of HIV/AIDS.

What emerged from the above section was the clear attempt to oppose claims that masculine domination can be justified on cultural grounds. The lesson for intervention would be that there is already a strong critical, reflexive consideration of 'culture' – at least amongst students in this context.

6.3 Elements affecting HIV/AIDS incidence in relationships

This section shares some of the experiences of women participants in relation to problems associated with relationships that could be attributed to the spreading of HIV/AIDS. These sub sections include, first, discussion of multiple partners[67], which is a phenomenon that occurs in all cultures across the world. In this section 'lived experience' reasons for infidelity are examined, and it raises some issues that would have to be addressed in any form of prevention. The second section relates to constructions surrounding gender-based violence, and examines some of the justifications that some research informants utilised in their description thereof. The key finding from this section is that if elements affecting sexual agency, such as multiple partners and sexual violence is related to a certain prevalent construction of masculinity, then it is 'cultural' in one sense; but the key point is that it is not passively accepted – culture is not a set of static or unchanging practices; it's a space of debate, contradiction and contestation.

6.3.1 Multiple partners

Infidelity is a world-wide phenomenon that occurs in all cultures and ethnicities. Many studies have examined the relationship between infidelity and HIV/AIDS across numerous countries, such as Mexico (Hirsch et al, 2002:1227); Malawi (Smith and Watkins, 2005:649) and Tanzania (Lary et al, 2004:200). Notably, studies have also shown that this can have correlation with gender violence and sexual coercion (Lary et al, 2004:201. From the cohort of key role players a prevalent justification of violence due to infidelity was mentioned by most of the research informants (16/20). The myth regarding beliefs pertaining to polygamy and its association with infidelity, as also examined by Price (2009:12), was also mentioned by these research informants. As Price puts it, the belief that Xhosa males are prone to infidelity due to a distant past practice of polygamy within certain contexts is incorrect and pejorative. Research informants emphasised that

[67] This discussion is done with Deluis and Glaser's (2004:84) notions of misconceptions surrounding multiple partners due to a past and distant belief of polygamy as a basis for interpretation.

polygamy is not commonly practised, and that it occurs only among the elite, such as traditional headman and leaders of the community. As per Price's indication, it was noticeable that in some instances research informants had to raise the problem of multiple partners when the discussion of polygamy was introduced. This created the impression that some of them were of the opinion that past polygamy was linked to modern day infidelity.

Example 1 (Key role players[68]):

Not in our days. Today people are now choosing monogamy relationships but there is this thing that I don't know even in other cultures, if they have mistresses because extra marital affairs do happen. It has hit women very hard because men don't want to use condoms. Let me not generalise, some of them or most of them do not want to accept the HIV/AIDS is out there. So you go out there and have an affair and one doesn't always use a condom. You come back to your wife who you have never used a condom with you know and you pass it on. It happens like that.

From the above example, it can be seen how incidents of multiple partners develop, and as already seen from previous sections, in some instances condom usage does not occur due to a particular understanding of masculine identity, which in some instances may mean that HIV/AIDS transmission occurs. As the research informant indicated, it would be incorrect to generalise, but she also stated that some people refuse to acknowledge the existence of the disease. This has similarities with findings from previous sections related to social distancing and the belief that HIV/AIDS is only contracted by 'other people'.

From the cohort of IAT students, the majority (18/20) also described polygamy as 'something for kings', or alternatively from the past:

Example 2 (IAT students[69]):

I think it was common to people who are like kings, like inkosi, or elder men, not with all the men because I have never seen someone who is not like a king who has two or three wives they only have one. It is just that someone will have a wife and then go for other girlfriends but not like plenty of wives…

[68] East London, Potsdam Residence Officer, Xhosa, 48, Male

[69] East London, College Street, Student: IAT, Xhosa, 26, Male

With regards to example 2, it can be seen how this research informant tied the past existence of polygamy with modern day infidelity, and does what Price (2009:12) described as incorrect and pejorative. Nevertheless, many of my respondents did see infidelity as a problem in relation to HIV/AIDS prevalence. Multiple partners as a cause of the spread of HIV/AIDS were also found in other studies, such as Krumeich *et al* (2001:125), Chopra et al (2009:72) as well as Wood and Jewkes (2005:97). Wood and Jewkes tied 'positioning' to the existence of the phenomena as follows:

> For the young men, acquiring a girlfriend was not necessarily enough. The actual number of partners acquired was also important in their 'positioning' process amongst peers. Multiple sexual partners, by all accounts universal amongst boys, was said to be an important defining feature of 'being a man' (Wood and Jewkes, 2005:97).

All research informants (20/20) from the cohort of key role players described instances of how infidelity occurs:

Example 1 (Key role players[70]):

One method is when you are having a relationship and you think that you are the only one in that relationship.. for instance … students here when they come they have partners.. And they have partners where they come from so if they have a boyfriend…girlfriend here and at home .. It means that the partners have ones as well…and two others, and if no condom… it means that whatever infection it will be transferred.

Example 2 (Key role players[71]):

Long ago it was just like that. My mother told me that when they were glad they were abstaining until they got married. Although nowadays you know Ian, you know it is sort of a, it has become a norm or if I can put it like that a habit that if you don't have a girlfriend or if you haven't slept with a girl in our culture you are old fashioned you know. There is peer pressure is dominating that why don't you sleep with your girl and even girls among themselves love others that are sleeping with their boyfriend. There is a pressure.

In the testimonies above, experiences concerning infidelity are shared. Example 1 describes how this occurs due to the necessity of migration; in example 2, comparing the

[70] Mthatha, Nelson Mandela Drive, Health Promoter, Xhosa, 33, Female

[71] East London, College Street, IAT Employee, Xhosa, 24, Female

'old' with the 'new', peer pressure was stated to be a factor causing the need to have multiple partners.

As for the cohort IAT students, fewer references to infidelity (9/20) were made, most likely related to life experience and general age of the cohort. In the example below the student justifies multiple partners to overcome relationship attrition:

Example 3 (IAT students[72]):

I think its probably you don't want to get a your heart broken when you lose a girl. One day you can be in love with this girlfriend and then she dumps you so you should have another shoulder to cry on. (Laugh). So it is a safe way.

Within a similar region of the Eastern Cape comparable findings prevail, with Masenyama (2004:22), who found, in a University of Fort Hare study, that students are at particularly high risk due to having multiple partners. The research informant's description also allows for the belief that a common understanding of 'maleness' is associated with the frequency of sexual intercourse with many women. It is becoming clear that a certain construction of maleness seems to prevail and this places men at the apex of relationships making them the sexual decision-makers and, therefore, also an appropriate focus of preventative action against HIV/AIDS.

6.3.2 Gender–based violence

Gender-based violence has been discussed in a number of studies, including those of Wood et al (1996), Jansen van Rensburg (2007) and Peltzer and Pengpid (2008). In 'a qualitative study conducted among Xhosa-speaking adolescent women in South Africa, which revealed [that] they [males] used violent and coercive practices to dominate their sexual relationships', the following finding was reported:

> Conditions and timing of sex were entirely defined by their male partners through the use of violence and through the circulation of certain constructions of love, intercourse and entitlement to which the women were expected to submit (Wood et al., 1996:2).

In a national, quantitative study with Xhosa people comprising 14% of the sample, Peltzer and Pengpid, (2008:1466) stated that 26,3% of females experienced physical and/or sexual

[72] East London, Chiselhurst, Student: 3rd year, ND: Mech Eng, Xhosa, 22, Male

violence in relationships. Whilst gender-based violence is not confined to the Xhosa and is found in almost all societies across the world, it is however important to discuss its impact on sexual behaviour, and to examine references in this regard. All research informants from the cohort of key role players (20/20) acknowledged in some way that gender based violence is a common problem:

Example 1 (Key role players[73]):

I think that it is one of those things that would have to be challenged, I think there is a lot of promiscuity, there is an acceptance for married males to sleep around, and many women know this and know that their husbands will not wear condoms it is like accepted practise. If women question their partners' behaviour, it often leads to violence.

Example 2 (Key role players[74]):

No, your husband will beat you to death because he will say you have a boyfriend and he has a right[75].

The above examples ties in with the previously constructed view of masculinity related to initiation, combined with views related to the forced acceptance of multiple partners. As with the first example, reference was made to a man's right to engage in what Wood and Jewkes describe as 'successful masculinity':

> Violence usually occurred in situations where girlfriends were perceived as stepping out of line by behaving in ways which threatened men's sense of authority in the relationship and undermined their public presentation of themselves as 'men in control' (Wood and Jewkes, 2005:98).

It can therefore be seen how views of masculinity, related to the manner in which research informants described men after having completed circumcision school, could be used in personal constructions of justification for multiple partner relationships. This, in turn, has a negative influence on the spread of HIV. Questioning authority could further be used as justification for violence in relationships, including rape, as described below.

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[73] East London, Chiselhurst, Snr. Lecturer, Mechanical Engineering, White, 55, Male

[74] Mthatha, NMD, Health Promoter, Xhosa, 33, Female

[75] I do not question the fact that any male would be upset under these circumstances. I do not however accept the term 'beating to death' – the imputation of such violence seems unacceptable.

Descriptions of rape occurred in the following manner:

Example 1 (IAT students[76]):

> *I've heard that some of them believe it's right to rape a woman and things like that, but I'm sorry to say that I don't believe in that. That's what the elders tell you that you must prove that you are OK and that you must find you can do it. But this is now our days and there is now AIDS and things to be careful of.*

Example 2 (Key role players[77]):

> *Ja, rapes. Unreported cases but they will come to my office through security sometimes reporting that there were rapes taking place but the victims are reluctant to come and report it because they were drunk….*

In example 1, it would be impossible to conceive that rape is central to Xhosa cultural beliefs and practices regarding gender construction (c.f. Mlisa, 2009:23). The key role player in example 2 confirmed that occurrences of rape have taken place on campuses of the WSU. Stories of rape have also been carried in newspaper reports (Township Times, 2011; Daily Dispatch, 2012). What remains evident from the quote of the key role player is the fact that many incidents are 'not reported' due to the fact that 'students were drunk'. The respondent's seeming assumption that rape couldn't be punished if the victims were drunk is clearly alarming. This is a further indication to key role players that the manner in which student activities on campuses take place needs to be regulated through strict security measures.

6.4 Agency development: Individuals shaping social structure

Giddens (1991:36) refers to our ability to engage in 'reflexive monitoring of actions' and explains that individuals can transform society and through their own agency can alter the structures in which they live. In fact, they change the manner in which society reacts to social phenomena. In making recommendations to the IAT on the prevention of HIV/AIDS whilst adopting a cultural approach sensitive to local knowledge, it would seem prudent to examine instances whereby individuals have already strategised and tried to implement

[76] East London, College Street, Student: IAT, Xhosa, 27, Male

[77] East London, Residence Officer, Xhosa, 48, Male

such approaches. Such an examination follows Denzin's methodology[78]. Similarly, Giddens reminds us in his structuration theory, empirical research and critique, of the importance of examining local strategies to overcome a 'problematic':

> All human beings are knowledgeable agents. That is to say, all social actors know a great deal about the conditions and consequences of what they do in their day-to-day lives. Such knowledge is not wholly propositional in character, nor is it incidental to their activities. Knowledgeability embedded in practical consciousness exhibits an extraordinary complexity – a complexity that often remains completely unexplored in orthodox sociological approaches, especially those associated with objectivism. … The rationalisation of conduct becomes the discursive offering of reasons only if individuals are asked by others why they acted as they did. Such questions are normally posed, of course, only if the activity concerned is in some way puzzling – if it appears either to flout convention or to depart from the habitual modes of conduct of a particular person (Giddens, 1984:281).

This section will therefore examine local strategies as proposed by research informants. Examining the success of such strategies and implementing elements proven to be successful in an approach to the IAT would take the IAT organisational unit, as well as key role players, a step closer to the construction of an effective HIV/AIDS prevention approach. Examining these strategies would also directly address elements central to the research question as well as various sub-problems mentioned earlier in the study. Some strategies were mentioned whereby females actively engaged in activities to overcome male patriarchal behaviour. The basis for such a strategy is contained in a finding by Barr:

> One area that needs attention is the message that leaders send out to the Xhosa community. Another focus for preventing the spread of HIV is to make the truth about HIV available, especially to Xhosa men. In a patriarchal society, it is essential that the natural leaders of the people, Xhosa men, take responsibility for overcoming the disease. If men in the Xhosa society assume their responsibility in the fight against HIV/AIDS, they can encourage uncircumcised boys to do the same, and as a result Xhosa women and children will be protected (Barr, 2008:24).

This section consists of two sub-sections. The first examines women's experiences and the subsequent realisation that empowering students is central to HIV/AIDS education. The second examines 'men preaching to men', which has proven to be a successful strategy in East London.

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[78] Denzin (2002:85-97) requires researchers to source various forms of data, inclusive of local strategies to overcome the 'problematic', hence the inclusion of this section on 'local strategies', also to be reflected in recommendations.

The key findings from this section relates to the fact that the respondents don't really distance themselves from gender inequality; they do say quite explicitly and unequivocally 'women need to be empowered'. It should be recognised that gender inequality is a problem, and seen as something that needs to be understood in designing interventions.

6.4.1 The need to empower

The need for females to be more assertive emerged frequently during interviews (10/20), especially with key role players who are responsible for counselling and intervention, one example is given below:

Example 1 (Key role players[79]):

> *They need to be empowered. They need really to be motivated and stand up and say 'NO' and stick to their rights. Some of them really don't want to but a man is forceful a man traditionally has a right to say whatever …*

From the previous sections it was clear that in some instances a strong form of patriarchy seems to prevail. It was also established that these views might have an effect on risk behaviour, and in some instances males also realise the need for females to be more empowered against male behaviour. A concern with the need to empower was less evident amongst the IAT students (8/20), although some students did see this as a 'cultural' problem:

Example 2 (IAT students[80]):

> *I would say because especially in our culture the black men dominate the women and the relationship and maybe she doesn't have the power and be assertive enough to tell him to stop or use a condom. If someone asks me to use a condom I will do it, but if she doesn't say anything I won't use one. If she becomes assertive I will do what she wants but if not I just carry on.*

What both cohorts did not address, however, were the reasons why females would feel disempowered. If some of the reasons for disempowerment are re-examined from the literature and the findings from earlier sections in this chapter, it can be stated that the role

[79] Butterworth, Ibika, HIV/AIDS co-coordinator, Xhosa, 46, Female

[80] East London, Chiselhurst, Student: 3rd year, ND: Mech Eng, Xhosa, 22, Male

of circumcision schools, and the subsequent formation of masculine identities play a significant role. The enforcement of masculinity associated with just-circumcised males, which manifests through practises such as *isiqwathi*, amongst others, is however personally constructed, whilst social elements (i.e. patriarchy) is enforced through use of traditional mechanisms, such as lobola. The problem arises from an HIV/AIDS perspective that these identities also curtails females' sexual agency, and hence has an effect on HIV/AIDS prevalence.

The impression is gained that, as Giddens also implies, agents in society prefer not to challenge the existing status quo since it often leads to dissent and retaliation (Giddens, 1984:179). It has already been seen that some forms of retaliation include gender violence, and in some instances, disapproval from the elders. Some research informants also stated that it would be an insult to a man if the elders were to perceive that a man 'does not have the ability to control his woman', and an even greater insult if this were to be stated within social circles. In this way the conceptualisation of respect, which could be tied to masculine identities, was also identified in Chapter 5, and has similarities with existing findings in the literature (Wood, 2009:1). The key finding to this section demonstrates the need to socially debate the position of women in society, in order to ensure that feelings of disempowerment are addressed.

6.4.2 Men preaching to men

The strategy of involving 'men preaching to men' in AIDS awareness campaigns has its origins in the belief that women, in some social contexts, are assumed to be subservient and therefore men would not listen to prevention strategies that are presented by women. There are some fundamental flaws in this argument, not least that there is a danger that it colludes with a chauvinist approach to HIV/AIDS education: i.e. if it suggests that only men can teach other men about gender discrimination and HIV/AIDS. A critical view would suggest that gender inequality is clearly a problem, and is something that needs to be understood in designing interventions. However, there is evidence that some of these programmes have been successful, and authors such as Masenyama have argued, in favour of this approach:

> Emphasis is on males because historical and social definitions of 'male' and 'female' incorporate within societies a culture that places men at its centre. Further, men's greater power is manifested, and is often mediated through sexual encounters. Therefore, because of their capacity to control the sexual act men still

> largely have a significant impact on the spreading or combating of HIV/AIDS, thus giving them the opportunity of changing the course of the epidemic (Masenyama, 2004:2).

Evidence from my respondents in the cohort of key role players is provided below; although only 3/20 spoke about this approach in any detail:

Example 1 (Key role players[81]):

What I am saying is that the question of the condom is not out it is just a tactical strategy on how we really at the end of the day mobilise men to assist us in capturing the issue of HIV/AIDS because really it goes back to the issue of gender in HIV/AIDS that one who has the power in the house. In the Xhosa culture it is the man who is the head of the house so the only person who speaks last in the house is the man not the woman. The buck stops with them they must decide and they must stand up and say that they are now doing this. But there is also an intervention that needs to be done in order for them to understand and also believe that we as women also have the responsibility to make the changes. We have started a 'men preaching to men' project on campus to overcome this problem.

Example 2 (Key role players[82]):

We have, in the community, work with men's NGOs. A feather in your cap concept - women just can't go through that, so we have men preaching to other men. That does help. In a way, for instance we have started a project in Duncan Village, with the men's group. We have worked with men for about four months now and we can see a change in the society. The men's group target community meetings and ask for five-minute presentations.

A strategy of involving men in HIV education is not unusual in the East London Xhosa community. For instance, the Ikhwezi Wellness Centre in East London ran the 'Other half Project: Involving men in HIV/AIDS programming'. The basis for the programme was as follows:

> The programme reflects and is built upon a fundamental understanding of the negative ways in which the unequal balance of power between men and women manifests itself in South Africa …. The Other Half Project seeks to address the disproportionate burden of HIV/AIDS on women in the Eastern Cape, one of

[81] East London, Chiselhurst, Lecturer, Department: Communication and Languages, Xhosa, 37, Female

[82] East London, Potsdam, HIV/AIDS co-ordinator, Xhosa, 44, Female

> South Africa's poorest regions, by promoting male involvement in HIV/AIDS prevention and treatment (Ikhwezi Wellness Centre, 2010).

According to the programme 'the process seeks to empower women by involving men, which ultimately strives for males to become role models, not only in respecting the rights of females but also in carrying the burden of shared responsibility'. Given the fact that this chapter has provided evidence of patterns of responses provided by research informants related to gender inequality, this approach should be considered by the IAT. Green (204:108) concluded that 'community-based schemes that tap into the potential of traditional social arrangements' should be used as an alternative to current prevention efforts. How to incorporate this approach in a prevention strategy scheme for the WSU key role players and the IAT students will be further examined in the next chapter.

6. 5 The ABC approach

The ABC approach has been critiqued in various instances within the thesis, although it is the primary intervention approach from the South African Government (Mash, 2006: 51), and subsequently also the Eastern Cape regional administration (Wedin, 2007: 41; Jajula, 2007:10). It was also noted that many authors have described it as a failure due to the fact that it does not take the context, environment, gender considerations and elements of social power into consideration (Campbell and Williams, 1998:57, Obaid, 2004:2, Dworkin and Erhardt, 2007:14, Setswe, 2007:5)[83].

In this respect some authors have described it as 'rather unsuccessful in the educational sector of the province' (Wood and Webb, 2008:111), whilst in a national survey the Eastern Cape (as all other provinces) showed that 'there was no significant difference' in HIV prevalence between communities that have been exposed to the ABC approach and those who were not (Pettifor et al, 2005:978). It was also established that cultural specific contexts need to considered in order for prevention approaches to make a difference to HIV prevalence at universities (Mulwo, 2009:iv), whilst Ntshebe et al (2006:466) show that the major deficiency of the ABC approach is its inability to address culturally specific

[83] The Setswe study (2007:6) consisted of reviewing '192 Abstinence, Faithfulness and Reproductive Health sites' across the world, and the report mentions countries across all continents. Due to the sheer number of programmes involved the study is considered to be authoritative on the matter, and it should be taken into consideration that the study was conducted by the HSRC (South Africa) with the aim of advising South African readers on the efficacy of the approach.

contexts. It could therefore be argued, following the recommendations of Green (204:108), that 'community-based schemes that tap into the potential of traditional social arrangements' be examined to be used in conjunction with or in addition to the ABC approach.

Following on from research which criticises the ABC approach for its lack of cultural sensitivity, I am now going to examine evidence from the data in my own research about how the approach was understood and received amongst the community I was researching. This section therefore introduces the reader to views expressed by research informants regarding the Government's response to HIV/AIDS, and focuses on the ABC approach specifically. One of the research informants criticised the strategy for its simplicity and stated that 'it is not comprehensive enough' to address the complexity of the environment. The vast majority of research informants presented counter-arguments against it, all claiming that the strategy is culturally insensitive, and that it does not take the environment into account. Secondly, this section examines in more detail responses to the 'abstinence' section of the ABC approach, and questions whether abstinence is a realistic goal for teenage youth. Thirdly, it examines the B and C sections of the ABC approach in terms of research informant responses and argues, as in the previous section, that faithfulness could be a difficult goal to achieve without taking local- and culturally sensitive factors into consideration.

6.5.1 Perceptions of the ABC approach

The South African Government's response to HIV/AIDS has been largely focused on the use of ABC prevention approaches (Mash, 2006:51), and was described by Mulwo (2009:3) in a South African University context, as 'the rallying call of most communication campaigns'. As expected, all of the research informants mentioned the term ABC when the topic of prevention was introduced.

The popular Love Life campaign, which uses the ABC approach as its basis, was also frequently mentioned by research informants. Discussions with research informants elicited numerous interpretations of the efficacy of the approach, with various reasons offered as to why it is wrong or why the approach does not work. Hence, the ABC approach has largely been used in prevention efforts at the WSU and emerged as an important topic with research respondents. Responses ranged from a focus on 'abstinence only', and 'condomise' component of the project, whilst the 'be faithful' component of the

approach was mentioned infrequently, to total abolishment of the entire ABC concept 'it doesn't work for me'.

The cohort of IAT students revealed responses in the following categories[84] as follows: abstinence only and/or condomise (6/20), be faithful (3/20) abolishment of ABC concept (11/20). The cohort of the key role players revealed responses in the following categories as follows: acceptance of the entire ABC concept (5/20), entire abstinence only and/or condomise (4/20), be faithful (2/20) abolishment of ABC concept (9/20).

As this discussion addresses every section of the ABC approach, as interpreted by research informants, it can be seen that each element elicited a specific interpretation and this interpretation was often related to 'cultural' beliefs regarding abstinence, faithfulness and the use of condoms. Each element elicited a counter–'cultural' interpretation, suggesting that culture maybe used as a reason for not adhering to the suggested path of HIV avoidance in some instances.

As with the previous sections, the use of the word 'culture' here follows the usage of the research informants themselves, and differs from academic definitions (c.f. Chapter 3). Eliciting answers from the student cohort was difficult (as illustrated in example 1), sometimes making categorisation difficult. It was generally accepted that, if a leading question had to be asked to elicit an answer, the response was excluded from the analysis:

Example 1 (IAT Students[85]):

I:	*How do students think? How can people stop getting AIDS?*
Zanu:	*By using condoms or by abstaining.*
I:	*Abstinence, condoms and what else?*
Zanu:	*You just stick to one partner and make sure you are both faithful to one another.*

[84] The category definitions were as follows: (1) Abstinence only and/or condomise: research informants who either stated that they believe in abstinence only OR the use of condoms; (2) Research informants who only believed in being faithful OR in conjunction with beliefs stated in (1); or (3) Research informants who said that they do not find the ABC concept useful as a guide OR do not subscribe to the ABC principles.

[85] East London, College Street, Student: IAT, Xhosa, 28, Male

As seen in example 1, this student was quick to refer to abstinence as a method of prevention, followed by 'condomising' should abstinence be out of the question. When I asked a further question, the term 'being faithful' also emerged, so it was clear that the campaign's formula was recognised, but the 'be faithful' component was always the last to be mentioned, if at all. It is probable that this has some correlation with findings related to masculinity in the previous sections. The cohort of key role players were far more open to discussion:

Example 2 (Key role players[86]):

You know, my personal belief is that the prevention of HIV/AIDS is simple. It's A, B, C and D. Abstinence, Be faithful, Condomise and Diagnosis. The preventative strategy is that you embark on explaining it to people who do not have knowledge of the medical side and health promotion. Just simple prevention, micro-organisms and how they spread, for example the virus, the spread of a virus sexually, and through contact with someone who has been cut…

For key role players ABC was an entirely different matter, since it was seen from a pedagogical vantage point. In example 2, a health promoter, suggested that the simplicity of the ABC approach implied that it was focused on people who have no knowledge of HIV/AIDS. If this was the case, the formula had not focused on the research population as a campaign public, since every interviewee showed a clear understanding of HIV/AIDS and prevention, as was earlier established with the study conducted by the Eastern Cape Youth Commission (2010:18).

The first assumption of the above argument, which suggests that it should be explained to people 'who do not have knowledge of the medical side…', is problematic as various studies have shown that even in very remote areas of South Africa, for example in Lusikisiki in the Transkei, there has been exposure to HIV/AIDS preventative programmes and that research informants understand the basic concepts of HIV/AIDS prevention (Steinberg, 2007:31). However, this study does not focus on rural beliefs, it focuses on the beliefs of students at the IAT and key role-players in HIV/AIDS at the WSU, and they demonstrated a good understanding of HIV/AIDS prevention. It is for this very reason that Peter's imputation, in relation to the research population, is not applicable. A, B, C and D does exactly that - it tells people how to avoid contracting HIV/AIDS. It addresses neither

[86] East London, Potsdam, HIV/AIDS coordinator/nurse, Xhosa,41, Male

localised and contextual beliefs nor social pressures related to abstinence. It also does not address social pressures on recently circumcised males to prove their manhood following acceptance into Xhosa society as a man. The fact that 'be faithful' component seemed not to be viewed as a possibility by student research informants and was infrequently mentioned, is a manifestation of findings of previous sections of this thesis. The issue of condoms has already been addressed and various reasons for not wearing condoms were explored in previous sections and chapters. Once again, it was clear that the ABC approach did not address cultural counter-arguments. However, the research informant had a valid point with the insertion of D into the ABC approach – diagnosis. The majority of the student research informants stated that they preferred not to be tested due to the stigma attached to an HIV positive person. This emerged as a matter that would have to be addressed in preventative strategies for the IAT, discussed in the next chapter.

6.5.2 Responses to 'A': abstinence

Various factors play a role in terms of beliefs about abstinence. Reasons given for not adhering to abstinence included: the need to conform, the need to be accepted as a man and the need to be perceived as 'strong' by male counterparts. Some students supported the idea of abstinence. Some reasoned that condoms are not 100% efficient, and abstinence is therefore the only sure method of HIV avoidance. Others based their reasoning for abstinence on morality and religion.

The reasons given for not adhering to abstinence seem to correlate with Stinson's (2008:4) description of just-circumcised males' perceptions concerning sex, as well as Vincent's suggestion that 'the role of traditional initiation schools has changed from 'the sexual socialisation of young men' to 'the emergence of the idea that initiation gives men the unlimited and unquestionable right of access to sex' (Vincent, 2008:431).

In relation to the proposition of abstinence, many research informants asked whether it is typical for a teenage male in the formative years of sexual maturity to strive for abstinence. The section below questions whether these youths would be any different from the youth in any other parts of the world in terms of sexual behaviour. Why would these youths subscribe to abstinence only? Firstly, some research respondents, at one end of the continuum, advocated that abstinence is the only method of not contracting HIV (example 1), whilst others (example 2) highlighted the fact that they might be stigmatised for it:

Example 1 (IAT students[87]):

> *I think when they do these HIV/AIDS Awareness things they always promote condoms and stuff. I think instead they should rather talk about abstinence rather than promoting condoms especially us students or youngsters or whatever when you say they must not do this thing they will do the opposite. So I personally don't think this giving out condoms and things is a good idea. They should rather talk about abstinence and stuff.*

Example 2 (IAT students[88]):

> *In most cases people are afraid that if I just tell guys that I'm not having sex they will think of me as this, this dumb guy or something.*

The student in example 2 was simply stating that he engaged in 'typical' male behaviour. The need to be 'male' seemed to be of prime importance to him. He was making specific reference to the fear of being stigmatised for not engaging in sexual behaviour amongst his counterparts, in fulfilling the male role as perceived by him in sexual relationships. It should be asked at this stage whether the relevance of Delius and Glaser's (2004:114) comment should be taken into consideration – whether 'a candid recognition and frank discussion about entrenched practises' should not be embarked upon in an approach that questions reasons why students would be stigmatised for adhering to notions of abstinence within prevailing perceptions of male and female gender roles. These perceived gender roles, male and female, have been the focus of Kay and Jackson's (2008:19) book which primarily criticises abstinence-only programs, as advocated by the PEPFAR position. These authors state that abstinence only programs 'often contain harmful and outdated gender stereotypes that cast women as the gatekeepers of aggressive male sexuality', and therefore undermines gender equality. In this light previous statements in the literature and comments made by research informants relating to 'assertiveness training', Kay and Jackson explains how these stereotypes within an abstinence only approach can be harmful:

> This 'hidden curriculum' on gender – teaching men and women 'proper' gender roles as necessary, but unacknowledged, part of teaching abstinence only – portrays women as socially and sexually submissive and strips them of ownership of their own ambitions and desires (Kay and Jackson, 2008:21).

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[87] East London, College Street, Student: IAT, Xhosa, 24, Male

[88] East London, Chiselhurst, Student: 3rd year, ND: Mech Eng, Xhosa, 23, Male

The mere emergence of these ideas about 'assertiveness training' and proposals for practices such as 'men preaching to men', as seen in earlier sections, therefore confirms the existence of gender stereotyping approaches infused within HIV/AIDS prevention efforts, which according to the above authors, are reinforced by approaches that presuppose abstinence. The fact that many of the research informants alluded to the fact that 'abstinence' is the only method of preventing HIV/AIDS, shows that stereotyped gender roles are entrenched. Green (2004:108) suggested that 'community-based schemes that tap into the potential of traditional social arrangements'. The mere fact that the 'A' of the ABC approach does not take into account these local factors suggests that it is insensitive towards Xhosa local conditions, and therefore not suited as a method for HIV/AIDS prevention.

6.5.3 Responses to 'B' and 'C': be faithful and condomise

Mash (2006:51) stated that the ABC approaches' emphasis on faithfulness and 'condomising' 'erroneously assumes that women are in control of sex, can control their partner's faithfulness and can influence the decision to use a condom'. In terms of being faithful as a response to the HIV/AIDS pandemic, opinions expressed by research informants were analysed to determine whether being faithful was considered a plausible solution to the problem:

Example 1 (IAT students[89]):

> *I'm not 100% sure of this. So can I come back to this of wearing a condom but I would have to take this up with my partner because I'm not use to wearing a condom with her and the problem is that before me she use to have sex without a condom and I don't know how many guys she's been with before and how many guys she will be with in the near future.*

Example 2 (Key role players[90]):

> *They accept it because it is something that has been happening all along. You know if a boy has another relationship it is something that you cannot stop; so that is why we have to teach them some skills on how to deal with this problem. How to be honest; how to*

[89] East London, College Street, Student: IAT, Xhosa, 26, Male

[90] East London, College Street, IAT Employee, Xhosa, 24, Female

communicate with one another so as to empower each other about these things, because they contribute a lot with the spread of HIV/AIDS.

It can be seen from the previous two examples how research informants reflected on contested areas of faithfulness in the research population. In the first example, the basis of faithfulness in the relationship is questioned by a student, and in the second, it can be seen how key role players, in recognition of the fact that faithfulness is a great problem, react, and educate students. Individuals were either in favour of, or against, male infidelity for various reasons. The statement, 'you know if a boy has another relationship it is something that you cannot stop', suggested that being involved in multiple sexual relationships was a predetermined matter. Such actions and their meanings are also described by Delius and Glaser (2004:114). Furthermore, in relation to Giddens' (1979:56) concept of agency, the major point of departure here was the idea, amongst some research informants, that some females accepted their fate and had no influence, nor the willingness to try to influence, a male in a relationship having a concurrent relationship with another female. In this manner the applicability of Giddens' theory on agency and power (1984:14) is clear:

> Action depends on the capability of the individual 'to make a difference' to a pre-existing state of affairs or course of events. An agent ceases to be such if he or she loses the capacity 'to make a difference', that is, to exercise some sort of power (Giddens, 1984:14).

One research informants' point of departure was the empowering of women to refuse to accept the status quo and to challenge the sexist reality, which could be seen to have been widely accepted by both males and females. This relates to Giddens' (1984:15) term of 'transformative capacity', which he states is 'logically prior to subjectivity, to the reflexive monitoring of conduct'. The call to educate women to refuse the status quo equates to what Giddens' (1984:16) describes as the dialectic of control, whereby he states that 'all forms of dependence offer some resources whereby those who are subordinate can influence the activities of their superiors'. It would be assumed that within a university environment such as the WSU, the stance that the institution takes towards certain issues, such as the above, becomes one of the 'resource[s] whereby those who are subordinate can affect activities'.

The need to educate people regarding the benefits of having a single partner was the main thrust of many students' reasoning and was reflected in many opinions expressed by research informants who held differing views on faithfulness. A female HIV/AIDS

counsellor supported the notion that there is 'nothing cultural' about the fact that some men have multiple partners, and also alluded to the fact that men are perceived to be 'powerful' (hence, being an actor controlling agency). She[91] stated as follows:

> *…I think it's also that because for males it's a question of they say it's a question of 'chumani'. I don't know how to put it in English, but they say 'chumani' when you only have one girlfriend. It's how do you say it when a guy has many girlfriends? For us, the Xhosas, it's like he is respected for having so many girlfriends. He is like powerful; he's the man. It's something like that. There is nothing cultural about it.*

In terms of her explanation, she referred to yet another phenomenon – men being proud of their sexual prowess and having many girlfriends. Males must clearly have the ability to find at least one girlfriend in order to establish themselves in societal circles. When a sexual connotation is implied, the message conveyed is that a man who has many girlfriends is 'utyebile' or 'fat', meaning that he is prosperous. Many girlfriends, in this context, would imply that the man is in high demand and that many women would be interested in him. Her question, 'how do you say in English?' suggests she believes that all males, irrespective of culture, are awarded some form of respect for having many girlfriends, for being a 'stud'. Hence, it's not 'cultural', it is a problem concerning men – patriarchy and perceptions of gender superiority.

Research informants presented opposing ideas concerning faithfulness and the use of condoms. Some clearly advocated that not being faithful and not using condoms was not a 'cultural' phenomenon; others stated that there is no correlation between these elements and 'culture' and that this behaviour was merely the male behaving in a typical male fashion. As indicated in the previous sections, it was clear that opposing thoughts exist in a changing and fluid 'culture'. Irrespective of the question of whether the behaviour has 'cultural' (in the minds of the research informants) connotations in relation to agency, it was clear that all research informants subscribed to the idea that the element of agency posed a great problem and that male control of decisions that affect social and sexual behaviour needs to be addressed as a matter of urgency, whether it takes the form of 'assertiveness training', or 'men preaching to men'.

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[91] East London, Potsdam, HIV/AIDS counsellor, Xhosa, 44, Female

6.6 Conclusion

It has been stated in the previous data chapter that a health-enabling environment that is sensitive to local constructions needs to be established before considering issues such as HIV/AIDS. Inclusive in this health-enabling environment should be an approach that is sensitive to local constructions of nutrition, as a subset of health-enabling contexts. In relation to consideration of the introduction of concepts related to HIV/AIDS prevention, this chapter takes the position that strong consideration of societal structures and contextual factors need to take place in order for HIV/AIDS messages to be effective. The mere message of 'ABC' is not sufficient to counteract strong social constructions of sexuality, masculinity and patriarchy. As the most significant emerging theme, I need to reiterate the view held by Ragnarsson et al (2010:3402), who stated that 'gender is also an integral part of the analysis as it works in an interwoven theoretical and practical manner and is essential in HIV programme design and prevention efforts.' In relation to the central aims and research question of this thesis, this section attempted to highlight some of the gender issues, an understanding of which would have to be 'interwoven' into an approach for HIV/AIDS prevention at the IAT.

It should be recognised that the term 'cultural constructions' needs to be understood in context, since it was established that, as Masenyama (2004:2) claims, any construction of masculinity should be seen as an individual construction, or even a broader societal construction, using the term 'culture' to explain personal beliefs. Whilst it could be contended that this is not the original intention of circumcision (Vincent, 2008:431) 'its cultural and social meanings have not remained unchanged'. In addressing views considering these issues that are harmful to the sexual rights of females a HIV/AIDS prevention campaign for the IAT would have to address these beliefs either through a 'men preaching to men' approach or in conjunction with a traditional person to which local beliefs are ascribed. Reasoning behind this would be the common belief that it is inappropriate for females to talk about matters concerning initiation. As per Delius and Glaser's (2004:114) recommendation, an understanding of historical teachings have a role to play in the prevention of HIV/AIDS as does an understanding of what the actual beliefs are and an evaluation of modern day interpretations.

In this approach myths such as 'isiqwati' would have to be addressed. From the male point of view, they would have to recognise that females with low self-esteem (for whatever reason) must be treated with special sensitivity and not be abused for their constructions of

respect, and in the same manner females would, as alluded to by numerous HIV/AIDS counsellors at the WSU, undergo 'assertiveness training'. The strongest emerging theme regarding structural gender-based relationships and the perceived causes of HIV/AIDS is the notion of infidelity. Addressing false understandings about polygamy can only take place by reverting to the reasoning that multi-partner sex increases the risk of contracting HIV. In line with Delius and Glaser's (2004:114) understanding, the 'strengths' of past practices need to be drawn upon. With regards to violence in relationships and its connotations with sexual control, the origins of the violence, suggested by some to be related to the oppression associated with apartheid (e.g. Moffet, 2006:3, Baradaran, 2000:46), strengthens the notion that local factors need to be controlled in order to address issues surrounding HIV/AIDS. The amount of social upheaval in this instance, specifically for IAT students, for whatever reason (i.e. numerous student and staff strikes during the course of the research period) all contribute to suppressed anger which may or may not manifest itself in relationships. This could ultimately affect agency, social power and control exerted within sexual relationships and ultimately affect HIV/AIDS prevalence. These contextual factors would have to be controlled and carefully monitored whilst providing IAT students with effective means to release such existing tensions, albeit through something as simple as providing access to basic health facilities.

Suggestions of violence, therefore, needs to be addressed and the promotion of a harmonious and peaceful environment must take precedence. The section on agency proved of particular significance for this chapter since it provided some guidance as it demonstrated some effective measures on how male and female prevention ideas should be crafted and communicated to the students of the IAT. The need to empower from a female point of view and the notion of men preaching to men 'because of their capacity to control the sexual act men still largely have a significant impact on the spreading or combating of HIV/AIDS, thus giving them the opportunity of changing the course of the epidemic' (Masenyama, 2004:1). The IAT would therefore have to look at designing an approach that, does not only look at all students collectively, but also separates HIV/AIDS programmes for males and females with entirely different goals and aims.

Perceptions on the notion of the ABC approach seem largely heterogeneous. Therefore, whether or not the ABC approach is advocated, at least, it should be informed by a greater awareness of local factors which will necessarily affect how campaign messages are received. Contextual alternatives to, for instance, abstinence, need to be included within the mode of delivery of the message, and could for instance include discussions on cultural

matters of the past whereby abstinence was managed and obtained. In this way it would be culturally sensitive. The B component has correlations with infidelity, but again, as pointed out by Delius and Glaser (2004:114), thus needs to brought in relation to history. Ultimately, all of these findings in the two previous data chapters have to be consolidated into a chapter that looks at an approach for the IAT in HIV/AIDS prevention that could be useful to WSU HIV/AIDS policymakers.

7: Key findings: Cultural, peer-driven social debate programs

7.1 Introduction

Overall, this chapter will address the main research question and ask how key role-players in HIV/AIDS at the WSU and students from the IAT conceptualise the term 'culture', and how this conceptualisation draws from local beliefs in ways that may affect their perceptions regarding HIV/AIDS, as well as related issues such as nutrition, gender and the ABC campaign. The chapter will thus ask: what are the implications of these findings for HIV/AIDS prevention.

The first section of the chapter addresses key findings from previous chapters. The key findings it will focus upon are that:

(1) Research informants demonstrated their own personal and heterogeneous constructs of beliefs in relation to cultural practices that might lead to the contraction of HIV/AIDS. Respondents described situations where the term 'culture' were challenged, especially where imagined conceptualisations of the term 'culture' were used to defend certain behaviours. This however also demonstrated the existence of social space for debate and reflection about what constitutes 'culture', and what not.

(2) That this data provides proof of reflection in contested areas, so that encouragement of community leaders to lead debate programmes for themselves could take place, and also act as strategy for HIV/AIDS prevention. Based on this, such a strategy would utilise the fact that issues need to be socially debated (hence the term, social debate programmes) and that this process needs to be led by those directly involved (hence, peer-driven). Therefore, secondly, based on the above, the chapter argues for the implementation of peer-driven social debate programs.

The third section of the chapter makes pertinent recommendations to the key role players in HIV/AIDS at WSU, based on the findings outlined above. These recommendations specifically fall outside the ambit of the IAT, and attempts to look at an approach that could be utilised University-wide. The fourth section of the chapter reflects back on the theoretical analysis of Giddens and discusses the findings against his theory of unintended consequences of action. The section demonstrates how various elements, including the

double hermeneutic, conceptions of agency and structure, as well as unintended consequences of action, manifested themselves in communication from research informants. Finally, this section demonstrates how these constructions have an influence on the HIV/AIDS prevalence rate.

7.2 Key findings

The key findings section of this chapter will first argue that research informants demonstrated their own personal heterogeneous constructs of beliefs in relation to cultural prescriptions pertaining to behaviour that might lead to the contraction of HIV/AIDS. The second section will argue that this data provides proof of reflection in contested areas, so that encouragement of peer leaders to lead debate programmes for themselves could take place, and also act as strategy for HIV/AIDS prevention. Based on this, such a strategy would utilise the fact that issues need to be socially debated (hence the term, social debate programmes) that this process needs to be led by those directly involved (hence, peer-driven).

7.2.1 Heterogeneous constructs of beliefs in relation to cultural prescriptions

The term 'in my culture' was used frequently by my research informants but often in a way that led to critical questions about the practices that were being discussed:

Example 1 (Key role players)[92]:

> *You know men are cheating. The problem is that in my culture we say that you need to have two legs to stand on. You cannot stand with one leg…you need two… one woman is not enough stand on, but the two legs are better….it creates a lot of problems, transmission and fuelling the spread of HIV/AIDS...*

Example 2 (IAT students)[93]:

> *I'll be talking about my culture to my group because I trust them. I trust my group I'd be open enough to see how we do things. This is how we can tackle that side of my culture, the Xhosa culture[94].*

[92] East London, College Street, Health Promoter, Xhosa, 41, Female

[93] East London, Chiselhurst, Student: 3rd year, ND: Mech Eng, Xhosa, 23, Male

Exactly what is meant by the use of the term 'in my culture' by a female health promoter (example 1) in this context is unclear. Does it represent common belief or is it just another HIV/AIDS myth? This difficulty comes about because for the reason that research informants offered entirely heterogeneous comments related to multiple partners. The impression could be gained that the informant is stating that infidelity is a 'cultural' phenomenon, whereas it might not be so. In this way, a male member of the institutional HIV/AIDS Committee stated that infidelity is a cultural phenomenon: 'no, it's not acceptable. But because of the cultural influence people do it'. Another male, upon being questioned about the morality of infidelity, stated 'no, that is not right'. From this it can be seen that culture is contested; claims about 'my culture' may imply that there is some fixed standard or practice that is defined as 'belonging to us', but in practice what we see is that such standards are always being negotiated and argued over. In the second example, an IAT student explained how he would go about HIV/AIDS prevention. It was important for him to ensure that he communicates to people 'of my culture', because he trusts 'people of my culture' and the fact that, behaviourally, he would understand traditions and customs 'in his culture', albeit with different variations. The mere fact that the term 'in my culture' is frequently used, does not refer to uniformity and neither does it refer to a simple subscription to local beliefs. To the contrary, research informants clearly contradicted one another all using the term 'in my culture' to justify their claims.

An analysis of the term 'in my culture' in a Foucauldian discourse analysis of 'sexually active Xhosa youth' (Wilbraham, 2008:100) revealed that use of the term is to justify a 'position of stasis and mobility'. In these group discussions it was revealed that 'the carriers, the brokers of authentic culture' were juxtaposed against the 'reflexive adoption of culture-positions [which] also afforded well-educated, professional, black, Xhosa-speaking discussants the right to speak against their traditional-culture backgrounds, and so the right to problematise and distance themselves from such practices' (Wilbraham, 2008:101). In this manner it was seen how the juxtaposed positions provided evidence of fluidity in 'the culture'. The term 'in my culture' was used in this study both for and against practices that were being discussed. My own findings are very similar, as with the Wilbraham study, for there was evidence of both distancing from 'cultural' practices whilst other respondents claimed to 'subscribe' to these practices.

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[94] c.f. Tenge (2006:5), where a research informant insists on slaughtering a sheep and not visiting a hospital before circumcision, because it is part of 'my culture'.

So, as discussed in the data chapters, there were many examples from respondents making reference to an imagined culture. All of the research informants justified the notion of respect towards 'cultural' practices, whilst only 10 % (four research informants) validated the use of violence to gain respect. Whilst some of these beliefs, such as ritual passage and the notion of respect, seemed to be shared, some of the associated interpretations with ritual passage such as 'isiqwati', and the concept of respect as validation for violence, appeared diverse and heterogeneous.

Differences between the two groups within the research design, regarding personal and subscription/non-subscription to cultural beliefs, could therefore only be described as heterogeneous, with very little patterned difference between the responses from key role players and students. Whilst it could be hypothesised that it would be expected that the older group, the key role players in HIV/AIDS, would be more likely to subscribe to conceptions of local knowledge, this was not the case in relation to any of the contextual factors that emerged.

Whilst it could be expected that, on issues such as gender violence and infidelity, females would have a different views to males, it should be remembered that females interviewed were mostly HIV/AIDS awareness campaigners and therefore from a background which could bias any data. There is also the reminder from research informants, both male and female, that 'women are submissive and need assertiveness training'. The question is whether the students' social community is applying pressure on students to see the benefits of adhering to certain behavioural standards. This would include hearing from HIV positive students about their interpretations of issues such as the dangers that engaging in risky sexual behaviours pose to their health.

7.2.2 Critical reflections: creating social spaces for debate

This section examines the views of the students pertaining to the key role players' efforts in HIV/AIDS, and compares it to the views expressed by the key role players relating to their own performance pertaining to HIV/AIDS prevention.

Example 1 (Key role players)[95]:

> *They should conduct HIV/AIDS workshops. They should have HIV/AIDS peer helpers that they counsel. I would love it if they would consult outside people to come and conduct tests so that each and every person knows their status. It is beneficial to know your status from the beginning, so that if you have to go for ARV's you do not do it too late, when the virus has gone too far. One of the main problems is that most of the people do not know their status. They do not go for testing, but if they can conduct a free test in the institution it would make a difference.*

Example 2 (IAT students)[96]:

> *But actually there is a bit of education from the WSU, they also told us, when doing the orientation, they were trying to tell us what the activities were and how to get involved. But it wasn't comfortable. They explained what's happening at that peer group. So actually they caused problems and situations for students because students didn't want to go there. So they explained it and they said it's a matter of choice, and if you don't want to get it you can come to the group and listen what's going on.*

The pattern of responses from research informants revealed that these were significant contested areas, thereby creating social spaces for debate. Three quarter of the responses from students regarding the impact of WSU intervention campaigns contained negative connotations, whilst half of key role players also made negative comments about the institutions existing attempts to address the HIV/AIDS prevalence rate.

The first example contains the views of a student who is also an employee and key role player. This research informant made several references to WSU intervention efforts by stating that 'it [is] not working'. A senior person in the WSU HIV/AIDS Committee, whilst recognising that the WSU was still a new institution at the time, positively mentioned elements such as the fortified milk project, joint projects with the provincial Department of Health and voluntary counselling and testing (VCT) clinics. In addition to this, a senior HIV/AIDS counsellor also mentioned peer education programmes, HIV/AIDS workshops, and student counselling. In contrast to this, three quarter of the students interviewed mentioned that they were not aware of most of the initiatives.

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[95] East London, College Street, IAT Employee, Xhosa, 24, Female

[96] East London, College Street, Student: IAT, Xhosa, 28, Male

From the second example the impression is gained that indeed some activities are happening on campuses but that many students are not aware of these activities and that a feeling of discomfort is created when the disease is mentioned due to its associations with stigma. Students would not necessarily take notice of things that do not concern them, especially in cases where stigmatisation occurs. However, sixteen out of the twenty IAT students interviewed indicated that they were not aware of HIV/AIDS activities on campus, which is an indication that the communication effort is not successful. One could reasonably expect that, in addition to the existing clinics on campuses, many information posters and pamphlets would be made available, whilst student HIV/AIDS information drives would be held on a regular basis to allow students to have knowledge of the current activities on campuses.

Overall, it was clear that students presented a more negative view of HIV/AIDS prevention efforts than the key role players did and that in many cases students also stated that they were not aware of the activities of the HIV/AIDS unit. In terms of creating a conducive environment where students can interact concerning HIV/AIDS messages, HIV/AIDS workers need to be more sensitive towards student needs and also need to pay special attention to issues such as stigmatisation. This would have to include examining issues such as the physical location of clinics on campuses, making it hard for them to access because it is too public, and causes embarrassment. Ensuring that clinics are more discreetly located would partially address this problem. Bandura (1990:12) recognised the fact that students' exposure to HIV/AIDS programmes do not culminate in 'safer sex practises' and argued that 'social diffusion' is required to bring about change. By 'social diffusion' he was referring to 'a network of social influences' (Bandura, 1990:15), without which peer engagement in a context of social debate could not be effective against the spread of HIV/AIDS.

Therefore, partially, these two examples could be related to the fact that indeed, information distribution has occurred, but that social debate programmes culminating in persuasive action has not occurred but indeed that the social space required for debate has been established, and needs to be utilised by such programmes. Whilst general comments surrounding the ABC approach were examined in the latter part of Chapter 6, the question remains whether, in the views of the students of the IAT, it would bring about a behaviour change that would result in the prevention of HIV/AIDS. As indicated in the literature review, the majority of criticisms in the wider public domain, as well as those from research informants surrounding the ABC approach concerned condoms – stating that it

promotes promiscuity, and that, if one had already ignored the 'A' and the 'B', bypassing the C is not too difficult. Students generally expressed the view that the ABC programme would not bring about behaviour change, and showed how condom use sometimes does not occur:

Example 1 (IAT students)[97]:

Handing out condoms? Ummm if you are handing out condoms at the bars and shebeens and high schools then you are actually promoting that people should have sex and then after that once they've had sex with condoms that's why I said it earlier they will then after a while go onto having sex without using condoms.

Example 2 (IAT students)[98]:

Because this thing of sex sometimes it just happens and one is not always wise and gets to use a condom. Even with me it just happened and you wake up the next morning and you realize that you did this thing without using a condom. Sometimes you don't condomise.

The student here argues that students do not abstain because they are curious, and when mixed with alcohol, this curiosity may lead to a loss of inhibitions making the abstinence part of the message unattainable. They also explained that during the formative teenage years one would not be faithful to one partner since this was a thing that was 'reserved for married people'. Taking into consideration that they also refuted the possibility of condomising, there are not many options left. This brings us to the fact that the ABC approach is viewed as mere *campaign content*, calling for unique *modes of delivery* (Vincent, 2010:21). The concern here is that the campaign content itself was mostly criticised for being unattainable, irrespective of the chosen mode of delivery. The nature of the criticism of the key role players in HIV/AIDS management were also about the 'C' part of the message, as expressed by the following examples:

Example 1 (Key role players)[99]:

So I've been unenthusiastic about the way programmes were in the past where everything was use a condom, use a condom, use a condom. Every time you say that you are saying I'm expecting you to have sex and so you are giving a message to people who may not be

[97] East London, College Street, Student: IAT, Xhosa, 24, Male

[98] East London, Chiselhurst, Student:3rd year, ND: Mech Eng, Xhosa,22, Male

[99] East London, Potsdam, Psychologist – Student Councillor, Xhosa, 41, Female

sexually active that this is something that everybody else does and because they are at an age where they are trying to be like everyone else you are actually promoting the very thing that is harmful you know.

Example 2 (Key role players)[100]:

Since they don't believe in the condom the only campaign that we have to use is to teach them how important it is to use the condom. Not to say that they must quit from having sex because that is just not going to work.

Whilst some of the key role players were advocating the A and the B of the ABC approach only as a suitable alternative, the majority agreed that the attainability of the message presents major challenges. What they all seemed to have agreed on, was that exposure of students to the HIV/AIDS prevention message was the big challenge and that the information should be localised, and made relevant to the local community. All the key role players made references to occurrences of some of the questionable behaviours that are said to occur that have been explored in previous chapters associated with myths, gender violence, and personal masculine identity manifestations, all highly contested areas of discussion. It would appear that addressing these contested areas is of greater significance in this study than the mere message of the ABC approach, and that a mode of delivery that fosters social debate about contested issues is required for the prevention of HIV/AIDS. Criticising the ABC approach in an analysis of gender in the South African context, Mitchell and Smith (2001:57) argued as follows:

> The Abstinence 'A' first of all suggests that young women necessarily have a choice about whether to abstain or not. While we know of no reliable data that would give a definitive reading on the absolute amount of consensual sex involving adolescent girls, what we do see is that the high rate of gender-based violence in schools, the incidence of gang rapes, the reports of male teachers who force girls to have sex, the issues of poverty and transactional sex in exchange for needs and wants…
>
> Likewise, the Be Faithful 'B' of the campaign suggests that girls have some say in controlling how many partners both they and their sexual partners, in turn, might have. As recent interviews with a group of young men working in a peer education HIV/AIDS prevention program suggests, it is far more likely that it is young men, rather than girls, who have as many as four or five sexual partners. Again, while there is little reliable data to suggest how many partners anyone-young men or young women have-we would conjecture that young women are

[100] Mthatha, NMD, Health Promoter, Xhosa, 32,Female

> likely to have less say about the implications of the faithfulness, or lack of it of their partners, and are hardly in a position to 'negotiate' this…
>
> Finally, the 'C' for Condomise brings with it a variety of issues that almost always place girls in a position of weakness. For example, if they insist that their male partners use a condom they run the risk of having this interpreted as 'you don't trust me.' They also run the risk of being beaten up. If they carry condoms themselves, they may be treated as sluts- 'good girls don't carry condoms' (extracts from Mitchell and Smith, 2001:57-58).

It has been seen from responses from research informants on the ABC approach, as well as from existing research of this kind, that it isn't working because it's not sufficiently sensitive to local context. These areas include a lack of engagement with local beliefs and practises. Based on the fact that it was proven within the first part of this section that local beliefs are areas of contestation as well, it is clear that the approach fails to address contested areas regarding sexual behaviour locally. This shows that a void exists, and needs to be filled, which could be done by supporting local debate strategies concerning sexual behaviour and contested areas, such as cultural prescriptions and beliefs.

The above sections have demonstrated that:

(1) Social spaces for debate on critical issues affecting HIV/AIDS proliferation has 'opened up', clearly due to the fact that beliefs pertaining to culture and sexuality are not fixed but are rather highly contested,
(2) That critical reflection on what is occurring has taken place by research informants, requesting a need for a different approach, which includes peer discussion through debate on social issues affecting HIV/AIDS prevalence, while
(3) The current content of delivery 'the ABC approach' is deemed ineffective, and, according to key role players, could easily be replaced by a approach sensitive to local norms and beliefs.

7.3 Peer driven, social debate programmes: a multi-step approach

This section argues for the implementation of peer-driven social debate programs. These peer driven social debate programs are based on four key recommendations, which are discussed below: (1) the establishment of a health-enabling infrastructure, (2) the introduction of social debate programmes (of which the topics 'cultural beliefs' and 'gender' emerged as key areas for debate), (3) peer-driven, based on the above-mentioned

existing space for debate, and (4) promoting local normative beliefs rooted in cultural practises, which was a strong topic recommended by key role players.

7.3.1 A health-enabling infrastructure

The various steps proposed for the creation of a health- enabling environment within this study, utilising some of Campbell et al.'s (2007:347) guidelines. In relation to this thesis, a health–enabling environment would be one that provides, first of all, the necessary physical infrastructure for students to provide them with the ability to ensure that they live a healthy lifestyle. Components of this would include ensuring that all students receive proper nutrition which is also sensitive to cultural beliefs. In relation to staff, a student residence supervisor was most critical with regards to the provision of an adequate number of staff members working on HIV/AIDS programmes:

Example 1 (Key role players)[101]:

> *Ja, that's it, but you see this is not happening at the moment. There must be people who are doing implementation of these programmes on the ground which is not happening at the present moment. We cannot rely on Peer Educators alone there must be staff that are driving these programmes together with them. There is only one HIV/AIDS Coordinator amongst 7000 Buffalo City Campus students. That's not going to work.*

This above description seems to summarise the nature of the problem. It has been established in Chapter 5 that the WSU has many strategies in place to address the HIV/AIDS problem, including some of the best policy documents and the necessary committee structures as expected by HEAIDS as the body that oversees HIV/AIDS implementation programmes at South African universities. Some of these strategies also take the position that the promotion of overall health and proper nutrition should be addressed as part of a HIV/AIDS programme, a position that is supported by this thesis.

However, the problem, as highlighted above, is related to sheer capacity in relation to student numbers, and therefore the adequacy of the facilities provided. Whilst it should be acknowledged that the WSU has done a lot to encourage a presence in the form of an office/clinic at every campus, the ability of these clinics to deal with these problems at the scale required is hugely limited. Support staff members from all three of the major clinics

[101] East London, Potsdam, Residence Officer, Xhosa, 48, Male

(Mthatha, Butterworth and Potsdam) were interviewed and it was stated that these clinics do not provide ARVs and specialised medical care. A HIV/AIDS worker in Butterworth stated that the provision in the clinics does not extend any further than providing 'immuno boosters' and 'Panado's' and the provision of support groups for students that are HIV positive. There were also occasional HIV/AIDS awareness days and addresses to students about HIV/AIDS at selected opportunities.

Given the fact that the WSU boasts a medical faculty with a training hospital in Mthatha, the question needs to be asked whether the medical school does not have the ability to extend its operations outside the hospital to the clinics in the various campuses, budget allowing. The faculty consists of three schools (Allied Health Professions, Medicine and Nursing) and even includes a regional HIV/AIDS Training Centre (WSU Faculty of Health Sciences Prospectus, 2011:12). The spread of involvement in regional initiatives is impressive, and it should be noted that the faculty are also involved in numerous HIV/AIDS community programmes. However, this does not seem to include the provision of sufficient health services to students on the various campuses.

Whilst the preceding text has looked at the problem from an institutional perspective, it should be remembered that this discussion focuses on the IAT based in Chiselhurst. In order for the IAT to be effective in establishing a health - enabling environment the unit should promote healthy living, proper nutrition and a health enabling infrastructure. The IAT, being a small unit, should find this attainable, but first consider the following two recommendations:

- The upgrading of the clinic facilities at the Chiselhurst campus. It would seem wholly unfair to upgrade facilities for just the IAT at Chiselhurst without extending the same to other students based at the campus. The campus in 2011 serviced 2000 students.
- The promotion of a health-enabling environment for students at the IAT. Students must be encouraged to partake in sport initiatives, whilst proper nutrition must also be encouraged in an appropriate way. Nutritional needs can be addressed through the establishment of a dedicated kitchen for the IAT that provides healthy meals for students on a daily basis. This should be done hand-in-hand with a communication and awareness programme that supports healthy living and proper nutrition.

7.3.2 Peer – oriented social debate programmes

Social environments where a high level of heterogeneity prevail, are referred to as 'contested environments' by Campbell et al. (2005), who examined 'social contexts' and showed how successful intervention strategies with young people in Ekhutuleni (Kwa-Zulu Natal, South Africa) took place. The level of contestation included some youth displaying (sexual) bravado with 'fatalistic notions' and complaining about 'information overload' (e.g. 'tell us something new') (Campbell et al, 2005). The tactic of encouraging social debate was mooted by these authors and a mode of peer education programmes was suggested by them: 'what makes peer intervention campaigns attractive as a method of message delivery, is the fact that it takes society into account whilst addressing the problem' (Pearlman et al, 2002:38).

Peer oriented social debate programmes would include the use of local sangomas and health professionals (as suggested by Wreford, 2009:1), in a program led by peer leaders. The term 'social debate programmes' are used here in the light of Campbell et al's (2007:347) discussion of the six key steps to creating a 'health-enabling environment' with specific reference to the step 'creating social spaces for dialogue and critical thinking'. Below, I highlight the key elements that need to be discussed, utilising social debate programmes, and explain the relevance of such an approach in relation to the findings of this thesis. The importance of allowing for such debate is based on the following two principles, as highlighted by Campbell (2001:188):

> Drawing on the social psychological concepts of social identity and perceived self efficacy/empowerment, participatory health promotion programmes succeed to the extent to which they facilitate these two inter-locking processes. Firstly they succeed to the extent to which they facilitate opportunities for people to make collective decisions to change their behaviour in negotiation with liked and trusted peers. Health related behaviour is shaped by collectively negotiated social identities, rather than by factual information about health risks as traditional health education programmes assumed (Stockdale, 1995). Secondly they succeed to the extent that they increase the sense of perceived self efficacy and confidence (or 'empowerment') experienced by target group members. This occurs as the result of peoples' participation in programme planning and implementation – given that people are most likely to take control of their health if they feel they are in control of other aspects of their lives (Bandura, 1990).

Key areas for debate in social debate programmes, that emerged from this thesis, were around understandings of the term 'culture', and beliefs labelled 'cultural', which might relate to sexual behaviour. The second key area for debate that emerged from this thesis,

and clearly linked to the first, were beliefs related to gender. A social debate programme for this context would therefore first have to establish what culture constitutes, and secondly address beliefs related to personal and social constructions of gender and agency.

7.3.2.1 Beliefs labelled 'cultural'

What emerged as one the most significant findings was the frequency and use of the term 'in our culture' to explain various beliefs surrounding constructions of HIV/AIDS beliefs, even though various research informants had very different beliefs on the same issue. This was also done against a backdrop of comments such as – 'they do it' – which served to distance the speaker from the beliefs which were being explained. Furthermore, various constructions of the word 'respect' emerged that seemed to have an influence on the construction of sexual agency, extending to women's perceived 'duty' to be submissive. This thesis argues that the simplicity of the ABC approach is not sufficient to counteract the complex social constructions surrounding HIV/AIDS. Addressing these social factors should be carried out against an understanding of students' constructions of sex, agency and socially acceptable behaviour. The difficulty with addressing these 'cultural' beliefs is that anything could emerge as a topic that has sexual connotation and has different interpretations in cultural, family and even individual representations. Thornton (2003:18) explains that these sexual meanings even differ 'within families'. The challenge of what constitutes 'cultural' and 'non-cultural' beliefs surrounding sexuality and the constructions thereof need to be debated and a social stance needs to be taken by the students themselves. Its relationship to the spreading of HIV/AIDS needs to be established. What is important here is that the research reveals existing fluidity and discussion as to what is culturally appropriate or acceptable, and it is that space for debate that these programmes might seek to support.

Since an 'imaginary' may exist between what may be discussed between males and females, it would be advised that a social debate prevention programme would first discuss the issues with the different genders separately, followed by an integrated approach whereby both genders interact to consider the outcomes of their discussions. Whilst it is, and will remain, difficult to predict what these discussions might bring forth, the design of the programme might take into consideration the following suggestions:

- Ensure that both a medical health practitioner and a traditional medicine agent lead the sessions so that this would result in a mutual debate/discussion.

- Focus on talking through cultural beliefs and constructions of the term ‘respect’ that have effects on sexual practises that would affect HIV/AIDS transmission.
- Ensure that the discussion addresses agency issues in the promotion of an equal rights atmosphere whereby males and females have equal rights in the sexual decision-making process.

7.3.2.2 Beliefs surrounding gender

In addressing gender issues, various social debates have emerged that surround two stages of belief formation relating to gender that may precipitate HIV/AIDS transmission: beliefs surrounding rites of passage and perceptions about masculinity. Both bio-medical practitioners and traditional healthcare practitioners should host debating sessions that focus on beliefs surrounding rites of passage and dominant conceptions of masculinity. Vincent’s (2008:433) finding that ‘the role of traditional circumcision schools has changed from the sexual socialisation of young men to the emergence of the idea that initiation gives men the unlimited and unquestionable right of access to sex’ seems to point to a significant, contentious issue and therefore needs special attention. Other topics for debate, as recognised from the data, includes identity constructions of ‘exaggerated masculinity’, as by-products of initiation, as well as specific practices such as ‘isiqwati’.

Based on the above, it can be stated that the position of males’ perceptions surrounding female sexual agency following initiation needs to be addressed. It would have to further address issues such as assertiveness (for females), understanding a female’s point of view (for males) and issues surrounding safe sex and gender constructions in relation to construction of initiation beliefs. There had been had correlations with the literature, specifically to Van der Riet’s (2009:209) finding that ‘there is a fundamental ambivalence in the female’s desire to use a condom’. This ambivalence could be ascribed to the construction of the term ‘respect’, which was described by 80% of males in this study as indicating that ‘they [women] are submissive’. These need to be addressed against modern beliefs and practices.

Gender violence has to be addressed also. The various strategies suggested within the thesis concerning the reasoning around ‘men preaching to men’, due to the fact that men would not accept messages communicated by females, need to be considered for implementation since these strategies seem to be successful and may also overcome bias that may exist before implementation of the programme.

7.3.3 Alternative message-content approaches: normative beliefs

In this thesis various references to normative behavioural approaches have been recognised, including value-laden awareness programmes such as those proposed by Herbst and Janssen (2011:53). Their suggestion is that norms and value systems, in conjunction with other approaches, could serve as a departure point for programmes that foster social debate. A number of Wreford's research informants referred to the erosion of normative values, which have contributed to the rise of STDs and HIV/AIDS:

> The opportunities for expression of sexuality, especially for women and girls, in contemporary South Africa can be profoundly shocking to those, like my teacher, who were brought up in more sedate times. Indeed, several of my *amagqirha* colleagues, women mostly in their early forties, who were all born in the Eastern Cape, although they accept that there have been some positive benefits for women in this liberality, also express great concern over modern morality. Importantly, several of them link this with the rising incidence of STIs and the appearance of HIV/AIDS (Wreford, 2005:70).

Similarly, research informants in this study stated that education about HIV/AIDS should include discussions surrounding normative behaviour. Intervention programmes that utilises social norms as its base, refers to the following:

> Intervention approaches are proposed that target networks and behavioural settings and provide participants with socially meaningful and rewarding behavioural options that are consistent with valued prosocial identities or roles (Latkin and Knowlton, 2005:S102).

Various research informants in this study commented on the lack of social norms displayed by society as a general cause for the proliferation of HIV/AIDS. The result of the analysis was that individuals either subscribed to traditional values that allowed for normative and respectful behaviour that prevents the spreading of HIV/AIDS or, contestation of traditional behaviour in such a manner that it promotes behaviour that prevents the spread of HIV/AIDS not characteristic of traditional behaviour.

Various target audiences can be identified and acceptable values, i.e. 'socially meaningful and rewarding behavioural options that are consistent with valued pro-social identities or roles' (Latkin and Knowlton, 2005:S102) could be communicated through existing social networks. The process of establishing what Cobb, Gresalfi and Hodge (2011:4) described

as a 'normative identity' becomes important through the 'collective or communal construct, rather than (the) … individualistic notion.'

The argument that emerges is that HIV/AIDS prevention requires an individual to accept certain norms of behaviour and that all members of society subscribe to the same behavioural norms to achieve the common goal of prevention. This may result in a system where all opinion leaders attempt to achieve these normative social values. Research informants, supporting this notion, all made some reference to the way in which the youth are educated, and in some cases, also showed how 'the self' emerges, in relation to other hegemonic power structures. In relation to norms, the following comments were made by key role players and IAT students:

Example 1 (Key role players)[102]:

I think the issue of condoms is the resource that we resort to because relevant to the day people miss the basics at home; that if at home they have good moral standards we won't have to talk about condoms. Because you would come to me and say whatever you want to say to me and I will be able to stand my ground and say that I am not ready for whatever. When I am ready I will start. But because now you are under pressure from your age group, forgetting who you really are and where you come from. Looking around, you see students that are HIV positive and you find that they are from families that are really suffering. But for them to be comforted, they have to find love from other methods. So there are a lot of issues involved. When you talk of morals and values, you also talk about respect and love. I was just talking to someone yesterday about the problem, being we do not get love from where we are supposed to get love. Love is something you get from home.

Example 2 (Key role players)[103]:

My personal beliefs in HIV/AIDS are one, in terms of my beliefs are a question of your principles as a person. Principles and values. It all revolves around principles and value systems. If you look around you HIV/AIDS everyday is killing people. Every day 10 or more people are being infected with the virus. It says that at the end of the day you can look at yourself and say that you are proud of yourself and who you are. If we can go back and look at issues of beliefs I think it all stems from that.

[102] East London, Potsdam, Psychologist – Student Councillor, Xhosa, 41, Female

[103] Butterworth, Ibika, HIV/AIDS co-coordinator, Xhosa, 46, Female

In example 1, the crux of her statement points to the upbringing and schooling of the individual which determines perceptions and beliefs. She referred to the fact that a person with good moral standards cannot easily be convinced to engage in risky sexual behaviour. She's arguing that normative morality in the culture would include a respectful attitude to sex, and that many of the problems around AIDS thus stem from the extent to which many families are 'suffering' from poverty etc. In other words, the problem is precisely not culture, but context. There is an issue here with her view, of course, as with that of the student below, which is that it throws the onus back on young women to be the guardians of their own chastity.

She continued to refer to another social group (the youth), influenced by custodians of morality. The use of a condom then becomes a safe second alternative, although it can be seen that this specific research informant opposed this based on morality. The argument therefore becomes a significantly negotiated alternative, which is representative of the beliefs of the youth, as opposed to the moral sensibilities by the parents. These contested identities clearly emerge and therefore the need for different target markets receiving differing messages via communication and awareness campaigns is clear. She equates oppositional love with 'a man from the streets' as not being the type of love that a young teenager should aspire to.

Love could therefore only come from a man who has gone through formal channels of engagement—in this case someone who has been through some of the rituals described in earlier chapters (such as initiation), with resultant gendered perceptions of expected behaviour. Again, it could be seen how yet another form of opposition emerged: the wife who believes in modern agency and the right to be heard about safe sexual behaviour and practices. In example 2, the student relates norms and value systems to not becoming HIV positive. By 'being proud of yourself' she is referring to traditional 'Xhosa' values, such as marrying as a virgin (abstinence and faithfulness), not being promiscuous and avoiding risky sexual behaviour. As per example 1, the same key role player continues to explain what normative behaviour entails, by making reference to what is expected of a young female by a father:

Ja, I think abstinence goes with various systems. It goes with your morals and values. When we grew, up my father would say, you cannot touch my cows - because they were considered lobola for the father. So immediately if you allow a man to touch you that

means that you have disrespected your father. But now there is no such thing and there is a lot that people are exposed to; and also us are very lax and we are to so busy working and don't have time for this. There is really a lot that contributes towards whatever is happening.

She explained that this is the manner in which things were done in the past. But things are different now, as revealed by various interviewees. The current system more commonly allows for a cash payment to be made, rather than payment in cows; and her reference to this indicates that the culture is in a state of flux. The major change is that daughters no longer respect their fathers as they allow men to 'touch'. This loss of chastity has an effect on future income for the father. When she refers to lax norms, she is questioning current moral values and is stating that there has been a relaxation of the stricter behavioural practices of the past.

She also refers to the phenomenon being complicated, with the complexity of issues making it difficult to obtain a clear picture and to make substantive conclusions about the topic. She is aware of the fact that levels of contestation have complicated belief systems about HIV/AIDS and alludes to a change in beliefs from the old to the new. She indicates how belief in the old ways could have promoted abstinence and expresses disenchantment with the new, more relaxed modern beliefs about sexuality.

Another health worker who focussed on the importance of instilling a normative belief system at a young age stated as follows:

Example 1 (Key role players)[104]:

If it was done in a correct way, or in such a way that they have grown up from Sub A knowing that they have to do this, it becomes the norm to their community and that they are not just doing it because of the major spread of HIV/AIDS. If I'm 13 years old, and you are telling me to go for a virginity test at that stage, I am starting to become an adolescent - and that's where I am starting to want to taste life. And to me that is too late. They should start this thing from the age of 5; and a child grows up knowing that it is in her culture. And that's what I have to grow through. The child will then go through this willingly, not just changing a child after 13 years; that child has been around talking to other teens about sex, so it's too late.

For her the correct way of educating people about HIV/AIDS is establishing normative, well-established sexual behaviour at a young age. This will then have an influence in the later years, ensuring the youth make the right decisions about risky sexual behaviour. This also alludes to many facets of the belief system that influence the thinking of present day youth. She admits that introducing intervention strategies to a thirteen-year-old is too late and refers to teenagers having a 'need to taste life'. This becomes a form of recognition that abstinence is indeed a difficult life goal to achieve and that within the modern sphere of education about HIV/AIDS there should be some recognition that cultural beliefs are changing and that alternative behaviours do exist, albeit in a negotiated position. In this manner the youth become accustomed to elements of norms being a negotiated truth and that contested identities are a way of life rather than a cultural change that needs to be brought about by one specific generation.

7.4 Key Role players: Local factors and peer education programs

The above sections demonstrated some of the considerations that are relevant to the design of HIV/AIDS prevention programmes at the IAT. However, the section merely supports the notion of utilising awareness programmes that support social debate that would allow for the establishment of a normative structure amongst recipients of such communication efforts. However, the very nature of the various intervention approaches that could be utilised at higher education institutions in South Africa means that some of these approaches would be more appropriate than others. The focus would be on approaches that allow for social debate within highly heterogeneous-belief environments, as opposed to approaches that assume a homogeneous audience. We can thus see that messages such as 'condomise' could be unsuccessful, whereas approaches that propose cultural debate which explore the use of condoms might be more appropriate. Campbell (1997:274) investigated perceptions of migrant mineworkers in South Africa, and based on her findings, proposed a peer-intervention strategy that was later implemented. Her basis for suggesting peer education programmes was simply that:

> …the argument that high-risk sexual behaviours (such as unprotected sex with multiple partners) are too complex to be changed by simply providing people with health-related information, as traditional health education programmes have sought to do (Campbell, 1997:274).

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[104] Butterworth, Ibika, HIV/AIDS Project Manager (USAID), Xhosa, 42, Female

She further explains that she proposed peer education programmes as a strategy due to the fact that peer education does more than the mere provision of information, and rests on the premise that 'people are more likely to change their behaviour if their peers are also committed to behavioural change' (Campbell, 1997:276). On these grounds, as previously suggested, a programme that encourages social debate would be more suited for the environment encountered at the IAT where beliefs, supported by individualised construction of identities, need to be addressed to encourage behaviour change. Students mostly acknowledged that pamphlets, posters and condoms were seen on University premises as part of awareness campaigns. However, they also stated that they did not see anything beyond pamphlets, and that information alone is insignificant.

Example 1 (IAT Students)[105]:

…it is just that people are just ignoring what is being said. I don't know if it has something to do with their personalities or something but if the government is supplying condoms and they are supplying pamphlets to the community about HIV/AIDS it is up to the person to decide if they are going the right direction or if they are going to move his/her own direction…

This statement by the student resonates with Campbell's (1997:276) argument. It was clearly stated that the mere provision of information seems insufficient to induce behaviour that would allow for students to behave in a different manner. Throughout the study, research informants presented reasons why they do not believe or do not agree with various elements of such information campaigns. This type of contestation is something that an information pamphlet or a condom dispenser cannot address. The system requires some sort of intervention that would allow students to interact and engage with the problem for themselves, in a context where there is already considerable debate about 'right' and 'wrong' practice.

The student makes the statement that it is '...up to the person to decide…'. The question is whether the student's social community is applying pressure on students to see the benefits of adhering to certain behavioural standards. This would include hearing from HIV positive students about their interpretations of issues such as male circumcision and the right to have sex (c.f. chapter 6), and subsequent dangers that engaging in risky sexual

[105] East London, College Street, Student: IAT, Xhosa, 26, Male

behaviours pose to their health. Likewise, the research informant appears to be recommending that something other than mere information provision is required to improve the situation.

The social context within the WSU needs to be taken into account for a programme to be successful. One such an example that had been proven to be successful, taking the social context into account, was discussed in Chapter 6, where a system of men preaching to men about gender issues in relation to HIV/AIDS was adopted. In that context, the research informant had indicated that it was one of her more successful projects.

Various key role players stated that one of the more successful avenues that had been followed by the former merger partners was that of peer-intervention programmes. The problem that existed with these previous peer-intervention programmes was that they were isolated in terms of the three merger partners of the WSU and that they had previously existed separately and only addressed pockets of students. One research informant, a member of the HIV/AIDS committee, also indicated that some of these programmes had become redundant since the merger. These programmes had existed separately without a health-enabling environment. An approach where a health–enabling infrastructure, inclusive of the physical buildings (i.e. clinics) and supported by health-enabling programmes (i.e. ensuring proper nutrition with sensitivity displayed towards local beliefs) is required. Implementation of peer-education programmes encouraging social debate around the issues discussed here is therefore recommended.

7.5 Conclusion

Key role players in HIV/AIDS at the WSU and students at the IAT exhibited commonality in relation to expressions such as ‘in my culture’ when explaining issues associated with local beliefs. However, upon deeper investigation, it was revealed that the term is commonly used to explain numerous behaviours, and often contradictory beliefs. The conclusion that can be drawn is that beliefs accompanying explanations related to ‘in my culture’ can only be linked to ‘imagined culture’, i.e. the way in which any particular practice can be justified by reference to some normative cultural standard, however spurious. These ‘imaginaned’ constructs of culture are often used as convenient excuses to explain risky behaviour in relation to the contraction of HIV/AIDS. Further constructions of the ‘imaginary’ were also present in the use of the term ‘respect’, which is elsewhere defined by Wood (2009:412).

Notions of the term ‘respect’, which are also present in the data, are also seen as part of imagined culture. The term respect was often used to suit the needs of the research informants, in a type of ‘uses and gratifications’ approach that allows people to use these notions as they need to in general society. In terms of societal strategies to overcome some of the problems associated with patriarchy, it has been demonstrated that local strategies should exist whereby men are used to discuss with men about HIV/AIDS, since it is believed that this approach would overcome challenges related to males not wanting to listen to what females have to say.

In terms of WSU intervention strategies to date, it was found that students at the IAT and WSU key role players in HIV/AIDS offered differing perspectives about the visibility of HIV/AIDS prevention efforts. Whilst the majority of students complained about not knowing about various HIV/AIDS initiatives, key role players in HIV/AIDS were extolling the success of their efforts. This can only lead to the conclusion that HIV/AIDS prevention efforts are not sufficiently visible and that more has to be done to ensure this.

Furthermore, WSU HIV/AIDS key role players and students were in agreement that the ABC approach was not sensitive to local problems and context and therefore that a different approach is required in order to be more effective. The implications for HIV/AIDS prevention for the IAT, derived from conclusions drawn from the data, are that the IAT should follow a multi-step approach towards creating a health-enabling environment, with the following key steps that were partially deduced from the study by Campbell et al, (2007:347):

(1) the creation of a health infrastructure, which include elements such as ensuring that students have access to sports facilities, and more relevant to this thesis proper nutrition that is sensitive to local considerations, inclusive of health treatment facilities, clinics and medical services,
(2) health awareness programmes that allow for social debate surrounding indigenous beliefs,
(3) programmes that address HIV infection through social debate of gender issues,
(4) the consideration of normative approaches in relation to message content, as opposed to the ABC approach.

Due to the highly heterogeneous nature of responses received from key role players and students alike, the data suggested that a programme system entailing more than the mere passing on of information would have to be implemented since social debate is required to bring about behavioural change. The only known mode of delivery that allows for this type of structure to date is that of peer – intervention, which has been used successfully in contested environments where HIV/AIDS prevalence is high (i.e. Campbell et al, 2007:347).

8: Conclusion

8.1 Introduction

This chapter will first provide a research summary, highlighting findings from each chapter. The discussion then continues in sections that detail the research implications derived from the main research findings. The limitations of the study, suggestions for further research and final conclusions are provided in the latter parts of the chapter.

Broadly, this study investigated notions regarding HIV/AIDS by examining the views of students at the IAT and key role players in HIV/AIDS at WSU. Previously HIV/AIDS prevention disregarded 'cultural assumptions' and 'social representation ascribed to by an individual' (Joffe, 1996:173), and this paved the way for authors[106] such as Campbell (1997:273) to lay foundations for acceptance of 'cultural sensitivities' and 'contextual factors' in HIV/AIDS research. Later publications by Campbell (2001, 2005 and 2007), suggested how these 'cultural sensitivities' should be included into peer prevention campaigns (Campbell et al, 2005; Campbell et al, 2007). Peer-intervention campaigns also constituted a method which had proved to be successful at various South African Universities and was emphasised by HESA (Pearlman et al, 2002:38 and HEAIDS, 2010:102) as successful. The fact that peer intervention campaigns 'encourage social debate' is one of the forces driving its success (HEAIDS, 2010:102). This study has been concerned with shaping HIV/AIDS prevention programmes in a culturally sensitive manner.

In this research I wanted to understand the interplay between conceptualisations of culture and HIV/AIDS, and found that issues surrounding local factors in society, individualised constructions, cultural sensitivities and social debate are major elements that influence how local beliefs are shaped. Based on the major findings of the research, it was proposed that current social debates surrounding sexuality and HIV/AIDS could be utilised for HIV/AIDS prevention, through social debate programmes as a subset of peer intervention. The approach introduced in this study is for utilisation in a complex social setting, that of a HEI, amongst respondents that exhibited heterogeneous, personalised, individual identity constructions.

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[106] Also c.f. Adimora and Schoenbach (2002:707) and Carael (1999:25)

Whilst the concept of peer-education programmes is not unique, and neither is the need of facing contentious issues head on through fostering social debate, this study has contributed to knowledge by demonstrating how key issues for social debate could be identified through research. Secondly, the major contribution resulting from this study is the fact that it paves a way forward for the IAT in approaching HIV/AIDS prevention. Proven to be successful it could be utilised in the whole institution as a model for HIV/AIDS prevention, through implementation of a number of steps, including (1) the establishment of a health-enabling environment, (2) through social debate programmes surrounding key themes, (3) in a culturally sensitive manner and (4) through a peer-driven approach.

8.2 Research summary

In relation to themes, the study first probed perceptions of the perceived causes of the high HIV/AIDS prevalence rate, as perceived by research informants. The data presented showed that the students and key role players in HIV/AIDS at the WSU mostly adopted a biomedical model of HIV transmission and recognised the disease as viral. There was little or no support for former President Thabo Mbeki's position on HIV/AIDS. In addition, research informants held specific, often personalised understandings about the disease.

The next research theme, which discussed perceptions surrounding nutrition and general health, found that research informants recognised value in local constructions of nutrition, although they generally preferred bio-medical remedies for general ailments. It was further determined that the WSU has envisaged the establishment of a health-enabling environment against the background of addressing HIV/AIDS at the institution, but that the relevant changes had not taken place due to organisational and economic challenges.

In the next section, research informants' understandings of gender and sexuality were explored. Notably many felt that the spread of HIV/AIDS was a result of male behaviour, driven by gender inequality, which affected sexual agency. Within this picture painted by research informants, some argued that these masculine identities allowed males to justify risky sexual behaviour such as promiscuity, and also refuse the use of condoms. The terms 'respect', 'in our culture', and the notion of social distancing (i.e. the distinction between 'us' and 'them') also emerged as commonly used phrases. The term 'respect' as used by research informants and which was closely correlated with use of the term 'in our culture', showed commonality with the findings of Wood (2009:412). It was explained by some

research informants that claims about culture were used to justify male gender inequality, and were used to curtail those who opposed patriarchy.

This alternate form of consciousness allows for greater forms of fluidity in social interaction, through greater reflection about cultural claims including those labelled 'traditional' in the Xhosa context. This manifested in discussions about issues such as beliefs surrounding having multiple sexual partners, gender–based violence, and females' need to be empowered. These forms of highly complex, social interactions were also found to be discussed by authors such as Delius and Glaser (2004:114) and Price (2009:12). Giddens' (1984:284) double hermeneutic aided greatly in the analysis of such questions.

Research informants also indicated that ritualised initiation played a significant role in forming the perceptions of young isiXhosa speaking males about gender relations. It was further reported that infidelity and gender violence occurred and subsequently also had an effect on HIV/AIDS transmission. As a social strategy to counteract the effects of gender violence and infidelity some females alluded to empowerment strategies. The realisation by women that such empowerment strategies were a method of decreasing the spread of HIV was clearly evident. Various research informants referred to 'assertiveness training' (advocated by HIV/AIDS activists) that encourages women to oppose gender violence and discrimination. Gender beliefs were highly contested, with some research informants subscribing to patriarchical ideas; others opposed these views, claiming that the behaviour of men was not acceptable and that female sexual agency needed to be strengthened in order to counteract risky sexual behaviour that could lead to the contraction of HIV.

In relation to the ABC approach it was established that most of the research informants did not believe that the approach was effective for a variety of reasons. Some participants explained the failure of the approach as being a result of its perceived insensitivity in cultural terms, but also referred to other reasons, such as the stigma attached to an individual who abstained. The data therefore indicated that the majority of the research informants felt that the ABC campaign was not sensitive to contextual beliefs. This is in line with the findings in a study by Campbell (1997:274) who alluded to the fact that it is more likely that people will subscribe to altered behavioural patterns if such change is brought about by their peers.

8.3 Research implications

In terms of the last data chapter, an overview of the four contextual factors that were investigated and used as the basis for recommendations to the IAT and key role players in HIV/AIDS at the WSU for use in HIV/AIDS preventative strategies is given. Peer education programmes were examined in more detail as a possible method of addressing the problem, since such programmes are specifically designed as approaches that are appropriate in highly-contested environments.

This examination culminated in the proposal for what is termed 'social debate programmes' through a peer driven approach. By examining previous studies done in relation to HIV/AIDS and peer education programmes (Campbell et al, 2005; Campbell et al, 2007) it was established that a programme had a better chance of success if it was not designed using a narrow approach with the intent of achieving a bio-medical objective. Instead, there should be a broader approach that establishes a health-enabling environment before implementing peer HIV/AIDS prevention programmes (Campbell et al, 2007), and in this study, a social debate programme. In this way, HESA also promotes the use of peer intervention campaigns since they allow for social debate whilst delivering a specific message (Pearlman et al, 2002:38). This therefore allows for addressing pertinent social issues, such as gender perceptions, whilst addressing HIV/AIDS as a subset to health intervention. Beeker et al (1998:832) classify this mode of delivery as part of an 'empowerment approach' whereby it is 'the process by which people, organisations and communities gain mastery over their lives' (Beeker et al., 1998:833).

8.3.1 Subscription to local beliefs in relation to contextual factors

The first contextual factor, perceived causes of HIV/AIDS, as an emerging theme, revealed that the most important perceived causes according to research informants were related to gender-agency issues, perceptions surrounding nutrition and general well-being and the insensitivity of the ABC approach to localised beliefs. What emerged during interviews with students and key role players alike with regard to nutrition was that they do not subscribe to the views portrayed by a South African Government minister during the time of research which proposed garlic and beetroot as a 'cure' to HIV/AIDS.

The majority of research informants also questioned the effectiveness of traditional medicine, especially beliefs related to 'miracle cures' and HIV/AIDS. Statements such as

'*So from that they mix them and from there they think something which maybe it is one which is the same as the ARVs'* were examples of these. Social debate programmes would have to interrogate these beliefs, against the background of a 'health-enabling environment' which the WSU key role players revealed to have in mind in their approach to HIV/AIDS management. Research informants, having expressed their orientation towards bio-medical beliefs, therefore have to know what proper nutrition entails, how it is linked to the immune system, and what diets need to be followed by HIV positive people in relation to the ARVs that they are taking. This approach does not only address local beliefs, but refines knowledge in relation to existing bio-medical nutritional practice.

Research informants continually reminded me of the need to be 'respectful' of 'the culture' when asking questions about local practice and it was subsequently concluded that a high level of respect existed towards local beliefs concerning nutrition and well-being. Therefore, in an approach that presupposes the establishment of a health-enabling environment, strategies that advocate proper nutrition and general well-being in an environment with HIV/AIDS prevention strategies would have to be sensitive towards local beliefs about nutrition. Social debate surrounding this element would have to be encouraged. Through the use of bio-medical practitioners and THPs students would have to be encouraged to ensure that their general health is taken care of. Since issues such as malnutrition are related to poverty and are common in the local environment, the institution would have an important role to play in ensuring that students are well-nourished, whether through feeding schemes or supportive funding.

In relation to gender, all research informants viewed initiation as a important rite of passage, although views regarding the associated rights related to sexual agency as a result of the initiation varied. All research informants tended to preface claims about Xhosa cultural beliefs with the phrase 'they believe', thereby engaging in a form of social distancing. This occurred due to the fact that research informants expressed heterogeneous beliefs related to gender, although they all stated that their beliefs were related to 'their culture'.

Furthermore, notions of respect could include the necessity of not expressing sexual agency as a sign of respect towards the husband – many male research informants made reference to statements indicating that 'women are submissive here'. Other specific clauses related to respect were brought in relation to patriarchy, with statements such as *'yes,*

because in the Xhosa culture it is the man who is the head of the house; so the only person who speaks last in the house is the man, not the woman'.

The above indicates that there is social space for debate surrounding the diversity of responses in relation to existing practises. This study found that, as in others, such as Wood et al (1996:2) that women do less frequently contest notions of male sexual agency, which - one may presume - has a negative effect on HIV prevalence. The occurrence of this translates into the idea that more attention needs to be given to issues pertaining to gender in social debate programmes.

A method advocating social debate, as opposed to a one-sided message, such as the ABC approach, would therefore be more appropriate. On this basis a peer intervention approach was recommended for the IAT. This would allow for such social debate, whilst including both bio-medical and THPs as a cornerstone of such debate.

New, innovative, culturally sensitive, social debate programmes would have to be peer intervention programmes with the ultimate goal of addressing the 'interpretative conflicts' that exists between the continuum of local and bio-medical beliefs in relation to HIV/AIDS. In relation to this study, some of the key questions that might be appropriate for debate would include:

- beliefs related to nutrition, with a focus on health enabling behaviour
- beliefs related to the construction of masculine identities, with a specific focus on the notions of respect, masculinity, sexual agency and condom usage. This would have an intermediary goal of assertiveness for females, but also have an overall objective of eradicating perceptions related to unequal social power due to gender.
- beliefs related to normative behaviour, eradication of misconceptions of the application of the term 'culture' and taking the participants back to what Delius and Glaser (2004:114) termed as 'candid recognition and frank discussion of entrenched practices'.
- beliefs related to the causes of HIV/AIDS, which has the focus of addressing misunderstandings related to misconceptions of bio-medical practice.

8.3.2 Local perceptions and social issues regarding HIV/AIDS

Having already established what a culturally-sensitive social-debate peer-intervention programme would look like and, broadly, what aspects they would address, this question has already partially been answered. However, this section will look more specifically at what culturally-sensitive assumptions should be made to in order to relate to the social-debate programme audience. Being a heterogeneous audience, falling somewhere in the realms between acceptance of bio-medical principles and traditional medicine, recognition would have to be given that local perceptions only partially constitute a topic for discussion. Some of the local perceptions however, are still great issues of contention, and would have to be discussed in social debate programmes:

- The notion that the reasons for initiation have changed: findings in this thesis that support similar findings regarding changing perceptions surrounding masculinity and the post-circumcised male as discussed by Vincent (2008:433). Social debate focusing on the purpose of circumcision schools needs to be encouraged. The findings of these debates, and the need for change, should be tied to active communication and awareness campaigns that specifically address gender inequality as a result of circumcision school beliefs.
- Personal constructions of infidelity: Personal constructions of infidelity as a world-wide phenomenon that do not only affect some Xhosa-speaking males but males world-wide, as part of a gender-equality strategy, need to be discussed and addressed.
- Personal constructions of HIV/AIDS myths: Myths such as isiqwati, as encountered in this thesis, and also having no correlation with traditional beliefs, need to be addressed and discussed. Discussions such as these could include debate about other myths, as encountered by other researchers (c.f. Delius and Glaser, 2004:84; Du Plessis and Maree, 2009:1), and their interrelationship with traditional beliefs clarified. It is important for clarification purposes that the tracing of the historical origins of some of these myths takes place, much as in the work done by Delius and Glaser (2004:84) as part of an awareness programme.
- Debate about specific cultural practises may help or not reduce the rate of transmission (c.f. Delius and Glaser, 2004:84).

8.4 Limitations of the study

This next section will be discussing the shortcomings of the study. The section will be examining other possible research approaches as well as the fast changing pace of developments in HIV/AIDS in the South African environment.

An action research approach (such as that adopted by Campbell, 2007) with the researcher actively taking part in an HIV/AIDS prevention campaign and infusing research into the process could be more effective in terms of making a difference, and could for example, include monitoring of the effectiveness of HIV/AIDS prevention activities (such as pre- and post-campaign monitoring). Second, whilst commensurability was increased through the researcher being a member of the HIV/AIDS Committee during the research, it was always the position of the researcher to take an observer-as-participant approach. Actively partaking in the decisions of the Committee through an action research approach could ultimately have had a greater impact on HIV/AIDS prevention at the WSU during the course of the study.

Another problem encountered was the fast-changing pace of developments in terms of HIV/AIDS in the South African environment. When the study commenced, President Thabo Mbeki was the president of the country and Minister Manto Tshabalala-Msimang was the Minister of Health. They had their own policies and principles regarding HIV prevention issues. Since this was the situation during the course of the field interviews, views expressed by research informants related to concerns regarding these two individuals are no longer directly relevant. During the later phases of the study, however, President Mbeki and Minster Tshabalala-Msimang disappeared from the political scene. After appointing an interim president (President Motlanthe) and Minister of Health (amongst others), it was clear that the ANC government was trying to address negative perceptions of their handling of the HIV/AIDS problem. The next major change came about following general elections in which President Jacob Zuma was elected as president. The newly appointed Minister of Health (interim Barbara Hogan) was Dr Aaron Motsoaledi. Authors such as Cohen (2010:500) are of the opinion that ‘a sea change’ has occurred since the new Government has come to power.

8.5 Further Research

A recent quantitative study dealing with gender (driven by recent research, according to the authors) in relation to South Africa was conducted by Shisana et al (2010:39). They found that gender is related to HIV infection in South Africa and that poverty is a social determinant... (and that) sex is a determinant only among the younger age groups…'. Further research investigating the link between poverty and the contextual factors addressed in this research, against the background of Campbell et al's (2007) findings, which indicated that HIV/AIDS should be addressed in a health-enabling environment, could culminate in strengthening strategies that address challenges associated with the contextual factors identified within this study and poverty-related issues simultaneously.

The contribution from such a study could indicate and confirm trends and has, with repercussions flowing from the implementation of a peer-intervention programme, possibilities for design implementations of similar groups in environments where scarce skills in a poverty-stricken area are of significance.

Further research in this area, inclusive of poverty and gender considerations, could use a qualitative, mixed-methods approach. This would be inclusive of in-depth interviews in an action research methodology that focuses on popular areas in relation to current research, such as poverty and gender, but also includes issues such as silence (linked to stigma) which in turn could be linked to childhood development (i.e. Piaget, 1977) in a cultural/contextual setting. The basic premise for research of this nature would be the breaking of the silence associated with sexual communication at childhood development level (c.f. Nduna and Jewkes, 2011:36), with cultural and community involvement, in an overarching health-enabling setting where HIV/AIDS education becomes accessible and peer-taught in all contexts, so that the entire community can benefit.

Further research would also include monitoring the effectiveness of HIV/AIDS prevention activities related to the recommendations in this thesis in an action research approach. This would be done in conjunction with the implementation of such a programme.

Socially networked small projects which would seek to implement a social debate peer intervention education programme at the IAT of the WSU, and utilisation of this model throughout the institution, would the starting point for any intervention. It could act as a small cog in a web of wheels which all, in turn, address HIV/AIDS concerns in a variety of

contexts and in a variety of ways, inclusive of upliftment of the entire community in a health-enabling context. There is a need for research that takes into account the overall picture of the entire society through an approach that could indicate how the various aspects of upliftment fit together.

8.6 Final Reflections

Research into contextual factors allows for sensitivities around localised issues to be determined that might not have been visible following other conventional approaches. A concern to understand the 'cultural meanings that shape and construct sexual experience', and the examination of 'structural forces that impinge upon sexual life' (Parker, 2001:173), expose the social forces and social determinants of sexual agency, and place the researcher in the middle of social debates that have an important effect on how HIV/AIDS proliferates in society.

The carriers of opposition have been found not to be necessarily related to age and gender as 'the most all-embracing criteria of attributes to social identity' (Giddens, 1984:84), but also within a diverse number of other factors. These factors included health beliefs in a mixture of bio-medicine and traditional health care practitioners in changing application of traditional rites and their respective purpose(s), such as initiation and virginity testing, all supposedly under the umbrella of HIV/AIDS prevention.

The emerging key to social change and addressing the pandemic of HIV/AIDS lies with social debate and consensus on what constitutes knowledge, beliefs and safe practices in an approach that is not prescriptive, but combines all the social forces impacting upon the proliferation of the disease, to publically state their views for the purposes of debate, which could result in a society advocating healthy sexuality. This can best be achieved through culturally sensitive, social prevention programmes that foster social debate in a peer approach, as described in the aforementioned sections, and should not only be focussed on the University environment, but all levels of society.

Appendices

Appendix A: Letter to research informants

Strathclyde Centre for Disability Research
Department of Sociology, Anthropology and Applied Social Science
University of Glasgow
Adam Smith Building
Glasgow
G12 8RT
United Kingdom
Tel (UK): +0944 141 330 4545
(South Africa): +27 83 454 5846
Email: I.Saunderson.1@research.gla.ac.uk

May/June 2006

Dear Interviewee

PhD Research

Thank you for your potential willingness to participate in this study. This research forms part of PhD studies under the supervision of Prof. Nick Watson and Dr Gerda Reith from Glasgow University, Glasgow, United Kingdom.

The purpose of the research is to help curb the spread of HIV/AIDS at the Tooling Design Centre of the Walter Sisulu University (East London, South Africa) through examining current practises and policies at the institution, by defining cultural and social constructions of the disease and examining the impact of extraneous variables such as perceptions created by the media.

As a potential interviewee, you were approached due to the fact that you are perceived as a significant roleplayer in helping curbing the spread of HIV/AIDS at the Walter Sisulu University.

An interview is a discussion between an interviewer and the interviewee on various topics surrounding the topic of the research. A pre-approved topic guide is formulated which acts

as guideline to the general outline of the discussion. The interviewee can withdraw from the discussion at any time since the interviewee is under no obligation to answer any or all of the questions posed, the interviewee do not have to elaborate on any information, especially where it is of a personal nature and considered to be sensitive and private (such as HIV status). Since the interviews are conducted in English, you may request a Xhosa translator, which will be provided at your request.

Please take note of the fact that the conversation is recorded, that all information collected will be kept strictly confidential and anonymous, and that the information will only be used as part of this study and for no other purposes. The only people that will have access to the data are the researcher, the supervisor and the Xhosa translator (only present during interviews at the request of the interviewee), whom are all bound (through strict or vicarious liability) by the ethical constraints imposed by the Glasgow University's Faculty of Law, Business and Social Sciences Ethics Committee, following approval of the study by the committee.

If you agree to participate in this study please complete the attached consent form before embarking upon the interview. Please retain the information sheet should you need to contact the researcher or the supervisor of the study for any reason. Should there be any complaints, concerns or comments regarding this study, the researcher could be contacted at ipsaunderson@webmail.co.za , or 083 454 5846 (South Africa) or +0944 1848 200 327 (UK). Alternatively, the primary supervisor to this study, Prof. Nick Watson, could be contacted at n.watson@socsci.gla.ac.uk or +0944 141 330 4545. The second supervisor to this study, Dr. Gerda Reith, could also be contacted at g.reith@socsci.gla.ac.uk or +0944 141 330 3849.

Kind Regards,

Ian Saunderson

Appendix B: Consent Form

Strathclyde Centre for Disability Research
Department of Sociology, Anthropology and Applied Social Science
University of Glasgow
Adam Smith Building
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Tel (UK): +0944 141 330 4545
(South Africa): +27 83 454 5846
Email: I.Saunderson.1@research.gla.ac.uk
May/June 2006

RESEARCH PHD CONSENT FORM: KEY ROLE-PLAYERS ON HIV/AIDS, WALTER SISULU UNIVERSITY STAFF AND KEY MEMBERS OF THE COMMUNITY

I, ...(name), declare that I give consent to the interview, have read and understood the terms and conditions as described in the information sheet to interviewees in the category Key role-players on HIV/AIDS, Walter Sisulu University staff and key members of the community and trust that information disclosed will be kept private and confidential.

I do understand that I am entitled to having a Xhosa translator present and request/do not (underline) request the presence of such a translator. I furthermore understand that I am under no obligation to answer any or all of the questions posed, and are participating in the interview of my own free will.

....

Signature Date

Appendix C: Approval - Glasgow University Ethics Committee

Faculty Ethics Committee
Email: A.Lindsay@lbss.gla.ac.uk

UNIVERSITY
of
GLASGOW

09 May 2006

Mr Ian Saunderson
"Dunollie"
Chapel Street
Moniaive
Thornhill
Dumfriesshire
DG3 4EJ

Dear Mr Saunderson

SSL/05/HIV/AIDS: Action Research at the Tooling Design Centre of the Walter Sisulu University, East London, South Africa

I am pleased to confirm that your application for ethical approval has been approved by the Faculty Ethics Committee.

As a condition of approval and in line with the committee's need to monitor research, the committee requires that a report be provided to it towards the end of the research, giving brief details of the project to date and any ethical issues which have arisen. You will be contacted in due course in this regard. In addition, any unforeseen events which might affect the ethical conduct of the research, or which might provide grounds for discontinuing the study, must be reported immediately in writing to the ethics committee from which you have received approval. The committee will examine the circumstances and advise you of its decision, which may include referral of the matter to the central University Ethics Committee or a requirement that the research be terminated.

Please note that this approval is valid for the duration of your project. Please confirm in writing the end date for approval. If the project should extend beyond the submission date you entered on your application form it will be necessary for you to contact the committee and seek an extension. As this approval is based upon the information you provided to the committee you will require to seek approval should any changes be made to your project. In particular, please note that if participants in your research involve children or adults with incapacity (as defined in the Adults with Incapacity (Scotland) Act 2000, available via the University Ethics Committee web site) you require to comply with the legislation which governs research involving these groups. If you have not complied with these requirements or you did not anticipate that your research may involve these groups you must exclude them from your study.

Please retain a copy of this letter.

Yours sincerely

Aileen Lindsay

p.p. Faculty Ethics Committee

FACULTY OF LAW, BUSINESS AND SOCIAL SCIENCES
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Web: www.gla.ac.uk/LBSS

Appendix D: Topic Guide

Topic Guide to key – role-players:

Topic Guide: Interviews with key role-players on HIV/AIDS at the WSU for the IAT

Explain nature and reasons for interviews. Explain ethical considerations, treatment of the interview, ensure participant retains information sheet and hands over consent form before interview session.
Probe: Personal history with WSU, involvement with IAT and/or HIV/AIDS
Probe on interviewees' personal beliefs on HIV/AIDS
Probe on perception of the complexity and severity of HIV/AIDS: SA as a whole (gov. views, Zuma, etc.) ECape (Premier, Dept of Health, etc.), WSU (what intervention efforts have we seen?)
How WSU is approaching the problem
How WSU should approach the problem
What intervention efforts is working / what not working / why not working
IAT specific approach to the problem
Account of the Xhosa culture. How sensitive to issues like HIV/ does culture have influence on perceptions regarding HIV/AIDS/ how should WSU/IAT incorporate Xhosa culture specifics in development of HIV/AIDS policy/teaching approach
Status of the media – how it affects the perceptions surrounding HIV/AIDS, IAT
Victims of HIV/AIDS – stigma, mysticism, fatalism, etc.

Topic guide to students:

Explain nature and reasons for interviews. Explain ethical considerations, treatment of the interview, ensure participant retains information sheet and hands over consent form before interview session.

Probe: Personal history with WSU
Probe on beliefs on HIV/AIDS
Probing questions:
Can you tell me what the students know about AIDS?
What is HIV?

What causes AIDS?

How can people stop getting AIDS?

Where do students learn about AIDS?

Do students wear condoms?

How do students feel about the concept of HIV?

How do students know if it is safe to sleep with someone?

Do students what the government are saying about it?

Do students agree with the government?

Who is at risk contracting HIV?

Probe on perception of the complexity and severity of HIV/AIDS

Who gets AIDS?

Do you know anyone with AIDS?

Have anyone close to you died of AIDS?

If someone dies of AIDS, do the community blame AIDS or do they call it something else?

Is somebody doing something about the problem?

Probe on exposure to HIV/AIDS prevention programmes: Gov and WSU

What is the government doing about the problem?

Do you think it is working?

What is the WSU doing about the problem?

Do you think it is working?

What should the WSU be doing?

Account of the Xhosa culture. How sensitive to issues like HIV/ does culture have influence on perceptions regarding HIV/AIDS/ how should WSU/IAT incorporate Xhosa culture specifics in development of HIV/AIDS policy/teaching approach. Focus specifically on gender related issues.

Probing questions:

Having many girlfriends - is it a good thing or a bad thing?

Is it good to sleep with many women? Does it prove manhood?

What do the elders teach about having many girlfriends?

What do the elders teach about having many wives?

What is considered normal?

What is flesh on flesh? What does it mean?

Do women have the right to demand a man to use a condom? Why or why not?

Can AIDS can be cured?

What happens if you have sex with a virgin if you have AIDS?

Can you be bewitched to get AIDS?

Can Sangomas or Nyangas cure AIDS?

Victims of HIV/AIDS – stigma, mysticism

Probing questions:

How do you feel about people with AIDS?

Do you have any friends that have AIDS?

Do you treat people with AIDS differently? How?

Do you think other people treat people with AIDS fairly and equally?

Media

Probing questions:

Have you learnt anything about AIDS from the media?

What media? (print/electronic) and what publication/channel/station ?

Do you think the media is doing a good job or a bad job in the fight against AIDS? How?

Appendix E: Photographs of the area

Fig. 5: WSU's main campus, Nelson Mandela Drive in Mthatha

Fig. 6: Students in auditorium, Nelson Mandela Drive, Mthatha

Fig. 7: The inside of the IAT main design centre

Fig. 8: IAT Centre Staff with Kerryn Newey, Director (Right)

Appendix F: Prevention Programmes, Master Toolmakers and living standards indicators of WSU students

Introduction

Based on the fact that master toolmakers are scarce (Van Reenen, 2005:1), the impact of HIV/AIDS were investigated and, at the very least, the main factors explaining the success or otherwise of prevention programmes identified. Whilst it would be incorrect to state that the impact of this research is applicable to the entire South African population, in the case of tool-making industry, it could be particularly pertinent. If 250 jobs are created down the line in the South African manufacturing industry for every one qualified toolmaker (Newey, 2004:10), the impact of the current HIV prevalence rate has a significant effect on the country's ability to produce manufactured goods. The question that clearly requires addressing is whether students at the IAT experienced HIV/AIDS preventative efforts promoted by HEAIDS and key role-players in HIV/AIDS at WSU to the extent that these efforts result in behavioural change.

This appendix consists of various tables and other indicators depicting some economic considerations concerning various arguments presented in the thesis. These include the following:

1. The cost of losing a Master Toolmaker to HIV/AIDS, given the fact that it has been established that every Master Toolmaker creates 250 jobs in the manufacturing industry (c.f. Section 2.5) in South Africa. The assumption is made that the loss of a Master Toolmaker will result in a higher import ratio of designed manufacturing tools, or alternatively, the import of the entire goods and not just the manufacturing tool.

2. The cost of prevention programmes. This is done by determining the cost per student that the WSU spends annually on HIV/AIDS prevention. It is assumed that the proposed prevention programme in this thesis does not have to lead to more costs, since budgetary considerations could simply be applied differently, as opposed to additional costs. The cost per student is compared to the financial loss to the manufacturing industry as calculated in (1).

3. Living standards of WSU students. This section, based on the fact that 95% of WSU students lives on NFSAS loans (WSU IOP 2007), provides some figures and other indicators related to living standards for a student at the WSU. The purpose of this section is merely to provide some sort of understanding in Pound Sterling terms to a reader not familiar with the South African environment, and should not be regarded as an accurate economic analysis.

Section 1: The cost of losing a Master Toolmaker to HIV/AIDS for the manufacturing industry

Economically, given the fact that 11 prospective toolmakers were interviewed during the research, the above translates to a total of 2750 jobs that these individuals alone could create in the manufacturing industry upon employment after graduation. If the assumption is made that the average worker in the manufacturing industry earns R10 000,00[107] per month (salary levels range between R2800,00 per month for unskilled workers and R20 000,00 per month for managers in the manufacturing industry – c.f. Clarke et al.,2008:843), this translates to a possible R27 500 000,00[108] per month that these 11 individuals could create for workers in the industry. If this figure is divided by 11, we can see that this amounts to R 2 500 000,00 per month[109] that it lost from the death of each toolmaker. It is also accepted that these master toolmakers are not necessarily replaced also due to loss of skills by the sector, mostly related to HIV/AIDS (Merseta[110], 2010:64). This results in more goods being imported into South Africa as opposed to it being locally manufactured. The additional cost of importing goods as opposed to manufacturing them locally could be added to this calculation, against the backdrop that the South African Government charges a premium on imported goods (to prevent excessive import of goods), but this calculation falls outside the ambit of this thesis. From these figures, even within a 20% standard error of calculation, it is very clear that the economic value of these individuals are extremely high. The cost of implementing an effective prevention programme for these individuals seems negligible against their earning potential for the South African economy.

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[107] At R15,00 to £1,00 this equates to £666,00 per month.

[108] At R 15,00 to £ 1,00 this equates to £ 1 833 333,00 per month for the loss of 11 skilled toolmakers

[109] At R 15,00 to £ 1,00 this equates to £ 166 667 per month for the loss of every skilled toolmaker.

[110] Merseta: Manufacturing, Engineering and Related Services SETA. A SETA is a Sector Education and Training authority (c.f. Ensor, 2003)

Section 2: The cost of HIV/AIDS prevention for a student at the WSU

During the time of data collection, the WSU IOP (Institutional Operating Plan) stated that expenses related to HIV/AIDS prevention at the time amounted to R10[111] million per annum, with an intake of approximately 24 000 students for the same year (WSU IOP, 2007). This calculates to R 416[112] spent on HIV/AIDS prevention per annum per student. The figures in Section 1 are based on estimates from 2008 and in Section 2 on figures from 2007, therefore making it not comparable to figures in 2013, and largely inaccurate due to the amount of estimation. However, if this estimation is done irrespective of the estimate error, then it can be seen that an amount of R 2 500 000 savings can be attained for the South African economy per month if a qualified toolmaker do not become HIV positive and remains working for the rest of his/her life. If the same amount is spent on IAT students using the method proposed in this thesis as the institution was spending during the time of data collection for the purposes of the student not becoming HIV positive, amounting to R 416 per month per student, with the initiative being successful, it can be seen that R 416 per month for the period that the student remains a student, can calculate to a saving of R 2 500 000 per month for the South African economy.

Section 3: Living standards indicators of WSU students

It was previously established that 95% of WSU students are studying on NFSAS loans. To qualify for a NSFAS loan, the following criteria are advertised on the website:

> A NSFAS study loan or bursary is for those who do not have the financial means to fund their studies and / or cannot access bank funding, study loans or bursaries. If you're: still at school and figuring out how to fund further studies; currently studying and needing funds to continue or further your studies; a young adult wanting to study further but needing financial assistance… (NSFAS, 2013).

To gain insight into the typical financial situation that a student at the WSU are in, we can turn to current income figures for the province as a whole, from where it would be assumed that students wanting to study at the Walter Sisulu University would originate from. Income figures from the province are depicted in table 10. From table 10 it can be

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[111] At R 15,00 to £ 1,00 this amounts to £ 666 667

[112] At R 15,00 to £ 1,00 this amounts to £ 28 per student per annum.

seen that, in Rand terms, the general income per family is rated as low as R32 204[113] per annum.

	Agricultural households					Non-agricultural households				
	African	Coloured	Asian	White	Total	African	Coloured	Asian	White	Total
Cacadu	12,674	11,304		96,735	21,077	22,795	22,892		78,836	33,199
Chris Hani	16,376	15,414		182,022	23,682	18,425	37,576	204,506	140,530	26,431
Ukhahlamba	12,466			285,066	36,428	19,818	17,117		115,993	23,857
Alfred Nzo	16,296				16,296	13,139				13,139
OR Tambo	11,465				11,465	19,313	67,667		139,000	19,531
Amatole	15,258			116,580	16,186	24,058	53,558	270,114	242,017	31,695
Nelson Mandela	13,173	18,542		86,892	20,399	25,495	47,790	110,432	159,661	64,066
Provincial average	13,690	12,749		145,806	17,729	21,070	41,197	148,376	154,883	32,204
National average	15,014	24,250	132,816	282,151	26,612	29,777	57,284	88,642	166,100	49,990

Table 10: Average Household incomes in the Eastern Cape (Pauw, 2005:7)

This figure could be compared tuition fees at the WSU, which for 2013, are as low as R 15 000 per annum (i.e. Diploma: Journalism; Diploma: Marketing). Despite tuition fees being low, the general income (or families responsible for payment) of the majority of students entering the University cannot afford these fees. In addition to the indicators of living standards above, figure 9 below reflects the Human Development Index for the Eastern Cape in 2010. The significant drop in the HDI was explained as follows:

> The HDI in the Eastern Cape has been lower than South Africa's HDI since 1995 and dropped from 0.582 (1995) to 0.513 (2010). There has been a downward trend for the last five years largely because of the lower life expectancy resulting from the HIV/AIDS pandemic (Eastern Cape Socio Economic Consultative Council, 2012:16).

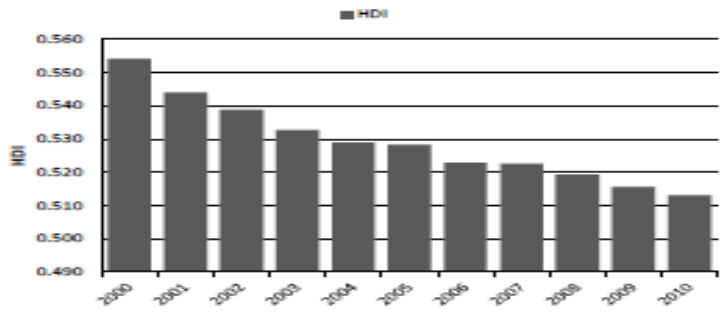

Fig. 9: Human Development Index, Eastern Cape, 2010 (Eastern Cape Socio Economic Consultative Council 2012:16)

[113] At R 15,00 to £ 1,00 this amounts to £ 2147 per annum.

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