DEVELOPING A TRANSFORMATIVE HIV/AIDS EDUCATION: AN ANALYSIS OF SCOTLAND AND ZIMBABWE

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Abstract

Global statistics indicate that currently 35 million people are living with HIV of which 4, 634 are living in Scotland (out of a total population of 5 295 00) and the figure for Zimbabwe is estimated at 1, 400 000 (out of a total population of 14 149 648).

In this thesis, I have suggested a framework that goes beyond a limited analysis of the complexity of understanding the HIV/AIDS origins, its evolution and prevalence beyond the epidemiological mapping. The approach allows for the development of a more rational, inclusive, broader and sustainable HIV/AIDS Education (Wood 2014, Wood and Rolleri 2014). This approach is not only emancipatory but also empowers (Freire 2000, Freire 2004) both those affected and infected by the HIV/AIDS epidemic.

I have chosen both Scotland and Zimbabwe as each of them has dealt with the epidemic in different ways. Scotland has had significant success in combating HIV/ AIDS through various initiatives. Zimbabwe on the other hand, is an example of a developing country in sub-Saharan Africa with one of the highest levels of HIV/AIDS infected and affected people in the world (UNAIDS Country Report 2014).

I used 'selected' documentary analysis that is, looking at selected documents that contain the major policy responses to the HIV/AIDS epidemic. I also conducted interviews with key informants using semi-structured interview questions and then analysed the resultant data using a range of heuristic tools.

The main findings of this research included how a number of conspiracy theories were constructed in order to explain the origins and the evolution of HIV/AIDS. Examples of these conspiracy theories included the homosexual link to HIV/AIDS, witchcraft and biological warfare among others. Other issues discussed focused on conspiracy as the construction of otherness, moralising the epidemic, assessing the impact of culture, religion and politics on the epidemic as well as the implications of these issues on Sex Education. The thesis concluded with suggesting a

framework for developing a transformative approach to HIV/AIDS and Sex Education.

Dedication

This Doctoral Thesis is dedicated to my dear Parents: Cecilia (1924-1983) and Fausto Douglas Nyatsanza (1921-1983). Although both of them did not live long enough to see and celebrate the value of all their efforts, they still remained my greatest source of inspiration in that they were my first educators who taught me the virtues of hard work, resilience and to always aspire to achieve the exceptional.

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Author's Declaration

I declare that this thesis does not include work forming part of a thesis presented successfully to another degree. I declare that the thesis represents my own work except where referenced to others.

Place: The University of Glasgow

Date: 29th September 2014

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Signature: ……..

1 Chapter One - INTRODUCTION TO THE THESIS

1.1 General Introduction

Global statistics indicate that currently 35 million people are living with HIV[1] of which 4, 634[2] are living in Scotland (out of a total population of 5 295 000[3]) and the figure for Zimbabwe is estimated at 1, 400 000[4] (out of a total population of 14 149 648[5]). Although anti retrovirals (ARVs) have since been developed to combat the epidemic, this study is timely as the limits to the bio-medical approach are now becoming clear in so far as they contribute to the stark statistical inequality between developed and developing contexts. This therefore demonstrates the need for a transformative approach to HIV/AIDS Education which is critically needed alongside the bio-medical approaches.

1.2 Aims of the Thesis

The aims of this thesis are:

1. To outline the history of HIV/AIDS in both Scotland and Zimbabwe in the context of a developed and a developing country context.
2. To identify the origins of and the responses to the HIV/AIDS epidemic in both Scotland and Zimbabwe
3. To describe and analyse the ways in which both contexts explained and engaged with the HIV/AIDS epidemic
4. To compare the ways in which the HIV/AIDS epidemic evolved in the two countries
5. To assess the impact that the HIV/AIDs epidemic had on the media, politics, the Health sectors, Education and the socio-cultural contexts within both countries

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[1] http://www.who.int/hiv/en/ (accessed 10.09.2014)

[2] http://www.hps.scot.nhs.uk/bbvsti/wrdetail.aspx?id=57704&wrtype=6#images (accessed 10.09.2014)

[3] https://www.google.co.uk/search?q=population+of+scotland&ie=utf-8&oe=utf-8&aq=t&rls=org.mozilla:en-US:official&client=firefox-a&channel=nts&gfe_rd=cr&ei=AJEiVJPgA8TH8gfph4LwCQ (accessed 24.09.2014)

[4] http://www.unaids.org/en/regionscountries/countries/zimbabwe/ - The Zimbabwe figure is an estimate because the data collection system is not as efficient as Scotland (accessed 10.09.2014)

[5] http://countryeconomy.com/demography/population/zimbabwe (accessed 24.09.2014)

6. To draw out what could be learnt in order to develop a transformative HIV/AIDS and Sex Education
7. To indicate possible areas of further research and development.

1.3 Rationale

In this study, I will suggest a framework that goes beyond a limited bio-medical analysis of the complexity of understanding the HIV/AIDS origins, its evolution and prevalence beyond the epidemiological mapping. The approach allows for the development of a more rational, inclusive, broader, defensible and sustainable HIV/AIDS Education (Wood 2014, Wood and Rolleri 2014). This approach is not only emancipatory but also empowers (Freire 2000, Freire 2004) both those affected and infected by the HIV/AIDS epidemic.

I have chosen both Scotland and Zimbabwe as each of them has dealt with the epidemic in different ways. Scotland has had significant success in combating HIV/ AIDS through various initiatives. Zimbabwe on the other hand, is an example of a developing country in sub-Saharan Africa with one of the highest levels of HIV/AIDS infected and affected people in the world (UNAIDS Country Report 2014). Scotland has enjoyed an advanced and reputable level of health care over the last decade while Zimbabwe has experienced a time of considerable socio-economic challenges. Different explanatory and cautionary narratives for the epidemic have grown in these different contexts (Ray 1987, McNeill 1998, Dickinson and Buse 2008).

1.4 Methodology

There have been various stages in the research process of this study, namely data collection, analysis and write up. For my methodology I use 'selected' documentary analysis that is, looking at selected documents that contain the major policy responses to the HIV/AIDS epidemic. I will analyse these documents in order to find out what key themes emerge out of them. Alongside the selected documents, I also conducted interviews with key informants using semi-structured interview questions and then analysed the resultant data using a range of heuristic tools namely analysing the narratives emerging from HIV/AIDS epidemic in both contexts, using Foucault's analysis of sexuality (Foucault 1976,

Foucault 1985, Foucault 1986, Riessman 2008) as well as subjecting part of the data to a post-colonial heuristic lens.

1.4.1 My Reflexive Stance

As part of my methodology within this thesis, I discuss my positionality, namely how my personal, academic and professional credentials impact on my research. I briefly introduce my positionality in Chapter Two in relation to the Qualitative Research Paradigm that I adopt and then discuss it more fully in Chapter Five.
There are two main aspects of my positionality, the first as an 'insider' and secondly, as an 'outsider'. However, the two aspects present themselves in a reflexive way throughout my research. It is reflexive in that my positionality impacts on my key informants and the way in which I interrogate and interpret their responses and the data that I gather from the policy documents in bidirectional processes. One strand is that as an insider, for example, I engaged in the field work process in Zimbabwe from where I was born, grew up, educated, imbibed the local culture and traditions and hence was already acquainted with the HIV/AIDS discourses at various levels. In Scotland, I am also an insider in so far as, for example, I worked with HIV/AIDS organisations both on a policy and service delivery level, contributed to seminars and advocacy work and delivered specific support for African migrant communities living with and affected by HIV/AIDS in Scotland. The nature of being an 'insider' is not only about being in a particular geographical location but going beyond that in terms of sharing historical and cultural experiences and identities, as well as drawing on the historical, medical, educational, popular and cultural capital which I consider as part of the collective experience for understanding and interpreting the HIV/AIDS discourses. I was also an insider in both Scotland and Zimbabwe in terms of sharing and gaining professional respect from colleagues in the area, possessing demonstrable competence in undertaking the research as well as selecting the relevant policy documents and literature for the study.

In terms of being an 'outsider', this will be instantiated in terms of spatio-temporal categories. In Zimbabwe for example, I was viewed as an 'outsider' by virtue of the fact that I have continuously lived in the UK for over a decade and would significantly have missed out on some of aspects in terms of the epidemic

and how it would have evolved since 2000. So both the time gap and absence from the location were critical factors in my being an outsider. There were also other levels which contributed to the complex perspective of being an 'outsider'. These ranged from engaging with key informants of the opposite gender, different age, religion, profession, educational levels as well as tribal/racial identities and historical-political experiences. Evidence of the indicators of my 'outsider' status is contained in the data from key informants in this study.

In the Scottish context, similar issues of time also constituted my being an 'outsider' in that when the epidemic started in Scotland, I was not yet around. Secondly, the socio-cultural differences between me and the key informants, the HIV/AIDS policy frameworks and the modus operandi of engaging with HIV/AIDS in Scotland was of course markedly different in certain respects in comparison to the Zimbabwean context. Although I had the competence to work with people infected and affected by HIV/AIDS in Scotland, their demographics was comprised of some people whose socio-cultural, linguistic backgrounds and immigration statuses differed from my own. These factors therefore shaped my own understanding of the HIV/AIDS discourse in Scotland in different ways from the experiences of the people I worked and interacted with. It is important to reiterate that a more detailed analysis of this discussion is contained in Chapter Five of this thesis.

However, despite the multiple ways in which my 'insider and 'outsider' statuses operated, their impact on my positionality shaped my reflexive stance throughout this thesis. This reflexive stance of being both an insider and outsider not only provides challenges and opportunities for interrogating and interpreting HIV/AIDS in Scotland and Zimbabwe, but it is also illustrative of the way in which it contributes towards the richness of the data analysis that forms the basis for developing a transformative HIV/AIDS and Sex Education.

1.5 Field Work

There were two phases of the fieldwork process. Phase 1 consisted of undertaking a pilot study in England in order to test the efficacy of my research

tools before I embarked on Phase 2. I chose England because at the outbreak of the HIV/AIDS epidemic in the UK, policy was developed and implemented from London (England). Although subsequent policy formulation and other initiatives were later developed in other devolved areas of the UK, the initial responses have shaped the way in which the current state of the epidemic across the UK has evolved (Berridge 1996). The pilot study was intended to find out how these responses were developed and how they were disseminated across the various constituencies.

Phase 2 focused on Zimbabwe and Scotland and the data in both locations was then analysed and written up in this thesis.

Central to my thesis is exploring the social construction of HIV/AIDS narratives that need to be aligned to the diversity of social forms of narrative construction (Riessman 2008). Special attention has been paid to how mistrust in selected vulnerable or created 'others' were made the subject of discrimination with regards to the HIV/AIDS epidemic (Patton 1990). Consequently narratives were used to identify, capture and analyze the complex historical patterns of discrimination that are present in HIV/AIDS in both Scotland and Zimbabwe (Gilman 1988, Grmek 1993, Jeater 1993, Elbe 2005, Kruger 2006).

1.6 Structure of Thesis

This thesis is made up of eight chapters including the Introduction. Although Sex Education is not explicitly discussed until towards the end of this thesis, HIV/AIDS Education is discussed through media messages, health board policies, public literature and other media. This thesis is about trying to understand the background messages in order to formulate an initial framework for HIV/AIDS Education. Central to this thesis is the challenging of the myths and the narratives that have been constructed around HIV/AIDS in both contexts. Both Scotland and Zimbabwe are influenced by religious, media and political perceptions.

1.6.1 Chapter One

Chapter One consists of the general introduction to the thesis which gives a brief overview of the global and contextual state of HIV/AIDS in both Scotland and Zimbabwe. I then proceed to demonstrate why it is important to undertake this research study and then outline the methods that I employed. The field work process is described, an overall justification of the study and an outline of the various chapters is summarised.

Secondly, Chapter One also contains a brief section on the Terminology that is used throughout the thesis and brief histories of both Scotland and Zimbabwe are presented.

1.6.2 Chapter Two

Chapter Two contains the heuristic tools that are employed in this thesis. First, research paradigms and documentary analysis are discussed and the three analytic tools used in this thesis are explained. First I discuss what the narratives are and how I will use them. I also explain how a critique of sexuality which is mainly based on Foucault will be applied to the data and then define what the post-colonial lens is and how I will also apply it to the data.

1.6.3 Chapter Three

In Chapter Three, I discuss the HIV/AIDS scenario in Scotland giving an overview of the developments from the outbreak of the epidemic in the mid 1980's to the present day. This brief historical section provides a useful background for understanding how the epidemic started and evolved in the Scottish context. Particular attention is paid to both the official and the unofficial explanations and understandings of the origins, responses and the roles of the various stakeholders involved in the HIV/AIDS epidemic. Given that Scotland is a developed economy and demographically smaller than Zimbabwe, its engagement with the epidemic was substantially greater than that of Zimbabwe in terms of the scope, medical/clinical and technological advancement as well as its recognition and application of the human rights framework to the epidemic.

1.6.4 Chapter Four

Chapter Four outlines the complex processes that underpinned the genesis of the HIV/AIDS epidemic in Zimbabwe. The complexities were in part informed by its unique colonial history, its cultural beliefs and experiences, exposure to Christian/missionary activities and the imbalances between the post-colonial challenges and opportunities for developing and sustaining a robust health and socio-political and economic infrastructure. The HIV/AIDS scenario is therefore characterised by a myriad of factors, some of which resemble those in Scotland but others which are distinctively Zimbabwean. These dynamics are essential in understanding the broader issues that determine the manner in which HIV/AIDS has and continues to evolve in Zimbabwe.

1.6.5 Chapter Five

In Chapter Five, the methodology that I have employed in this thesis is presented. Firstly, I discuss the discourse of positionality which critically analyses how my own positioning as a researcher in this thesis is both an advantage as well as a challenge. The insider and outsider perspectives of my positionality are outlined as both challenges and opportunities that contribute towards the richness of the data analysis as well as the constant interactive processes between me and the key informants.

I also describe and give a justification for the sample that I chose as well as discussing the methods that I used. Given that I study two different contexts, Scotland and Zimbabwe, I provide bases for comparison for the two locations. This chapter is a relevant prelude to the next one which presents the findings from both the field work and the selected key policy documents.

1.6.6 Chapter Six

This Chapter contains the findings from both Scotland and Zimbabwe in thematic form. Similarities in both contexts are highlighted and the differences are also indicated. Sex Education is also discussed in this chapter and a fuller explanation

is in the next chapter. While some preliminary analysis of the data is made in this chapter, a deeper analysis is made in Chapter Seven.

1.6.7 Chapter Seven

Chapter Seven discusses and analyses some of the key emerging themes from both Scotland and Zimbabwe. Central to these themes are the explanations of the origins of the HIV/AIDs epidemic, the responses that were made and the explanatory models that were employed. These discussions form part of the journey that has explored various issues which surround the HIV/AIDS discourse in Scotland and Zimbabwe.

1.6.8 Chapter Eight

In this last chapter, I indicate how I have explored a range of issues, some successfully and others less so. The critical point is that in this chapter, I argue how this thesis forms part of the initial framework on HIV/AIDS and the broader Sex Education project which would be the basis for further research and exploration.

This chapter concludes by indicating that this study will significantly add value to the existing HIV/AIDS initiatives through integrating a transformative HIV/AIDS Education approach into the prevention and halting of the epidemic as well as promoting collaborative interdisciplinary research and best practice.

1.7 TERMINOLOGY

Below are the definitions of the key terms used in this thesis.

1.7.1 AIDS

AIDS refers to the Acquired Immune Deficiency Syndrome, a condition that compromises the human's immune system. It is generally transmitted through semen, blood, vaginal fluid and breast feeding. It often manifests itself through various types of cancers, body wasting and other symptoms. AIDS is the advanced stage of being HIV positive. Not all HIV positive cases necessarily develop into AIDS especially when treated by anti-retroviral drugs.

1.7.2 ARVS

ARVS is an acronym used for Anti-retroviral drugs; namely, the medication used to reverse the replication of the HIV virus which prolongs the life of people infected by HIV.

1.7.3 Asylum seeker

An asylum seeker is a person who has made an application for asylum and is waiting to hear the decision on their application. An asylum seeker is a person who looks for safety in a country other than their own for safety due to political insecurity in their country of origin (Cowen 2011).

1.7.4 Colonial

The colonial period in Zimbabwe refers from 1890 until 1980 when Zimbabwe gained its independence from Britain after the signing of the Lancaster House Agreement in 1979. There is a vast body of literature on Zimbabwe's colonial experience but in this thesis the emphasis is more on British colonialism beginning with Cecil John Rhodes from which got Zimbabwe its colonial name 'Rhodesia'.

1.7.5 Epidemic

An epidemic is understood as a widespread of an infection disease within a particular geographical area at a particular time (Dry and Leach 2010). In this thesis, I use the term 'epidemic' in reference to HIV/AIDS in Scotland and Zimbabwe. However, the term 'pandemic' (which refers to a infectious disease covering a wider/global geographical location) is only used within citations.

1.7.6 HIV

HIV is a Human Immunodeficiency Virus condition that one develops beyond being HIV positive. This is normally exhibited through a range of infections that the human body suffers.

1.7.7 Refugee

A refugee is a person who has received a positive decision on their asylum application and who is recognised as a refugee under the UN 1951 Convention on Refugees and has been given leave to remain in the country where they applied for asylum. A refugee is a person who is granted official status for residence and other benefits in the host country beyond their asylum seekers status (Cowen 2011).

1.7.8 Post-colonial

The post-colonial refers to the period and experiences after gaining independence from the colonising country. In the case of Zimbabwe, it refers to 18th April 1980 onwards. Edward Said is an example of a great exponent of the post-colonial theory as explained in this thesis.

1.7.9 Pre-colonial

Pre-colonial refers to the period and experiences prior to colonisation and in the case of Zimbabwe before 1890. Ranger,T.O., Mlambo,A., and Raftopoulous, B, have been cited as major proponents of this discourse in respect of Zimbabwe.

1.7.10 Sex Education

Sex Education is a discourse associated with how to communicate issues relating to sexuality, the human body, human reproduction, the various ways of birth control, sexually transmitted diseases and the discussions that surround what is considered acceptable or unacceptable sexual practice in various societies. In this thesis, Sex Education will be discussed in reference to HIV/AIDS and related matters.

1.7.11 Witchcraft

Witchcraft is the belief and practice of using magical, religious/divine and medicinal techniques to control and manipulate human life and experiences. This is normally culturally specific and takes various forms and combinations. Some modern scholars argue that such beliefs and practices are unscientific,

primitive and untenable. Evans- Pritchard is a classical exponent of witchcraft in anthropological studies. In the context of Zimbabwe, Chavunduka has written extensively on the subject and Rődlach has been cited in the thesis with specific reference to HIV/AIDS and witchcraft in Zimbabwe. While witchcraft was traditionally associated with rural African communities, it has also been noted that in Zimbabwe, witchcraft is both a rural and urban phenomenon.

1.8 BRIEF HISTORIES OF SCOTLAND AND ZIMBABWE

1.8.1 Introduction

The following sections provide outlines of the histories of both Scotland and Zimbabwe. The histories are important in understanding the kinds of issues that shaped the HIV/AIDs discourses in both locations. Examples of these are the impact of colonisation, migration, culture, the media, Sex Education and the policy responses to HIV/AIDS. Sex Education is a discourse associated with how to communicate issues relating to sexuality, the anatomy of the human body, human reproduction, different methods of birth control, sexually transmitted diseases and the discussions that surround what is considered acceptable or unacceptable sexual practice in various societies. As such, there are huge controversies around at what age, who should and the manner in which Sex Education should be delivered within different societies and religious groups[6]. In this thesis, Sex Education will be discussed in reference to HIV/AIDS and related matters. More detailed accounts of the histories of each nation are found are appended at the end of this thesis.

1.9 Brief History of Scotland

1.9.1 Introduction

Current Scotland is a country that is made up of approximately 30 0000 square miles (Mackie 1991) and a population of about 5 295million[7]. In this section, I

[6] http://www.sciencedaily.com/articles/s/sex_education.htm (accessed 20.04.2015)

[7] http://www.scotland.org/about-scotland/the-scottish-people/population-of-scotland (accessed 16.05.2013)

will look at the brief history of Scotland from three broad areas; namely pre-devolution, devolution and post-devolution.

1.9.2 Map of Scotland[8]

1.9.3 Pre-Devolution

The long pre-history of Scotland is not the focus of this thesis. While it is important to note that there were many events that shaped Scotland as it is today, this thesis will mainly focus on issues of migration, religion, demographics within the 20th and 21st century in terms of how they have and continue to impact on some of the key issues of devolution.

Pre-devolution Scotland evolved out of various different formations and influences surrounding present-day Scotland now known as the Highlands, the Grampian, Strathclyde and the Borders (Mackie 1991). Underlying these

8 http://www.google.co.uk/imgres?imgurl=http://www.lonelyplanet.com/maps/europe/scotland/map_of_scotland.jpg&imgrefurl=http://www.lonelyplanet.com/maps/europe/scotland/&h=350&w=466&sz=56&tbnid=0AxG_ZOuHc0ZkM:&tbnh=90&tbnw=120&zoom=1&usg=__YQC_gSHvPSVog4Uf5lFhR3T8SLg=&docid=jIjliKJAOWnzKM&sa=X&ei=60bIUu2XPO6p7AbI14HwAQ&ved=0CDYQ9QEwAg (accessed 16.05.2013)

developments were common factors like the impact of Christianity, the rise of Pictland, the Scandinavian attacks and the pressures from England (Mackie 1991). Beyond this, there were also several military and diplomatic attempts by Scotland to gain its own sovereignty from its southern neighbour England (McCrone 2001).

1.9.4 Demographics

Famines and epidemics in Scotland between 1691 and 1755 reduced the population growth in this period. Epidemics may be understood as a widespread of infectious diseases within a particular geographical area at a particular time (Dry and Leach 2010). In this thesis, I use the term 'epidemic' in reference to HIV/AIDS in Scotland and Zimbabwe. However, the term 'pandemic' (which refers to an infectious disease covering a wider/global geographical location) is only used within citations. Houston and Knox (2006) argued that existing materials prior to 1755 provide patchy evidence for calculating the population of Scotland.

The demographics of Scotland have since continued to diversify although the white Scottish still remain the predominant majority. In terms of ethnicity, the 2011 Scottish census indicates that the whites make up 96% and all other ethnic minorities constitute only 4%. The Asians constitute the largest ethnic minority group with 2.7% followed by Africans with 0.6%, then the mixed/multiple ethnic groups with 0.4%, Other Ethnic group 0.3% and the least being the Caribbean or Black with 0.1%[9].

In terms of Religion, although the Church of Scotland claims to have more adherents than other churches, there are also significant populations of Catholics, other Protestants and more lately other churches brought in through the process of immigration into Scotland. This has shaped the perception of the Scottish population on a range of issues from politics to culture, health, education and national identity among others. According to the 2011 Scottish census, 54% of Scotland claimed to be Christian with 32% belonging to the

[9] http://www.scotland.gov.uk/Topics/People/Equality/Equalities/DataGrid/Ethnicity/EthPopMig (accessed 25.01.2014)

Church of Scotland, 16% being Catholics, 1.4% being Muslims, 0.7% being Buddhists, Hindus and Sikhs together and the Jewish being just under 6000[10].

1.9.5 Migration

The idea that Scotland is homogenous is contested by the fact that there have been at least three types of migration. The first can be referred to as internal migration as was the scenario with the movement of people from the poor Highland soils to the Lowlands. This was also the case when for example the urban centres attracted people from rural areas as labour for the growing commerce and industries in establishments like Glasgow, Greenock, Paisley, Edinburgh and Falkirk (Houston and Knox 2006). The overall urbanisation of Scotland was so rapid that by 1800, Scotland was one of the most urbanised countries in Western Europe.

The second type of movement was the emigration of the Scottish people who left for North America, Canada and the Carolinas (Jones 1970, Houston and Knox 2006). In the late 18th and the late 20th century, Scotland was the emigrating capital of Europe (Devine 2006). The former movements were initiated by rich land-owners who would then sub-let their property for profits and then take along with them people who would be engaged in working on their new properties abroad.

The third type of migration was from outwith Scotland as was the case with the German Jews who funded the import of flax and hemp from the Baltic to Dundee as well as the Irish who migrated into Scotland during the 1848 famine and beyond. In terms of the Irish there were at least two main categories namely the Catholics and the Protestants (Miles and Dunlop 1986). Of significance was the fact that the immigrants brought with them their cultural and religious traditions, a factor which has persisted even within present day Scotland. Most notably, Religion in terms of Catholics and Protestants is one which has tended to be played out as a major signifier of those traditions between the migrants themselves and also between the immigrants and their hosts. While the majority of the Irish were Catholics, the minority Protestants strengthened the Protestant

[10] http://www.scotlandscensus.gov.uk/en/news/articles/release2a.html (accessed 25.01.2014)

Orange Order, a discourse which forms part of the texture of sectarianism in Scotland today (Miles and Dunlop 1986).

The latest Scottish census (2011) indicates that of all ethnic minorities, the Asians constitute the largest percentage with 2.7%. Virdee (2003) for example explains how the Scottish merchants, administrators and military personnel made contact with people from the colonies through the auspices of the British Empire thereby enabling them to bring back to Scotland Asians whom they employed as domestic servants or other low ranking jobs. From a legal point of view, Asian migrants were granted British citizenship by the 1948 British Nationality Act. This further increased the population of Asians into Scotland in the post-World War II period whereby there was a high demand for labour that the local British population was then not able to meet (Dunlop and Miles 1990, Virdee 2003). Given the fact that Asians were traditionally given low ranking jobs, the current scenario is that the pattern has tended to remain the same and most of them have tried to improve their plight by being self-employed in family and retail businesses (Virdee 2003).

More recently, dispersal of asylum seekers and refugees has also added to the number of immigrants into Scotland (Sim and Bowes 2007). This category of immigrants has been at the centre of the origins and spread of HIV/AIDS in Scotland (Creighton, Sethi et al. 2004, Government 2009, Palattiyil 2011).
Although the Schengen agreement of a borderless Europe in 1995 led to an increase of European immigrants into the UK in general and Scotland in particular (Whitaker 1992), it should also been borne in mind that Asians and other migrants who have been resident since the last two centuries and more were also conduits of bringing in more of their kin.

1.9.6 Devolution

Devolution was established through the Scotland Act 1998[11] and this was followed by the establishment of the Scottish Parliament in 1999. By virtue of devolution, there were both devolved and reserved powers. Devolved powers allow the Scottish Parliament to make decisions without depending on the Westminster

[11] http://www.legislation.gov.uk/ukpga/1998/46/contents (accessed 20.12.2013)

parliament whereas reserved powers are for those issues that are decided by the Westminster establishment. The devolved matters are health education and training, local government, social work, housing, planning , tourism, economic development and financial assistance to industry, some aspects of transport, including the Scottish road network, bus policy and ports and harbours, law and home affairs, including most aspects of criminal and civil law, the prosecution system and the courts, the Police and Fire services, the environment, natural and built heritage, agriculture, forestry and fishing, sport and the arts, statistics, public registers and records[12]. Health, Education and Social Work will be important in framing the HIV/AIDS initiatives in Scotland throughout this thesis.

Reserved matters are constitutional matters, UK foreign policy, UK defence and national security, fiscal, economic and monetary System, immigration and nationality, energy: electricity, coal, gas and nuclear energy, common markets, trade and industry, including competition and customer protection, some aspects of transport, including railways, transport safety and regulation, employment legislation, social security, gambling and the National Lottery, data protection, abortion, human fertilisation and embryology, genetics, xenotransplantation and vivisection and equal opportunities[13].

In the context of this research, devolution also coincided with the dispersal of asylum seekers to Scotland through the Immigration and Asylum Act 1999[14]. A fuller discussion of the impact of this initiative is contained in another section of this research study.

1.9.7 Church and State Relations since the 19th century

One way of understanding the role and function of religion in Scotland in the early twentieth century is to consider its relationship to the state and civic society. The term 'religion' of course is being used in a broad sense to refer to Christian denominations predominantly the Protestants and the Catholics. The landscape of religion changed as new migration patterns emerged and people

[12] http://www.scotland.gov.uk/About/Factfile/18060/11552 (accessed 20.12.2013)

[13] http://www.scotland.gov.uk/About/Factfile/18060/11555 (accessed 20.12.2013)

[14] http://scotland.gov.uk/Publications/2003/02/16400/18348 (accessed 2012.2013)

brought with them their own religions. In terms of Africans in Scotland, they are more likely to be incorporated by the Evangelical churches as the latter resonate more with the Africans' experiences of issues relating to HIV/AIDS. Part of this is informed by the rise of the Evangelical churches and the increase of their influence on the healing discourses especially with respect to HIV/AIDS[15].

Devine (2006) argues that religious belief has also been part and parcel of the Scottish people despite some of the contrary arguments that with the industrialisation of the 19th century religious values declined and secularisation became the order of the day. He provides evidence of how religious values constantly influenced the Scottish politics and national identity issues. Thomas Chalmers who was himself a church leader championed the Poor Law Amendment Act, debates on Education and as well as a range of other social matters. In the same vein, kirk elders often doubled-up as town councillors. According to Devine (2006) the Victorian Age was characterised by 'a fusion between Christian ethos and public policy'(p.365). Other examples of church-state overlap and collaboration were instances when the General Assembly of the Church of Scotland facilitated a platform for debating national issues (Devine 2006).

In a sense, the church was not only a moral guide in Scotland but it also served as a barometer for acceptable social standing. In 1890, the Commission on the Religious Condition of the people concluded that the 'unchurched' were considered to be in the same category with the poor and the unskilled despite the fact the Catholics took care of the Irish immigrants who in the main fitted this category (Devine 2006).

1.9.8 Religion, National Identity and Imperialism

While Scottish people often perceive themselves as 'victims of oppression… and not as perpetrators'[16] the situation is much more complex in that they have also been part of the oppressive regimes. On another level, the colonialism and oppression might also have been a class issue in that it was the more affluent

[15] Evidence of this is from the African Health Project Support Groups in Glasgow ran between 2007-2009

[16] http://www.heraldscotland.com/news/home-news/teaching-of-slavery-in-scots-schools-branded-tokenism.23126288 (accessed 25.01.2014)

who took a more pro-active role in colonial and empire issues rather than the rank and file of the Scottish people. As Geoff Palmer the only Scottish black Professor has argued in a recent article in the Scottish Herald (9th January, 2014), within the current Scottish school system, there is very little evidence of how Scotland was actively involved in slavery and colonialism through the conduit of missionary activity[17]. Prof Palmer is quoted as arguing that modern Scottish history tends to focus on the 1960s onwards and tends to ignore the period prior to that.

In the same article, Tom Devine is cited as working on the 'first full-scale academic analysis devoted to the subject entitled *Scotland, Slavery and Amnesia'* in which he admitted that issues like slavery and colonialism are often left to the individual teacher[18]. If this is what is in the contemporary Scottish psyche, an excavation of earlier historical developments would effectively challenge focusing on the victims rather than the perpetrators who colluded with some of the exploitative and colonial activities. Dunlop and Miles (1990) argue that Asians who have been resident in Scotland since the middle of the 19th century onwards were in recognisable ways 'victims of racism and exclusionary practices' (p. 145). This was the case because of Scotland's involvement in British colonialism and Empire building. As the demographics indicate today, there is great evidence that Glasgow is characterised as a *multi-cultural city* but this is in part due to the fact that the migrants from the Scottish Highlands agricultural producers were during the 19th century joined by migrants from Ireland, Eastern Europe and Italy. McKinney (2008) indicates current demographics in Scotland are dependent on immigration from similar countries.

Religion played a pivotal role in terms of framing the Scottish national sense as well as its imperial identity. As Devine (2006) argued, 'the role of Scots in the British empire was given a powerful moral legitimacy by the missionary movement' (p. 366). Scottish missionaries in fact played a leading role in India, Africa, the Caribbean and in China with the greatest British Medical Missionary centre in Edinburgh. Such missionary explorations were not only geared at

[17] http://www.heraldscotland.com/news/home-news/teaching-of-slavery-in-scots-schools-branded-tokenism.23126288 (accessed 25.01.2014)

[18] http://www.heraldscotland.com/news/home-news/teaching-of-slavery-in-scots-schools-branded-tokenism.23126288 (accessed 25.01.2014)

winning souls to God but they also saw part of their mandate as bringing to the colonies acceptable morals, civilisation, education and commerce but also delivering public health from a western perspective. When they returned to Scotland, they did bring with them some of the colonised people who they would engage in menial jobs and sometimes the colonisers and missionaries did not live up to what they advocated in terms of the values of equality, morality and civilisation (Dunlop and Miles 1990).

Some of the key Scottish colonial missionaries who were and are celebrated in Scotland are David Livingstone, Mungo Park, Mary Slessor and Christina Forsyth. However, some modern critiques of the colonial missionary ventures view them as having been double-edged swords in terms of some of the negative effects of their activities in so far as they failed to recognise the importance, value and place of local cultures, talent, moral systems and other institutions (Zeleza 1997).

1.9.9 Post-Devolution

The Calman Commission of 2007[19] was established to review the provisions of the Scotland Act of 1998 so that necessary recommendations would be made in terms of any constitutional changes that would enable Scotland to better serve its people. The opening up of the new Scottish parliament by the Queen on 1 July 1999 since the first one of 1707 was a landmark occasion.
However, following the success of the Scottish national Party (SNP) in 2007, the former Scottish Executive was rebranded as the Scottish Executive as the Scottish Government.

1.9.10 Multiculturalism, Sectarianism and Racism

One of the consequences of migration in the post devolution period was that the Scottish Government had to engage with issues of multiculturalism, sectarianism and racism within the Scottish context. Multiculturalism entailed dealing with the challenges of creating harmonious communities among people coming from different cultural backgrounds and traditions. On another level, racism is linked

[19] http://www.scotland.gov.uk/News/Releases/2009/06/15151304 (20.12.2013)

to different forms of hate crime of which sectarianism is a significant one in Scotland.

McKinney (2008) has suggested what he calls the 'working' definition constructed by Leichty and Clegg (2001:102-103) based on their work in Northern Ireland

> *Sectarianism is a system of attitudes, actions, beliefs and structures, at personal, communal and institutional levels, which always involves religion, and typically involves a negative mixing of religion and politics. Sectarianism arises as a distorted expression of positive human needs, especially for belonging, identity and the free expression of difference and is expressed in destructive patterns of relating: hardening the boundaries between groups; overlooking others; belittling, dehumanising, or demonising others; justifying or collaborating in the domination of others; physically or verbally intimidating or attacking others* (p.336).

Sectarianism in Scotland has manifested itself through the tensions between the Catholics and the Protestants physically and psychologically, football club affiliation in which Catholics identify with Celtic and Protestants with Rangers and the media has indeed also made high profile coverage of sectarianism (Zannoni 2012). One of the key emerging discourses surrounding sectarianism is that apart from the physical tensions between the opposing groups, it has also become more of an attitudinal issue which is rooted and nurtured in the psyches of both groups.

The then Scottish Executive (now the Scottish Government) did not just watch sectarianism proliferating. Jack McConnell the former First Minister of Scotland called sectarianism 'Scotland's secret shame'(Devine 2006). Initiatives to address that involved the production of: *Global Citizenship: A Guide for Schools, 2007.*

Racism is also another discriminatory discourse that devolved Scotland has had to grapple with. Like sectarianism it is also connected with the discourses of immigration and multiculturalism as well as the struggle to deal with matters of

national identity. The *One Scotland Campaign of 2007* was one of the official responses in combating racism.

The movement of asylum seekers and refugees to Scotland in the post devolution era was met by negative attitudes **of** some mainstream white Scottish hosts. This led to the secondary migration of the asylum seekers and refugees from Glasgow to other bigger cities in England like Manchester, Birmingham and London which had a longer experience with ethnic minority migrants (Sim and Bowes 2007).

1.9.11 Section 2A

One of the most contentious issues that Donald Dewar dealt with was the removal of Section 2A (sometimes referred to as Section 28) whereby local authorities were prohibited from denouncing homosexuality because it led to stigma, fear and discrimination for the targeted group (Rennie 2003, Devine 2006). In response to this initiative, Cardinal Tom Winning led a vigorous campaign consisting of Catholics, The Daily Record, Brian Souter (an evangelical Christian) and other sympathisers but they were not successful in getting the legislation retracted (Devine 2006). The Cardinal Wining campaign saw the removal of Section 2A from the statute book in 2001 as an attack on family values. In their view, the Catholics perceived the Scottish Executive as pursuing a politically correct agenda at the expense of the traditional moral principles while the Church of Scotland were more cautious by not necessarily voicing the same sentiments. Section 2A is indicative of the power of the gay lobby in terms of how they articulated their entitlement to their values being upheld as part of the human rights agenda within Scotland and other developing countries.

Devolution has meant that not only has Scotland needed to challenge issues of multiculturalism, sectarianism and racism, it also has had to make responses to the HIV/AIDS epidemic within its borders. This is evidenced by the various policy documents for example, *The Respect and Responsibility Sexual Health Strategy Annual Reports* (2005-2007), *HIV and Hepatitis: Current Controversies in Prevention and Public Health* (2005), *HIV Action Plan in Scotland December 2009 to March 2014* (2009), *The Sexual Health and Blood Borne Virus Framework 2011-15* (2011), *Health Protection Scotland* (HPS)website with robust details on

HIV/AIDS as well as a dedicated Scottish Government Health website, *The Penrose Enquiry Preliminary Report (2010)* which have since been put in place, the training of appropriate personnel and engaging with issues of HIV/AIDS through various aspects of the school curriculum. In Scotland, homosexuals have been more empowered than in Zimbabwe hence their ability to take a leadership role in responding to the issues of HIV/AIDS. Through the Equalities and Human Rights legislation[20] as well as the *Embracing Equality, Diversity and Human Rights in NHSS Scotland*, (December 2013) the homosexuals and other suppressed groups have managed to emancipate themselves by successfully refusing to be solely blamed for the origins of the epidemic to being champions of advocacy and equality of treatment within the HIV/AIDS discourse. In Zimbabwe, the homosexuals have to date not managed to extricate themselves from the persistent blame on them being the cause of the HIV/AIDS epidemic.

1.9.12 Conclusion

Houston and Knox (2006) argue that that Scotland has always struggled to be independent and maintain its identity, it has 'never lost its ability to govern itself' (p.535).

Despite the above, the current SNP government continues to publicly argue for a pro-immigration attitude as witnessed by Scotland's acceptance of refugees and asylum seekers, as well as the Home Coming Event in 2009[21] intended to woo back Scottish people in diaspora. In addition to its pro-immigration attitude, the SNP government is also in the process of advocating for Scottish Independence through a referendum scheduled for September 2014[22]

[20] http://www.scotland.gov.uk/Publications/2013/12/3747/3 (accessed 11.02.2014)

[21] http://www.scotland.gov.uk/Publications/2010/09/14081057/0 (accessed 20.12.2013)

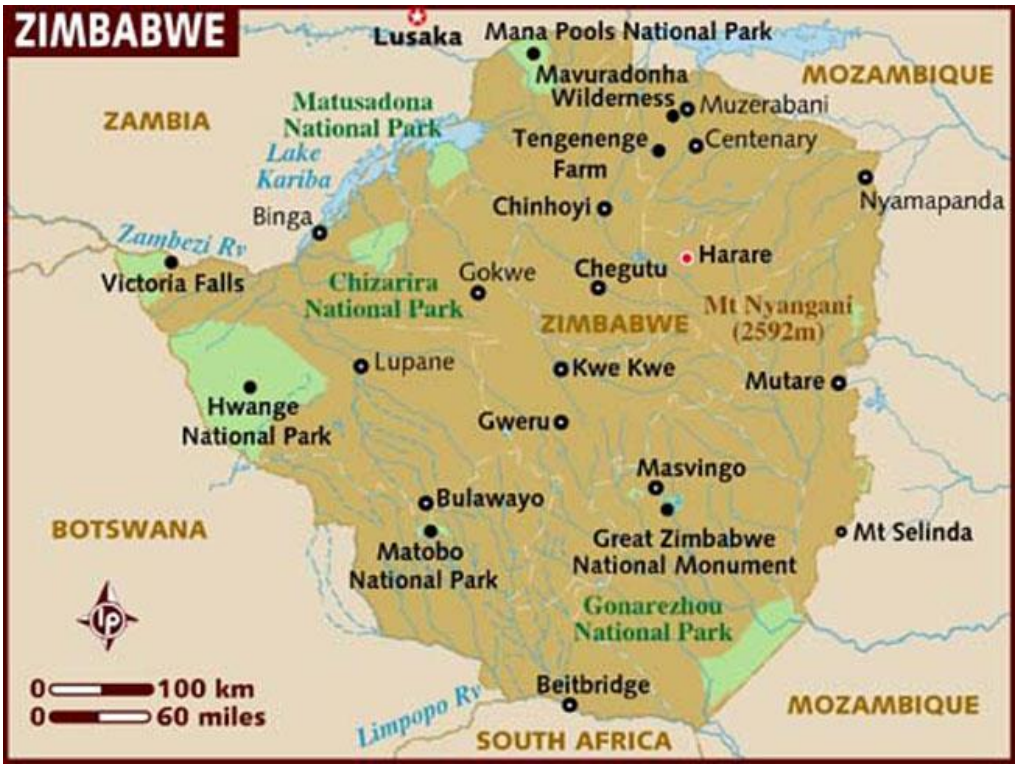
[22] http://www.scotland.gov.uk/News/Releases/2013/03/referendum-date21032013 (accessed 201.2013)

1.10 Brief History of Zimbabwe

1.10.1 Background

The country now known as Zimbabwe did not always have the geographical boundaries that it bears today prior to formal colonisation. This is why a number of historians referred to it as the historical plateau of southern Africa (Hole 1926, Windrich 1975, Bhila 1982, Sylvester 1991). Zimbabwe lies in the tropics with a total land area of 390 000 square km, approximately 725 km long and 835 km wide (Palmer 1977, Sylvester 1991) with two major rivers, the Zambezi on its northern border with Zambia and the Limpopo on the south bordering with South Africa. To the east Zimbabwe borders with Mozambique and to the west with Botswana and Namibia to the northwest (see the map below).

1.10.2 Map of Zimbabwe



The discussion that follows is based on the pre-colonial, the colonial and the postcolonial periods. Although there is no unanimous consensus on the content and character of each period, there is however some general agreement on the

fact that these periods inform the development of the events, the culture and status of the debates about present day Zimbabwe.

Zimbabwe has a history which stretches back several centuries. The exercise of compiling its history has used a range of sources to construct it in the form of oral tradition and evidence, various material artefacts deposited in different collection points both within and outside Zimbabwe as well as the huge resource of ongoing historical and other forms of research relating to Zimbabwe. Both the period of time and the diversity of sources contribute to the complexity of compiling the history of Zimbabwe. Given that there was a collusion of discourses between the colonists and the missionaries in Zimbabwe, both the colonists and the missionaries became the main sources of compiling the history of Zimbabwe.

Based on my field work research at the Zimbabwe National Archives in Harare and the Kew National Archives in London (the latter is a repository of a range of resources collected from the former British colonies), these sources are not without the colonial prejudice of their authors. Much of the pre-colonial and colonial history was almost exclusively dominated by western and often imperial researchers and authors. However, more recently local Zimbabwean authors have started to contribute to the writing of their own history (Raftopoulos and Mlambo 2009).

1.10.3 The Pre-colonial Period

The pre-colonial period in Zimbabwe may be defined as the period prior to the formal colonisation of the country by Cecil John Rhodes in 1890. Within the pre-colonial period, various strands may be identified. On one level it may be argued that the pre-colonial period is characterised by some kind of pristine culture, which had not had any interaction with foreign or external contact or influence prior to formal colonisation (Chigwedere 1980, Chigwedere 1982, Chigwedere 1986). But this view is contested by other scholars.

The Shona collectively comprise the largest linguistic/tribal 'group' as compared to the Ndebele who are the second largest. There are also other smaller tribal groups.

There are two main explanations of how Zimbabwe became populated. The first is that it was due to the *mfecane*[23]. The *mfecane* consisting of the Nguni tribal groups[24] came about as a result of the early 19th century economic and environmental pressures experienced in South Africa at the time (Mazarire 2009).

The other explanation is that there was equally a south-bound movement known as *Gurusuwa*[25] from the present day Tanzania moving into Zimbabwe (Palmer 1977, Bhila 1982, Lilford 1999). The history of the black Zimbabweans remains a matter of controversy as will be demonstrated later. This is partly due to the fragmented and sometimes contradictory historical and other evidence between the Boer, British, Portuguese colonists and missionaries who first tried to put the history together as well as the more recent initiatives by scholars from within and outwith Zimbabwe.

From a pre-colonial historical perspective, Mudenge (1988) also argues that there is literature that indicates that the Portuguese traders and missionaries interacted with Zimbabweans prior to the formal colonial period. What one can therefore draw from this is that the pre-colonial period was in fact not as 'pristine' as it may otherwise be argued.

1.10.4 The Colonial Period

The colonial period in Zimbabwe was marked by the arrival of the colonists in 1890 (Windrich 1975, Raftopoulos and Mlambo 2009). The colonisation of Zimbabwe by Britain was part of a larger exercise that other European countries

[23] The North-bound movement by the Nguni tribal groups who migrated from South Africa into Zimbabwe

[24] The Nguni are made up of three large subgroups namely the Northern Nguni (the Zulu and the Swazi); the Southern Nguni (notably the Xhosa, but also including other smaller groups); and the Ndebele. Each of these Nguni groups is a heterogeneous grouping of smaller ethnic groups.

[25] Guruuswa is variously interpreted as ' the place of the long grass', a water source or a woman's pubic hairs symbolic of where all live comes from http://www.persee.fr/web/revues/home/prescript/article/jafr_0399-0346_1999_num_69_1_1193 (accessed 18.12.2012)

embarked on following the Scramble for Africa which resulted in the partitioning of the continent on the basis of the Berlin Colonial Conference of 1884. Although there had been previous contacts between Europe and Africa, the partition of Africa effectively marked the official colonisation of the continent. The latter was necessitated by a range of factors most notably economic expansion, the need for raw materials, space for experimental work for new technologies outside Europe, a dumping ground for social misfits and the sheer need for territorial control among other factors (Koponen 1993).

In the case of Zimbabwe, its colonisation came about as a result of the British discovery of gold and other resources in South Africa (Phimister 1988). However, given the tensions between the Boers and the British over the control of South Africa, Cecil John Rhodes had a dream to conquer Africa from Cape (southern-most part of South Africa) to Cairo (the northern-most part of Africa) (Hole 1926, Palmer 1977).

Colonisation in present day Zimbabwe was a complex process predicated on coercion, contestations, negotiations, manipulations, rejections and concessions between the white settlers and the local African Zimbabweans (Mazarire 2009). In his analysis of the colonisation of Zimbabwe, Hole (1926) argues that there were several contestations and rivalries between the white settler groups who were pursuing similar interests and that this in turn caused the local leadership to raise concerns about the credibility of the white colonists.

1.10.5 Missionary Role in the Colonial Process

Apart from the concession seekers, traders and hunters, missionaries played both a pivotal and ambivalent role in the colonisation of Rhodesia. It is important to highlight that missionaries perceived themselves to be custodians of truth but this point is challenged by the African writer and critic Chinua Achebe[26]. In the 1820s, Robert Moffat, a British missionary of the London Missionary Society (LMS) befriended King Mzilikazi Khumalo of the Ndebele and

[26] For example: Things Fall Apart (1958), No Longer at Ease (1960), Arrow of God (1966), A man of the People (1966), An Image of Africa (19750 Anthills of the Savannah (1987), Conversations with Achebe (1975) and many others.

then visited him in 1854 and subsequently established the first LMS mission station at Inyathi in western Zimbabwe in 1859 (Ndlovu-Gatsheni 2009).

On the whole, the missionaries facilitated the colonial process as language interpreters but also by inculcating western values and Christianity as part of creating the pre-requisite to an appropriate world-view which would enable a buy-in of the formal process of colonisation. The role of the missionaries and their colonist counterparts is well documented in archival materials both in Zimbabwe and in London.

1.10.6 The Pioneer Column

The Rudd Concession was a significant landmark in ushering the north-bound movement of the colonists from South Africa into Zimbabwe known as the Pioneer Column which set out in 1893. The Pioneer Column triggered resistance not only from the Ndebele but also from the Shona who were located along the route that the Pioneer Column pursued on its Road to the North. A number of protest movements have been recorded namely the 1893 war, the 1896-7 war and much more recently the last *Chimurenga*[27] staged in the 1960s culminating in the birth of the new Zimbabwe (Raftopoulos and Mlambo 2009).

1.10.7 Racial Segregation

The colonists in Zimbabwe segregated people on the basis of their racial categories (Windrich 1975, Palmer 1977), namely the whites, the blacks, as well the mixed race commonly referred to as the 'coloureds'.

Legal statutes were developed in order to enforce racial segregation and discrimination examples of which were the Land Apportionment Act of 1941 with its amendments in 1944, 1945, 1950, 1951, 1960, 1961 and 1970 (Windrich 1975).

[27] The guerrilla war for independence

1.10.8 Federation

The federation was the amalgamation of Southern Rhodesia (now Zimbabwe), Northern Rhodesia (now Zambia) and Nyasaland (now Malawi) on 3 September 1953 until 31 December 1963 (Wood, 1983, The Welensky Papers). The rationale for the federation was to enhance labour and exploit the resources in central Africa for the benefit of Her Majesty's economy. However, the local inhabitants become increasingly sceptical of the advantages of the federation in terms of their own self determination and began to agitate for self-rule. In response to these sentiments, a landmark constitution was passed in Southern Rhodesia in 1961 intended among other things to extend the franchise to black Zimbabweans as well as to increase the powers of the Southern Rhodesia government (Windrich 1975). However, this move did not in itself satisfy the increasing demands for legislative participation by the local blacks.

On the other hand, Britain as the colonial power directly in charge of the federation, was unable to meet the demands of the local black Rhodesians due to its feeble military strength and was not prepared to face another front of revolt beyond the Northern Irish one.

1.10.9 Liberation War and the Land issue

While Zambia and Malawi were able to develop into African independent states beyond the federation, Rhodesia remained under white colonial rule until the 18th of April 1980. The Rhodesian struggle for independence was marked by a bitter guerrilla war. The driving force for the struggle was not only self-rule but the demand for an equitable distribution of resources and most crucially land. The land question has since characterised Zimbabwean politics and economics thenceforth to the present. Even after independence the struggle for land has manifested itself in various forms especially through the Land Acquisition Act of 1992 and the Land Acquisition Amendment Act of 2000, the subsequent 'land grab' exercises and the Indigenisation Policy which have remained operational to date.

1.10.10 Post- colonial

The post-colonial period in Zimbabwe was marked by its independence on 18 April 1980. The term post-colonial is one which is complex in that both in content and in historical terms, there is no single agreement. One can identify at least two strands of thought namely; one argues that colonised spaces (countries) have not yet evolved out of the experience of colonisation while the other postulates that there are significant milestones to indicate political and/or some form and shape of economic independence.

The fragmented transition from colonial to post-colonial sets the context for problematising what in Zimbabwe's experience can be strictly referred to as 'colonial' and 'post-colonial.' A more in-depth analysis of the discussion of the 'post-colonial' lens will be made in reference to the responses that have been to the HIV/AIDS epidemic in Zimbabwe in the forth-coming chapters.

1.10.11 The Period of Success

Zimbabwe inherited a healthy economy at independence in 1980. It was against this backdrop that the new political establishment also moved very quickly to expand education, health, rural development, water and sanitation and other services especially in areas that had been deprived during the colonial period (Muzondidya 2009). This is evidenced by Mlambo (1997) with the expansion of enrolments at both primary and secondary school levels. Zimbabwe was popularly referred to as the 'bread basket' of Southern Africa because of its outstanding food production and a very stable economy. The same period also witnessed political democracy as evidenced by critical parliamentary debate, high judges' opposition to government interference, the formation of the opposition party Zimbabwe Unity Movement (ZUM) by Edgar Tekere, the former Secretary General of the ruling ZANUPF, student demonstrations as well as public academic discourse in various formats (Muzondidya 2009).

1.10.12 The Crisis Era 1997 Onwards

Raftopoulos (2009) notes that the period from the late 1990s onwards are generally characterised as the 'Crisis in Zimbabwe'. This period has also been written about extensively as demonstrated by the vast literature on it.

In 1997, a coalition of civic groups, church organisations, trade unions, academics and other concerned members of society led to the formation of the National Constitutional Association (NCA) on 31 July 1998 at the University of Zimbabwe (Raftopoulos 2009). The main focus of this organisation was to push for a constitutional change as a way of dislodging the ruling party. Initially the NCA was bank-rolled by the German Friedrich Ebert Stiftung organisation. In Sept 1999, the Movement for Democratic Change (MDC) political party evolved out of the NCA in order to challenge the ruling ZANUPF party. One of the reasons why the NCA and MDC gained rapid currency was the deepening of the socio-economic crisis that was prevalent in Zimbabwe. The crisis was evidenced by job mass-stay-aways as well as food riots.

In response to the NCA, the government set up a Constitutional Commission (CC) in order to pre-empt the constitutional reform process. However, the NCA insisted that the government's CC was simply a ploy to divert public attention from critical engagement with constitutional reform and therefore continued to mobilise and educate the public on the constitutional reform agenda (Raftopoulos 2009). The government bulldozed its way through with its CC resulting in referendum in February 2000 in which it lost to a 54% 'NO' vote that the NCA campaigned for (Raftopoulos 2009). Agitated by this loss, the government mobilised its ex-combatants and youth militia to enforce a compulsory land acquisition exercise colloquially referred to as *jambanja*[28].

Another notable outcome of the Zimbabwean crisis was the increased momentum of migration into neighbouring countries in the region and much far afield like the USA, New Zealand, Australia, Canada and the UK.

[28] Literally means havoc or an activity fuelled by anger

In urban areas, the land issue took a different twist when Operation Murambatsvina[29] was launched in May 2005. Most of those who were displaced were equally were perceived as being anti the ruling establishment (Vambe 2008). This exercise destroyed much of the affected dwellers' livelihoods and had a significant impact on the HIV/AIDS programmes (Sachikonye 2003) details of which are discussed in a separate part of this thesis. In 2008, Zimbabwe once again engaged in elections the results of which led to another dispute between the ruling ZANPF and two MDC parties, one belonging to Morgan Tsvangirai and another to Arthur Mutambara and Welshman Ncube. The impasse was eventually resolved through the signing of the 11 September 2008 Government of National Unity (GNU) agreement but its implementation was not until January 2009 (Raftopoulos 2009). The GNU was dissolved after the July 2013 elections in which ZANUPF claimed victory of over both MDC parties and is in power at the time of writing of this thesis.

1.10.13 Conclusion

This section has highlighted the major milestones in Zimbabwe's history which is basically anchored on its experience of and reaction to colonialism. Although there have been periods of growth and development, the current scenario demonstrates ongoing tensions and challenges to extricating itself from the colonial legacy and framing a new agenda that would characterise an vibrant and fully independent state.

Despite the July 2013 elections, the current scenario paints a rather bleak picture of Zimbabwe in so far as its' socio-economic status and its human rights record goes.

[29] In the local Shona language, the expression literally means drive out filth

2 Chapter Two Heuristic Tools

2.1 Introduction

In this chapter, I have outlined the heuristic tools that I employed in my qualitative research study. I will describe the research paradigm that I use, explain why I have chosen the three heuristic tools namely, the use of narratives, current attitudes to sexuality as well as the post-colonial lens. The main reason for these choices lies in the fact that they provide critical frameworks for understanding and analysing the issues that circumscribe the HIV/AIDS issues in this thesis. I have proceeded to define each of these tools and explained the ways in which they provide a basis for engaging with the data in this research.

2.2 Research Paradigms and Documentary Analysis

In the next section, I will highlight the key characteristics of the quantitative and the qualitative approaches. I will also indicate the major differences between them and then proceed to describe the qualitative approaches which I adopted within my own research study.

2.2.1 Quantitative and Qualitative Methods

Research has traditionally been defined in terms of quantitative and qualitative. However, more recently, arguments have been made to the effect that both approaches can be combined (Driscoll, Appiah-Yeboah et al. 2007, Scott 2007) although some scholars still believe that there is constant tension between them (Denzin and Lincoln 2005). Quantitative research is often defined in terms of that approach that uses quantities like numbers, statistics, surveys, questionnaires which often include large populations. Quantitative approaches tend to emphasize measurement and statistical analysis of various kinds.

Qualitative research has its history in the early anthropology of scholars like Bateson, Boaz, Evans-Pritchard, Malinowski and Radcliffe-Brown (Denzin and Lincoln 2005). More recently, qualitative methods have been associated with the

Chicago School which sought to study group life and the related phenomena (Shah and Corley 2006). Denzin and Lincoln (2005) argue that qualitative researchers study phenomena in its natural settings and try to make sense of the meaning s that people bring to it. Denzin and Lincoln argue that qualitative research is often 'a site of multiple interpretive practices' that are shaped by 'multiple ethical political positions' (2005, p. 6-7).

Some of the major differences between the quantitative and the qualitative approaches are that while the former emphasizes positivism as a way of understanding the social world, qualitative researchers often criticize the quantitative approach as simply emphasizing cause and effect (Flick 2014). While quantitative researchers capture the responses of their respondents in a remote way, qualitative researchers on the other hand are able to capture more detailed data because of the live engagement and proximity of their respondents. Finally, the qualitative researcher s argue that they are better able to obtain a richer and more deeper description of the views of their respondents than the quantitative researchers (Denzin and Lincoln 2005).

2.2.2 The Qualitative Research Paradigm

In this study, I have used the qualitative method but focused on two types; the key informant semi-structured interviews and the analysis of selected key policy documents. There is a strong connection between the research paradigm and the methodology that one chooses to use.

The research paradigm contains the researcher's epistemology, ontology, ideology and axiology (Guba and Lincoln 1994). Epistemology deals with how knowledge is acquired and how that knowledge can be shared by the researcher. As suggested above, the knowledge gathered in this thesis is based on key informant responses and selected key documents analysis but it is also framed within my own positionality as the researcher. So while epistemology is a critical component of the research paradigm there is need to be cognizant of the sources of that knowledge as well as my own positionality. This point is highlighted by various authors within the context of the reliability and the

knowledge acquired in the process of research (Guba 1994, Becker 1996, Edwards 2002).

While epistemology focuses on how to obtain knowledge, ontology has to deal with what it is that we can know, often referred to in philosophical terms as the science of being. There is evidence that epistemology and ontology can be linked in order to provide reliable knowledge. An example of this is the study by Wickramasinghea (2006).

The other two factors are ideology and axiology of both the researcher and the researched. Ideology in this sense refers to the system of political and cultural beliefs and axiology is about the system of values within which one operates. While Guba and Lincoln (1994) highlight the significance of these two factors, they also explain how both one's positionality and the research ethics are critical processes in minimizing bias within the qualitative research study.

In my research study, I have chosen the interpretivist paradigm because in their responses, the key informants are not simply giving neutral answers, but they are also interpreting how they conceptualise and understand the issues being investigated. As a researcher, my own analysis and write up of those responses are in themselves equally interpretivist. On one level, the documents contain the policies as articulated by how those who decide what the HIV/AIDs epidemic means within a particular context as well as how they stipulate how it should be engaged with. The third aspect is how as a researcher I analyse the contents of the policy documents, try to decipher what I think they mean both to the policy makers and the consumers of those policies. I then proceed to write up my own analytical understanding of what they contain and prescribe. As such these various activities are essentially interpretivist. The above has demonstrated the complexity of the qualitative research paradigm as well as articulating how I will be taking cognisnace of them within my study.

2.2.3 Hybrid Approach

My research is located within a hybrid approach that is constituted by interpretivist, critical, transformative/emancipatory elements (Mackenzie and

Knipe 2006). My reason for choosing a hybrid paradigm is because no single paradigm on its own would do justice in explicating the complex issues that I would like to explore. Secondly, it is also currently recognised that the traditional stand-alone paradigms are increasingly inadequate as explanatory heuristics and that a more comprehensive approach can be taken in combining two or more lenses *(*Lincoln 2000, p 164) such that complex processes like policy making on HIV/AIDS are better interrogated within a hybridised paradigm. First, the interpretivist approach within the paradigm is about how the issues are narrated and represented rather than being presented in a vacuum (Creswell 2013). Within the context of my research, the key informant responses and the selected key policy documents are very much representations about the HIV/AIDS epidemic. The interpretive approach allows for a deeper understanding of the phenomena as well as a rigorous analysis of the data collected (Shah and Corley 2006). Given that I use more than one qualitative tool of obtaining the data, the two in fact serve to minimize bias and to explore the commonality of themes and the kinds of narratives and the manner in which they are represented.

The critical approach within my hybrid paradigm is pertinent to my research in that it highlights the central importance of the different strands and permutations of how power is transacted in complex societies and how power relations shape social and political discourse as well as social and legislative action (Harvey 1990). These permutations in turn account for how meaning and representation are constructed. The critical approach is in fact part of the continuum of the transformative/emancipatory approach.

The transformative/emancipatory paradigm is equally related to the above paradigm in that it is based on the principles of emancipation and social transformation. In that regard, it is committed to the social justice agenda as demonstrated by the fact that it

> *is concerned not only with unpacking reality, but suggesting ways of altering it; to provide genuine support, in other words, in the struggle against the structural oppression of discernible groups (Troyna 1994, p.82)*

This second form of appraisal is about using the critical data in order to more fully understand how we might transform social attitudes and practices. This is not just a descriptive but an ethical project determined to understand the more effective engagement of the historic failures in the politics of AIDS/HIV Education.

My hybrid paradigm is informed by both critical theory and philosophical thinking. While critical theory is a useful instrument for subjecting the empirical data to rational clarification and justification. Conroy *et al* argue that philosophical scrutiny is an indispensible basis for creating sound policy and practice (Conroy, Davis et al. 2008) thereby disaggregating description from analysis from prescription.

I therefore sought to investigate through the key policy documents (the word 'documents' is used in this research to refer to texts as contained in various formats) and the key informant interviews, the nature and the relationship between the varied and various HIV/AIDS narratives, in terms of the whether they are similar, overlapping or different, and why. I also explored whether or not some narratives are more powerful than others and the messages that they evoked and /or communicated. This is necessary since social scientists are apt to hold the view that social science requires an excavation of those potential structural and systemic biases that are determined by race, class, gender and other factors. It is on this basis that Harvey argues that

> *Critical social research does not take the apparent social structure, social processes, or accepted history for granted. It tries to dig beneath the surface of appearances. It asks how social systems really work, how ideology or history conceals the processes which oppress and control people* (Harvey 1990).

2.2.4 Documentary Analysis

Documentary analysis is the other qualitative type of research that I have utilised in this study. In this thesis, I use the term 'documents' to refer to the official texts that have been produced by the governments, HIV/AIDS organisations and related institutions. As I have used a range of these

documents, I have appended a list of them at the end of this thesis. These documents contain National HIV/AIDS Policies, selected Texts on Sex Education, Pastoral Letters, a selection of other church-related documents, An HIV/AIDS Public Enquiry and a Health Demographic Survey.

The significance of the key policy documents is that they not only capture the history of the phenomena under study but they also communicate the political and ideological positions on whose behalf they are written and published (Denzin and Lincoln 2005, May 2011). Documents are differentiated on at least three levels: primary, secondary and tertiary (May 2011). Primary documents may be understood as the original texts that contain a policy, describe an event(s) or provide first hand evidence by eye-witnesses or participants in a particular discourse. Secondary documents are those that are viewed within the broader social context of a particular discourse and tertiary are those that enable the location of those documents and examples of which include indexes, abstracts and bibliographies. While these classifications were used by May (2011), modern technological/electronic and corporate development and storage of information has tended to blur such distinctions. For example, the recognition of other forms of documents like photographs, textile and forensic materials has made the distinction between primary, secondary, and tertiary more complex than before. As such the boundaries of authenticity have not only shifted but they have also expanded. To this extent, my reference to documents will take cognisance of these later developments as contributory factors in assessing the authenticity and impact of the documents on HIV/AIDS in Scotland and Zimbabwe. All these documents may either be private or public, solicited or unsolicited. This study will focus more on the public documents although reference will be made to other types of documents as required.

There however tends to be debate around whether or not documents represent what they are intended to represent or sometimes communicate the 'unstated meaning structures' of the document (Cicourel 1964). Part of the complexity of the documents is that they cannot be read in a neutral way. As a researcher with a particular positionality, my reading of the various documents will also in part be informed by my perceptual and experiential position. In terms of the analysis of the selected key documents, attention will be paid not only to what they

contain but equally what they exclude (May 2011). Documents may be viewed as constructions of social reality, texts that communicate certain types of social power as well as presenting the cultural contexts in which they are written (Habermas 1984, Agger 1991, Giddens 1993). In the context of my study, one resultant effect of the policy documents is the way in which people affected and infected by HIV/AIDS are marginalised and blamed for the epidemic. A more detailed analysis of this perspective will be pursued in Chapter 6.

In terms of my own analysis of the documents, the very act of reading them to some extent entails reconfiguring what it is that they would be communicating. However, the data gathered from the key informant responses would balance out issues in terms of exploring the points of divergence and convergence and seeking a clarification of why that would be the case. A key aspect of documents has so much to do with 'hidden meanings of the text' as well as the ambiguous role of the author. Barthes talks about the death of the author which means that the meaning ascribed to the text may not necessarily correspond to those intended by the original author (Barthes 1977, Foucault 1984). While these perspectives make a significant contribution to document analysis, they also demonstrate the possible limitations of exclusively relying on the documents as authentic and unquestionable texts. For example, there is a likelihood of choosing which parts of the documents to use to prove an argument and which ones are factored out.

Despite the above limitations, document analysis is a useful way of referencing the data collected in that the physical text remains the same despite the hermeneutic challenges that might characterise it.

2.3 Narratives

Narratives have been defined and characterised in various ways as I will demonstrate in the discussions that follow. There are also some similarities and differences regarding the origins of the narratives.

2.3.1 Origins and Definition of Narratives

There are different perspectives regarding the origins of narratives. Riessman and Quinney (2005) and Riessman (2008) argue that the use of narratives came to prominence in social science research from the 1960s onwards. While the real origins are often associated with Aristotle (2008), references have also been made to Ricouer (1991), (Riessman and Quinney 2005). Riessman (2008) also states that according to Susan Chase, narratives are closely associated with the studies of the Chicago School in so far as studies of human behaviour were based not merely on genetic causes but on the significance of the particular people's histories, life experiences, a range of social and other structural factors like their physical environments.

2.3.2 Structure of Narratives

Traditionally narratives have been associated with Aristotle in his explanation of the Greek tragedy in his classical book *Poetics* (Ricoeur 1991). Aristotle defines tragedy in the context of the three unities; namely time, place and action (Riessman 2008). He argues that action is imitated (mimesis) in which the dramatist portrays a representation of events, experiences and emotions. Central to this is the fact that narratives have sequence and a structure. Within this sequenced structure of events played out by different actors there is a beginning, middle and end. Each narrative also has a plot which in turn evokes emotions of fear and awe. This occurs when there is a breach of expectations (peripeteia). This breach results in the audience's response which creates some catharsis (Riessman 2008).

Narratives have a surface structure and a deep structure. They may also be grounded within a particular time-frame and place but they can also be extrapolated to create meaning for the future or it may be applied post the event(s) or occurrence(s). This is because, as will be explored later, the *setting and situation* of a narrative and the position and power of the narrator are important. Austin (1975) uses the term 'speech acts' to shed light on the various activities and processes involved in the construction, communication, consumption and reaction to narratives. Following Ricoeur (1991), Squire (2008)

argues that narrative is constituted by various determinants namely the 'intersection of the life worlds of speaker and hearer, or writer and reader' (p.18) and indeed the various locations in which the narrative is presented.

Narratives are also differentiated from other types of discourse by other factors (Riessman and Quinney 2005). One of them is that there is both a sequence and a consequence in so far as the material is always structured for a specific audience. Secondly, there is always an analysis of the language in terms of the 'how and the why events are storied' (Riessman and Quinney 2005, p.394). Finally, narratives are also structured both 'thematically and episodically' (Riessman and Quinney 2005, p.395).

Beyond the initial development of narratives, they also evolved through French structuralism, Russian formalism, post-structuralism, cultural analysis and more recently postmodernism (Riessman and Quinney 2005, Riessman 2008).

2.3.3 Contexts of Narratives

Narratives are depicted in various contexts. For example, Riessman (2008) observes that although narratives were originally located within literary works, she cited Bakhtin who argues that different forms of texts equally constitute narratives. This can be exemplified by the epigraph in the Riessman's (2008) book where Bakhtin is quoted as saying that

> *If the word 'text' is understood in the broadest sense – as any coherent complex of signs – then even the study of art….deals with texts. Thoughts about thoughts, experiences of experiences, words about words, texts about texts.* (Bakhtin, speech Genres and Other Late Essays, 1986).

Riessman (2008) also quotes Barthes in Sontag's 1982 Reader that:

> *Narrative is present in myth, legend, fable, tale, novella, epic, history, tragedy,*
> *Drama, comedy, mime, painting…, stained glass windows, cinema, comics, news item, conversation. Moreover, under this almost infinite*

> *diversity of forms, narrative is present in every age, in every place, in every society; it begins with the very history of mankind (sic) and there nowhere is nor has been a people without narrative…is simply like life itself.*

It is in fact against this background that narratives began to be used across disciplines within the social and human sciences (Riessman and Quinney 2005).

2.3.4 The Purpose of Narratives

As Reismann (2008) argues, 'narratives often serve different purposes for individuals than they do for groups'(p.8). Some of the examples in which narratives function are courtrooms where lawyers organise their clients to present specific scenarios regardless of whether or not that would be a portrayal of 'objective' truth rather than credible evidence. Narratives also engage with their audiences in diverse ways and more critically, narratives can also mobilise people into progressive social change as is the case with civil rights and gay and lesbian movements (Riessman 2008, Squire 2008). Equally, narratives also play an important part in society in that they are strategic, functional, serve one or more purposes.

Within the scope of this study, narratives do political work through changing minds, consciousness and the flow of power (Riessman 2008). Narratives also have overlapping functions where both the teller and the audience may influence each other in their respective contexts of speaker and listener (Squire 2008). In some instances, narratives draw on a range of cultural resources in order to achieve their intended goals (Riessman 2008).

While narratives are often meant to argue for, justify, persuade their audiences to accept, engage in or even mislead them, they are sometimes told in order to entertain even if the narrative being told is not ordinarily entertaining (Riessman 2008). The latter may be the case as when drama about HIV/AIDS messages not only communicate health messages but create entertainment for their audiences.

In the West of Scotland, for example, the Clyde Unity Theatre developed and performed a play based on HIV/AIDS called *Killing Me Softly* (1989). While on one hand it was intended to convey effective public health messages, it also provided social entertainment and a sense of worth/occupation given that the performers were drawn from unemployed workers in the socially deprived areas of Drumchapel and Maryhill. The play also targeted the 'at risk areas' of Castlemilk, Easterhouse, Possil, Clydebank, Govan and Paisley. Questions have been subsequently asked around the ethics and possible exploitation and stigmatising of communities from deprived areas as potential reservoirs of the epidemic thereby creating potentially negative perceptions about the effectiveness and sustainability of messages communicated.

Part of the rationale for this is that narratives often portray complex discourses like HIV/AIDS in ways that resonate with their audiences' ability to consume and interpret them in multiple ways. As Squire (2008) argues,

> *Citizens are urged to achieve better comprehension of difficult circumstances by reading or hearing the 'stories' of those affected people - for example, the World Health Organisation portrays the HIV pandemic to us through individual 'Stories of Tragedy and Hope'*[30]

Narratives are a critical heuristic lens in that not only can they be applied in an interdisciplinary context, but they can also combine 'modern' interests with 'postmodern' concerns (Squire 2008) like analysing the origins of HIV/AIDS through historical, cultural, colonial, post-colonial and missionary discourses.

2.3.5 Narratives as a Heuristic Tool in This Research

Narratives in this research will be a useful heuristic tool in that narratives about epidemics are not new within human experience. For example it has been argued that:

- HIV and Ebola originated 'out of Africa' in the 1980s and 1990s
- Severe Acute Respiratory Syndrome (SARS) originated 'out of Asia'

[30] http://www.who.int/features/2003/09/en/ (accessed 17.03.2014)

- Swine flu and the pig influenza are associated with Mexico and Egypt
- There has also been the argument of zoonosis, which is the idea of linking epidemics to animal rather than human origin. This aspect will in fact circumscribe one of the narrative myths that purports that HIV in Africa started in animals and jumped species into humans (Dry and Leach 2010).

A focus on narratives allows for the exploration not just of how the stories about the epidemics are constructed but also for investigating the manner in which they work, the author of those narratives, who the audience is and how they are consumed (Squire 2008). Despite that, in relation to the HIV/AIDS narratives it is useful to examine not only how they are produced and consumed, but also, how they 'are silenced, contested or accepted'(Squire 2008, p.5). The outbreak narrative is therefore dependent on who is defining it within space and time, which populations are being held accountable, what institutions are involved and what interventions are used (Dry and Leach 2010).

The current study has chosen narratives as one of the methods of enquiry that have been used to explore the origins of HIV/AIDS as well as how they were used as a basis for subsequent responses and policies. Narratives being studied are those contained in the written stories, policy documents and forms of texts generated by the state through its institutions, by faith-based organisations and other official representatives (Sontag 1989, Pastore 1993, Andrews 2004, Kruger 2006).

In a sense, these narratives ebb in and out in that the different constitutive parts ebb and flow in a fluid manner as they are informed by the location, the contextual worldview, gender and power dynamics. Dry and Leach (2010) argue that the *framing* of narratives implies that the constituents of the various narratives are not always fixed as some aspects are framed-in and others out (Dry and Leach 2010).

In some cases, narratives tend to be selective in that they omit certain factors and dynamics that may actually be crucial in developing appropriate responses to the epidemics. Such selectivity is based on reductive rather than broad and developmental approaches. A common tendency in the narratives that are

constructed for public consumption is that they portray a dominant image as they silence alternative narratives. Dry and Leach (2010) argue that critics of selective narratives suggest that alternative narratives provide a better and more sustainable way of engaging with the HIV/AIDS and other epidemic narrative. Examples include localised interventionist narratives that take cognisance of local expertise and initiatives which are based on the histories and memories of past disease and intervention experiences. All communities are in fact replete with such knowledge capital which remains untapped and excluded by dominant institutions. Other alternative narratives are constituted by the stories of suffering (Sontag 1989, Squire 2008) which constitute the identity of certain communities. In such circumstances, priority is often given to indigenous cultural models of disease causation, particular logics and practices of risk transmission (Rödlach 2006, Dry and Leach 2010).

While narratives are a way of representing and communicating how different and more notably powerful constituencies perceive and construct their understanding of epidemics, there is often tension between truth, falsity and ideology. This tension may or may not necessarily be self-evident to the architects of the narratives. In respect of HIV/AIDS, the narratives may well be intended to communicate official public health messages but they often simultaneously depict a specific type of language notably that of shock, fear, hate, sadness, helplessness, crisis, confusion, political ideology rather than sympathy, empathy, compassion or being neutral or supportive. Barthes' seminal essay on 'The death of the Author' (Barthes 1977) may serve here as a useful critique on the idea of intentionality. The underlying argument is that a distinction can be made between the intention of the author and the impact of the resultant product. The significance of Barthes' essay in this instance is that it sheds light on understanding how and to what extent those who construct and officialise the HIV/AIDS narrative may be held accountable. These issues will be explored in more detail in the sections of the fieldwork findings and the selected key policy documents. Central to narratives is that they are developed, constructed, modified or /and manipulated (Andrews, 2004).

This research study will focus on the ideological, political, moral, cultural and religious messages that the narratives individually and collectively convey. The

narratives demonstrate the complex ways in which different meanings about the HIV/AIDS are evoked. Although there are some commonalities among the narratives, different narrators often have varying impacts on their different audiences. On one level, the HIV/AIDS epidemic has led to narratives that characterise it as a sexual apocalypse which has led the human body to be a viral contestation site (Hatty and Hatty 1999). Such metaphoric language has reinforced the ideas of the epidemic 'invading the body' and 'polluting the one it infects'. These descriptors have often led to evoking disgust and other negative feelings and attitudes towards those living with and affected by HIV/AIDS (Hatty and Hatty 1999). Showalter has argued such portrayal of HIV/AIDS is 'creating epidemics of hysteria in a climate of angst' (Showalter 1997). A follow on action from that has been creating the logic of contagion that has seen the establishment of a regime control and surveillance by the state through immigration, medical, political and other regimes. Rather surprisingly, HIV/AIDS has remained *not* a reportable disease[31] despite the existing immigration controls. This clearly demonstrates part of the tension that underlies the complexity of how best to engage with and respond to the epidemic. The negativity that circumscribes the HIV/AIDS epidemic does raise critical and fundamental moral and ethical questions as human rights advocates and other activists have made more robust arguments against the inherent stereotype and discriminatory aspects of any move towards making HIV/AIDS reportable (Dry and Leach 2010).

On one level, narratives provide some useful information in respect of the origins and the spread of the HIV/AIDS epidemic and how this in turn was and is still being used as a basis for responding to the epidemic. On another level, HIV/AIDS narratives sometimes result in negative dominant messages about those infected and affected (Grmek 1993) by the epidemic.

On the basis of the fieldwork and the selected policy documents, I will use narratives as one of the heuristic tools to interrogate HIV/AIDS in both Scotland and Zimbabwe.

[31] A reportable infection is one which would result in legal prosecution and a penalty imposed on those who fail to so declare upon entering another state.

2.3.6 Use of the term 'Narrative' in relation to Policy and Key Informants

In this thesis, I use the term 'narrative' to refer to the construction of the stories about and the framing of HIV/AIDS discourses (Dry and Leach 2010) in Scotland and Zimbabwe. Both selected policy documents and the key informants' responses contain various narratives about HIV/AIDS. It is on the basis of these narratives that I then draw out the thematic issues (Riessman 2008) that I discuss in detail in Chapter Seven.

The relationship between narratives that are generated by the key informants and those that emerge from the selected policy documents is multi-layered. Within this research, there were instances where key informants prefaced their responses by drawing from popular perceptions. An example of that was example that was the association of the origins of the HIV/AIDS epidemic with homosexuals from the US. However, on further interrogation, different key informants would resort to their professional expertise in explaining what they thought were the actual origins of the epidemic. On another level, there although key informants blamed HIV/AIDS on 'others' the target group depended on the different historical circumstances between Scotland and Zimbabwe. Colonialism, witchcraft, and loose morals were perceived as the predominant causes of the pandemic by Zimbabwean key informants whereas poverty, migration and IDUs were what the Scottish key informants presented as the major causes.

In terms of the selected policy documents, the narratives in both Scotland and Zimbabwe presented viewed the HIV/AIDS pandemic as a major medical challenge but they however differed in how they strategized in responding. In Scotland, the initiatives were coordinated by the central government whereas in the Zimbabwean case, the multiplicity of the documents is evidence of the multi-sectoral approach that was adopted. On another level, the policy documents in Scotland were self-funded whereas in Zimbabwe, it largely depended on external donors. Such dynamics influenced both the content and the strategies that were adopted. In short, the relationship between the HIV/AIDS narratives from the key informant and the selected policy documents

sometimes complimented each other but at other times they varied within and between the two countries.

The term narrative is understood and has been used in a range of contexts. While I have highlighted its history in Chapter Two, I would like to reiterate that in relation to selected policy documents and key informants, the term has been used to refer to complex discourses. The complexity of the discourses that make up narratives is because of the fact that it always depends on the issue (in this case HIV/AIDS) is conceptualised, who will be narrating, who the audience(s) is/are, when, where and how they are articulated. Underpinning the narratives of epidemics is that fact that they are intertwined with issues of power, culture and social justice (Squire 2008, Dry and Leach 2010) - hence my argument for a transformative approach to HIV/AIDS Education. Narratives in this instance play a critical role in that they are not just stories in the ordinary sense of the word, but they are discourses which serve particular purposes in excavating, describing and shaping the way in which HIV/AIDS has been understood in both Scotland and Zimbabwe.

While the selected policy documents provide the official guidance in terms of describing what HIV/AIDS is, how it started and evolved and what needs to be done in order to respond to the pandemic, it is my contention that their contents is not only informed by medical expertise but that it also relies on the popular and the culturally situated narratives(Rödlach 2005, Rödlach 2006, Ross, Essien et al. 2006) that characterise the epidemic. In Chapter Six, I have given some examples of how these narratives are constructed and shaped by the media, popular discourse and historical anecdotes. In both Scotland and Zimbabwe, homosexuals, migrants, poor people, prostitutes, people of loose morals are described as 'at risk groups' who are essentially the vectors of transmission of the epidemic. Consequently, the stigma and discrimination that is embedded in the policy documents is evidence of how such narratives play a central role in framing such policies sometimes at the expense of giving priority to medical and epidemiological evidence as well as human, environmental and other agency.

Invariably, key informants from both Scotland and Zimbabwe prefaced their responses with narratives that have been prevalent in popular discourses about HIV/AIDS. Further exploration of their own understanding based on their own expertise only subsequently tried to distinguish the latter from the former. As such, both the policy documents and key informant responses did rely on narratives that were not necessarily medical but also based on popular myths, conspiracy theories and the concomitant stigma and discrimination associated with HIV/AIDS in both Scotland and Zimbabwe.

2.4 Attitudes to Sexuality

2.4.1 Introduction

In this second major section, I am going to explore attitudes to human sexuality as another heuristic tool that I will use to interrogate HIV/AIDS in Scotland and Zimbabwe. I will outline the key issues that Foucault discusses in his three volumes of A History of Sexuality (Foucault 1976, Foucault 1985, Foucault 1986). Foucault begins by looking at the early Graeco-Roman times through to the modern era. The main themes that underlie his discussions are how and why sexuality has been repressed within human history, the impact of paganism and Christianity in shaping these repressive discourses as well as the institutions of power that were created and replicated to govern these technologies of power. Foucault's analysis is complex as demonstrated by the fact that power underlies the understanding of sex and sexuality alongside the institutions that legitimise and de-legitimise it. Although Foucault's work is referred to as a *history (*own italics*)* of sexuality, he states that he does not claim to be a historian. He emphasizes the fact that he builds on the work that was already done by others by engaging in a philosophical exercise upon them (Foucault 1985). By this he means excavating and analysing the discourses that impact on sexuality.

I will also explore how far his analysis of sexuality is still applicable or not to current understandings of sexuality in both Scotland and Zimbabwe by looking at what constitutes normal and abnormal sex and the concomitant notion of sexual deviance. I will then examine the current debates around Sex Education and how they form the bases for exploring possible ways of engaging with the discourse.

2.4.2 Repression of Sexuality

A recurrent theme in Foucault's history of sexuality is his attempt to demonstrate the fact that within the western world, different forms of sexuality have co-existed in both the private and public spaces from the 17th century onwards. By implication the private and public spaces would involve both the individual and the collective spheres of sexuality. It is important to note that there is a distinction between 'sex' and 'sexuality'. Sex refers to sexual *acts* (Beck 1999) while sexuality is a 19th century social construct (although it is often used retrospectively) 'operating within fields of power, not merely a set of biological promptings...(but one which is) involved in the formation and consolidation of modern social institutions' (Giddens 1993). Foucault acknowledges that sex and sexuality were discourses that were part of the public domain from classical antiquity until the 17th century (Foucault 1976). In general terms, there was a liberal atmosphere that circumscribed sex and sexuality. The advent of the Victorian age marked a period where sex and sexuality entered the realm of privacy in that it was domesticated within the home, the family, reserved for reproductive purposes and for heterosexual relationships (Foucault 1985). This new era of sex and sexuality was not only sanctioned by legal and civic instruments, but it also derived its legitimacy from religion. The relationship between the secular and the religious discourses is important in understanding how sexuality was to be perceived and defined in subsequent history.

Despite the emergence of the repressive regime on sexuality, there were some exceptions that were made. Foucault (1976) argues that the 17th century coincided with the development of capitalism and as such contributed to the fabric of the bourgeois order. Foucault uses the term 'bio-power' to describe the techniques of controlling people's bodies and their lives (Larmour 1998). The group which was the propertied class viewed itself as having the right to exercise and enjoy a range of privileges that also included engaging in sexual activities that would ordinarily be socially unacceptable. Examples of the vocabulary that condoned such practices were the brothel, the prostitute, the client, and the pimp. Some important themes begin to emerge here: first, the

idea of the bourgeoisie indicates power differentiation and class distinctions. By virtue of being the dominant and powerful class, the bourgeoisie were able to engage sex and sexuality in both the *ordinarily legitimised* (own italics) spaces as well as those that needed pecuniary and other forms of investment like the brothel. The dominated class was left to engage only in those forms of sex and sexuality that were within the legitimised spaces otherwise they risked being subjected to the confinement to the mental hospital/asylum which considered them as being 'abnormal' and therefore requiring medical treatment and exclusion from the rest of the population (Foucault 1976).

The critical point that Foucault makes is that despite the apparent repressive discourse on sex and sexuality, the irony is that it is in fact so much discussed and talked about and what is important is

> *to account for the fact it is spoken about, to discover who does the speaking, the positions and viewpoints from which they speak, the institutions that prompt people to speak about it and which store and distribute the things that are said* (Foucault 1976, p 11).

Foucault then goes on to explore how the sexual discourse is regulated by different kinds of power. In fact the ambivalent position of modern societies is that although sex seems to have been 'consigned to a shadow of existence..they have dedicated themselves to speaking about it *ad infinitum (own insertion)* while exploiting it as the secret.'(Foucault 1976).

The 18th century demonstrated that there was a very clear awareness of sex as depicted in various spaces namely architecture, regimentation in schools e.g. partition in dormitories, installation of curtains and even the organisation of leisure activities. The sex of young people became a focus of doctors, educationalists and families. As a result, there were clear and notable places for producing discourses of sex: medicine which described nervous disorders as a result of sexual problems, psychiatry and the criminal justice system. (Foucault 1976) illustrates his analysis with the story of a farm hand who had caressed a little girl in 1867. The discourse developed in the following manner. The farm hand caressed a little girl who was less powerful and socially and sexually

immature. A dominant institution is invoked to make a legal decision on the conduct of the farm hand. The diagram below demonstrates how an individual sexual encounter is described not only in medicalised terms but it is also legally judged to be inappropriate. This is done by drawing on medical theories in terms of what is and what is not acceptable sexual behaviour. Sexuality in this sense becomes inextricably linked to nervous disorders, psychiatry and the criminal justice system as demonstrated in the diagram below.

2.4.3 An Example of Medicalising Sexual Behaviour

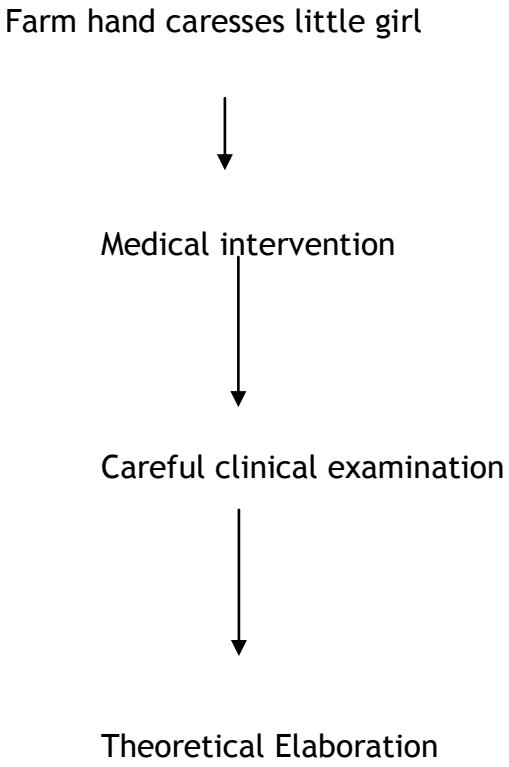


Fig 1: Medicalising sexual behaviour

Despite the above being a simple example, the issue is that there was public intolerance which led to all those power processes unfolding as shown in fig 1.

The irony behind the repressive and medicalised discourses is that 'they function as mechanisms with a double impetus: power and pleasure' because there is pleasure in evading the power of surveillance and there is power in showing off

the restricted pleasures thereby ending in ‘perpetual spirals of power and pleasure’ (Foucault 1976).

The family is a contested site as exemplified by the fact that it is a complicated network, saturated with multiple, fragmentary and mobile sexualities. These are evidenced by separate bedrooms, surveillance of children’s sexuality especially their puberty and the operations of servants within the household. Educational and psychiatric institutions exercise similar surveillance albeit in a magnified scope.

The modern bourgeois society has in fact produced a ‘sexual mosaic’ in an effort to understand each of the sexual prohibitions for example; infantile sexualities, sexualities of the gerontophile, the fetish, the doctor-patient, the teacher-student, the psychiatrist – mental patient. These polymorphous power relations are exercised in the home, school and prison as appropriate (Foucault 1985).

Foucault deals with sex as a discourse of confession – power – truth which leads to so many permutations. Foucault identifies two ways of viewing sexuality. The first is the one that was prevalent in China, Japan, India and the Roman Empire where sexuality was termed ‘Ars erotica’ meaning ‘erotic art’ (Foucault 1985). Within this context, sex was perceived as an art and a special experience which was neither dirty nor looked down upon. The reason for not deliberating them within the public space was that they would run the risk of losing their power and pleasure. Foucault acknowledges that in the patristic period the confessional roles were taken over by the priests and later by the educational, medical and psychological institutions (Foucault 1985). The second one is that found in Western society which Foucault calls ‘scientia sexualis’ meaning the science of sexuality. According to Foucault, sex is described is being central to confession in order to generate truth about oneself. It is on this basis that confession is extended beyond the Christian context to include other areas like psychiatry, medicine, the prison and related institutions of power. Sexual confession became constituted within scientific terms through clinical codification as well as through medicalising the effects of confessions as part of the therapeutic process. As a result, this led to the ‘explosion of unorthodox sexualities’ which the law and other institutions of power have had to engage

with (Foucault 1985). Foucault also criticises psychoanalysis in that he perceives it as an institution that legitimises confession within the modern era. However it might be argued that this is a rather skewed interpretation of the role of confession in people's wider life experiences as it is also considered as meaningful and beneficiary beyond the boundaries within which Foucault discusses it.

2.4.4 Negative Conceptions of Sexuality

Although early Christianity is often charged with associating sexuality with negativity by encouraging sexual renunciation as a form of controlling the human body and acquiring spiritual purity even sometimes going so far as to regulate when (heterosexually) married couples could and could not engage in sexual activity (Brown 1988). Such reading of early Christianity has tended to lay emphasis on viewing sex as the source of sin and evil through the episode the fall and the occurrence of death as recounted in the biblical story of Genesis. However, Brown (1988) and other theologians do highlight the positive messages around the role and function of sexuality within people's lives in both the pagan and Christian contexts. Prior to Christianity, paganism was credited for 'investing positive and symbolic values' of sex (Foucault 1986). The major difference between Christianity and paganism were that while the former restricted sexual encounter to monogamous marriage, relationships between opposite sexes, engaging in sex for procreation and prohibition of incest, the latter seemed to have a more liberal view which tolerated the opposite. Sex between men and even between men and boys was not necessarily condemned (Foucault 1985). More recently, negativity towards sex – both heterosexuality and homosexuality has been profiled in its connection with HIV/AIDS (Giddens 1993). Foucault (1985)also provides further insights regarding the relationship between sex and power, polygamy, lesbianism and pederasty.

2.4.5 Foucault's Definition of Power

Foucault starts off by stating what *power* is not. He argues that it is not a group of institutions or mechanisms that ensure subservience, nor is it simply a mode

of subjugation, neither is it a general system of dominance exerted by one group over another. Power is not the sovereignty of the state.
Power, Foucault argues is:

> *the multiplicity of force relations immanent in the sphere in which they operate and which constitute their own organisation...It is the process through which ceaseless struggles and confrontations transform, strengthen or reverse them, thus forming a chain or system or on the contrary, the disjunctions and contradictions which isolate them one from another.*
>
> *The strategies in which they take effect, whose general design or institutional crystallisation is embodied in the state apparatus, in the formulation of the law, in the various social hegemonies....Power is ubiquitous and is a result of a complex strategic situation in particular society'*(Foucault 1985).

While power may be used to restrain sexual pleasures, it may equally produce those pleasures resulting in sexuality being focal space within which power is simultaneously concentrated and distributed in complex and multifarious ways.
The forces of relations are always unstable and therefore power is instantiated in complex and multifarious ways without a single but multiple loci.

2.4.6 Implications of Locating Sex In The Restrictive Domain

Following Foucault (1976, p. 104 -105), I will replicate the four implications of locating sex in the restrictive domain.

i. *A hysterization of women's bodies* - the woman's body is saturated with sexuality and therefore medically pathologised so that it needs to be coned to the family in order to guarantee the life of the children that it produces. As such, this is a biologic-moral responsibility imposed on women throughout their lives. This is an exercise of power across gender, age, time and social space.

ii. *A pedagogization of children's sex*- the idea is that all children indulge or are prone to sexual activity. Although it is natural, it is contrary to nature and poses

physical, moral, individual and collective dangers because children are viewed as 'preliminary' sexual beings. Foucault's analysis indicates that parents, families, educators, doctors, psychologists would need to take continuous care of how children are used as both objects and subjects of sex. In South Africa for example there are myths/lay beliefs that having sex with virgins or children would rid one of the HIV/AIDs infection (Meel 2003).

iii. *A socialisation of procreative care* – This has often been interpreted as Malthusian in terms of its implications for population control

iv. *A psychiatrization of perverse pleasure* – Sexual instinct was separated as a biological and psychic: a clinical analysis made of anomalies which was pathologised and needed corrective technology to deal with it.

2.4.7 Some Emerging Issues

According to Foucault, the regulation of sex was first tried by the bourgeoisie on themselves before being exercised on the lower classes. The irony is that the 'ruling classes' under-estimated the complexity of sex and the body. The scenario was more complicated than it appeared in that sex and sexuality knows no class or power boundaries. For the bourgeoisie class consciousness involved the affirmation of the body and its sexuality whereas there was little consideration about the fact that the exploited classes had a body and sexuality (Foucault 1976).

Through bio-power, the various technologies and disciplines exercised power over human sexuality namely the universities, schools, barracks, workshops, political and economic controls of birth-rate, longevity of life, public health, housing and immigration. Interestingly, these institutions become the signposts for engaging with the HIV/AIDS epidemic. As such sex becomes a political and politicised issue which operates as a unique signifier and as a universal signified. Foucault observes that

> *sex is the most speculative, most ideal, and most internal element in deployment of sexuality organised by power in its grip on bodies and their materiality, their forces, energies, sensations, and pleasures* (Foucault 1985).

While Foucault's exposition of sexuality is to some extent tenable, there are questions to be raised in respect of his silence on gender as demonstrated by the sexual revolution of the 20th century and the specific role that women played in making decisions around interpreting and controlling their own sexuality (Larmour 1998). While it is true that the sexual revolution was influenced by an array of factors within modernity, it is also a fact that women participated and influenced the shaping of that modernity. For example, the development of birth control techniques and more recently the development of artificial conception empowered women with choosing where and how to experience their sexuality (Giddens 1993). Besides female sexual autonomy thriving in modernity, another category of sexual expression also began to flourish within modernity, namely homosexuals. To a great extent both of these developments owe their existence to the liberal ideas of the 1960s which characteristically undermined the status quo across the social spectrum (Giddens 1993).

Although Foucault makes a valid observation of the connection between 'power and knowledge' he does not seem to go beyond this rather singular characterisation to include the *institutional reflexivity (*Giddens 1993) which is not static. While change tended to be more domesticated in pre-modern societies, globalisation has added a whole new dimension in the speed and manner in which change is distributed, internalised and adapted across the globe. Thus these changes progress from the individual to the collective and vice versa. Given that there is no longer a single controlling force, the generation, ownership and debate about sexuality are simultaneously private and public, individual and collective. To that end, the role and function of confession as an explanatory mechanism of getting the truth becomes inadequate. The liberal democratic state has equally facilitated the proliferation of sexual pluralism which in turn has impacted in different ways on behaviours that were traditionally considered to be perverse. It seems as if the rise in sexual pluralism has emerged as a substitute for sexual perversion (Jeater 1993).

Foucault (Foucault 1985, Abraham 2011) argues that the 'self' is defined by a specific technology but current evidence demonstrates that modernity has given rise to new ways of determining self –identity beyond one's defined sexuality

(Giddens 1993). Both male and female heterosexuals and homosexuals reflexively and continuously interrogate themselves about their own identity in terms of the past, the present and the future relying on the multimedia resources of TV, radio, magazines and a range of electronic gadgets and packages (Giddens 1993). A follow on point from this is the connection between food, diet, physical appearance, self-identity and one's sexuality. The paradox is that in the developed and modern west where food is in abundance, there are constant efforts to regulate one's diet in order to achieve the perceived acceptable and admired physical and sexual identity (Giddens 1993). The key point here is that this is an agenda that is driven in the secular space whereas in pre-modern times it would have been hailed as a mark of ecstatic devotion. The irony is that the portrayal of an emaciated body evokes different meanings in the poor south where such an identity is interpreted as a representation of a high likelihood of being HIV positive and therefore having possibly indulged in 'risky' or 'prohibited' sexual encounters.

Foucault also makes an interesting observation when he notes that sex could be *affected* by its own diseases, t*ransmit* its own diseases and *creates* (italics – own emphasis) others that could affect future generations and HIV/AIDS is very much be a case in point.

Beyond the medical discourse, sexuality was also used as part of a political project for organising state management of marriages, births, life expectancies as well as sex and fertility resulting in the control the urban proletariat. It has been argued that a similar practice was also co-opted into most of colonial Africa (Stoler 1995) whereby control of sexuality was part and parcel of the package of the colonisation process.

2.4.8 Perceptions of Sex/Sexuality

The diagram on the perceptions of Sex/Sexuality (fig. 2) comprises two circles which broadly represent the perceptions of normal and abnormal sexuality. However, the intersections between the two indicate that the various sexual acts overlap the two sectors. The top far right and far left indicate examples of the trajectories of the public perceptions on each of the two main sexual

groups. Parallel to this on the right are the institutions that govern and influence the perceptions of sexual attitudes within both groups. The bottom centre indicates the contexts within which the sexual relations take place.

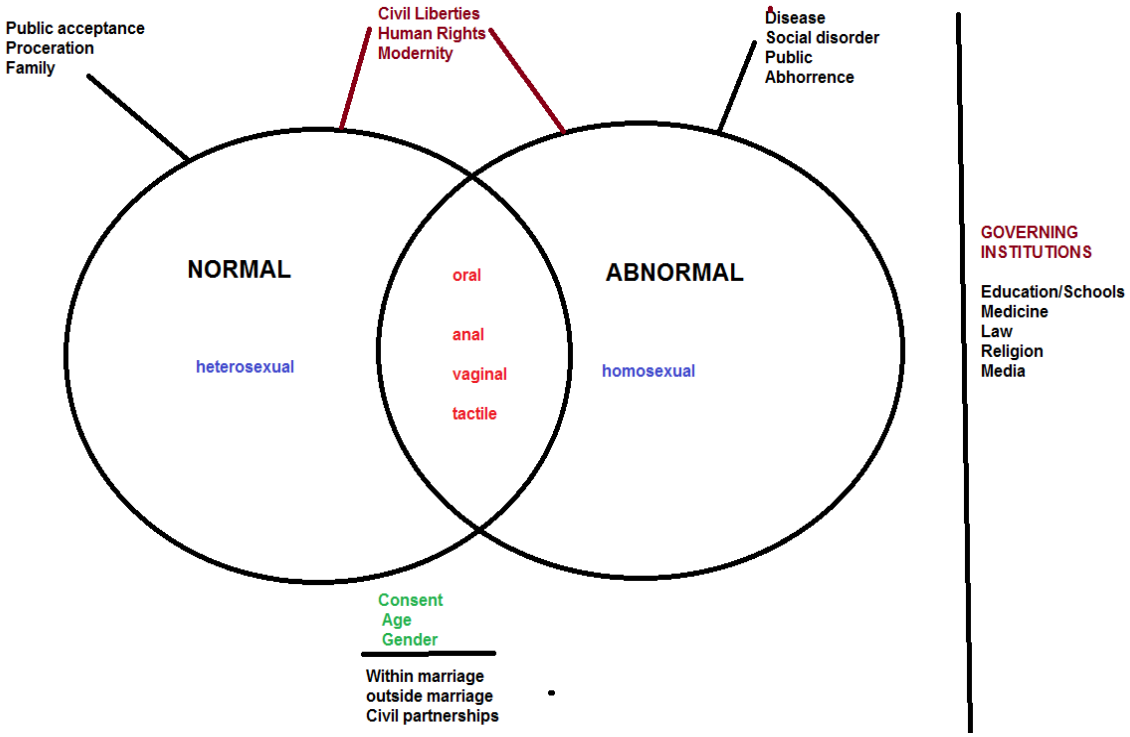


Fig 2 Diagram on perceptions of sex/sexuality

Although the liberal values of modernity and the west facilitated the recognition of alternative sexualities by increasing civil liberties and human rights entitlements, there still remains huge concerns around the attitudes of some sections of western society (and others too) in respect of both male and female homosexual practices. It is in this regard, that those who do not subscribe to that viewpoint consider homosexuals as sexual deviants. But in order to discuss sexual deviance, I suggest that it would be useful to explore the general discourse of deviance itself and then look at how it is applied to sexual practices.

2.4.9 Sexual Deviance

A simple definition of sexual deviance may be understood as sexual behaviour that does not conform to the socially accepted standards. However, as

demonstrated by fig 2, it has increasingly become complex to streamline what kinds of activities are considered sexually deviant and which ones are not. For example, the American Psychological Association no longer considers homosexuality as deviant sexual behaviour and considers it as part of legitimate adult sexual practice (Morin 1977). Current debate and controversy of what constitutes 'normal' and 'abnormal' (sexually deviant) behaviour is illustrated in the same diagram above. Deviance is a term which has been used both within and beyond matters of sexual behaviour and I therefore propose to examine its origins in order to put the discussion into context.

Becker developed the theory of labelling which has been used to explain and understand deviance (Becker 1973). Becker argues that humanity is constituted by various social groups all of which make rules that guide their behaviour. Two sub-groups are identified within each of those groups; one is made up by those who follow the rules and they are perceived as law-abiding and those who break these rules are termed 'outsiders'. The term 'outsiders' is used to describe the complex types of behaviours that those who break the rules indulge in as well as to the persons who engage in those prohibited behaviours (Becker 1973).

A number of issues surround this idea of 'outsiders'. In the first instance, Becker clearly recognises that while on the face of it things may seem clear and simple; they are in fact much more complex than that. Looking at what may be considered an outsider is very much dependant on the observer, the time and the circumstances. Central to the notion of outsider is *who* (own emphasis) and why the rules that judge some as outsiders will have been so constituted? On a general level, rule-breaking and rule-enforcement may seem to be a matter of consensus but a close scrutiny of the issues demonstrates that in fact the term 'outsider' is very much double-barrelled (Becker 1973) in that one group may label a behaviour or indeed a personality as an 'outsider' yet the one upon whom that is pronounced may in fact view the 'judges' as the ones who are 'outsiders' (p.2).

Becker also identifies degrees of being an 'outsider' and the varying ways in which society tends to respond to those scenarios. He argues that if for example a traffic offender get a little drunk after a party and get commits a minor traffic

offense, they will not be scorned upon to the same degree as rapists, murderers or those who commit treason. These categories however tend to accept the label that they are ascribed. The flipside of this is that there are some categories who are labelled as 'outsiders' but they refuse that label and instead prop up a strong defence on why they are right and their accusers are the ones in the wrong. Examples of the latter group are drug addicts and homosexuals. The negative label of homosexuals is one which resonates with the repressive hypothesis of those who are considered sexually abnormal as discussed earlier and represented in fig 2.

While Foucault argues that medicine and related disciplines are used to determine and exercise control over what is and what is not acceptable sexual practice, Becker uses the medical metaphor (Sontag 1989) as one of the theoretical models to explain deviance (1973). While there is some overarching theme of medicalising human behaviour (including their sexuality), there is also a subtle difference between Foucault and Becker. The difference lies in the fact that Foucault uses medicine as direct policing institution on human sexuality where (Becker 1973) uses the metaphoric sense of medicine to explain deviance in terms of health and illness. Following the logic of Becker's metaphor, rule abiding is good behaviour and reflects a healthy social group whereas rule-breaking represents disease and a dysfunctional and socially disorganised group.

The second model considers deviance in terms of the failure to obey rules (Becker 1973). A closer analysis of the two models indicates that they are subject to some limitations. The first model does not seem to take into cognisance the complexity of human agency in processing how best to arrive at the desired course of action. This process is by no means mechanistic. It involves a whole range of factors that has to do with human reason, experience and other dynamics. On the other hand, the second model does not seem to factor in the idea that the very idea of an 'outsider' is a social construct. This reflects the earlier point discussed around the negative perceptions on homosexuality discussed in the section on Foucault's history of sexuality. Becker (1973) initially described rules as the products of social groups. On reflection, he interrogates the whole idea of the group in terms of whether or not the groups are homogenous, or if in fact the same or different individuals may belong to

different groups at different times or simultaneously. Equally, the process of establishing the rules itself is less likely to be smooth and consensual than being a result of both overt and covert tensions between those involved.

If one were to use a Marxist analysis, the argument would be that social class plays a significant role in rule making. To that effect, it is the class that wields power that makes rules and the corresponding sanctions that reflect its own interests. In addition, the constant class struggles may actually re-shape the manner in which these rules are constituted and applied at any given time. Becker (1973) uses a typical example of how elders and those in authority often make rules to the younger people as demonstrated by the nature of discipline in schools, the courts and elsewhere. Apart from class, power differences are also informed by age, sex, gender, ethnicity and other variables (Battle and Barnes 2009). These debates are important in asking questions around what kind of values should inform the modern western liberal society today. Some of the ongoing tensions revolve around how the institutions that protect and uphold those values are constructed? Whose interests do they serve? Are they the reflections of or the generators of those values? The key question is *whose* values and *why* those values (own italics)?

In terms of homosexuality for example, is it simply an alternative sexual life style (Beck 1999) or one which invokes blame for the origins and spread of HIV/AIDS? Becker rightly suggests that it is important to be alert to and critical of certain social generalisations like the assuming that there is logical connection between race – crime- class- intelligence or to say poverty is connected with war and by extension that homosexuality is responsible for HIV/AIDS (Becker 1973).

Because this raises critical epistemological and political issues, I think that looking at Sex Education may be one useful way of beginning to deconstruct the issues in sustainable way. In my view, given the multiplicity of stakeholders, there are various levels at which Sex Education may be explored namely, the students who are to be taught and make sense of what it is that the Sex Education curriculum delivers, their parents, education responsible authorities and public who invest in what and how the schools deliver. The matrix and

intersection of the stakeholders' viewpoints form the basis upon which both policy and practice will be crafted.

2.4.10 The HIV/AIDS Policy Making Matrix

The diagram below represents to what extent the data gathered from the documentary analysis and the key informants will address policy issues relating to how the origins and the responses to the HIV/AIDS epidemic were developed.

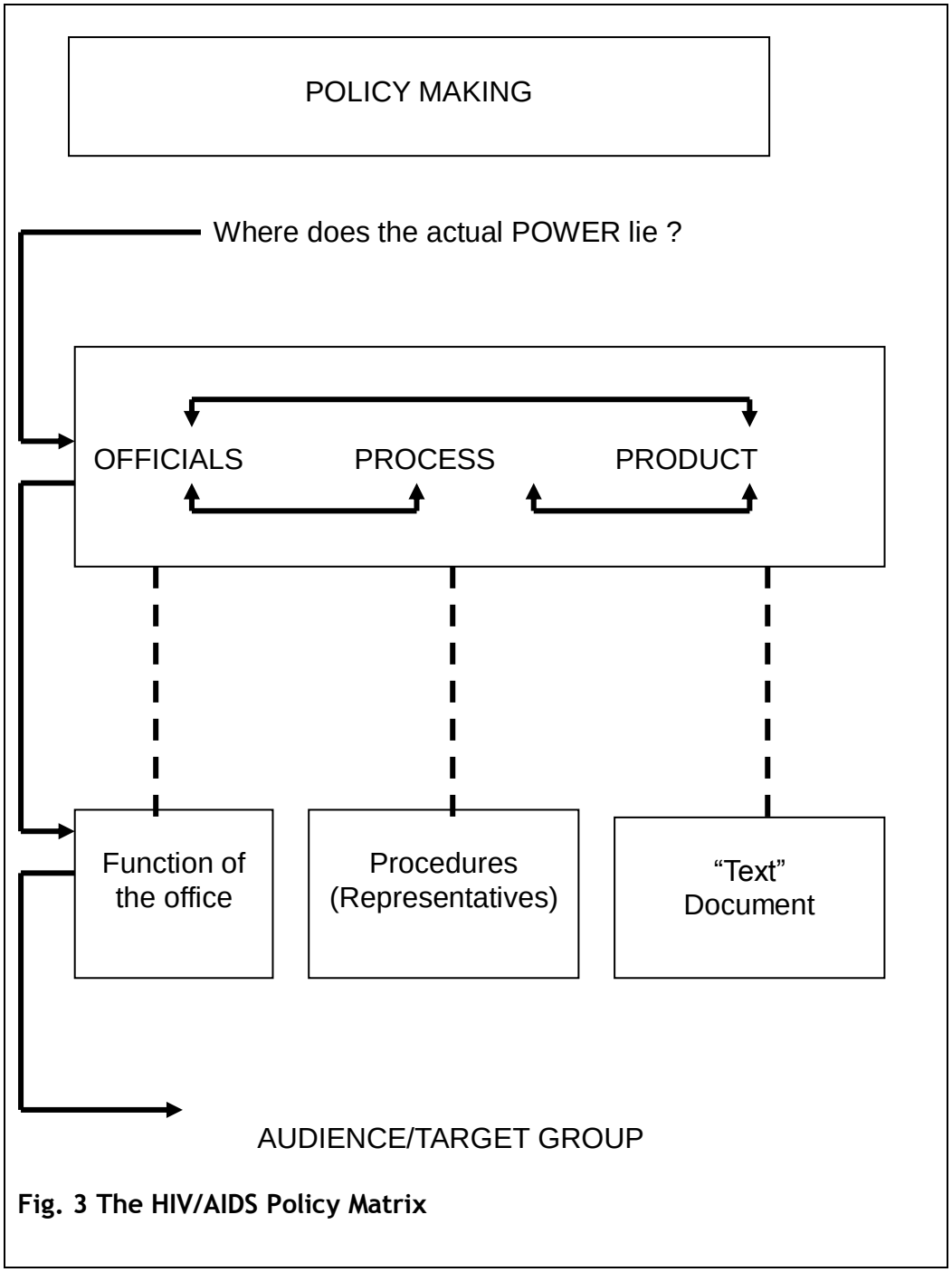


Fig. 3 The HIV/AIDS Policy Matrix

2.4.11 Feminist Critique of Foucault

2.4.11.1 Introduction

In this section, I will highlight how Foucault's critique is developed within a Western Euro-centric perspective as well as the validity of its significance beyond the Euro-centric boundaries. This is the case in so far as other stakeholders have also used it either as a starting point or in conversation with it in order to construct, complement or in contradicting some of its tenets. In the conversation below, I will demonstrate how the Focualdian critique of sexuality is intricately interconnected with the colonial and the post-colonial discourses. These discourses will be broad on one level and there will also be sub-categories of 'Western' and 'African' perspectives on sexuality, gender, class, race, ethnicity as they interface with the views of the feminist scholars.

Within the Western world, the 1960s onwards are generally regarded as the point at which new understandings of sexual knowledges came to prominence mainly due to the influences of feminism, lesbian, gay politics and other sexual movements (Weeks, Holland et al. 2003). It is also important to recognise that these developments were mainly emerging from the western world partly due to the more liberal and enabling frameworks as compared to the colonial and post-colonial (African) contexts where the main focus was on existential issues of constructing a new framework for post-colonial society. This is not to say that the latter did not engage with issues of sexuality but that they tended to be decentred to the periphery. Instead, issues of governance, economics and a new political order of what to and what not to incorporate between the traditional and the modern/western systems and institutions invariably took centre stage.
It is in this context that Foucault was one of the major Western contributors to a critique of sexuality. It should be emphasised from the onset that Foucault's ideas contain the main though not the exclusive heuristic tools for interrogating sex and sexuality and is also constructed within a Euro-centric perspective. As I will demonstrate in this section, their applicability is wider than the context within which it was developed. Deveaux (1994) rightly argues that while there has not been consensus and uniformity of interpretation of Foucault's critique of

sexuality, it has nonetheless formed a useful basis for interrogating sexuality across space and time. As indicated below, she argued that

> *Although it is disappointing that his work does not engage directly with feminism, this does not diminish the heuristic usefulness of certain of Foucault's insights on power, resistance, and sexuality.*

To that extent she continues to argue that

> *It is vital however, to keep a critical edge when attempting to appropriate Foucauldian concepts for feminist ends. In the process, we may discover that there are resources within feministic theory better suited to the task of developing an alternative vision of power and empowerment than are attempts to make Foucault fit feminist purposes* (p.244).

2.4.11.2 The Evolution of Studies on Sexuality

Foucault's work on sexuality was not the origin of the sexual revolution but it was a development on already extant work by feminist, gay, lesbian and other radical social movements.

The focus of early studies on sex evolved to compare the interconnections between the biological, the psychological, the social and the cultural. Although the work by scholars like Krafft-Ebing, Havelock Ellis, Freud, Magnus Hirschfield and Alfred Kinsey were initially focused on the Western world, with colonisation, studies on sexuality were also undertaken in the colonised spaces. However, what is intriguing is the fact that while on one level the European colonial anthropological bias permeated the findings, on the other hand they were also were applied beyond the colonial domains . Weeks, Holland et. al (2003, p.3) argued that

> *Evidence collected during colonialism demonstrated a huge variety of cross-cultural patterns of attitudes towards the family, gender divisions, reproduction and what the sexologists called the 'perversions'.*

Ironically, this dossier of evidence led the Euro-centric scholars to challenge the 'perverse' attribution of such behaviours in their own societies and instead advocated for sex reform. An example of such behaviour was noted from Alfred Kinsey's research which showed that 37% of his male participants reported some form of homosexual experience leading to orgasm. Such findings led to reconsidering the 'perverse' as being on the same continuum with the 'normal' (Weeks, Holland et al. 2003).

In order to understand sexuality today and its impact on people, there is need for taking cognisance of the diverse contexts in which meanings are attached to the intimacy and eroticism as well as the complex social interactions which shape the erotic cultures of those contexts. The major determinants of gender, race, class and ethnicity exist both on micro and macro levels of societal groups. Foucault's critique of sexuality is framed on his analysis of the relations of power and how these are instantiated through various institutions like religion, the clinic, schools, the judicial system, the law and others. As a heuristic lens and an analytical tool, it enables the interrogation of how sexuality is defined, understood and affected within various locations and experiences. Basing her citation on Foucault's *History of Sexuality Vol 1*, Stoler (Stoler 1995, p.3) argues that Foucault considered

> *Sexuality was a result and an instrument of power's design, a social construction of a historical moment.*
>
> *For Foucault, sexuality is not opposed to and subversive of power. On the contrary, sexuality is a dense transfer point of power, charged with instrumentality.*

The binary division between heterosexual and homosexual has since been undermined by various permutations of alternative sexualities. This has sometimes taken the form of 'reverse discourse', in which Foucault treats *sex* as an effect rather than the origin of the resistance approaches to the norm (Foucault 1976). As a result, sexuality has become a site for both the cultural and the political confrontations in both the West and Non-Western worlds in

which old and new narratives of sexuality compete for recognition. In the same vein, the argument of whether or not sexuality is a private or public discourse is itself essentially contested.

Socially constructed views of sexuality by both Western imperialism and non-Western (Zimbabwean) societies was a product of the colonial and post-colonial discourses (Weeks, Holland et al. 2003).

Foucault is relevant in understanding how bio-power and part of the colonial project entails not just what is and what is not acceptable sexuality but also birth control (see item 2.4.7 in this thesis) in the colonised nations of which Zimbabwe was one. The colonial is relevant in elevating how the project was not only about colonising the natural resources and the minds of the indigenous people, but is was also evidently about colonising their bodies. This point is illustrated by Pat McFadden a Swaziland-born feministic researcher, academic and activist who has done extensive work on Zimbabwe and the wider global Black Women's Discourses. She critiques how religion and colonisation have framed sex and sexuality in Zimbabwe (and beyond) as masculine and dominant tools and symbols to control women's bodies so that pleasure and choice are essentially restricted from their domain of experience(McFadden, undated). In the same paper, she argues that

> *The systematic suppression of women's sexual and erotic inclinations has led to the conflation of sexuality and reproduction within a hetero-normative cultural and social matrix.*

In the same paper, McFadden emphasises how engaging in feministic sexuality issues becomes a securitised issue within the African/Zimbabwean context in so far as it explodes the dominant patriarchal myth and status quo. Thus in her own experience, that kind of discourse translated into how

> *Homophobia, xenophobic claims that I constituted a 'national threat, and deep anxiety about women's sexual freedom and choices permeated the rumours and statements surrounding efforts to deport me (own italics for*

> *emphasis), and strongly informed the suspicion, caution and hostility with which I was treated by many within the Movement.*

By his own admission, Foucault's views evolved as he developed his ideas over time. To that extent, he considered himself more of an 'experimenter' rather than a theorist. He argued that he wrote not in order to uniformly apply the same systems across his different fields of research but in order to change himself and his thinking (Stoler 1995, p. ix).

Feminism as a project has not been exempt from internal criticism in terms of the differences between the two broad and sub-categories of 'Western' versus 'African/Black/Third World' contexts. In my introduction to this section, I pointed out the differences of priorities regarding scholarly activity on issues of sex and sexuality between the West and Africa. In the same context, while some feminist advocates have propounded for

> *a global sisterhood linked by invariant, universal characteristics, i.e. essentialism* (McNay 1992, p.2*),*

such an approach has been criticised as being an uncritical assessment of the reality on the ground. The fact of the matter is that there are differences within differences, namely that Black and Third World feminists have tended to be ethnocentric in their approach and have not always resonated with (white) middle class feministic aspirations (McFadden, undated, Sawicki 1991, McNay 1992). Beyond the ethnographic considerations, categories of race, geographical location, politics, religion and historical considerations inform the power relations and the types of feminisms that would be pursued.

2.4.11.3 Some Feminist Perspectives on Foucault

Deveaux(1994)and Ramazanoglu (1993) identify the different viewpoints which either collude with the Foucauldian docile thesis of women's bodies and sexualities or those who challenge it. In relation to Foucault's limits of his power analysis and its implications is the Deveaux's citation of Jennifer Terry who argues that prenatal surveillance, fetal rights discourse and surrogacy are a case

in point. While this borders on eugenics, it is important to recognise that in terms of HIV/AIDS and women's sexuality, they are almost invariably subject to ante natal screening as part of the sexual surveillance discourse enmasked under the protection from infection. Despite its potential and perceived positive utility for the state and the mother, the male counterpart is not subject to much scrutiny as the mother and the foetus are.

More worryingly, while there have been some mandatory requirements for HIV testing prior to getting a marriage in some of parts of the United States (Deveaux 1994), there have been similar implications emerging from the 2005 Heads of Christian Denominations in Zimbabwe HIV and AIDS Policy Item 2 page 7

> *The need for couples to be tested for HIV prior to marriage*

As well as Strategy 8 on page 15

> *Pastors and Priests may choose not to marry a couple that do not know each other's HIV status*

While Judith Butler accepts that the categories of sex, gender and desire are determined by specific formations of power, she *troubles* and challenges Foucault and his reformulation of Nietzsche through his genealogical excavation in that his project is premised on compulsory heterosexuality. She argues that the notions of *female* and *woman* are in fact products of performance which are culturally and socially determined through ritualised repetition of norms (Butler 2002). Butler (2002) criticises the phallogocentric approach which ignores the importance of the centrality of the feminine in understanding the political stakes that designate the origin and cause of the identity categories shaped by the institutions, practices and the multiple heterosexual discourses. This critique is relevant in challenging how in this thesis the HIV/AIDS epidemic is gendered and that women are often considered as vectors of transmission. This is the case as when for example perceptions like HIV/AIDS is transmitted by *female* prostitutes, women of *loose morals*, *mother* to child transmission, the *girl child*. Such perceptions need to be critically engaged with given the fact that *women* in general disproportionately bear the brunt of the epidemic because of the systemic oppression and patriarchal dominance that they are subjected to.

Butler's focus of challenging heteronormativity is also instantiated in her other publications, notably *Bodies That Matter: On the Discursive Limits of Sex (1993), The Psychic Life of Power (1997)* and others.

On the other hand, Sawicki disagrees with scholars like Julia Kristeva and Luce Irigaray that Western cultural discourses are univocally masculinist. She makes the case that Foucault implicitly recognised that there are voices at play beyond the masculine ones (Sawicki 1991).This makes Foucault's analysis subject to contested interpretations. According to Sawicki (1991), neither men nor women have total control of power discourses, both have to negotiate them. She is more optimistic in search for the emancipatory technologies inherent within the domain of individual and collective feminism. To that end she cites Deborah Cameron

> *Men do not control meaning at all. Rather women elect to use modes of expression men can understand because that is the best way to get men to listen*[32].

McNay (1992) also draws on the critical work of Foucault particularly in his *Discipline and Punish* as well as *The History of Sexuality* , Vol. 1 in terms of how power is central for feminists to explain the impoverishment of women's experiences and oppression and how that is culturally determined through images of feminine sexuality. It is on this basis that the cultural rather than the natural construction of the body provided a useful basis for feminist engagement.

Despite Foucault being a heuristic tool for the feminists, McNay challenges the idea of absorbing Foucault's analysis of power which lacks any emancipatory agency on the part of women as autonomous subjects who can re-discover and improve their plight. The main focus of this thesis is to develop a transformative approach to HIV/AIDS Education, one which not only deconstructs the limitations imposed by the power relations of dominant institutions but one

[32]Quoted in Carolyn Heilbrun, *Writing a Woman's Life*, New York, Ballantine Books, p.105

which will enable the subjects to emancipate themselves through transformative Education.

To Foucault's credit, McNay (1992) argues that his later work, *The Use of Pleasure* and the *Care of the Self* are more reflective of the self not just as a passive body but one which can actively fashion their own identities.

2.4.11.4 Some African Feminist Views on Sexuality and HIV/AIDS

Given that part of the thrust of this thesis is to analyse Scotland and Zimbabwe I will highlight some of the views that inform or represent the African feministic discourses on sex and sexuality. As already indicated in the Introduction to this section, scholars from Africa (Zimbabwe) used different approaches to engage with issues of sex and sexuality within colonial and post-colonial Africa. Two main strands can be identified: one is by Western and African Western-trained scholars trying to deconstruct issues of sex and sexuality through a hybrid lens, namely their own situated experiences coupled with their externally internalised western value systems (Lennox and Waites 2013). While the latter focuses on the Commonwealth of which Zimbabwe used to be part of, the thrust of its scholarly work is on decriminalisation of alternatives sexualities to heterosexuality which are also invariably constructed as the vectors of transmission of HIV/AIDS. In the Zimbabwean case, feminist scholars like Rudo Gaidzanwa, Joyce Kazembe, Pat McFadden and Tsitsi Dangarembga can also be viewed as part of the Western –educated but of African origin.

A second strand is that of creative writers who use analytical literary genres to articulate their feminist critiques on HIV/AIDS in the culturally patriarchal Zimbabwean society. Although these feminist authors do not directly engage with Foucault, their ideas and representations do engage with the issues of power relations and sexuality that Foucault addresses. Examples of these include *Desperate,* Virginia Phiri (2002), *High Way Queen,*Virgina Phiri (2010); *A Collection of Essays by the Zimbabwean Women Writers (2000): Women of Resilience: The Voices of Women Ex-Combatants*, Anna Chitando's *Fictions of Gender and The Dangers of Fiction in Zimbabwean Writings on HIV & AIDS* (2012), Josephine Nhongo-*Simbanegavi's For Better or Worse? Women and Zanla in Zimbabwe's Liberation Struggle*. Further afield but within the same category

would be Pam O'Connor AND Jaya Earnest's *Voices of Resilience: Stigma, Discrimination and Marginsalisation of Indian Women Living With HIV/AIDS* (2011).

In her article on *Contemporary African Feminism: Conceptual Challenges and Transformational Prospects,* Pat McFadden also argues that there is scope to deconstruct and transform African(Zimbabwean) feminism and its implications on women's sexuality[33] as well in her other article on Zimbabwean post-colonial feminism (McFadden 2005).

This section set out to offer a feminist critique on Foucault's attitude to sexuality as well as his articulation of the role of function and power relations as a heuristic lens in the HIV/AIDS discourses in both Scotland and Zimbabwe. While feminists in both the Western and African (Zimbabwean) contexts are not agreed about the ultimate validity of the Foucauldian analysis, there is consensus on the fact that Foucault does indeed provide a useful starting point and is also illustrative of some of the ways in which the analysis of sex and sexuality may be engaged particularly in the context of HIV/AIDS. Both Foucault's and the feminist critiques are significantly pivotal in contributing towards the construction of a framework for a transformative HIV/AIDS Education in Scotland and Zimbabwe and beyond.

2.4.12 Concluding Remarks

In this section, I have shown how Foucault has highlighted the fact that modern attitudes towards sexuality are as much a product of the specific historical period that they were located in. Beginning with the early Graeco-Roman period, sex was a given but sexuality has been a social construct. Foucault's analysis centred on how power-knowledge was obtained through confession. I have also demonstrated how Foucault argued that confession has been facilitated by the controlling and governing institutions of medicine especially psychiatry, the hospital, education through the school, law, prisons and others. While most of his analysis holds, Giddens raises questions with respect to the

[33] http://www.osisa.org/buwa/womens-rights/regional/contemporary-african-feminism-conceptual-challenges-and-transformational (accessed 31.03.2015)

role of the sexual revolution as influenced by other factors outside the Foucauldian framework.

I have also highlighted a feministic critique of Foucault on sexuality in so far as how his ideas may be a starting point but also how they have limitations in engaging with the discourse in all its dimensions.

One of the major effects of medicalising sexuality is categorizing sexual behaviour into acceptable and deviant behaviour. I have argued that the latter may be understood through Becker's theory of labelling especially on the controversial perceptions around homosexuality. I have concluded by examining the current debates around sex education and also suggested some of the methodological approaches that may bring a developmental approach to the delivery of this controversial subject.

2.5 The Post- Colonial Lens

In this third section of the heuristic tools, I will discuss how I will use the post-colonial lens to interrogate HIV/AIDS mainly within the Zimbabwean context. However, the role of religion, morality, culture and the politics surrounding the epidemic also apply to the Scottish context although in a nuanced way.

2.5.1 Definition of Post- Colonial

The term 'post-colonial' is a complex one and difficult to define. Reference to colonial, is often perceived as a historical precursor to post-colonialism. However, the discussion below will indicate that the distinction between colonialism and post-colonialism is not a simple one (Schwarz and Ray 2005). Some arguments purport that the colonial still exists within the post-colonial (San Juan 1999). The colonial and post –colonial are experiences that have occurred and continue to occur both in the developed world as well as the developing world. For the purposes of this present study, Zimbabwe will be examined in the context of being a former British colony. In the case of Scotland, although it was never formally colonised, the devolution and the

current initiatives towards independence may be understood as indicative of the search for a distinct identity separate from the Westminster establishment.

The term colonial involved the process of creating binary positions of 'traditional versus modern, oral versus written and printed, agrarian and customary communities versus urban industrialised civilisation, subsistence economies versus highly productive economies' within the colonised spaces (Mudimbe 1988, p. 4). One of the negative outcomes of the colonial process was that it disrupted the traditions of the local African communities within their own settings. It also created a huge proletariat urban population which found it difficult to uphold the customary arrangements and it also failed to cope with the new urban social arrangements. Basically, colonial culture sought to trivialise the traditional mode of life and its spiritual framework (Mudimbe 1988, p. 4). One resultant effect of the colonial processes was that it marginalised the colonised into an intermediate space between African tradition and the projected modernity (Mudimbe 1988).

The term post-colonial refers to at least two levels of trying to understand what the term means. One of them is that it refers to a temporal period, namely, that period after decolonisation. The second refers to what (Abraham 2011, p. 5) quotes Loomba et al saying that:

> *shifting and often interrelated forms of dominance and resistance; about the constitution of the colonial archive; about the interdependent play of race and class; about the significance of gender and sexuality; about the complex forms in which subjectivities are experienced and collectivities mobilized; about representation itself; and about the ethnographic translation of cultures…*

In terms of the second level, post-colonialism may be understood to refer to a whole range of practices that are active in changing the legacies of the Euro-centric western dominant discourses of colonialism.

Central to the post-colonial is the fact that the formerly subjugated people are able to experience both cultural and political independence. Ashcroft and

Ahluwalia (2001) make an interesting observation that the 'post' in post-colonialism refers to the 'after colonialism began' rather than when it ended (p.15). Post-colonialism does not refer to a single and simple set of discourses but to a wide

> *range of cultural engagements, the impact of imperial languages upon colonised societies; the effects of European master discourses such as history and philosophy, the nature and consequences of colonial education and the links between Western knowledge and colonial power* (Ashcroft and Ahluwalia 2001:15).

The term post-colonial denotes the struggle against European domination through colonisation and the emergence of new political and cultural actors in the later part of the twentieth century (Schwarz 2005) with the impact of re-shaping the power distribution on the world stage. In other words, the term post-colonial means a whole range of practices and perspectives in relation to power issues that have shaped the world. It is an active engagement to change the legacies of colonialism and the western/Euro-centric dominance of the colonised spaces.

2.5.2 Edward Said on Orientalism

Said (1978) argues that the West created the 'Orient' as the 'Other' of the West. In effect, the Orient, is a construction and an ideal. At least two forms of orientalism are identified; namely that which comes out of classical scholarship and the other based on travellers, pilgrims and statesmen. Although the two views are in constant tension, they come together in a single form of colonisation. Young (1991) however argues that such a representation is conflictual. The same point is highlighted by Stuart Hall in his essay on the 'West and the Rest: Discourse and Power' (Stuart 1992) in which Europe (and the US) characterise themselves as 'the powerful and developed west' and see the other parts of the world as the 'rest'.

Like Said, Mudimbe (1988) also argues that Africa was invented as the 'Other' of the West in order to serve the interests of Western hegemony by ordering the world with the West as the centre. Post-colonialism in this sense is understood

as moving beyond this Euro-centric western perspective and critiquing it in order to recognise the 'other' not as an inferior or primitive experience but one which is valid in its own right. This is why in his articulation of 'negritude', Senghor (1966) argued against the fact that African people had not created anything, invented anything, written nothing, painted nothing and sung nothing. For him traditional Africa in fact has always had its own corpus of knowledge. While the Euro-centric and colonial perspective emphasised the universalising of truth and modes of truth as espoused by Kant and Hegel, Senghor challenged this as being a limited view that failed to take into cognizance African and other world views (Senghor 1966).

Aschcroft and Ahluwalia (2001) argue that Said does not effectively defend his thesis of the orient as a construction rather than a reality. While Said considers that the constructed orient is a coercive creation of the west, he does not view himself as operating within the same coercive western framework that limits his possibilities of generating an alternative knowledge framework (Young 1991). While Said argues that the Orient represents the colonised who are constrained in representing themselves, Ahmad (1994) criticises Said alongside other scholars like him – Spivak and Rushdie- with access to the west and its privileges for using the particular western locations to theorise about their marginality. James Clifford is cited as highlighting the fact Said uses the tools of a western theoretical framework in order to critique the values of a western anthropological approach (Ashcroft 2001). As third world migrants, they in fact take advantage of their class positions to attack colonial discourse using orientalism as a substitute to Marxism and avoiding gender and class, although Spivak highlights the gender aspect in her seminal work: *Can the Sub-altern Speak?* (Ashcroft 2001).

Part of the criticism levelled against Said is that he prefers a reductionist and single directional approach that moves from the powerful to the weak. In that regard, he fails to take cognisance of the cultural exchanges that have facilitated the complex strategies that have affected the processes of de-colonisation and post-coloniality (Ashcroft 2001).

Amal Rassam makes two important points regarding what Said does not address (Ashcroft 2001). First, he questions how one can really know another culture in its own terms? Second, Said does not suggest any alternatives to Orientalism which are of course conceived as possibilities. Underlying these critical questions is whether it is possible to have a type of humanistic knowledge that does not play a dominating role in the population which it seeks to study? Can the silent achieve a voice and represent themselves? I think that Bhabha responds in the positive to the last question through his notions of hybridity, mimicry, ambivalence and third space to mean 'in between', 'not quite/not white' to articulate the ideas of the split selves and the relationship between the coloniser and the colonised between the dominant and the subaltern in the post-colonial period (Kennedy 2000, p. 120). It is on this basis that Bhabha argues that the voices of those who resist can be heard whether they are 19th century or contemporary non-western writers and artists (Kennedy 2000).

Bhabha is cited as emphasising the contradictions and conflicts in colonial power and argues that they ultimately subvert the colonial and neo-colonial authority (Kennedy 2000). The same point is reiterated by Jeater (1993) in her analysis of the process of colonisation of Zimbabwe. While the missionaries and colonists were both agreed on the mission to civilise they however differed on some points. First, the colonists realised that civilising the colonised would empower the latter to challenge the coloniser in terms of demanding the same rights and privileges that the colonisers enjoyed. Secondly, because of the eugenic nature of the coloniser in which they perceived themselves as being morally superior and therefore in control of their own sexuality, civilising the colonised would in fact lead to inter-racial sexual relations, a point which the colonisers saw as the enfeeblement of the superior white race (Jeater 1993).

2.5.3 The Relevance of the Post- Colonial Heuristic Lens

There are a number of reasons why the post-colonial heuristic lens is relevant. One of the key factors is that is helps to shift the focus from the dominant hegemonic perspective to considering the significance of the constructed 'other' (Said 1978) which would ordinarily be viewed as being subordinate and voiceless. In her seminal work (Spivak 1988) argues that in fact the marginalised,

disenfranchised and the oppressed group (the women) can in fact speak out and make themselves heard. It is in this regard that post-colonialism has often been associated with what is known as 'subaltern studies.'

As a heuristic lens, post-colonialism is useful in that it provides a useful tool in understanding those spaces and spheres that have been and continue to be subjugated to different types of socio-political domination. As 'subjects', the dominated begin to negotiate and seek recognition beyond what they would otherwise have been ascribed (Mbembe 1992).

The post-colonial heuristic lens is also pertinent not only in understanding the power imbalances between the western and the traditionally third world countries, but also within national contexts as when for example ethnic or other internal minority groups are suppressed. More recently, post-colonialism is exercised through militarised and globalised power of the United States through its networks against the rest of the world (Abraham 2011). As such, this explication helps to unpack how current perspectives of views of what are globally acceptable and unacceptable world views are constructed and mirrored around the globe.

San Juan(1999) points out like globalisation the post- colonial creates new and unlimited possibilities for engaging with cultural studies and the human sciences. In the context of this study, the outbreak of HIV/AIDS in both Zimbabwe (a developing nation) and Scotland (a developed nation) provided space to explore and contest a range of issues without necessarily arriving at a consensus. For example, the outbreak of the epidemic led to number of reactions like shock, fear and panic. That was then followed by a phase which saw the epidemic being highly moralised and associated with perceived sexual 'perverts' like homosexuals, prostitutes and social misfits, the intravenous drug users and the poor. Within religious circles, the epidemic has been associated with a punishment from God for some wrong doing and for those who frame it within an apocalyptic perspective, HIV/AIDS has been interpreted as the signs of the end of the world. Much later on, science started to develop bio-medical approaches some of which were based on the above assumptions. As a result, ferocious debates started to be exchanged between the developed world and the

developing world. Africa refuses the argument that HIV started there for at least two reasons. First the political leadership thought that accepting the argument would reduce tourism drastically (Kalipeni 2004) and secondly, political rhetoric also indicated that this was the usual racist and colonial argument levelled against Africa (Chirimuuta and Chirimuuta 1987, Kalipeni 2004, Flint 2011).

2.5.4 Challenges of Post-Colonialism

Although the post-colonial heuristic lens is a sustainable and useful way of interrogating my data, there are also some challenges associated with it. In the context of this research, the term 'post-colonialism' becomes ambivalent in that not only does it refer to the period after colonisation, but it also refers to those initiatives of returning to pre-colonial times and experiences. A number of examples will emerge throughout this study. In the case of Zimbabwe, Chikova wrote that:

> *President Mugabe hailed chiefs for being custodians of Zimbabwe's tradition and culture. He said while it was important for black people to adopt some foreign cultural practices that were progressive, alien practices like homosexuality should never have a place in Zimbabwe's culture…..*
>
> *President Mugabe said the same people who brought heinous practices like homosexuality to blacks colonised and oppressed them under the pretext of bringing civilisation'* (Chikova 2013, p.2)

Mugabe's selectivity of what the post-colonial should look like proves to be problematic in that there is an aspiration to revert to the pre-colonial. But reverting to the pre-colonial is complicated in that in terms of documented and profiled material, the colonists actually documented and profiled those traditions and practices that they saw as being congruent to their own perspectives (Shwarz 2005). Ranger in his *Invention of Tradition* (Hobsbawm and Ranger 2000), Rudolph in her *The Modernity of Tradition (*1984) and (Ndlovu-Gatsheni 2009) are clear testimonies of such revisionist exercises.

If post-colonial is understood in the sense of being 'after the colonial' then this in part explains Mugabe's repeated rhetoric that 'Zimbabwe shall never be a colony again'[34]. In both this instance and others, the idea behind is that as a post-colonial state, Zimbabwe would sever its links with Britain, which in his view is a representation of the *evil* (own italics) west and the negative experiences of colonisation.

This thinking is also closely linked with Thabo Mbeki's argument that 'much of the HIV/AIDS discourse is racist' (Flint 2011, p.11) a point which is also echoed by Chirimuuta(1987). In his argument, Mbeki argues against the fact that only Western science and medicine can save Africa of the epidemic. Drawing on the fact that the scramble for Africa was based on imperialist and colonial motives, the hegemony of western medicine was propelled by missionaries and western medical practitioners (Flint 2011). While the renowned late professor of medicine in Zimbabwe Michael Gelfand ascribed the success of western medicine to dealing with tropical diseases, Flint argues that such a view easily plays into the colonial perspective of Europe as the medical saviour of 'passive' Africa (Flint 2011).

A Zimbabwean political commentator and cultural critic[35] is on record for arguing that the spread of HIV/AIDS and other sexually transmitted diseases was facilitated by the colonial and capitalist political economy which required men to work in urban areas and segregated them from their families. Apart from the migrant labour, the missionaries and their colonial counterparts down-played and even outlawed the practice and development of traditional social norms and medicine. Such was the case in the in the Suppression of Witchcraft Act of 1889 (Zimbabwe) Chapter 73. This essentially undermined the licensing and practising of traditional healers who among other things administered herbal medicine and served as custodians of the local traditions and culture (Chavunduka 1994).

The colonial racial legislative structure set a legacy that the post-colonial has not been able to wean itself off from. It is rather paradoxical that while the

[34] This is part of the rhetoric that Mugabe often uses when addressing public and official gatherings both in and outside Zimbabwe.

[35] Personal communication

colonists wanted to introduce colonial laws and undermine local African traditions, it also found itself establishing 'a two-tiered political-administrative regime or colonial state' with the colonists ruled by civil law and independent courts on the one hand and the colonised subject to customary law. This is because the Europeans who were white considered themselves Christians and civilised rulers while the colonised were natives and inferior subjects (Seidman 2013). It is the local chiefs who were appointed to administer and implement customary law according to the dictates of the colonists: what is however not clear is if in fact the chiefs totally renounced their traditional beliefs and values in order to discharge their new functions?

Although the appointed chiefs were perceived to be pro the colonists, it cannot be verified how much of their world-view and day to day practice changed (Jeater 1993). If we grant that Mugabe was right in describing chiefs as the custodians of culture in the citation before, then this explains the current two-tier medical system in Zimbabwe which sanctions the practice of both western and traditional medicine (Chavunduka 1994). The latter is in fact governed by the Zimbabwe National Traditional Healers Association authorised through the Traditional Medical Practitioners Act of 1981(just a year after Zimbabwe gained its independence in 1980). By virtue of the way in which traditional medicine operates, witchcraft cannot be ruled out of the equation. A study on what some Zimbabweans think causes HIV/AIDS indicates that witchcraft is still very significant despite the bio-medical explanations (Rödlach 2006). What this shows is that the explanation for the origins of the HIV/AIDS epidemic is not based on a single factor: it ranges from homosexuality, witchcraft, missionaries, colonisation and viral infection.

2.5.5 The Collusion of the Missionary and Colonial Discourses

The post-colonial cannot be fully understood without taking cognisance of the impact of missionary activities on the colonial enterprise. In terms of HIV/AIDS, the post-colonial lens heavily relies on the missionary and colonial collusion in terms of its sexual construction of sex and sexuality in the colonial space.

A recurrent theme in this research is the collusion of the colonial and the missionary discourses. First, I would like to make a distinction between two often confused terms. Following (Mudimbe 1988), the term colonists refers to ' those settling in a region, while colonialists refers to 'those exploiting a territory by dominating a local majority' (p. 1). The two terms will often be used interchangeably given that there are notable overlaps between the two. Both the missionaries and the colonists are a temporal marker in terms of the historical period they interact with the respective populations. They are also significant in the ways in which they impact on the populations that they come into contact with. In Zimbabwe for example, local African oral histories and social mores were suppressed and dominated by western Euro-perspectives (Ndlovu-Gatsheni 2009). Mudimbe (1988) gives a number of examples of how western euro-centric perspectives undermine and trivialise African knowledge systems and culture for example:

> *Since the Africans could produce nothing of value; the technique of Yoruba statuary must have come from Egyptians; Benin art must be a Portuguese creation; the architectural achievement of Zimbabwe was due to Arab technicians; and Hausa and Buganda statecraft were inventions of white invaders (p. 13).*

Another example of such a perception is the West's denial of the Dogon cosmology and astronomical knowledge and its symbolism (Mudimbe 1988) as pointed out below:

> *The more carefully one studies the histories of missions in Africa, the more difficult it becomes not to identify it with the cultural propaganda, patriotic motivations, and commercial interest, since the missions' program is indeed more complex than the simple transmission of the Christian faith. From the sixteenth century to the eighteenth century, missionaries were, through all the new worlds part of the political process of creating and extending the right of European sovereignty over 'newly discovered' lands (1988, p.45). It is to this extent that: 'the missionaries, preceding or following a European flag, not only helped their home country to acquire new lands but also accomplished a 'divine'*

mission ordered by the Holy Father, Dominator Dominus' (Mudimbe 1988,p. 45).

In Zimbabwe, the Church and the missionaries continue to be major contributors in development projects but more critically in health and education. It is their involvement in the latter two which makes them come face to face with the HIV/AIDS epidemic. The Catholic Church tends to tow the official line of the church by highlighting the anti-homosexual rhetoric. Both in its school curricula and its health institutions homosexuality is not tolerated. Instead, there is a tendency to pathologise homosexuality as contained in selected pastoral letters of the Zimbabwe Catholic Bishops' Conference (1981- date). However, the challenge with the Catholic view is that it tends to be construed as playing into the hands of the Mugabe rhetoric who is himself a Catholic and anti-gay. The Catholic Church in Zimbabwe has yet to extricate itself from this collusion if it is to avoid such a perception. Catholic schools and health institutions generally enjoy a supportive role from central government but tensions often arise when certain practices are deemed by government to be perpetrated by western missionary workers.

While the Catholic Church shares its ethos with the official teaching, the protestant churches are more liberal, at least in principle towards issues of homosexuality and its relationship to HIV/AIDS. Today, many of the western-funded NGOs also bring with them the western liberal values as part and parcel of their 'aid package'. This is a point which has often caused the Zimbabwean government to exercise tighter controls through legislation (Dorman 2001, Simon and Watson 2005, Gershman and Allen 2006, Elone 2010).

In Scotland, apart from the low-scale projects run by the Church of Scotland, there is very little work directly linked to HIV/AIDS initiatives. Most Church-related HIV/AIDS initiatives are directed overseas especially in Africa.

2.5.6 Issues of Morality

A concomitant theme of the missionary/colonial collusion was the simultaneous creation of a new morality based on Christianity and western values. In broad

terms, morality deals with the rightness and wrongness of human actions. Despite this general perception, there are unresolved debates in terms of whether humanity uses the same or different yardsticks to determine what actions are right and which ones are wrong. There are various theories and approaches that determine how morality is constructed both on an individual level as well as on a collective level. For the purposes of this study, morality will be understood as those actions that are considered right or wrong. In terms of this study, HIV/AIDS has been variously described as a result of moral transgressions of both a sexual and a non-sexual nature.

Morality like humanity has also evolved over time. In the western post-war period for example, there has been a gradual shift of culture that has considered individual morality as a matter of private rather than the public realm. This was mainly due to the influence of the western liberal tradition. Whereas public morality was sanctioned by God and would be a matter of public interest, private morality was up to the individual.

A number of points are pertinent to understanding the evolution of the discourse of morality in Zimbabwe. Prior to colonisation, regulation of moral issues was developed and managed on a clan and lineage level. There were traditional structures that rewarded good morals and one that chastised bad morals. In her book, *Civilisation, Morality: Marriage, Perversion, and the Power of the Construction of Moral Discourse in Southern Rhodesia, 1894-1930* Jeater (1993) gives an interesting analysis of the impact of colonisation and missionary activity in one region of Zimbabwe. Although the findings are to an extent contextual, the theoretical paradigm she uses can be applied to colonial Zimbabwe and beyond.

Certain key factors emerge from Jeater's (1993) study. First, the British who colonised Zimbabwe came with British views of morality which emanated from the 18th century Victorian England part of which celebrated Britain's end of slave trade. Colonisation came as a package with Christianity and commerce to form what Jeater (1993) calls the 'unholy Trinity'. It is referred to as such because the ideals of missionaries that is, to evangalise and teach Christian morals and values, they were not always in tandem with the commercial enterprises of the

colonists. For one thing, both agreed on some basic literacy and civilisation but what they did not always agree upon was the content (Jeater 1993). The missionaries for example, were interested in teaching the Bible and Christian values which invariably saw all souls as belonging to God and capable of attaining desired moral standards. But for the colonists, the natives were essentially incapable of attaining the superior moral standards and the literacy levels that the former already possessed. Just to return to the issue of slave trade: The British colonists saw it as their mandate to teach other nations to abolish slave trade and more so to discourage native chiefs from indulging in that practice(Jeater 1993). The moral high ground they stood on did not always match their own practices in terms of their relationship with the colonised especially around issues of morality and civilization as demonstrated below.

Various examples are given of how the African natives were incapable of self-controlling their sexuality. Such depictions are chronicled by several Native District Commissioners and explorers (Jeater 1993). It is on that basis that the British colonists always viewed the African natives as unnatural because they were barbaric, primitive, cannibalist and sexually perverse. On their own part, they regarded themselves as being natural, heterosexual, and with a self-policing conscience that managed their private morality (Jeater 1993). The African natives were viewed as sexually perverse because they indulged in unnatural sex including sex with children and needed to be subject to social reformers through medicalisation and various agents and institutions of the judiciary. The latter point highlights the Foucauldian analysis of the regulation of sexuality (Foucault 1976) discussed elsewhere in this chapter.

Although the colonists were viewed as painting a negative picture of the sexual morality of the native Zimbabweans, current critics have also raised issues with, for example the liberation movements which equally claimed moral high ground by being sexually upright, just and defenders of human rights and equality. In *For Better or for Worse? Women and ZANLA in Zimbabwe's Liberation Struggle*, a book that caused political controversy in Zimbabwe's male-dominated liberation struggle, Nhongo-Simbanegavi (2000) chronicles and analyses the sexual abuses that the female combatants and collaborators suffered at the hands of their male counterparts. Such a depiction cuts across the otherwise

romanticised view of a liberation struggle that was based on equal gender and other justice and equality values.

In post independent Zimbabwe, Mugabe and his colleagues' utterances have located morality in the public and political domain both of which are said to be circumscribed by Christian values. This is why at the 1995 International Book Fair and other subsequent public fora, Mugabe castigated homosexuals as being 'worse than dogs and pigs'[36]. He has also alluded to the fact that westerners are in general responsible for moral decadence resulting in the HIV/AIDS epidemic. Mugabe's sentiments were also reiterated by senior clergymen in the likes of Dr Michael Mawema who called for 'crusade against homosexuals, as God commands the death of sexual perverts', and Bishop Peter Hatendi, then head of the Anglican Church in Zimbabwe who argued that 'homosexuality and Christianity don't mix because homosexuality is a sin and practising homosexuals cannot be accepted into the church'.[37] The rhetoric was also echoed by the then editor of the national newspaper, The Zimbabwe Herald as well as one of the then senior politicians Governor Border Gezi.[38] The irony though is that it is part of the same 'western' values and practices that Mugabe and his colleagues denigrate that he would espouse as a Catholic Christian or a representative of modern civilisation.

In the Zimbabwean scenario, the high profile case of the first President of Zimbabwe Rev Canaan Banana who was charged with homosexuality and defrocked as a cleric was evidence enough to undermine both the cultural and the ecclesiastical assertions that homosexuality was 'un-African' or that it did not exist[39].

In terms of HIV/AIDS, there have been debates around the moralising of the epidemic especially by Faith-based organisations (FBO) working in the field (Flint 2011). Although there is an admission that the FBOs are positively involved and deliver better quality programmes than governments, secular organisations have

[36] http://news.bbc.co.uk/1/hi/programmes/crossing_continents/143169.stm accessed 2.11.2010

[37] http://news.bbc.co.uk/1/hi/programmes/crossing_continents/143169.stm accessed 2.11.2010

[38] http://news.bbc.co.uk/1/hi/programmes/crossing_continents/143169.stm accessed 2.11.2010

[39] http://news.bbc.co.uk/1/hi/world/africa/257189.stm accessed 15.10.2012

accused them of demonising and stigmatising those living with HIV/AIDS. The FBOs have been seen as propagating a 'social vaccine' at the expense of harm reduction strategies. Flint (2011) states that such an approach is reminiscent of blaming the immoral sexuality of African women for spreading sexually transmitted diseases during the colonial era. The Catholic Church has been criticised for its outspoken position with regard to homosexuals as well as the use of condoms as preventive tool. While Uganda has been hailed as a high flying African example for reducing HIV/AIDS, secular critics argue that the American New Religious Right 'hijacked' the HIV/AIDS agenda which should be more broad-based than just limiting it to a faith-based perspective (Altman 1988, Patton 1990, Jeater 1993, Flint 2011).

In Scotland, the recent resignation of the former head of the Catholic Church and outspoken anti- homosexual anti- same sex relationships Cardinal Keith O'Brien on allegations of homosexual practice has caused the Catholic Church to look at the case as a recognition of the existence of both 'sinners and saints' within the Church rather than one which merits a collective shift from its official teaching against homosexuality. In the public domain, the allegations, the resignation and vague apology by Cardinal Keith O'Brien has raised the debate of anti-homosexuality to a different level[40].

2.6 Conclusion

In this chapter, three heuristic tools of narratives, attitudes to sexuality and the post-colonial lens have been presented which will be used to interrogate the data from the fieldwork as well as issues that emerge from the selected key policy documents either singly or collectively depending on the theme under discussion.

In terms of the narratives and the attitudes to sexuality, I will use them in respect of the data from both Scotland and Zimbabwe although I will pay attention to how each of the two contexts in some cases represent common and in others unique experiences of HIV/AIDS. With regards to post-colonial heuristic

[40] http://www.guardian.co.uk/world/2013/mar/04/cardinal-keith-obrien-vatican-inquiry accessed 4.03.2013

lens, it will be particularly useful in exploring HIV/AIDS issues in Zimbabwe although there will be some instances in which it will also be deployed in understanding the Scottish experiences.

3 CHAPTER THREE – THE HIV/AIDS SCENARIO IN SCOTLAND

3.1 Introduction

The McClelland Report states that first cases of HIV to be reported in Scotland in December 1985 were based on two studies that had been carried out in Edinburgh(The Scottish Home and Health Department 1986). In the same report, it was also noted that the two studies referred to the statistics of the HIV-positive being much higher among the intravenous drug misusers (IDUs) as compared to the rest of the United Kingdom, Europe and the United States. While this publication marked the beginning of a closer examination of the nature of the epidemic by the Scottish Health and Home Office, Health, like other portfolios, was still largely and centrally controlled from Westminster until devolution in 1999 (Devine 2006).

3.2 Reactions to HIV/AIDS in Scotland

The evolution of HIV/AIDS in Scotland was met with a plethora of reactions. If one were to put them on some kind of continuum, they would range from anger, ignorance, panic, isolation, stigmatisation on the one extreme to empathy, sympathy, moralising, medicalising to socialising the discourse on the other. These complex reactions often occur singly or in various combinations depending on the particular discourse at play.

From the beginning, HIV/AIDS in Scotland was associated with gay men and intravenous drug users (IDUs) thereby earning Edinburgh the title the 'AIDS capital of Europe'(Berridge 1996). In the early years of the epidemic both the data that was compiled and the relevant legislation[41] was developed UK-wide. On a UK-wide government level, reactions to the epidemic initially remained rather stern and almost punitive given that the blame was levelled against members of the gay community and IDUs (Berridge 1996). Berridge (1996) attributes part of the reasons for the negative attitude to the conservative morality and the influence of Thatcherism at the time.

[41] The Aids Control Act 1987.

In the light of the blame culture and moral conservatism, it was the voluntary sector and other charitable organizations who took the centre stage in the epidemic. As Berridge (1996) argues, the HIV-positive people mobilized themselves in order to provide peer support, demanded government involvement in fighting against the rampant stigma and discrimination targeted at them. One such development was that following the death of Terrance Higgins from AIDS in 1982, a trust in his name was founded. Two years later, in 1985, Body Positive London was formed as a self-help group. In the same year, the UK Minister of Health enacted powers to keep people with HIV in hospital against their will. In the following year, the same government launched the 'Don't AID AIDS Campaign' despite HIV having been recognised by scientists as the virus that causes AIDS. It was not until 1988 that a world summit on AIDS was held in London which culminated in the London Declaration on AIDS Prevention and the opening of the London Lighthouse by HRH Princess Margaret (Berridge 1996).

In 1994, Glasgow set up The Steve Retson Project focusing on gay men's health. In Edinburgh, the Scottish Aids Monitor opened a service that offered support to heterosexuals until they succumbed from pressure from the gay community to set up the Gay Men's Project in March 1994. What is critical to note here is that there was no coordinated approach and efforts seemed to be piece-meal. In fact from 1996 onwards, the HIV scene was characterised by funding rows, heterosexual versus gay focus, volunteer effort versus lack of sufficient interest from the public bodies. The projects that developed were basically from the voluntary sector namely: Project for HIV/AIDS Care and Education (PHACE WEST)- 1995, Gay Men's health Edinburgh -1996, Reach Out Highland, and lately Waverley Care Trust with its Solas centre and Milestone House (Scotland's only AIDS hospice) and the sex workers' groups Scot-PEP and SHIVA. In Glasgow, there was the HIV/AIDS Carers' Group, the Inter Faith Group Haven, Positive Accommodation Team, Foodline and Networks.

In the following sections, I will look at the narratives that were constructed regarding the origins of HIV/AIDS as well as the various responses that the various constituencies came up with in Scotland.

3.3 HIV/AIDS Narratives in Scotland

The reactions to the HIV/AIDS epidemic in Scotland followed a similar pattern from other countries in terms of laying blame on certain populations within society and also in terms of struggling to come to terms with the epidemic. While the exact date of when the first case of HIV in the world was discovered remains a matter of debate, there is some consensus that the first known cases came to light in the early 1980s (Hastings, Leather et al. 1987, Berridge 1996, Konotey-Ahulu 1996, Fordham 2001). Part of the contestation also arises from the fact that on the one hand, Luc Montagnier, a French virologist, leading a team of fellow scientists claimed that he had discovered HIV in 1983, Robert Gallo, an American biomedical virologist on the other hand also claimed that he had discovered AIDS in 1984 (Grmek 1993). The rivalry between these two opinions ended up engaging both the American and the French presidents to resolve the contestation (Avert 2011).

It is in this context that certain narratives were constructed in order to explain the origins and the spread of HIV/AIDS (Altman 1988, Sontag 1989, Dry and Leach 2010). In the case of Scotland, the initial paucity of the data in the early days of the epidemic meant that apart from the media hype, there were three key policy documents on the basis of which the narratives of HIV/AIDS were initially constructed, namely the McClelland Report: (The Scottish Home and Health Department 1986), the Tayler Report (The Scottish Office 1987) and the Penrose Inquiry (2010).

3.3.1 Gay/homosexual Narrative

An analysis of the three key documents namely, The McClelland Report:(The Scottish Home and Health Department 1986),The Taylor Report (The Scottish Office 1987), (The Scottish Office 1992, Flowers, Smith et al. 1997, Government 2009), The Penrose Inquiry Preliminary Report (2010) as well as other public health statements indicate that emphasis was placed on the gay/homosexual community activity as the reason for the origin of the epidemic. In a way the message being conveyed by this narrative has tended to imply that the rest of the wider population would not have much to worry about. Although there might

be some medical evidence to that effect, the complexity surrounding such a narrative is that being gay and homosexual in Scotland was a real cause for concern as demonstrated by the fact that gays and lesbians were said to be more likely to be discriminated against than disabled people, that homosexuals were deemed less able parents and the rest of the negative trajectory against gay/homosexual community (Scottish Government: Attitudes to Discrimination, 2003). In essence, this narrative placed the blame of the epidemic on homosexuals.

3.3.2 Blood and Blood Products Narrative

A second narrative is also generated out of the McClelland Report (The Scottish Home and Health Department 1986), Tayler Report (The Scottish Office 1987) and the Penrose Inquiry Preliminary Report (2010) which placed emphasis on the origins of HIV/AIDS on the blood and blood products that were routinely supplied from a whole range of local donors as well as other commercial manufacturers. The argument behind this narrative is that some of the blood and blood products were later identified to have contained both the HIV and the Hepatitis C viruses. The Penrose Inquiry (2010) explains that due to the inadequacy of existing resources, procurement arrangements were made to obtain blood and blood products required by the Scottish National Transfusion Service (SNBTS) from the United States. This decision was based on established professionally proven practice of blood procurement from the US. The Penrose Inquiry (2010) also emphasises that the procurement followed approved existing standard procedures. For some reason, some contaminated blood was released into Scotland. The American suppliers had previously demonstrated both the competence and the capacity to provide such blood and blood products as required.

Some of those who received the contaminated blood and blood products got infected and in other circumstances died. Campaign initiatives were mounted to investigate how this scenario had unfolded. The Penrose Inquiry was instituted by the Deputy First Minister for Health and Wellbeing in Scotland on the 23rd of April 2008 to investigate what had happened (2010). It is important to highlight that this enquiry was instituted against the somewhat perceived view that the

blood and blood products take precedence in explaining the anomaly. The final report of the Penrose Inquiry is yet to be produced. Questions have also been raised regarding other possible sources of contaminated blood like prison inmate donors as well as others from the general population. According to this narrative, haemophiliacs have been identified as the largest cohort of patients who received the contaminated blood and the rest of the population as being less affected (The Scottish Home and Health Department 1986).

While the first cases of HIV infection in Scotland were recognised in 1984 among haemophiliacs, routine HIV testing began in 1985(The Scottish Office 1987). As such, focus was on a population group already diagnosed with a health condition rather than the wider population. The haemophiliacs are therefore being described as the transmission route for HIV/AIDS in the same way as the gay and homosexuals were and are still perceived as the origin and transmitters of HIV/AIDS by virtue of their interaction with other gays from outside Scotland as well as through local gay/homosexual practices. The central point of this narrative is that it tends to emphasise blame on an external source of the blood and blood products that resulted in the internal *victims* within Scotland **(**Penrose Inquiry 2010). On the face of it, this narrative purports to be grounded on the bio-medical discourse but the discourse of the 'outsider' underpins this narrative. The idea of the HIV virus as something external and 'outside' the human body is a recurrent theme that Grmek(1993) Hatty and Hatty (1999) and others have equally explored. The discourse of the 'outsider' and how it links with other scapegoating narratives will be discussed in greater in this study.

3.3.3 The Arrival of Eastern Europeans and the Intravenous Drug Users (IDUs) Narrative

Directive 2004/38/EC granted free movement to members of the European Union. As a result, Scotland witnessed an increased inward migration by eastern Europeans for both short and long stays. The narrative emerging from this scenario is that the eastern Europeans bring with them the challenge of HIV infection causing the Scottish numbers of those infected to rise. This narrative reflects some of the concerns raised in a UNAIDS Press release in 2010 which can be summarised as follows:

- HIV incidence in Eastern Europe and Central Asia is continually on the increase.
- It has been noted that injecting drug use remains the primary route of transmission in the Eastern Europe. Use of contaminated equipment during injecting drug use was the source of 57% of newly diagnosed cases in eastern Europe in 2007
- There is an estimated 3.7 million people in the Eastern Europe that currently inject drugs, of which one in four are believed to be HIV positive.
- Most injecting drug users are sexually active with many of them in relationships with non-injecting partners who have thereby fuelled the growth in heterosexual transmission of HIV in the Eastern Europe (UNAIDS 2010).

Although this narrative demonstrates that while there are some useful pointers in terms of the route of transmission for HIV/AIDS in Eastern Europe, there are also critical questions which remain in terms of movement within the EU and HIV/AIDS infection monitoring. This is even more so because if HIV/AIDS is not a reportable disease[42], how epidemiologically accurate are the claims made by this narrative? However, studies in Scotland (McClelland Report 1986, Penrose Inquiry 2010, Goldberg 1994 and other Scottish Government Publications) have indicated that drug injection has been and continues to be an issue particularly in the major Scottish cities prior to the EU directive mentioned above.

Migration within and outside Europe is equally a common phenomenon in today's globalised world and therefore simply laying blame on Eastern Europeans as significantly responsible for the increase of HIV/AIDS in Scotland may well play into the scape-goating discourse. Two key issues emerge here: one is migration and the other the concept of 'outsiders' being held responsible for the epidemic. One of the resultant effects of such narratives is brewing a culture of blame, fostering contentious ideas of identity and investing less in developing more sustainable and broader approaches of combating the epidemic. The next narrative is closely linked to this one in that it also emphasises inward migrants as carrying HIV/AIDS within their 'body- baggage'. In a way this compromises any

[42] A disease that is monitored through epidemiological instruments in order to establish the patterns of its spread within particular demographic spaces

positive initiative to appreciate the richness of the cultural, intellectual and the possible and additional diverse HIV/AIDS strategies that the migrant communities bring to Scotland and the UK in general.

3.3.4 The Devolution and the Dispersal of Asylum Seekers and Refugees to Scotland Narrative

Another key narrative that has gained public social currency is that the dispersal of (African) asylum seekers and refugees is argued to have led to the upsurge of the epidemic in Scotland. This narrative shares the 'outsider' and' migrant' aspect that keeps on being referred to both in Scotland and the rest of the United Kingdom (Barbour and Huby 1998, Kalipeni 2004, Anderson 2008, Farmer, Saussy et al. 2010, Palattiyil 2011).

The dispersal was based on the 1999 Immigration and Asylum Act. This obviously came after the first case of HIV both in Scotland and UK as a whole (given that Terrence Higgins was one of the first people to die with AIDS in 1982,[43]). On one level, the dispersal of asylum seekers and refugees accounted for significant challenges within Scotland in terms of managing the epidemic and creating appropriate responses hitherto(Wren 2007).

On another level, the dispersal of (African) refugees and asylum seekers to Scotland also implied that they would still be subject to the blame that is laid on them by those African independent Churches who preach that HIV/AIDS is a direct punishment from God for sexual and other moral transgressions (Altman 1988, Fordham 2001, Anderson and Doyal 2004, Creighton, Sethi et al. 2004, Anderson 2008, Battle and Barnes 2009, Chitando 2013). As a consequence of the above, migration in terms of movement from country of origin to the UK and secondly through dispersal to Scotland has affected the African asylum seekers and refugees in a number of ways. The movement of refugees and asylum seekers from England to Scotland essentially constituted part of the myth that they are the source and the reason for the sudden increase of HIV/AIDS in Scotland and throughout their routes of passage. In essence such perceptions reinforce the rhetoric proffered by the host and mainstream society.

[43] *www.nat.org.uk/HIV/Facts/History-of-HIV. aspx (accessed13/10/09)*

Refugees and asylum seekers are viewed as belonging to the 'at risk category' in terms of HIV/AIDS. While some of the following descriptors about asylum seekers and refugees form part of the epidemiological explanation of the spread of the HIV/AIDS epidemic, there is also a level at which they are sensationalised in order to justify the scapegoating effect of the narrative. Some of the commonly used stereotypes are that they:

- come from areas of high prevalence (especially sub-Sahara Africa)
- bring HIV positive pregnancies in and outside formal relationships
- Fleeing civil strife and persecution
- are more prone to infection due to sexual and other forms of abuse while in transit
- are often at risk of infection while in holding centres –(they have equally been cases of child abuse)
- take advantage of the fact that HIV is not a reportable disease at port of entry.[44]

Part of the reason why asylum seekers and refugees are prone to the HIV/AIDS scapegoating is the fact that they formed part of the intersection of the already entrenched Scottish sectarianism, the shared UK-wide homophobia and the impact of the British immigration rhetoric against migrants in general[45].

3.3.5 Responses to HIV/AIDS in Scotland

In this section, I will look at the responses to the HIV/AIDS epidemic in Scotland by the government, the voluntary sector, the religious faith-based organisations as well as the media. The initial reaction to the epidemic in Scotland was that HIV was not really something for the nation to worry about partly because of its association with gay-men and haemophiliacs in particular. To that extent, the rest of the nation seemed to perceive those associated with HIV as some sort of societal outcasts and were simply unfortunate enough to have been infected. Not only were gay-men seen to be indulging in unacceptable sexual practices but

[44] African HIV Policy Network, Issue 10, October 2006

[45] African HIV Policy Network, Issue 10, October 2006

they were strongly linked with the illegal use of drugs and drug injection. Thus, in 1984, the total number of people diagnosed with HIV was recorded to be over 100 and gay men were asked to stop donating blood (McClelland Report 1986).

3.3.6 Government Responses

The Scottish Health Monitor was set up in 1983 to co-ordinate Scotland's response to AIDS.[46] Although initial reactions to the epidemic were not on a wide scale, Scotland commissioned two key reports, namely the McClelland Report (The Scottish Home and Health Department 1986) as well as the Tyler Report (The Scottish Office 1987). Scotland took leadership within the UK to introduce the clean needle exchange. Although it was initially unpopular from both the public and some medical professionals, it proved to be a very efficient strategy in combating the spread of the epidemic by intravenous drug misusers (The Scottish Home and Health Department 1986). This was also followed by Scotland's adherence of the AIDS control Act of 1987 which required every health board to submit regular statistics on the prevalence and programmes of HIV/AIDS across the UK.

Politicians have since tended to address the public World Aids Days. The official launch of the *HIV Action Plan* on 26.02.09 was demonstrable evidence of the incremental efforts that the Scottish Government has been embarking on since the outbreak of HIV/AIDS. This was a platform of public conversation and consultation with various stakeholders. Out of this plan have come several initiatives to take further forward combating the HIV/AIDS epidemic in Scotland.

Below is an outline of some of the major milestones that have demonstrated the shift in attitude by the Scottish Government in respect of HIV/AIDS.

- Throughout the 1990's to date, Health Protection Scotland has continued monitoring and reporting on various aspects of HIV/AIDS in Scotland.

[46] http://www.nat.org.uk/History-Facts/Histroy-of-HIV.aspx (accessed 13/10/09)

- The devolved Scottish government was represented at the July 2001 Representation at the UK *All Party Parliamentary Group on AIDS*. Although the recommendations from that group would be binding for the Westminster Government, representatives in the group included MPs and Peers from all political parties.

- The official launch of the *Respect & Responsibility* document on 27.01.05 by the Scottish Government was a momentous occasion in that it contained extensive information on HIV/AIDS and the way forward. The tone of the document is more sympathetic and appreciative of the nature and scope of the issue.

- Commissioned studies include Philomena de Lima et al (July 2007) Communities Scotland Report 89: *A Study of Grampian Migrant Workers* which contained a section on African and other migrant workers in relation to HIV/AIDS.

- A report by Alison Wells, (Sept 2008) entitled *Whispers and Closed Doors: the Experiences of Gay Men Living Long-Term with HIV* with a focus in the Lothians.

3.3.6.1 The Penrose Inquiry

Several decades after the outbreak of the epidemic, the Scottish government set up the Penrose Inquiry on 13 January 2009 to collect evidence on how blood and blood products contaminated with HIV and Hepatitis C viruses was given to some people thereby contracting HIV/AIDS and Hepatitis and in some cases leading to death. From a narrative point of view, part of the argument is that that blood was originally purchased from the United States, then stored by the Scottish National Blood Transfusion Service (SNBTS) (Penrose Inquiry 2010) and then later administered to National Health Service patients in Scotland. An analysis of the findings and implications of this enquiry will be given below.

In April 2008, Nicola Sturgeon the then Cabinet Secretary of Health and Wellbeing issued a statement on Hepatitis C and HIV in the Scottish Parliament in which she re-visited the 18 April 2006 Scottish Parliament's Committee which had called for an enquiry into the infection of people with Hepatitis C but had been refused by the previous administration. In the presentation, she expressed gratitude that the results would be published. She equally acknowledged that although that debate had centred on Hep C, she had instructed that the inquiry also include the transmission of HIV from similar circumstances[47]. The tone of her presentation demonstrated sympathy and the recognition that the Skipton Fund[48] should benefit the Scottish '*sufferers*' to the tune of £14million.

In its 12th and final chapter, the Penrose Inquiry (2010) gives a very robust outline of the regulatory framework regarding the production, licensing and dispensing of medical and associated drugs within Scotland, the UK and the EU (The Medicines Act 1968, Council Directive 65/65/EEC). While some scientific explanations have been offered in the past, the rhetoric surrounding the narrative of the 'US-imported' blood and products contaminated by both HIV and Hepatitis C and how they found their way into the Scottish National Blood Transfusion Service (SNBTS) and onward administration onto Scottish National Health patients remains a matter of controversy on various levels.

Part of the stereotype is instantiated through some of the assumptions that the developed world sometimes makes. A Blood Transfusion flyer[49] developed across UK and sanctioned by NHS Health Scotland circa 1993 states that:

> *A man (or woman), of any race living in Africa * or had sex with anyone living there should not give blood.*

The asterisk (*) then explains in brackets: But not Morocco, Algeria, Tunisia, Libya or Egypt.

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[47] The Penrose Inquiry Preliminary Report (2010) p.1

[48] This was fund UK- wide fund set up in 2004 to benefit claimants infected by Hepatitis C through treatment of NHS blood or blood products prior to 1991

[49] NBTS flyer – (no date)

The assumption here is that it is assumed that if one comes from the countries above, they would not transmit the virus. One can only surmise that such policy thinking is based on misplaced religious constructs that people from Moslem countries albeit being in Africa cannot contract and communicate the virus. Belonging to that or any other religion does not seem to necessarily guarantee immunity from the epidemic despite the strict sexual ethics contained within their religiosn. A comparative analysis of the interaction between perceptions of culture, religion and morality will be explored in subsequent chapters.

3.3.7 Voluntary Sector Responses

The voluntary sector involved in HIV/AIDS initiatives have always recognised that faith-based communities have an indispensable role to play in engaging with people infected and affected by HIV/AIDS. Firstly, it is about supporting and secondly, it is around challenging some of the negative stereotypes that some of these faith communities may portray towards its own folk living with or affected by the HIV/AIDS. This has on that level created a passionate, sympathetic, supportive and more understanding role than other strands in terms of coming to grips with the epidemic. The voluntary sector is by nature constituted by stakeholders who have a passion for what they do and believe in. They almost always fill in a gap that the public sector does not construe as a political or policy priority. In that regard, the HIV/AIDS voluntary sector in Scotland presented and continues to present itself as the singular space where people both infected and affected by HIV/AIDS could relate to in any meaningful way.

Despite the hurdles that the various HIV/AIDS voluntary sector charities initially encountered, they almost defied reality by leaping from one step to the next. Part of the challenge that the voluntary sector encountered was to justify its legitimacy for existence in so far as they claimed to fill in a gap that the NHS was not already providing for. This was informed by a general resistance to why HIV/AIDS would be a health-worthy cause like cancer or other similar untreatable conditions. There was a need to shape public debate around their legitimacy by engaging in sustainable advocacy that was backed by recognised scientific research. In 2005, Eunice Sinyemu and Martha Baillie of Waverley Care published *HIV Becomes My Name: A Report on the Issues Facing Africans Living*

in Scotland Who Are HIV Positive. The report is a good piece of research that clearly demonstrates how immigration legislation in the UK (Scotland included), stigma and discrimination are recurrent themes for Africans both infected and affected by HIV/AIDS. This publication is but one example of how devolution is short-changed by the Westminster Parliament. Martha Baillie, the Senior Community Services Manager of Waverly Care is quoted in an advocacy publication *Women to Women: Positively Speaking* saying:

> *People's level of ignorance is just as great as it ever was….It's very easy for the majority of people of people to think that HIV/AIDS has nothing to do with me. There was, is still is, the notion of the innocent and the guilty. …The biggest common issue for anyone who is positive is the fear of stigma, the fear of other people's reaction to them, of being discriminated against. However real or perceived that is, it matters to them. Fear of stigma maintains HIV as something you don't talk about, as a secret you can't share. ..What does make a difference is when people feel able to talk about being positive. But for most the choice is not to be open about their status because they are so scared*[50].

In the same publication, there are individuals who confidently talk about their status, flagging up the case for advocacy and stigma reduction. Some are from Scotland but others are from elsewhere within the UK.

Waverley Care has also been involved in the Crusaid Hardship funding which although UK-wide has a Scottish chapter. This specifically assists individuals positively living with HIV but have no access to public funds because of their immigration status. The primary ground rule is that one has to declare their HIV status to a health worker before they can access assistance. This raises a number of questions particularly given that the most of the at-risk groups have so much else to deal and cope with (Palattiyil 2011). The Fund has played a very pivotal and crucial resource for the vulnerable HIV positive individuals and families. Crusaid Poverty and HIV Findings from 2006, 2008-2008 have been demonstrable cases in hand (Palattiyil 2011).

[50] http://www.fashionfightsaids.org/testimony-martha.htm (accessed 06.03.2014)

The HIV/AIDS scenario in Scotland cannot be complete without the organization *HIV Scotland*. On 29 June 2005, Roy Kilpatrick issued a fitting political advocacy statement to the G8 heads of states entitled: *G8 Hearing AIDS?* In it he argued that:

> *'G8 leaders must do more and better. Debt relief of just less than one billion pounds annually sounds a lot, but it will cost each of us all of the G8 countries just two pence a week. When we look at prevention, we see a lack of effort and commitment from G8 countries. ..'*

There are a couple of other voluntary sector responses that are worth noting. The African HIV Policy Network, (AHPN) a UK- wide HIV/AIDS organisation to which Waverley Care (Scotland) is a member produced an editorial on HIV and Immigration by Rhon Reynolds, Senior Policy Officer on Stigma and Discrimination piece stating that:

> *Migration plays an intrinsic role in life and life chances of African people living with and affected by HIV in the UK. Many people live within fear of …the five D's, Death, Deportation, Destitution, Detention and Dispersal. This is accompanied by evidence of systematic and institutional HIV related stigma and discrimination and driven by public anti-asylum sentiments and entrenched racism.*
>
> *The same point is reiterated in that that there is a low uptake of voluntary testing from immigrant African communities partly because of stigma and discrimination. In a subsequent publication, Georgina Caswell reinforces the same theme of stigma and discrimination.* (*African HIV Policy Network, 2006 p.1***)**

From a Scottish perspective, the author argued that:

> *HIV is a growing concern in Scotland, particularly among Africans and Minority Ethnic populations. Social and legal factors like racism, HIV-related stigma and immigration problems make it increasingly difficult*

> *for those who are living with or affected by the virus. As a community and more so for those in rural Scotland, everyone is affected in one way or another with respect to the HIV/AIDS pandemic (*African HIV Policy Network, 2006).

Realising that African migrants are disproportionately affected by HIV/AIDS, the voluntary sector worked from within their client groups and developed a model where appropriate messages would bring sensitive issues into the public arena about their plight. One way in which that was instantiated was through drama. *Sharing the Stories of Hope* **(**Greater Glasgow and Clyde, 1989**)** [51] is basically a play that highlights HIV related fears, ignorance, myths, and celebrates living positively with HIV. One of the pieces deals with how in the African community there is a denial of the existence of gay Africans which in turn has led to serious homophobic tendencies. The play also highlights that if we have to fight stigma we have to start by tackling it within the family setting. It also looks at the political angle, demonstrating how politicians and the media discriminate against HIV positive immigrants.[52]

An important subset of the voluntary sector is that of the African immigrants living in Scotland with whom the writer has both experiential knowledge and anecdotal evidence. This group is broadly comprised of various generational differences, immigration statuses and complex religious affiliations or none. The latter is complex in that an individual may have come to Scotland (and the rest of the UK included) belonging to a specific religious group but because of local dynamics shifts to others which would be convenient or more responsive to their particular context. Unfortunately, no documented evidence as such does exist but verbal testimonies have been noted in the different support settings.

Given that there is constant movement of African migrants within and across the UK, any public conversation about HIV/AIDS cannot take place without taking this factor into cognisance. No single African migrant or any of the UK countries could be addressed in isolation. To that end, the writer was the co-author of the

[51] Greater Glasgow and Clyde Health Board HIV/AIDS Forum Meeting RHS 9990, Box 86 (1989)

[52] Greater Glasgow and Clyde Health Board HIV/AIDS Forum Meeting RHS 9990, Box 86 (1989)

initiative that brought together the Southern Africa Ambassadors in order 'to present a united voice on the needs and experiences of African communities living with HIV/AIDS in the UK so as to inform policy and combat stigma. The idea of the forum was basically to engender visible leadership from African Ambassadors in providing HIV information and access to communities of Africans living in the UK' (HIV Scotland Newsletter, Spring 2008).

There have also been notable collaborations between the government, voluntary sector and academic institutions as evidenced by the examples of studies and seminars below:

- The HIV voluntary sector organisations and MSPs and the public have been involved in the Scottish Cross Party Group on Sexual Health which among other things discusses HIV/AIDS in Scotland. In fact, the secretariat to this group is run by an officer from one of the HIV voluntary sector organisations. This goes a long way to demonstrate how far the Scottish government is engaged in the public conversation and policy change around HIV/AIDS.

- The then Public Minister of Health Key note address at the Waverley Care organised *HIV Human Rights & Immigration Seminar*, August 2007

- Viv Cree (May 2008*) It's Good to Go for a Test*, with a special focus on the migrant African communities around greater Glasgow & Clyde

- George Plattiyil and Dina Sidhva (2011) *they call me: YOU ARE AIDS… A Report on HIV Human Rights and Asylum Seekers in Scotland*

The leadership of the voluntary sector in the HIV/AIDS sector has always recognised that faith-based communities have an indispensable role to play in people infected and affected by HIV/AIDS. Firstly it is about supporting and secondly it is around challenging some of the negative stereotypes that some of these faith communities may portray towards its own folk living with or affected by the HIV/AIDS.

3.3.8 Religious/Faith-based Responses

There are at least three categories in respect of faith-based perceptions to HIV/AIDS in Scotland. First is the Roman Catholic Church. Given that its doctrine is universal its position is the same world-wide. In as much as it advocates for responsible sexual behaviour, supports HIV/AIDS programmes both locally and internationally, reducing poverty on both levels, it has often brought itself into serious controversy around homosexuality and condom use. Ironically, these are some of the very contentious areas in respect of HIV/AIDS. Its central message has been around delivering moral education in line with the natural law.

The Church of Scotland has tended to champion HIV/AIDS programmes both locally and abroad and is more tolerant towards homosexuality and condom use. In fact, apart from running a church of Scotland AIDS Project it has also seconded a full-time chaplain to engage with people both infected and affected by HIV/AIDS. They see their role as engaging with service users irrespective of their origin, sexuality or otherwise. Alongside Waverley Care, they co-hosted a Faith Health and HIV Conference in Glasgow in December 2006. Further initiatives responding to the unique needs of people living with and affected by HIV/AIDS in Scotland are in progress.

The third category of faith communities is what I would refer to as the African Independent/Charismatic and the Pentecostal Churches[53]. However other authors have used the term 'African/Independent/Indigenous/Initiated/Instituted Churches' (AICs) to refer to them (Chitando 2013). Although they are not a uniform grouping, except that they differ from the mainstream traditional churches like the Catholics and Presbyterians. Despite its following being predominantly of African origin, when it comes to HIV/AIDS, there is a tendency to argue that living with the condition is a punishment from God or the work of the devil (Altman 1988, Anderson and Doyal 2004, Chitando 2007, Chitando and Gunda 2007, Anderson 2008). Such interpretations seem to be based on a selective use of scripture in which according to the Old Testament disease and

[53] I use this identification in so far as it captures the various aspects in terms of origins, focus, and style of worship.

plague represent communal punishment or is evidence of ritual contamination including prohibited forms of sex.

In the New Testament, disease and suffering are often related to the apocalypse and the eschatological signs of the parousia (Chitando 2007, Chitando and Gunda 2007, Chitando and oecuménique des Eglises 2008). Homosexuality is viewed as a very serious pagan and moral transgression (Foucault 1985, Foucault 1986, Brown 1988, Epprecht 1998). The irony is that while most African migrants sought solace from the AICS, these churches were often responsible for the stigma and discrimination that the migrants were trying to deal with because of their HIV/AIDS conditions. This is one of the major reasons why the voluntary sector engaged with the faith leaders and the more moderate members of these and affected by HIV/AIDS.

In respect of the three faith categories, there are still some important questions to address namely:

- How do the ethics of care and non-judgement affect the pastoral role of faith-based organisations in the context of HIV/AIDS?
- Given the current realities of HIV/AIDS, how do faith-based moral ideals relate to the condom and other bio- medical technologies?

The above characterisation is quite broad and may in fact not do justice to the specific programmes and theologies that each of the faith groups are involved in within Scotland (and beyond). Thus, in respect of the three faith categories, there still remain meta-ethical questions which may be posed namely:

- What is morality and how can it be applied to human sexual behaviour in the context of HIV/AIDS in Scotland (and elsewhere?)
- What is the role of biblical and theological hermeneutics in understanding the different moralities as they relate to HIV/AIDS?
- How do the ethics of care and non-judgement affect the pastoral role of faith-based organisations in the context of HIV/AIDS?
- Given the current realities of HIV/AIDS, how do faith-based moral IDEALS relate to the condom and other medico-scientific technologies?

3.3.9 Media Responses

Traditionally, the simultaneously hostile and sympathetic media in Scotland and beyond have tended to be perceived as being adverse in their treatment of HIV/AIDS coverage. The perception of media in Scotland resonated with the media elsewhere in that it promoted a culture of silence, then the idea of a gay-man's syndrome and later-on an African disease. Deborah Jack of the National Aids Trust rightly put it when she said:

> *The power of media- its increasing influence over our cultural social and political life – is one of the undisputed facts of the modern world. It has the power to communicate news, information and important public health messages. It can also misinform, reinforce prejudice and hound individuals. This issue of* ***Impact*** *looks at HIV and the media – at the current state of reporting HIV, at how we can challenge negative and inaccurate coverage, and at how we can promote constructive discussion of HIV (Impact Policy Bulletin 12, Feb 2007, p4)*

In order to demonstrate the negativity and sensationalisation of HIV/AIDS reporting in Scotland the author will just highlight a few headlines:

- 'Fears for sufferers after HIV verdict' (BBC Scotland, 23 February 2001)
- 'HIV ***victim*** says justice is done' (BBC News Scotland, 16 March 2001)
- 'HIV case man jailed for five years' (BBC Scotland, 16 March 2001)
- 'African Immigrants bring More AIDS to Scotland' by Mandy Rhodes, The Scotsman, Rense.com)
- 'AIDS: Scotland facing HIV crisis, Cases set to double, Treatment to cost £200m (Adam Forrest, Sunday Herald, 2 Dec 2007)
- 'Ministers review ban on health workers infected with HIV' (Scotland on Sunday, 29 Oct 2009).

In some cases the government has also used popular media to convey its own messages on HIV/AIDS. The official government literature, HIV/AIDS campaign and awareness raising materials carrying very graphic and skewed messages like the tombstone and iceberg images.

There are many other examples which the media pander to despite efforts by people within the HIV/AIDS sector in Scotland to explain both the Science and the Technology of what is actually transpiring. The media continues to encapsulate the fact that HIV/AIDS is a gay disease and its spread in Scotland has been made worse by African immigrants. Glasgow is affected more than other Scottish places because of the dispersal of asylum seekers and refugees. The emergence of the Eastern Europeans has fed into the myth of exacerbating the spread of HIV/AIDS through IUDs. Throughout the eighties and the nineties, HIV/AIDS in Scotland was treated with fear, as a death-license and a symbol of being a social and religious outcast.

In some ways the media still retains part of its original emphasis that HIV/AIDS is a gay disease and its spread in Scotland has been exacerbated by immigrants. Glasgow gets the worst hit because of the dispersal of asylum seekers and refugees. The emergence of the Eastern Europeans has fed into the myth of exacerbating the spread of HIV/AIDS through IUDs.

Although in the early days the negative media perceptions were premised on ignorance, more recently there has been a shift in that new and digital media tends to convey user-friendly messages which avoid stigmatising and are also are more likely to engage with the rest of the public in more productive ways (Flowers, Smith et al. 1997, Flowers, Duncan et al. 2000, Flowers 2001, Flowers and Church 2002).

3.4 Conclusion

Current perceptions and trends on HIV/AIDS in Scotland indicate some kind of cyclical process in which although some progress is being made to have a balanced debate of the HIV/AIDS discourse, stigma and discrimination are still

rife through the lenses of race, immigration and poverty. This is entrenched in media bias as well as limited and effective public education and moral engagement.

4 CHAPTER FOUR - THE HIV/AIDS SCENARIO IN ZIMBABWE

4.1 Introduction

In this chapter, I will outline the development of HIV/AIDS in Zimbabwe from when it was first officially discovered to the present. Although an attempt will be made to follow a chronological format, emphasis will be laid on the thematic milestones that influenced the evolution of the epidemic. These milestones will be characterised in the context of the historical, socio-political and economic issues that Zimbabwe experienced and continues to experience.

Zimbabwe is one of the sub-Saharan countries that has a high prevalence of HIV/AIDS with an estimated one in seven adults living with HIV/AIDS (UNAIDS 2008 'Report). The first HIV/AIDS reported case in Zimbabwe was in 1985[54] despite the fact that there was neither public acknowledgment nor debate about the problem after that report. This happened against the backdrop of Zimbabwe's political independence and thriving economy in 1980 and throughout the decade (Muzondidya 2009). The current political regime uses the political struggle for independence as informing part of the way is which it has responded to the HIV/AIDS epidemic.

It is equally important to note that in 1980, Zimbabwe inherited an administration system that was built on the colonial legacy that was essentially racialised. This in turn resulted in a society comprising of divisions that were manifested in the rural-urban, government-private and religious categories (Windrich 1975). The concomitant effect of this was that the allocation of resources and management system also depended on which category an institution belonged to. As a result, the responses to the HIV/AIDS epidemic depended in part on the racial categories among other factors.

4.2 The Contextual Framework

The HIV/AIDS epidemic in Zimbabwe can best be understood by grounding it within the wider evolution of epidemics and plagues. The following is an outline

[54] http://www.avert.org/aids-zimbabwe.htm 6/09/10

from the western world but in many respects it resonates with what transpired in Zimbabwe. The common thread in epidemics is that they are infections that rapidly cause a high rate of mortality. By their nature they tend to inflict a 'shock effect' (Ranger and Slack 1996). The shock reaction invariably occurs among

> '*all continents and cultures; because they (epidemics) raise particularly broad issues in the history of ideas because they support, test, undermine or reshape religious, social and political as well as medical assumptions and attitudes* (Ranger and Slack 1996).

Ranger and Slack (1996) raise a number of recurrent themes run through the book. [55] One of the key themes is that 'carriers of diseases were identified and *scapegoats stigmatised'*. In Renaissance Italy, epidemics were associated with foreigners (thereby reinforcing the discourse of *otherness*) and the local poor whereas in the case of India they were referred to as untouchables (by virtue of religious segregation). In Africa disease carrying was blamed on ex-slaves and during the time of Black Death, the Jews were held responsible (Ranger and Slack 1996). An analysis of these themes demonstrates that disease carriers are blamed and stigmatised, they are folk of low social standing as demonstrated by the reference to poverty and being untouchable. Underpinning all these labels is also the fact of migration, both internal and external. Society identifies itself as 'us' and 'them' with the latter being held accountable for the disease misfortune.

The victim groups were either directly persecuted for the perceived evil that they had brought both on themselves and to the 'us' or they literally chose to migrate away or suffered the consequences of the exclusion which sometimes culminated in death. These themes continued to be used as heuristic frameworks for epidemics that have been discussed more fully in Chapter Two of this thesis. What is also interesting both to previous epidemics and to the current HIV/AIDS epidemic is that they

[55] The book is based on conference edited papers whose focus was around the history of epidemics and how populations across the world have tended to engage with those crises.

> '*present and presented common dilemmas, arising from the need to explain them; and the answers to them repeat themselves in history…various forms of religious ritual indicate, intellectual and social responses assumed a different social, cultural and political contexts*'(Ranger and Slack 1996).

In the context of Zimbabwe, the HIV/AIDS epidemic in Zimbabwe broke out against a background of the last of Africa emerging from colonial domination and the cultural devastation that it had hitherto experienced (Flint 2011). On the one hand, this historical epoch also marked the emergence of new local African and celebrated technologies and political successes demonstrated by a new calibre of intellectual and academic stature. On the other hand, there has been, a very significant resurgence of civil strife based on north-south disagreements as well as the more locally precipitated tribal and racial tensions. Thus, the initial resistance to HIV/AIDS as either unreal or of non-African origin and the perpetuation of conspiracy theories (Rödlach 2006) based on homosexuality, theological abomination, cultural decadence and similar perceptions are commonplace. The theoretical framework is also connected with the historical epochs broadly identified as the pre-colonial, the colonial and the post-colonial Zimbabwe.

4.3 The Impact of Zimbabwe's Colonial History

Arguments have been made regarding Zimbabwe and external contacts and the impact of Islam in pre-colonial Zimbabwe (Mandivenga 1992). From a pre-colonial historical perspective, Mudenge (1988) also argues that there is documentation to the effect that the Portuguese traders and missionaries interacted with Zimbabweans prior to the colonial period.

Subsequent arguments to the effect that HIV/AIDS is against the norms and values of a 'pre-colonial' Zimbabwe should be considered cautiously because they are in part historically controversial. The sympathisers of the romantic view clearly echo what Ranger has aptly demonstrated in a chapter entitled: *The Invention of Tradition* (Hobsbawm and Ranger 2000).

Among other things, Ranger (2000) broadly argues that colonial masters imposed a foreign ideology and system of governance on colonised Africa. On the other hand, the local Africans also adjusted to the new paradigms but without necessarily abandoning all of their traditional belief systems. What eventually transpired was a result of a constant mutation and reconfiguration of traditions both within each domain colonial and colonised and a combination of both.

The next major epoch is that which is generally referred to as colonial. This framework obviously not only informs but problematises how the HIV/AIDS response is subsequently presented within the post-colonial epoch. Settler colonialism sets the trend in disproportionate allocation of a whole range of services and resources along the race, colour, tribe, geographical location and ethnic origin paradigm.

The degree to which a country or a geographical location may be regarded as living in a post-colonial era may in part be evidenced by the content and experience of a (new) culture. Edward Said(1978) is often considered as the exemplar and founding work of the post-colonial experience. Similarly, other authors like Franz Fanon, Spivak and Cesaire have significantly contributed to the post-colonial discourses.

Airhihenbuwa and DeWitt Webster rightly argue that

> *culture is the foundation on which health behaviour in general and HIV/AIDS in particular is expressed and through which health must be defined and understood*[56].

Their argument was premised on the study findings of the role of culture and African contexts of HIV/AIDS prevention, care and support.

The above resonates very much with how in Zimbabwe, the ruling African regime perceives and interprets homosexuality as foreign and colonial. HIV/AIDS is defined as being derived from and transmitted by homosexuals. Homosexuals are said to be un-African, 'not part of *our* African (Zimbabwean) culture. Mugabe is

[56] http://www.sahara.org.za/index2.php?option=com_docman&task=doc_view&gid=226&Itemid=85 Accessed 2.11.2010 p.5

on record for having likened homosexuals as 'worse than dogs and pigs' at the International Book Fair in Harare in 1998.[57] The blame and conspiracy theory is discussed at great lengths in Rődlach's (2005) book which is based on research carried out in Zimbabwe. Zimbabwe's response is necessarily informed by a skewed understanding of both culture and tradition.

While part of the agenda is clearly political, the national psyche has been continuously bombarded with a negative narrative that is supported by the pro-government national media, religious conservatism of all faiths, the mantra of a traditional ideal and the ignorance of some Zimbabweans on how HIV/AIDS is actually contracted and spread. Some political commentators view the epidemic as a handy scapegoat for the socio-political and economic issues that Zimbabwe is reeling under. [58]

The argument that HIV/AIDS in Zimbabwe is a result of a violation of its culture is not sustainable in that there is no such thing as a pure Zimbabwean (African) culture and tradition. According to Said, what exists is a result of:

> '*… the interdependence of cultural terrains in which coloniser and colonised co-existed and battled each other through projections as well as rival geographies, narratives, histories ...*' (Said 1993,p. xxii-xxiii)

The purity of culture is also challenged on the basis of the fact that during and in the aftermath of liberation wars, images are created and constructed by 'national poets and men of letters' depicting how *pure* (italics own emphasis) and grand their traditions would have been prior to colonisation. Said (1993)goes on to emphasise that

> '*the power of images and traditions…and their functional or at least romantically coloured fantastic quality..*' (p.17)

are indispensable propaganda instruments that post-colonial states invariably resort to.

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[57] http://news.bbc.co.uk/1/hi/programmes/crossing_continents/143169.stm

[58] John Makumbe, Political Science Professor at University of Zimbabwe

Central to the whole debate is that the ruling regimes represent and regulate what is consumed as the singular and main dominant narrative. Given that the Zimbabwean government regulates media, health education and other public goods and services, the determination of how to engage with the HIV/AIDS epidemic remains unbalanced. It is however important to recognise that despite the dominant paradigm, there exists parallel to it other voices which emerge from other constituencies. Examples of these are: the suppressed GALZ (Gay and Lesbian Association of Zimbabwe) which was formed in 1989 for the purposes of advocating for gay and lesbian rights, providing a space for bisexuals and like-minded people, providing space for community events, networking with other human rights organisations, women's movements and initiating outreach activities on HIV/AIDS nationally, regionally and beyond. The other constituencies of marginalised yet articulate voices are the many groups of people living with and affected by HIV/AIDS themselves and within the religious context, ZINERELA (Zimbabwean Religious Leaders Living with HIV/AIDS). The initiatives of these constituencies are generally supported by a range of volunteers and NGOs.

4.4 The Impact of Culture

Hobsbwam and Ranger (2000) identify the two legacies of invented traditions namely; one imported from Europe that continues to influence the ruling class culture in Africa today. This is often demonstrated in public practices and official institutions like the Education systems, judicial etiquette, official languages in documents, dress and other material and non-material symbolisms and insignia. The other legacy is the so-called 'traditional' African culture re-invented during colonialism. This tends to be selectively invoked for political expediency rather than for consistent and sustained cultural historical and national identity reasons. Central to Hobsbawm and Ranger's (2000) argument is that traditions that are often argued and perceived to be *African* (italics own emphasis*)* are in fact not pure in form. They are also products of the interactions between traditional systems and practices and those imported from Europe via colonialism, missionary ventures and trade. Chapter One has

demonstrated the value of archaeological evidence is supporting this line of argument.

Another important point highlighted by Hobsbwan and Ranger is the fact that colonialism itself created conditions in which traditions of the colonized were re-invented to suit the colonial discourse. The colonizer manipulated several Zimbabwean African traditional structures in order to dominate and lure the support the colonized. For example, African Zimbabwean traditional leadership could operate at various levels as long they did not undermine the colonial structures. In fact, they were built-in incentives in the form of monetary remuneration and other colonial privileges as evidenced by the fact that:

> *Chiefs and headmen were rewarded with money, regalia and other tokens of state appreciation if they persuaded their people to peacefully comply with the provisions of the various land Acts* (Chitiyo 2000).

In many instances, western missionaries collaborated with the colonial masters upon whom they often depended for their own safety as well as the fact that they had significant ideological similarities (Zvobgo 1996).

There was also the strand of African Zimbabweans who resisted colonization but were forced by circumstances to adjust the modus operandi so that they (Zvobgo 1996) could continue to uphold tradition but also so that thereby putting themselves in difficult situations by the colonial masters. The author re-collects the reflection of a retired head-teacher who argued that this strand of Zimbabweans played a significant role in the struggle for independence through mobilizing villagers clandestinely for fear of the repressive measures of the colonial regime.

The critical point is that these epochs are part of the wider picture in understanding the genesis, development as well as the responses to the HIV/AIDS epidemic on various levels namely, the cultural, political and the socio-economic. The various strands also inform the demographics of race, tribe, rural versus urban divide and other social indicators pertinent to understanding the HIV/AIDS epidemic in a comprehensive way.

4.5 The Role of Religion

Culture and Religion in particular posed contesting challenges to the epidemic. As already discussed, Zimbabwe evolved through the pre-colonial, colonial and post-colonial periods. There are also the African Traditional Religion(s) which are to some extent based on tribal groupings although there are some notable common characteristics, mainstream Christian Religions and Independent/African Evangelical Denominations.

The Roman Catholic Church and some of the churches generally opposed the use of condoms although they purported to give support to those living with HIV/AIDS. Abstinence was flagged up as the ideal norm although there was controversy among the different denominations. To an extent, such a position was seen as playing into the hands of Mugabe's view which demonised HIV/AIDS for different reasons.

However, traditional culture played a rather ambivalent role in that although it claimed through Zimbabwe National Association of Traditional Healers' Association (ZINATHA) to be able to offer a cure for HIV, it also played into the conspiracy theory of witchcraft and magic (Rödlach 2006). It is important to note that the idea of working with African traditional healers in the search for a cure for HIV/AIDS is not unique to Zimbabwe. C. O. Airhihenbuwa and J. DeWitt Webster highlight the critical role of African culture in defining, understanding and combating ill-health within the boundaries and social spaces of its adherents. Traditional healers are seen as indispensable figures in managing and engaging with HIV/AIDS as demonstrated in studies referred to in Zimbabwe, Kenya, Nigeria and Senegal.[59] Their study identified nine lessons to be learnt in respect of the relationship between traditional culture and HIV/AIDS in Africa. The fifth lesson was characterized as: 'Existential enablers'. They however go on to conclude that:

> *It is now evident that traditional healers in Senegal have developed a treatment regimen for successfully treating HIV.A similar effort is*

[59] http://www.sahara.org.za/index2.php?option=com_docman&task=doc_view&gid=226&Itemid=85 (3.11.10)

> *currently in progress in South Africa, where an AIDS treatment drug developed by traditional healers is currently undergoing clinical trials at the Medical Research Council, with promising initial results.*[60]

While there is some logic in the importance of the role of African traditional culture and ethnomedicine, their impact on the HIV/AIDS epidemic remains contestable within the western pharmacological circles. However, both African traditional culture and the contribution of ethnomedicine are gradually continuing to make some recognisable difference in terms of facilitating the treatment, care and support of HIV/AIDS people within the African communities.

4.6 The Role of Politics and Government

The initial response to HIV/AIDS in Zimbabwe was a rather unique continuum ranging from disbelief, to fear, finger pointing and some mythical explanations like an experiment gone wrong or simply resigning to fate. Although subsequent efforts witnessed a mixture of disagreements within the medical fraternity, some advances to combat the epidemic steadily grew from strength to strength. It is important to mention that it was the bio-medical and clinical approaches that had the centre stage although interestingly the mythical undertones continued to prevail. This section will highlight some of the key players involved: fear, disbelief, finger pointing and myths which were encapsulated in the argument that HIV/AIDS originated from homosexuals, migration (by western/colonial white people to Zimbabwe/Africa) and by other residents from poverty-ridden origins in the region and beyond.

No serious analysis of the epidemic in Zimbabwe can be made without actually focusing on the political leadership of the post-independence era which oftentimes overshadowed any efforts to respond to the HIV/AIDS epidemic. In the first few years following the announcement of the first HIV/AIDS case in 1985, there was almost a culture of silence as if nothing significant had happened. Avert in an article entitled *HIV and AIDS in Zimbabwe (18 Dec 2009)* states that: 'Discussion of HIV and AIDS was minimal and President Mugabe rarely

[60] http://www.sahara.org.za/index2.php?option=com_docman&task=doc_view&gid=226&Itemid=85 (3.11.10)

addressed the subject in his speeches.' Also as argued by Jovonna Rodriguez (undated), '...critics believe Mugabe's leadership is the cause of the increased severity of HIV/AIDS...it is the government's responsibility to decrease the denial and the silence surrounding the disease in order to help open the door for improvements.' (Aids in Zimbabwe: How Socio-political Issues Hinder the Fight against HIV/AIDS).

One of the key reasons why there was a culture of silence is the link that was made between homosexuality and the origins of HIV/AIDS.

In Zimbabwe, Mugabe is quoted at the 1995 International Book Fair saying 'Lesbians and gays are sexual perverts who are lower than dogs and pigs.'[61] It will be useful to explain the significance of the two animals referred to by Mugabe. In Zimbabwean traditional culture, both animals are viewed as being 'dirty' both literally and figuratively. The dog is figuratively dirty because it eats its own vomit as well as human excrement and on the other hand the pig is considered ritually unclean by Biblical Judaism. There is here a strong connection between HIV/AIDS and impurity and immorality. Mugabe considers himself to be a staunch Catholic as well as a custodian of Zimbabwean 'culture'. Despite pushing homosexuality underground, Keith Goddard, a former (Rhodesian) cabinet minister helped to spearhead GALZ (Gay and Lesbian Association of Zimbabwe). Central to Mugabe's demonization of homosexuality is his making strong connections between the practice of homosexuality and the genesis of HIV/AIDS.

Despite the fact that Mugabe and those who subscribe to his view demonise homosexuality as against Zimbabwean culture and foreign, there is also evidence to the contrary that homosexuality has always existed in Zimbabwe. Examples of this evidence is based on the study by (Epprecht 2004) who argued that even in colonial times, court records existed of men who practised it, Banana the first post-independence president was charged with homosexuality and defrocked as a cleric.[62]

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[61] http://news.bbc.co.uk/1/hi/programmes/crossing_continents/143169.stm

[62] http://news.bbc.co.uk/1/hi/world/africa/257189.stm (accessed 15.10.2012)

The introduction highlighted the fact that Zimbabwe evolved through various historical epochs. Concomitant with this is the fact that the pre-colonial sometimes referred to as the 'old days' were all nice and glorious. There is a sense of re-reading history in a sense that there were no social ills at all. There is a tendency from the political establishment that any current social problems are explained back to colonialism. While it is true that colonialism cannot be viewed as discourse that was positive to Africa (Zimbabwe), it is also not true that all of Africa (Zimbabwe)'s problems are due to colonialism. To that extent, the Harare Gay community in Zimbabwe argued that Banana's trial

> *went a long way to convince people that being gay is not a white-imported thing.* [63]

Oliver Phillips reiterates the same point in an article about gay men (Phillips 1997). Prof Gordon Chavunduka the former president of ZINATHA argued that homosexuality did happen among some African boys as part of the process of growing up. Homosexuality remains illegal and banned in Zimbabwe while sadly the epidemic continues to rise. The implications for homosexuals living with HIV/AIDS is that they are systematically disadvantaged from receiving testing, treatment, support and care like the rest of the population. As part of a wider political rhetoric Mugabe lays blame on colonialism, white people, homosexuality and HIV/AIDS as the basis for all of Zimbabwe's problems. In a bid to address the endemic problems, Mugabe introduced the controversial land question.

Homosexuality is generally viewed as a male phenomenon in prisons due to the confinement inmates live in (Phillips 1997). There is evidence that demonstrates that being imprisoned in Zimbabwe is a double punishment in that not only does the male inmate serve their jail sentence but they will almost invariably be infected with the virus from other infected inmates (Phillips 1997, Epprecht 2004, Phillips 2004). Secondly, it is has also been argued that even if one is HIV positive, administering of medication is often non-existent or at least haphazard

[63] The Zimbabwe Times, 28 April 2009.

(Alexander 2009). There is also the unfortunate factor that once out of prison, there is a high likelihood that the infected person would pass it on to others either intentionally or by default.

The concept of otherness did not only carry blame as part of its package, but it also had with it a connotation of inferiority and suspicion. Thus Slack argues that in their essays,

> *Chandavarkar and Vaughan find British responses to epidemics reflecting deep-seated colonial anxieties about India and Africa, just as Crosby and Vaughan again demonstrate the importance of missionary perceptions of indigenous cultures and moralities* (Ranger and Slack 1996).

Berridge (1996) also argues that epidemics are interpreted according to pre-existing agendas of questions which arouse anxiety and debate.

4.6.1 Background to the Zimbabwe Land Question

There has been and continues to be a strong correlation between the Zimbabwe land issue and the way in which HIV/AIDS spread. Some commentators would describe that correlation in terms of the apparent failure to deal with epidemic in the context of the myriad of challenges that then arose and continue to exacerbate the problem. Edward Said makes a plausible case for the inherent problems associated with land in a colonial and post-colonial phase (Said 1993). Said (1993) raises very pertinent issues in respect of land ownership, settlement rights and the whole issue of reclaiming it in cases where it would have been misappropriated. The centrality of land is underlined by the fact that land is a critical resource that is embedded in the whole idea of nationhood, a people and a country's identity. In Said's view, the relationship between land and the identity of nations creates a power discourse. According to him, nations are in fact narratives and hence the power to narrate or to block other narratives from forming or emerging is very important, particularly in relation to culture. As a result,

> *culture comes to be associated often aggressively, with the nation or the state; this differentiates us from them almost always with some degree of xenophobia (*Said 1993).

This point ties in well with the fact that in terms of Zimbabwe, issues around land were and still are being reflected upon, contested as well as being decided in narrative. The themes of identity, culture, nationhood, *us* versus *them* foreign and colonial menace form part of the rhetoric that is characteristically recurrent in responding and engaging with the HIV/AIDS crises.

4.6.2 Zimbabwe Land Reform

In the light of the above, it is important to locate the Zimbabwean land question within a historical context. The author will outline the major milestones that characterised how land was appropriated from the local inhabitants and how that was the backdrop against which a liberation war was fought. The rationale in post independent Zimbabwe was to redistribute the land. What was perhaps not as clear from the beginning was the criteria and modus operandi for so doing, hence the subsequent chaos. The land question in Zimbabwe dates back to the late 1880's when there were competing European interests between the German and the British culminating in the Rudd Concession which effectively granted the British South Africa Company (BSAC) mining and land rights in Zimbabwe. The Rudd concession is often viewed as a result of colonial ploy by most Zimbabwean historical critics in so far as the 'concession' was essentially skewed towards the colonisers rather than a mutual agreed 'concession (Raftopoulos and Mlambo 2009). The year 1890 is officially noted for the occupation and subsequent dispossession of land from black Africans to their colonial white masters. Subsequent milestones were made in 1965 when Ian Smith announced the Unilateral Declaration of Independence (UDI) in the then Rhodesia which saw the legal institutionalisation of preserving and allocating huge tracts of the best land to white colonialists and the disproportionate allocation of the arid areas to the black Africans. This was reinforced by further racially-biased land statutes like the Land Apportionment Act of 1930 and the Land Tenure Act 1969 respectively. This forms part of the background against

which the struggle for political independence had land as one of the core grievances.

4.6.3 Farm Invasions and Urban Housing

The 1979 Lancaster House Agreement put in place a framework for land re-distribution, resettlement and supported new guidelines for ownership (Raftopoulos and Mlambo 2009). Failure of the Zimbabwean government to successfully carry out the exercise coupled with the British reneging on their undertaking to bank-roll the process compounded the economic problems that Zimbabwe was going through in the 1990's. Some analysts suggest that growing internal political dissatisfaction particularly from the former guerrillas as well as the spiralling economic woes led to haphazard land invasions. Several publications (Palmer 1977, Mlambo 1997, Chitiyo 2004, Moyo and Yeros 2005, Crush and Tevera 2010, Abraham 2011) written about the land issue in Zimbabwe indicate that the colonial legacy left a serious imbalance of land distribution between the former white rulers and the majority of the local black population. It is a fact that land was one of the resources that was racialised alongside other goods and services. The land reform process that ensued around the same time that HIV/AIDS mushroomed in Zimbabwe proved to be catastrophic.

Tensions around land and entitlements to specific locations were commonplace prior to colonisation. However, land contestations in pre-colonial Zimbabwe were informed by different cultural and agrarian values (Palmer 1977, Mlambo 1997, Chitiyo 2004, Moyo and Yeros 2005, Crush and Tevera 2010, Abraham 2011). The colonial period complicated a land discourse which was already a cause for concern among the local indigenous populations. This is evidenced by clan and chieftainship and tribal contests and sometimes military rivalry in connection with land and related resources. The new dimension that colonisation added was the racialisation of the land issue. It is therefore important to understand that dynamics of land in post-colonial Zimbabwe have a history prior to colonisation but that it was exacerbated and complicated by both colonial and post-colonial developments.

Although forced removals have their history in colonial times the irony is that in post-independent Zimbabwe, a replay of those scenarios was enacted when the

residents of some squalid parts of Harare police-marshalled to Porta Farm on Harare's outskirts in 1991. As part of Zimbabwe's hosting of the Commonwealth Heads of States meeting, the Zimbabwean authorities forcibly removed the capital city's residents where the Queen was scheduled to visit as part of what was perceived to be creating an image of a clean and developed city. However, this move did not go down well with other sections of the society in that without any structured assistance, the forcibly removed residents were left to build squatters' shelters for themselves under the banner of a "clean-up" campaign that preceded the visit of Her Majesty, the Queen (Dyer 2005).

Pressure from the ensuing economic crisis resulted among other things in the former liberation struggle ex-combatants taking a lead in pressuring the government for monetary and material compensation for the role they had played in the liberation struggle. In response to that pressure, the government not only sanctioned the issuance of monetary compensation but also facilitated the invasions of formerly white-occupied farmland (Sachikonye 2003, Raftopoulos and Mlambo 2009). This resulted in the land discourse taking a reverse racialisation process against the whites as well targeting the perceived political opponents of the ruling regime. In the process, the spread of HIV/AIDS in Zimbabwe was exacerbated. This formed a significant prelude to the notorious Operation Murambatsvina (Remove the Filth) which was an urban forced removal exercise of people perceived to be in the political opposition or beneficiaries of 'western imperialist agendas of regime change' (Vambe 2008). These forced removals were carried out on people who either originally worked or resided on white farms, normal urban squatters or folk who had fled political persecution from the rural areas. The government used its machinery of police, intelligence operatives as well as drafted party militias to carry out the exercise. The impact of these dynamics in understanding the response to HIV/AIDS is crucial. Operation *Murambatsvina* had very devastating consequences as demonstrated by the fact that:

> *As farming communities were disrupted, the economy deteriorated, leading to increased poverty and reduced access to education and healthcare. Many farm workers were forced to move to different areas and in some cases families were separated: both factors that are likely to have widened sexual networks and increased the risk of HIV transmission.*

> *Violence against farmers was practically encouraged, a climate of lawlessness ensued in many areas and rape became increasingly common, making women more vulnerable to HIV infection.*[64]

The height of the land question which was reconfigurated into the so-called 'Operation Murambatsvina' raised the critical question of: Who was the trash being driven out? Sadly the answer to that question is:

> *Operation Murambatsvina had displaced some 700,000 people, including over 79,500 adults living with HIV. A number of these people had previously been receiving antiretroviral drugs (ARVs) to delay the onset of AIDS, but now had no access to them as treatment centres and clinics had been demolished. The interruption of ARV treatment can lead to drug resistance, declining health, and in some cases death*[65].

One of the resultant effects of this dispersal (what I will refer to as internal forced migration) was affecting people who were already living with HIV/AIDS, the campaign may also have contributed to the spread of infection. Factors such as increased population mobility, the separation of couples and an increased number of women turning to sex work in order to survive are likely to have increased the frequency of unsafe sex in many areas. Access to education and information about HIV decreased, and nationwide sales of condoms fell: between May and June 2005, sales of male and female condoms dropped by over 20% and 40% respectively (Moss and Patrick 2006). It goes without saying that this forced dispersal did not only have internal ramifications in Zimbabwe but created ripple effects in the Southern African region which was and is still reeling with the epidemic. Kajumulo Tibaijuka, A (2005), the UN Human Special Envoy on Human Settlement Issues in Zimbabwe clearly testifies to these and other implications (Moss and Patrick 2006).

On a similar note Nyatsanza,W. (2002) also argues that the Zimbabwe Bishop's Conference wrote a Pastoral Letter entitled *Marriage, Family, Sexuality and the AIDS Epidemic* that highlighted how Christian family life and African values had been clearly violated by the whole land question. In his monograph in which the

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[64] http://www.avert.org/aids-zimbabwe.htm 6/09/10

[65] http://www.avert.org/aids-zimbabwe.htm 6/09/10

above letter is cited, he argues that the land question had its roots in colonial times and migrant labour but this was no excuse for how the Mugabe regime dealt with the issue. A characteristic impact in respect of the HIV/AIDS epidemic is how the poor and the black/African[66] Zimbabweans were disproportionately affected in comparison to their more affluent white counterparts.

4.6.4 Operation Murambatsvina

Although the land question is a real issue in Zimbabwe, there is a level at which it has also been used as a scape-goat for political ends (Sachikonye 2003). In fact migration both by white colonialists and regional African populations has been construed as some kind of 'invasion' of space that has eroded local traditional values and demographics. In 2005, Mugabe referred to migrants of Malawian origin as 'totemless'[67] people and accused them of supporting white colonial supremacy and the Movement for Democratic Change (MDC) opposition political party (John Simpson on BBC Africa 30.05.2005).

During the Mozambican civil strife in the mid- eighties, Zimbabweans abused the neighbour refugees and blamed them for any social disruption within the society. They in fact earned a derogatory name of 'makarushi' again resembling people of no worth (McGregor 2010). Thus, the Operation Murambatsvina (Vambe 2008) and attribution of HIV/AIDS was a discourse that characterised the Zimbabwean post-colonial socio-political history.

Another notable impact of the land issue and the HIV/AIDS epidemic was emigration. An example of this is cited in AVERT where:

> *A rise in the number of people dying from AIDS is thought to have played a role in the decline, as well as an increase in the number of people (HIV positive or otherwise) who have migrated to other countries …* (and ironically) *Other reports have revealed that people living with HIV/AIDS*

[66] The term 'black' and 'white' are acceptable for use in distinguishing the respective Zimbabwean racial groups within the Zimbabwean context.

[67] Totem is a black Zimbabwean clan identity usually associated with a particular animal (or part of it), fish or bird species.

> *in Zimbabwe have crossed the border into Mozambique in order to receive ARVs, which Mozambique provides for free.*[68]

4.6.5 Impact of Land Invasions and Poverty Issues

Coupled with the issue of migration is that of poverty. Sandra Bhatasara, a lecturer in the department of Sociology at the University of Zimbabwe argued that:

> *There is no doubt that HIV and AIDS are thriving upon severe economic problems in Zimbabwe. In the Zimbabwean context, women have emerged as the poorest group as compared to their male counterparts. Scholars have come up with phrases such as "poverty has a woman's face" and "the face of AIDS is an African woman" to link issues of poverty, women and HIV and AIDS.*[69]

In the same article, Bhatasara goes on to highlight some key points in her study in respect of the impact of poverty and HIV/AIDS namely that:

- Young women cannot negotiate safe sex because of cultural imbalances that favour men.
- The practice of sugar daddies turns the university female students into 'prostitution of poverty' despite their literacy levels in general and more specifically around the dangers of HIV/AIDS
- The payment of lobola (bride price) further compromised into a master-servant relationship[70].
- The 'small house' phenomenon is a further instantiation of the gendered nature of HIV/AIDS. Married male adults engage in multiple illicit relationships with other women which they call the 'small house' as distinct from their homes of official marriages.

Such a scenario would invariably lead to a consumerist culture of sex on globalisation and the role of the international modern western media.

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[68] http://www.avert.org/aids-zimbabwe.htm 6/09/10

[69] http://iolsresearch.ukzn.ac.za/Sandra18625.aspx 1.02.10

[70] This meant that the female partner would be disadvantaged in negotiating for safe sex.

While anti-retroviral drugs are now available in Zimbabwe, access by different income groups remains a huge problem. Despite the fact that 'those on ARVs are receiving adequate nutrition for the drugs to work effectively, there are reports of HIV positive patients in such desperation that they are actually selling their ARV medication in order to buy food'[71]

Poverty in relation to HIV/AIDS has also manifested itself through young girls being married off to either wealthy men or people of some church sects (popularly known as *Vapostori* – a transliteration of 'Apostolic Churches'). There are however conflicting views in terms of the country's legal guidance and actual practice in relation to the legal stipulation of when a girl can get married and which statute to invoke.[72] Phyllis Kachere argued that:

> *Single adolescent girls who become pregnant are more likely to drop out of school, thus compromising their future earning capacity and becoming more likely to end in poverty. Maternal mortality and mortality from HIV/AIDS related causes become a reality for these girls and often lead or exacerbate poverty…... The Union for the Development of Apostolic Churches in Zimbabwe-Africa (UDA-CIZA), a coalition of 160 apostolic sects in Zimbabwe, said tries to raise awareness among apostolic sect leaders of the dangers of early marriages. But in most cases, it faces serious resistance.*[73]

As already discussed earlier, the government of Zimbabwe was very slow in responding to the epidemic. Apart from political instability, part of the argument put forward by the government was that publicly engaging with the epidemic would create a negative impact on the tourism industry. It was not until 1999, that the National Aids Co-ordination Programme was set up. The Zimbabwean government also introduced the AIDS Levy (National AIDS Council Act of 2000) but this proved to be unpopular because the already over-stretched tax payer reeling with other economic burdens did not see the immediate

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[71] *Physicians for Human Rights (January 2009) Health in Ruins; A man-made disaster in Zimbabwe*

[72] There are three types of legal marriages one can enter into in Zimbabwe: registered customary marriage which is potentially polygamous; civil marriage under the Marriage Act which is monogamous; and unregistered customary law unions which are recognized only for limited purposes such as maintenance of the child and inheritance.
http://www.equalitynow.org/english/campaigns/un/unhrc_reports/unhrc_zimbabwe_en.pdf

[73] *http://ipsnews.net/news.asp?idnews=46447 1/02/10*

benefit of the levy. As if that was not enough, the intended beneficiaries did not get sufficient support.

4.7 The Role of NGOs

Non-Governmental Organisations (NGOs), Religion and culture were often at pains to unpack what the best strategy for engaging with the epidemic was. At one point, the ABC model was promoted but in other instances only some aspects of it were invoked. At a later stage, ABC model was used.[74] Apart from the religious argument, condoms were often victims of the conspiracy that the Western organisations were distributing infected condoms to further worsen the epidemic. The government stance on NGOs made their work difficult because they were viewed as similar with the political opposition.

The role of the media in combating HIV/AIDS in Zimbabwe has always been problematic. Most of the media that exists is pro-government and would therefore be concerned with the powers that be. With the new legislation known as the Public Order and Security Act of 2002 (Government of Zimbabwe), it became even more difficult for any independent media to operate. The very little private media was through newsletters or underground NGO-funded initiatives. However, on an informal level, popular music and community-based theatre groups tried to communicate HIV/AIDS prevention messages (Chitando 2002, Rödlach 2006). The religious groups tended to tread carefully only issuing statements that would be deemed uncontroversial by the state.

The epidemic still faces a number of challenges despite arguments that the prevalence rate is going down. In fact, with fewer people accessing health services, lack of affordability of antiretrovirals (ARVs) and emigration, the current statistics could be misleading. One of the major challenges observed by Kearsley Stewart in his review of Rodlach's book is that:

> *Also of interest to healthcare practitioners is an explanation of why even literate and educated Zimbabweans can simultaneously hold both*

[74] A= Abstinence, B= Be faithful, C=Condomise, T= Testing

biomedical and conspiracy explanations for the origin and transmission of HIV. Elite and healthy civil sector professionals who initially discredit sorcery charges may later invoke these same explanations to account for why they are diagnosed with AIDS when others are not. [75]

4.8 HIV/AIDS Policy Developments

Despite the fact that HIV/AIDS was discovered around 1985 in Zimbabwe, no policy documents were put in place until much later. For example, the National Aids Council was only set up in 2000. It was only from then that the policy framework was developed in much more robust and systematic manner.

On an official level, the president first publicly acknowledged the existence of HIV in Zimbabwe in 1999. It is also important to recognise the ambivalent role of the Zimbabwe National Association of Traditional Healers Association which often posed a medical -cultural and legal challenge to the HIV/AIDS discourse in that it operated from a different point of view from western bio-medical approaches.

4.9 Understanding Re-negotiated Notions of the Body and the Self

The responses to and the challenges of HIV/AIDS may be interpreted through a broader analysis of the interplay of various prisms that human beings use to understand stereotypes constructed around diseases like HIV/AIDS. One such analysis is presented by Gilman (1988) in his collection of essays on *Disease and Representation*. His critique offers a useful template in respect to disease and illness in general but more specifically to HIV/AIDS. Gilman argues that human beings use a range of schemata in constructing ways to self-perpetuate and when this vision is under threat of destruction, individuals 'project this fear onto the world in order to localise it and indeed to domesticate it'(Gilman 1988) into otherness. While disease (HIV/AIDS) may be real, the way that it is perceived is also a product of social construction. Illness is considered as *otherness* and not

[75] http://www.ncbi.nlm.nih.gov/pmc/article s/PMC1820792/ *(01.02.2010)*

part of normalcy. The stigma that HIV/AIDS carries is more to do with this otherness and social construct. This is part of the reason why despite huge strides in the development of anti-retroviral medicines, people infected and affected by HIV/AIDS are viewed by various strands of society as being circumscribed by otherness and negativity. The stigma and negativity are depicted in symbolic imagery. Gilman(1988) outlines some interesting typologies ranging from the four H's: namely; homosexuals, heroin addicts, haemophiliacs, and Haitians (because these categories were viewed as being at risk. When HIV/AIDS began to affect 'normal' people, it was sexualised to infect heterosexuals but these heterosexuals were either poor, illegal migrants or those who had had contact with the at-risk categories.[76] Although Gilman's (1988) typologies were set within the American context, they were in fact replicated within the Zimbabwean scenario along similar imagery and explanatory models.

Lizzy Attree offers an example of the Zimbabwean experience of HIV/AIDS within the context of the evolution of the dynamics of the historical racial and rural/urban divide in her aptly titled paper *Aids and the City- shared spaces of infection.*[77] In this article, she analyses the role both Zimbabwean and South African literary works in their quest to characterise the city as the central location where the reality, drama and narratives of HIV/AIDS are constructed, de-constructed and played out all at the same time. The key themes that constantly emerge are the colonial legacy, migrancy and the function of racial segregation of whites from blacks in the construction of apartheid as based partly on health grounds. [78] By extension, the assumption was that whites in the cities would be free from contracting the communicable diseases (HI/AIDS included) brought by the upsurge of black rural populations into the city. The irony is that for those male African blacks who found their way into the city for labour purposes, they lived lives restricted of their legitimate spouses thereby creating the opportunity to rapidly spread any communicable infections and most notably sexually transmitted ones. One of the subtle observations made by Attree is the fact that 'movements to the city triggered by colonialism and

[76] Ibid p 245-246

[77] http://www.gold.ac.uk/media/paper_Attree.doc (cited 2.11.2010)

[78] ibid p.1

apartheid have been further exacerbated by globalisation' which is a conduit of development.[79]

Another key aspect that Attree raises is the whole idea of how the body experiences the infection of HIV/AIDS.

> *…in the context of AIDS the body becomes a 'discursive formation', imbibed with meaning and potential consequences.*
> *The body moving through the city is at risk of infection, anonymous and lacking definition, it is in a limbo state in which it is neither 'infected' nor 'diseased'. Once the HIV virus has intersected with the body, the body becomes a site of struggle or mourning, resonating with personal, political, economic and sexual contestations. It can also become a signifier of the unknown, entering a liminal state as we know that infection does not always register instantly – it can take six months to appear – what then is the status of the 'diseased' body or person in this situation? How is the individual defined and portrayed, if even when HIV-positive there are no elements of sickness present? Does this lead to a new type of 'nervous condition', in which the colonised, or diseased subject encounters a form of doubling, becoming the living haunt of contradictions.*[80]

Within the context of Zimbabwe, cities and more recently their *urbanised imitations (own emphasis)* referred to as growth points or service centres are traditionally known for fast transmission of disease and immorality facilitated by western values and the corruption and sometimes destruction of traditional local cultures. Cities are therefore concentrations of human populations due to the legacy of colonialism, migrancy and globalisation [81]. As such, they have become sites for infection and circulation of HIV/AIDS. The culture of globalisation and urbanisation has seen the HIV/AIDS experiences equally mirrored and replayed in rural Zimbabwe.

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[79] Ibid p.1

[80] Ibid p.3-4

[81] Conversation with Dr Beacon Mbiba, Oxford Brookes University on Growth Points and Urbanisation in Zimbabwe

There is also a sense in which HIV/AIDS like other epidemics is an intellectual construct in that once formulated, it has a history, vitality and resilience of its own (Ranger and Slack 1996). This perception is based on Thucydides's description of the plague of Athens. The point being made is that intellectual responses to HIV/AIDS follow the logic of the above perception. It is a fact that currently there is no vaccine or cure for HIV/AIDS. Responses to the epidemic have ranged from focusing on societal dislocation, the failure of doctors, flights to and from religion to rumours about poisoned wells (in this case the allegation of a laboratory experiment intended to get rid of some populations which went wrong). Vaughan makes an important point that AIDS has been 'socially constructed'. She blames this in the way in which sexuality and 'African health problems were viewed as technical problems, like any others' as well as the impact of a 'century of colonial rule and of a medicalised discourse on the *African* has had lasting effects'(Ranger and Slack 1996).

What this goes to point out is that within the Zimbabwean scenario and probably true of others similarly circumstanced, the bio-medical and clinical approach to HIV/AIDS is not the wherewithal to deal with the epidemic. The above demonstrated that there are recurrent themes of homosexuality, migration, poverty and the role of media in shaping and sustaining the origin and development of the HIV/AIDS discourse in Zimbabwe. These will need to be further critiqued in order to create and come up with a more transformative HIV/AIDS Education approach.

4.10 Bases for Comparison

I have already indicated that this research took place in both Scotland and Zimbabwe. The object here is not to nurture a simplistic comparison between two very different polities but to analyse at least two ways of understanding these different polities' readings of the emergence of HIV/AIDS and their ways of responding to this.

Scotland and Zimbabwe have been chosen as ideal contexts out because they provide important historical and thematic data on HIV/AIDS. The table below

demonstrates the various areas in which experiences resonate across both contexts as well as those in which there are divergences. Even where there are differences, they are to a great extent nuanced. The various indicators on the table form part of the raw material for engaging with the creating a framework for developing a transformative HIV/AIDS Education.

Moreover, it is import ant to understand something of the political shape of such responses together with particular cultural impediments and opportunities. Communities can learn from each other, even where such learning is heavily context dependent as articulated by Stephen Ball is his concept of policy travel. Below are the bases on which the two contexts will be compared.

Zimbabwe	**Scotland**
First known HIV case reported 1985 (1980's)	First known HIV case 1980-83 (1980's)
Developing-world context characterised by immediate post-colonial legacies and constantly shifting and often a mismatch between policy and practice	Good Health delivery model characteristic of western developed contexts
HIV/AIDS funding predominantly donor-dependant and how that affects policy	Self-sustaining HIV/AIDS funding and impact on policy
How HIV/AIDS is collected and published: a culture of modesty and national self-preservation	Fairly robust HIV/AIDS data collection although skewed towards perceived 'at risk' groups rather than the general population
Responses: Initially 'controlled' due to the politicisation of the epidemic and an impulsive reaction to consider possible adverse impact on local economy Late evolution to be more open thereby including both those infected and affected by the epidemic and the	**Responses:** Initial blame on homosexuals, IDUs and other 'at risk groups' Link to inward migration of asylum seekers and refugees and Eastern Europeans Sense of 'false' security partly

general public Despite the above, there seems to be a continued and mixed culture of blame on homosexuality, witchcraft, loose morals...although taking on board the bio-medical explanations Lack of a sustainable capacity to manage the impact of labour migration, internal, regional and global travel in and out of Zimbabwe Public messages are often conflicting as there are often tensions within and between the role of traditional and modern medicine, traditional and the more recent Pentecostal/evangelical churches	generated by easy and stable access of ARVs Public messages tend to be more subtle than they look on the surface Tensions between and within the churches, the public and civic society

5 CHAPTER FIVE METHODOLOGY

5.1 Introduction

In this chapter I will focus on my use of the semi-structured interviews as one of the two types of qualitative research tools that I employed in this study. The semi-structured interviews were conducted with 9 key informants in Scotland and 16 in Zimbabwe. The choice of the key informants and the difference in numbers in the two countries will be explained in the subsequent sections in this chapter. The other qualitative research tool that I used was document analysis and I have described it in detail in Chapters Two and Five of this thesis.

I will first of all discuss the research paradigm that I have used followed by the process and the importance of the ethical approval which guaranteed choice, anonymity and confidentiality of the participants as well as how I then proceeded to access data from both the key informants as well as the selected key policy documents. In this chapter, I will also explain the significance of the pilot study and the manner in which it was carried out to provide legitimacy and validity for the main study. The choice of the number, categories, the profiles and the coding of the key informants and the types of key policy documents will also provide a basis of how the themes that emerged from the fieldwork were subsequently identified and discussed. Cognisant of the effort to minimise bias, I will explain how my own positionality demonstrated my own competence as well as playing a reflexive role in grounding my fieldwork within the opportunities and tensions that generated data that would be analysed into coherent and systematic themes.

5.2 Qualitative Research

While the general historical distinction is between quantitative and qualitative research, the current understanding is that these two broad categories overlap and within each one of them one can also make further distinctions (Denzin and Lincoln 2005). I have chosen the qualitative approach because of the way in which it engages with human subjects and their reactions to issues, how they form their opinions and attitudes and how they express them (Denzin and Lincoln

2005). As Denzin et al (2005) argues, qualitative research allows studying phenomena within their natural contexts and enables direct responses or the representation of views, attitudes and opinions within the 'text', in this case, the key policy documents. This is in contradistinction to quantitative methods which are more interested in samples of statistical data. Thus, the choice of the qualitative research for this study is because of the way in which it enables a much deeper understanding of the complex issues explored as well as the ability to create a transformative approach to the study of the phenomena (Silverman 2000, Denzin and Lincoln 2005, Creswell 2012).

I have therefore used two types within qualitative research namely interviewing key informants and examining selected key policy documents in Scotland and Zimbabwe. My use of semi-structured interviews for the key informants is because it allows for clarification and follow up on the responses given (Kennedy, Christie et al. 2008).

In order to compliment the key informant responses, I also used key policy documents. This led to document analysis through identifying the language, structure, target audience and the themes that are included or excluded in explaining the origins and responses to the HIV/AIDS epidemic in both localities. Examples of these policy documents are government reports, policy initiatives, strategic plans, consultation papers and HIV/AIDS organisations' documents. These documents are available from the respective institutions that I used but others are also available in public spaces like health institutions, archives, libraries as well as online. It is worth noting that these documents reflect different aspects along the policy continuum from what might be referred to as 'hard policy'[82]documents to general information -type texts as those found on bill boards or leaflets and flyers. I explored how the weighting of these documents is characterised by the responses from the interviewees alongside critical analyses from other sources.

[82] The term 'hard policy' in this case is used to refer to official documents that are legally enforceable as opposed that contain information for the general public

5.3 Ethics

This research was carried out under the specified guidelines of The University of Glasgow Ethics Committee. Written permission was granted prior to undertaking the research (see copy in the appendix). (Homan 1991, Denzin and Lincoln 2005, Miller, Mauthner et al. 2012).

In line with the requirements of Ethical Approval, every prospective key informant was given a consent form, a copy of the purpose of the research, a plain language statement and a copy of the questions that they were going to be asked. Each of these forms were fully discussed and explained to the key informants. It was also explained to each key informant that they had a right to withdraw or terminate the interview at any stage even after signing the consent form. The key informants were informed that the result of the research would be used for the PhD but also for other academic purposes including seminars, conferences and papers for publication. Underlying all this was the fact that the identity of the key informants would be confidential.

Apart from being identified for their professional expertise and the profile of the organisations they were involved with, no personal data was sought or utilised in the research. As indicated below, I then proceeded to gain access to the key informants and the selected policy documents before and then started with the pilot study before going onto the main study.

5.4 The Research Process

5.4.1 Access to Research Data Collection

Once the Ethical Approval had been granted, I made contact with potential institutions and the key informants through email, fax and follow-up telephone calls. While it was comparatively easier to contact the prospective respondents in Scotland, there were some hurdles in contacting the Zimbabwe respondents due to the erratic communication systems. As a result, I had to make several phone calls and made various trips to the respondents' offices before finalizing details of the appointments.

In terms of accessing the key informants, contact was made via email and follow-up telephone calls and the interviews were carried out in a venue of the informants' choice. As the researcher I explained the procedures of the Research Ethics comprising the consent form and the related documentation. Once this was done, I advised the key informant that I would ask them questions, take notes and audio-record them. It was also explained to the key informants that that they could seek clarification about any of the questions as required. Both the written notes and the audio-recordings were always secured after each interview.

5.4.2 Pilot Study

A pilot study (Van Teijlingen, Rennie et al. 2001) was undertaken prior to the main study in order to test the efficacy of the proposed semi-structured questions. The same questions were used in the pilot and the main study as a heuristic in interrogating the information by the respondents. However, given the distance and travel logistics to Zimbabwe and the small size of Scotland, the pilot study was done in England. The other reason for the choice of England was also informed by the fact that during the early stages of the epidemic, prior to the 1999 Scottish devolution, all health policy matters (UK-wide) were directed from London (Berridge 1996). England has also been a destination of many African migrants emanating from countries of high HIV/AIDS prevalence (of which Zimbabwe is also one). Since devolution, health and indeed HIV/AIDS policy is one of the areas that are controlled within Scotland's own jurisdiction.

The semi-structured interviews in this research were initially tested in a pilot study and they were found to generate useful information regarding the study. Both in the pilot and the main study, the questions provided a basis for follow-up questions thereby providing rich data for later analysis.

5.4.3 Sample

In this study, a total of 9 key informants were identified in Scotland and 16 in Zimbabwe. Although in the planning stage a larger sample had been identified,

the 9 and 16 were the ones who actually agreed to participate in the semi-structured interviews. I have also indicated in the section on Scotland that although one other key informant had initially agreed to participate, they turned down the offer at the last minute and referred me to their publications instead. This issue is discussed more fully in the section on some of the challenges of the key informant method. Key informants are a range of experts within a particular field of investigation with whom one can conduct in-depth qualitative interviews.

> *The purpose of key informant interviews is to collect information from a wide range of people—including community leaders, professionals, or residents—who have first-hand knowledge about the community. These community experts, with their particular knowledge and understanding, can provide insight on the nature of problems and give recommendations for solutions.*[83]

Although key informants have been used in a range of research settings the technique has also been proven to be ideal within a health context around the world (Marshall 1996). I chose key informants because they were best suited to give the kind of information I needed for my particular research because of their unique expertise and experience. Some of the main advantages of the key informant approach are that one relies on a relatively small but efficient body of people with expert knowledge on the subject. Secondly, the key informant technique has been used in different contexts within anthropological field work because of its efficacy of providing rich data in a short period of time (Flick 2014).

Key informants are also useful in that they recognise me as someone with the necessary credentials to interrogate them on the issues. Given that key informants are experts in their own right, they would be less likely to accommodate a request from a researcher they deemed less knowledgeable or less competent in the field under investigation (Flick 2014). Part of the process involved in key informants agreeing to be interviewed had to do with the fact

[83] *healthpolicy.ucla.edu/programs/health-data/trainings/.../tw_cba23.pdf- no date (accessed 01.06.2014)*

that they understood the invitation to share professional trust. They felt confident that I would understand the complexity of the issues and therefore not misrepresent their responses. As a result, the power balance between me as a researcher and that of the key informants is consciously kept under check. Not only did I have access to the key informants, the key informants themselves accepted me as an expert in the area (Mikecz 2012).

In terms of the key informants, I used the purposive sampling technique (Tongco 2007) because it is 'fundamental to the quality of the data gathered; thus the reliability and competence of the informant..'[84]. The key informants were identified in terms of their professional expertise regarding the HIV/AIDS policy, clinical care and education. I deliberately targeted a broad range of key informants as can be seen in the sections on the profiles and categories of informants in this chapter. An attempt was also made to balance the gender ratio of the key informants although this was not always possible given the male-dominated professionals in the senior policy and clinical care settings. I also considered the range of the organisations where the key informants came from in terms of public, private and voluntary sectors (Marshall 1996, Tongco 2007).

Key informants are important in that they are central, although not exclusive to the process of creating the policy documents using a range of instruments that communicate particular messages around HIV/AIDS. My research explored the nature of the relationship between the key informants as actors and also how far their views reflected the position of the contributors in the respective key policy documents.

In terms of selected key policy documents, I specifically prioritised official HIV/AIDS policy and related documents and other documents within the public domain. I also looked at faith-based materials and Sex Education within the school systems because they contained information on HIV/AIDS. In terms of the academic perspectives on the HIV/AIDS discourse in both locations, I have used published books and articles which I have referred to throughout this thesis.

[84] http://hdl.handle.net/10125/227

5.4.4 Research Participants in the Main Study

The main study was done in Zimbabwe between August 2012 and September 2012 while in Scotland it was conducted between November 2012 and February 2013.

5.4.5 Semi- Structured Interviews

Semi-structured interviews are a qualitative interview technique that is used to obtain data regarding a piece of research. Although it has a 'structure' and the same questions are posed to each key informant, these questions are meant to be a guide as well as providing an opportunity for the key informant to answer the questions without unnecessary restrictions. One of the advantages of the semi-structured interviews is that it allows the interviewer to follow-up on specific themes and ideas related to the research study.[85] Semi-structured interviews use open-ended rather than closed questions.
Semi- structured interviews are in fact

> *well suited for the exploration of the perceptions and opinions of respondents regarding complex and sometimes sensitive issues and enable probing for more information and clarification of answers* (Louise Barriball and While 1994).

Both Bariball et al (1994) and Denzin et al (2005) emphasize that semi-structured interviews provide the critical dialogic and conversational approach which allows the key informants to communicate their ideas while at the same time recognising their own personal histories and narratives within the discourse. The data that was obtained from the key informants was valid in so far as they were well-versed in the issues and they were also able to provide further clarifications as required. As the section on data analysis will indicate, the emergence of similar thematic issues is itself part of the evidence of the validity of the data obtained.

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[85] Cohen D, Crabtree B. "Qualitative Research Guidelines Project." July 2006. http://www.qualres.org/HomeSemi-3629.html (accessed 01.06.2014)

5.4.6 Categories of Informants

The key informants have been classified into six categories in order to link them to the themes that emerged. Some of the key informants belong to more than one category by nature of their work.

Category	Description
1	Medical/Health
2	Religious –Catholic
3	Religious – Protestant
4	Gay Rights/Voluntary sector/NGOs
5	Academic
6	Cultural critic

5.4.7 Key to codes

SC= Scotland
ZW = Zimbabwe
1-5 = categories (as above)
F = female
M = male
a = first informant
b = second informant

5.4.8 Profile of Key Informants in Zimbabwe

The profile of the key informants was deliberately intended to cover the various stakeholders who are involved with HIV/AIDS in Scotland and Zimbabwe. The main focus was on the policy and the construction and commentaries of the HIV/AIDS narratives from perceptions of the origins through to the current debates and the future of the epidemic. Their selection was chosen with the interview questions and the respective key policy documents in mind.

5.4.9 Zimbabwe Key Informants

Date of interview	Profile of respondent	Category	Code	Gender
15.08.12	Community Activist/ cultural critic/author	**4,6**	ZW4,6F	Female
16.08.12	Religious Minister/Former WCC/Political Negotiator	**3**	ZW3M	Male
17.08.12	Academic/author on HIV/AIDS/Consultant for WCC	**3, 5**	ZW3,5M	Male
28.08.12	Roman Catholic HIV/AIDS Programme Worker	**2**	ZW2F	Female
28.08.12	Religious (Catholic) National HIV/AIDS Programme Co-ordinator	**3**	ZW3F	Female
03.09.12	ZINERELA: (HIV+ Pastors' Organisation)	**3 &4**	ZW3,4M	Male
03.09.12	NAC: National HIV/AIDS Programme	**1**	ZW1Ma	Male
25.09.12	Cultural Critic/Author/Academic	**4 & 5**	ZW4,5 M	Male
25.09.12	Cultural Specialist	**6**	ZW6 M	Male
26.09.12	Author/Academic/Archivist/Cultural Critic	**5**	ZW 5M	Male
03.10.12	Senior Education Official/Former Teacher	**5**	ZW5F	Female
03.10.12	Local NGO Director/HIV/AIDS Activist	**4**	ZW4Ma	Male
03.10.12	Protestant Church HIV/AIDs Programme Worker	**3**	ZW3M	Male
08.10.12	Government Epidemiologist HIV/AIDS & TB	**1**	ZW1bM	Male
10.10.12	Gay And Lesbian Association of Zimbabwe (GALZ) Programme Officer	**4**	ZW4F	Female
11.10.12	International NGO Programme Officer	**4**	ZW4Mb	Male

5.4.10 Total number of Respondents: 16

The number of respondents in Zimbabwe is higher than that in Scotland because of the nature of the demographics. Secondly, it is also dependent on the number of stakeholders involved in the HIV/AIDS discourse in the respective countries.

5.5 Scotland

Scotland has a population of 5 295 000[86]. Since the outbreak of HIV/AIDS, the policy on the epidemic was initially controlled from Westminster across the whole of the UK until the Scottish devolution in 1999(Berridge 1996). My key respondents were selected from Edinburgh and Glasgow for the following reasons. Edinburgh has always been referred to as the AIDS capital of Europe due to the intravenous drug users (IDUs) as contained both in the literature(Berridge 1996) and as testified by all the informants. To date, Edinburgh runs one of the major HIV/AIDS clinics and it is also the capital city of Scotland. Glasgow was chosen because due to the dispersal of asylum seekers and refugees to the city, there is a huge population of HIV/AIDS positive people compared to the rest of Scotland. Both Edinburgh and Glasgow have a similar spread of HIV/AIDS voluntary sector initiatives.

5.5.1 Scotland Key Informants

Date of interview	**Profile of Respondent**	**Category**	**Code**	**Gender**
16.11.2012	Presbyterian HIV/AIDS Voluntary sector Officer	**3 & 4**	SC3,4F	Female
19.11.2012	National HIV/AIDS Voluntary Sector Officer	**4**	SC4M	Male
11.12.2012	Academic/ HIV/AIDS Consultant	**1 & 5**	SC1,5Ma	Male
12.11.2012	Roman Catholic Church Education Worker	**2**	SC2M	Male

[86] http://www.gro-scotland.gov.uk/press/news2012/census-2011-pop-est-scotland.html (accessed 15.03.2013)

11.01.2013	HIV/AIDS Clinical Psychologists	**1 & 5**	SC1,5Mb	Male
14.01.2013	Pro- Gay United Reformed Church HIV/AIDS Chaplain	**3 & 4**	SC3,4M	Male
14.01.2013	HIV/AIDS Policy Worker	**1**	SC1F	Female
18.01.2013	NHS Consultant and Initial HIV/AIDS Policy Lead Team Member	**1**	SC1M	Male
07.02.2013	Academic and HIV/AIDS Researcher	**5**	SC5M	Male

Total number of Respondents in Scotland 9

5.5.2 Demographics of key informants

The smaller number of key informants in Scotland is partly due to the much more centralised HIV/AIDS initiatives through the NHS as compared to the situation in Zimbabwe.

In both locations, the sample is heavily male-gendered given that the leadership of health structures is disproportionately male.

5.6 Reflections on Positionality

5.6.1 Introduction

Lichtman (2013) quotes a Chinese philosopher that 'he who knows others is wise: he who knows himself is enlightened.' I think that this aphorism is a useful depiction of the relevance of positionality in qualitative research in that it underlines the need for the researcher not only in knowing who (in terms of the others) to select as key informants, but also in terms of knowing their own history and credentials as a researcher (Lichtman 2013).

'Positionality has, to-date, been conceptualised by social scientists as a central component in the process of qualitative (and to an extent quantitative) data collection' (Ganga and Scott 2006, p.1). In line with this thinking, I will reflect

on my own positionality in respect of this research. Positionality is informed by a number of aspects notably, one's own background, the knowledge of the issues under investigation as well as personal and professional engagement with the research participants and related issues.

Within qualitative research, positionality has been gaining credibility as a useful technique of generating knowledge (Berger 2013) and that is why my own personal credentials (as will be described below) have been key in undertaking my research.

5.6.2 Research Context

Although the HIV/AIDS epidemic is a global issue, I have chosen Zimbabwe as an example of a developing world country which is struggling to cope with the epidemic due to a number of cultural, socio-political and economic challenges. On the other hand, I have also chosen Scotland as an example of a developed country that has managed to contain the epidemic because of the nature of its stable economy and its efficient health systems.

5.6.3 Personal and Professional Background

My own background is located in both my Zimbabwean and Scottish connections. My exposure to and professional experience in both locations facilitated my easy access to the key informants that I identified. By virtue of being born and bred in Zimbabwe, I have been able to experience its history, culture and health systems. In relation to its history for example, I have been able to trace and analyse the impact of the pre-colonial, the colonial and the post-colonial discourses. I have done that not only in terms of the socio-economic contexts but also in relation to the organisation and delivery of health in so far as it was based on racial and cultural considerations. In terms of the black African Zimbabweans, I have also been able to rely on my personal experiences of how some of their cultural beliefs of health and wellbeing are rooted in witchcraft and other aspects of their traditional worldviews. These attachments have continued to shape their beliefs about their explanations of the origins of and responses to the HIV/AIDS epidemic.

As a teacher-trainer at universities in Zimbabwe, I was involved in preparing student teachers, not only in teaching children orphaned due to HIV/AIDS, but by also in embedding issues of HIV/AIDS in their different subject areas so that they would be effective community champions of addressing the HIV/AIDS epidemic in their different school settings.

Part of my volunteer work with the Zimbabwe Catholic Commission for Justice included raising awareness of people especially women and children affected and infected by HIV/AIDS of their rights and entitlements, signposting them to relevant service providers and organising support groups that helped them cope with their plight.

Apart from the above, I have also been able to interact with a range of people across the various strands of society in Zimbabwe. On the academic level, I delivered a discussion paper on: *A study of Student Gender-Related Violence in Zimbabwe's Tertiary Institutions: Experiences from the University of Zimbabwe*, at the University of Cape Town, South Africa in 1996 as well as another one on: *A Case for Human Rights Education in an African Context: The Concept and the Practice,* at the Konrad Adenauer Stiftung (Foundation), Democratic Transformation of Education in South Africa September 2000. While the former specifically addressed implications for HIV/AIDS the latter touched on the more general theoretical issues that underpin the HIV/AIDS discourse.

The fact that I was born and bred in Zimbabwe locates me within the socio-cultural world view from within which the Zimbabwean key informants articulate their perceptions of the debates that surround the origins and responses to the HIV/AIDS epidemic. I have personal knowledge and experience of how some Zimbabwean cultural beliefs affect their perceptions of HIV/AIDS. I do know about the culturally distinctive practices among some Zimbabwean men who resort to circumcision and engaging in sexual intercourse with young virgin girls as a way of ridding themselves with the HIV/AIDS infection.

Although I do not necessarily share the same views, I have a deep understanding of the beliefs. While polygamy and the idea of older men having sex with young

girls are more likely to facilitate the fast spread of HIV/AIDS, it is in line with this thinking that the latter is usually construed as a mechanism of getting rid of the one's HIV/AIDS infection. Such perceptions are not unique to Zimbabwe but they are in fact more prevalent in South Africa where having sex with young girls also involves the virgin rape myth which is perceived as an HIV/AIDS ritual cleansing process (Meel 2003).

I am also aware of the fact that polygamy is one of the cultural practices that is often criticised by the western world as being primitive, unchristian and responsible for the spread of HIV/AIDS (Kalipeni 2004). I am also equally aware that while there might be some epidemiological sense in terms of the spread of HIV/AIDS, most African leaders and their respective communities still uphold polygamy as an acceptable practice and do not necessarily perceive it as primary driver of the spread of HIV/AIDS.

Part of my own experience of the Zimbabwean response to HIV/AIDS is that it has often been politicised arguing that there is a reluctance in the west to acknowledge poverty as a more fundamental issue that facilitates the spread of any epidemic in Africa of which HIV/AIDS is just but one example (Kalipeni 2004).

My own professional work in Scotland exposed me to the rhetoric and the belief that people from Black and Minority Ethnic communities have conservative sexual and cultural perceptions which militate against their preparedness to get tested for HIV/AIDS.

I also lived and worked in England where I worked both as a teacher as well as a volunteer with community groups and the voluntary sector. Two of my previous jobs addressed HIV/AIDS from the entailments of race, migration, asylum seekers and refugees. Evidence of my personal involvement was delivering a workshop *on Understanding Race* to the Rock Community Project in Stirling in June 2005, a presentation on Human Rights, HIV & Immigration at the Post Graduate School of Medicine Seminar, Glasgow, in August 2007. I prepared a *Special Report on Africans and Aids* in The Scottish Sunday Herald, 2 December 2007, conducted an HIV/AIDS Awareness campaign among African communities in

Glasgow culminating in the *It's Good to Go for a Test* Report, May 2008, delivered a paper on *A Scottish response to HIV/AIDS: Best Practices from Black and Ethnic Communities* in Arnhem, The Netherlands, 3 October 2008 and delivered a paper on *Opportunities and Challenges in developing good practice within an international context: a focus on HIV/AIDS* at the Network of International Development Organisations in Scotland(NIDOS*)* University of Glasgow Medical School, 19 January 2009.

In addition to being a member of the Scotland Advisory Group on HIV/AIDS (SHIVAG), I also delivered training sessions to Glasgow General Practitioners (GPs) on *Barriers to HIV/AIDS Testing* between 2007 and 2009. I was a panel member of the HIV/AIDS Network in Greater Glasgow and Clyde in 2009, I was also a co-facilitator of the *Everyone In – the Minority Ethnic LGBT Project* in Scotland as well as the focus groups for the National Aids Trust Research Report on *A study of the employment experiences of gay and bisexual men and black African men and women living with HIV in the UK*. Currently, I am a member of GRAMNet (Glasgow Refugee Asylum Migration Network) and NHS Greater Glasgow and Clyde Primary Care Deprivation Group. Both organisations have as part of their main foci issues regarding asylum seekers, refugees and those infected and affected by HIV/AIDS.

My experiences in Scotland and Zimbabwe have over the years enhanced my credentials in understanding and dealing with HIV/AIDS. Within this study, my credentials helped me to get to know how the HIV/AIDS epidemic was being responded to by various categories (1 -6). I have also always been aware of the link often made between homosexuality and HIV/AIDS in both Scotland and Zimbabwe. I was also able to appreciate a positive dimension of a theological analysis in terms of how Christianity and the Bible legitimise homosexuality.

There are at least two categories within which I operated as a researcher, namely as an 'insider' and secondly as an 'outsider'. It has also been argued that beyond those two categories, there is a space between them (Kerstetter 2012). Corbin Dwyer and Buckle (2009) for example argue that:

> *The notion of the space between challenges the dichotomy of insider versus outsider status. To present these concepts in a dualistic manner is overly simplistic. It is restrictive to lock into a notion that emphasizes either/or, one or the other, you are in or you are out. Rather, a dialectical approach allows the preservation of the complexity of similarities and differences (p.60).*

By 'insider' I mean one who has knowledge from within the affected community and understands the same values as those of the researched group (Macbeth 2001). In this study, my 'insider' status is to do with belonging to the same academic/professional community as the key informants whom I interviewed. While my insider status generally refers to my research in Zimbabwe, there were also instances when this simplistic dichotomy was called into question. See for example a more detailed comment regarding key informant ZW4,5M when the delayed response and change of dates for the interview might have been influenced by a different understanding of 'insider' and 'outsider' status. One way of addressing such dichotomies is to recognise the tensions between them by coming up with more creative ways of accommodating the space between them on the continuum (Kerstetter 2012).

Within Scotland, my position as a researcher was initially that of an 'outsider' in so far as I did not share the historical and ethnic experiences of the key informants. What we did share however, was the professional experience around HIV/AIDS given that I arrived in Scotland in 2004, almost ten years after the outbreak of the epidemic. However my 'outsider' status is only limited to the time and my ethnicity but it does not apply to my credentials in terms of how the epidemic has been engaged with as evidenced by my professional involvement as shown below. Although I was initially an outsider, I would argue that within Scotland, my status evolved into a complex insider-outsider status because despite being an outsider in terms of coming from outwith the Scottish context, I was also involved with the various key groups that shaped the policy and practice around HIV/AIDS policy and practice over the years. My professional involvement was essentially recognised in that I provided a different perspective in terms of how Zimbabweans (and indeed other Africans) engage with the prevailing discourses of HIV/AIDS.

With regards to the UK, my status would generally be that of an 'outsider' given the professional knowledge and active involvement with the HIV/AIDS issues but there has also been a significant element in which I was an insider. Perhaps one way of characterising this relationship is one of zooming- in and zooming –out during the process of interviewing. Although I continued to retain an insider status, the longer I stayed in Scotland and was involved in the various networks, the more immersed in them I became. My insider-outsider status has been quite nuanced.

My choice of England for the pilot study was based on both my knowledge and experience of how the epidemic was initially managed from London prior to devolution in Scotland (Berridge 1996). In the last nine years I have worked and studied in Scotland thereby providing me with the appropriate experiences of understanding how HIV/AIDS is managed and engaged with. One of my jobs involved working closely with the HIV/AIDS sector from where many have been key informants in my research.

As a reflective process, positionality enabled me to turn the researcher lens back onto myself in order to take responsibility of my own situatedness within the research (Berger 2013). This made me understand how my own credentials created a reputation that the key informants were able to recognise and respond to the interview questions as co- professionals rather than a scenario of an 'I and them'.

As a researcher, the fact that I have always been aware of who I am makes my research more meaningful by recognising my own role in it. As Bourdieu (1992) has argued, being cognisant of our own positions and their implications on the research undertaken is of critical importance. It is in this context that my own professional and academic history has shaped my identification of the key informants (Haskell, Linds et al. 2002, Lichtman 2013). The reflexive process enabled me to determine the tensions of what it means to be involved in a research area in which I have been actively involved in terms of maintaining the rigour of the study within the provision of the research ethics (Macbeth 2001).

My personal credentials in the field of HIV/AIDS also enabled me to assess the responses that people gave. Part of my insider status allowed me to assess that data I received when I asked about the statistics of HIV in Scotland and SC3,4F for example gave a very conservative response saying that: *' I know very few people living with HIV in Scotland – I am aware of only 5 people who are openly living with HIV*.' Because of my positionality, I was aware of the fact that her answer was not accurate because her organisation actively works with many self-declared HIV positive people and also regularly invites them to public HIV/AIDS seminars and workshops that they organise. Another example is when asked about methods of spreading messages in Zimbabwe, ZW1Ma responded, 'billboards are there' when in fact I do know that funding constrains and the controversy of content of the billboards in terms of being gender punitive towards the perpetrators of HIV/AIDS resulted in them being withdrawn from public places.

Interrogating my positionality and its implications for validating my credentials within this research is central to what Lichtman (2013) calls 'researcher self-disclosure' in which as a researcher I initiated authentic dialogue around the HIV/AIDS discourse. Lichtman (2013) rightly points out that researcher self-disclosure 'is a way of sharing the self of the researcher, exposing the beliefs and feelings, and contributing to the construction of research narrative' (p.166-7). Given that researchers are 'situated actors', it is imperative that 'we need to understand the nature of our participation in what we know'(Lichtman 2013, p.167). In the process of doing the research, I realised that my positionality enabled me to excavate how my personal and professional backgrounds impacted on my research, but it equally provided a trajectory in terms of the journey on which I had embarked. As Lichtman(2013) rightly states, 'We are always in a place of becoming….the journey and process' are very important in understanding the research product (p.163). It is therefore my contention that my own positionality as a researcher has influenced the process and the selection of the key informants.

5.7 Evaluation of Key Informants

Apart from the advantages of the key informant, there are however, some challenges associated with the approach. While interviewing key informants provides critical information within a short period, access to them often poses a major difficulty (Mikecz 2012). Within this research, several efforts had to be made in order to secure appointments let alone getting those who had agreed to avail themselves as per arrangement. In the pilot exercise in England for example, despite several phone calls and emails, it turned out that the selected Catholic key informants simply resorted to emailing general documents and could not commit themselves to the live interviews as requested. It seemed to be the case that while the prospective respondents indicated that access to them would be possible, it turned out that it was not always possible to establish trust and rapport (Mikecz 2012) in order to execute the interviews.

Although the key informant method can be used within a short period of time and the professional nature of the responses, the task of codifying and analysing the responses into thematic areas is made more complex (Coffey and Atkinson 1996).

A common problem with key informants is that they tend to display a culture of professional authority that might potentially interfere with the interview process. Given that this research included medical and other senior professionals, there was always a prefacing of responses from the official and professionally acceptable rubric. When asked about policy responses, ZW1aM said:

> *Initially, I know one of the very first things done with all the blood at the National Blood Transfusion that that it was tested. That was back in 1985. That was quite revolutionary. It was as a result of HIV…We were pioneers with some of the countries…in Zimbabwe, we swung into action, I think we also even went beyond what other countries were doing.*

A similar sentiment was echoed by key informant SC1,5aM when he said,

> *Scotland has first class epidemiological standards for diagnosed HIV cases coordinated by HPS (Health Protection Scotland).*

Such responses reflected an attitude of avoiding undermining their own professional authority and integrity. Such attitudes are of course characteristic of the challenges surrounding self-reporting (Innes 2009).

Where issues were controversial both in Zimbabwe and in Scotland, the professionals drew a line between themselves and the political establishment and effectively blamed the latter for the shortcomings as expressed by respondents ZW1Ma, ZW1Mb, SC1,5Ma and SC1m. An example of such a response was given by key informant SC1,5Mb who said that:

> *The Public Health awareness seems now lost in that while at one point HIV was a stand-alone initiative, but now it is part of the BBV (Blood Borne Viruses) framework and this is a compromise. Bureaucratic priorities mix up priorities. In future the transmission of HIV/AIDS among gay and bi-sexual men will continue just as much as there is a growing HIV infection among the heterosexuals. Unfortunately, the central government which is made up of white heterosexuals continues to deny that.*

Another reason why key informants behave this way is the fact that they are 'relatively unstudied because of their power and ability to protect themselves from intrusion and criticism'(Mikecz 2012, p.483). In some cases, they tend to generalise their responses only divulging data that they perceive to be politically acceptable (Marshall 1996). For example, ZW1M said that

> *We have made massive successes, there is no question about it, we have more successes than challenges.*

But when challenged about the demographic spread of these successes in terms of the rural-urban divide, the key informant resorted to official reports rather than accepting the challenges involved in describing the data that had not at all been captured in the remote rural areas in relation to the epidemic. The same key respondent (ZW1M) also went on to say that:

> *Again our programme is one of the best in terms of our use of our resources of combating HIV and AIDS. Right now, I think that the AIDS levy is contributing about 40% treatment, very commendable.*

In this regard, there tends to be consensus in responses that are professionally set and every key informant would adhere to them. For example, when asked about the challenges, SC1,5M's response is characteristic of most key informants in Scotland in that given the challenging circumstances that African migrants have, they are more likely to have more complex and conflicting needs between their migration issues, poverty and HIV/AIDS concerns. Given the fact that they have a priority to prove their asylum or refugee status, issues to do with their HIV/AIDs tends to be relegated in their hierarchy of priorities.

The same idea is reiterated by SC1F when she argued that,

> *The gloomy issues are that refugees were running away from conflict and because they were coming from chaos, they came with their baggage one of which was HIV.*

Some key informants tended to dominate the interview and there were instances when clinical/medical informants simply thought certain questions were not important for them. When asked about the initial responses to HIV/AIDS in Scotland, key informant SC1,5Ma said:

> *I think you're asking me lots of medical history going over 30 years, so again you need to just go and read the literature.*

Some key informants tended to patronise by just talking about what they preferred would have been asked. For example, SC1,5Ma went on to say:

> *BHIVA (British HIV Association), a professional body, has championed clinical guidelines on a large range of issues: it has also been able to influence government, sometimes in the absence of a patient voice alongside the third sector THT (Terrence Higgins Trust), NAT (National Aids Trust), Waverley Care, etc in order to keep HIV on the map. The*

main threat to the policy framework already in place is the current Health Care Reforms.

While what he said was true, the last sentence has actually no relevance to Scotland but to England because Health is a devolved issue and the policy frameworks are very different. No cuts have been announced around health or HIV/AIDs in particular in Scotland.

There is a pattern in literature that while prospective key informants agree to be interviewed, some of them are less prepared to adapt to the researcher's schedule or cancel at short notice thereby incurring unprecedented costs on the time and money of the researcher (see note on Scotland key respondents where a professional academic ended up referring me to his publications despite a previous commitment to personally respond to the interview questions). As such this poses a problem for the researcher in that I would be reading the publications instead of having a live interview with the key informant. An explanation of this response may be that careers are built within the HIV/AIDS domain yet the study of it might be of second order importance. Invariably, the location of the interviews was always determined by the key informants.

Due to the sensitivity of the organisation for which the key informant (ZW4F) worked, that is one which represents gay and lesbian rights, the venue was changed at very short notice on the day of the interview. A United Nations-related office was chosen because of its guarantee of security and non-arbitrary interference from state security agents. Although this eventually worked out well, it tended to have considerable influence in terms of the timing and the pace of the interview process (Mikecz 2012).It is worth noting that their organisation has often experienced a history of repression through police raids, illegal arrests/detentions and blame for undermining the country's cultural and Christian values from the official main political establishment[87].

Interestingly, one of the key informants selected for the interview who is one of the leading researchers on HIV/AIDS and Gay issues in Scotland kept on

[87] http://www.refworld.org/type,COUNTRYNEWS,,,503cba652,0.html (accessed 8.06.2013)

postponing the interview and ended up referring the researcher to his published work which will be discussed in the selected key documents.

Despite the challenges posed by the key informant interviews, the researcher can always re-position himself/herself so that they adapt to the dynamics of the interview process. One way of doing this is thorough preparation of the issues to be researched and anticipation of dealing with possible challenges. Another useful technique is to recalibrate the interview by rephrasing the interview questions (Mikecz 2012).

HIV/AIDS is imbued with issues of sexual orientation effectively creating a culture of blame on homosexuals. As a result, researcher sensitivity to key informants' own contexts is of vital importance as the researcher experienced when engaging with gay and lesbian informants who generally felt that some religious groups, the political establishment (at least in the case of Zimbabwe) and certain sections of the media tend to influence mainstream society not to sympathise but blame them for the origins and spread of the HIV/AIDS epidemic. The general public rhetoric that is associated with the conspiracy of demonising the targeted groups, like homosexuals in African being perceived as responsible for the origins of the epidemic was also another feature that raised some sensitivity in cases where the key informants were from those particular groups.

In spite of the challenges, I think that given the richness of the data and the possibility to ask follow-up questions and clarifications, key informant interviews are indeed one of the essential data collection methods that sit very well with this kind of research.

While I acknowledge the merits of key informant interviews, I was also aware of the effects of the power relations involved between myself as the researcher and the key informants. A notable example of how power relations played out and ethical issues raised in Zimbabwe were that despite having been granted the Ethics Approval by the University of Glasgow, key informants in Zimbabwe asked me if I had also secured Ethics approval from the Zimbabwean authorities. In the Ministry of Education, I made several visits to the head office before being

granted a letter signed on behalf of the Secretary for Education and Culture (see letter dated 16 August 2012 in appendix).

I also had to make several attempts to secure permission through the permanent secretary of the Ministry of Health part of whose remit is to oversee research in the field of health. My request for undertaking research in HIV/AIDS in Zimbabwe had also included asking him to be one of the key informants. While he granted me permission to do the research he declined to be interviewed himself saying : ' *No you can't interview me'* (2.10.2012) and instead instructed the director of Epidemiology to '*kindly assist the above mentioned (*myself*), who is carrying out PhD research around HIV*' (see letter dated 2.10.12 in appendix). Such power-play is very much characteristic of the relationship between the key informant and the researcher.

The above scenarios are important in understanding the research ethics process. While on one level it did make sense for the Zimbabwean authorities to demand that I secure permission from them to carry out my research over and above the University of Glasgow Ethics Approval, there was also another level where it seemed to be the case that other issues were raised. One interpretation of this could be that perhaps given the length of time I have been in the United Kingdom (UK) against the background of the current strained Britain-Zimbabwe relations economically and politically, I could easily have been perceived as an outsider influenced and sympathetic to western culture and values. In that regard, the University of Glasgow might have been perceived as an institutional representation of foreign UK values. The fact that the prospective key informants reacted differently in both Zimbabwe and in Scotland might imply that in some cases my positionality opened doors and in others it created barriers. It simply depended on the context.

It also took several attempts to establish a date and venue to interview key informant ZW4,5M despite their original agreement. While they eventually turned up for the interview, their prolongation of getting the interview done may be explained by the general political resistance of the population from the ethnic minority group they belong to which often perceives interviewers like myself as politically 'outside' their own context of historical and cultural

experiences. The notion of 'outsider' here has taken a different twist from the one previously described in that although I am an 'insider' as a Zimbabwean, my ethnic group credentials would be differently assessed in this particular demographic area. It is to this extent that Corbin Dwyer (2009) argues that one's ethnicity becomes part of the narrative of interpretation of the issues under research. Despite that fact, ZW4,5M still recognised me as having the professional credentials to engage with the interview as planned. This is because the key informant already knew me within academic and professional circles. As such this demonstrates what Law (2004) calls research as a messy business in that the distinction between 'insider' and 'outsider' is not only complex but also messy. I was both an 'insider' and an 'outsider' depending on through which lens he would be looking at (and he was looking through two different lenses).

I also noticed that within the process of key informant responses, there is some inherent bias that often accompanies such self-reporting. In a response to the question about HIV/AIDS policy frameworks, ZW3M avoided discussing the national policy at all but instead argued that

> *The Reformed Church in Zimbabwe has adopted an HIV/AIDS policy recently. This involves training, workshops with our friends in the Church and we also have a community-based Aids programmes. I would say that we as a Church take responsibility, but on the other hand you will still see amongst congregation you will see that dual "Oh no, yes" realising that it's sensitive. We do take our responsibility in the community.*

As discussed earlier, my credentials were significant in providing me with privileged access to the key informants. It however also needs to be noted that within a self- reflexive context, such a privilege might turn out to be a disadvantage in so far as it might limit me as the researcher to be more robust in critiquing the data collected (Corbin Dwyer and Buckle 2009).

5.8 Thematic Analysis

The data from this research was collected from two main sources namely the key informants as well as selected policy documents. These sources generated huge

amounts of data and I had therefore to decide which data to select and analyse in greater depth. In terms of the data from the key informants, the data was grouped into themes. I then selected and I prioritised the main themes that covered the main issues from the questions asked. The responses to interviews were coded according to the issues that the question addressed and the profile of the key informant (Gough and Scott 2000). The main themes comprised the prevalence of HIV/AIDS, the homosexual link to the origin of HIV/AIDS, conspiracy theories, the Churches' responses, the politicians-medics and public responses, policy responses, media responses, Sex Education and the role of statistics. Going over the responses and these thematic issues indicated that there was a significant amount of data overlap although there were also some distinguishing characteristics in each of them.

I however decided to focus on four main themes that I analysed in detail namely, conspiracy theories of the origins of HIV/AIDS, The Religious and Moral views on the origins of HIV/AIDS, the Homosexual Link to HIV/AIDs and Sex Education. These themes are broadly represented in both Scotland and Zimbabwe although the specific narratives sometimes differ according to the context. Given the fact that this thesis proposes a transformative approach to HIV/AIDS Education, these themes do form the basis of the emancipatory nature(Caudle 2004, Denzin and Lincoln 2005) of the suggested HIV/AIDS Education.

In terms of the selected policy documents, I compared how far their content matched or differed with the responses given by the key informants. It is however important to note that key HIV/AIDS documents came into existence well after the epidemic started. Part of the explanation of the late development of robust HIV/AIDS policies lies in the contested origins of the epidemic, the perception that it was a passing epidemic and that the origins were strongly associated with the constructed 'other' rather than the general population (Chirimuuta and Chirimuuta 1987, Grmek 1993, McNeill 1998, Kalipeni 2004, Rödlach 2006, Chitando and Gunda 2007, Flint 2007, Dry and Leach 2010, Farmer, Saussy et al. 2010).

This chapter has outlined and discussed the various tools and processes employed in the methodology of this thesis. The findings of the research have

been presented in a separate section of this thesis based on the chosen themes and draw from data given by the key informant responses and the selected policy documents and also utilise the three heuristic tools of narratives, a critique of sexuality and use of the post-colonial lens described in Chapter Two of this thesis.

In the sections above, I have discussed how the methodology that I used, the research process, the critical importance of my positionality as well as the advantages and disadvantages of key informants. Taken collectively, these various aspects explain the processes through which the data was collected and analysed on a thematic basis.

6 Chapter Six – Findings

6.1 Introduction to Findings in Scotland and Zimbabwe

This chapter will describe the research findings in both Scotland and Zimbabwe. These findings formed the basis of the thematic issues that emerged from the responses given by the key informants as well the references to some of the key policy documents and selected literature.

6.2 Scotland Thematic Responses

In the first instance, I will outline the thematic issues based on the responses given by the key informants in Scotland. These responses revolve around three main themes/motifs of homosexuality, Intravenous Drug Users (IDUs) and migration. The term 'migration' within this context needs to be understood on at least two levels. One refers to the movement and the perceived sexual and intravenous drug exchange between homosexuals in the US and Scotland and more lately from Eastern Europe[88]. The other level which is in some way more predominant is the migration of Africans into the UK through the dispersal of asylum seekers and refugees and the search for higher education, employment and other reasons to Scotland (Rice 2004). The three main themes of homosexuality, IDUs and migration are not necessarily separate, but in fact they often overlap with each other in complex ways. They are also circumscribed by other sub-themes as will be highlighted below.

6.2.1 Origins

There has been a consistent perception that the origins of HIV/AIDS are invariably associated with homosexuals, Intravenous Drug Users (IDUs) and African migrants especially refugees and asylum seekers (Palattiyil 2011). There has however been a sense of lack of precision in terms of the specific origins of the epidemic. As SC1M stated

[88] http://www.penroseinquiry.org.uk/preliminary-report/ (accessed 04.07.2013)

> *It's hard to pinpoint exactly how HIV came to Britain, but they did find in the early 1980s once HIV testing was established that it already existed in several sub groups including men who have sex with men, IDUs and recipients of blood products especially haemophiliacs.*

Key informant SC1,5Ma argued that across the UK some people resorted to the use of drug injection as a way of coping with the economic hardships imposed by the Thatcher era especially poll tax. All the medical key informants also indicated that the epidemic until fairly recently, only affected a small proportion of the heterosexual general public.

The homosexual and IDU factors are repeatedly highlighted in connection with Edinburgh as is the case in the expression 'in the 1980s, Edinburgh was the AIDS capital of Europe' (Berridge 1996). Key informant SC3,M for example stated that

> *I'm not sure but it goes back to the 1980's especially the drug user community. I suspect the gay community brought it from the US.*

Alongside homosexuals and IDUs, the origins of HIV/AIDS have also been strongly linked to (African) migrants as alluded to by SC1,5Mb in the following citations

> *It was probably gay men travelling abroad especially those travelling to and from the US. Back in the late 70's and early 80's, needle sharing was the main cause…the monkey theory is a reasonable explanation that holds most scientific scrutiny.*

The reference to the monkey theory implies that the HIV virus started among the monkeys and was then passed onto Africans and the latter spread it to the rest of the human species.

The origins of HIV/AIDS are also inextricably linked to specific groups affected by it who have been credited with a greater awareness than the rest of the population within Scotland. Such a perspective has been aptly argued for by SC2M when he remarked that

> *Personally, I am not sure if the public is much more aware today than before. It's not on the public radar except for the medical folk and the active homosexual group, vulnerable drunkards, sex workers and IDUs.*

While the initial perceptions of the origins and the spread of HIV/AIDS were attributed to Edinburgh in that it was referred to as 'the AIDS capital of Europe', the focus certainly evolved to also include Glasgow but for two reasons. The first was that

> *In terms of the Glasgow demographics, there is ongoing transmission between MSM (Men who have sex with men) (SC1,5Mb).*

The second reason was to do with migration in the general sense of people from high areas of prevalence coming to the UK but Glasgow was in particular a destination of asylum seekers and refugees from sub-Saharan Africa. As SC2M argued,

> *A significant number of infections is due to migration from sub-Saharan Africa.*

What is significant is that even beyond the initial arguments of the perceived origins of the epidemic, SC2M states that the political establishment has also held the perception that the origins of the epidemic were a result of homosexuals, IDUs and (African) migrants.

While it is true that the political establishment in Scotland is dominated by white males, ascribing their failure to consider HIV/AIDS as a key priority in Scotland could be part of a wider agenda of the processes of prioritising public health needs of which HIV/AIDS is just but one. As will be demonstrated in the section on 'Successes and Challenges' many of the informants agreed that Scotland had made significant advances due to the early and efficient introduction of ARVs as well as managing the epidemic in a demonstrable way.

In as much as the above responses highlight the broad themes of homosexuals, IDUs and migrants as the perceived originators of the HIV/AIDS epidemic, there

are mixed views about the exclusive nature of these origins. The various key informants indicate that the origins of HIV/AIDS are perceived in many different and complex ways.

6.2.2 Responses to the HIV/AIDS Epidemic

The initial responses to the epidemic were punctuated by fear, shock and bewilderment across the various groups within society. While some notable medical achievements in dealing with the HIV/AIDS epidemic reduced the initial panic and despondency to a great extent, there is evidence that there is some significant negativity that still surrounds the epidemic. In order to characterise the nature of the responses, I will look at how different stakeholders portrayed their perceptions of the epidemic. While these stakeholders belong to different categories, their responses often straddled across more than one category. Different kinds of media were used as conduits for communicating these responses. It is in this context that some sections of the media tweaked the messages to meet their own agendas.

6.2.3 Politicians and the Health Sector

The 'tombstone' image was one of the most highlighted images in so far as it was intended to evoke shock and fear towards HIV/AIDS. As described by SC3,4M

> *Certainly for the initial response, probably the one that the government launched… so I think that the politicians and the general population had fear about whether or not there was going to be a general epidemic. The tombstone campaign indicated that HIV was a death sentence because there was no medication. …For the medics there was surprise, questioning, a sense of despair because there was no cure. The needle exchange had a positive effect although it was criticised by some that it was promoting drug abuse.*

The shock effect was also reiterated by SC2M when he said

> *I certainly think politicians are aware of HIV/Aids and there were apocalyptic television images, probably in my memory for the first time.*

Politicians were persuaded by public health officials that there was a need for public health campaign. Apocalyptic TV campaigns meant that people were dying as a result of people's behaviour. The tombstones were about the fact that the world could come to an end. The idea I guess was to scare and terrify people. The general campaign to the general public was pretty dramatic.

The shock was accompanied by a genuine sense of medical dilemma in that

For the medics, like the rest of the NHS (National Health Service), they struggled to deal with something new especially in terms of issues of hygiene, isolation of those infected? Staff wearing multiple barriers to protect themselves -it was just learning on the job (SC4M).

SC1M corroborated the above idea that

Also a lot of anxiety health professionals at that stage when things weren't very clear what they were facing epidemiologically. On the other hand there was an approach to explore a scientific method. Actually this more scientific approach gained momentum and by the mid-1980s there was agreement on how to educate the public in terms of how infection was spread.

Alongside the above initiatives it was also decided that various approaches be put in place of which

One was to prevent further spread of HIV and secondly was to care for HIV families that were affected. The third approach was to work with voluntary organisations that emphasised a human rights approach that focused on the need to treat the infected with care and compassion.

The positive reactions included the fact that

The major successes were at the beginning of the epidemic. There were very good public health campaigns. There were World Aids Days held by each health board.

> *Initial response through the Scottish Home Office was good. Good health promotion, condoms and availability of testing* (SC1,5Mb).

One key health professional however argued to the contrary and said that in the initial stages in Scotland the initiative of tackling

> *HIV was left to people who were infected which worked alongside the third sector. Examples of these groups are THT and Waverley Care (SC1,5Ma).*

At that point, central government did not necessarily see it as a priority. In fact when it then did, somehow the same attitude re-surfaced as attributed by the comments below where once again government is not playing centre stage by either distancing itself from HIV/AIDS-specific work or is simply considering it as one of the Blood Borne Viruses (BBVs). SC1,5Mb expressed concern at such strategy in both the short and long term as the voluntary sector may not be able to sustain the support for HIV/AIDS without guaranteed resources.

While the efforts of the government were indeed initially commendable, concerns have been raised of late as seen in the following comments

> *… there is less current information because there is a feeling that it (HIV/AIDS) is less of a problem because of ARVs and people now live longer. A 2012 campaign by the Scottish government was aborted because it was perceived as inappropriate and stigmatising (*SC1M).

6.2.4 Churches

There are basically two broad churches represented by the key respondents. One is that of Roman Catholics and the other is of Presbyterians. Their specific responses will highlight their doctrinal inclinations although in parts the key informants do give personal views on how the 'churches' responded to the epidemic.

A recurrent theme that runs through both church-related and other key informants is raised by SC3,4M that

> *The churches took a very moralistic point of view that it was God's punishment of immorality, drug abuse, homosexual sex, promiscuity and adultery. I personally I don't believe in that, it's far too simplistic.*

It was also within the context of characterising homosexuality as part of the perceived moral transgressions as suggested by SC4M when he said that

> *For the churches at that time, they were really not sure. They thought that it was an obvious backlash against the people who had brought it on themselves.*

Given that HIV/AIDS was a medically complex and an unprecedented epidemic, the reaction of the churches also reflected this complexity. The connection of the epidemic to sexuality and loose morals made any public debate initially difficult. This is why

> *The Churches were placed in a difficult position – they were not comfortable, especially the Catholic Church because they did not want to publicly discuss about sex and sexuality – it was considered private and sensitive, something that should be between husband and wife.*

In fact, the church found itself in a kind of dilemma. On the one hand, it generally perceived itself as the custodian of moral guidance but on the other hand, the part of the connection of the epidemic with 'unacceptable' sexual behaviour made it difficult for the church to discern a clearer role and function in relation to HIV/AIDS. The dilemma was complicated by particular beliefs about sex and sexuality, the unpreparedness for the epidemic and simply the lack of a clear vision to pursue at that stage. This is why SC2M highlighted the fact that

> *The Church recognised that if behaviour was irresponsible – i.e. uncontrolled sexual action outside marriage, serious health consequences would ensue.*

The church needs to help people understand the moral and physical consequences of their behaviour. HIV brought moral discernment into sharp focus for the church. I must mention that the Church was ill-prepared at the beginning. The difficulty is that the church's teaching about morality is often caricatured in the media. The church's role in HIV is more around treatment through its medical institutions.
The Pope is quoted as recently saying that… but it is morally complex in terms of understanding the intention/moral action – simply avoid the danger!

Another religious key informant SC3,4M emphasised the same point when he said

There was a lot of fear, frightening people into monogamy. The idea was 'Don't have sex unless you know the person is HIV free'. There were huge iceberg campaign on TV ads namely that HIV= DEATH.

Unlike the rest of the church representatives, SC3,4M was more prepared to talk about the responses to HIV/AIDS in a more integrated way. In fact most of his discussions resonated very well with a book by Byamugisha et al (2012) entitled *Is the Body of Christ Positive? New Ecclesiological Christologies in the Context of HIV Positive Communities.* He argued that

Within the churches, there were huge gaps in grasping the issues: HIV is in the body of Christ: If the church is about Christ in the world, Christ in the world today is living with HIV. It is part of what the church is about. Christ would embrace/embody HIV/AIDS in order to liberate those living with it. He would liberate the stigma just like he did those who had leprosy. Jesus would not hesitate touching and healing those living with HIV. Earlier, people were barred from using the same cutlery but Jesus would not do this. This church affirms people living with HIV just like it does those living with other conditions – it is something that is talked about.

Part of the significance of SC3,4M's explanation is that it is unique, non-stigmatising and non-judgemental.

In the light of contributions like the one above, it seems to be the case that the fear and shock that the churches grappled with were more to do with the ignorance about the medical and factual information about the epidemic and that the concomitant stigma was more of an attitudinal issue than a reflection of a profound understanding of the epidemic. The moralising and theological interpretations that ensued were attempts to come to terms with an epidemic that had very much gone beyond any similar historical experiences of epidemics. This point is highlighted by Berridge (1996) when she states that even the bubonic plague was not comparable to the medical, social, moral and religious havoc that HIV/AIDS was unleashing across all sectors of the population.

6.2.5 Media and Communication About HIV/AIDS

As mentioned above, media was often the conduit through which HIV/AIDS responses and messages were relayed. The more traditional methods of media were the TV, radio and newspapers. More recently, other forms of new social media like face book, twitter and internet and email have been used and are popular across the various sectors of society. Examples and discussions of the impact of these evolutions and their impact will be demonstrated below.

6.2.6 Consensus on the Role of Media

There was consensus among all the key informants that the media sensationalised the HIV/AIDS right from the start. The key informants were also in agreement that the role of media did not help matters in terms of the shock, fear and indeed the initial ignorance that surrounded the real nature of the epidemic. I will discuss the key informants' idea that the media significantly contributed and fed their audiences with the perception that homosexuality, IDUs and migration were the critical drivers of the epidemic. While there might have been some epidemiological rationale to it, the way in which it was presented was and to an extent still remains a cause for concern in that it lacked the balance and critical perspective that such a complex discourse required and still requires.

SC3,4M summarised the function of the media with regards to HIV/ADS in Scotland when he said, '*The media was very sensational and pessimistic'*.

In describing the role of the media on HIV/AIDS, a key informant (SC1M) who was one of the early medical specialists to engage with the epidemic stated that

> *From 1985-1986 the initial approach was a mass information campaign. All the main media radio, TV and newspapers and also for the first time since the 2nd World War, information leaflets to every home to raise awareness so that there was a general public campaign. Alongside campaigns focused on at risk groups involving gay community, drug services and other groups travelling to areas of high prevalence, blood donors and those to avoid donating blood. It was a multi-pronged approach and that's obviously quite a long time ago. It's nearly 25 years.*

6.2.7 Tensions surrounding Media Messages

Some analysis of the content and nature of the initial media messages characterises them as being unique partly because they intended to create a particular impact

> *The campaigns represented a radical shift, the content was remarkably explicit with words and ideas about sexual behaviour openly used in the media and information sources: oral sex, anal intercourse, prostitution. There was a need to be clear. There had been no such previous public discourse on this (SC1M).*

The explicit nature of the messages is one which was not received without criticism from certain sectors of the community. For example a Catholic key informant (SC2M) commented that such media messaging had a potentially negative impact. Three points emerge here. The first had to do with parental consultation in producing those messages and the key informant doubted that such a process had been undertaken. The second point is whether or not the parents themselves had the capacity to decide what kinds of messages would have been appropriate for their children. As noted below

> *There was some concern about that I think probably in the parents. I am not sure if parents were consulted as this was seen as a public campaign but not an education or school issue. Concern was raised about what was decent and sensible: parents were asking themselves how they would communicate to children about these media messages? They asked themselves how equipped they were to do that? As a parent myself I also felt very concerned.*

The third point relates to the use of condoms from the view of parents in the protection and guidance of their children. To that extent, SC2M stated that

> *Use of condoms was of concern to some parents as children were exposed to concepts and language alien to them as this would damage their innocence.*

What could perhaps be gleaned from this is that on one hand there might have been a genuine effort to deliver undiluted media messages, but on the other there were also questions about the responsibility of media to take cognisance of the wide range of the age, sex, contexts, religious and the accompanying diverse socio-cultural values within which such messaging was being delivered.

6.2.8 Examples of Negative Media Messages on HIV/AIDS in Scotland

When HIV/AIDS started, the media responses were UK- wide but it was only in post-devolution Scotland that the messages changed. Within the context of media's role of demonising people living with HIV/AIDS SC3,4M noted that '*The media tends to latch on to court cases and the tabloids see this as something to be condemned'* without necessarily unpacking the complexities that circumscribe the issues.

Examples of a fear-instilling attitude of the media were the January 1983 *The Sunday People* article 'A Killer Love Bug Danger', *The Sun's* 'AIDS flew in on cheap transatlantic charter flights'. In the spring of 1993, the BBC ran a

programme entitled 'Killer in the Village'[89]. Its impact was psychologically devastating among those already infected, the 'at risk groups' as well as the general public. Rice (2004) described the general attitude of media towards HIV/AIDS in the 1980s with a quotation from a remark by Pat Buchanan a political commentator and twice a Republican Party Presidential Nomination, '*the poor homosexuals -they have declared war on nature and now nature is exacting an awful retribution*'. Other headlines were, 'A Million will have AIDS in Six years' and 'Gay Plague Kills Priest' and 'AIDS: Three British Airways Crew Die' and 'Scared Fireman Ban Kiss Of Life'(Rice 2004).

While these graphic negative headlines alongside the tombstone and iceberg campaigns dominated the early part of the epidemic, there was gradual change especially given the fact that the government took over leadership of the HIV/AIDS programme when it realised that it was more than just a 'gay disease' (Berridge 1996).

In Scotland, the story of Stephen Kelly hit the headlines in 2001 for various reasons. One was that Stephen Kelly had been an inmate in Glenochil, the other was that he as an IDU and thirdly, it was because he was accused of having knowingly passed on HIV to his former lover Anne Craig and was therefore jailed for five years[90]. The widespread media coverage and the public concern and anxiety around HIV/AIDS not only reinforced the usual stigma associated with the epidemic, but it also led to intensive professional debates as evidenced by the article by Bird and Brown (2001) in the prestigious British Medical Journal entitled: '*Criminalisation of HIV transmission: implications for public health in Scotland*'. The importance of this article is that it explored how the legal judgement arrived at had set a precedent within the Scottish context. It also raised questions around how in future a balance would be struck between service provision (for those with HIV), the (medical) ethics underpinning good health practice, the use of scientific knowledge in prosecution and the legality that circumscribed the handling of such issues.

[89] http://www.scribd.com/doc/92424550/Hiv-and-Aids-Frank-Rice (2004)(accessed 05.07.2013)

[90] http://news.bbc.co.uk/1/hi/scotland/1186093.stm (23.02.2001) (accessed 05.07.2013)

Another typical example of media negativity is that which linked HIV/AIDS to migration. An article by Mandy Rhodes in the Scotsman was entitled, 'African Immigrants Bring More AIDS to Scotland.'[91] Both the title and the tone of the article played into the stereotype of the usual scapegoats.

The trend of media negativity seems to have taken a different turn in recent years as noted by SC3,4F when she stated that

> *The Scottish government intended a campaign in December 2012 against stigma but it was dropped because of the stereotype: the 'at risk groups' challenged it saying is there going to be huge problem?*

The significance of this citation is that unlike the early days of the epidemic when the tombstone and iceberg images were used in order to evoke shock but also target certain groups within society, stakeholders are now more alert and critical of the types of messages that are communicated through public media. Given that the stakeholders are more pro-active, they will ensure that they will not allow any stigmatising and negative images being communicated to the public. It is against this background that the December 2012 campaign message was successfully withdrawn. Another important issue which emerges from the above scenario is that both power relationships in the context of HIV/AIDS messages have been reconfigured in that the government can no longer easily prescribe what the media puts outs. Equally, the media itself cannot portray certain viewpoints without being challenged by various stakeholders.
It is in that context that SC4M states that

> *There is a real challenge now. The government messaging is very little.*

[91] http://rense.com/general45/aff.htm (accessed 05.07.2013)

6.2.9 Implications and Contestations of Media Messages on HIV/AIDS in Scotland

As can be deduced from above, the role of the media towards HIV/AIDS affected the discourse in many ways. One was that media tended to promote a blame game towards those infected namely homosexuals, IDUs and (African) migrants. In the case of Stephen Kelly, it brought key professionals into a public debate about an issue that had no precedence. Part of the result of this public professional conversation led to a number of issues being raised. Some of the issues raised had to do with:

- how to resolve the tensions between (medical) ethics and legality
- how much scientific knowledge existed about the HIV virus in order to necessitate the kinds of judgements that were arrived at in Kelly's case
- how far the medical decisions were based on ethical considerations and
- what kinds of legal justification existed in order to engage with these issues in a human rights framework?

Given that there were no obvious and easy answers to the issues raised above meant that it became imperative to reframe the whole HIV/AIDS discourse in ways that would recognise the complexities and the tensions that are inherent in trying to maintain good public health on one hand and to ensure that legality does not necessarily undermine the good public health initiatives on the other hand.

6.2.10 New Social Media

The reporting of the HIV/AIDS at the beginning of the epidemic entailed using the traditional and existing types of media namely the TV, radio, newspapers and leaflets. However as media has changed, the way it is now being addressed has also adapted and adjusted to the new social media. As SC4M rightly points out,

> *The voluntary sector tends to do more and they use a variety of media: twitter, face book and email. One of the successful ones was the social positioning 'Make* Your *Position Clear', an advert on the buses and in the underground in Glasgow. This was perceived as a more subtle approach to*

> *tackle the issue in the West of Scotland in that it was not just put out in the usual public arena. Prof Paul Flowers was commissioned to evaluate that campaign. The other campaign was the 'HIV Wake Up.'*[92]

The above citation means that HIV/AIDS is going to be absorbed into the current life styles of the public whose use of social media is not just for entertainment but communication, business, accessing information, education and a matter of course. As such HIV/AIDS would cease to be an exclusivist and specialist discourse with a specific audience as its target audience but one which the new social media will generalise through its technological proliferation.

6.2.11 Sex Education

Although I am reporting on Sex Education as part of the response to the HIV/AIDS epidemic, it will also be discussed in greater depth in chapter 7. Sex Education raises questions of the content, context, audiences and the mode of delivery on the one hand, on the other hand, it is also a site of contestation in so far as whether or not it should exist, in what form, where and when. It also provides space for raising questions about who it is who should engage in Sex Education and why? The varied responses from the different key informants demonstrate the disagreements surrounding the issue of Sex Education.

While there was general agreement that Sex Education is a useful tool in raising HIV/AIDS awareness, concern was raised with respect to when to introduce HIV/AIDS Education as well as the nature and content of the curriculum (Cree, Kay et al. 2006, Wallace, Cree et al. 2006).
SC3,4M reflects this thinking when he states that

> *Obviously YES, Sex education should be taught in schools. Part of the sexual health policy set in considerate and respectful relationships. There is need to be included like issues around STIs and also in Moral Education in terms of anti-discrimination, anti-stigma just as is done*

[92] 'Make your Position Clear' and 'HIV Wake UP' were part of the mass media campaign used to encourage men who have sex with men and bisexual men around the West of Scotland to test for their HIV status given the perception that they were considered to be the most at risk of HIV infection.

about people with mental health: its attitudinal and prejudice, people need to know the facts.

Despite the consensus that Sex Education should be taught in schools, concern was also raised about much more robust programmes that would ensure that young people are currently well informed about HIV/AIDS within their own contexts and beyond. It seemed to be the case that initial efforts on this tended not to have been followed especially with the introduction of ARVs.

Yes, sex education should be included in different parts of the curriculum. Unfortunately, young people are not getting much in their Education about HIV. There is need for concerted approach to re-introduce professional education about how it is and how it is not spread (SC3,4M).

As SC4M argues while some programmes on Sex Education exist, there does not seem to be any uniformity across the board in terms of content and the strategies for delivery.

Absolutely YES without doubt, Sex Education should be included in all schools. How? Here lies the difficulty in terms of how it is delivered in schools. For example, in Glasgow, there is the SHARE programme, now we also have the Curriculum for Excellence (CfE) and teachers exploring ways of doing that. There is need for supporting them that HIV is still a concern which needs to be taken seriously however, it tends to be ignored or forgotten in most schools.

SC4M goes on to argue that the consensus of teaching Sex Education is made more problematic by the disagreements between the non-denominational and Catholic school viewpoints.

Within denominational schools, it is delivered differently: Catholic schools and other faith schools have designed their own content based on their beliefs. Many and ongoing discussions have tried various things to ensure all issues are covered but challenges still exist.

Although the differences are sanctioned by law in Scotland, the absence of consensus means that each party was pursuing what it felt was the best way to educate young people and the public about sex and HIV/AIDS (Savage 2007).
Key informant SC3,4M expressed that not teaching Sex Education would simply be a matter of naivety given that

> *It's a myth that young people don't know about sex, it is not always the case.*

The above perception may be linked to the idea that young people are already knowledgeable about sex through different kinds of media and peers and that in some cases, they begin to experiment with sex without appropriate guidance of when and why they should.

In SC3,4M's view young people may have some exposure to issues of sex within certain school subjects but the argument is that more is needed if Sex Education inclusive of HIV/AIDS is actually strategically implemented. This is why he said,

> *In Biology yes, but the real issues about emotional issues and touching etc need to be done professionally. Young people need information in order to make good choices and decide to share their lives with other people. Schools are the best context for Sex Education. Maybe teachers are not necessarily the best. Outside agencies may be better and other young people for example peer work has proved to be successful, so it has benefits.*

The key factors about Sex Education therefore revolve around the content, the timing of the delivery, where it should be taught/delivered and who it is who should be tasked with the delivery. These issues are also dependent on variables like what the young people know or do not know with regards sex and Sex Education. The issues are also dependent on who influences their perceptions of sex and Sex Education.

6.2.12 Statistics

Apart from Sex Education in the broad sense, statistics are indeed a way of communicating about a whole range of HIV/AIDS issues. These of course can be communicated through the traditional conduits of TV, radio and print media but more recently these can also be accessed through the new social media. In fact as young people are part of the main target audience, new social media has a much better uptake among them than the traditional media.

Most of the respondents were unable to give specific details regarding the prevalence as shown by the responses given by example SC3,4F who said

> '*the prevalence is relatively small, about 0.1% with about 5000 people living with HIV.'*

When asked about prevalence, key informant SC3,4M '*I just can't remember now.'*

SC2M said:

> *I think this is one of the questions probably this office isn't best to provide you with information as they are not responsible for gathering statistics for matters relating to health…*

The fact that the key informants did not give exact statistics may be attributed to self-reporting whereby the effort is made to ensure that they do not undermine themselves by giving certain kinds of answers. Another reason for such responses may be the fact that people do not have privileged access to their own minds. Conroy (2009) explains the way in which professionals often unknowingly portray themselves in such modes. They obscure reality by narrating themselves in particular ways. This was the case when for example SC1,5Ma viewed himself as essentially a clinician whose main role is to deal with the bio-medical aspects of the epidemic and does not therefore wish to talk about the history of the epidemic or about its exact statistics. In respect of the

medical history I was simply referred to go and look up the literature myself when he said

> *I think you are asking me lots of medical history going over 30 years, so again you just need to go and read the literature.*

In relation to statistics, SC1,5Ma saw it as the role of another body of specialists, the statisticians rather than clinicians. The same key informant nonetheless acknowledged that they are doing a good job. Below are further examples of how some of the key informants avoided giving specific responses.

Just like the origins and prevalence, all the categories of key informants linked the statistics with the perceived 'at risk groups' of homosexuals, IDUs and African migrants. Apart from the medical respondents, the rest were in fact not sure what the current statistics on HIV/AIDS in Scotland are and how they would impact on the general public**.** The hesitancy to give precise statistics were demonstrated by the following responses:

> *I know very few people living with HIV in Scotland. I am aware of only 5 people who are openly living with HIV. This is because it is symptomatic of the fear to divulge* (SC3,4F).

When asked about statics, SC2M said,

> *I am not able to answer that. It's done by medical officers and statisticians.*

SC3,4M echoed the similar hesitation by saying

> *I'm not a great one for numbers. Public Health needs to be informed about new infections. However, there are no stats for the untested. I am not sure that stats are significant beyond funding and projecting level of care. On a personal level, stats are stats, HIV is about people and lives. Numbers are not necessary, Education and support are more important.*

The fact that SC3,4M sees no connection between statistics and actually resourcing how well to provide the care and support might well be another clear example of lack of accessing one's own mind beyond the ordinary level.

However on a rather positive note, SC1M argued that

> *The role of stats is crucial, Scotland can be proud of establishing a method of gathering AIDS cases. The system is very complete. It is based on sex, age, risk group and where acquired. HPS – publish on a regular basis – quarterly reports – continuous reports to date: they are supplemented by prevalence surveys e.g. among injectors. The approach has been of a high standard. People would be better off if they provided necessary information and take precaution.*

The same sentiments were also corroborated by SC5M when he said

> *Statistics are extremely important because they show the prevalence and who is 'at risk'. They allow for developing the policy framework and targeted intervention. Scotland is in a very unique situation compared to the rest of the UK and the world because it has a robust data collection system.*

Despite a level of hesitation to talk about statistics in terms of giving specific figures, SC5 was prepared to argue that Scotland has the strategy of collecting statistics. The recognition of Scotland's efficient statistics is corroborated by SC1M who argued that

> *The role of statistics is crucial. Scotland can be proud of establishing a method of gathering AIDS cases. The system is very complete. It is based on sex, age, risk group and where acquired. HPS (Health Protection Scotland) publish on a regular basis, quarterly reports, continuous reports to date. They are supplemented by prevalence surveys.*

6.2.13 Policy Frameworks

Prior to devolution in 1999, Scotland's health policy was directed from Westminster in London. It was on this basis that the government was complemented for initial robust policy efforts, notably the UK- wide 1987 Aids Control Act which as SC1M commented

> *An important development was that in 1987 there was the AIDS Control Act which among other things required every health authority to publish annual reports that set out the statistics and plans for action*.

While this was a UK-wide legal requirement, Scotland has been hailed for the 1986 needle exchange programme for IDUs in Edinburgh. Despite its epidemiological success, the public reaction to this initiative was rather

> *hostile because the drug injectors were characterised as people gone outwith the normal bounds of behaviour and responsible for crime, to be shunned and avoided. It took a large effort to communicate that the idea was to stop the spread of infection as drug users could not easily stop drug-taking. The emphasis was to stop the transmission among themselves (IDUs) including the MTCT (Mother to child transmission) and the heterosexuals* (SC1M).

Despite the above successes, there has also been a period when HIV/AIDS was not on the main government agenda (Scottish Government 2009) as it was left to the voluntary sector and the gay men. The same comments have also been made in respect of more recent developments when the HIV/AIDS Policy has been lumped together with other Blood Borne Viruses (BBVs). As SC1,5Mb highlights,

> *The Public Health awareness seems now lost. At one point HIV was a stand-alone, but now it is part of the BBV (Blood Borne Viruses) framework and this is a compromise. The bureaucratic priorities mix up priorities.*

However, Scotland has to its credit developed an HIV/AIDS Policy as contained in the *HIV and Hepatitis 2005, Respect and Responsibility Sexual Health Strategy (2005 -2007, The Sexual Health framework 2009-2013, The HIV Action Plan Dec 2009 – March 2014, The HIV National Framework and the BBV Prevention and Treatment 2011-2015* among others.

It is also worth noting that the Scottish government through Ms Nicola Sturgeon the then Deputy First Minister and Cabinet Secretary for Health and Wellbeing set up a judicially led public enquiry, the *Penrose Enquiry* on 13 January 2009. Its mandate was to investigate 'the transmission of Hepatitis C and HIV from blood and blood products to National Health service patients in Scotland'(p.1). Part of the idea behind this enquiry was to understand what transpired as well as using the findings to compensate the victims of the infected blood. While a preliminary report has been the final is yet to be published[93]. It is however worth noting that this process took years to be instituted after the initial outbreak of the epidemic.

6.2.14 Successes and Challenges

All respondents concurred that there were major successes at the beginning of the epidemic in that there were very good public health campaigns as evidenced by the fact that each health board organised a World Aids Day (WAD).

The first strand of successes was around the policy issues. Given that Edinburgh was deemed 'the AIDS capital of Europe' specifically because of the high prevalence of homosexuals and IDUs, Scotland took the bold step of introducing the needle exchange programme. Despite a significant level of public outcry that allowing IDUs to exchange their used needles for clean ones was exacerbating the practice of illicit drug injecting, the programme paid very good dividends in that it remarkably controlled HIV transmission through this route. As highlighted by SC3,4F '*the clean needle exchange'* was a major policy success.

Alongside the needle exchange, Scotland also embarked on preventing the transmission of HIV from expecting mothers to their babies. As argued by SC3,4M

[93] As of the completion of this thesis the final report had not been published.

> *Also, with ante natal screening (ANC), there is no reason why anybody should be born HIV positive.*

Similarly, SC1M stated that

> *There has been much more success – one of the greatest public health achievements through the application of scientific principles.HIV is under control, and the Blood transfusion is also under control, MCT (Mother to Child transmission) is also controlled.*

While on one level HIV/AIDS was indeed a bio-medical condition, on another level, it also brought with it serious psycho-social challenges of stigma and discrimination for those infected and affected by it. In that regard, Scotland and the UK scored a success in that

> *Discrimination is at low level compared to other countries as demonstrated by Diana touching the HIV positive.*

The second strand of success was around HIV/AIDS policy. SC1M stated that

> *An important development is the 1987 Aids Control Act: Every authority to publish an annual report and describe measures to tackle the problem: it is very detailed in terms of services, how much was invested.*

Although the AIDS Control Act was UK-wide, Scotland also invested heavily in engaging with the epidemic. This is why

> *Funds were ring-fenced for HIV specifically. Alongside routine collection of data, unprecedented research on behaviour of gay men, drug-injecting area e.g. prison service following outbreak in Glenochil prison. In terms of prostitution there has been research on why they are doing it, who their clients are and what can be done to prevent it and the findings enabled us to inform policy to quite an accurate degree.*

Global research led to the discovery of antiretroviral medication (ARVs) and Scotland certainly took advantage of this scientific discovery to mitigate HIV/AIDS within its own domain. In fact unlike in England where medical care is among other things based on immigration status, Scotland made access to all including HIV/AIDS treatment and care available to everyone, regardless of immigration or other status.

Despite the above successes, there have also been some challenges. For example the advent of ARVs led to the Public Health awareness around HIV/AIDS being somehow lost. SC1,5Mb highlighted

> *At one point HIV was a stand-alone, but now it is part of the BBV framework and this is a compromise to the whole HIV/AIDS initiative. The prognosis of the medical respondents is that the transmission of gay and bi-sexual men will continue and heterosexuals may be affected by what they feel is a 'silent' epidemic given that there is a growing HIV infection among them.*

The primary focus on one's HIV/AIDS status often led to oversights over other medical conditions that HIV/AIDS positive people are grappling with. A case in point is what SC4F attributed to

*The challenge of (*not*) dealing with those with co-morbidity due to the initially bad (HIV drugs) was not effectively addressed.*

From a policy perspective, SC1,5Mb argued that there is concern around the fact that

> *Central government made up of white heterosexuals continues to deny that HIV/AIDS is an issue of national significance in Scotland because of its homosexual and African links.*

As such the tendency to scape-goat homosexuals and migrant Africans remains potentially high.

It follows that some bureaucratic priorities are seen as mixing up priorities by imagining that HIV/AIDS is no longer important (Scottish Government 2009).

Despite Scotland's clear position about providing access to everyone regarding HIV/AIDS, SC5M observed that

> *HIV is (still) a challenging public health concern because HIV flourishes in areas of poverty – the very nature of the virus is a concern – it keeps on mutating and it is not easy to deal with clinically.*

This is in part why

> *Some health boards are uncertain about giving ARVs to everybody especially those with unclear immigration status – given the cost of the drugs (information obtained from informal conversation with a health board member), also because Health Boards are going through stringent cuts (SC5M).*

Equally, SC5M has argued that despite the fact that

> *There have been huge strides in the management of HIV but we should not lose sight of the stigma. There is need to work more jointly across the sectors UKBA, Public Health and the voluntary sector. Complacency can make things go wrong because of stigma.*

6.2.15 Conclusion

This section has highlighted the major themes that arose out of the key informant interviews that I conducted. While a number of successes have been made in response to the HIV/AIDS epidemic in Scotland, significant challenges still remain. These major themes will form the basis of the discussion and analysis alongside the issues identified in the selected policy documents in a subsequent chapter of this thesis.

6.3 Introduction to Findings in Zimbabwe

In this section, I will present the thematic responses that were given by the key informants in Zimbabwe based on the same interview questions that were also

administered in Scotland. While the same questions were asked in both countries, the themes that emerged were in some instances similar or they overlapped and in others they differed. Responses have been reported alongside issues that were identified in the major key policy documents that were used in a separate chapter in this thesis. A detailed discussion and analysis of these findings will be made in chapter 7 of this thesis.

6.3.1 Prevalence

This point is confirmed by the current political rhetoric which constantly emphasises HIV/AIDS as a result of colonial and western imperial legacies in Zimbabwe particularly the homosexual theory among others.

The majority of the key informants were generally hesitant or simply declared ignorance with respect to giving the exact figures of the prevalence of HIV/AIDS in Zimbabwe as demonstrated below:

> *Difficult to give statistics, maybe one million, verify with National Aids Council and other organisations* (ZW4,6F)

> *I hesitate to give an absolute figure due to the massive movement of people in and out of Zimbabwe - 3-4 million. The national prevalence is at 13%* (ZW3M)

> *14.1% of the population is infected'* (ZW3,4M).
> *Currently 14.2% of the population are infected and in fact that has come down over the last ten years when it was double that figure* (ZW1M).

There was however unanimity on the fact that at least every family in Zimbabwe is now *affected* by HIV/AIDS while a good number of individuals are infected by the epidemic. The unanimity was also expressed in terms of the devastating consequences of the epidemic. Further enquiry on reasons for hesitation revealed that Zimbabweans tend to express the magnitude of negative experiences not in exact figures or percentages but rather in broad descriptive terms.

> *Even if granted that the pandemic had been recognised, indigenous wisdom suggests that a community does not wash its dirty linen in public, I mean 'kufumura hapwa'* (ZW3,5M) (translated as: displaying one's dirty armpits' which means making public something that should be kept privately because of its negative and embarrassing nature).

This may in part be due to the influence of indigenous knowledge systems which operate in a different framework from that of modern western societies.

6.3.2 Origins and Conspiracy Theories

Key informants did not necessarily link the origins of the epidemic to local or individual agency but to external factors. This idea was highlighted for example by one key informant when they argued that

> *The pandemic came as a result of migrant workers, men and women looking for employment, holiday and education* (ZW4.6F)

Another key informant explained his understanding by making reference to some of the views that have shaped public perceptions on the epidemic

> *The origins in Zimbabwe are not known but the common narrative is that of the gay community in the US and then it travelled around the world (*ZW3,5M).

The following quotation captures both a faith-based and some of the popular views about the origins of the HIV/AIDS

> *There are several origins. One is punishment from God for sinfulness or somebody developed it in some laboratory to punish certain people or just malice…the virus came from the West to Africa.*
> *As a person with a Catholic background with rural traditional Catholic values, evil can cause misfortune be it sickness or natural disasters* (ZW3F).

Other key informants located their explanations within a military discourse that referenced the struggle for independence in Zimbabwe (see point 6.3.9).

The above issues also resonate with the political rhetoric which constantly emphasise that HIV/AIDS is a result of colonial and western imperial legacies in Zimbabwe particularly the homosexual theory among others (Phillips 1997, Flint 2011).

6.3.3 Conspiracy Theories

Conspiracy theories broadly represent the practice of ascribing blame for negative occurrences to some evil. Conspiracy theories are not in themselves wholly unrelated to the reality that they will be seeking to explain but they are often self-justifying rather than seeking to subject themselves to the laws of rationality and objectivity source. In the case of HIV/AIDS in Zimbabwe, conspiracy theories lay blame on negative powers or practices that are perceived to be responsible for its origins and spread. Although these assertions are made, they are not necessarily subjected to logical or scientific proofs. In the case of the homosexual link to HIV/AIDS there is one level at which the medical argument has been made and proven but there is another level on which it has also been used as a scapegoat because of the negative religious, moral and social connotations ascribed to it by the main stream constituencies. In the latter sense, it also counts for being part of a conspiracy that is being orchestrated towards the homosexuals. Because homosexuals are demonised by the general indigenous Zimbabwean population under the banner of culture and tradition, most of the faith-based organisations and the main political establishment, this in itself may be construed as a conspiracy. In the context of Zimbabwe, Rodlach has highlighted the role and function of HIV/AIDS conspiracy theories in his famous *book Witches, Westerners and HIV: AIDS and the Cultures of Blame in Africa* (Rödlach 2006). A number of conspiracy theories were identified from the responses given by the key informants with some more recurrent than others.

6.3.4 The Homosexual Link to HIV/AIDS in Zimbabwe

Homosexuality tended to be consistently linked to the epidemic by a number of the key informants. While there is global evidence that homosexuality continues to increase the HIV/AIDS epidemic in both the developing and the developed world (Beyrer, Baral et al. 2012),it is also important to note that the negative socio-cultural perceptions about the practice of homosexuality have equally fuelled the conspiracy that homosexuality is the major if not exclusive driver of the epidemic. However, given recent human rights developments, the negative perceptions towards homosexuals have significantly declined in the developed West but they still remain a huge challenge in most developing countries including Zimbabwe. As one of the key informants identified homosexuality as one of the factors among others when he argued that

> *It was a combination of factors: sexual intercourse, promiscuity, prostitution, the gays ambushed us…*(ZW4Ma)

While the other specifically singled out homosexuality as a prime cause when he stated that

> *…the origins in Zimbabwe are not known but the common narrative is that of the gay community in the US and then it travelled around the world (*ZW3,5M).

Two of the key informants (ZW3,5M;ZW4,5M) argued that given that colonialism and missionary ventures brought with them the baggage of social misfits from the colonising country, it becomes problematic to identify the existence and scale of homosexuality in Zimbabwe prior to external influence and the role of colonialism, missionary ventures and trade in introducing and exacerbating homosexuality. The packaging of homosexuality with colonialism and missionary activity also broadens the base for developing the anti-western conspiracy rhetoric in Zimbabwe and other developing countries.

6.3.5 Witchcraft

Key informant ZW4,6F argued that

> *HIV has always been linked to witchcraft. People spend time and money with traditional healers who made a fortune and they died bitter because they lost livestock, money and other resources. Herbalists' claims never worked….Males believed their wives were witches newly born babies died from HIV.*

Another key informant argued that

> *Initial reaction was culture laden, that it was witchcraft and other general cultural explanations (*Z5M).

The above citations can be understood in the context of anthropologists who have conducted studies on Africa and have profiled witchcraft as part and parcel of most of the continent's belief systems that attributes causality of misfortune, illness, death and other negative experience to this negative force. Evans-Pritchard highlighted the meaning and function of witchcraft among the Azande but his findings may be extrapolated to other African countries (Evans-Pritchard and Gillies 1976). In the context of Zimbabwe, the Zimbabwe National Traditional Healers' Association (ZINATHA) confirms that witchcraft has always been part and parcel of the indigenous Zimbabwean society. However, during the colonial period, a law to suppress witchcraft was passed known as the *Witchcraft Suppression Act 1899*. Ironically, the same law has been held up even in post- colonial independent Zimbabwe. This is yet another paradoxical example of how colonial legislation is still being upheld in post-colonial Zimbabwe despite the current regime demonising the colonial legal and political legacies. The reason for suppressing witchcraft by colonialists was in part due to not fully understanding its significance in the culture it was articulated and practised and secondly simply as a system of power and control over the colonised. I think that the reason why post-colonial Zimbabwe still has the *Suppression of Witchcraft Act* on its statute books is indicative of the unclear demarcations of what is and what is not colonial, what is counted in and what is

excluded as part of the authentic Zimbabwean culture. In short, there is no simple answer to this. It is simply an on-going process of a search for the constituents of the identity of a postcolonial state, the consensus of which might not be easily reached or achieved. Notwithstanding the legal statute, HIV/AIDS in Zimbabwe is still attributed as a result of witchcraft. This point is made by Rodlach (Rödlach 2006) and confirmed by a number of the key informants although they vary in terms of the sustainability of the argument.

Traditional culture also played a rather ambivalent role in that it claimed through ZINATHA to be able to offer a cure for HIV. As the other respondent indicated, traditional medicine also contributed to the HIV/AIDS epidemic through the practice of traditional healers using often unsterilized razor blades from one client to the next to make incisions on one's body as a way of curing the HIV or any other infection known as '*kutema nyora*' in the local Shona language. The irony here is that first, those incisions do not necessarily in themselves lead to disease cure and secondly, they are a prime recipe for infection and cross-infection (ZW3,4M).

6.3.6 An Experiment Gone Wrong Theory

In a review of Rodlach's book (2006), Stewart argues that: 'The origin of HIV is sometimes attributed to "clever" (meaning selfish) western researchers and their Zimbabwean colleagues whose experiments on HIV in primates went awry and infected the human population' (Stewart 2007). His argument is grounded on the fact the local communities are suspicious about the function and role of biomedical research which is carried out against a perceived background of a breach of strong-held taboos between primate-human boundaries. The underlying critical issue is that 'the researchers' failure to adhere to other local knowledge and traditions, and the suspect intentions of anyone who is personally enriched by biomedical research.'(Stewart 2007). This argument clearly depicts that the west had an agenda that did not care much about the negative impact of their experimentation on the local (African) populations, a theme which is closely linked to the ones below.

6.3.7 The Racism Theory

As some of the key informants suggested, HIV is viewed as part of the racist discourse against the black population of Zimbabwe (ZW3,5M, ZW5F). As such, this feeds into the racism theory propounded by Chirimuuta a Zimbabwean doctor argues that the West had a deliberate racist discourse of using HIV to wipe out the black populations of Africa (Chirimuuta and Chirimuuta 1987). The racist approach is reiterated in the edited volume by Kalipeni (2004). My own analysis is that while racist agendas have tended to characterise medical anthropology in Africa (Zimbabwe) during the colonial and post-colonial eras, a total dismissal of the linkage of Africa to the HIV/AIDS epidemic origins and spread without qualification may lead to closing the doors of ongoing research on the exact source and factors that led to the epidemic.

6.3.8 Green Monkey Theory

The green monkey theory suggests that the earliest HIV was found in monkeys and through zoonosis the virus jumped from monkeys to Africans in Central Africa and then spread across the world. Although some of the key informants made reference to this theory, they highlighted the fact it was equally racist and prejudiced against Africans in general (ZW3M, ZW4Mb, ZW5M). As with the above theory, the legacy of colonialism has contributed to such perceptions and interpretations of disease origins although the legitimacy of the argument remains controversial.

6.3.9 Use of Biological Warfare Theory

A third medico-political theory that emerged from the key informants was the use of biological warfare. As one key informant states

> *There is also the Chirimuuta racist discourse of HIV and how that relates to the black population of Zimbabwe. Brigadier Chiweza talks about the use of biological warfare by the Rhodesian forces as the source of the origins of HIV (*ZW3,5M).

Another key informant also argues that

> *The origins issue, not new: disease coming after independence, brought in by people outside the country. It is biological war, war in a geo-political sense. Cold War competition -use of anthrax through guerrilla poisoning of clothes* (ZW4,5M).

This conspiracy is reinforced by the retired Zimbabwean Brigadier David Chiweza's proposition that the use of biological warfare in the then Rhodesia now Zimbabwe (Friedman 2006). The basic argument of Chiweza is that during the liberation struggle in Zimbabwe, the Smith regime in conjunction with the apartheid South African government used biological warfare to combat the guerrillas. His evidence is based on anecdotal evidence, secondary sources and his own personal recollection as a freedom fighter.

6.3.10 The Liberation Struggle Theory

What the biological war-fare and the liberation have in common is that both are about military-based conspiracies although they are each distinct from the other. The former purports that the virus was instigated by the white Rhodesian military forces while the latter ascribes responsibility to the black African (Zimbabwean) guerrillas/freedom fighters. As one key informant stated,

> *Zimbabwe is part of the wider African community. The origins in the 1970-1980 dispersal during the liberation struggle which integrated the rest of Africa with the rest of the world* (ZW5M)

Although in a somewhat problematised way key informant ZW3,5M argued that

> *the liberation struggle prepared the way for the levels of sexual laxity in that the spread of HIV may have been necessitated by 'comrades'(guerrillas/freedom fighters), 'mujibhas' and 'zvimbwidos', such an idea raises controversy and resistance*

The 'zvimbwidos' (civilian young females who assisted them in providing a range of services including preparing food, doing their laundry, providing local military

intelligence, assisting with the liberation war propaganda activities at night vigils (pungwes) and other activities like gathering and sourcing material help from local communities to support the activities of the liberation struggle). Both some 'zvimbwidos' and 'mujibhas' also served as potential recruits into the liberation struggle. However, part of the narrative of this conspiracy is that during the liberation struggle, the freedom fighters used shrewd methods of indulging in unprotected sexual activity thereby contributing to the spread of HIV/AIDS which would have been potentially contracted from outside Zimbabwe, namely, in countries where the guerrillas/freedom fighters would have been exposed to. This conspiracy is developed around how the 'mujibhas' and 'zvimbwidos' were then forced to blame any infection or pregnancies on the 'mujibhas' who were the young male counterparts who also provided similar support minus the sexual favours.

Whether or not the sexual interaction was voluntary or involuntary remains a matter of controversy. Research to establish the authenticity of this view has remained patchy and inconclusive. What remains however, is that sexual activity did take place as is evidenced in some cases with pregnancies or sexually transmitted infections. The research by Nhongo-Simbanegavi is a useful pointer in this direction (Nhongo-Simbanegavi 2000).

6.3.11 Churches Responses and the Link to Sin: From Apocalypse and Healing

The key informants gave various answers with regards to how churches responded to the epidemic. In their responses, they were partly informed by their own religious beliefs and partly by their reflections as specialists in the HIV/AIDS sector in Zimbabwe. The general themes that emerged were that churches tended to moralise the whole HIV/AIDS issue and linked it either to individual or collective sin. As one of the key informants said

> *As a person who grew up within the traditional Catholic Church in the rural areas: Evil can cause misfortune be it sickness or natural disasters. Personally, I believe that evil and sin even ordinary illness like STIs are a punishment' (italics own emphasis. HIV/AIDS is a result of unacceptable*

> *behaviour – a disease associated with promiscuity and therefore adopted 'a holier than thou attitude* (ZW3F).

Within this frame of reasoning, HIV is simply a moral issue and a result of a transgression against God. Some of the key informants explained that HIV/AIDS was seen by some faith adherents as an apocalyptic sign and not a medical issue that needed to be addressed on its own merit. It was apocalyptic in that it was perceived as a sign of the cataclysmic end of the world and the inauguration of the new dispensation. As most key informants stated, such a view resonates with most Pentecostal and Evangelical churches (ZW2F, ZW3F) (Chitando and Gunda 2007, Chitando and Gabaitse 2008, Chitando and oecuménique des Eglises 2008, Chitando 2013). It is not just a dogma, but the followers accept it as the 'truth'. One of the key informants took the view that

> *The Church should encourage people to keep sixth commandment in order to avoid HIV/AIDS. This should be based on abstinence, no sex outside marriage and faithfulness to one's partner (*ZW3F).

One of the significant factors was that,

> *At the beginning, the churches tended to be silent, they did not open up; they tried to provide healing but people still died. The type of healing that the churches offered was based on the usual ministry for the sick which would have accompanied normal hospitalisation or medication. Given that this was nothing like the usual known aliments, the churches only woke up with a rude shock when some leaders and ordinary adherents of their churches were affected and even died from HIV/AIDS defining illnesses (*ZW4,6F).

Another key informant also argued that

> *The churches were challenged to think through providing a new type of healing - one which took cognisance of the reality of HIV/AIDS and its related medical complications and challenges. A new ministry of healing*

> *was then developed as an appropriate response to the new dynamics* (ZW3M).

Despite the above, one of the key informants indicated that

> *Although the mainstream churches began to take the pandemic seriously, a challenge still remains with the traditional culture of polygamy and wife inheritance, a factor that some of the Evangelical and Pentecostal churches sanction and promote* (ZW3,4M).

Despite the fact that Christianity is generally viewed as a mark of civilisation and by extension in some sense a post-colonial value to be upheld, the form it takes in this instance is one which is built on traditional values that are pre-colonial and possibly at variance with the expectations of modernity.

Two of the faith-based HIV/AIDS key informants (ZW2F, ZW3F) explained that their organisations have over the years taken a responsible position of engaging HIV positive staff on their boards and as employees. However, with regards to the use of condoms they argue against them except for the discordant couples on condition that they get the appropriate counselling before being allowed to use them. Part of the challenge lies in the fact that for some reason there is a perception that the history of condoms in Zimbabwe seems to be linked to prostitution (Bassett and Mhloyi 1991). Secondly, they also used to be distributed by village health workers who were viewed as being of dubious moral standing. To therefore promote condom use would be a huge challenge for faith-based organisations because their values would stand in a different light from the view expressed above.

6.3.12 Politicians – Medics – Public Responses

When HIV/AIDS first came on the scene in Zimbabwe, there was a sense of panic, fear and disbelief because both traditional and western medicine could not deal with the epidemic in any meaningful way. As one of the key informants argued,

> *It devastated communities. It was a very serious issue beyond medicine and health* (ZW3M).

As a result, the various constituencies did not move at the same pace namely; the churches, medics, the community and the population in general.
The raft of responses included blaming witchcraft or resorting to the Biblical explanation of 'a curse from God' for transgressions committed. As one of the key informants remarked, the politicians tended to deny it in the 1980s because of its link to homosexuality (ZW4,5M). It has been argued that because sex is not talked about openly within African culture, HIV/AIDS -- which in Zimbabwe is predominantly transmitted through sex -- made any public conversation initially impossible. The latter point raises some controversy in respect of whether or not it was African culture per se or the influence of colonialism and Christianity that made conversation about sex a public prohibition. This was a result of the combination of all those factors rather any one of them on its own. The resultant stigma of those infected by HIV was also due to the perceived connection of the epidemic to sexual immorality.

> *This led to some community leaders initially resisting any efforts to acknowledge the presence of the HIV/AIDS pandemic and declaring that HIV is 'not for us but for others' outside the community* (ZW3,5M).

One of the reasons proffered for the early silence around the epidemic was that it was part of the rationale to avoid discouraging tourism. This position worked alongside the African proverb that discourages washing one's dirty linen in public, a point referred to in 6.3.1.

Despite the initial hesitancy in responding to the HIV/AIDS epidemic Zimbabwe was the third country in the world to test blood at their National Blood Transfusion Service in 1985 after the US and Germany a few months ahead of the UK. As stated by key informant ZW1M

> *All blood at the Blood Transfusion Service (BTS) was screened from 1985 and we were a pioneer in that respect*.

As such, it was also one of the first in the developing world (Illife 2006). The response was purely medicalised and coordinated by the Ministry of health, a strategy that proved inadequate as the epidemic progressed. It goes without saying that medicalising the epidemic was very much a post-colonial approach despite the general population operating with traditional and in some respects pre-colonial and colonial worldviews.

One key informant remarked that one way in which society tried to cope with the epidemic was to create humour as a way of dealing with the unprecedented. Thus instead of just relying on either witchcraft or modern medicine as the exclusive explanatory models, indigenous wisdom resorted to the creative and popular way of addressing the unfamiliar. This in a sense defied the conventional and narrow scientific approaches of engaging with matters medical. Thus, new metaphors and performance art were developed to characterise the epidemic and those who endured it. In some cases the language was even pejorative but the community was able to appreciate the profound messages contained in that kind of language. As one key informant summed it up; in Africa (Zimbabwe),

> '*dances are microcosms of society in motion' (*ZW4,5M*).*

6.3.13 Policy Responses

Although African communities like Zimbabwe traditionally tended to operate on the basis of orality, with colonisation and beyond, the function of the written word becomes the new norm. One way in which the written norm is exemplified is through law. May be due to the oral nature of the Zimbabwean indigenous community, it certainly did take some time after the first HIV case for written policies to be crafted into place. The first of these was the 1999 National Aids Council – National Aids Levy which stipulated that 3% of one's earnings would be deducted from all employees to contribute towards HIV/AIDS initiatives. By virtue of the same piece of legislation, a National AIDS Council was established. As articulated by key informant ZW3,5M

> *Of course in 1999 I think the government of Zimbabwe, the Minister of Health set up the National Aids Council and then put in place the*

national HIV and Aids policy. The key words emerging from Uganda was the importance of the multi-sectoral project basically shifted HIV from being a medical condition to being a multi-sectoral challenge, in other words the solution and the response would no longer be confined to what medical personnel did or did not do, but would include what would take place in schools, what would happen in communities, what would happen in Churches and so the 1999 HIV/Aids policy then sought to provide this comprehensive response to HIV looking at gender, looking at the role of religious leaders and various other players, so you witnessed then a more focused national HIV and within that matrix and framework you also witnessed the massive if you want explosion of HIV and Aids non-governmental organisations and some of them pre-dating the '99 watershed, but many coming on board as the state realises its own limitations you witness a lot of funding to non-state factors period.

Alongside this was the registration and recognition of HIV/AIDS non-governmental organisations (NGOs) to complement government initiatives.
As highlighted by key informant ZW1M

All Blood at the Blood Transfusion Service (BTS) was screened in 1985. We were a pioneer in that respect. Initially, there was a medicalised response in the Ministry of Health. Then there was the national Aids Control Programme (NACP). But now in Zimbabwe that's why I was saying when we swung into action I think we also went even beyond what other countries were doing. This is a multi-sectoral programme which cannot be tackled by just one sector… then we also came up with the National HIV Strategy Plan in 1999. It was a strategy framework and then a national policy, but we developed the policy into one now, the same policy in Zimbabwe was formed in 2005 into one the National HIV and Aids Policy. In various sectors also come up with strategies. Those two documents I've highlighted with the mother strategy. The most specific strategies now that you will see if it's for the original mother to child transmission you will see the Global Fund have changed strategy, but these are all children of the main strategy, so the private sector response to HIV, public sector response to HIV, all of these strategies. These are

all sub-strategies that you will come across, but they are all guided by just one and not two now.

Other key policy documents signed off by the head of state were the National Aids Strategic Framework: ZNASP 1 (2006-2010) & II (2011-2015). Complementing these efforts were the Aids Education programmes in Schools starting with Teacher training colleges in order to embed it in the schools curricula (1990s) which are outlined in section 6.2.8 of this chapter. However, these initiatives seemed to have waned off due to insufficient resources as well as the assumption that that it is now the remit of specifically HIV/AIDS institutions and organisations. The key informants in the schools system tended to take a different view as they expressed the fact that popular and community education does not always achieve what the formal school system achieves particularly in delivering education around sensitive topics like HIV/AIDS and Sex education.
A decade after the first HIV/AIDS case in Zimbabwe, parliament passed *The Deliberate Transmission of HIV Act 2004* in order to protect the public from intentional infection of the virus. As a number of key informants commented, while this was a well-intentioned piece of legislation, current debate demonstrates that it is almost impossible to implement and sometimes acts as a deterrent to people who might potentially want to test if they would have been subject to the likelihood of criminalising those perceived to have 'deliberately' infected them.

6.3.14 HIV Messages

Key informants indicated that there are a variety of media that are used to communicate HIV/AIDS messages in Zimbabwe. For example, ZW4,6F stated that

Radio is very important because it reaches all corners of the country and communicates in local languages. Local leadership works very well in this too. Orality is the best …there are follow-ups as well. Conferences, worskshops by churches, schools, and using platforms like weddings, drama and documentary films are instant and tangible for example those by playrights like Mparutsa, Chifunyise, Dave Guzha, Stix Mhlanga Patience Tavengwa and Eunice Tava.

The other mechanisms are outreach programmes which involve live speech in local languages are

> *Through print media, issues being raised and discussed over the radio, NGOas, pamphlets, 'Edu-tainment' (Education and Entertainment), drama. There is a huge uptake by Zimbabwean authors to write on the pandemic using various styles for example 'fa-ction' (mixture of fact and fiction)* (ZW4Ma).

The use of orality including music has been a very effective method as written messages depend on levels of formal literacy in the traditional western sense because indigenous knowledge systems use different indicators for assessing literacy levels.

> *While posters and bill boards were used during the early part of the pandemic but currently there is no public evidence of the latter. Three explanations were given by respondents: first that the cost of production and publicising is high and the NGOs who used to support these initiatives are no longer doing so. Apart from donor fatigue, there is also the issue of the rather prohibitive political and economic climate in Zimbabwe. Secondly, the respondents felt that almost everyone knows about HIV/AIDs and therefore the focus has shifted to testing, treatment, support and care rather than awareness per se. Thirdly it was also indicated that the content of the public messages has sometimes caused controversies leading to the posters and bill boards being pulled down. One example was the content of some poster interpreted by some as blaming women for the spread of the pandemic and more recently the adverts on circumcision led to disagreement among various stakeholders with some saying it sends misleading messages and others saying it was communicating scientifically proven messages* (ZW3,4M).

The last point is of critical importance in that it boils down to a power issue: who decides the content of the messages? What are the audiences that are targeted and why? How are the messages put together and in what form are they

distributed? How effective are these messages? Given that Zimbabwe is a post-colonial state that is also grappling to fix its identity within a traditional cultural and as well as a modern framework answers to the questions above remain contestable.

6.3.15 Sex Education in Schools

There was general agreement among the key informants that teaching Sex Education in schools is subject to the following issues:

- That it should be based on age- groups
- That it takes cognisance of specific faith-beliefs in the respective schools given that there is fear in some faith communities as they tend to view that anything with the word 'sex = sin'. The missionary system of education and the colonial legacy of considering indigenous populations as more prone to dubious sexual morals is still a challenge that needs to be addressed.

There are current challenges regarding some of the content of local text books in Zimbabwe in that some of them are sponsored and sourced from external western donors. As such, there may be scenarios where such dynamics may not engage with the local issues in a sufficiently culturally-specific way. Examples of such texts are The *Girl Empowerment Movement (GEM): Resource Pack for Zimbabwe* (UNICEF – Harare, 2010), *Boys Empowerment Movement (BEM) Resource pack for Zimbabwe* (UNICEF-Harare, 2010), *Think About It! An AIDS Action Programme for Schools* Series (UNICEF – Harare), *Let's Talk: An AIDS Action Programme for Schools* Series (IUNICEF-Harare), *HIV/AIDS & Life Skills Education Secondary School Syllabus Form 1-6,* Curriculum Development Unit, Zimbabwe Ministry of Education, Sport & Culture, Harare, 2003. Given that Zimbabwe is a fragile and transitional economy, the opportunities for developing home-grown curricula are compromised by lack of resources for all schools and young people. One key informant (ZW5M) argued that this has resulted in some situations in which Zimbabwe has resorted to using donor-provided materials which may be construed to perpetuate a legacy of colonial outlook within a post-colonial context.

> *Traditionally, the aunties and uncles would talk to 13-year olds but now their role has been superceded by other institutions like schools and the media* (ZW2F).

The same point was reiterated by ZW,45M when they argued that

> *The pedagogy has now changed. Learning used to be family-based. The aunties would have dealt with this in the past. Now teachers have taken over. Schools are the best tools to deal with issues before children formulate dangerous ideas. Zimbabwe is a patriarchal society and men are important. My sister is a female male 'baba kazi', meaning 'the auntie is a female father'. Because there is a father-daughter barrier the aunt is well-placed to deal with the girl child.*

This in itself poses serious challenges in as far as schools are put in a situation of being re-active rather than pro-active (Mano 2004).

Most of the key informants stated that Sex Education should be presented in a meaningful and dignified manner although it was not exactly clear what the exact content of 'meaningful' and 'dignified' implied. Concerns were also raised around when and to whom Sex Education should be targeted. One suggestion was that HIV/AIDS Education needs to be taught much earlier because young people are now exposed earlier through peers and various media e.g. orphans, Orphaned and Vulnerable Children (OVC), child-headed families tend to be abused most given the complexity of the current environment.

A recurrent theme was that Sex Education should consider the cultural implications of teaching it in rural versus urban schools. The perception was that it is easier to teach it in urban schools as the students are already exposed to more liberal sexual messages via the various media than those in rural areas (ZW2F). The rural- urban divide is a product of the colonial but has been upheld by the post-colonial state. I think that the perception that the rural represents conservatism and 'tradition' in its more original state and that the 'urban' represents modernity and the liberal spectrum is a matter of debate. Secondly, the movement of people and ideas from rural to urban has in fact blurred this

distinction. Within independent Zimbabwe, the indicators of rural and urban have been collapsed by the established of 'growth points' and service centres which represent both tradition and modernity in terms of life style, ideology and physical infrastructure (researcher's own analysis and observation).
Key informants (ZW2F) noted that

> *within the urban areas, the aunties' roles have been taken over by parents but there is the challenge of the work economy which does not always give parents enough time to parent fully including systematic and in-depth conversations about sex education. Secondly, some parents may not be competent enough to educate their children around sex and sexuality in meaningful ways due to having a traditional perspective to sex education. Parents with a professional background (by western definitions) were better-placed to handle sex education issues with their children.*

However, based on personal observations and conversations, questions may be raised regarding the sustainability of such an argument. For example, how does one explain how some of the parents successfully reinforce traditional values within an urban context and vice versa? Equally problematic is the fact of children who stay with guardians who are not necessarily their own biological parents and indeed this may present challenges around how best to engage these children around sex education issues.

6.3.16 Collection and Significance of Statistics

While the responses on the collection of statistics were provided a considerable range of views in Scotland, the same process proved to be more problematic in the case of Zimbabwe. This is evidenced by at least three main responses which represented the challenges that surrounded the efficient collection and interpretation of the HIV/AIDS statistics.

The first one was highlighted by key informant ZW4,6F propounded that

> *The Aids Levy in Zimbabwe requires that statistics be collected and published, but the Ministry of Health tends to hold on to the data – there is just the 'odd' mention, it should be more intensely and publicly discussed.*

Other key informants in Zimbabwe noted that the mode of publication is not always intelligible to the general public e.g. use of percentages. In fact raw figures or other forms of representation were deemed to be more meaningful by a number of key informants. This may be reflective of the manner in which the indigenous community quantifies issues.

The second main response emphasised the fact that HIV/AIDS statisitics in Zimbabwe are not evenly collected as commented by key informant ZW1:

> *adequacy is an issue in that there is a the tendency is to collect from easy points, like the ante- natal clinics, the urban settings and the New Start Centres which are not evenly distributed across the country* (ZW1M).

The same point is corroborated in the Zimbabwe Demographic Health Survey (2010-2011) that

> *these surveillance data results do not provide an estimate of the HIV prevalence among the general population (p.215*).

Finally, it was also argued that the statistics about HIV/AIDS-related deaths are not accurately collated

> *despite the perceived efficient bureaucratic medical structures, HIV-related deaths are not always consistently recorded and passed on as part of national HIV statistics. Information is not always fed in correctly hence the HIV statistics may not be as accurate despite the recent WHO publications that HIV in Zimbabwe was on a downward decline* (ZW1M).

The above practices were in part be due to a culture of silence around HIV/AIDS as well as those Zimbabwean perceptions that understand health and illness through conspiracy theories that have been described in this thesis.

6.3.17 Success and Challenges

There are a number of successes that have been made since the HIV/AIDs epidemic broke out in Zimbabwe. Notable among them is the raising of awareness in different notably among local groups and communities and public institutions like schools, clinics, hospitals, churches as well as other spaces like billboards (ZW4,6F; ZW3,5M; ZW3F; ZW4F). This has meant that messages about HIV/AIDS became part and parcel of people's daily experiences. As ZW4,6F highlighted, HIV/AIDS became part of the public discourse at funerals and weddings, through community-based theatre and other public gatherings.

As ZW1aM stated, Zimbabwe was one of the first countries in the world to screen blood for HIV/AIDS as early as 1985. These successes were complimented by the establishment of the National AIDS Council (NAC) and the AIDS Levy[94] in 1999. Alongside this there was also a raft of policy developments like *The Deliberate Transmission of HIV Act 2004* and the series of the *Zimbabwe National Aids Strategic Framework* (2000-2015) which guided a multisectoral approach to the responses to the HIV/AIDS epidemic (ZW1aM). Within schools, workplaces and community groups a range of HIV/AIDS literature was developed in order to educate people about HIV/AIDS. Examples of such literature have been referred to in section 6.3.15 of this thesis.

The above successes have not only been recognised by the World Health Organisation (WHO), but they have also enabled by the presence and activities of many HIV/AIDS-related NGOs (ZW3,5M; ZW4M).

Despite the general success outlined above, there are challenges that still exist around stigma across society and the role of some of the conspiracy theories highlighted in the section on the perceived origins of the epidemic.

[94] 3% was deducted from every employee in order to fund the NAC activities.

> *The erratic supply of ARVs continues to be a major cause for concern especially for those from far afield from the health service centres. While the ARVs are normally available, some people simply cannot afford to travel to collect them or they may not always get the regime that they require* (ZW1M).

As ZW3M argued,

> *Child mortality due to HIV/AIDS is still high…men are not supportive enough and tend to ignore the preventive messages. There is an indication of multiple sexual partners based on cultural practices and issues of late presentation are still common. Targeting of HIV/AIDS was more directed at women…For some reason, the history of condoms in Zimbabwe seems to be linked to prostitution.*

Given Zimbabwe's fragile economy,

> *the public sector is not always efficient and there isn't adequate national support because it's all donor-funded. Pharmaceuticals started an onslaught by putting bottle necks – preventing generic drugs on the market yet the brand names are very expensive* (ZW4F).

This is also compounded by the fact that

> *Poverty is a big issue in terms of transport to pick up the ARVs as well as the lack of sufficient information about the pandemic. Beliefs in witchcraft reduce the chances of the hospital as an option for those who fall ill and the attitudes of those teaching and imparting knowledge about HIV/AIDS is a crucial factor as they sometimes tend not to practice what they teach* (ZW5F).

A similar point was also raised by ZW3F when she argued that

> *Poverty is still a big challenge and this has vast implications on the spread of the pandemic. Some women still sell sex for survival – young*

> *girls are vulnerable in colleges because they are economically taken advantage of.*

ZW4,6F also argued that due to the negative impact of the Zimbabwean socio-political and economic climate

> *A lot of men and women are so stressed that they go on binge drinking out of frustration and they do not use protection.*

As a result, the behaviour of the people does not always match the rhetoric.

The roles of culture, Religion (both African traditional and Christianity), conspiracy theories and political interference often negatively impact on the gains that would have been made in spreading messages about safe sex and the sustainable ways of preventing and halting the spread of the epidemic (ZW4,6F; ZW3,5M; ZW3,4M; ZW4,5M).

A point was raised regarding the use and effectiveness of condoms: while many were distributed and picked up by prospective users, there still exists no robust mechanism for assessing their correct and consistent usage (ZW4Mb).

6.4 Conclusion

The thematic responses that emerged from the Zimbabwean context were in some respects similar to those found in Scotland but because of the differences in the demographics of the key informants, the economic and socio-cultural contexts, some of the issues raised were simply peculiar to each of the countries. The reasons for these variations will be discussed in greater detail in analysis Chapter Seven of this thesis.

7 Chapter Seven – Discussion and Analysis

7.1 Comparison between Scotland and Zimbabwe

7.2 Introduction

This chapter will discuss the thematic issues that arose in both Scotland and Zimbabwe by focusing on some of the broad areas that provide a framework for understanding the nature of the epidemic in both contexts. These areas will cover the conspiracy theories, medical political theories, the religious and moral views, a cultural critique and Sex education.

7.3 Conspiracy Theories of the Origins of HIV/AIDS

7.3.1 Definition of Conspiracy Theory

Conspiracy theories are prevalent all over the world. They exist in both scientific and popular domains. One of the key underlying factors of conspiracy theories is its negativity, arousing fear and ascribing of blame and the attempt 'to explain the cause of an event as a secret, deceptive plot by a covert alliance' (Rödlach 2006). He goes on to argue that conspiracy theories are part of 'a broad cross-cultural category of origin narratives' (p.108). In relation to HIV/AIDs conspiracy theories also seek to establish the origin narratives of the epidemic.
One of the reasons for the generation of the conspiracy theories for the origin of the epidemic was contained in the responses of some of the key informants who highlighted the inadequacy of the bio-medical explanations of its origins.

7.3.2 Conspiracy and Moscovici's Social Representations Theory

In explaining how Zimbabweans sought to make sense of and come to terms with the HIV/AIDS discourse, Rodlach draws on Moscovici's Social Representations Theory as a useful tool (Rödlach 2006). Rodlach argues that Moscovici identifies how new social representations are triggered by 'points of fracture and tension' (Rödlach 2006, p.10) of which HIV/AIDS is a classic example. Within that context two processes emerge namely anchoring and objectification. Anchoring occurs

through resorting to familiar ways of explaining the extraordinary through a system of shared beliefs and values. Objectification happens when with the passage of time people affirm and ascribe AIDS to these popular beliefs and values.

While Rodlach observed this trend of blaming others for the occurrence of HIV/AIDS in the Zimbabwean case, this was also articulated by key informants from my field work. Similarly, the notion of blaming others can equally be applied to the Scottish context where homosexuals, blood and blood products from the US were the common rhetoric from many of the key informants.

The Social Representations Theory has also been used in relation to social representations in HIV/AIDS and risk taking sexual behaviour amongst undergraduates in a large South African university. Five key themes emerged out of this study namely that 'AIDS is a punishment for sexual immorality, AIDS in an evil perpetrator, AIDS targeting the vulnerable 'Other' AIDS as a Polluter and AIDS as the slow Punisher (Howard-Payne 2010). What is interesting about these themes is that they were reiterated by key informants in both Scotland and Zimbabwe. While the results of this study were premised on the legacy of racial apartheid and different social classes in that the superior white race blamed their black counterparts for the epidemic, the blacks on the other hand blamed the whites for orchestrating the epidemic through apartheid and social class distinction. The idea of looking at HIV/AIDS as a western (white) conspiracy led to the controversy surrounding the alleged refusal of former South African president Thabo Mbeki to recognise the existence of HIV/AIDS as real disease (Flint 2011).

7.3.3 Conspiracy theories and HIV/AIDS in Zimbabwe

7.3.4 The Homosexual Link to HIV/AIDS

While on one level it makes epidemiological sense to talk about the homosexual connection between the origin of HIV/AIDS and homosexual practice, it is also important to recognise that this perception has been turned into a conspiracy by main stream heterosexual society which sought to exclusively explain HIV/AIDS

as a direct product of homosexual activity. In fact there are other methods of HIV/AIDS transmission besides homosexual sex, namely blood transfusion of HIV/AIDs infected blood and blood products, intravenous drug use, anal sex between an HIV/AIDS infected individual and indeed through heterosexual sex with an infected individual.

In Scotland the homosexual factor is repeatedly highlighted in connection with Edinburgh as evidenced by the fact 'in the 1980s, Edinburgh was the AIDS capital of Europe'(Berridge 1996). I think that part of the significance of this is the epidemiological connection between HIV/AIDS and homosexuality, since the 1980's there has also been a construction of the perception of HIV/AIDs as a gay disease. Although subsequent initiatives have broadened the understanding of the nature of epidemic within Scotland (and elsewhere), the *myth and memory* (own italics) of HIV/AIDS as a gay disease still lingers on. The fact that origins of HIV/AIDS are linked with the gay community from the US also raises a critical point about looking for a scapegoat and perpetuating a culture of blame on outsiders. The idea of a scapegoat and blaming outsiders is reiterated in relation to migrants. In Scotland, migrants and most notably Africans from sub-Saharan Africa and 'homosexuals' become scapegoats and demonised 'others' in relation to HIV/AIDS.

Although HIV/AIDS is still linked to homosexuality, the terminology has since evolved to 'men who have sex with men' in an apparent effort to de-stigmatise the practice. It seems to be the case that saying 'men who have sex with men' is intended to be viewed in the same context of the traditionally accepted heterosexual view of 'men who have sex with women'.

Given that Zimbabwe and Scotland have different cultural contexts, although homosexuality is perceived as linked to HIV/AIDS, the way in which the arguments have been articulated are similar in some ways and different in others. The similarity lies in the fact homosexuals are considered in both contexts as scapegoats and also as coming from outside.ZW3,5M for example argues that

> *A common narrative is that it (HIV/AIDS) was brought by the gay community in the US and then due to travel, it was spread around the world.*

In the case of Scotland, the homosexuals emanate from the US (SC5M) and in the case of Zimbabwe the argument is that homosexuality was brought by the foreign colonial powers and the western missionaries (ZW4,5M). While in Scotland the position and perception of homosexuals in general has shifted because of the lobby for equality and human rights, in Zimbabwe, efforts to shift their position and perception has proved problematic. In fact in relation to access to treatment support and care for HIV/AIDS, homosexuals in Scotland have not only championed the cause but the official perception has accepted them as part of the society.

In Zimbabwe on the other hand, apart from constant negative rhetoric towards homosexuals, it has also been noted that in terms of treatment support and care for HIV/AIDS, they have been systematically discriminated against and marginalised[95]. Such practices are in fact in contradiction of the policy documents that emphasise human rights and equality of access and treatment for all who need HIV/AIDS services as evidenced by for example the National HIV/AIDS Policy (Republic of Zimbabwe) 1999 and the Zimbabwe National HIV and AIDS Strategic Plan (ZINASP II) 2011-2015 with the latter document stating that 'Zimbabwe is committed to *zero discrimination* by 2015' (p.44) and 'the National Health Strategy, 2009-2013 aims at ensuring *equity and quality in health* for all people from a human rights perspective' (p.50).

7.3.5 Witchcraft

HIV/AIDS in Zimbabwe is still attributed to be a result of witchcraft by many African people although this raises issues in terms of scientific and medical authenticity. Rodlach's study (2006) in Zimbabwe is one clear example where such views have been explored in depth. Anthropologists who have done studies on Africa have profiled witchcraft as part and parcel of most of the continent's

[95] http://www.newzimbabwe.com/news-12336-Gays+lament+HIV+treatment+exclusion/news.aspx (accessed 18.09.2013).

belief systems that attributes causality of misfortune, illness, death and other negative experience to this negative force. In his seminal work, Evans-Pritchard highlighted the meaning and function of witchcraft among the Azande but his findings may be extrapolated to other African countries (Evans-Pritchard and Gillies 1976). While witchcraft features significantly among Zimbabweans within Zimbabwe, it does not feature among the indigenous (white) Scottish people. However, witchcraft does exist among some Zimbabwean migrants living in Scotland in so far as it is used as an explanatory cause for disease and illness, a perception that is perpetuated from their country of origin (Fontein 2014).

One way of looking at the role and function of witchcraft in relation to HIV/AIDS is that it serves as an explanatory model for the unknown. As such it moves beyond being a mere conspiracy but an exercise in searching for the meaning, origin and solutions of disease and illness(Evans-Pritchard and Gillies 1976). While traditionally witchcraft has tended to be associated with rural African communities, Togarasei (2005, p.372) demonstrates that in Zimbabwe, it is very equally an urban phenomenon in that

> *The new Pentecostal movement with its urban character has moved away from the use of these perceived traditional healing practices. They uphold the traditional African world-view but the healing of witchcraft and other spirit-caused illnesses is only done in the name of Jesus through laying on of hands and sometimes ecstatic prayer accompanied by speaking in tongues. This way they have won many of the middle class and elite Africans who, still uphold the traditional worldview but because of their modernism, do not want to be associated with traditional practices.*

Rodlach (2005) makes the point that witchcraft as a cause of HIV/AIDS is very much a Zimbabwean urban perception despite the robust efforts by various health agencies to explain HIV/AIDS from a western bio-medical perspective.

7.3.6 An Act of Racism/The Green Monkey Theory/Use of Biological Warfare and An Experiment Gone Wrong

I have grouped the above aspects as a cluster of factors that inform related themes of a broad conspiracy theory. The common thread through them is that they allege that HIV/AIDS originated because of the intention to harm specific target groups. Key informants in both Zimbabwe and Scotland made reference to either one or a combination of the above in their response to the question on the origins of HIV/AIDS. Rodlach(2006) for example makes references to the role of the print media and his own interviews purporting to the fact that HIV/AIDS in Zimbabwe was a deliberate plot by westerners to harm blacks. He also argues that in Zimbabwe one still finds the pseudoscientific publications like Wolff *Geisler's AIDS: Origin, Spread and Healing* (1994) that argues that the American government funded a project to eradicate Africans.

Farmer, Saassuy et al (2010) confirm what a number of the key informants stated regarding blaming the Americans for the HIV/AIDS virus. Beyond that, references are also made to the novels set in southern Africa e.g. Ben Geers' 1998 thriller *Something More Sinister* in which racist Nazi scientists and South African Boers fabricated a deadly virus to affect blacks. These were then given to the white Rhodesians (now Zimbabwe) to use on the black Africans. While it has been difficult to provide unquestionable evidence regarding the use of biological warfare using a range of chemicals, there is certainly a body of research that strongly purports that anthrax, pesticides and other types of chemicals were used by the Rhodesian forces against the African Zimbabwean guerrillas (Ellert 1989, Brickhill 1992, McGregor 1999, Alexander, McGregor et al. 2000, Martinez 2002, White 2004). Claims have also been made that the former Rhodesian head of Central Intelligence (CIO) did testify that biological warfare was used.

Taken from one perspective, these arguments would confirm that not only was biological warfare used but that this was equally premised on the racial nature of the war and the idea of wiping out the black Africans through manufactured disease as articulated by retired Brigadier David Chiweza, Chirimuuta (1987) and former Minister of health in Zimbabwe Dr Timothy Stamps (Friedman 2006).

Chirimuuta further alleges that arguments around the HIV/AIDS came from green monkeys and through zoonosis into (West and Central) Africans.

While the various aspects of this conspiracy theory are thought to be framed from within a colonial perspective, it is interesting to note that the literature places a substantial amount of blame of the experimentation and racist initiatives on the United States (Altman 1988). In part the United States Centre for Disease for Control (CDC) is viewed as having been central in facilitating these medical experiments as part of the American ideological agenda towards the homosexuals, Haitians, Cubans and Africans (Altman 1988).

In her research, Nhongo-Simbanegavi alleges that villagers testified to the fact that Rhodesian helicopters dropped poisoned canned beef and sometimes they were channelled through the African retail chain and poisoned cigarettes were also included in the package (Nhongo-Simbanegavi 2000). The same evidence equally applies to the Liberation Struggle theory in the next section.

The racist conspiracy theory is also premised on the missionary and colonial collusion in which in the wider scheme of themes, whites have always been suspects in Zimbabwe anyway. Part of that is based on for example the notorious physician McGown who engaged in suspicious experiments on black Zimbabweans using morphine and led to a number of fatalities. His experiments coincided with the arrival of HIV/AIDS which then led to a link between his experiments and the origins of HIV/AIDS (Mutizwa-Mangiza 1999). Race as a critical category of constructing conspiracy beliefs about the origins of HIV/AIDS has also been substantiated by Ross, Essien et al. (2006). Closely linked with this is the whole ethical debate surrounding the panic that ensued when the virus is said to have crossed the boundaries into the western terrain. The resultant effect was to drug test the 'other' with or without their consent thereby reinforcing the same racial and domineering legacy as described above.

7.3.7 The Liberation Struggle Theory

The liberation struggle theory is based more on the responses made by some of the key informants that the male freedom fighters engaged in unsolicited and

even coerced sex with the female combatants and war collaborators. Given that the freedom fighters travelled back and forth from and through countries within southern Africa (notably Mozambique, South Africa, Zambia, Botswana and Tanzania), there is a likelihood that they brought and spread the virus (Rödlach 2006). While the book by Nhongo-Simbanegavi (2000) makes an argument regarding both coerced and consensual sexual relations between the predominantly male and few female freedom fighters and their accomplices.

From her research, she demonstrates that the main form of sexual exploitation was by men on women. This was either by Rhodesian forces on African women in the villages or perceived collaborators of guerrilla warfare in which case rape was used as method of extortion and extracting information. In terms of the guerrillas themselves, they either negotiated consensual sex or also resorted to rape. Other accounts of the same research demonstrate that due to harsh conditions and lack of basic resources in the military zones both within and outside Zimbabwe, some women used sex in exchange for such goods and services. In occasional circumstances, senior female combatants also solicited sex from young guerrilla recruits simply to satisfy their sexual desires.

All the above does demonstrate that sexual activity did exist in one form or another. Although it cannot be decisively argued that the origins of HIV/AIDS lay in the liberation struggle but given its was transnational nature that arose from movements of the freedom fighters and their Rhodesian soldiers counterparts, this remains very much part a military discourse that may well have contributed to the spread of infectious sexual diseases (Coburn and Young 1949).

7.4 Conspiracy Theories and HIV/AIDS in Scotland

In Scotland, the conspiracy theories of the origins of HIV/AIDs have continued to revolve around nuanced perception that *contaminated blood and blood products from the US* was key to the spread of HIV/AIDS. In that context, the Penrose Enquiry (2010) was set up by the Scottish government to investigate how contaminated blood was given to the Scottish patients. While the findings of this investigation have produced a preliminary report, the final report is yet to be commissioned. What is however critical is that it is now part of the Scottish

psyche that HIV/AIDS came to Scotland via that conduit. In fact this seems to resonate well with the 'homosexual link to the origins of HIV/AIDS' in Scotland discussed elsewhere in this research.

Some key informants (SC1F;SC1M; SC1,5aM) have argued that the arrival of Eastern Europeans into UK and Scotland in particular has generally added to the negative attitudes towards migrants and the baggage of HIV/AIDS they bring. A number of authors have also highlighted how similar views have been expressed regarding migrants arriving into the UK (Creighton, Sethi et al. 2004, Anderson 2008, Palattiyil 2011). Popular among some of the negative perceptions is the fact Eastern Europeans have a high prevalence rate of intravenous drug users thereby fuelling the increasing of infection in Scotland.

Invariably, most of the key informants in Scotland alleged that devolution and the dispersal of asylum seekers and refugees to Scotland have led to a sharp increase of HIV/AIDS prevalence. Notwithstanding the fact that no robust statistics had been collected prior to this and that no ethnic monitoring was in place in the early days of the epidemic, the term 'asylum seekers and refugees' is used almost synonymously with African migrants (Creighton, Sethi et al. 2004, Anderson 2008, Palattiyil 2011).

7.5 Conspiracy as 'Otherness'

The recurrent discourse that underpins the conspiracy theories of the origins of HIV/AIDS is the construction of 'otherness' (Patton 1990). Patton (1990) argues the construction of otherness in terms of the origins of HIV/AIDS was based on one level on the west's colonial and post-colonial perception of superiority and the inferiority of the developing world. Where the 'other' was constructed within the western space, e.g. homosexuals, IDU and asylum seekers, this was premised on sexual and moral perversion(Jeater 1993) or the negative impact of migration into the west. In terms of the latter, there seemed to be a deliberate avoidance of engaging with wider issues of globalisation. The process of globalisation also entailed the dialectical negative impact on the marginalised groups who were scapegoated as the conduits of the sexual and moral perversion. The irony is that the same developed West that played an active role

in the construction and implementation of globalisation also resulted in the marginalisation and ascription of HIV/AIDS to specific groups in society (Hall and Gieben 1992, Hall, Held et al. 1992, Hall 1993, Hoogvelt 2001, Held 2002, Hoogvelt 2002, Klein 2007).

These 'others' are in a sense *texts* that have been constructed but not much effort has been made to effectively deconstruct them (Patton 1990). The deconstruction of such texts would need to take into cognisance the power relations that have historically existed between the coloniser and the colonised, the emerging narratives of HIV/AIDS and which narratives gained currency and which ones did not and why. Here an application of Foucauldian analysis of power would give a more nuanced explanation of how the traditional 'other' has not necessarily remained powerless and singularly blamed for the epidemic but in fact took a powerful leadership stance in the HIV/AIDS epidemic. This is was particularly the case in across the UK (Scotland) where the gay lobby for legal recognition, governmental and pharmaceutical and other forms of assistance made them a *significant other* rather than a *marginalised other* (italics – own emphasis). Both Scottish key informants and researchers in Scotland highlighted this point (Berridge 1996, Flowers 2001).

While there are different characterisations in Zimbabwe and Scotland, the common thread and emphasis is that blame tends to be ascribed to the other rather than the local. From a western dominant viewpoint, HIV/AIDS is ascribed on the African 'other' because of the latter's inability to uptake the use of condoms, endemic poverty, inherent moral and sexual perversion as well as medical backwardness (Patton 1990). In a sense these are sub-texts that are created in order to reinforce the position of and the exoneration of the developed west from being the origin of HIV/AIDS. Critiques of such views argue that in terms of condom uptake, there is no demonstrable evidence that the developed west is any better than in Africa (Patton 1990).

Conspiracy theories perpetuate a culture of fear, hate and mistrust (Ranger and Slack 1996). Despite the robust efforts of medical research and a de-construction of the conspiracy theories, they are still sustained in the collective memory of both locations as through the perpetuation of the relevant narratives. This is

evidenced by the kinds of metaphors that are used to describe HIV/AIDS in both locations (Sontag 1989, Chitando 2012).

7.6 Medical- Political Theories

In Scotland the initial response to the HIV/AIDS epidemic was part of the UK-wide initiatives because the first case was prior to the 1999 devolution. As a result, the 'tombstone' image was one of the most highlighted in so far as it was intended to evoke shock and fear towards HIV/AIDS.

Due to the absence of a sufficient medical explanation of the epidemic at the beginning, the tendency was to resort to some kind of political conspiracy against the gays in so far as they were perceived to engage in unusual sexual practices. Alongside this lack of real knowledge about the nature of the epidemic, the medical fraternity were experiencing certain practical dilemmas as evidenced by issues of hygiene and other protocols of dealing with HIV-infected people. It was only much later that scientific explanations were sought in order to pursue research and the development of appropriate treatment.

In view of Zimbabwe, a review of Rodlach's book (2006) by Stewart (2007) indicates that:

> *The origin of HIV is sometimes attributed to "clever*" (meaning selfish) *western researchers and their Zimbabwean colleagues whose experiments on HIV in primates went awry and infected the human population.*

Stewart's (2007) argument is grounded on the fact the local communities are suspicious about the function and role of biomedical research which is carried out against a perceived background of a breach of strong-held taboos between primate-human boundaries. The underlying critical issue is that 'the researchers' failure to adhere to other local knowledge and traditions, and the suspect intentions of anyone who is personally enriched by biomedical research.'(Stewart 2007). This argument points towards the view that the west had an agenda that did not care much about the negative impact of their experimentation on the local (African) populations as exemplified below.

While racist agendas have tended to characterise medical anthropology in Africa (Zimbabwe) during the colonial and post-colonial eras, a total dismissal of the linkage of Africa to the HIV/AIDS epidemic origins and spread without qualification may lead to closing the doors of ongoing research on the exact source and factors that led to the epidemic.

The first case of HIV/AIDS in Zimbabwe in 1985 coincided with the independence euphoria and therefore any link to disease would have been seen as counter-productive. Political independence could not have been construed as co-terminus with disease because the freedom fighters could not have been perceived as 'disease carriers' but a *constituency that was highly regarded as having brought about freedom, independence, justice, development and equality. They were* heroes of freedom who facilitated that successful change through the celebration of 'blackness'. However the colonial representation of the 'black body' represented evil and disease (both metaphorically and otherwise). According to colonial logic, this blackness needed to be destroyed.

In post-colonial Zimbabwe, it becomes untenable to propound the argument that the liberation fighters were associated with such behaviour and that they were part of the genesis of the HIV/AIDS epidemic. In fact, if this were to be the case, then one would argue that holding such a view would be tantamount to equating the activities of the liberators' with those of the colonial oppressors.

While the colonial construction of sexuality defined the black Africans as having a greater propensity to moral looseness, the early nationalists saw themselves not as 'diseased' but as healthy. Liberation movements and their adherents celebrated blackness until the HIV/AIDS disrupts and re- problematises the discourse of blackness.

However the binary and simplistic colonial view of blackness as the representation of darkness, evil, disease, backwardness and inferiority as opposed to as the representation of whiteness, purity and superiority is challenged by Mudimbe (1988). Starting with the early anthropologists, colonisers and missionaries, Mudimbe explicates how for example Africanists like Senghor and his idea of negritude, Franz Fanon and his colonial critique,

Nkrumah as his pan-African agenda, Hountondji and his African Philosophy project, Steve Biko and the *Black Consciousness Movement* (BCM) and more lately Nyerere and others have emulated and located blackness as the nexus for dislodging the naïve colonial views of blackness as negativity but rather viewing it as a signifier of and an inspirational force for black African emancipation and an indispensable symbol of their cherished identity (Mudimbe 1988). In a way, Mudimbe's argument inspires those who dismiss the equation between black Africans with being the undisputed source the HIV/AIDS epidemic. It follows that the nationalist and liberationist rhetoric in Zimbabwe is very much grounded in similar thinking as demonstrated by externalising the origins of HIV/AIDS through apportioning blame to the western and the colonially imported homosexual discourse.

7.7 Religious and Moral Views

7.7.1 Introduction

The following section will explore in greater depth how the religious and moral views characterised the HIV/AIDS epidemic in both Scotland and Zimbabwe. It is on the basis of this analysis that implications for Sex Education and more specifically HIV/AIDS Education will be drawn out. Within this context, explanations of the origins of HIV/AIDS are located within religious explanations as well as moral decadence. The term 'religious' in this context will be used to refer to a broad range of beliefs about the existence of a single or multiple beings who are perceived as being responsible for human existence and to whom different groups of human beings owe their lives and wellbeing. The kinds of religion that the key informants drew their responses from ranged from African Traditional Religion(s), Catholicism, Presbyterianism, the Augustine United Church, as well as other Pentecostal and Evangelical Churches. It is also important to note that while the key informants were not specifically asked about their own personal religious beliefs, they were however asked what they thought were the religious explanations to the origins of HIV/AIDS.

In discussing the religious and moral views, I will base the conversations on the responses given by the key informants some of whose views were influenced by

denominational approaches (SC2M; SC3,4F; ZW2F; ZW3M) as well as those who gave more nuanced views of the various religious and moral perspectives.

7.7.2 Moralising the Epidemic

A recurrent theme that runs through the church representatives' responses is that of moralising the epidemic namely that it was a result of people's bad behaviour. Closely connected with this is the religious idea that the epidemic was an apocalyptic sign of the end of the world. I will now examine the evidence from both locations and consider the points of convergence and divergence.
In Scotland, SC3,4M argued that the churches took a very moralistic viewpoint which demonised those who suffered from HIV/AIDS. The moralising aspect is typical of the blame game.

While the Protestant churches made an effort to discuss and explore the issues to do with epidemic, their Catholic counterparts found it more difficult to do the same. Evidence of that can be seen in SC2M's argument that the churches' position was problematic regarding the HIV/AIDS epidemic. Part of the problem lay in the churches' discomfort in openly discussing issues of sex and sexuality which were inextricably linked to the epidemic on the one hand and on the other hand, they had a responsibility to provide credible pastoral and theological guidance on an issue of paramount significance as the HIV/AIDS epidemic. Within the context of western society, the churches grappled with how to balance sex as private, sensitive and individual as well as well as reconciling these discourses within their own belief systems.

There were however different viewpoints among the Churches. The Catholic Church emphasised the role of pastoral care in the same way as they would do with sick members of their congregations. Because of the homosexual link and the perceived sexual immorality linked to HIV/AIDS, the Catholics tended to be less vocal in engaging in public theological debates about HIV/AIDS. The Protestant churches engaged with the epidemic at a much deeper level than others. Such views were expressed by for example Byamugisha et al (2012) in their book *Is the Body of Christ Positive? New Ecclesiological Christologies in the Context of HIV Positive Communities.*

In Zimbabwe, sentiments about moral transgressions and the apocalypse are also highlighted. In terms of the Catholic Church the same views regarding the epidemic are expressed (ZW3F; ZW3M). The difference arises when it comes to non-Catholic churches where beyond the traditional Presbyterian Churches, there is also a proliferation of African independent churches which are heavily Pentecostal and Evangelical (ZW3,5M). A major characteristic of some of these churches is that they sanction both polygamy and marrying under-age girls (ZW3,4M) which some critics view as creating opportunities for possible infection with HIV/AIDS (Chitando 2007, Chitando 2013).

In Zimbabwe, there are different types of churches which imply different understandings of morality. In Scotland, there seems to be a clear distinction between private and public morality in that people's sexual choices and sexual orientations are not a matter for public scrutiny or approval (SC1M). On the other hand, in Zimbabwe there is not always a clear distinction between private and public morality. Polygamy for example is sanctioned by most of the African independent churches and homosexuality is denounced both politically and culturally.

In both Zimbabwe and Scotland, some key informants (SC2M; SC3,4F; ZW3,5M; ZW2F) tended to alternate between religious and moral views in their responses. This was evidenced by the fact that they expressed the view that religious groups and society at large were perplexed by the epidemic and the latter simply resorted to explanations that highlighted the fact that the epidemic was a result of a moral transgression, a punishment by an almighty power(s) and a symptom of societal disintegration. Such thinking in part led to the laying of blame on the 'other' in society like the homosexuals, prostitutes, intravenous drug users or migrants.

Key informants in Zimbabwe (and to some extent the African diaspora in Scotland) indicate that while Christianity and African tradition do not always share the same views (Anderson and Doyal 2004),(ZW4,6F;ZW5F), they certainly shared a moralistic perspective of the origins of HIV/AIDS (Illife 2006, Gwaravanda 2011). Both the key informants and the research carried out by

Anderson and Doyal (2004, Anderson 2008) do indicate that the African migrants living in the UK (and in Scotland) made strong connections between morality and religion in that some of them considered suffering from HIV/AIDS as a curse from God or their ancestors for their sexual immorality. On another level, they also viewed belief in God and belonging to a church as a way of making good their relationship with God (Illife 2006). In his address to the 1991 Seventh International AIDS Conference in Florence, Italy, Museveni the Ugandan President who himself is both an African and an avowed Christian, emphasised the breach of sexual morality as a cause for the epidemic (Seidel 1993). In the same article, Siedel (1993) argues that HIV/AIDS has been both the object and subject of various power discourses. For example, morality and religion are used as mechanisms of determining the appropriate sexual behaviour within society. Such practices are grounded within a Foucauldian framework of the regulation of sexuality (Foucault 1976, Foucault 1985, Foucault 1986, Seidel 1993). On another level, African tradition is in its own right a powerful discourse which regulates human sexual behaviour. It often does so through patriarchal dominance and the suppression and exclusion of women from articulating their responses as well as blaming them for being the reservoirs and conduits of the epidemic (Seidel 1993, Baylies and Bujra 2002). As such, there are instances when and where African tradition relies on patriarchy to deploy oppressive and selective gender-limited applications of human rights (Seidel 1993, Baylies and Bujra 2002).

Sontag (1989) analyses how religious groups and society across both the developed and the developing world used biblical and other metaphors to describe how HIV/AIDS was both a religious and nature's reaction to the inappropriate interruption of sexual activities. Sontag(1989) herself is highly critical of such interpretations in that not only do they construct 'victims' for blaming but that they are also not robust enough to deconstruct the construction of 'otherness' and the culture of blame on those who are structurally disenfranchised. Despite the fact that from this perspective, HIV/AIDS was generally perceived as religious and moral evidence of one's wickedness, the accompanying stigma was social class-based. Iliffe (2006) argued that in Africa in general, the urbanised and more economically independent and affluent HIV/AIDS positive people suffered less humiliation than their rural and poor

counterparts. This becomes a class issue in which the rich HIV/AIDs positive people have social capital which they use to minimise damage on themselves unlike their poor counter parts (Altman 1988, Patton 1990). In this research study, examples of such views were also expressed by key informants SC1,5bM; ZW4F and ZW6M.

Some of the key informants (ZW1bM;ZW3F) could not be drawn to discuss the issue of the homosexual link to HIV/AIDS beyond its simply being viewed as the cause of the epidemic. Altman (1988, p. 33) dismisses the religious and moral crusade against homosexuals by arguing that 'homosexual activity' does in fact happen in both 'homosexual' and 'heterosexual' spaces. Like Altman(1988), Sontag (1989) and Ray (1987) regarded HIV/AIDS as a way in which the powerful West and more so the New Right seized the opportunity to struggle for dominance over the marginalised 'other'. The New Right manifested its agenda not only through religious conservatism but also through influencing a political ideology that suited their interests (Altman 1988). The New Right often used expressions like 'moral bankruptcy'[96] to capture the imaginations of the general populace. HIV/AIDS therefore was viewed as an example of such moral bankruptcy through sexual perversion. Similar ideas of sexual perversion and the dominance of western (white) colonial values have been highlighted by Jeater (1993). In the case of Zimbabwe, the state is used as the instrument through which such surveillance, judgement construction of preferred morality and legalizing punishment for the perceived transgressors is implemented. This practice is characteristic of the moral panic and construction of national order that was perpetrated in Thailand at the outbreak of the epidemic (Fordham 2001).

7.7.3 Religious Conflicts and Consensus

Key informants (SC3,4M;SC2M;ZW3M) described how the epidemic initially divided religious opinion with regards to the attitude towards those infected and affected by HIV/AIDS. Some of the religions went along with the extreme views taken by some members of the public and political establishment in that they

[96] This term was used to denote a lack of moral capacity which would necessitate making the right and acceptable moral decisions.

advocated for and participated in murdering those perceived to be living with the virus (Illife 2006).

Examples of the tensions that existed around the initial religious and moral responses to the epidemic included Catholics who held onto their beliefs that condoms are not acceptable because they were viewed as interfering with the natural law. In East Africa, a Catholic priest is reported to have refused to conduct funeral services for people who died from HIV/AIDS-related illnesses because they believed that that would be tantamount to condoning the religious and moral sin (Illife 2006). The Zimbabwe Catholic Bishops' Conference Pastoral letters (1991 -2005) took a clearly conservative view on condoms and were less prepared to engage with other denominations whenever they viewed such engagement as contrary to the 'official' teaching of the Catholic Church.

In a rather rare show of solidarity, 'in 1996 Cardinal Otunga and the Imam of Nairobi's central mosque jointly presided over a public bonfire of condoms (Illife 2006, p. 96). This of course was in stark contrast to the medical fraternity as well as the more accommodating religious groups who regarded condoms as a practical medical tool to fight the epidemic.

7.7.4 'The HIV Positive Body of Christ'

One of the key informants (SC3,4M) raised a very controversial and radical view of the role of religion and Christianity by arguing that if the people who suffer from HIV/AIDS are part of the body of Christ then Christ is indeed also 'HIV Positive'. While this view is still fairly new, the collections of contributions in Byamugisha's (2012) book are evidence of the move towards a new theology, ecclesiology and Christology. While the views of this book are shared by some, there still exists a considerable body of religious conservatives who find such a characterisation unpalatable to the way they understand and express their faiths.

7.7.5 Inter-Religious Cooperation

Beyond the initial shock and demonization of people living with HIV/AIDS, key informants (ZW3M;ZW3,5M) noted that at least in Zimbabwe, the World Council of Churches, ministers of religion, lay people, academics, NGOs, researchers, people living with and affected by HIV/AIDS and activists managed to get together to focus on a common challenge. These groups have since engaged in various activities to address the epidemic and to support those infected and affected in more open and robust ways (Byamugisha 2012).

It can therefore be argued that religion as such played a very ambivalent role: on one hand it demonised those with HIV/AIDS and on the other hand it provided a healing space for some (Chitando 2013). Several studies highlighting the ambivalent role have been carried out at in the UK (Anderson and Doyal 2004, Andrews 2004, Ridge, Williams et al. 2008).

7.8 A Cultural Critique of HIV/AIDS

7.8.1 Introduction

The cultural critique of HIV/AIDS in this section mainly draws from the findings in Zimbabwe although reference is also made to Scotland. The discussion on the Zimbabwe provides more examples of issues and narratives that arise from the complexity of the relationships between African traditions/culture, colonisation, missionary activities/Christian, western values and post-colonial experiences. In addition the demographics and population of Zimbabwe thereby contributing towards a wider range of HIV/AIDS narratives. In respect of Scotland, the population is much smaller but more importantly, the application of human rights and the faster and more robust responses to the HIV/AIDS epidemic reduced the spectrum of narratives that were developed.

7.8.2 Issues in Zimbabwe and Scotland

The post-colonial lens is relevant in articulating the cultural critique on how HIV/AIDS originated and developed in the colonised spaces of which Zimbabwe is

one. While 'culture' is a complex concept, it may be understood as 'the complex of values, customs, beliefs and practices which constitute the way of life of a specific group'(Eagleton 2000, p. 34). Eagleton also cites Stuart Hall defining culture as 'lived practices or practical ideologies that which enable a society, group or class to experience, define, interpret and make sense of its conditions of existence' (Eagleton 2000). Culture is related to nature in a relational way in that one depends upon the other in that human beings are just products of their environments but they also produce those environments, hence the tension between making and being made (Eagleton 2000).

The world 'culture' has also evolved as much as humanity has. Williams (1959) identifies various levels of understanding culture in the modern world. One level is that of civility which is linked to civilisation. The other level refers to manners and morals. This was very much connected to the general spirit of the Enlightenment (Williams 1959). The word 'cultured' also evolved to mean someone with high and superior tastes but this view is challenged in that it tends to communicate a dominating effect and does not recognise other experiences as belonging to the realm of culture. Such would be the attitude of the colonists in relation to the natives that they interacted with.

In terms of Zimbabwean culture, sex and sexuality are not public discourses. In terms of HIV/AIDS, strong links are made between HIV/AIDS and homosexuality, colonialism and missionary activity a point which Mugabe has highlighted as being 'un-African' and against 'our culture'. The anti- homosexual utterances above have been a source of controversy in terms of human rights and debates about the role of the church and state in matters of personal morality and sexual choice. In Zimbabwe the pro-government press continues to demonise homosexuality while the independent press tends to use the rather subtle approach that all Zimbabweans are entitled to human rights irrespective of colour, creed, religion, gender or other conditions. While Mugabe uses the anti-homosexual mantra as a cultural, political and nationalist tool, the opposition party leader Morgan Tsvangirai has generally treaded more carefully around the human rights issue although he has been quoted as denying them at times[97]. The

[97] http://www.telegraph.co.uk/women/sex/sexual-health-and-advice/8958520/Average-man-has-9-sexual-partners-in-lifetime-women-have-4.html accessed 06.02.2013

latter could be for political expediency given the controversy that surrounds the debate and the possible backlash from the main political establishment and the general electorate.

In Scotland, it is the popular media which pushes the liberal agenda but tended to single out homosexuality as responsible for HIV/AIDS. This view is of course becoming increasingly untenable as heterosexuals are equally responsible and at risk of transmission. According to The Health Survey Study for England published in the Telegraph published on 15 Dec 2011, one man has sexual intercourse with 10 or more partners of the opposite sex and women had sexual intercourse with an average of 4.7 partners[98]. These statistics maybe potentially higher and could equally be applied to Scotland.

Ranger has argued that what is termed 'tradition' is invented (Hobsbawm and Ranger 2000). He identifies two legacies of invented traditions namely; the one imported from Europe that continues to influence the ruling class culture in Africa today while the other is 'traditional' African culture re-invented during colonialism (Hobsbawm and Ranger 2000). Central to this argument is that traditions that are said and perceived to be African (or Zimbabwean for that matter) are not in fact that pure in form. They are products of interactions between traditional systems and practices and those imported from Europe via colonialism, missionary ventures and trade. This collusion of discourses sheds light on the controversy surrounding the homosexual connection of HIV/AIDS on various levels. A number of key informants argued that given that colonialism and missionary ventures brought with them the baggage of social misfits from the colonising country, it becomes problematic to identify the existence and scale of homosexuality in Zimbabwe prior to external influence and the role of colonialism, missionary ventures and trade in introducing and exacerbating homosexuality.

In Zimbabwe, Mugabe's stance of a pre-colonial and a pure uncontaminated Zimbabwean culture draws not only on his aspired ideals, but it is also informed by the colonial anti-Sodomy legislation which is based on the legacy of the

[98] http://www.telegraph.co.uk/women/sex/sexual-health-and-advice/8958520/Average-man-has-9-sexual-partners-in-lifetime-women-have-4.html accessed 06.02.2013

British law of 1861 which had in fact been used to arrest, try and imprison black African men found to have committed homosexuality (Epprecht 2004). In terms of Mugabe's stance, it seems fairly problematic in that one cannot easily disaggregate between the pre- colonial, colonial and post-colonial and similarly between pre- and post-independence. One way of characterising this is to say that 'one of the most poignant ways in which experience is reincarnated is through the tortured dichotomy, created by colonialism between men and women in neo-colonial times' (Ibrahim 1990, p. 85).

In his study based on court records, Epprecht (2004) argues that the majority of all prosecutions was of black African men. However, this evidence needs to be weighed against the general colonial racial discrimination which favoured the white colonial masters in issues of crime and the hostel conditions – the congested residential accommodation – where the African male labourers were forced into in the urban areas in order to provide cheap labour for the colonial establishment and their industries. Homosexuality was among other things precipitated by the socio-economic structures that demanded migrant labour yet placed men in over-crowded male residential compounds and then prohibited regular visits by their spouses to or from places of work to unite with families.

Dambudzo Marechera, a creative writer and a radical colonial and post- colonial critique, purports that Zimbabweans across the board have always engaged in different sexual practices other than heterosexuality. In his 1984 novel *Mindblast*, he portrays an erotic Shona (Zimbabwean) lesbian woman having engaged in a sexual encounter (Epprecht 2004, p.176). It is worth mentioning that although Marechera's views might not have attracted much attention before independence, once the post- independence euphoria started to wear off, there was a 'shift from the sexists, transphobic, mildly xenophonic humour and imagery to state-sanctioned backlash against sexual freedom..' (Epprecht 2004) as evidenced by the rounding up of suspected women prostitutes from the capital Harare and deporting them to camps in the rural areas as well as the closing down the gay men's activities in the city centre. Such brutality only stopped when the Spanish ambassador was murdered in 1986 in unclear circumstances connected with the gay repression (Epprecht 2004. p. 177).

While Marechera's perspective would have been seen by some audiences to be radical, one of the key informants who works as one of the officers at the Gay and Lesbian Association of Zimbabwe (GALZ) and a self-declared lesbian, in fact gave a more subtle analysis of how homosexuals were always part and parcel of the indigenous Zimbabwean culture and practice. She argued that 'traditionally, communities knew but did not talk about it – they didn't demonise it as we see today' (ZW4F). She gave the example of arranged marriages during the early days in order to take care of scenarios where one or both of the partners were homosexual because these were considered to be sensitive issues. She claimed that the traditional elders had mechanisms of knowing and therefore organised with the relevant aunties and uncles to make the discreet arrangements where the younger brother could move in to father kids on behalf of a homosexual elder brother who due to his sexual orientation would not have sexual intercourse with his wife. This was done because tradition took care of these situations because married people were always perceived as 'couples with children'.

However, the situation with lesbians was different. She explained how it was considered easier to 'exploit' the women as they were simply impregnated with or without their consent in order to cover up for the possible public interrogation for explanations. The idea was just to keep the whole discourse as subtle and normal according to the traditional communities' perception.
In the same interview, the respondent also recalled anecdotally an interview she had had with one traditional elder who confirmed the existence of homosexuality from times immemorial among the indigenous populations in Zimbabwe (ZW4F).

ZW4F's conclusions from these observations were that the major reason why homosexuality was not initially factored-in in respect of it being a 'normal or natural' cause for HIV/AIDS was because so doing would have legitimised the existence of something that has been continually denied and suppressed in Zimbabwe. This is why the politicians in particular tended to deny it especially in the 1980s due to its link to homosexuality.

The logic of ZW4F's argument is that homosexuality was allowed to exist with self-censorship although this seems to contradict the evidence given by Epprecht above (Epprecht 2004). The contradiction may lay in part from the fact the interviewee was arguing from a point of normalising homosexual practice among the Zimbabwean indigenous populations while Epprecht based his findings on colonial court records which on his own admission contained some ethnic, racial and statistical bias (Epprecht 1998). When asked to explain about the colonial anti-sodomy legislation, the key informant (ZW4F) shifted position and instead saw that as the influence of Christianity on the colonial establishment, maybe again reflective of the collusion of the two discourses. The particular key informant's (ZW4F) line of thinking is that there was traditional family consensus as long as it was kept discreetly within but the verification of such assertions remains debatable. The silence that circumscribed these practices raises questions about the legitimacy of the homosexual practices per se although the 'moving in by the young brother' practice is widely recognised as normal practice even by some current indigenous Zimbabweans. The latter is a challenge that many HIV/AIDS practitioners and organisations are battling with in combating HIV/AIDS (ZW4F).

The view that homosexuality existed in Zimbabwe was also acknowledged by Prof Gordon Chavunduka, the former president of ZINATHA (Zimbabwe National Traditional Healers' Association) argued that

> *homosexuality is a mental problem that can be treated with traditional therapies. He also argued that the primary reason why homosexuality was banned traditionally was because it had no potential for procreation. He also argued that African cultural ethos were under threat owing to the proliferation of alien cultural practices, largely borrowed from the West* (Gunda 2010, p.443).

If it is granted that homosexuality was permissible under the above conditions of silence, it follows that going public about one's homosexuality would be an infringement of the traditional community expectations. This raises an interesting point about how those who currently seek to go public about their homosexuality and demand that as a question of human rights find themselves

being suppressed and punished. Because they are viewed as perpetrators who are undermining the social establishment, their cause does not win the sympathy of some of the Zimbabwean traditionalists, the government and its political institutions.

7.8.3 Cultural and Political Implications

Some of the key informants (SC3,4F; ZW3M) referred to the origins of HIV/AIDS as a 'punishment' from God or the ancestors while other disputed it (SC3,4M; ZW6M). As Iliffe (2006, p. 97) suggests HIV/AIDS

> *was only part of a wider crisis afflicting the late twentieth-century Africa, a crisis combining destabilisation of indigenous cultures with the failure of the modernisation expected after independence.*

The above citation very much reflects the tensions circumscribing the Zimbabwe Liberation War theory which in part suggests that HIV/AIDS might have originated from the potentially 'reckless'[99] sexual behaviour of the freedom fighters (Nhongo-Simbanegavi 2000). The counter argument given by one of the key informants is that given the independence euphoria such a view could not have gained any currency at the time despite the fact the end of the liberation war in Zimbabwe also coincided with the first cases of HIV in the country (ZW3,5M).

The religious and moral views of the origins of HIV/AIDS were often cascaded into cultural and political issues in that they led to conversations of what constitutes acceptable and non-acceptable morality. What are the differences between private and public morality and how can they be resolved? Key informants (ZW6M; ZW3,5M; SC1,5bM) indicated that the HIV/AIDS epidemic often got embroiled in cultural and political debates, issues which have framed the way in which the epidemic has to a great extent been addressed.

[99] The word 'reckless' here is used to denote the selfish way in which some freedom fighters wanted to fulfil their personal sexual desires and egos without consideration the wider implications on those upon they sexually forced themselves on or negotiated to have sex with.

One of the wider implications of the religious and moral views regarding the origins of the HIV/AIDS epidemic was that it shifted the locus of the power of medicine in terms of health and disease in that no medical explanations were available and neither could science provide a satisfactory explanation to HIV/AIDS at the beginning of the epidemic. This is not a new phenomenon in that in the 14th century, Black Death was explained by Religion as God's punishment on Christians and on the other hand doctors resorted to mysticism in order to understand the inexplicable cause of Black Death (Altman 1988). As some key informants testified, this was a case in which modern medicine has in fact found itself working alongside religion within a curing and healing context (ZW2F; ZW3,4M; SC2M). To that effect, key informants in both Scotland and Zimbabwe testified that their role and involvement within the HIV/AIDS arena is now much more pronounced than ever before (ZW1aM; ZW3M; SC1,5bM; SC3,4M).

7.9 Implications for Sex Education

In the preceding sections I highlighted Foucault's main themes in the history of sexuality as well as some of limitations of his analysis. I also described how sexual deviance can be understood within the broader theory of deviance and how that is a useful precursor in locating the current debate on how to engage with issues relating Sex Education in the western society.

Sex Education within the west has been punctuated by controversy in terms of why it should be taught, if it is to be taught when to start to teaching it, the mode of teaching it and the content of the curriculum(Beck 1999, Halstead 1999, Eagleton 2000, Beck 2001, Steutel and Spiecker 2004). Liberal western society is broadly constituted by people of all faiths and none. Within the faith groups, there are different beliefs and values based on religious founders, texts or other sources while those who do not adhere to any faith also hold beliefs and values but they are not necessarily religious. Both categories argue that the values which inform their perspectives on sex education are derived from their moral philosophies although there is no agreement on which system of morals should be used to determine issues around sex education. I will explore three levels on which the controversies rotate namely the state, religion and moral philosophy. There are nonetheless instances in which the three levels intersect

but the various stakeholders disagree in terms of the best option to adopt. One of the more recent driving forces in teaching sex education has been the rise in sexually transmitted diseases among young people as well as the fear of the impact of HIV/AIDS.

In Scotland for example, Sex Education is part of Relationships Education enacted legislation (Savage 2007). The history of the Scottish legislation on Sex Education dates back to times before devolution in 1999. Within Scotland, although guidance exists, there is no universal legislation that requires a specific Sex Education curriculum to be delivered across all schools. Catholic schools for example have their syllabus while other schools raise the issues of sex education in Science or in citizenship education (Savage 2007). The argument is that the state has the right to ensure public morality through appropriate sex education (Steutel and Spiecker 2004). Steutel and Speicker are however cautious in their recommendation of the role of the state as they consider it necessary only in so far as it ensures the moral growth of the child as well as cultivating particular moral attitudes. Given the western liberal culture, different forms of media have changed the public and indeed the young people's view on what is and what is not sexual behaviour. The sexual revolution has also been significantly impacted upon by some extreme feminist views which purport that women are free to dispose of their sexuality as they wish including refusing sex even within legitimate conjugal relationships.

One way in which the sexually liberal values have been challenged is by making a distinction of arguing that if sexual mutual consent exists then it is morally permissible. One sense of morally permissible entails moral acceptability and legitimacy whereas the second one implies that one is entitled to exercise a right. The second sense can sometimes pose a problem as when someone exercises their legal right to vote for 'a political party with morally repugnant manifesto' (Steutel and Spiecker 2004). Although Steutel and Speicker argue for the involvement of the state, they are also clear that the state has no jurisdiction in the sphere of private morality as exemplified by their discussion on homosexuality where they argue that the state has the duty to ensure that there is mutual respect among people of divergent beliefs and values.

While the role of the state is one that functions at a macro level, Jan Steutel also makes the case that at the micro level, it is parents as adults who are capable of making informed consent. While he does not deny the fact that children have welfare rights, he disputes the competence of children to make the morally right sexual decisions(Steutel 2009). This position is one which resonates with his position in relation to people with 'mental retardation' where he argues that there is scope for reasonable paternalism (Steutel and Spiecker 2002). Lack of unanimity on the issue is in part due to ongoing medical, legal and other explorations on the most appropriate way of set of principles to guide action.

The second strand that claims a stake in Sex Education is religion. Two points are important here. There is a range of views within each of the religious faiths and there are also notable differences between one religious faith and another. An example of the first might be Catholics and Anglicans. Within each of them, there is a range of beliefs with regard to sex education in terms of what should and what should not be taught. The more conservative Catholics and Anglicans oppose homosexuality and same sex relationships whereas the more radical are more tolerant. There are of course those Catholics and Anglicans who sit on the fence or hesitate to make their opinions known (Callegher 2010, McDonough 2010). Callegher (2010) argues that young liberal Catholics increasingly find issues of sexuality very controversial and McDonough on the other hand argues that often teachers defer controversial religious issues like sexuality and homosexuality in particular to the homes of learners.

While the state and religion are key players in providing guidance around sex education within the western liberal context, moral philosophical engagement seems to offer a more rational and sustainable approach. One observation is that there is some general agreement about morally acceptable and morally unacceptable sexual activities. Examples of these may be paedophilia, necrophilia and zoophilia. While general agreement maybe a reflection of liberal democratic values, there is always a danger of viewing majoritarian views as unanimity since the very same western liberal democratic framework also propagates the rights and protection of minority views (Beck 2001). The advantage of a moral philosophical approach is that it encourages both those

who hold majority and the minority views to engage in logical discourse about sex education without prejudice (Beck 2001).

In an editorial article Reiss cites James Sears as arguing that one way of engaging with the controversies surrounding sex education is to embark on a comprehensive multicultural curriculum in order to develop what he calls 'a critical sexual literacy (Reiss 1997). That curriculum would be based on four models of tolerance, diversity, difference and *differance*. My response is that although the suggestion sounds tenable, similar models have been used in terms of race equality and tolerance but current evidence suggests that the issues remain problematic both within and outside schools. It is also not clear that given the extreme tensions around homosexuality and other less acceptable sexual preferences, such a curriculum would provide a panacea for those challenges. What is clear is the fact that research 'has highlighted the complexity of human sexuality and shown how different assumptions about the nature of sexual orientation may influence research findings' (Halstead 1999). To that end, Halstead recommends that schools should adopt a neutral stance in order to deliver sex education across the diverse range of its students which presupposes that the teachers themselves would have worked through a clear and morally justifiable methodology for delivery of the material.

Given that there is ongoing contestation surrounding Sex Education, there is need to explore more innovative ways of engaging with it. One such approach has been suggested by Morris (1997) who argues that on the basis that by their very nature, young people are dynamic, creative and reflective. He proposes allowing the young people to take the initiative, contribute and participate in their own sex education as an alternative to the dominant myths of delivering sex education (Morris 1997). He does not use

> *the popular usage of myth as falsehood or illusion…(but) myth in the sense of narrative, paradigm or vision (*Morris 1997,p.353).

Morrison (1997) argues that such an approach has the great potential to engage both the teachers and students of the subject (Morris 1997). Such an approach

goes beyond information only, and emphasises the importance of values, attitudes, decision-making and general communication skills (Morris 1997).
He starts by giving a critique of what he calls the utilitarian-missionary myth which conceptualises Sex Education as a way of ascertaining positive behavioural results from young people. He argues that this perception is based on the archaic missionary motif that if you evangelise among people you will save them from sin and punishment from God. Such a view, he argues is too functional and narrow-minded to the extent of not considering the complexity of human behaviour both young and adult. Instead, Morris presents his argument in the form of three narratives of the *Parable of the Detached Parent*, *The Gifts of the Magi Story* and *The Don Juan de Marco story* to represent the alternative ways of engaging with Sex Education for the young people (Morris 1997). The first narrative is offered as an alternative to the saviour-rescuer utilitarian myth. In this narrative, Morrison explains how a young boy packs his bags with his special belongings and leaves home. His parents on the other hand do not directly intervene but watch him form a distance as he sojourns, plays with other children and ends up coming back home. The essence of this narrative is that his parents are not necessarily unconcerned about their son but they give him space but they are indeed concerned about his welfare. Morrison applies this narrative to Sex Education in that it is not only about delivering information about sex and sexuality as a useful component of Sex Education, but it clearly needs other less-patronising and singular approaches in order to enhance a real change of attitudes, behaviours and generate sustainable values among the stakeholders.

The second narrative is about a young couple who trade in all that they have in order to demonstrate their love to each other. In the context of Sex Education, Morris emphasises the importance of value beyond use. In real terms, exposing young people to Sex Education is of critical importance rather than trying to measure the outcomes of the delivery. Morris notes that in terms of Sex Education,

> *This kind of self-understanding … is extremely valuable. It can make a qualitative difference in a person's life since it addresses concerns relating to one's very identity* (Morris 1997,p.358).

This narrative is based on how objections and actions become valuable even if considered to be worthless. In terms of Sex Education, issues that might be considered valueless might in fact be critical for young people in terms of their curiosity about their sexuality and sexual experiences. This is why I think Morris makes an interesting case for his methodology which is grounded on the premise that

'*narratives have a wonderful capacity to express a depth of insight not easily communicated through formal arguments*' (p354) as well as ' *the pervasiveness of the beauty of the myth and its power to influence young people'* (Morris 1997).

In this way sex education will

> *place a premium of artistic expression, exploring sexual questions and issues through poetry, theatre, dance and song. In other words, sexuality education becomes embodied, imaginative, joyful and celebrational* (Morris 1997).

I think that Morris makes a valid point around capturing the learners' all-round potential in engaging with Sex Education as a necessary yet controversial subject both within and out of school. His emphasis on the learners places a sense of ownership as well as a sense of valuing that which is taught.

The third narrative is based on the story of Don Juan de Marco, a clinical psychiatrist and his younger suicidal client. The significance of this narrative is that it emphasises the fact that Sex Education need to critically reflect on their own experiences and personalities in their own roles so that they appreciate the complexities of delivering on a subject that draws on emotional, experiential and other contexts in a sensitive and discursive subject like Sex Education.

In the developed world to which Scotland belongs, one might argue that the dominant perceptions around HIV/AIDS may be summarised by the old-age adage that 'although the battle with HIV/AIDS has been won (through the success of ARVs), the war is still not over'. Such narratives are salient in the more recent

Scottish Government official documents *Respect and Responsibility: Strategy and Action Plan for Improving Sexual Health* 2005; 2006; 2007; 2008 as well as the *HIV Action Plan in Scotland December 2009 to March 2014.* In the Respect and Responsibility documents, mention of HIV/AIDS is very minimal and where reference is made the emphasis is on men who have sex with men (MSM), bisexuals and migrants from Africa. Overlapping these characterisations is the mentioning of the overall success of ARVs in managing the epidemic. One resultant effect is that HIV/AIDS as a health condition in its own right seems to have disappeared from the health priority radar as stated on p.2 of *The HIV Action Plan in Scotland December 2009 to March 2014* has resulted in inconsistent responses to HIV prevention and mixed methods of care across Scotland.' Although the latter document demonstrates a renewed commitment to re-engage with the epidemic in a more robust manner, both earlier and current HIV/AIDS policy documents revolve around selecting and targeting MSM, bisexuals and populations of African origin. While there might be some epidemiological sense in this approach, given the complexity of sexuality and sexual relations and human interaction, one wonders how much is done to consider the potential impact of the epidemic on the local indigenous Scottish populations. The signage on most of the information and campaign materials against HIV/AIDS in Scotland (indeed the rest of UK) depicts to a great extent the categories of the target groups mentioned above.

The current focus of the HIV/AIDS policy development in Scotland has more recently (from 2006 onwards), broadened to involve faith groups, ethnic minority groups, parents and schools. Many of these will draw on a diverse range of pedagogies and media from traditional methods to more creative and innovative ones like music and drama (Scottish-Government 2007). Despite these developments, controversy still exists in terms of the content and context of delivery especially along faith-based and cultural priorities of the different stakeholders. For example, the Catholic Church requires that their particular curriculum be taught within their own schools and rule out certain aspects that are taught in other schools (Savage 2007). In that regard, Catholics consider sex as permissible within a marital relationship and for procreative rather than recreational purposes. Within the Catholic tradition, there is a long history of specifying when and what forms of sexual encounters are permissible (Brown

1988). This prescriptive theological position has formed the basis of the Catholic perspective on Sex Education. Contestation was demonstrated for example by Section 28 of the Scottish Local Government Act 1988 about which Catholics argued against what they perceived to be promoting homosexuality and same-sex relationships. What makes the Catholic viewpoint distinctive alongside other church groups who share the same sentiments is the fact that they uphold what some people view as conservative views of sex, relationships and marriage based on heterosexuality. This is at the expense of equally recognising other forms of relationships and the expression of one's sexuality in for example unmarried heterosexual relationships, same sex relationships, stable long term gay and lesbian couples, masturbation and other forms of sexuality considered 'bad' or 'sinful' (Savage 2007).

The Catholic opposition of homosexuality and the concomitant 'bad' and 'sinful' sexual activities is also shared by some non-Catholic Christians, Jews, Muslims and Sikhs (Beck 1999). Beck begins his article by highlighting the pertinent conclusion of Patricia White's paper on Parents' rights, Homosexuality and Education (1991):

> *As I read Ruse's Homosexuality with its dust jacket facing fellow passengers, there was much frowning and tutting on the Northern Line of the Underground*.

The argument that Beck(1999) pursues is that it seems to be the case that there is generally less support by Catholic as well as other non-Catholic religions who consider homosexuality and other sexual practices as unacceptable. What emerges from this is the fact that there are at least two polarised positions: one which argues for a more 'traditional and conservative' perspective and another which argues for the alternative sometimes described as being 'liberal' in that it diverges from the historically perceived normative position. Attempts to reconcile these two positions have proved difficult with the conservative view claiming primacy and accuracy, while the liberal position lays claims to authenticity based on the logic of the consistence of holding on to more than one conception of sexuality. Beck (2001) has cited theorists such as Foucault and Weeks as arguing that homosexuality is a social construction that is intended

to control sexuality through various institutions like medicine, the prison, the school and others. Given that the current HIV/AIDS epidemic is also circumscribed by issues of homosexuality, it goes without saying that any HIV/AIDS policy initiatives become entangled in the religious-medical and political discourses.

The way forward therefore, is to think more creatively around how to embed HIV/AIDS Education within Sex Education. The first step is obviously to recognise the history of the debate around Sex Education. This is important in mapping out what have been the major points of agreement and disagreement. I also contend that the fact that there has been and continues to be debate is itself useful in moving towards a more informed and richer approach to Sex Education. This study considers use of a philosophical approach as both a critical and necessary heuristic lens through which the contestations can be clarified and used to generate a more sustainable Sex Education programme. The use of a philosophical approach is one which Conroy *et al* has already aptly argued for (Conroy, Davis et al. 2008). By challenging the dominant status quo, possibilities for a more transformative approach will be created. This of course will be done alongside other existing working schemes.

It is important to introduce Sex Education on at least two levels namely, within the formal school setting and secondly as part of the public discourse through various media. This two-pronged approach will facilitate all stakeholders to engage with how narratives are constructed around HIV/AIDS policy. Part of that exercise will examine the processes involved and the texture of the language that is used and more importantly the kinds of messages that those HIV/AIDS policies communicate.

The approach taken in Zimbabwe is to foreground in an increasingly explicit way the need to make HIV/AIDS a public concern as can be seen on bill boards and the recent parliamentary commitment to take a lead on HIV/AIDS testing and counselling[100]). Within the Zimbabwean Education system, there is positive evidence in terms of the literature that has been developed for use in the schools. Examples of these include: The *Girl Empowerment Movement (GEM):*

[100] (http://allafrica.com/stories/201203030197.html accessed 6.03.12

Resource Pack for Zimbabwe (UNICEF – Harare, 2010), *Boys Empowerment Movement (BEM) Resource pack for Zimbabwe* (UNICEF-Harare, 2010), *Think About It! An AIDS Action Programme for Schools* Series (UNICEF – Harare), *Let's Talk: An AIDS Action Programme for Schools* Series (IUNICEF-Harare), *HIV/AIDS & Life Skills Education Secondary School Syllabus Form 1-6,* Curriculum Development Unit, Zimbabwe Ministry of Education, Sport & Culture, Harare, 2003.

The above resources are not only evidence of the government's commitment to engage with the epidemic at an early stage of the young's people's education and exposure to the epidemic, but it also provides a useful starting place for both learners and educators.

There are a number of distinctive features in the above resources. For example, the titles themselves are telling: they emphasise the following: '*empowerment, talking, thinking, action, life skills, resource and movement'.* In terms of their content and methodology, they are inter-active, participatory, learner-centred, exploratory, signposting, engaging with and deconstructing myths, discussion of Sex Education in the wider social contexts, highlight the importance of children's Rights and most importantly provide other relevant reference literature from a variety of areas that young people find user-friendly and meaningful.

However, as commented by some of the key informants, the existence of these useful resources are more of a reflection of the policy rather than the practice (ZW3,5M; ZW3F, ZW1aM; ZW5F;Zw4,5M). Another observation was that while these resources do exist there is a tendency in most schools that because they HIV/AIDS and Sex Education are not examinable like other 'academic' subjects, it is often left to individual teachers or to school heads to ensure that it is delivered. Some teachers and indeed some learners have tended to prefer using the HIV/AIDS and Sex Education time-table slots for covering material in the examinable subjects (ZW5). As a result, there is little evidence that demonstrates that the learners and educators have been actively involved in evaluation the efficacy of these resources. Similar observations have been documented in South Africa although the reasons for the latter were more informed by their apartheid legacy (Wood 2014, Wood and Rolleri 2014).

In Zimbabwe, the other challenges that affect the effective delivery of HIV/AIDS and Sex Education arise from the cultural tensions between the fact that issues of sex and sexuality are not public discourses on one hand and the educational imperative to deal with an issue which is of contemporary health importance within the schools and other fora rather than assume that this would be dealt it within the traditional settings of the home which in any case have been affected by modernisation of society. Alongside these challenges is the ambivalent role of the different churches in Zimbabwe. The teachings on Sex Education vary between the Catholic Church, the (traditional) Protestant Churches and the newly formed African Independent/Evangelical/Pentecostal Churches (Chitando and Gabaitse 2008, Chitando 2013).

It is however important that these very public initiatives and others need to be tweaked in order to fit the current milieu. Despite the arrival of ARVs, public perceptions of HIV/AIDS in Zimbabwe are still replete with non-medical narratives like witchcraft (Rödlach 2006), faith-based demonising of those living with HIV (Chitando and Gunda 2007, Chitando and Gabaitse 2008) as well as the recurrent controversies of linking homosexuals to the origin and spread of HIV/AIDS, HIV/AIDS as being part of a western imperial agenda, un-African (against 'African' culture) and being anti-Christian (Mathuray 2000, Phillips 2004)[101]. The Zimbabwe HIV/AIDS community-based initiatives are not always in tandem with the pronouncements that come from the traditional (cultural), political, faith-based and medical leadership. While these pronouncements are sometimes issued by one of the above leadership strands, at other times they are conveyed as collective positions shared by more than one. For example Mugabe often plays the role of the supreme politician as well as the custodian of Christianity, culture and civilisation[102].

In the light of the above observations, HIV/AIDS and Sex Education remain a challenge that characterises the discourse. Part of the reason for the challenge is the fact that there is a continual contestation of spaces of power to control

[101] http://www.dailymail.co.uk/news/article-2106720/Robert-Mugabe-rambling-anti-homosexual-rant-David-Camerons-global-gay-rights.html (accessed 15.03.2012)

[102] Chikova, L. (2013). Vote Peacefully. The Zimbabwe Herald. Harare, Zimpapers: 2.

and manage the epidemic between the government (through the various Ministries, notably Education and Health), the NGOs (both local and international), traditional leadership, HIV/AIDs groups and the various community groups. These tensions however remain part of the main the drivers of change for developing a transformative approach to HIV/AIDS Education.

7.10 Transformative Approach to HIV/AIDS Education[103]

Transformative Education is a discourse that has been developed over the years. Central to it is the idea of challenging assumptions, critical reflection and making meaning about one's beliefs, assumptions and experiences (Mezirow 1990, Mezirow 2003). In this thesis, a transformative approach to HIV/AIDS Education entails a critique of the major cultural, media/popular, biblical/theological and political myths and narratives that circumscribe the HIV/AIDS epidemic (Wood 2014, Wood and Rolleri 2014) in both Scotland and Zimbabwe[104]. The transformative Approach is essentially about the

> *critical-dialectical discourse - the intersubjective process of communicative learning…* (Mezirow 2003,p. 58).

Essentially, transformation is about questioning the status quo, reflecting on alternatives and endeavouring to validate new and progress experiences. The impact of such an exercise is that it leads to

> *the expansion of consciousness and the working toward a meaningful integrated life as evidence in the authentic relationships with self and others* (Boyd and Myers 1988,p. 261).

Given that the HIV/AIDS epidemic has led to the construction and scapegoating of otherness- especially the homosexuals, the poor and migrants – a transformative approach of HIV/AIDS Education enables looking beyond the usual explanations and making sense of otherness, *critiquing the exclusionary and discriminating discourses* of HIV/AIDS *(*Wood 2014) to engaging in critical

[103] The term HIV/AIDS Education will be used alongside Sex Education although I do recognise that the former is part of the latter and that the latter is much broader than the former.

[104] Some of these myths and narratives also apply to other parts of the world

conversations that bring about more sustainable ways of conceptualising and responding to the epidemic.

A transformative Education Approach does not necessarily imply a singular alternative to the status quo, but it recognises multiple possibilities. In this case for instance, developing a transformative approach to HIV/AIDS in Scotland will not necessarily be the same as that which is developed in Zimbabwe because of the unique socio-cultural contexts, different histories, varied demographics and multiple complex health dynamics each of them have experienced. As such, the different interest groups will try and promote their own vision and versions of HIV/AIDS and Sex Education. Examples of these might be that the Catholics offer their own while the Protestants offer different ones, the State might also offer their own and other cultural and interest groups might also lobby their own. Such diversity becomes part of the transformative dynamism that characterises the development of the HIV/AIDS Education.

Part of what underlies these various contestations is the Foucauldian discourse of power which I discussed in Chapter Two of this thesis. In this regard, the type of HIV/AIDS and Sex Education to be implemented will depend on the interplay of power between the various stakeholders described in the above paragraph. Underpinning these power dynamics are for examples the cultural tensions that circumscribe issues of sex and sexuality in Zimbabwe. ZW2F argued that the traditional role of aunts and uncles has been eroded by modernity and young people now have to depend on Sex Education delivered by their teachers in schools. She also mentions that despite this new development, the rural-urban divide tends to disadvantage rural children in terms of resources as well as the rather conservative traditional set up in the latter.

Within a Freirian (Freire 2000, Freire 2004, Wood 2014) context, transformative education is by itself emancipatory and participatory. Taylor (2008) identifies at least three key features of transformative emancipatory education which can be argued to fit within the framework of the Zimbabwean Sex Education documents described in Chapter Six of this thesis:

> *First is the centrality of critical reflection, with the purpose of rediscovering power and helping learners develop an awareness of agency to transform society and their own reality. Second, a liberating approach to teaching couched in acts of cognition not in the transferal of information is a problem-posing and dialogical methodology. Third is a horizontal student-teacher relationship where the teacher works as a political agent and on an equal footing with students* (p.8).

Developing a transformative HIV/AIDS Education involves a critique of the existing Sex Education curriculum, content and method of delivery, examining its contextual relevance, exploring the capacity of those who deliver it and influencing other stakeholders in order to ensure a successful uptake of the programme.

The above demonstrates that while some progress has been made in responding to the HIV/AIDS epidemic and policy frameworks have been put in place, the challenge that exists is how these initiatives are delivered in a transformative and emancipatory way (Pietrykowski 1996, Freire 2000, Freire 2001, Freire 2004). Conspiracy theories, stigma and discrimination still underpin the HIV/AIDS discourse in both locations.

7.11 Concluding Remarks

In this chapter, I have discussed and analysed the finding based on key informant responses as well as selected policy documents. I have also demonstrated the similarities and differences between Scotland and Zimbabwe. While modern bio-medical explanations of the origins and spread of HIV/AIDS have been presented, I have also highlighted the impact of conspiracy theories which are grounded in certain popular and cultural perceptions. I have ended by examining some of the current debates around Sex Education and suggested some of the ways in which this might form a basis for a transformative approach to HIV/AIDS Education.

8 CHAPTER EIGHT – CONCLUSION

8.1 TRANSFORMATIVE APPROACH TO HIV/AIDS EDUCATION

8.1.1 Introduction

In this thesis, I set out to investigate how to create a transformative approach to HIV/AIDS Education in Scotland and Zimbabwe. The data from the field work produced a number of key themes which are linked to each other in one way or the other. In this final chapter, I would like to draw out some of the key themes discussed in the previous chapter and how they form the basis for constructing a framework for a transformative HIV/AIDS Education. Although I select some of the themes, I am not suggesting that those I do not discuss here are not important but they in fact all feed into each other in various and complex ways. I will use Religion and gender as templates for suggesting how a transformative HIV/AIDS Education can be developed.

8.1.2 Summary of Selected Themes Discussed

From the data collected, Religion provided a context for understanding the origins, development and responses to HIV/AIDS in both Scotland and Zimbabwe. The views ranged from those of key informants, popular and other media as well as selected key policy documents. It is important to note that although I used the term 'Religion' in the singular, its application is in fact much more nuanced in that it covers, African Traditional Religions (in the case of Zimbabwe), various forms of mainstream Christianity like Roman Catholicism, Presbyterianism and the Evangelical/Pentecostal religions. Within each of those Religions, there also continua of the more conservative on the one hand and the radical/liberal on the other. Religious viewpoints about HIV/AIDS were not necessarily expressed by adherents to those faiths but they were sometimes also expressed by observers of those religions. While no specific focus on Islam was made in this study, their religious views resonate with those of the other religions in many ways (Esack and Chiddy 2009).

In Chapter 7, I have already indicated the ambivalent role that Religion plays in that on one level, it provides a safe space for those suffering with HIV/AIDS but on the other hand it is also instrumental in stigmatising them through moralising and profiling the apocalyptic messages of the HIV/AIDS as punishment for sin and the end of the times. Religion becomes a contributor to the conspiracy theories of blame. For example, the position of the Catholic Church against the use of condoms in preference for abstinence becomes untenable in the face of the absence of a cure for the HIV/AIDS epidemic.

The intersection of religion and gender requires a deconstruction of how HIV/AIDS is not only an epidemic that capitalises on the powerlessness of those who in most cases cannot negotiate safe sex or sustain their own livelihoods, but it is disproportionately skewed towards masculinity which reproduces patriarchal sexual dominance yet it is the women, the girl child and the female prostitutes who bear the most brunt of the ravages of HIV/AIDS (UNAIDS 2010). Alongside such challenges are the systemic discourses of migrant labour, access to ARVS, Education, support and services particularly in Zimbabwe. Within Scotland, the latter often present themselves to migrants whose immigration issues take precedence over issues of HIV/AIDS. A transformative HIV/AIDS Education needs to take cognisance of these challenges which are often necessitated by religious and gender biases. Going beyond these biases enables reconfiguring new strategies that empower service users, policy makers and those in leadership positions to pursue more sustainable approaches.

I will suggest some of the ways in which a transformative HIV/AIDS Education can be developed beyond the current status quo. One way is to build on the emancipatory pedagogy initiated by Paul Freire (Freire 2000, Freire 2001, Freire 2004) and Mezirow (Mezirow 1990, Mezirow 2003). Freire and Mezirow argue that transformative learning is a critical process. In terms of HIV/AIDS Education, this would involve a positive change of behaviour, exercising the power to test, living with sero-positivity, having a greater awareness of the epidemic, recognition of the gender disparity and mutual respect for each other (Jewkes, Nduna et al. 2007).

Another one is to take on board the feminist critiques of Foucault on sexuality offered by the various authors (McFadden , Sawicki 1991, McNay 1992, Ramazanoglu 1993, Deveaux 1994, Butler 2002, McFadden 2005, Lennox and Waites 2013). Central to their critiques is how Foucault tends to be silent on the dominance of the social constructions of gender which compromise women's potential to define and assert their own sexuality. While some women have already started to challenge the status quo, a transformative approach would facilitate and expedite such a reflective and radical process which not only looks at masculine dominance, but also addresses the colonial and post-colonial emancipation as mechanisms of extricating themselves from the current inhibiting *sexual cul de sacs* (McFadden 2005).

As I indicated above, the intersection of religion and gender reinforce the exploitation of women in general but it makes it worse in the blame game of HIV/AIDS. It is to this end that engaging with all religions in so far as they associate themselves with specific sexual mores that align themselves to particular values of civilisation and globalisation becomes imperative. Given that 40% of all AIDS care is provided for by religious groups (Esack and Chiddy 2009), religion has the power and the capacity to shift the locus of the current gender oppressive HIV/AIDS discourses through advocacy, Education, Policy and empowerment strategies that align with the MDGs (Kim, Lutz et al. 2011).
One of the key principles of the transformative approach to Education which can be applied to HIV/AIDS is

> *the expansion of consciousness and the working toward a meaningful integrated life as evidenced in authentic relationships with self and others* (Boyd and Myers 1988, P.261).

While HIV/AIDS has tended to stigmatise those living with and affected by the epidemic with the self, a transformative Education will create the possibilities of coming to terms with the condition as well as to relate to others within the community. Evidence of such change is demonstrated in the *Stepping Stones Programme* successfully rolled in many parts of Africa (Jewkes, Nduna et al. 2007).

Mezirow (1996) also argues that transformative education involves

> *learning …as the process of using a prior interpretation to construe a new or a revised interpretation of the meaning of one's experience in order to guide the future* (p.162).

This very much resonates with Pietrykowski's argument around power and knowledge in which individuals construct complex ways of understanding their lifeworld. So, despite the construction of *otherness* and the stigma around people living with HIV/AIDS, a transformative Education approach enables the critical occupation of multiple positions that change their plight for the better (Pietrykowski 1996).

Apart from the intersection of religion and gender, a transformative approach to HIV/AIDS Education also entails a radical approach to Christian hermeneutics. As discussed in Chapters 6 & 7 of this thesis, such critical work has already been initiated by Byamugisha et al (2012) by calling for a reflection on whether or not the Body of Christ is HIV positive and how new ecclesiological Christologies are to be pursued in the context of HIV Positive communities. Using this similar type of radical shift, believers of various faiths and none would be able to interrogate how their belief systems go beyond the traditional understanding and can provide a richer resource and interpretation of the epidemic.

Within the formal education settings, at least two important points emerge. First, Wood and Rolleri (2014) argue that one of the reasons

> *why sexuality education seems to have had little impact on sexual risk-taking is that existing curricula have neglected to take account of the complexity of the social, cultural and gender norms that influence behaviour of school-going young people in sub-Saharan Africa* (p.525).

Their findings are based on research in poor resource settings despite the anomaly that it is in such settings that HIV/AIDS tends to thrive as compared to better-resourced contexts. While poverty is a major determinant in this instance, it is also accompanied by lack of a consistent and well- managed policy

framework, clear guidance and a profound understanding of the required practical initiatives.

The sequel to this is the broader issue of how ill-prepared pre-service and in-service teachers are in effectively delivering HIV/AIDS Education. Wood and Rens (2014) point towards the kind of 'AIDS blindness' that exists among student teachers in a well-resourced mostly white middle class university setting. The same could be extrapolated to apply to some of the Scottish schools. While the qualitative data from that research demonstrated substantial lack of knowledge about how best to embed HIV/AIDS Education beyond a bio-medical approach, there was also evidence of the need to engage with student teachers so that they may understand the multi-layered and nuanced nature of epidemic before they can effectively communicate it to their students. Engaging with the 'AIDS blindness' at tertiary level is imperative. Similarly, classroom-based initiatives, community-based activities and constant engagement with policy at all levels are also required.

In this thesis, I have also discussed the use of narratives as a way of understanding the origins and the responses to the HIV/AIDS epidemic. The increase in the use of narratives as part of qualitative research is not only gaining increased momentum within the social sciences (Andrews 2004, Riessman and Quinney 2005, Kruger 2006, Squire 2008) , but Jewkes, Nduna et al (2007) have also argued that the *Stepping Stones Programme* are a proven tool that has used the HIV/AIDS narratives of the participants as part of the qualitative data that is indicative of contributing towards a transformative approach to HIV/AIDS Education across Africa.

The above arguments suggest that there is an opportunity for the developed West to learn from and to share best practice within the context of HIV/AIDS Education. Examples of such learning might involve the adopting and adapting of *ubuntu* – a system and philosophy of (moral) values that centre on personhood within the African context. Incorporating *ubuntu* within HIV/AIDS Education would militate against the stigma and discrimination that is often directed at people living with and affected by the epidemic. Swartz and Taylor (2013) not only trace and deconstruct the colonial narrative that made interacial sexual

relationships illegal, but they also highlight how the discourse of morality was skewed against the black people who were perceived to be inferior. Ubuntu is therefore argued as the basis of a moral philosophy which considers human being as equal and worth of respect regardless of race, gender, age, creed or religion. In the same vein, a transformative HIV/AIDS Education can also be built on *ubuntu* based on what Praeg and Magadla (2014) argue is a post-colonial framework that develops an African Philosophy which is essentially emancipatory. According to them, *ubuntu* also has the potential to challenge the wider cultural and specific gender imbalances that are restrictive in understanding humanity in a broader and more complex fashion. It is my contention that the conspiracy theories that I discussed in this thesis will be undermined by a transformative approach to HIV/AIDS Education especially where challenging the retrogressive aspects of (African) culture like older HIV positive men engage in sex with young female virgins or the girl child under the banner of ridding themselves of the pandemic.

In developing its own Transformative approach to HIV/AIDS Education, Zimbabwe can also learn from Scotland's Curriculum for Excellence[105] which emphasises on the four key capacities of developing successful learners, confident individuals, responsible citizens and effective contributors. In adapting Curriculum for Excellence, Zimbabwe would be able to consider and explore some of the ways in which the four capacities can be imbedded within their Education system. My argument is that this would create potential for enabling and providing scope for young people to develop non-discriminatory and deeper understandings of the HIV/AIDS epidemic than they would otherwise have. It would capacitate them to form better views which are not stigmatising but are more reasoned and respectful of other people regardless of their HIV/AIDS status.

Incorporating these milestones will not only addresses issues of the stigma and discrimination normally associated with HIV/AIDS, but it will also empower young people and the wider society to engage in responsible sexual behaviour and promote a greater level of health and wellbeing. There is also scope for Zimbabwe as a developing world to review and incorporate other strategies like

105 http://www.educationscotland.gov.uk/learningandteaching/thecurriculum/whatiscurriculumforexcellence/thepurposeofthecurriculum/index.asp (accessed 14.04.2015)

the new social media (discussed in Chapter 6 & 7) in effectively communicating HIV/AIDS Education in ways relevant to their specific audiences.

This thesis has been a journey that has explored various issues and started to evaluate them. Among the key issues discussed were the backgrounds of both Scotland and Zimbabwe and how they provided the contexts for interrogating the HIV/AIDS within them as indicated in aims 1 and 2.

In Chapter One, I gave a general introduction to the thesis, explained the key terms that I was going to use and then gave brief histories of both Scotland and Zimbabwe.

In order to engage with the issues in both Scotland and Zimbabwe, I developed the heuristic tools that I used in the research in Chapter Two thereby meeting the aim of objectives of 2 and 3 of my thesis. The research paradigms and the documentary analysis mapped out part of the theoretical framework that I employed. I also used Narratives, an analysis of Sexuality and the post-colonial heuristic lenses.

In Chapters Three and Four, and based on aims 4 and 5 of this thesis, I outlined the key milestones and the responses to the HIV/AIDS epidemic. As discussed throughout this thesis, the dynamics in the two locations varied considerably although there were also sufficient bases for comparison.

In the methodology Chapter, I described the tools that I used in both locations in order to maintain uniformity and comparability of the data collected. Chapter Six gave a comprehensive report of the data in thematic form. This means that there were other pieces of data that were not discussed in this thesis but would form a profound basis for further research and exploration. The discussion and analysis of the data in Chapter Seven and a central aspect of aims 6 and 7 of this thesis was based on the findings in Chapter Six although only the major themes were selected for analysis.

8.1.3 A Framework for a Transformative Approach to HIV/AIDS and Sex Education

This thesis has started to develop a framework for a transformative approach to HIV/AIDS and Sex Education through:

- Interviews with key Informants
- An assessment of selected policy documents
- Evaluation of Media Messages
- An Appraisal of some of the existing literature and the ongoing debates on HIV/AIDS in Scotland and Zimbabwe
- Where appropriate, beginning to link up some of the HIV/AIDS themes with experiences from other parts of the world.

The major accomplishment of this thesis is that it has started to develop an initial framework for developing a transformative HIV/AIDS and Sex Education in both Scotland and Zimbabwe. This framework will not only be relevant to the two contexts, but it will also serve as a basis for replicating and adapting it to the contexts where HIV/AIDS and Sex Education faces similar dynamics.

8.1.4 The Way Forward

While many parts of this thesis have been successful, there have also been some areas that need further exploration that could be further developed in the future.

Although the issue of the use of new social media was identified in chapter Six, it is one that very much resonates with both the young and older generations in both Scotland and Zimbabwe. This thesis indicated that its use tended to be targeted particularly at gay men in Scotland while it is my contention that rolling it out and adapting it to the different socio-cultural needs in both contexts could pay more dividends. The use of social media is almost ubiquitous in today's modern society (Kahn and Kellner 2004) and embedding it in delivering and communicating appropriate HIV/AIDS and Sex Education messages is imperative.

In the findings in Zimbabwe in Chapter Six, ZW3F made an interesting comment regarding the traditional roles of uncles and aunties who used to provide Sex

Education to the young people in safe spaces. She also noted that with modernisation and the impact of the rural-urban divide, the dynamics have now shifted that teachers and other people have now taken over these roles. I have argued elsewhere that *dare (*a social space and institution for education, discussion of sensitive and other socio-cultural-political issues) in Zimbabwe has among other things played a pivotal role in Sex Education and related matters (Nyatsanza,T.M.,2012, unpublished). In the same paper, I have also argued that in the context of diasporic and modern day experiences, there is need for a reconfiguration of the traditional roles of the uncles and aunties in order to meet the current needs of (in this case) HIV/AIDS and Sex Education challenges and opportunities beyond the MDG 6 in 2015. Oluga, M, et al (2011) argue that Sex Education among young African people used to be collectively discussed in designated 'public'[106] (own brackets – see footnote below) spaces during the collective initiation and other ritual ceremonies. My suggestion is that further research and development of how these spaces could be recreated in the context of the current socio-cultural dynamics could add value to the HIV/AIDS and Sex Education discourses.

In Chapter Seven, I indicated that a number of the Zimbabwean documents do refer to the issue of Children's Rights as espoused by UN Charter. While this thesis did mention the Children's Rights, a deeper and a more culturally nuanced explication of Children's Rights and other relevant UN stipulations that provide guidance and legislation on HIV/AIDS and Sex Education will need to be pursued. For example, there is need to resolutely challenge the practice of adults engaging in sexual activities with young girl virgins as a means of mere sexual satisfaction or cleansing the adults of HIV/AIDS infection.

It follows from the above that more research needs to be undertaken in terms of exploring the roles and relationships between traditional cultural perceptions and the Christian and modern understandings of healing especially with regards to HIV/AIDS. The critical and central question is how far these could possibly be harmonised? Oluga (2011) has rightly argued that there are some cultural practices which are *deceptive* in so far as they operate from a purely cultural

[106] In a sense, these places were not as public but were specifically reserved to designated participants. Public in this sense refers to a shared space among the particular participants.

and not a scientific perspective. As such, they do raise critical questions surrounding the understanding and of issues of sex and sexuality and HIV/AIDS in particular. Alongside the issues of culture is the fact of the culture of silence around sex and sexuality which will need to be dealt with in greater depth if HIV/AIDS is to be effectively tackled. In essence, they are based on particular cultural conspiracy perceptions and until and unless they are challenged, they will remain a perpetual barrier to reversing the ravages of the HIV/AIDS epidemic. It should be noted however that engaging with this challenge will also need to take cognisance of some of the positive contributions of traditional and indigenous knowledge in relation to the HIV/AIDS epidemic (Nattrass 2008).

Within the formal school system, I would argue that there is a need to reshape both the content and the delivery of the HIV/AIDS and Sex Education programmes. In the light of the field work data in both Scotland and Zimbabwe, I would suggest that more robust and sustained strategies of teacher preparation and compulsory monitoring and evaluation of the HIV/AIDS and Sex Education programmes in schools and beyond be implemented. As part of that initiative, a wider distribution of roles and responsibilities beyond just the official top-down policy development would ensure the enhanced capacity and development of a transformative and emancipatory approach to HIV/AIDS and Sex Education.
In Zimbabwe, it was reported that senior management staff tend to shun HIV/AIDS testing and picking up condoms even if they are placed in the comfort of their own office suites[107]. While this evidence comes from a newspaper article, the broader indications are that there is little research that has been undertaken at least in Zimbabwe to demonstrate the lack of will power and psychological courage on the part of the privileged and the educationally enlightened. This evidence is in contradistinction to the popular perceptions that HIV/AIDS often faces challenges among: those who are poor, have little or no formal education, are prone to cross-border migration, are overly influenced by traditional culture, have been victims of the negative effects of colonisation and post-colonisation, have been exploited by Christianity and suffer public stigma and discrimination. The article cited above in fact demonstrates that condom uptake among the elite is minimal. Within the wider population, ZW1aM

[107] http://www.newzimbabwe.com/news-1626 CEOs+spurn+condoms,+HIV/AIDS+tests/news.aspx (accessed 17.06.2014)

admitted that condom uptake does not necessarily translate into condom use despite the emphasis and record levels of condom distribution. As such, it is still imperative to investigate the relationship between condom distribution, condom uptake and condom use. This kind of research is as much valid for Zimbabwe as it is for developed Scotland.

The cultural myths and conspiracies described above have also been part of the major focus of this thesis. However, there are other issues that would need further and more sustained investigation in the context of HIV/AIDS. One such example is the issue of the efficacy and value of circumcision. As ZW3,4M highlighted, there has been so much rhetoric at least in Zimbabwe, about the preventive impact of circumcision to contract HIV/AIDS. Both in this thesis and in other literature, questions have been raised about the medical reliability of this argument. I would therefore argue that further research and evidence is required before such a position would be unquestionably tenable. In sub-Saharan Africa, there are equally other cultural myths and conspiracy theories which undermine progress of harnessing the HIV/AIDS, most notably of which is widow cleansing (for example in Tanzania, Kenya, Zimbabwe, Botswana). Widow cleansing refers to rituals practised in some parts of Africa whereby the dead's man's male relatives engage in sexual intercourse with the widow in order to signal the total end of the relationship between her and her dead husband as well as to cast away the evil spirits that might bring misfortune to her and the surviving family (Barnett and Parkhurst 2005, LaFraniere 2005). This is a patriarchally- dominated discourse in which the widow does not have a say and is simply expected to comply in the interests of the family and the clan of the dead husband.

The importance of the example of widow cleansing is that it is connected with the earlier point on adult HIV positive men having sex with young virgins to rid themselves of the epidemic. Both are important examples for illustrating the gender-biased constructions of HIV/AIDS that need robust feminist and broader deconstructions that allow for more balanced and emancipatory perceptions of engaging with the HIV/AIDS epidemic.

There is also significant scope for developing HIV/AIDS and Sex Education within the larger context of Human Rights (Mann 1996) Education and Moral Education.

8.1.5 Conclusion

While this thesis has raised a number of pertinent issues regarding HIV/AIDS and Sex Education, it is my contention that the initial framework for developing a transformative approach to HIV/AIDS and Sex Education will be further developed through the facilitation of an open-minded critical insider who is well-versed on the dynamics of local cultures and can equally appreciate their complexities. Critical thinking underpins the success of analysing and developing a transformative HIV/AIDs and Sex Education approach within a constantly evolving scenario like both Scotland and Zimbabwe are currently undergoing.

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Appendices

Appendix A1 - BACKGROUND HISTORY OF SCOTLAND

Pre- Devolution

The long pre-history of Scotland is not the focus of this thesis. While it is important to note that there were many events that shaped Scotland as it is today, this thesis will mainly focus on issues of migration, religion, demographics within the 20th and 21st century in terms of how they have and continue to impact on some of the key issues of devolution.

Pre-devolution Scotland evolved out of various different formations and influences surrounding present-day Scotland now known as the Highlands, the Grampian, Strathclyde and the Borders (Mackie 1991). Underlying these developments were common factors like the impact of Christianity, the rise of Pictland, the Scandinavian attacks and the pressures from England (Mackie 1991). Beyond this, there were also several military and diplomatic attempts by Scotland to gain its own sovereignty from its southern neighbour England (McCrone 2001).

Demographics

Famines and epidemics in Scotland between 1691 and 1755 reduced the population growth in this period. Although Houston and Knox (2006) argued that existing materials prior to 1755 provide patchy evidence for calculating the population of Scotland, they do acknowledge that Dr Alexander Webster's *Account of the Number of People in Scotland* provides a more accurate account. Webster was able to collate the demographic statistics through the use of his educated kirk ministers. As such, this also demonstrated the close relationship between the church and state in that the church provided a service that the state needed for its own administrative purposes. However, the period 1750 - 1850 also marked a notable Scottish population growth, a characteristic that resembled the rest of Europe (Houston and Knox 2006).

The demographics of Scotland have since continued to diversify although the white Scottish still remain the predominant majority. In terms of ethnicity, the 2011 Scottish census indicates that the whites make up 96% and all other ethnic minorities constitute only 4%. The Asians constitute the largest ethnic minority group with 2.7% followed by Africans with 0.6%, then the mixed/multiple ethnic groups with 0.4%, Other Ethnic group 0.3% and the least being the Caribbean or Black with 0.1%[108].

In terms of Religion, although the Church of Scotland claims to have more adherents than other churches, there are also significant populations of Catholics, Protestants and more lately other churches brought in through the process of immigration into Scotland. This has also shaped the perception of the Scottish population on a range of issues from politics to culture, health, education and national identity among others. According to the 2011 Scottish census, 54% of Scotland claimed to be Christian with 32% belonging to the Church of Scotland, 16% being Catholics, 1.4% being Muslims, 0.7% being Buddhists, Hindus and Sikhs together and the Jewish being just under 6000[109].

Migration

The idea that Scotland is homogenous is contested by the fact that there have been at least three types of migration. The first can be referred to as internal migration as was the scenario with the movement of people from the poor Highland soils to the Lowlands. This was also the case when for example the urban centres attracted people from rural areas as labour for the growing commerce and industries in establishments like Glasgow, Greenock, Paisley, Edinburgh and Falkirk (Houston and Knox 2006). The overall urbanisation of Scotland was so rapid that by 1800, Scotland was one of the most urbanised countries in Western Europe. Jones (1967) gives an analysis of internal migration in Scotland based on the 1960-1961 census which considered the criteria for such internal migration. Notable findings included a common type of movement namely within or to the nearest local authority area. There was also movement from the small burghs to the urban fringes as well as the periphery of the large

[108] http://www.scotland.gov.uk/Topics/People/Equality/Equalities/DataGrid/Ethnicity/EthPopMig (accessed 25.01.2014)

[109] http://www.scotlandscensus.gov.uk/en/news/articles/release2a.html (accessed 25.01.2014)

cities. In terms of age, the 15-24 years group moved more than the 25-44 because the latter had children in schools and other factors to consider prior to moving. Jones(1967) also points out that professionals and skilled people moved much more than the unskilled workers did. Finally the last type of movement was induced[110] in that it was necessitated by the overcrowded Glasgow which had to relocate people to the outlying areas like Lanarkshire, Dunbartonshire and Fife (Jones 1967).

The second type of movement was the emigration of the Scottish people who left for North America, Canada and the Carolinas (Jones 1970, Houston and Knox 2006). In the late 18th and the late 20th century, Scotland was the emigrating capital of Europe (Devine 2006). The former movements were initiated by rich land-owners who would then sub-let their property for profits and then take along with them people who would be engaged in working on their new properties abroad.

The third type of migration was from outwith Scotland as was the case with the German Jews who funded the import of flax and hemp from the Baltic to Dundee as well as the Irish who migrated into Scotland during the 1848 famine and beyond. In terms of the Irish there were at least two main categories namely the Catholics and the Protestants (Miles and Dunlop 1986). Of significance was the fact that the immigrants brought with them their cultural and religious traditions, a factor which has persisted even within present day Scotland. Most notably, Religion in terms of Catholics and Protestants is one which has tended to be played out as a major signifier of those traditions between the migrants themselves and also between the immigrants and their hosts. While the majority of the Irish were Catholics, the minority Protestants strengthened the Protestant Orange Order, a discourse which forms part of the texture of sectarianism in Scotland today (Miles and Dunlop 1986).

The latest Scottish census (2011) indicates that of all ethnic minorities, the Asians constitute the largest percentage with 2.7%. The history of Asian migration into Scotland has been highlighted by Miles (1986) and Dunlop (1990) .

[110] 'induced' is used here to denote the fact that the movement from Glasgow to the outlying areas was not voluntary but was involved an element of coercion by those who moved them.

Virdee (2003) for example explains how the Scottish merchants, administrators and military personnel made contact with people from the colonies through the auspices of the British Empire thereby enabling them to bring back to Scotland Asians whom they employed as domestic servants or other low ranking jobs. From a legal point of view, Asian migrants were granted British citizenship by the 1948 British Nationality Act. This further increased the population of Asians into Scotland in the post-World War II period whereby there was a high demand for labour that the local British population was then not able to meet (Dunlop and Miles 1990, Virdee 2003). Given the fact that Asians were traditionally given low ranking jobs, the current scenario is that the pattern has tended to remain the same and most of them have tried to improve their plight by being self-employed in family and retail businesses (Virdee 2003).

More recently, dispersal of asylum seekers and refugees has also added to the number of immigrants into Scotland (Sim and Bowes 2007). This category of immigrants has been at the centre of the origins and spread of HIV/AIDS in Scotland (Creighton, Sethi et al. 2004, Government 2009, Palattiyil 2011).
Although the Schengen agreement of a borderless Europe in 1995 led to an increase of European immigrants into the UK in general and Scotland in particular (Whitaker 1992), it should also been borne in mind that Asians and other migrants who have been resident since the last two centuries and more were also conduits of bringing in more of their kith and kin.

Devolution

Devolution was established through the Scotland Act 1998[111] and this was followed by the establishment of the Scottish Parliament in 1999. By virtue of devolution, there were both devolved and reserved powers. Devolved powers allow the Scottish Parliament to make decisions without depending on the Westminster parliament whereas reserved powers are for those issues that are decided by the Westminster establishment. The devolved matters on the one hand are health education and training, local government, social work, housing, planning , tourism, economic development and financial assistance to industry, some aspects of transport, including the Scottish road network, bus policy and

[111] http://www.legislation.gov.uk/ukpga/1998/46/contents (accessed 20.12.2013)

ports and harbours, law and home affairs, including most aspects of criminal and civil law, the prosecution system and the courts, the Police and Fire services, the environment, natural and built heritage, agriculture, forestry and fishing, sport and the arts, statistics, public registers and records[112]. Health, Education and Social Work will be important in framing the HIV/AIDS initiatives in Scotland throughout this thesis.

Reserved matters on the other hand are constitutional matters, UK foreign policy, UK defence and national security, fiscal, economic and monetary System, immigration and nationality, energy: electricity, coal, gas and nuclear energy, common markets, trade and industry, including competition and customer protection, some aspects of transport, including railways, transport safety and regulation, employment legislation, social security, gambling and the National Lottery, data protection, abortion, human fertilisation and embryology, genetics, xenotransplantation and vivisection and equal opportunities[113].

In the context of this research, devolution also coincided with the dispersal of asylum seekers to Scotland through the Immigration and Asylum Act 1999[114]. A fuller discussion of the impact of this initiative is contained in another section of this research study.

Church and State Relations since the 19th century

One way of understanding the role and function of religion in Scotland in the early twentieth century is to consider its relationship to the state and civic society. The term 'religion' of course is being used in a broad sense to refer to Christian religions, predominantly the Protestants and the Catholics. Of course the landscape of religion changed as new migration patterns emerged and people brought with them their own religions. In terms of Africans in Scotland, they are more likely to be incorporated by the Evangelical churches in so far as the latter resonate more with the Africans' experiences of issues relating to HIV/AIDS. Part of this is informed by the rise of the Evangelical churches and the increase of their influence on the healing discourses especially with respect to

[112] http://www.scotland.gov.uk/About/Factfile/18060/11552 (accessed 20.12.2013)

[113] http://www.scotland.gov.uk/About/Factfile/18060/11555 (accessed 20.12.2013)

[114] http://scotland.gov.uk/Publications/2003/02/16400/18348 (accessed 2012.2013)

HIV/AIDS[115]. Examples of such discourses are highlighted by Anderson and Doyal (2004) and Chitando (2013).

Devine (2006) argues that religious belief has also been part and parcel of the Scottish people despite some of the contrary arguments that with the industrialisation of the 19th century religious values declined and secularisation became the order of the day. He provides evidence of how religious values constantly influenced the Scottish politics and national identity issues. For example, Thomas Chalmers who was himself a church leader championed the Poor Law Amendment Act, debates on Education and as well as a range of other social matters. In the same vein, kirk elders often doubled-up as town councillors. According to Devine (2006) the Victorian Age was characterised by 'a fusion between Christian ethos and public policy'(p.365). Other examples of church-state overlap and collaboration were instances when the General Assembly of the Church of Scotland facilitated a platform for debating national issues (Devine 2006).

In a sense, the church was not only a moral guide in Scotland but it also served as a barometer for acceptable social standing. In 1890, the Commission on the Religious Condition of the people concluded that the 'unchurched' were considered to be in the same category with the poor and the unskilled despite the fact the Catholics took care of the Irish immigrants who in the main fitted this category (Devine 2006).

Religion, National Identity and Imperialism

While Scottish people often perceive themselves as 'victims of oppression… and not as perpetrators'[116] the situation is much more complex in that they have also been part of the oppressive regimes. On another level, the colonialism and oppression might also have been a class issue in that it was the more affluent who took a more pro-active role in colonial and empire issues rather than the rank and file of the Scottish people. As Geoff Palmer the only Scottish black Professor has argued in a recent article in the Scottish Herald (9th January,

[115] Evidence of this is from the African Health Project Support Groups in Glasgow ran between 2007-2009

[116] http://www.heraldscotland.com/news/home-news/teaching-of-slavery-in-scots-schools-branded-tokenism.23126288 (accessed 25.01.2014)

2014), within the current Scottish school system, there is very little evidence of how Scotland was actively involved in slavery and colonialism through the conduit of missionary activity[117]. Prof Palmer is quoted as arguing that modern Scottish history tends to focus on the 1960s onwards and tends to ignore the period prior to that.

In the same article, Tom Devine is cited as working on the 'first full-scale academic analysis devoted to the subject entitled *Scotland, Slavery and Amnesia'* in which he admitted that issues like slavery and colonialism are often left to the individual teacher[118]. If this is what is in the contemporary Scottish psyche, an excavation of earlier historical developments would effectively challenge focusing on the victims rather than the perpetrators who colluded with some of the exploitative and colonial activities. Dunlop and Miles (1990) argue that Asians who have been resident in Scotland since the middle of the 19th century onwards were in recognisable ways 'victims of racism and exclusionary practices' (p. 145). This was the case because of Scotland's involvement in British colonialism and Empire building. As the demographics indicate today, there is great evidence that Glasgow is characterised as a *multi-cultural city* but this is in part due to the fact that the migrants from the Scottish Highlands agricultural producers were during the 19th century joined by migrants from Ireland, Eastern Europe and Italy. McKinney (2008) indicates current demographics in Scotland are dependent on immigration from similar countries.

Religion played a pivotal role in terms of framing the Scottish national sense as well as its imperial identity. As Devine (2006) argued, 'the role of Scots in the British empire was given a powerful moral legitimacy by the missionary movement' (p. 366). This very much resonates with the theme I discuss in relation to Zimbabwe in terms of the collusion of the colonial and missionary discourses in the chapter on *The Brief History of Zimbabwe* in this thesis. Within the Scottish context, involvement in empire building was very much part of the pre-requisite for the expansion of the kingdom of God as well as engaging in winning over the colonised multitudes from the ills of paganism (Devine 2006).

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[117] http://www.heraldscotland.com/news/home-news/teaching-of-slavery-in-scots-schools-branded-tokenism.23126288 (accessed 25.01.2014)

[118] http://www.heraldscotland.com/news/home-news/teaching-of-slavery-in-scots-schools-branded-tokenism.23126288 (accessed 25.01.2014)

Scottish missionaries in fact played a leading role in India, Africa, the Caribbean and in China with the greatest British Medical Missionary centre in Edinburgh. Such missionary explorations were not only geared at winning souls to God but they also saw part of their mandate as bringing to the colonies acceptable morals, civilisation, education and commerce but also delivering public health from a western perspective. When they returned to Scotland, they did bring with them some of the colonised people who they would engage in menial jobs and sometimes the colonisers and missionaries did not live up to what they advocated in terms of the values of equality, morality and civilisation (Dunlop and Miles 1990).

Some of the key Scottish colonial missionaries who were and are celebrated in Scotland are David Livingstone, Mungo Park, Mary Slessor and Christina Forsyth. However, some modern critiques of the colonial missionary ventures view them as having been double-edged swords in terms of some of the negative effects of their activities in so far as they failed to recognise the importance, value and place of local cultures, talent, moral systems and other institutions (Zeleza 1997).

Post-Devolution

The Calman Commission of 2007[119] was established to review the provisions of the Scotland Act of 1998 so that necessary recommendations would be made in terms of any constitutional changes that would enable Scotland to better serve its people. The opening up of the new Scottish parliament by the Queen on 1 July 1999 since the first one of 1707 was a landmark occasion (Devine 2006). In his speech the Labour Prime Minister Donald Dewar highlighted the fact that the opening of the new parliament was a renewal of democracy on Scotland, the creation of a new voice and the creation of a new identity for the nation (Devine 2006). Despite his very optimistic remarks, there were some pessimists like Andrew Neil who thought that devolution was a failed project.

[119] http://www.scotland.gov.uk/News/Releases/2009/06/15151304 (20.12.2013)

However, following the success of the Scottish national Party (SNP) in 2007, the former Scottish Executive was rebranded as the Scottish Executive as the Scottish Government.

Multiculturalism, Sectarianism and Racism

One of the consequences of migration in the post devolution period was that the Scottish Government had to engage with issues of multiculturalism, sectarianism and racism within the Scottish context. Multiculturalism entailed dealing with the challenges of creating harmonious communities among people coming from different cultural backgrounds and traditions. On another level, racism is linked to different forms of hate crime of which sectarianism is a significant one in Scotland. One example of these initiatives targeted addressing the issue of the identity of ethnic minorities in Scotland. In a seminal article, Netto (2008) discusses both the challenges and the possibilities that the arts space creates or negates for ethnic minorities negotiating their identities within a multicultural devolved context in Scotland. One of the major challenges is that the discourse of multiculturalism is heavily contested in that sometimes it accommodates contradictory views (Netto 2008). Part of what then emerges is that the politics of equality, dignity and the due recognition of difference often throw up new challenges in a predominantly white society. Netto (2008) claims that

> *While issues of identity construction in a devolved context have been the subject of a growing body of research, relatively little attention has been paid to how minority ethnic groups and individuals see themselves (*p. 51).

The term 'ethnic minority' is itself used to exclude the main stream white society but it becomes problematic to enumerate exactly what it constitutes as well as what it does not. On one level for example, it has been used to denote people of African, Asian, Caribbean and Chinese origins but it has more recently also included asylum seekers, refugees, Gypsies and Travellers. On another level, ethnic minorities have also included immigrants from Europe.

Although equality of belonging entails that religious, cultural, linguistic and other differences be recognised and be non-discriminatory, there are circumstances where these differences have presented themselves as grounds for developing and perpetuating sectarian and racist attitudes by the predominantly white Scottish host population. While sectarianism has been defined in various ways, Zanonni (2012) has given what he terms a popular understanding of the term:

> *the word sectarianism describes the religious conflict and prejudice between Catholics and Protestants in Scotland and it is directly connected with the events in Northern Ireland, but it doesn't involve the mainstream of Protestant and Catholic churches* (p122).

McKinney (2008) has suggested what he calls the 'working' definition constructed by Leichty and Clegg (2001:102-103) based on their work in Northern Ireland

> *Sectarianism is a system of attitudes, actions, beliefs and structures, at personal, communal and institutional levels, which always involves religion, and typically involves a negative mixing of religion and politics. Sectarianism arises as a distorted expression of positive human needs, especially for belonging, identity and the free expression of difference and is expressed in destructive patterns of relating: hardening the boundaries between groups; overlooking others; belittling, dehumanising, or demonising others; justifying or collaborating in the domination of others; physically or verbally intimidating or attacking others* (p.336).

Sectarianism in Scotland has manifested itself through the tensions between the Catholics and the Protestants physically and psychologically, football club affiliation in which Catholics identify with Celtic and Protestants with Rangers and the media has indeed also made high profile coverage of sectarianism (Zannoni 2012). One of the key emerging discourses surrounding sectarianism is that apart from the physical tensions between the opposing groups, it has also become more of an attitudinal issue which is rooted and nurtured in the psyches of both groups.

The then Scottish Executive (now the Scottish Government) did not just watch sectarianism proliferating. Jack McConnell the former First Minister of Scotland called sectarianism 'Scotland's secret shame'(Devine 2006). Initiatives to address that involved the production of: *Global Citizenship: A Guide for Schools, 2007.*

Racism is also another discriminatory discourse that devolved Scotland has had to grapple with. Like sectarianism it is also connected with the discourses of immigration and multiculturalism as well as the struggle to deal with matters of national identity. The *One Scotland Campaign of 2007* was one of the official responses in combating racism.

Section 2A

One of the most contentious issues that Donald Dewar dealt with was the removal of Section 2A (sometimes referred to as Section 28) whereby local authorities were prohibited from denouncing homosexuality because it led to stigma, fear and discrimination for the targeted group (Rennie 2003, Devine 2006). In response to this initiative, Cardinal Tom Winning led a vigorous campaign consisting of Catholics, The Daily Record, Brian Souter (an evangelical Christian) and other sympathisers but they were not successful in getting the legislation retracted (Devine 2006). The Cardinal Wining campaign saw the removal of Section 2A from the statute book in 2001 as an attack on family values. In their view, the Catholics perceived the Scottish Executive as pursuing a politically correct agenda at the expense of the traditional moral principles while the Church of Scotland were more cautious by not necessarily voicing the same sentiments. Section 2A is indicative of the power of the gay lobby in terms of how they articulated their entitlement to their values being upheld as part of the human rights agenda within Scotland and other developing countries.

Although the dispersal allowed for the movement of asylum seekers and refugees to Scotland in the post devolution era, the challenges of negative attitudes by some mainstream white Scottish hosts led to the secondary migration of the asylum seekers and refugees from Glasgow to other bigger cities in England like

Manchester, Birmingham and London which had a longer experience with ethnic minority migrants (Sim and Bowes 2007).

Devolution has meant that not only has Scotland needed to challenge issues of multiculturalism, sectarianism and racism, it also has had to make responses to the HIV/AIDS epidemic within its borders. This is evidenced by the various policy documents for example, *The Respect and Responsibility Sexual Health Strategy Annual Reports* (2005-2007), *HIV and Hepatitis: Current Controversies in Prevention and Public Health* (2005), *HIV Action Plan in Scotland December 2009 to March 2014* (2009), *The Sexual Health and Blood Borne Virus Framework 2011-15* (2011), *Health Protection Scotland* (HPS)website with robust details on HIV/AIDS as well as a dedicated Scottish Government Health website, *The Penrose Enquiry Preliminary Report (2010)* which have since been put in place, the training of appropriate personnel and engaging with issues of HIV/AIDS through various aspects of the school curriculum. In Scotland, homosexuals have been more empowered than in Zimbabwe hence their ability to take a leadership role in responding to the issues of HIV/AIDS. Through the Equalities and Human Rights legislation[120] as well as the *Embracing Equality, Diversity and Human Rights in NHSS Scotland*, (December 2013) the homosexuals and other suppressed groups have managed to emancipate themselves by successfully refusing to be solely blamed for the origins of the epidemic to being champions of advocacy and equality of treatment within the HIV/AIDS discourse. In Zimbabwe, the homosexuals have to date not managed to extricate themselves from the persistent blame on them being the cause of the HIV/AIDS epidemic.

Conclusion

Houston and Knox (2006) argue that that Scotland has always struggled to be independent and maintain its identity, it has 'never lost its ability to govern itself' (p.535). The future of Scotland not only depends on the outcome of the just held Independence Referendum but also on the developments in Westminster, Europe and the rest of the global world.

[120] http://www.scotland.gov.uk/Publications/2013/12/3747/3 (accessed 11.02.2014)

Despite the above, the current SNP government continues to publicly argue for a pro-immigration attitude as witnessed by Scotland's acceptance of refugees and asylum seekers, as well as the Home Coming Event in 2009[121] intended to woo back Scottish people in diaspora. In addition to its pro-immigration attitude, the SNP government is also in the process of advocating for Scottish Independence through a referendum scheduled for September 2014[122].

[121] http://www.scotland.gov.uk/Publications/2010/09/14081057/0 (accessed 20.12.2013)

[122] http://www.scotland.gov.uk/News/Releases/2013/03/referendum-date21032013 (accessed 201.2013)

Appendix A 2 - BACKGROUND HISTORY OF ZIMBABWE

The Pre-colonial Period

The pre-colonial period in Zimbabwe may be defined as the period prior to the formal colonisation of the country by Cecil John Rhodes in 1890. This period would have been broadly characterised by the Stone Age and the Iron Ages respectively. It is however important to note that within the pre-colonial period, various strands may be identified. On one level it may be argued that the pre-colonial period is characterised by some kind of pristine culture, which had not had any interaction with foreign or external contact or influence prior to formal colonisation (Chigwedere 1980, Chigwedere 1982, Chigwedere 1986). This seems to be an over-romanticised idea because other evidence indicates that Zimbabwe has not been a homogenous country with a homogeneous historical and cultural experience but that in fact it was and still is constituted by a mixture of tribal groupings and cultural experiences (Mazarire 2009). Beach, for example disagrees with Chigwedere's description of Zimbabwe's pre-colonial period being constituted of a homogenous group that had not had contact with other external cultures (Beach 1980, Bhila 1982). Instead Beach (1980) and Bhila (Bhila 1982) offer a more complex and broader interpretation of how the Shona established themselves within Zimbabwe. The word '*Shona'* is a linguistic term invented during the colonial period for the purpose of describing a group of dialects, such as Karanga, Zezuru, Manyika, Ndau and Korekore, spoken throughout and around modern-day Zimbabwe' (Ranger 1967, Palmer 1977, Bhila 1982, Mano 2004) . The Shona are collectively the largest group as compared to the Ndebele who are the second largest and then there are other smaller tribal groups. Although it is disputable among historians, Beach (1980) argued that two thirds of the present day Ndebele are of Shona origin.

There are two main explanations of how Zimbabwe became populated. The first is that it was due to the *mfecane*[123].The *mfecane* consisting of the Nguni tribal

[123] The North-bound movement by the Nguni tribal groups who migrated from South Africa into Zimbabwe

groups[124] came about as a result of the early 19th century economic and environmental pressures experienced in South Africa at the time (Mazarire 2009). This argument may be challenged in the light of the fact that the Boers had already set foot in South Africa and therefore might equally have contributed to the displacement of the Nguni towards the north. The other explanation is that there was equally a south-bound movement known as *Guruuswa*[125] from the present day Tanzania moving into Zimbabwe (Palmer 1977, Bhila 1982, Lilford 1999). Despite these broad explanations, the history of the black Zimbabweans remains a matter of controversy as will be demonstrated later. This is partly due to the fragmented and sometimes contradictory historical and other evidence between the Boer, British, Portuguese colonists and missionaries who first tried to put the history together as well as the more recent initiatives by scholars from within and outwith Zimbabwe.

In relation to the pre-colonial period being pristine, Muhammad (2006) has demonstrated that there had been early contacts with Arab and Chinese traders resulting in cultural exchanges with some parts of Zimbabwe prior to formal colonisation (Windrich 1975). In his essay, he highlights the fact that Zimbabwe like other African economies:

> *was stimulated by distance trade, which was accompanied by the establishment of kingdoms and city states, for example….the Shona Kingdom of Great Zimbabwe….Gold mined in Zimbabwe was marketed through the Arab town of Kilwa in Tanzania. This trade with the Shona Kingdom brought about some of the most imposing architecture of the iron age in Africa; for example, at Great Zimbabwe, a large number of artefacts from Persia, China and the Near East were found* (Windrich 1975).

[124] The Nguni are made up of three large subgroups namely the Northern Nguni (the Zulu and the Swazi); the Southern Nguni (notably the Xhosa, but also including other smaller groups); and the Ndebele. Each of these Nguni groups is a heterogeneous grouping of smaller ethnic groups.

[125] Guruuswa is variously interpreted as ' the place of the long grass', a water source or a woman's pubic hairs symbolic of where all live comes from http://www.persee.fr/web/revues/home/prescript/article/jafr_0399-0346_1999_num_69_1_1193 (accessed 18.12.2012)

Mandivenga (1984) has also argued that Zimbabwe had pre- colonial contacts through interaction with the Moslem world. From a pre-colonial historical perspective, Mudenge (1988) also argues that there is literature that indicates that the Portuguese traders and missionaries interacted with Zimbabweans prior to the formal colonial period. What one can therefore draw from this is that the pre-colonial period was in fact not as 'pristine' as it may otherwise be argued. As such, the pre-colonial world view would be a result of some kind of syncretisation of cultures.

The Colonial Period

The colonial period in Zimbabwe was marked by the arrival of the colonists in 1890 (Windrich 1975, Raftopoulos and Mlambo 2009). The colonisation of Zimbabwe by Britain was part of a larger exercise that other European countries embarked on following the Scramble for Africa which resulted in the partitioning of the continent on the basis of the Berlin Colonial Conference of 1884. Although there had been previous contacts between Europe and Africa, the partition of Africa effectively marked the official colonisation of the continent. The latter was necessitated by a range of factors most notably economic expansion, the need for raw materials, space for experimental work for new technologies outside Europe, a dumping ground for social misfits and the sheer need for territorial control among other factors (Koponen 1993).

In the case of Zimbabwe, its colonisation came about as a result of the British discovery of gold and other resources in South Africa (Phimister 1988). However given the tensions between the Boers and the British over the control of South Africa, Cecil John Rhodes envisaged that gravitating northwards would create a new niche in a new space of territorial control that would guarantee mineral resources, cheap labour and colonial domination. This is often referred to as Rhodes' dream to conquer Africa from Cape (southern-most part of South Africa) to Cairo (the northern-most part of Africa) (Hole 1926, Palmer 1977).

Colonisation in present day Zimbabwe was a complex process predicated on coercion, contestations, negotiations, manipulations, rejections and concessions between the white settlers and the local African Zimbabweans (Mazarire 2009).

It is worth noting that the white settlers were not a simple homogenous group but a mixture of missionaries, traders, hunters, concessions seekers and their empire-minded sponsors. While the common denominator between them was that they were Europeans[126] their reasons for coming to Zimbabwe were not always the same. For example, while the missionaries principally saw themselves as coming to evangelise and civilise, the traders and hunters were economically-minded and the empire-builders went beyond the other categories by viewing themselves as not only wishing to colonise through control and exploitation but also to expand the empires of their countries of origin. In his analysis of the colonisation of Zimbabwe, Hole (1926) argues that there were several contestations and rivalries between the white settler groups who were pursuing similar interests and that this in turn caused the local leadership to raise concerns about the credibility of the white colonists.

Given the complex nature of the operations of the white settlers, the reactions to these operations by the local Zimbabweans were also varied. As already indicated earlier, Zimbabweans were (and still are) constituted by tribal groups whose identity and perceptions about the intentions of the white settlers were equally varied and fragmented. It is on that basis that Ndlovu-Gatsheni (2009) argues that

> *The British South Africa Company administration pursued policies of social and spatial segregation based on race as part of governance. The ambiguities and contradictions of colonial governance provoked equally ambiguous and contradictory African reactions* (p.40).

Colonisation in Zimbabwe was marked by a number of events aimed at the control and domination of the black Zimbabweans by the white settlers a summary of which is given below.

Missionary role in the colonial process

As already highlighted above, apart from the concession seekers, traders and hunters, missionaries played both a pivotal and ambivalent role in the

[126] The key players were the Portuguese, the Boers (also known as Afrikaners) and the British.

colonisation of Rhodesia. It is important to highlight that missionaries perceived themselves to be custodians of truth but this point is challenged by the African writer and critic Chinua Achebe[127] in his several publications. One of the early missionaries was the Portuguese Jesuit Fr Gonzalo da Silveira who converted one of the Mutapas[128] to Christianity before da Silveira himself was murdered in the 1560s (Bhila 1982). In the 1820s, Robert Moffat, a British missionary of the London Missionary Society (LMS) befriended King Mzilikazi Khumalo of the Ndebele and then visited him in 1854 and subsequently established the first LMS mission station at Inyathi in western Zimbabwe in 1859 (Ndlovu-Gatsheni 2009). Later on, Reverend Charles D. Helm and Reverend John Smith Moffat (the son of Robert Moffat) were also involved in various concessions especially the Rudd concession described below.

On the whole, the missionaries facilitated the colonial process as language interpreters but also by inculcating western values and Christianity as part of creating the pre-requisite to an appropriate world-view which would enable a buy-in of the formal process of colonisation. The role of the missionaries and their colonist counterparts is well documented in archival materials both in Zimbabwe and in London. But due to the fact that pre-colonial black African Zimbabweans relied exclusively on oral tradition, their views and testimonies were never scripted by their own authors but were instead scripted 'on their behalf' by the colonists (Ndlovu-Gatsheni 2009). As such, the latter records would need to be considered critically rather than literally.

The Three Treaties

The contestations for securing mining, trading, hunting and occupation rights by the rival settler parties were prefaced by 'friendship' treaties. The 'friendship' in question was in fact not understood in the same way by both parties, namely by the settlers or their representatives on one hand and the Ndebele king and his

[127] For example: Things Fall Apart (1958), No Longer at Ease (1960), Arrow of God (1966), A man of the People (1966), An Image of Africa (19750 Anthills of the Savannah (1987), Conversations with Achebe (1975) and many others.

[128] Mutapa is the title that was given to the early African kings in Rhodesia

indunas[129] on the other. From the onset, the settlers' strategy was to set up the king into believing what seemed to be a 'friendship' treaty when in essence it was a mischievous attempt to secure the king's permission to something much more profound namely territorial, political, economic and other forms of control and ownership (Ndlovu-Gatsheni 2009). In fact, this point is true of the treaties that will be described below.

The Afrikaners initially settled in South Africa with their base in Cape Town but later discovered gold further north in the Witwatersrand. This prompted the Afrikaner President Paul Kruger to send the missionary Piet Grobler as an emissary to Lobengula the Ndebele king to sign a treaty of friendship in 1887. As Hole (1926) rightly comments, the treaty was 'spurious' (p.61) and 'fictitious' (p.62) given the fact that Lobengula's previous contact with other potential white settlers, he was less likely to sign such a treaty without one of his trusted resident missionaries. Secondly, the appended signatures of his *indunas* lacked any authenticity. Thirdly, the place where the treaty was signed did not exist anywhere in Rhodesia and finally any such document should have included the signatures of two independent European witnesses (Hole 1926).

The above initiative was certainly a cause for concern to Cecil John Rhodes who saw himself as being privy to any concessions that might be entered into with the Ndebele. His reaction was therefore to send his own missionary negotiator John Smith Moffat who happened to be a confidante of Lobengula the Ndebele King because Moffat's own father had been a friend of the king. The king's trust in John Smith Moffat was such that he called him 'Joni' although he was oblivious of John's subversive attitude towards the Ndebele state. This treaty signed on 11 February 1888 was popularly referred to as the Moffat Treaty. Unbeknown to Lobengula, this treaty was far from a 'friendship' treaty as it in fact essentially prohibited him from entering into any arrangement with any other concession seeker without the prior approval of Her Majesty's Commissioner in South Africa (Ndlovu-Gatsheni 2009).

The third and perhaps most notable treaties in the process of colonising Rhodesia was the Rudd Concession which granted Rhodes exclusive access,

[129] The king's advisors

control and ownership of minerals and other resources. Despite initial hesitation by King Lobengula, Rhodes engaged the shrewd and linguistically able missionaries and other white settler negotiators to convince the king. The team engaged by Rhodes involved Rev D. Carnegie, Rev C.D Helm (the chief negotiator and interpreter), John Smith Moffat, Sir Sydney Shippard and Major H. Goold-Adams (Hole 1926). As with previous treaties, it has been argued that Lobengula was cajoled into signing this treaty because the verbal interpretations that the missionary C.D. Helm made to him and his indunas were not necessarily reflective of what the written document contained (Hole 1926, Ndlovu-Gatsheni 2009). Lobengula was in turn promised an annual subsidy, a gunboat on the Zambezi River on the northern border of Zimbabwe as well as a thousand rifles (Hole 1926).

Questions have been raised regarding why Lobengula signed the Rudd Concession and various explanations have been proffered. Suffice to say that most historians and critics concur that Lobengula offered initial verbal resistance but was pressured into signing due to the manipulative techniques of the white settler party, his misplaced trust in the good will of the British and as well as the fear of potential political unrest which he considered difficult to quell if it ever arose from within and outside his own camp (Beach 1980, Ndlovu-Gatsheni 2009).

Despite Lobengula realising that he had been cheated into signing the Rudd Concession, 'the British government granted a Royal Charter on 29 October 1889, authorising Rhodes to create the British South Africa Company (BSAC)' which had the mandate to operate as a commercial-political entity that had rights to appropriate any resources in order to enhance British capital (Ndlovu-Gatsheni 2009). Alongside these commercial-political enterprises, the BSAC could raise its own flags and run its own police force. In effect, what had started as a cultural project of evangelising and civilising turned out to be a well-orchestrated political project of colonising Rhodesia (Ndlovu-Gatsheni 2009).

The Pioneer Column

The Rudd Concession was a significant landmark in ushering the north-bound movement of the colonists from South Africa into Zimbabwe known as the

Pioneer Column which set out in 1893. The Pioneer Column triggered resistance not only from the Ndebele but also from the Shona who were located along the route that the Pioneer Column pursued on its Road to the North. A number of protest movements have been recorded namely the 1893 war, the 1896-7 war and much more recently the last *Chimurenga*[130] staged in the 1960s culminating in the birth of the new Zimbabwe (Raftopoulos and Mlambo 2009).

Racial Segregation

The colonists in Zimbabwe segregated people on the basis of their racial categories (Windrich 1975, Palmer 1977), namely the whites, the blacks, as well the mixed race commonly referred to as the 'coloureds'. The latter category enjoyed some of the colonial privileges depending on a number of variables. There were other more complicated ones like what kind of surname one used. So for example, if one used a surname reflecting those from the white colonial race even if they had a black Zimbabwean father and a white mother, then that effectively gave them access to a number of privileges. If one had white paternity and also used their paternal surname, regardless of their mother's ethnic origin that as well gave automatic access to certain privileges over and above the black Zimbabweans.

Legal statutes were developed in order to enforce racial segregation and discrimination against the black Zimbabweans and to some extent the coloureds and Asians in the provision of goods and services from access to wealth, land, employment, health, education, leisure and other areas of human enterprise. One of the outstanding legal statutes was the Land Apportionment Act of 1941 with its amendments in 1944, 1945, 1950, 1951, 1960, 1961 and 1970 (Windrich 1975). This legislation favoured Europeans who had more and better land and facilities as opposed to Africans who were forced into smaller unproductive areas. While Europeans could own and add commercial value to the land they resided on, the Africans were marginalised into the Tribal Trust Lands (TTLS) which had no commercial value or ownership rights (Windrich 1975, Bassett and Mhloyi 1991, Raftopoulos and Mlambo 2009). The land division legislation was

[130] The guerrilla war for independence

the basis of the larger framework of the racial discriminatory practices that straddled across the fragmented Rhodesian society.

Federation

The federation was the amalgamation of Southern Rhodesia (now Zimbabwe), Northern Rhodesia (now Zambia) and Nyasaland (now Malawi) on 3 September 1953 until 31 December 1963 (Wood, 1983, The Welensky Papers). The rationale for the federation was to enhance labour and exploit the resources in central Africa for the benefit of Her Majesty's economy. However, the local inhabitants become increasingly sceptical of the advantages of the federation in terms of their own self determination and began to agitate for self-rule. In response to these sentiments, a landmark constitution was passed in Southern Rhodesia in 1961 intended among other things to extend the franchise to black Zimbabweans as well as to increase the powers of the Southern Rhodesia government (Windrich 1975). However, this move did not in itself satisfy the increasing demands for legislative participation by the local blacks.

On the other hand, Britain as the colonial power directly in charge of the federation, was unable to meet the demands of the local black Rhodesians due to its feeble military strength and was not prepared to face another front of revolt beyond the Northern Irish one. It is also equally true that the idea of empire and commonwealth was gradually weakening and so the only practical thing to do was to let go of the federation. Given that Britain had stood on moral high ground regarding slavery, continued political dominance in Africa in a manner reminiscent of slavery just became abhorrent (Coleman 2005). These developments inevitably led to the collapse of the federation with Malawi's secession granted in 1962 and that of Zambia on 28 March 1963. Southern Rhodesia on the other hand, declared the Unilateral Declaration of Independence on 11 November 1965.

Liberation War and the Land issue

While Zambia and Malawi were able to develop into African independent states beyond the federation, Rhodesia remained under white colonial rule until the

18th of April 1980. The Rhodesia struggle for independence was marked by a bitter guerrilla war. The driving force for the struggle was not only self-rule but the demand for an equitable distribution of resources and most crucially land. The land question has since characterised Zimbabwean politics and economics thenceforth to the present. Even after independence the struggle for land has manifested itself in various forms especially through the Land Acquisition Act of 1992 and the Land Acquisition Amendment Act of 2000, the subsequent 'land grab' exercises and the Indigenisation Policy which have remained operational to date.

Post- colonial

The post-colonial period in Zimbabwe was marked by its independence on 18 April 1980. It is however important to locate the discussion of the application of the term 'post-colonial period' to Zimbabwe within the general discussion that circumscribes the conversations about what it means. The term post-colonial is one which is complex in that both in content and in historical terms, there is no single agreement. One can identify at least two strands of thought namely; one argues that colonised spaces (countries) have not yet evolved out of the experience of colonisation while the other postulates that there are significant milestones to indicate political and/or some form and shape of economic independence. Central to the post-colonial epoch is the fact that the formerly subjugated people are able experience both cultural and political independence. In the context of Zimbabwe, the post-colonial period refers to the government's efforts in 1980 to dismantle the regime that was essentially racist in structure and operations. Ironically, it retained the state machinery of the security, the police and the army. Interestingly too, the state of emergency was also left intact. A range of colonial laws were also retained some of which are significant for this current research on HIV/AIDS for example, The Witchcraft Suppression Act of Zimbabwe 1889 (Chapter 73)(Chavunduka 1994, Rödlach 2006), The 1867 Anti-Sodomy Laws and others. This fragmented transition from colonial to post-colonial sets the context for problematising what in Zimbabwe's experience can be strictly referred to as 'colonial' and 'post-colonial.' A more in-depth analysis of the discussion of the 'post-colonial' lens will be made in reference to the

responses that have been to the HIV/AIDS epidemic in Zimbabwe in the forth-coming chapters.

The Period of Success

Zimbabwe inherited a healthy economy at independence in 1980. It was against this backdrop that the new political establishment also moved very quickly to expand education, health, rural development, water and sanitation and other services especially in areas that had been deprived during the colonial period (Muzondidya 2009). This is evidenced by Mlambo (1997) when he states that for example in education primary school enrolment rose from 820 000 in 1979 to 2 216 8787 in 1985 and secondary school enrolment rose from 66 000 to 482 000 in the same period. In its first decade of independence, Zimbabwe was popularly referred to as the 'bread basket' of Southern Africa because of its outstanding food production and a very stable economy. The same period also witnessed political democracy as evidenced by critical parliamentary debate, high judges' opposition to government interference, the formation of the opposition party Zimbabwe Unity Movement (ZUM) by Edgar Tekere, the former Secretary General of the ruling ZANUPF, student demonstrations as well as public academic discourse in various formats (Muzondidya 2009). These dynamics very much resonated with what Sithole(1999) called 'Zimbabwe Struggles within the Struggle' during Zimbabwe's war of liberation. However, this period of success fast evolved into a period of crisis as demonstrated below.

The Crisis Era 1997 onwards

Raftopoulos (2009) notes that the period from the late 1990s onwards are generally characterised as the 'Crisis in Zimbabwe'. This period has also been written about extensively as demonstrated by the vast literature on it. Examples of such literature[131] include Bond and Manyanya (2002), Meredith (2002), Jensen, Raftopoulos, et al (2003), (Ranger 2003), Moyo and Yeros (2005),Alexander (2006), Auret (2010) Holland (2012), Zimudzi (2012) Chan and Primorac (2013) and many others. Although these historians describe and analyse the conflict as it unfolded, it also seems to be the case that while these critics highlighted the

[131] Crisis in Zimbabwe discourse

crises that the country was going through, there was also a level at which they were also influenced by the populist and ideological discourses that were in the public domain. As a result, there often some tensions between participants objectivity and subjectivity and the conflictual nature of the historical discourses that they were engaging with.

In the following section I will highlight the major milestones that characterised the crisis that Zimbabwe has been going through. In 1997, a coalition of civic groups, church organisations, trade unions, academics and other concerned members of society came together to map a way forward as a response to the crisis. The result of this coming together led to the formation of the National Constitutional Association (NCA) on 31 July 1998 at the University of Zimbabwe (Raftopoulos 2009). The main focus of this organisation was to push for a constitutional change as a way of dislodging the ruling party. Initially the NCA was bank-rolled by the German Friedrich Ebert Stiftung organisation. It is important to note that because this is a western funding organisation, it formed part of Mugabe's (Zimbabwean President) anti-western rhetoric of political interference in the local and domestic governance issues of Zimbabwe. In Sept 1999, the Movement for Democratic Change (MDC) political party evolved out of the NCA in order to challenge the ruling ZANUPF party. One of the reasons why the NCA and MDC gained rapid currency was the deepening of the socio-economic crisis that was prevalent in Zimbabwe. The crisis was evidenced by job mass-stay-aways as well as food riots.

In response to the NCA, the government set up a Constitutional Commission (CC) in order to pre-empt the constitutional reform process. However, the NCA insisted that the government's CC was simply a ploy to divert public attention from critical engagement with constitutional reform and therefore continued to mobilise and educate the public on the constitutional reform agenda (Raftopoulos 2009). The government bulldozed its way through with its CC resulting in referendum in February 2000 in which it lost to a 54% 'NO' vote that the NCA campaigned for (Raftopoulos 2009). Agitated by this loss, the government mobilised its ex-combatants and youth militia to enforce a compulsory land acquisition exercise colloquially referred to as *jambanja*[132].

[132] Literally means havoc or an activity fuelled by anger

While the issue of land is one that has been hotly contested in Zimbabwe, there seems to be general criticism by the political opposition, civic society and western countries on the manner in which the 2000 land acquisition exercise was carried out as evidenced in the literature in footnote 8 above. One of the major criticisms of this exercise was the politicisation, militarisation and the centralisation by the government rather than a broad-based and consultative exercise (Raftopoulos 2009). The land issue[133] threw up some important themes in understanding the nature of the crisis. One was the radicalisation of the land discourse by the ruling party, another was the constant reference to land as the raison de'tre for having fought the liberation war. Out of this also emerged the discourse of 'outsiders' and 'enemies of the nation' (Raftopoulos 2009, p. 213) namely the white farmers as well as their farm workers most of whom were of Malawian origin. Within this category of outsiders were also civil servants – teachers, health workers and local government officials in the rural districts who were perceived to have voted 'NO' in the referendum.

Another notable outcome of the Zimbabwean crisis was the increased momentum of migration into neighbouring countries in the region and much far afield like the USA, New Zealand, Australia, Canada and the UK. In fact, Zimbabwe has always had a history of migration dating back to the pre-colonial days, during colonisation (particularly during the federation), and in the post-colonial time during the Matebeleland tribal atrocities known as Gukurahundi[134] as well as the more recent migration for labour, political safety and looking for new opportunities (Raftopoulos 2009). The issue of migration is one of themes which will also be explored in relation to the origins and spread of HIV/AIDS in Zimbabwe in Chapter Four of this thesis.

Following the land acquisition programme were the 2000 and 2002 general and presidential elections which were equally marred by extreme violence despite the fact that the opposition managed to gain 47% against the 49% in the general elections and 42% as opposed to the 56% in the presidential elections (Raftopoulos 2009). The continued atrocities led to Zimbabwe's suspension from

[133] Robert Mugabe, Inside the Third Chimurenga, Harare, Government of Zimbabwe 2001

[134] This term means washing away the chaff

the Commonwealth and the imposition of targeted sanctions by western countries.

In urban areas, the land issue took a different twist when Operation Murambatsvina[135] was launched in May 2005. Most of those who were displaced were equally were perceived as being anti the ruling establishment (Vambe 2008). This exercise destroyed much of the affected dwellers' livelihoods and had a significant impact on the HIV/AIDS programmes (Sachikonye 2003) details of which are discussed in a separate part of this thesis. In 2008, Zimbabwe once again engaged in elections the results of which led to another dispute between the ruling ZANPF and two MDC parties, one belonging to Morgan Tsvangirai and another to Arthur Mutambara and Welshman Ncube. The impasse was eventually resolved through the signing of the 11 September 2008 Government of National Unity (GNU) agreement but its implementation was not until January 2009 (Raftopoulos 2009). The GNU was dissolved after the July 2013 elections in which ZANUPF claimed victory of over both MDC parties and is in power at the time of writing of this thesis.

Conclusion

This section has highlighted the major milestones in Zimbabwe's history which is basically anchored on its experience of and reaction to colonialism. Although there have been periods of growth and development, the current scenario demonstrates ongoing tensions and challenges to extricating itself from the colonial legacy and framing a new agenda that would characterise an vibrant and fully independent state.

Despite the July 2013 elections, Zimbabwe today portrays a very different image from that which it did in the early years of its independence when it boasted of prosperity, growth and a shining example of African good governance and development. Today, there are perceptions that Zimbabwe is a country with a struggling economy, a tarnished human rights record and political uncertainty. Part of these perceptions are informed by the fact that President Mugabe is often described as instigating some views through use of anti-western (notably

[135] In the local Shona language, the expression literally means drive out filth

Britain and the US) anti-colonial rhetoric (Orwenjo and Ogone 2010). The current scenario paints a rather bleak picture of Zimbabwe in so far as its' socio-economic status and its human rights record goes.

Appendix B

Ethics Approval

University of Glasgow | College of Social Sciences

Ethics Committee for Non Clinical Research Involving Human Subjects

Postgraduate Research: NOTIFICATION OF ETHICS APPLICATION OUTCOME

Application Details

Application Type: Amendments to Check Application Number: CSS2012/0190
(select from drop down as appropriate)

Applicant's Name: Tarsisio Majinya Nyatsanza

Project Title: Developing a Transformative Human Rights Approach to HIV/AIDS Education: An analysis of Zimbabwe and Scotland

Date Application Reviewed: 20/11/2012

Application Outcome

☒ **Fully Approved**
(select from drop down as appropriate)

Start Date of Approval: 07/08/12 End Date of Approval: 31/12/2014

If the applicant has been given approval subject to amendments this means they can proceed with their data collection with effect from the date of approval, however they should note the following applies to their application:

☐ Approved Subject to Amendments without the need to submit amendments to the Supervisor

☐ Approved Subject to Amendments made to the satisfaction of the applicant's Supervisor

Some amendments only need to be submitted to an applicant's supervisor. This will apply to essential items that an applicant must address prior to ethical approval being granted, however as the associated research ethics risks are considered to be low, consequently the applicant's response need only be reviewed and cleared by the applicant's supervisor before the research can properly begin. If any application is processed under this outcome the Supervisor will need to inform the College Ethics Secretary that the application has been re-submitted (and include the final outcome).

☐ Approved Subject to Amendments made to the satisfaction of the College Ethics & Research Committee

The College Research Ethics Committee expects the applicant to act responsibly in addressing the recommended amendments.

A covering note (letter or email) must be provided highlighting how the major and minor recommendations have been addressed.

☐ Application is Not Approved at this Time
Please note the comments below and provide further information where requested. The full application should then be sent to the College Office via e-mail to Terri.Hume@glasgow.ac.uk. You must include a covering letter to explain the changes you have made to the application.

☒ **Amendments Accepted. Application Complete.**
(select from drop down as appropriate)
This section only applies to applicants whose original application was approved but required amendments.

Application Comments

Major Recommendations: *(where applicable)*

Not applicable.

Minor Recommendations: *(where applicable)*

Not applicable.

If amendments have been recommended, **please ensure that copies of amended documents are provided to the College Office** for completion of your ethics file.

Reviewer Comments (other than specific recommendations)

None.

Please retain this notification for future reference. If you have any queries please do not hesitate to contact Terri Hume, Ethics Secretary, in Room 104, Florentine House, 53 Hillhead Street, Glasgow G12 8QF.

End of notification.

Appendix C

University of Glasgow | School of Education

Plain Language Statement

The following is a plain language statement for the doctoral research that I am undertaking at in the School of Education at the University of Glasgow.

1. Study title and Researcher Details

i. Title of Project

Developing a Transformative Human Rights Approach to HIV/AIDS Education: An analysis of Zimbabwe and Scotland

ii. Name and details of Researcher

Tarsisio Majinya Nyatsanza, University of Glasgow, School of Education, St Andrews's Building, 11 Eldon Street, Glasgow, Scotland, UK, G3 6NH
Telephone: + 44 (0) 7957900753 Email: t.nyatsanza.1@research.gla.ac.uk

iii. Research Supervisors

Professor James C. Conroy PhD, Head of Internationalisation, College of Social Sciences, Head of Creativity, Culture and Faith, School of Education, University of Glasgow, St. Andrew's Building, 11. Eldon Street, Glasgow, G3 6N, Tel: ++ (0)141 330 7375, Email: James.Conroy@glasgow.ac.uk
Dr Stephen McKinney, School of Education, University of Glasgow, St Andrew's Building, 11. Eldon Street, Glasgow, G3 6NH, Tel: ++ (0) 141 3303051, Email: Stephen.McKinney@glasgow.ac.uk

iv. Degree being sought

I am undertaking this research as a requirement for the degree of doctor of philosophy.

2. You are being invited to take part in this research study which will be based on a semi-structured interview. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me or my supervisors if there is anything that is not clear or if you would like more information. Do take time to decide whether or not you wish to take part. Thank you for reading this.

3. What is the purpose of the study?

The current status of HIV/Aids is sufficient testimony for the need for continued global and local efforts to combat the epidemic. Although significant strides have been made in producing antiretroviral drugs (ARVs), there still remains disproportionate availability, access, treatment, support and care for those infected and affected by the epidemic between the developed and developing worlds. In this study, Scotland will represent the developed world in terms of its overall standard of healthcare but more importantly in terms of the significant success that it has made in combating HIV/Aids. Zimbabwe on the other hand will be used as

an example of a developing country in sub-Saharan Africa where HIV/Aids have one of the highest proportions of infected and affected people in the world. This study will seek to provide a much wider framework for analysing the complexities of the issues that underpin the discourse of HIV/AIDS through utilising a transformative human rights approach given that it provides a more inclusive and justifiable approach. It will also provide a critical framework in terms of its interdisciplinary dimension, its overall practical relevance, as well as well as its vital contribution to international scholarship in the HIV/AIDS and related areas**.**

Given that HIV/AIDS is a epidemic, not only will it draw from exemplars of the selected scenarios but it will also contribute to the wider dimensions of research, policy and practice and identify how lessons from one scenario may be replicated in others beyond geographical boundaries. As such, findings from this research will enhance best practice of International Development and improve the north-south partnerships on global issues like HIV/AIDS. Skills-sharing and transference will be located in and developed from within this research study.

4. Why have I been chosen?

You have been chosen to take part in this study because you have been identified as a key informant on issues of HIV/AIDS and because you have demonstrated expertise and interest in HIV/AIDS within your professional capacity.

5. Do I have to take part?

Your participation in this research is entirely voluntary. I f you decide to take part in the research, you will be given this information sheet and you will also be asked to sign a consent form. If for any reason you decide to withdraw from the study, you are free to do so and you do not need to give your reasons for doing so.

6. What will happen to me if I take part?

The interview session will last up to an hour and an hour and a half. The interview will be audio-taped and transcribed and analysed for use in the research study.

7. Will my taking part in this study be kept confidential?

Information about you and the interview will be treated strictly confidentially throughout and beyond the research study. Any personal details will be removed from the information and any reference made will only be through anonymous codes.

8. What will happen to the results of the research study?

The data collected from this study will be used for the award of a doctoral degree and any future use will be for presentations in lectures, seminars, workshops and publications in journals, books and conferences. In all these future presentations, your anonymity will still be maintained.

9. Who is organising and funding the research? (If relevant)

This research is funded and sponsored by the ESRC grant and University of Glasgow towards the ward of a doctoral degree.

10. Who has reviewed the study?

The research study has been reviewed by the School of Education Ethics committee.

11. Contact for Further Information

Please feel free to contact the university's ethics officer as well as my research supervisors if you wish to raise any issues regarding the conduct of this research. These can be contact as follows:

Main Research Supervisor:

Prof James Conroy, Head of Internationalisation, College of Social Sciences, Head of Creativity, Culture and Faith, School of Education, University of Glasgow, St. Andrew's Building, 11. Eldon Street, Glasgow, G3 6NH, Tel: ++ (0)141 330 7375

Email: James.Conroy@glasgow.ac.uk

School Ethics Officer

Mrs Irene McQueen

Email: irene.mcqueen@glasgow.ac.uk

Thank you very much for taking part in this study

Appendix D

Interview questions

i. How prevalent do you think HIV/AIDS in your context? Would you be prepared to put any numbers to the incidence of HIV/Aids?

ii. What in your opinion is the explanation for the origins of HIV/AIDS in your national context? Why is this the case?

iii. What was the initial national response of politicians/medics/ churches/community leaders/population in general to HIV/AIDS?

iv. What HIV/AIDS policy frameworks, for example, were put in place to guide the responses to the epidemic?

v. How do you think the messages about HIV/AIDS are communicated to the population as a whole? Which are the most popular tools of transmission of these messages and why?

vi. Should learning about HIV/AIDS be included in Sex Education in Schools? If so, how?

vii. In your experience/understanding how are statistics on the prevalence of HIV/AIDS collected and published? How adequate do you think they are? How important is the role of statistics in the public understanding of HIV/AIDS infection?

viii. What are the balances between the successes and challenges of your HIV/AIDS initiatives?

Appendix E

University of Glasgow | School of Education

Consent Form

Title of Project:

Developing a Transformative Human Rights Approach to HIV/AIDS Education: An analysis of Zimbabwe and Scotland

Name of Researcher: Tarsisio Majinya Nyatsanza

6.0.1

1. I confirm that I have read and understand the Plain Language Statement for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any explanation.

3. I have been made aware that the interview will be audio-taped and then transcribed and that a copy of that transcript would be made available to me for further comment and confirmation.

4. I have been assured that the data collected from this study will be used for the award of a doctoral degree and that anonymity will be maintained.
5. I have also been assured that any future use will be for presentations in lectures, seminars, workshops and publications in journals, books and conferences.
6. I have been made aware that when in future the interview data may be used for presentations, my anonymity will still be maintained.
7. I have been made aware that should I so need, a copy of the finished research report will be made available to me.
8. I agree / do not agree (delete as applicable) to take part in the above study.

6.0.1.1	**Name of Participant**	**Date**	**Signature**
6.0.1.2			
6.0.1.3	**Researcher**	**Date**	**Signature**

Appendix F

SCOTLAND SELECTED KEY POLICY DOCUMENTS

1. HIV Infection in Scotland: Report of the Scottish Committee on HIV Infection and Intravenous Drug Misuse (McClelland Report), Scottish Home and Health Department, September 1986
2. Report of the National Working Party on Health Service Implications of HIV Infection (Tayler Report), May 1987
3. The AIDS Control Act (UK) 1987
4. A national Survey of HIV Infection, AIDS and Community Nursing Staff in Scotland: a Summary Report of Findings, University of Edinburgh, Department of Nursing Studies, 1989
5. HIV and AIDS in Scotland: Prevention the Key, Report of Ministerial Task Force, The Scottish Office Home and Health Department, Edinburgh, 1992
6. AIDS Control Act Report: Greater Glasgow Health Board, Glasgow, 1992-1993
7. AIDS Control Act Report: Greater Glasgow health Board, glasgow 1993-1994
8. ANSWER (AIDS News Supplement to the Weekly Report): HIV & AIDS Surveillance in Scotland, Review of the Epidemic to December 1994, Scottish Centre for Infection and Environmental Health, Ruchill Hospital, Glasgow, 1995
9. Building on Good Practice: HIV Prevention Initiatives in Scotland. A Report from the SHAIR group: The Scottish HIV and AIDS Initiatives Register, Education Health Board, Edinburgh,1995
10. Respect and Responsibility: Strategy and Action Plan for Improving Sexual Health, Scottish ~Executive, Edinburgh, 2005
11. HIV and Hepatitis: Current Controversies in Prevention and Public Health, Health Protection Scotland, Edinburgh, 2005
12. Respect and Responsibility: Sexual Health Strategy Annual Report, Scottish Executive, Edinburgh, 2006
13. Respect and Responsibility: Sexual Health Strategy Annual Report, Scottish Executive, Edinburgh, 2007
14. HIV Action Plan in Scotland: December 2009 to March 2014, November 2009

15. The Penrose Enquiry, Preliminary Report, Edinburgh, 2010
16. The sexual Health and Blood Borne Virus Framework 2011-15, The Scottish Government, Edinburgh 2011

Catholic Sex Education

1. Called to Love Series, Scottish Catholic Education Service, Glasgow, 2008

Other Selected Documents

2. Sex Education in Scottish Schools: A guide for Parents and Carers, Scottish Executive, Edinburgh www.**scotland**.gov.uk/Resource/Doc/158295/0042865.pdf (accessed 24.09.2014)
3. Sexual Health and Relationships Education (SHARE), Glasgow https://www.glasgow.gov.uk/index.aspx?articleid=8735 (accessed 24.09.2014)
4. Talk 2: (Sexual Health Programme) Glasgow City Council http://www.talk2glasgow.com/?pid=4 (accessed 24.09.2014)

Appendix G

ZIMBABWE SELECTED KEY POLICY DOCUMENTS

Zimbabwe Government HIV/AIDS Documents

1. National HIV/AIDS Policy, republic of Zimbabwe, Harare, 1999
2. Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) 2000-2004, Harare, 2000
3. Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) 2006-2010, Harare, 2006
4. Zimbabwe National HIV and AIDS Strategic Plan (ZNASP II) 2011-2015, Harare, 2011
5. Criminal Law (Codification and Reform) Act Chapter 9:23, No. 23/2004
6. National AIDS Council of Zimbabwe Act, Chapter 15:14, No. 16/99
7. Zimbabwe Demographic Health Survey (ZDHS), March 2012, Harare

Zimbabwe Ministry of Education Documents

1. Let's Talk: An AIDS Action Programme for Schools Grades 3-7, developed by the Curriculum Development Unit with assistance from UNICEF, Harare (1996 -2000)
2. Think About it! An AIDS Action Programme for Schools Forms 1-6, developed by the Curriculum Development Unit with assistance from UNICEF Forms 1-6 (1994 -2000)
3. HIV/AIDS Life Skills Education Secondary School Syllabus Form 1-6, Curriculum Development with assistance from UNICEF, Harare, 2003
4. Girl Empowerment Movement (GERM): Resource Pack for Zimbabwe, Ministry of Education & UNICEF, Harare 2010
5. Boy Empowerment Movement (BEM): Resource Pack for Zimbabwe, Ministry of Education & UNICEF, Harare 2010

Other Documents

1. Inheritance Under Customary Law and General Law, Know Your Rights Series, Legal Resources Foundation, Harare, 2012
2. HIV/AIDS & The law, Know Your Rights Series, Legal Resources Foundation, Harare, 2012

ZIMBABWE CATHOLIC CHURCH DOCUMENTS

Zimbabwe Catholic Bishops' Conference Pastoral Letters

1. AIDS and Our Moral Responsibility, October 1987
2. Save Our Families: Pastoral Letter on Marriage, Family, Sexuality and the AIDS Epidemic, March 1992
3. Even Children of HIV-positive Mothers Have a Right to Life, February 1992
4. The Family is the Basic Unit of Society: Pastoral Statement on the Cairo World Conference on Population and Development, 1994
5. Male and Female He Created Them, January 1996(a)
6. You are My Witnesses to Make Christ Known: A Letter from the Bishops of Zimbabwe to the Laity, Religious and Clergy on the Implementation of the African Synod in Preparation for the Celebration of Jubilee Year 2000, 1996(b)
7. Responsibility – Honesty- Solidarity, April 1997 (b) ZCBC Patoral Letter for the New Millenium 2000 A.D., December 1999.
8. Tolerance and Hope, May 2001
9. Proclaiming a Gospel of Life, 2102

OTHER ZIMBABWEAN CHURCHES' DOCUMENTS

1. Plan of Action: The Ecumenical Response to HIV/AIDS in Africa, Nairobi, 2001
2. Responses of the Faith-Based Organisations to HIV/AIDS in Sub-Saharan Africa, Geneva, 2003
3. Heads of Christian Denominations in Zimbabwe: HIV/AIDS Policy, Harare, 2005
4. The Methodist Church of Southern Africa: Revised HIV & AIDS Strategy & Implementation Plan, 2006
5. Ecumenical HIV and AIDS Initiative in Africa: A Re-Reading of the Book of Job in the Context of HIV/AIDS, Charles Klagba, Lome, 2009

Other Zimbabwean HIV/AIDS Policy Documents

1. HIV/AIDS Policy Document for Schools (Undated)
2. A Worker's Guide to the Zimbabwe Catholic Bishops' Conference HIV and AIDS Workplace Policy, Prepared by the Catholic Commission of Justice and Peace

3. Vera Humanitas (True Humanity), AIDS Free Generation: A Possibility or Utopian Ideal? Chishawasha Seminary Resource Centre, Issue No.1, December 2011
4. Growth? Without Equity? Brian MacGarry, SJ, Silveira House Social Series, No.4, Harare 1993
5. ESAP & Education for the Poor, Anthony Berridge, SJ, Silveira House Social Series No.5, Harare, 1993
6. Double Damage, Brian MacGarry, SJ, Silveira House Social Series No. 7, Harare, 1994
7. Land for Which People? Some Unanswered Questions, Brian MacGarry, SJ, Silveira House Social Series No.8, Harare 1994
8. Forward in Hope: A Plan of Action for the next Twelve Months: A Response to HIV/AIDS by the Joint Conference of Major Religious Superiors of Zimbabwe, Harare, 2005

ZIMBABWE HIV/AIDS LEAFLETS

1. The Blackmailers' Charter: Advice to Homosexuals at risk of blackmail in Zimbabwe Harare, (undated)
2. Young People's Network on Sexual Reproductive Health HIV and AIDS, Harare, (undated)
3. Positive Living for Young People in Zimbabwe, Harare, (undated)
4. Stop Stigma & Discrimination: The Young People's Network on SRH, HIV & AIDS, Harare, (undated)

Appendix H

Telephone: +263-4-790039
Telegraphic Address:
"MEDICUS", Harare
Fax: +263-4-720119/702293
Telex: MEDICUS 22211ZW

ZIMBABWE

Reference:
Ministry of Health and Child Welfare
P O Box CY1122
Causeway
HARARE

2 October 2012

Dr O Mugurungi
Director – National Aids Council

Re: MR T. NYATSANZA

Kindly assist the above mentioned who is carrying out PHD Research around HIV.

Brigadier General (Dr) G Gwinji
SECRETARY FOR HEALTH AND CHILD WELFARE

SECRETARY FOR HEALTH AND CHILD WELFARE
(01) SECRETARY OFFICE (01)
2012 -10- 02
P.O. BOX CY 1122, CAUSEWAY
ZIMBABWE

Appendix I

all communications should be addressed to
"The Secretary for Education Sport and Culture"
Telephone: 734051/59 and 734071
Telegraphic address : "EDUCATION"
Fax: 794505/705289/734075

ZIMBABWE

Ref: C/426/3
Ministry of Education, Sport, Arts and Culture
P.O Box CY 121
Causeway
Zimbabwe

TARSISIO NYATSANZA
C/o BISHOPS' HOUSE
DIOCESE of MASVINGO ROMAN CATHOLIC CHURCH
MASVINGO
ZIMBABWE

RE: PERMISSION TO CARRY OUT RESEARCH

Reference is made to your application to carry out research in the Ministry of Education, Sport and Culture institutions on the title:

DEVELOPING A TRANSFORMATIVE HUMAN RIGHTS APPROACH TO HIV/AIDS EDUCATION: AN ANALYSIS OF ZIMBABWE AND SCOTLAND

Permission is hereby granted. However, you are required to liaise with the Provincial Education Director responsible for the schools you want to involve in your research.

You are also required to provide a copy of your final report to the Ministry since it is instrumental in the development of education in Zimbabwe.

MINISTRY OF EDUCATION
16 AUG 2002
I. Gweme
FOR: SECRETARY FOR EDUCATION, SPORT AD CULTURE