THE CONTRIBUTION OF CULTURE TO THE SPREAD OF HIV

by

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submitted in fulfillment of the requirements for
the degree of

MASTER OF SCIENCE

in the subject

PSYCHOLOGY

at the

UNIVERSITY OF SOUTH AFRICA

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September 2008

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DECLARATION

I declare that **THE CONTRIBUTION OF CULTURE TO THE SPREAD OF HIV** is my own work and that all the used and quoted sources have been indicated and acknowledged by means of complete references. I also declare that this work has not previously been submitted for any other degree at any other institution.

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Marié Joubert-Wallis (signature) **Date**

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ABSTRACT

Cultural factors have been shown to play a role in human decision making and behaviour. The main objective for this research was to identify and evaluate the possible influence of Shangaan cultural beliefs, myths and behaviours, on the spread of HIV within the Mnisi tribe. A qualitative method of investigation was followed; interviews with three participants and observations of the Mnisi culture were used in the construction of the investigation and findings. Through the information obtained two cultures influencing the spread of HIV in the Mnisi tribe were identified, they are (1) The culture of power-rule and fear, and (2) The culture of poverty.

Key words: HIV, AIDS, Culture, Power, Poverty

Acknowledgements

Thank you to,

everyone who has contributed to the construction of this investigation and document.

In particular,

- James Wallis for his support as my husband, best friend and lifelong conversational partner;
- Johan and Suzette Joubert, my parents, without whom I wouldn't have had the opportunities that I have had in life;
- Eduard Fourie who has been an excellent supervisor and support throughout the entire period of the investigation;
- Mr. D, Ms. J and Ms. P (the participants) for their active contribution in the co-construction of this document;
- D. Prinsloo for her willingness to be a critical reader of this document at a very busy time in her life;
- Our Heavenly Father for life and the opportunities He has given me.

Dedication

I dedicate this dissertation to all the members of the Mnisi tribe who are suffering due to the affect and effect of HIV and AIDS in their community.

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LIST OF ABREVIATIONS

AIDS……. Acquired Immunodeficiency Syndrome
ARV's……... Anti-retroviral drugs
HIV……. Human Immunodeficiency Virus
STI……. Sexually Transmitted Infection
TAC……... Treatment Action Campaign
TB…….. Tuberculosis

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CHAPTER 1

INTRODUCTION

Each person's map of the world is as unique as their thumbprint. There are no two people alike...no two people who understand the same sentence the same way...So in dealing with people try not to fit them to your concept of what they should be.

(Milton Erickson, cited in Constable Research BV, 2007, electronic version)

'Everything flows,' said Heraclitus… Therefore we 'cannot step twice into the same river.' When I step into the river for a second time, neither I nor the river are the same.

(Jostein Gaarder, 1995, p. 30)

Yea, That I might them better palliate,
I did too with them thus Expostulate:
May I not write in such a style as this?
In such a method too, and yet not miss
Mine end, thy good?

(John Bunyan, 1678, p. 9)

I aim to set down in this journal all that happens to us on
this trip. I shall do it as truly and faithfully as I can...

(Barbara Brenner, In Perrin, 1994, p. 46)

1.1 Introduction

HIV and AIDS are complex issues affecting many individuals around the world. It has been the main subject of many international talks and seminars, and has been incredibly costly to the international community, both directly and indirectly. It seems that a cure to HIV/AIDS will not be found in the near future and therefore the current main aim of investigations and interventions should be to stop the spread of the virus.

This dissertation aims to give an accurate account of the investigation, which aimed to, through qualitative research and thematic analysis, obtain a better understanding of the complexity of the spread of HIV using a cultural perspective. I wanted to identify and evaluate the possible influence of Shangaan cultural beliefs, myths, and behaviours, on the spread of HIV within the Mnisi tribe. The investigation was done by exploring HIV/AIDS as a problem in a village in the Bushbuckridge municipal area in the South African Lowveld. In order to compile this dissertation I drew on the results of approximately 18 months of fieldwork, which included both interviews and observations.

The reader must not expect to find a neat and precise study, but rather a blemished account of a journey of discovery. I make no claim that this is an absolute and fixed truth, but rather a version of the truth as I have experienced it through this journey. A journey through which I used the lenses of social constructionism, which holds that knowledge results from interaction and is situated in social space – in the in-between (Viljoen, 2004). Since meaning is created and re-created in the social space between the reader and the text, I hereby invite the reader to become a co-author of this dissertation – there will thus be as many interpretations as there are readers of this text.

Throughout the research process I was involved in a number of interviews with three members of the Mnisi tribe, Mr. D, Ms. J., and Ms. P. Through the research process I came to understand myself as well as my role as researcher better. I learned that I couldn't, no matter how hard I tried, be totally untouched by this process of investigation and that I couldn't completely step back from the topic being investigated. Due to the

reductionistic nature of writing. The words of Margaret Fuller (In Perrin, 1994, p. 53) can be aptly quoted here “[t]o one who has enjoyed the full life of any scene, or any hour, what thoughts can be recorded about it seem like the commas and semicolons in the paragraph – mere stops”.

1.2 Outline of the dissertation

One of the more consistent pieces of advice I received on writing a dissertation was that I should write the first chapter last. At first I found this concept rather strange, but as I came to the end of my research journey it became apparent that it would indeed be best to write this chapter last. Why, might you ask? The reason is simple: one can only truly know what will happen once it has already happened. As we often say: hindsight is 20 / 20 vision. Chapter 1 is thus an overview, written after the investigation, of how the investigation will be presented through the rest of the dissertation.

In Chapter 2 I attempt to communicate the research topic conscientiously by giving an overview of the literature on health, HIV/AIDS, culture, and the Mnisi tribe. I investigate the literature on the important part good health plays in our modern day, the effect HIV/AIDS has on Southern Africa and the individuals living in this part of the world, and what role culture plays in the life of an individual. An overview of the Shangaan culture is given, looking at what is seen as important within the culture, the ‘life world’ of the Mnisi tribe is also discussed. The chapter ends with the objectives of the investigation.

Chapter 3 is my attempt to explain the methods used during the research process, which is situated in a postmodern context. It describes how the process evolved. Because of the central place the researcher takes in the experience, observation, description and creation of data, I included a description of myself as a research instrument. I also included a description of the participants in the investigation and how both the participants and I handled the interviews. The statement made by Covey (1999, p. 37) that one “cannot pretend for long, for you will eventually be found out” has

been as true for me as it has been for the participants in this study. Both parties (i.e., the participants and I) expected to 'find' certain things in the other that were simply part of the expecting party and not of the one that it was expected of. It took quite some time, but eventually both parties came to this realization and accepted the other's 'truth' for what it was. The manner the data was gathered and the general process of thematic analysis that was used for the interview analysis is discussed. Here I also refer to the participant consent form, which can be found in Appendix A.

Chapter 4 provides my version of what has been 'found' by the investigation. There could possibly be hundreds of different interpretations of the data from the interviews. I have attempted to let the voices of the participants be heard throughout the text, but as a human being with my own background and views I also have an influence on the data creation and the data should therefore be seen as a single construction of the truth. Through the use of member checks (i.e., going back to the participants to see whether my interpretation and that which I wrote made sense to them, as well as whether it reflected their experiences), I believe the data to be representative of the participants' views. The two cultures that were identified, through the interviews and observations, as playing a role in the spread of HIV within the Mnisi tribe are discussed in this chapter. These cultures were:

1. The culture of power-rule and fear, and
2. The culture of poverty

Chapter 5 concludes the investigation. I make some recommendations on how HIV transmission can be reduced within the Mnisi tribe. Care is taken that these recommendations are only put forward as a point of departure for more investigations regarding the possible effect of culture on the spread of HIV within the community. The limitations of the investigation are given and the investigation is concluded.

1.3 Conclusion

Through this investigation I aimed to obtain a better understanding of the complexity of the spread of HIV within the Mnisi tribe using a cultural (specifically the Shangaan cultural) perspective. A better understanding of these cultural factors might be a step closer to finding better, culturally acceptable methods to prevent the spread of HIV within the Mnisi tribe and from the Mnisi tribe to others. The participants and I, as researcher, have through this study gained insight into the cultural influences on the spread of HIV within the Mnisi tribe. The research findings can be used as a departure point for designing a culture-specific HIV prevention intervention within the Mnisi tribe.

CHAPTER 2

LITERATURE

> [I]f the head and body are to be well, you must begin by curing the soul; that is the first thing. And the cure… has to be effected by the use of certain charms, and these charms are fair words; and by them temperance is implanted in the soul, and where temperance is, there health is speedily implanted to the whole body.
>
> (Plato, cited in Hook, 2004, p. 210)

> [I]ndividual change is most likely to come from projects in which people collaborate not only to change their own behaviour but also to understand and challenge the social circumstances that place their health at risk.
>
> (Freire, cited in Campbell, 2004, p. 335)

In this chapter I attempt to communicate the research topic conscientiously by giving an overview of the literature on HIV and AIDS, the concept ‘culture’, as well as the Mnisi tribe and its people.

2.1 Health

Our present day society has an extreme interest in and is exceedingly concerned about issues related to health. We are consistently being encouraged to exercise more, eat healthily, avoid smoking and excessive drinking, et cetera. People are joining gyms and sport clubs more than ever before. The media constantly bombard us with advertisements of products that will ‘help you loose weight’, ‘live healthier’, ‘feel more

energetic', et cetera. Some medical aids now reward people for complying with certain standards which qualify them as living healthily and even provide their clients with gym contracts and subscriptions to health magazines at reduced prices. The benefits of traditional African medicines (Sempbembwa, 1983) are widely being advertised and promoted. Dr Ebrahim Samba, WHO Regional Director for Africa, said he wants people to continue to use African herbal plants and traditional medicines, and action plans are currently being developed (by WHO in collaboration with African leaders) so that traditional medicine will soon form an integrated part of the minimum health care package in African countries (Health & Wellness Resource Centre (HWRC), 2000). Hunger, malnourishment, and resultant poor health of individuals living in Africa have become a great concern to many individuals, health institutions, and world leaders (e.g., Kruger, Schönfeldt & Owen, 2008; Leon & Walt, 2000; United Nations, 2005). The European Commissioner for Health and Consumer Protection, David Byrne (2004), holds that good health for all is far from a reality, but that the achievement thereof is possible and that in order to achieve good health the grass root problems (e.g., poverty, social exclusion, and healthcare access) need to be addressed, this has in the last couple of years become the main focus of many studies and proposed interventions (O'Farrell, 2001).

Bloom, River Path Associates, and Sevilla (2002) claim that the renewed interest in health has three causes; the first of which is its importance to people. According to the United Nation's Millennium Poll (cited in Bloom et al., 2002) good health topped the list as the thing people value most in life. The second reason why health has become so important is because we now know its importance to economic and social development (Bloom & Canning, 2000). A society that is healthy has a better chance to become a wealthy society than one that is not. The third reason is the complex challenges that health poses to local, regional, and national governments. The ability to respond to major health challenges depends on the health of institutions themselves. Populations that are getting older, increased drug resistance, and the unceasing burden of disease in rich and poor countries, all indicate that policy-makers must try to solve a continuously mutating problem (Bloom et al., 2002).

2.2 HIV/AIDS

HIV has in the last thirty years gone from a rare, barely-ever-heard-of-virus to a virus known and feared by almost everyone around the globe. Unfortunately, the spread of HIV/AIDS across the globe, and especially in Africa, has become a familiar story to most (Webb, 1997). South Africa is currently experiencing one of the most severe AIDS epidemics in the world, where almost 1,000 AIDS deaths occur every day (AVERT, 2007).

HIV/AIDS, and other infectious diseases, take more of a toll now than it has at any other time since the early part of the 20th century (Hawa, 2001). The rate at which HIV is spreading would have been unimaginable twenty years ago. The enormous impact that HIV/AIDS has on our country and its people becomes dreadfully clear when looking at current statistics. UNAIDS (2006) states that, although Sub-Saharan Africa has just over 10% of the world's population, it is home to more than 60% of all people living with HIV (25.8 million). Table 2.1 illustrates statistical findings of the South African HIV/AIDS epidemic by UNAIDS for 2006.

Table 2.1. South African HIV/AIDS estimates for 2006

HIV AND AIDS ESTIMATES	
Number of people living with HIV	5 500 000 [4 900 000 – 6 100 000]
Adults aged 15 to 49 HIV prevalence rate	18.8 [16.8 – 20.7]%
Adults aged 15 and up living with HIV	5 300 000 [4 800 000 – 5 800 000]
Women aged 15 and up living with HIV	3 100 000 [2 800 000 – 3 400 000]
Deaths due to AIDS	320 000 [270 000 – 380 000]
GENERALISED EPIDEMICS	
Children aged 0 to 14 living with HIV	240 000 [93 000 – 500 000]
Orphans aged 0 to 17 due to AIDS	1 200 000 [970 000 – 1 400 000]

(adopted from UNAIDS, 2006, electronic version)

According to studies done by the World Health Organization (WHO) and UNAIDS in July and December of 2002, the estimated and projected deaths in Southern Africa, due

to AIDS and AIDS related illnesses, of people aged 15 to 34 years, have been placed at approximately 1.8 million between the years 2010 and 2015 (Craythorne, n.d.).

Alan Gelb, World Bank economist for Africa, holds that HIV/AIDS have been even more devastating than statistics suggest. He states that countries' economies have been severely impacted as HIV is most likely to infect adolescents and young adults (being in the most productive period of their lives); an entire generation is being erased by the epidemic, leading to a severe shortage of skilled person-power (Hawa, 2001). The UNAIDS director, Peter Piot, was quoted in Hawa (2001, p. 3) as saying AIDS is "the single greatest threat to global development". In his article 'The vicious circle of AIDS and poverty', Loyn (2003) agrees with the above authors when he says that the most productive people die or are weakened by HIV just when society needs them most.

The course of the HIV epidemic is influenced by, for example, our expression of our sexuality, drug and alcohol use, the role of the media, the response of governmental institutions, and the public's perception of the seriousness of the disease. The magnitude of the HIV/AIDS problem should force us to re-examine our social systems, our beliefs, our behaviours, and our institutions (Muir, 1991). Hawa (2001) holds that the collapse of social and public health and delivery systems provide the ideal conditions for the spread off ill health, epidemics, and death. She also notes that the number of deaths due to war in 1998 was two hundred thousand while those who died due to the effect of AIDS was close to two and a half million.

Despite the South African government's massive efforts to inform the public about the risks of HIV/AIDS, behavioural changes are still not occurring as was expected. For many years (especially from 1993 to 2000) the AIDS epidemic in South Africa had gone unchecked due to the distraction caused by major political changes and valuable time were lost where prompt action and acknowledgement of the impact of the epidemic could potentially have lessened the severity of the epidemic (AVERT, 2007). The disease has already claimed the lives of millions of people and the "context of life in the new southern Africa is increasingly one of HIV/AIDS" (Webb, 1997, p. xi).

Waldo and Coates (cited in Sigogo & Modipa, 2004) have highlighted how HIV-prevention has been hindered by individual-level explanations of sexual behaviour, which has led to individual-level interventions (which should lead to individual-level change). These interventions fail to consider features of social context, which might either enable or hinder an individual's ability to act in a certain way. Social factors such as poverty, gender, and stigma make it difficult for individuals to protect their sexual health. Green (2003, p. 5) argues that:

> [T]he basic model of AIDS prevention adopted virtually everywhere derived in large measure from the first programs designed in the United States for the local epidemic. These programs were developed for high-risk groups. Yet most HIV infections in the world are found in sub-Saharan Africa…, and in majority populations rather than in high risk groups.

HIV crosses social, physical, cultural, cross cultural, ideological, economical, political, religious, moral, legislative, and international borders. The disease does not discriminate to specific socio-economic, racial, and ethnic groups and has an impact on individuals' as well as groups' lives. The manner in which societies organise and reproduce themselves have been, and still continues to be, affected by the changing structure of populations – changes partly caused by the effects of HIV and AIDS (Webb, 1997).

Webb (1997, p. 29) holds that "(t)he complexity of the HIV/AIDS issue in developing countries, in Africa in particular, necessitates a certain degree of conceptualisation in order to define the parameters of the subject and the relative importance of factors involved". The Red Cross 'World Disaster Report 2002' (in Loyn 2003, p. 3) also realising this, asked whether it is morally acceptable for relief agencies to deal with this humanitarian disaster any longer without addressing its causes. Lots of money is being spent without any 'dividends' to those in need.

The transmission of HIV is dependant on a whole host of physiological, psychological, sociological, economic, and political factors, and it is rooted in a historical context (Webb, 1997), all of which should be taken into account when looking at this disease and the spread thereof. According to literature the HIV/AIDS epidemic is complex and multifaceted; therefore multidimensional strategies should be used in order to combat the spread of the virus (Byrne, 2005; UNESCO, 1999; Webb, 1997).

The whole idea of prevention should be reconceptualised into a long term intervention approach, which will mean that awkward political questions will have to be raised regarding resources, human rights, and empowerment (Webb, 1997). The answers of all these awkward questions lie, and should thus be looked for, in the communities and lives of people infected and affected by HIV and AIDS.

Mkhize (2004) argues that research regarding problems such as illiteracy, the disintegration of extended family systems, learning under conditions of extreme poverty, certain issues surrounding HIV/AIDS, et cetera. are put on the back seat and that the research tackling these issues run the risk of being ignored as it is not seen as addressing ‘hard-core’ psychological issues.

The importance of conducting appropriate research in developing societies has been brought home by the AIDS pandemic. Earlier interventions failed miserably, because they were based on research done in developed countries and thus did not take into account the socio-cultural context of people in developing countries (Mkhize, 2004).

From literature (e.g., Osagbemi, Joseph, Adepetu, Nyong, & Jegede, 2007; Piot, Russel, & Larson, 2007; Richey, 2008; Schoepf, 1991; Webb, 1997) three areas of study, within the field of HIV/AIDS, can be identified, which are the cultural environment, the political economy, and the ‘life worlds’ of individuals. The relationship between these areas can be represented as recursive and changing through space and time due to the fact that determinants in any situation act in relation to each other and not as separated entities (see Figure 2.1). Webb (1997) holds that any approach which examines only

some determinants while ignoring others are thus incomplete. If accuracy is to be maintained, conceptualisation of a situation must include all cultural, structural, and behavioural factors. When following such a holistic approach the question asked should change from 'what are the determinants?' to 'how important are the different determinants within this specific context?'

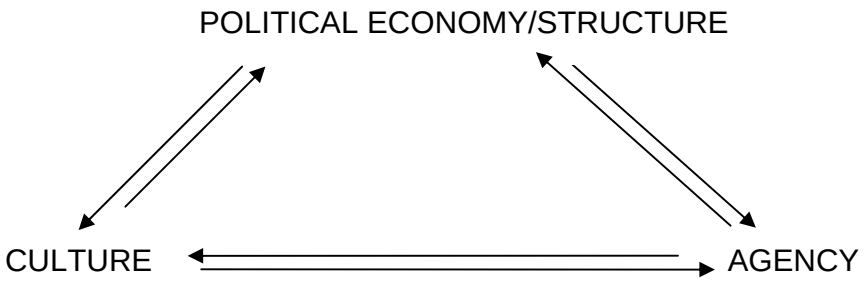


Figure 2.1. Conceptualisation of the study themes within HIV epidemiology (taken from Webb, 1997, p. 32).

According to Webb (1997) individuals both create and interpret the social context in which HIV is spreading. It is thus necessary to examine the 'life worlds' of individuals in order to answer the complex question 'why is HIV spreading the way it is?' He also states that there are two basic forms a community's perception of HIV/AIDS can take on, the first being knowledge of the disease, methods of transmission, and prevention. The second form is the psychosocial construction of the disease where beliefs relating to its origins and aetiology, risk perception, and attitudes toward infected individuals are incorporated into the perception. He also says that, in order to formulate legitimate prevention programmes and to make them truly place sensitive interventions (interventions suited to local conditions) the analysis of the social constructions of HIV and AIDS are crucial.

Muir (1991) states that individuals make limited choices when functioning in their environment. Their functioning is affected by political, economic, and legal structures, which form the norms and institutions of their society. Efforts that attempt to alter the sexual behaviour of individuals must acknowledge that behaviour is rooted and

sustained through ongoing relationships and exchanges within the individuals' social network. Individuals usually behave in a manner that makes sense to them within their current situation or life space. Individuals' attitudes and choices are influenced by the social and cultural norms that they observe and people therefore need not (and in many societies / situations do not) act autonomously (Moncrieffe, 2004).

The founding director of WHO's Global Programme on AIDS, Jonathan Mann, made the link between individuals' deprived social and economic conditions and their vulnerability to AIDS. He said that AIDS "seemed to flourish in and reinforce conditions of poverty, oppression, urban migration and social violence" (quoted in Hawa, 2001, p. 1). In a report entitled 'Can Africa Claim the 21st Century' the World Bank and its partners stated that nearly half of Africa's people live below the poverty line; three quarters do not have access to proper sanitation, two thirds of rural people lack adequate water supplies and less than one in five have electricity available to them (in Hawa, 2001).

Halperin (2001) holds that, although HIV/AIDS has become an enormous problem throughout Africa, we should not give up in despair, but rather examine other social and cultural factors which have helped with the aggravation of the epidemic. He uses male circumcision as an example of what may become an important tool in the prevention of HIV.

As the construction of any construct (including the constructs HIV and AIDS) can be linked to a person's culture (Güss, 2002), I have decided to investigate the spread of HIV from a cultural perspective in more depth. Culture is by no means the only factor influencing the spread of HIV, but it plays a definite role therein (Webb, 1997).

2.3 Culture

> [P]aradigms are the source of our attitudes and behaviors. We cannot act with integrity outside of them. We simply cannot maintain wholeness if we talk and walk differently than we see. . . To try to change outward attitudes and behaviors does very little good in the long run if we fail to examine the basic paradigms from which those attitudes and behaviors flow. . . Each of us tends to think we see things as they are, that we are *objective*. But this is not the case. We see the world, not as *it is*, but as *we are* – or, as we are conditioned to see it. (Covey, 1999, p. 28)

Western approaches to psychology have a number of presuppositions about the individual and the world which has been used in the formulation of western theories. These theories have been imposed on non-western populations as it has been assumed that they are universal (Mkhize, 2004).

Mkhize (2004) argues that indigenous people's languages, philosophies, and worldviews (their basic assumptions surrounding their reality as well as place and purpose in this world) should be taken into account when doing a psychological study, as it is through these constructs that people make sense of themselves and their world. Sire (cited in Hamel, n.d.) agrees with her when he suggests that everybody should think in terms of worldviews and thus be conscious of their own way of thought as well as that of other people. He argues that this is the only way in which people can firstly understand one another and then genuinely communicate with others in South Africa's pluralistic society.

In Table 2.2 a comparison has been made between the components of the 'western' and the traditional African worldviews.

Table 2.2. Components of the 'western' and traditional African worldviews.

Description	Example
Time orientation A culture may emphasize history and tradition, the here and now, or the distant future. Time and space orientation is intertwined. Self-awareness involves an appreciation of where one is coming from, the present, as well as where one is likely to be in the future.	Western view: The future tends to be emphasized. Time is organized into linear segments, marked by what people are doing at a time. Traditional African view: The past and present are concentrated on. It is not the passage of time per se that is important, but the relationship one has with one's ancestors (the past) and one's fellow human beings (the present). Paying attention to context and relationships is more important than the mathematical division of time.
Orientation to nature This dimension answers the question: How is the relationship of people to nature to be understood?	Western view: Mastery and control over the environment is emphasized. Traditional African view: External forces beyond one's control determine life (e.g., God, ancestors and fate). People and nature co-exist, living harmoniously with each other.
Human activity The human activity dimension answers the question: What is the preferred mode of human activity?	Western view: Value is placed on doing over the being or being-in-becoming (the process) mode of activity. This emanates from the belief that one's value as a person is determined by personal accomplishments. Traditional African view: Emphasize being or being-in-becoming, valuing harmony with

	others and the social milieu, as well as spiritual fulfillment.
The relational orientation This is concerned with how the self is defined in relation to the Other and the environment.	Western view: 'The self' is regarded as a bounded entity. People are defined in terms of internal attributes such as thoughts and emotions (self-contained individualism or independent view of self). Traditional African view: 'The self' is defined in terms of one's relationships with one's family, one's community, and one's status within these groups.

(Adapted from Mkhize, 2004, p. 36)

South Africans have a wide range of beliefs, habits, religious, and healing practices, including aspects of both the western and the African worldviews. As in other cultures, Shangaan cultural identity and continuity are maintained through traditional practices. In the past it has been assumed that some traditional practices promote the transmission of HIV, but not many studies have been conducted to establish the linkage (Loosli, 2004).

A tradition (from the Latin word *traditio,* which means 'to hand down') can be seen as information or composed information, that is whatever is brought to the present from the past in a specific societal context (Wikipedia, 2008b). Tradition thus seems to be a fixed link between us and our ancestors. Tradition can also be seen as an economically efficient way of transferring knowledge (Hayek and Sowell cited in Wikipedia, 2008b), decision-making, for example, consumes time while cultural traditions offer a low-cost, consensually reliable manner to use less of the resources required to make decisions independently. According to Loosli (2004) those traditions should be preserved to save the origin of mankind – to do good and not bad. People's behaviour is largely influenced

by the culture in which they had grown (Loosli, 2004). As culture influences the day-to-day activities and decisions of individuals it also affects issues surrounding health.

The terms culture and race are at times used interchangeably in our daily use of the English language. This is however problematic as the term race refers to the concept of dividing people into different groups on the basis of various traits. Most commonly visible traits such as skin colour, facial features, and hair texture are used to place individuals into racial categories (Reber & Reber, 2001). The term culture, on the other hand, is a much broader term.

The word culture comes from the Latin *cultura* which means 'to cultivate' and is generally used when referring to patterns of human activity and the structures that give these activities meaning and importance (Wikipedia, 2008a). According to Jary and Jary (cited in Wikipedia, 2008a) culture can be called the "way of life for an entire society". Culture thus includes codes of conduct, norms of behaviour (e.g., law and morality), dress, language, religion, and systems of belief, rituals (Jary and Jary cited in Wikipedia, 2008a), and is visible in a society's music, literature, painting, sculptures, theatre, et cetera (Williams, 1983). The term culture has many usages and meanings in the language usage of the current day, but in using the term culture I would like to refer to the definition used by Nhlanhla Mkhize (2004, p. 34) who said that culture "refers to knowledge that is passed on from one generation to another within a given society, through which people make sense of themselves and the world. It incorporates language, values, assumptions, norms of behaviour, ideas about illness and health, etc." According to the American Heritage Dictionary (2004, electronic version), culture is, "the totality of socially transmitted behavior patterns, arts, beliefs, institutions, and all other products of human work and thought".

Literature (e.g., Joffe, 1996; Kelly, 1995; Mills, Singh, Nelson, & Nachega, 2006; Stockemer & Lamontagne, 2007; Ying et al., 2006) tells us that finding one solution to stop the spread of HIV that will help everyone, in every community, in every country,

and on all continents, is most probably an impossible task – each community has to be helped in a unique way that will ‘fit’ their communal needs and wants.

Already in the 1990’s Muir recognised and acknowledged that, if we are to control the HI virus, and the spread thereof, we must first acknowledge all the factors that are contributing to the existence and the livelihood thereof. The culture of any community embraces many factors that influence the people who belong to that community and who live according to that culture. Culture thus also influences community members’ behaviour, including sexual behaviour. This should thus be an adequate place to start with an investigation into the spread of HIV within a community.

Through various empirical studies Strohschneider (2002) found that cultural factors play a role in human decision making and states that, “(t)he process (of complex decision-making) is open to a number of cultural influences, among them educational practices, environmental predictability, and power distance” (electronic version).

Individual factors such as knowledge and confidence play, without a doubt, a key role in sexual behaviour (Hook, 2004) and thus also in the spread of HIV, however, these (and other) individual factors are shaped by a person’s social context. Campbell (2004, p. 336) provides the following examples as justification for this statement:

> [A] man may choose not to act on information about the risks of HIV/AIDS due to the social construction of masculinity, which dictates that a ‘real man’ should have sex with many women, and should not be afraid to take risks. A woman’s confidence to assert her rights to sexual health may be undermined in contexts where she depends on gifts from male sexual partners to support herself and her children. A young person’s motivation to attend a clinic for STI’s may be reduced in a social context where adults (ranging from parents to clinic nurses) refuse to acknowledge the existence of youth sexuality, and where STI’s are heavily stigmatised.

Byrne (2005, p. 25), troubled by “the issue of whether the social constitutes a system or whether the social is the space within which that system is located”, came to the conclusion that it must be both. The complexity of any social system and everything within that social system can thus be seen as immense – all things contribute, in some way or another, to the livelihood of everything else within a social system as well as to the livelihood of the social system itself.

We, as individuals, are social creatures and society therefore plays a big role in the way in which we behave (Campbell, 2004). Socially constructed norms and values, which are constructed and reconstructed in interaction between people of a social group, deeply influence a person’s sexual choices or decisions. It is thus clear that social conditions often make it incredibly difficult for a person to act in a health-enhancing way.

Due to the fact that norms, values, and truths are socially constructed concepts, which differ in different communities / settings, the truth or knowledge concerning the cause or causes of the spread of HIV will be different in different settings. Graham (1992, p. 398) expressed this concept as follows:

> [K]nowledges are fully constitutive social processes rather than dependent reflections of an independent real . . . Like other social processes, knowledges differ from each other in ways in which they are constituted and in their social effects, but they cannot be ranked hierarchically on the basis of their closeness to or distance from a singular objective or unchanging ‘reality’. In other words the truth of particular knowledges is not adjudicated in a universal setting but is particular to certain social settings and validation practices.

A factor that plays a big role in social constructions (or social knowledge), of which social norms and values are examples, is culture. Culture, according to Dalton, Elias, and Wandersman (2001, p. 155), “is often expressed in what the society or group seeks to transmit (e.g., by education or example) to younger generations or to immigrants”.

Behaviours that sprout from cultural beliefs and traditions are thus important to individuals within a community as well as to the community as a whole and can therefore not simply be changed by education / knowledge about HIV or other health hazards.

According to Güss (2002) cultural values influence a person's decision making. These values can influence the way in which a person perceives a problem and thus also influence his / her generation of strategies and alternatives as well as which alternative he / she will select from the available alternatives (see Figure 2.2). An individual is guided by cultural expectations and values when he / she selects specific dynamic decision-making strategies.

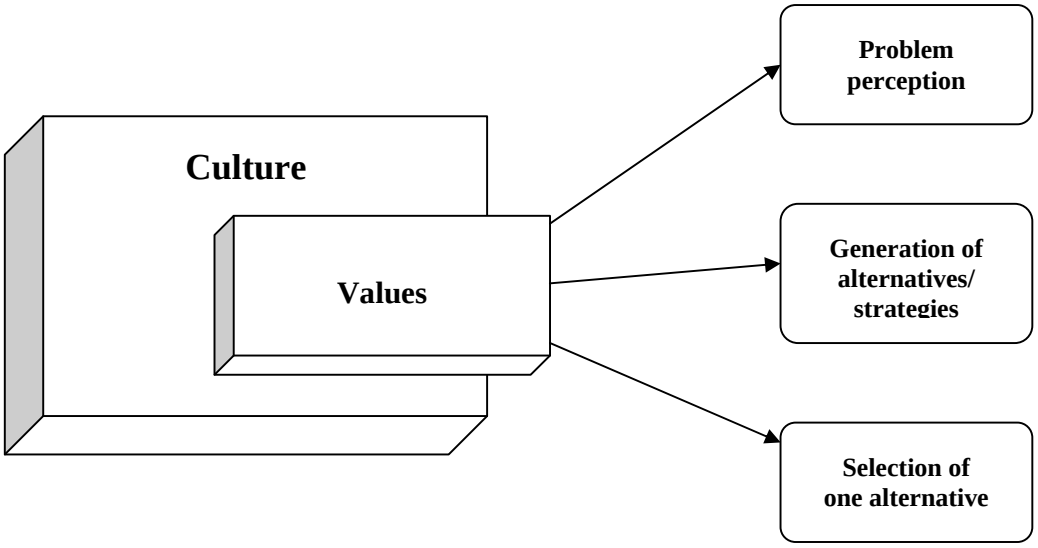


Figure 2.2. Cultural influences on decision making (adopted from Güss, 2002, electronic version.)

Güss (2002) wanted to know how cultural values could influence individuals' decision making and – using a number of studies – he integrated the findings into a model which can be helpful to derive hypotheses for further studies. This model (depicted in figure 2.3) differentiates between the methods of decision making by people with individualistic

value orientations (seen as the ‘Western’ way of thinking) and those with collectivistic value orientations (seen as the ‘African’ way of thinking).

The success with which specific problems are dealt with is influenced by these decision-making strategies and how they are employed. Most of the African cultures favour the collectivistic value orientation which favours a hierarchical social structure and stresses the limitations of the individual’s initiatives and responsibility. Individuals thus use more reactive and adaptive decision-making strategies (Mkhize, 2004).

Culture specific values and expectations are transmitted from generation to generation. These values and expectations are the indicators of what is appropriate within the culture. Making the culturally ‘correct’ decision requires specific expertise that develops through exposure to making different kinds of decisions within different domains of one’s life. This exposure is in part created by culture, for example value systems, familial socialisation, and patterns of schooling – all of which are influenced and shaped by culture (Strohschneider, 2002).

A value is an ambiguous concept as values are considered subjective. Values vary across people and cultures. Personal values are not universal and evolve from circumstances in one’s external world and can change over time (Wikipedia, 2008c). Cultural values identify those objects, conditions or characteristics that members of a society consider essential (Wikipedia, 2008c) and according to Loosli (2004) these values lead the society’s culture.

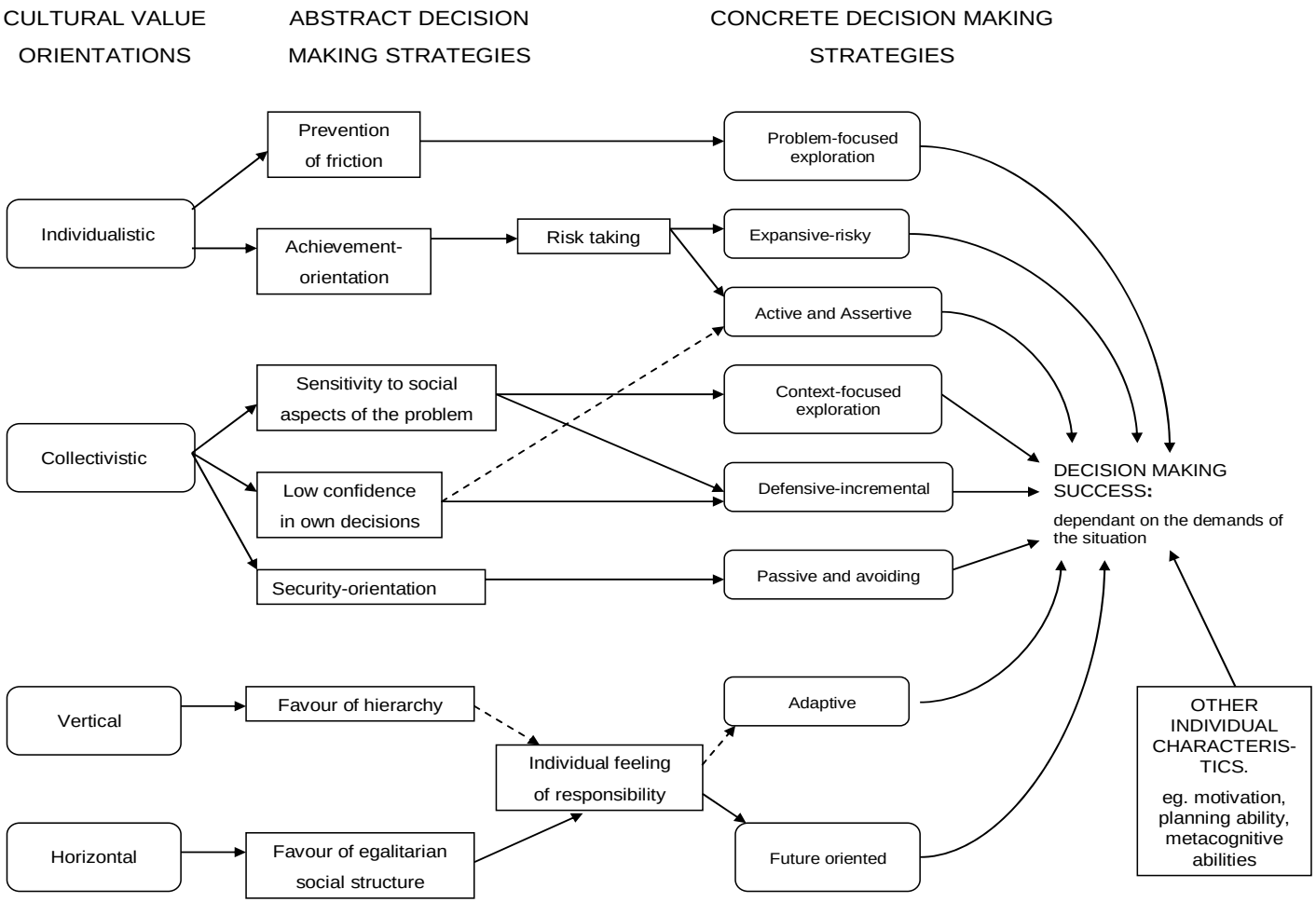


Figure 2.3. Relationship between cultural value orientations, abstract and concrete decision making strategies, decision-making success, and other possible influences. (The solid arrows stand for a positive relationship between variables, the broken arrows for a negative relationship, the curvilinear arrows for a unclear relationship) (taken from Guss, 2002, electronic version).

Strohschneider (2002) states that individuals have limited freedom in making decisions as in many cultures decisions are more influenced by the social and cultural context than by individual decisions. As culture influences (but not determines) marital systems, household structures, circumcision practices, sexual mores, and the social use of space, it is difficult to put culture (an aspatial structure in itself) into the concept of 'high risk behaviour' (Webb, 1997). Individual behaviour will vary according to context but it is not determined by it. There is no simple cause-effect link or answer, only a relationship based on probability; an individual is more likely to contract HIV from participating in high risk sexual activity than when he / she does not participate in such activities. Culture cannot be blamed for spreading HIV, but it can be seen as one of the factors contributing to the complexity of the spread thereof.

Religion and other belief systems form an integral part of one's culture and has been part of cultures throughout human history (Wikipedia, 2008a). Although culture and religion are two different concepts, they go hand in hand contributing to the formation of a person's life paradigm – his or her belief of what is true or false as well as what is right or wrong. It will be hard to conclude which has the most influence. Does culture have a greater influence on one's choice of religion or does religion shape culture in such a manner as to 'fit' its beliefs and prophesies?

Folk religions, practiced by tribal groups, are common in South Africa and, like other major religions, folk religion provides in the needs of all humans for reassurance in troubled times, hope for healing and preventing misfortune, and providing rituals that address the major courses and traditions in human life (Wikipedia, 2008a).

Boyd (1990, electronic version) defined religion as "a belief system that posits a supernatural agency, power or idea behind the manifestation of human affairs and the universe". Religion dictates, not only moral standards, but also which doctrines are correct and it delimits acceptable and unacceptable behaviour and actions. According to Boyd (1990) religion act as a conditioning agent by influencing will, social and cultural

norms, morality and values, perception of the physical and spiritual worlds, belief, emotionality and spirituality, and behaviour.

Will is conditioned by religion by creating what Boyd (1990) calls a “forced choice scenario”, thus one does not truly have free determination of choice or action, as the term will portrays (Reber & Reber, 2001). Religion conditions social and cultural norms when peoples’ careers and social roles are influenced by their adherence to a particular religion – when the religion’s values are used in dictating policies, rules or laws. People are trained in what is ‘right’ and what is ‘wrong’ by virtue of the strict moral codes exhorted by their religion. These moral codes are internalized as an individual’s personal values and may influence choices made by him / her throughout his / her life. A person’s conscience is for the most part constructed by the warnings, scolding, and reprimands of parents, peers, educators, employers, and by religious education.

Boyd (1990) stated that a person’s perception of his / her external environment, which is not compromised in one way or the other, reveals a fairly consistent, unchanging personal world. A person’s belief about his / her abilities and his / her self (self image) as well as the cognitive labeling of objects as either ‘safe’ or ‘dangerous’, that is either ‘good for you’ or ‘bad for you’, come to build one’s distinct attitudes about other people, places, objects, and circumstances or situations. This cognitive map of one’s environment – created by belief – cause individuals to no longer experience (i.e., see, hear or feel) what is actually ‘out there’. People merely see constructs based on their fears. A person’s perception of his or her world (the world revealed to him / her by his / her senses) is often molded and dictated by his / her religion – the body of beliefs he / she holds about what constitutes ‘good’ and what constitutes ‘evil’. Together with dictating the physical world religion, has an even more powerful impact on an individual’s perception of his / her inner world by specifying the ‘correct’ cosmology or worldview he / she should follow. According to Boyd (1990, electronic version),

> [r]eligion shapes beliefs by associating stimuli with strong positive emotions (exultation, ecstasy, joy, blessedness, total serenity) or strong

> negative emotions (disgust, horror, terror, rage, shame, condemnation, revulsion), thus creating a wide duality between right and wrong, ‘our religion's true way’ and ‘their way, which is sinful and in error’. Note that the items which are held out as ‘evil’ are associated with strong negative emotions and terrifying or disgusting images, and those that are ‘good’ are associated with positive emotions, and images of goodness, virtue, and praiseworthiness.

As noted, religion has a powerful influence on belief, cultural norms, morality, perception, and emotions and thus religion strongly affects behaviour. According to O’Neil (2006) cultures may both embrace and resist change, depending on culture traits; there are thus dynamic influences that encourage acceptance of new things and conservative forces that resist change. O’Neil listed three kinds of influences that can cause both change and resistance to it, these are: (1) forces at work within a society, (2) contact between societies, and (3) changes in the natural environment.

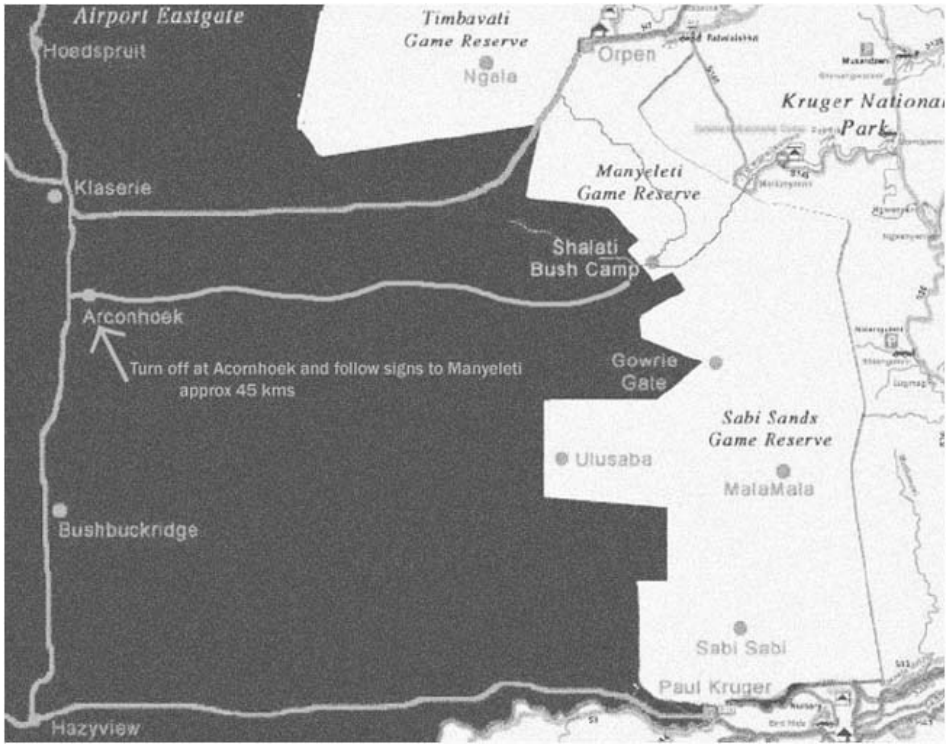
As mentioned earlier, culture cannot be blamed for spreading HIV, but it can be seen as one of the factors contributing to the complexity of the spread thereof.

2.4 Shangaan culture

First I would like to point out why I chose the Shangaan culture for this study:
My interest in the Shangaan culture started in Mozambique. I once witnessed people standing in line at a Maputo cemetery to burry their deceased loved ones. It looked like a fast food drive through – people buying their flowers, moving forward, buying a garland, moving forward, quickly burying their loved one and then moving out, because there are others waiting in line. This touched me deeply and it is something that I will remember for the rest of my life.

As I was living and working among the Mnisi tribe members (one of the Shangaan tribes in the Bushbuckridge area) during the time of the study I asked members from the tribe to volunteer as participants in the study.

The Shangaan are a large group of people living mainly in southern Mozambique, but there is also a large Shangaan grouping here in South Africa, in the Limpopo Province (see Map 2.1). In South Africa the Shangaan are often called the Tsonga. They speak Xitsonga as well as European languages such as Portuguese, Afrikaans, and English. Most of the Shangaan people consider themselves Christians, being either Catholic or Protestant (Wikipedia, 2006b). According to Niehaus (2002) the Shangaan identity in the South African lowveld has developed from the assimilation of different identities from diverse origins such as Mozambique and Swaziland.



Map 2.1. Part of the Limpopo Province where the Shangaan community lives (taken from Niehaus, 2002, p. 576).

Niehaus and Jonsson (2005) found that within the lowveld area of South Africa, where the Shangaan people reside, the scale of the HIV/AIDS epidemic is 'frightening'. Secrecy and denial heightens suspicion (Sanders & West, 2003) and the attribution of blame for HIV/AIDS is expressed differently between genders (Niehaus & Jonsson, 2005).

Women blame men and envious nurses for spreading HIV, while men raise "conspiracy theories, blaming translocal agents – such as Dr. Wouter Basson, Americans, soldiers, and governments – for the pandemic" (Niehaus & Jonsson, 2005, p. 179).

Identity is that set of social and cultural rules (or understandings) through which we come to know and experience ourselves, that is who we understand ourselves to be (Hook, 2007). Identity has a number of cultural resources open to it and the negotiation of value and meaning of self identity takes place within a specific context (Franchi & Swart, 2004). Social identity then, according to Campbell (2004, p. 342) "consists of those aspects of our self-definition that arise from our membership of social groups… or from our positioning within networks of power relationships shaped by factors such as gender, ethnicity or Socio-economic position". These different identities are associated with different options for behaviour. According to Niehaus (2002) there are four items or traits that are perceived as markers of Shangaan identity. Niehaus holds that these traits can, on closer examination, be seen as mechanisms of social integration. The traits are:

a) *Muchongolo* dances

Green valley's first *muchongolo* dance groups were founded by the Mnisi and Nyathi families. These groups formerly danced at weddings, but after some serious fighting occurred amongst some of the male dancers, the dances were outlawed by the chief. Soon after the dances were outlawed they were reconstituted and are now controlled by a formal association, who strictly controls conduct. The dances are extremely popular and it is worth mentioning that large amounts of alcohol are consumed during these events.

b) Healing with alien spirits (divination)

According to the research of Niehaus (2002, p. 571) “(t)he first Shangaan healers were the woman *Nkomo we Lwandle* (Cow of the Ocean) and the man *Dunga Manzi* (Stirring Water). The powerful water serpent Nzonzo purportedly trained them. It captured them and submerged them in deep pools” where they lived under water for months, breathing like fish. After the captives’ family slaughtered a cow for Nzonzo it released them and they crawled from the water with an extensive range of potent medicines.

c) Kinship and marriage

Niehaus (2002) found the Shangaan marriage to be strictly exogamous. “No man was permitted to marry any of his cousins, nor any person who had even the same surname as any of his four grandparents… Some argued that it was only by marrying another ethnic group that they could avoid incestuous unions, given the high prevalence of extramarital affairs among their parents” (p. 573). Shangaan men were only allowed to visit their parents-in-law accompanied by their wife and only after all bride wealth payments have been made. He had to wear a jacket and tie, bring gifts to his wife’s parents, sit on the floor of a special room and eat all the food given to him. When the Shangaan parents go to visit their daughters they would bring liquor and tasty foods “which the man had to estimate the value and pay them the cash equivalent. He also had to slaughter a goat and present his father-in-law with its heart, kidneys, and head” (p. 573).

d) The permeability of boundaries / ethnicity

According to Niehaus (2002) a Shangaan identity was achieved rather than ascribed by birth. “At the most basic level, becoming Shangaan involved changing the language one prefers to speak and one’s surname. Such changes were easiest in the case of surnames that were not specific to any particular ethnic group” (p. 574). Some people presented themselves as Shangaans in order to disguise the fact that either they or a family member had been accused of being witches or thieves; others did so because they were raised by their mother’s family or because they discovered that their biological fathers were Shangaan.

According to the belief system of the Shangaan people, different levels of being can be identified (see Figure 2.4). The lowest level of the hierarchy is occupied by inanimate objects and plants – these have no direct influence on superior beings (which include human beings). The level immediately above that of objects and plants is occupied by animals. The next level, also called the intermediate world by Ngubane (cited in Mkhize, 2004), consists of human beings, who can communicate directly or indirectly with the ancestors (also called the living-dead). In Xitsonga a person's life force is referred to as *seriti* which means 'the shadow'. It is believed that human beings can influence events in the world to a certain degree, as they partake in the creative life force, that is energy or power that is the essence of all phenomena (Mkhize, 2004).

The ancestors occupy the next level on the hierarchy. The world of the ancestors consists of two parts (Ngubane cited in Mkhize, 2004), the first of which is the world of the recently deceased. When an individual has died he / she do not proceed directly to ancestorhood and cannot immediately intercede with God on humans' behalf. They remain in an in-between state until their relatives have performed rituals of integration on their behalf. Those who have had rituals performed for them form the second part of the world of the ancestors – the world of the integrated ancestors. They can communicate with God on behalf of their relatives.

Human beings maintain a link with their ancestors, whose world is both parallel and adjacent to that of human beings (Teffo & Roux, 1998), through acts of libation and sacrifices.

God is at the top of the hierarchy. He is rarely called upon directly by human beings who communicate with Him through the ancestors. God is not seen as being apart from the rest of the world; rather He is seen as filtering through everything in the world (Mkhize, 2004).

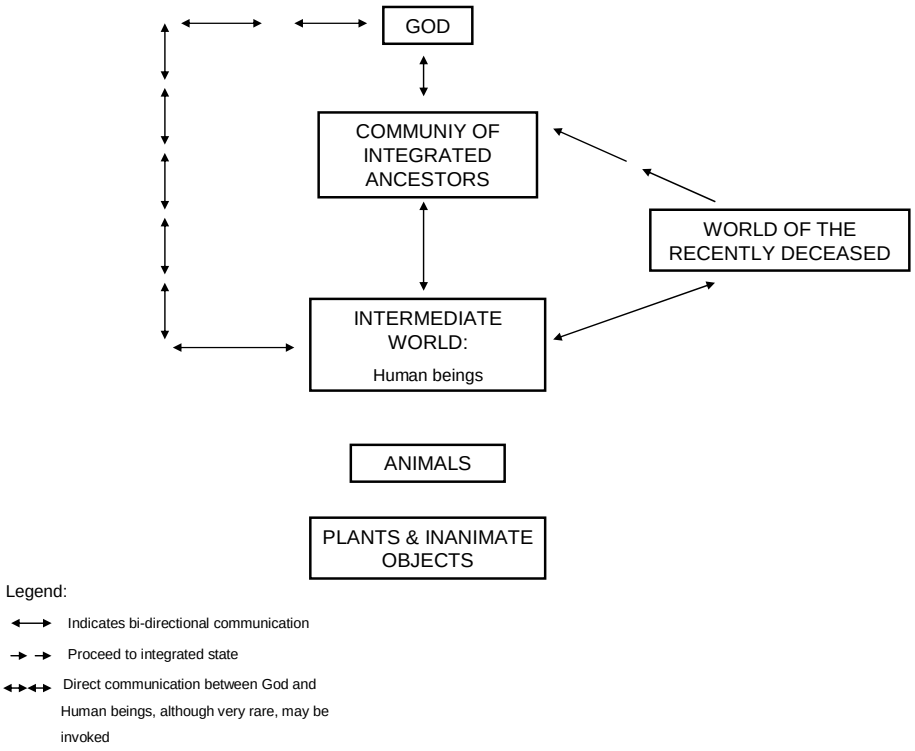


Figure 2.4. Relationships between elements in the hierarchy of beings (taken from Mkhize, 2004, p. 40).

Fanon (1963, pp. 42–43) explained the importance of God and the unknown in his book 'The Wretched of the Earth' as follows:

> [L]ife goes on… inhibitions which contain his aggressiveness by drawing on the terrifying myths which are so frequently found… There are maleficent spirits which intervene every time a step is taken in the wrong direction, leopardmen, serpent-men, six-legged dogs, zombies – a whole series of tiny animals or giants…The atmosphere of myth and magic frightens me and so takes on an undoubted reality. By terrifying me, it integrates me in the traditions and the history of my district or of my tribe, and at the same time it reassures me, it gives me a status, as it were an identification paper.

Traditional African thinking (also that of the Shangaan people) is that of communal life. Personhood is defined in relation to the community and possession of the qualities of personhood is reflected in one's association with others. In the Shangaan culture this is referred to as *ubuntu* which is the "concrete or practical realisation of the knowledge that the possession of the qualities of personhood is reflected in people's relationship with others. Ubuntu is characterised by caring, just, and respectful relationships" (Mkhize, 2004, p. 50).

Considering all that has been discussed in this chapter, how a person's 'life situation' influences his / her behaviour, one might ask whether one's culture and its traditions complicate the basic *modus operandi* of the spread of the HI virus. The recognition of the importance of cultural, ethnic, and gender differences is important when seeking to understand the factors that influence social behaviour and social thought (Baron & Byrne, 2003). The term self-fulfilling prophecies, that is predictions that, in a sense, make themselves come true (Baron & Byrne, 2003) can be used to explain the way in which behaviours are shaped by beliefs and expectations.

People are products of their environment. This environment contains many different aspects – culture, religion, educational bodies, the physical environment, et cetera. What people experience as true or false as well as what they experience as right or wrong are products of their environment. This is why I have decided to introduce the reader to the 'life world' of the Mnisi people. In order for the reader to be accurately introduced I use the participants' own words and explanations from time to time.

2.4.1. The 'life world' of the Mnisi people

The majority of the Mnisi tribe's people is of a low socio-economic class and lives under the so-called bread line (Lehohla, 2002). They live in small houses made of bricks that they make themselves with mud and cement, roofed by corrugated iron. As many as four generations of a family lives in a single house, on average a household contains 6.3 people (Orkin, 1998). Pit latrines are used and sanitation and waste removal services are non-existing (Orkin, 1998). Water is obtained sometimes as far as 5km

from their homes and food is not always readily available. Mr. D, one of the participants, said that first thing to the people what's important is water the people they suffering with water. Roads in and around the villages are gravel and taking a taxi is extremely expensive, but has to be done when one needs to go to a town or a city as this is the only means of transport for the majority of people.

Medical facilities are in the form of clinics where there is only nurses to assist patients (there are doctors at the hospital which is situated approximately 40km away). The medical equipment is rarely in a working condition and the medicine available for distribution consists mostly of Panado (paracetamol) which is given for any kind of ailment. As Mr. D said *when you go to the clinic you find that there's no tablets, they give you maybe only Panado*. According to a local nurse the major health problems in the area are: Malnutrition, Diarrhoeal diseases, Tuberculosis (TB), Hypertension, Alcoholism, Sexually Transmitted Infections (STI's), HIV and AIDS (personal conversation, October 9, 2007).

Every village has its own school or a school situated near by. Many of the educators in these schools do, however, not have the proper qualifications, but due to the incredible shortage of educators in South Africa (Hazelhurst, 2007; Panchaud, Clarke & Pillai, 2003) many schools use whoever are willing to help. Many of the tribe's young people only finish school up to grade 10 as many of them have, by that time, their own children to care for and therefore they have to find a paying job to do so. Mr. D had the following to say regarding this issue:

> *So you find that's having the children while they are still little boy, little girl and then you find that they are not working and it's a problem when you are not working and you have a child, because sometimes you want something for that children and you have no money. Maybe even your parents are not working. Sometimes you have no parents. So, if it's that and they are not working so it's going to be the problem, you'll have to stand… uh… you have to go to look for the job.*

According to Lehohla (2006) the level of education among African individuals of twenty years and older living in Mpumalanga (this also includes the Mnisi tribe as they are a representative group of people living in Mpumalanga) can be summarised as follows: a total of 27.5 per cent of individuals have no schooling, 15.9 per cent have some amount of primary school education, 5.9 percent finished primary school, 26.6 per cent of individuals started secondary school, but did not finish, 18.2 per cent finished grade 12, and 5.9 per cent have some form of tertiary education.

The ancestor belief influences most people's attitudes and behaviours in times of illness, drought, infertility or other misfortune. Most of the tribe's people refer to themselves as Christians and many also make use of traditional healers or sangomas when they feel the need to do so. As one of the participants stated *they* [referring to the ancestors] *are helping me and also them they're helping by God you see, they are not alone* and *you will have to follow the instruction of your forefather*. It is commonly believed that Shangaan healers are empowered by alien spirits (Niehaus, 2002). The first signs that spirits have entered a person's body are his / her experience of persistent pains, infertility, and bouts of aggression. "In a ritual which included drumming, she danced until she began to go into a trance. The spirits were then exhorted to speak through her mouth and to state their demands. Once appeased and converted from a hostile to a benevolent force, the spirits assisted their medium" (Niehaus, 2002, p. 571). Three categories of spirits have been identified by Niehaus (2002), which are:

1. The Malopo, who are Sotho spirits (they help in treating venereal diseases and sick children),
2. The Ngoni, who are the spirits of Tsonga, Zulu and Swazi ancestors (they assist in healing paralysis of the limbs and red spots), and
3. The Ndau, originating from Mozambique, who is fierce spirits able to grant the powers of clairvoyance and the ability to detect witchcraft.

The cultural customs of dancing and singing form an important part of the Mnisi tribe's daily lives (Niehaus, 2002). Boys and girls go to their separate initiation schools and are seen as men and women when they return after three months. Ms. J said the following

regarding the initiation school: *if their children have got some ten years, or more than ten years, they go to the winter school to do some… not the school for… to learn… for the school for the culture. Yes. Like the boy and also the girl, they went to the winter school, like the… it's from June or July for three months*".

It is preferred that women look after the children, clean the house, and prepare the food. Men, on the other hand, are seen as the breadwinners and are expected to work and bring money home to care for his family. According to Ms. J for men *it's very important to have a wife and also to work, to get some money to buy food* and *it is very important for the woman is to live their child nicely and to work in our home*.

The Tsonga language (also called Shangaan) is related to both Sotho and Zulu (Junod, 1966) and is the home language of many of the Mnisi people.

2.5 Objectives of the investigation

In May 1998 UNESCO's culture sector proposed that a cultural approach should be taken in the attempt to stop the spread of HIV. Taking a cultural approach would, according to UNESCO (1999), mean that a population's characteristics (which include their beliefs and lifestyles) would be taken into consideration as essential references when planning and implementing HIV/AIDS interventions.

Taking the approach postulated by UNESCO into account, this study aimed at investigating the Shangaan people's cultural beliefs and traditions that might act as either contributing or opposing factors to the spread of HIV among the Mnisi tribe members. The aim of the investigation was to obtain a better understanding of the complexity of the spread of HIV using a cultural (specifically the Shangaan cultural) perspective. The main objective for this research was to identify and evaluate the possible influence of Shangaan cultural beliefs, myths, and behaviours, on the spread of HIV within the Mnisi tribe.

A better understanding of the cultural factors playing a role in the spread of HIV might be a step nearer to finding better, culturally acceptable methods to preventing the spread of HIV within the Mnisi tribe and from the Mnisi tribe to others. The participants, researcher, and other interested parties have or can, through this study, gain insight into the cultural influences, of the Shangaan culture, on the spread of HIV within the Mnisi tribe. The research findings can be used as a departure point for designing a culture-specific HIV prevention intervention within the Mnisi-tribe.

2.6 Conclusion

In this chapter the importance of health as well as the effects of HIV and AIDS was briefly discussed. Culture was looked at as one of the factors that influence human behaviour and decision making and we have also been introduced to the culture of the Shangaan people.

In Chapter 3 the research process is described in detail. The chapter explains the manner in which the research was conducted, as well as the steps I had to go through in order to obtain the information and how I went about analysing and interpreting the information derived from the interviews.

CHAPTER 3

RESEARCH PROCESS

> You cannot pretend for long, for you will eventually be found out. Admission of ignorance is often the first step in our education. Thoreau taught, 'How can we remember our ignorance, which our growth requires, when we are using our knowledge all the time?
>
> (Covey, 1999, p. 37)

This chapter explains the manner in which the investigation was conducted, as well as the steps I went through in order to obtain the information and how I went about analysing and interpreting the information given to me by the participants. The reader would have noticed from the previous chapter and will once again observe in this and following chapters that I have used many on-line references as information sources. Due to the fact that I literally live in the bush, with the nearest library situated one-hundred-and-seventy kilometers away, the internet is the only relatively stable source of literature information available to me.

3.1 Research design

3.1.1 Qualitative methods

According to Henning, van Rensburg, and Smit (2004) it is the *purpose* of the research that influences the paradigm one chooses to work within most and, as the purpose of this study had to do with cultural interaction and people's subjective interpretation thereof, a qualitative study, embedded in a social constructionist paradigm, was best suited to 'fit the purpose' of this study.

A qualitative method of investigation was best suited for the purpose, aim, and objectives of this study. Qualitative research makes, according to Denzin and Lincoln (2005), the world visible through a set of interpretive, material practices which transform the world, where the researcher can be seen as the maker of a quilt, piecing together a set of representations that is specific to a complex situation.

Qualitative research is a set of interpretive activities and has no theory or paradigm that is distinctly its own (Denzin & Lincoln, 2005). Scholars find it difficult to agree on any one definition for this field of research, but in order to provide a definition I will borough the definition used by Nelson, Treichler and Grossberg (1992, p. 4):

> Qualitative research is an interdisciplinary, transdisciplinary, and sometimes counterdisciplinary field. It crosscuts the humanities and the social and physical sciences. Qualitative research is many things at the same time. It is multiparadigmatic in focus. Its practitioners are sensitive to the value of the multimethod approach. They are committed to the naturalistic perspective and to the interpretive understanding of human experience. At the same time, the field is inherently political and shaped by multiple ethical and political positions.

As my point of departure I took the insider perspective on social action (Babbie & Mouton, 2005) and I favoured inductive research; studying words and images rather than numbers (Creswell, 1998; Hammersley, 1992). The focus was “on the meaning of the data and the presentation of the findings” as descriptive and persuasive (Viljoen, 2004, p. 70). I was viewed as an instrument of data collection and attempted to build a complex, holistic picture by analysing words and observations of the subjective views of my informants (Creswell, 1998).

3.1.2 Postmodern, Social constructionism

Postmodernism places enormous emphasis on context and local knowledge (Geertz, 1983) and holds that:

> [F]orms of life are relative, ungrounded, self-sustaining, made up of mere cultural convention and tradition, without any identifiable origin or grandiose goal . . . truth is the product of interpretation, facts are constructs of discourse, objectivity is just whatever questionable interpretation of things has currently seized power, and the human subject is as much a fiction as the reality he or she contemplates, a diffuse, self-divided entity without any fixed nature or essence. (Duke University, n.d, electronic version)

Considering this statement postmodernism had the best fit for establishing the ways in which the people of the Mnisi tribe participate in the creation of their perceived realities. In this study I did not rely on any 'expert' voice (Babbie & Mouton, 2005), but on the voice of science involved with the Mnisi people, their knowledge and their culture. The findings of this study is not generalisable (Babbie & Mouton, 2005), but may provide an enhanced understanding of the local knowledge (Creswell, 1998) of the Mnisi tribe and its people.

Social constructionism focuses on unveiling the ways in which perceived realities are created by individuals and groups; socially constructed realities are seen as a dynamic process where reality is re-produced by individuals and groups on their interpretations and their knowledge thereof (Wikipedia, 2006a).

The core of social constructionism is twofold; it has a critical agenda and an epistemological agenda (Foster, 2004). The critical agenda is concerned with the notion that if social order is seen as constructed then it can be deconstructed in order to be reconstructed in a different, possibly better, manner. The epistemological agenda is concerned with how we know things. How can certain pieces of knowledge be seen as self-evident truths? How can we 'just know' certain things are true while others are not?

There is a stance within constructionism which holds that, just because knowledge is constructed, it does not mean that the actuality and consequences thereof are not real. In principle constructionism does not rule out that material as well as discursive or ideological factors are involved (Foster, 2004), for example in the construction of patriarchy. The numerous realities that are formed in this manner comprise the imagined worlds of human social existence and activity,

> "gradually crystallised by habit into institutions propped up by language conventions, given ongoing legitimating by mythology, religion and philosophy, maintained by therapies and socialisation, and subjectively internalised by upbringing and education to become part of the identity of social citizens" (Wikipedia, 2006a, electronic version).

Stated differently social constructionism can be seen as being concerned with the processes by which human communities construct, deconstruct, and reconstruct their abilities, experiences, common sense, and knowledge (Kiguwa, 2004). These constructed, deconstructed, and reconstructed abilities, experiences, common sense, and knowledge do not have an essential reality, but are constituted through the language individuals use to describe them (Foster, 2004). Language is thus not simply used to label objects in the world it is also used to reflect the way in which society structures the experiences of individuals (Collins, 2007). "In our information age, words have no innocence. Language is our weapon, our primary tool for dealing with the world around us…" (The Star, 16 January, 2000, cited in Duncan, 2007, p. 71).

Social constructionism makes a conceptual shift from the processes in the person to interpersonal processes. According to Gergen and Gergen (1991) social constructionism holds that language absorbs the object into itself and that it is not the cognitive processing of the individual observer that does this.

As my aim was to establish the ways in which the people of the Mnisi tribe participate in the creation of their perceived reality in terms of their culture and the possible cultural

influences on the spread of HIV; and as social constructionism “has an implicit sensitivity for the complexity of the phenomena” (Cilliers, 2005, p. iix) it deals with, and because it can enable us to escape the confines of the taken-for-granted (Gergen, 1985) social constructionism was congruent with my research question and objectives. This should also be evident in the manner in which I constructed ideas in and through conversation, as well as my attempt to be sensitive to the grand narrative that operated within this context.

3.2 Entering the community

3.2.1 Obtaining consent

Entering the community was not hard – or so I thought. The community members were very accepting of me and my being there. Everybody was willing to give a helping hand when I told them about my study and what I wished to do. That was until it came to signing the informed consent forms… then all of a sudden nobody was sure whether they should be helping me with my study or not. Suspicion and wariness were the order of the day.

Explaining to the potential participants that I do not mean to do them or their families any harm did not seem to make any difference. They were scared of signing their name on any document. They were scared of prosecution by the public and scared of going to jail. This has been quite an experience for me as, prior to this study, I would never even have thought that others might think and feel this way. After many days of explaining and negotiating, the two people that I initially asked to volunteer as participants once again agreed to do so. They understood why the forms had to be signed, that it was for the protection of all involved and that it will not be used to prosecute them in any way. The forms were signed and the interviews commenced.

3.2.2 The interviews

Ludwig Wittgenstein (1961, electronic version) once wrote, “the limits of language …mean the limits of my world”. This has been very true for me during the interview process. Not being able to communicate with the participants in their mother tongue has taken away much of the richness of the information they shared with me.

The interviews turned out to be much more challenging than I initially thought it would be. The first woman whom I asked to participate, because of her lingual abilities (i.e., being able to talk a great deal of English in a manner I can understand as well as her ability to understand me) became so nervous that she could not give comprehensive answers or explanations for shorter answers to the interview questions. It was only after I got to know her better that I could see that she only spoke openly about trivial things and that she never elaborated on issues concerning herself or her family. It had been my own ambivalence that led me to think that she will talk to me about anything I asked her about, an impression that had more to do with myself than with her. In the end, after numerous attempts for more elaborate answers, I asked a second woman to also participate in the study, she agreed to do so. This was some months into the study and as I have been living and working with and among the participants and their families I could make a more informed decision as to whom to ask to participate.

HIV/AIDS is a controversial issue in many spheres, for example religion, morally, political, et cetera, and not many people wish to talk about (and for that matter think about) it. This posed a threat to the validity of the study as participants may have answered questions in a socially acceptable way rather than telling and proposing what they really felt and experienced. Initially all the participants told me things they thought I wanted to hear and only after months of living and working with them did they start unveiling “the truth” to me, that is their true experiences and feelings toward the spread of HIV within their community.

Entering into this community has been a humbling experience for me. I have learned a lot about the Mnisi tribe and the Shangaan culture, but I have also learned a great deal about myself.

3.2.3 The participants

The participants are all part of the Mnisi tribe from the Bushbuckridge area. Two are brother (Mr. D) and sister (Ms. P) and live in the same village, the other participant (Ms. J) lives only a short distance from the siblings. They have all been living in this area for most of their lives and although they have been to other places in South Africa they have informed me that they truly wish to stay in their birth community as they want to stay with their families. The siblings have four other brothers and two sisters. Mr. D, aged 40 years, has two boys and Ms. P has two boys and one girl and, only 37 years old, is also grandmother to a 4 year old boy. Ms. J, aged 37 years, has seven siblings and two children of her own. Mr. D is married and staying with his wife, Ms. P is a widow and stays with her parents, whom she also supports, and Ms. J and her husband divorced a couple of years ago, she now also lives with her parents.

The three participants have all matriculated and can each speak at least three languages. They all wanted to study further after they matriculated, but due to financial restraints were unable to do so. Both the female participants wanted to become nurses with the aim to help the people in the community, whilst the male participant wanted to become a taxi / truck driver in order to make enough money to care for his family. The three participants currently work at a lodge where they cook and clean for the tourists that pass through.

I met all three participants at their place of employment, which also became my place of employment shortly after we met for the first time. Here we spent many hours together, mostly working, but through this we learned a great deal about the other's culture, mannerisms and manner of interpretation.

During the interviews the participants gave their full co-operation as best as they could, never refusing to answer any of the questions even though it was evident that some of the questions, especially those relating to sex, made them feel a little uncomfortable.

3.2.4 The researcher

I am a white, Afrikaans, heterosexual female, a university student who was fortunate to have enjoyed a privileged life in many ways and who has lived almost all my life on the outskirts of big cities. My parents were always in a position to provide food, clothes, and shelter to all three of their children and it was never necessary for any one of us to leave school in order to find a job to provide for the family.

According to Denzin and Lincoln (2005, p. 21) the "researcher approaches the world with a set of ideas, a framework that specifies a set of questions that he or she then examines in specific ways". The researcher's approach to a situation is determined by his / her definition of his / her field of inquiry, their paradigmatic and ontological assumptions (i.e., what they consider to be 'true' knowledge), their theoretical orientations as well as the methodologies they favour (Ratele, 2007). Ratele (2007) argues that how we make sense of any story is a complicated process. We do not always listen with complete attention, are not interested in every part of a story, subconsciously do not believe every part of a story and we do not view stories only through our disciplinary lenses.

During the study I attempted to think with the mind and see with the eyes of the participants, but I used my own eyes and mind to gather information; it was thus impossible to completely separate myself from that which was investigated (Henning et al., 2004). According to Hook (2004) psychology is always powerful and always gives rise to a relationship of power; a researcher prioritises certain views over others – it is thus not a neutral, unbiased view of the world. Shweder (cited in Mkhize, 2004, p. 27) postulated that "subject and object, self and other, psyche and culture, person and context, figure and ground, practitioner and practice, live together, require each other, and dynamically, dialectically, and jointly make each other up". It is therefore possible

that, although I attempted to communicate only the voices of the participants, my own voice might also be heard through my attempt to convey their thoughts and feelings.

3.2.5 Cultural context

For this study, values, motivations and behaviours had to be looked at within a certain cultural context, that is the Shangaan culture of those individuals from the Mnisi tribe living in the Bushbuckridge area of South Africa.

The term culture has been described in chapter 2, but can, simply stated, be called the "way of life for an entire society". Shweder (1991, p. 2) argues that:

> A socio-cultural environment is an intentional world… because its existence is real, factual and forceful… [inasmuch as] a community of persons whose beliefs, desires and emotions, purposes and other mental representations are directed at it… are thereby influenced by it… What makes their existence intentional is that such things would not exist independent of our involvement with them and reactions to them; and they exercise their influence in our lives because of our conceptions of them.

According to Franchi and Swart (2007) a South African individual's self-identity is constructed, deconstructed, and reconstructed against the backdrop of structurally entrenched asymmetries, which was created and is maintained by historical processes. Identity is thus not only defined by, but also functions to re-define, contest, legitimate or transform social and historical processes.

The values and the meaning systems of both participants and myself had to be respected and accepted by the other before meaningful, insightful conversations could take place. Negotiations of values and meanings take place within a particular context which is defined by its spatial, temporal, and symbolic boundaries – this is constructed by differences between individuals (Franchi & Swart, 2007).

South Africa has a wide range of beliefs, habits, religious, and healing practices. I was different in regards to many of these aspects relative to the participants; the participants also differed from one another in certain degrees with regards to beliefs, habits, religion, and healing practices. While the participants and I consider ourselves to be Christian the participants also believe, in varying degrees, in the powers of their ancestors and that of the sangomas. Should I fall ill I will most probably make use of a medical doctor while the participants would most likely first call upon a sangoma (traditional healer) to help them. Time is another concept that we understand differently from one another. In the traditional African view time is two-dimensional, it has a long history and a present (and virtually no future), while according to the Western view time has an infinite past, a present and an infinite future (Viljoen, 2002).

As culture plays a central role in this investigation I would like to give a brief summary of the culture of the study: A qualitative method of investigation was followed using a social constructionistic point of view which is concerned with the processes by which human communities construct, deconstruct, and reconstruct their abilities, experiences, common sense, and knowledge (Kiguwa, 2004). I have attempted to be sensitive to social relations and practices as well as to forms of life valued in the Mnisi-cultural context (Mkhize, 2004).

3.3 Data gathering methods

Purposive sampling (Patton, 2002) was used in order to select the participants from the Mnisi tribe. Data were collected by interviewing three individuals, one man and two women. Each participant participated in between two and seven interviews, which were conducted in English. I kept a diary of observations which assisted me in understanding the ‘ways of the Mnisi tribe’. The interviews and observations continued until a point of saturation was reached, that is when new thoughts no longer added new ideas to what has already been said and observed (Terre Blanche, Durrheim & Painter, 2006).

The purpose of the observational data was to give me a better understanding of the 'ways of the Mnisi people' which assured more credible and trustworthy interpretations of the data collected during the interviews. During the interview sessions I asked the participants to explain and clarify the observations and questions that I had written in the journal – for example why people within the tribe responded in certain ways to certain situations. The observations were of the interactions amongst the people, including the body language of and between individuals. The participants thus functioned as intermediates between the Mnisi tribe and me. As I was permanently employed within the vicinity of the Mnisi tribe villages, observation took place on a daily basis and assured that I could have better cultural insight while doing the investigation.

Before we started with the interviews I explained to each participant what I meant or referred to when I used the phrase 'culture'. I explained to them that I would like to know more about the everyday doings of the people in their community, thus the community culture. I explained that a culture included both what people said and what people did; that the culture surrounding drinking excessive amounts of alcohol might be to say it is wrong, but to drink excessively despite what you have said. The culture of 'saying' and the culture of 'doing' might thus not always be the same thing, but they are both equally important when one wants to learn about and understand a culture.

As part of the data gathering process a questionnaire was also used to help me obtain a vague understand of the knowledge and perceptions that the Mnisi people have regarding issues surrounding HIV and AIDS.

3.4 Research data

3.4.1 Data capture

Data was recorded with a dictaphone, which the participants agreed could be used. Transcription of the interviews took place immediately after conclusion of each interview or as swiftly as possible thereafter. A diary of observations that I made during

interviews, as well as at other times, were kept in a locked safe (when not kept on my person).

3.4.2 Data analysis

Viljoen (2004) holds that it is profoundly impossible to follow any one epistemological approach in the analysis of qualitative data and argues that the "approach any researcher uses develops as a process in language and is a result of the voices that inform the creation of the socially constructed self. In this way one uses aspects of different approaches (some of which may be in conflict), at different times in the process. There is no metatheoretical perspective, metanarrative or single over-arching epistemology" (p. 60).

A qualitative study is done in such a way that the researcher uses every available technique and/or strategy to construct the 'whole story' and the choice of interpretive practices to employ isn't always decided on before hand (Viljoen, 2004). The context was the most important predictor of the interpretive strategies that were employed, as the context determined what I could do in the setting (Denzin & Lincoln, 2005).

I will describe my method of analysis as thematic analysis, of which the main aim was to identify and analyse themes (or patterns) within the collected data. Different discourses that occurred within the data are discussed as such under a theme. Discourses are, according to Collins (2007, p. 29), "systems of meaning that operate at individual, social, cultural, and historical levels and inform how we interpret and understand our lived experiences". Discourse analyses, that is the attempt to work out what underlying systems of ideas is structuring the way the participants think and experience things (Collins, 2007), are therefore not excluded from the method of interpretation, but incorporated into the thematic analysis approach.

The issues brought about by the study might be seen as complex, situated, and problematic, and may draw attention to ordinary experience as well as to the disciplines of knowledge. The selection of key issues was necessary in order to organise the study

as well as to report my findings in a well organised manner. I have attempted to do this by using and discussing the complexities in the lives of the participants and their community under a number of themes.

The phases of thematic analysis, as depicted in Table 3.1, were followed in the analysis of the data I obtained.

Table 3.1. Phases of thematic analysis

Phase	**Description of the process**
1. Familiarising yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions, and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question, and literature, producing a scholarly report of the analysis.

(Braun & Clarke, 2006, p. 87)

First I familiarised myself with the texts – this was done by transcribing each interview, listening to the recorded interviews, reading, and re-reading each interview while writing down my initial idea – which led me to get a feeling for the text and helped me to develop a sense of the overall and different types of meanings in the text.

I then organised the data into clusters and themes, and considered the interrelatedness of the themes. According to Kelly (1999) this is where you start to look at the material 'from the outside'. I found it challenging to create the necessary distance between the information gathering process and the process of analysis. This distance is, however, necessary in order to make meaningful interpretations from the gathered data, as one must now portray what has been said without being influenced by one's own feelings and interpretations. I must, however, agree with Viljoen (2004, p. 142) that perception already contains interpretation and that it is not possible to clearly distinguish between the processes of data gathering and data analysis – "Interpretation is ever present in co-constructive relational processes".

For the purposes of this explanation 'analyses' and 'interpretation' will refer to that part of the research process where all the research material were available for interpretation. Lastly I set out to interpret the information in relation to a broader cultural and theoretical framework (Kelly, 1999). Themes were discussed by using the participants' views from the interviews as well as vital literature, which I then related back to the research question.

3.5 Ethical issues

In accordance with the American Psychological Association's (APA) (2003) ethical principles participation in the research were neither deceitful, nor harmful to the participating individuals or their community. The participants were handled with respect with reference to their culture, them as individuals and within their different roles in the community.

Participants were made aware of the foreseeable uses of the information generated through the study, but were reassured of their privacy and of the confidential and anonymous nature of the study (Henning et al., 2004).

In order for participants to have given informed consent, they were informed about the purpose of the research, expected duration, and the procedures that will be followed. They were informed about their right to decline to participate and to withdraw from the research once participation has begun, as well as about the foreseeable consequences of declining or withdrawing (which were simply that they will not be able to receive any benefits). The reasonably foreseeable factors that may be expected to influence their willingness to participate such as potential risks, discomfort, or adverse effects were explained to them. I also informed the participants about any prospective research benefits, the limits of confidentiality, the incentives for participation, and whom to contact for questions about the research and research participants' rights (APA, 2003, electronic version). Participants were also asked to consent to the recording of their voices during the interviews and were made aware of the function thereof, that is for use for later transcription and analysis.

(See Appendix A for ‘Participant Information Leaflet and Informed Consent’)

3.6 Trustworthiness

Within the qualitative paradigm reliability and validity refers to the credibility, usefulness, and trustworthiness of the data (Olshansky, n.d.). I employed a number of strategies in order to achieve trustworthiness and credibility in this particular study (Olshansky, n.d.).

Firstly, in order to obtain a deep and complex understanding of the Shangaan culture and of the Mnisi tribe’s people, I developed a trusting relationship with the community (and especially with the participants), as well as observed and interacted with people of the Mnisi tribe in various contexts over a one and a half year period (prolonged engagement with and observation of informants). Secondly I used triangulation; three participants participated in the study (data triangulation) and three forms of data collection were used, i.e., interviews, questionnaires, and observations (methodological triangulation). According to Kelly (2006) “(t)riangulation entails collecting materials in as

many different ways and from as many diverse sources as possible. This can help researchers to ‘home in’ on a better understanding of a phenomenon by approaching it from several different angles“ (p. 287). Next, in order to make sure of the credibility and trustworthiness of the interpreted data, I went back to the participants to see whether my interpretation and that which I had written made sense to them, as well as whether it reflected their experiences (member checks). My appointed supervisor performed the function of an auditor. This means that he verified the steps I went through in arriving at my interpretation of the collected data, he also verified that a systematic approach was undertaken. The interpretation of the data represents the diversity of perspectives among the participants and can therefore be seen as ‘thick’; this leads to an interpretation that includes variability under varying contexts. Data collection continued until a point of saturation was reached, that is when new thoughts no longer added new ideas to what had already been said and observed (Terre Blanche et al., 2006). Finally, I maintained a journal in which I did not only write and reflect on the observations that I made within the Mnisi tribe, but I also kept track of my own ideas, responses, and biases in order to be able to separate my own responses from that of the participants as far as possible.

3.7 Chapter summary

In this chapter the research process was described in some detail. The qualitative nature of the study and the implications of following a social constructionist approach were expressed. The participants were introduced and the manner I entered into the community discussed. The methods of data gathering and interpretation were explained and the ethical issues and trustworthiness of the study discussed. The findings of the study can be found in chapter 4.

CHAPTER 4

FINDINGS AND DISCUSSION

> Men make their own history, but they do not make it just as they please; they do not make it under circumstances chosen by themselves, but under circumstances directly encountered, given and transmitted from the past.
>
> (Karl Marx, 1987, p. 15)

> Mankind is faced with a number of difficult questions that we have no satisfactory answers to… People are, generally speaking, either dead certain or totally indifferent.
>
> (Jostein Gaarder, 1995, p. 59)

In this chapter the reader will find my version of what has been 'found' by the investigation. There could possibly be hundreds of different interpretations of the data from the interviews – depending on the reader and his / her background. I have attempted to let the voices of the participants be heard throughout the text, but as a human being with my own background and views I also have an influence on the data creation and the data should therefore be seen as a co-construction of the truth. Although, through the use of member checks (i.e., going back to the participants to see whether my interpretation and that which I wrote made sense to them, as well as whether it reflected their experiences), I believe the data to be representative of the participants' views.

4.1 Introduction

At the outset of this study I aimed to investigate possible cultural influences to the spread of HIV within a Shangaan community where HIV and AIDS are devastating problems. During the interviews Ms. P noted that *nowadays we find that all the people is having HIV and AIDS. So you can't… can't understand why AIDS is like this nowadays*. It, however, soon became clear that it is not the Shangaan culture per se that is contributing to the spread of HIV (either positively or negatively), but the cultures that formed within the community due to their environment and living circumstances. As mentioned in chapter 2 the term culture refers to a society's way of life. This 'way of life' is affected by factors such as the society's traditions, social circumstances, and environment.

During the five interviews with each Ms. J and Mr. D and the two interviews with Ms. P two 'cultures' emerged. What I mean when I refer to 'culture' is how a certain construct contributes to the formation of certain attitudes and behaviours within the community. The two cultures that emerged were:

- The culture of power-rule and fear, and

- The culture of poverty

Through thematic analysis codes were generated which were collated into sub-themes and themes. The sub-themes were depicted from, and led to themes through, the knowledge and themes I found in literature. The manner in which I 'arrived' at the two themes (or cultures) is depicted in Figure 4.1.

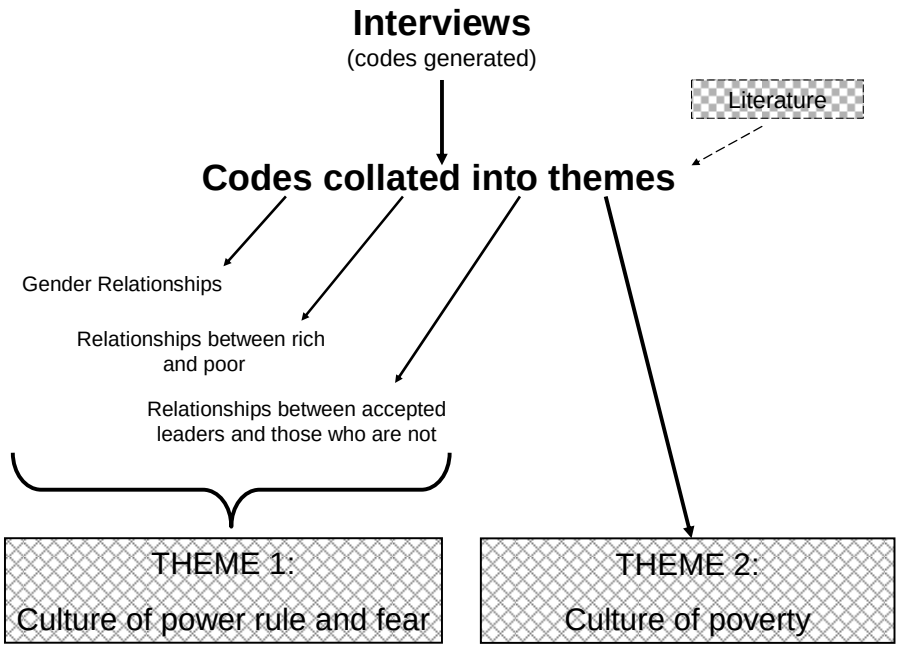


Figure 4.1. Themes identified through thematic analysis.

4.1.1 Local HIV/AIDS knowledge

As this study looked at issues surrounding HIV and AIDS I wanted to also investigate the knowledge the Mnisi people have of the basic information of HIV and AIDS. Mainstream health-psychologists tend to look at individual-level factors, for example the accuracy of one's knowledge of the risks of HIV/AIDS, in explaining a person's likelihood of engaging in unsafe sexual practices (Norman, Abraham & Conner, 2000; Rutter & Quine, 2002). Although I do not agree with this simplistic view I have included the results of a questionnaire on HIV/AIDS knowledge (see Table 4.1) which I asked some members of the Mnisi tribe to complete. I agree with the findings of Hoosen and Collins (2004), and Perkel (1992) that knowledge of HIV and AIDS do not directly render safe sexual-practices, but that it is still needed in order to make people aware of the disease and give them options as how to prevent the virus from spreading. After I received the answered questionnaires I processed the information using the programme Moonstats. Table 4.1 illustrates the questions asked as well as the answers received. (For each statement the person had to say whether the statement is true or false.)

Table 4.1. HIV/AIDS knowledge among some of the Mnisi tribe members

Number	**Statement** *(correct answer in brackets)*	Correct Answer	Incorrect Answer
1.	HIV is caused by AIDS. *(false)*	8	11
2.	AIDS damages the body's defence system. *(false)*	2	17
3.	There is no cure for AIDS. *(true)*	9	10
4.	People with AIDS often die from serious diseases. *(false)*	3	16
5.	STI means Standard Time in Light of day. *(false)*	12	7
6.	Someone can have HIV or a STI and have no symptoms (i.e., not know it). *(true)*	6	13
7.	There is no way to protect yourself from AIDS and STI's. *(false)*	16	3
8.	An example of an STI is gonorrhoea.	6	13
9.	It is difficult for women to get AIDS. *(false)*	17	2
10.	If you are strong and healthy you can't get HIV/AIDS/STI. *(false)*	11	8
11.	AIDS and HIV infection is the same thing. *(false)*	11	8
12.	HIV/AIDS can be cured by having sex with a virgin. *(false)*	10	9
13.	You can get AIDS from a mosquito bite. *(false)*	14	5
14.	Women will be safe from HIV if they take a contraceptive pill. *(false)*	12	7
15.	You can get HIV by kissing. *(false)*	18	1
16.	If a couple are both HIV positive, safer sex is unnecessary. *(false)*	10	9
17.	TB causes AIDS. *(false)*	9	10
18.	During the window period you will test HIV negative even if you are HIV positive. *(true)*	15	4
19.	Eating healthily will prolong your life if you are HIV positive. *(true)*	12	7
20.	Eating healthily can cure HIV. *(false)*	9	10

(Note: I received this questionnaire from the Centre for the Study of AIDS at the University of Pretoria)

The questionnaire, with twenty questions on basic HIV and AIDS knowledge, was administered to a convenience sample of nineteen people that ranged in age from 12 to 52 years and included men and women, literate and illiterate individuals. The illiterate individuals were assisted in answering the questions in their mother tongue by Mr. D and Ms. J. Unfortunately the information obtained may have been influenced by a number of factors, the first being the language use and sentence construction of the questionnaire. When translated the statements might not have the exact same meaning as the original English statements. Using translators might also bias the answers obtained as the participants might have answered questions in a manner they thought would be the 'appropriate' answer to give. The number of right and wrong answers should however give the reader a sense of what these individuals know about HIV and AIDS.

Most of the individuals have been taught about HIV/AIDS by social workers or nurses. Many could repeat what they have been told by these individuals verbatim, but they did not understand what it meant and how it should be implemented in their daily lives. Later during the interviews the participants used the terms HIV and AIDS interchangeably – as if talking about the same thing. Mr. D, for example, said *…HIV that's the one that it attacks the immune system of the body. So, immune system is the one that protects our body from the illness. So, that AIDS when it attacks that immune system, so you find that later so which means your soldiers will have no power to protect you against illness. So, and then the AIDS… AIDS is the collection of different disease, after the immune system has been compromised*…

As is evident, when looking at Table 4.1, the basic general knowledge regarding HIV and AIDS in the sample was not very good. The difference between HIV and AIDS was not understood by most of the participants. Many believe that HIV and / or AIDS can be cured. This was substantiated during the interviews when Ms. J said that *if you have HIV you can be healed, but if you've got AIDS you can't be healed… You'll find that if you've got the HIV, when you go to the clinic they give you some pills and they say… maybe if you've got some pills… every month you can go to the clinic, they can check*

you and if you've got already AIDS you can't be… get maybe some pills. A belief also exists that a person with HIV will show signs of illness immediately after contracting the virus. Individuals do not know or understand the scientific and English names for STI's and can therefore not always understand what doctors and nurses tell them or what a diagnoses means. It is also commonly believed that a strong, healthy person cannot contract HIV and should you get infected you can be cured by eating healthily. The myth that one can be cured of HIV by sleeping with a virgin is widely believed amongst community members, this could also be deducted from the interviews where the participants said that they heard *when you want to be healed from HIV you will have to sleep with the virgin… I heard another one talking like that that if you sleep with the people who have never sleep with another man you can get healed* and *if you sleep with the virgin or the baby you can heal the HIV*.

Moore and Oppong (cited in Kalipeni, Oppong, & Zerai, 2007) found that poor knowledge about HIV/AIDS prevents the acceptance and understanding of dual and recombinant infections, and the complications of elevated viral loads. Individual factors such as knowledge and confidence plays, without a doubt, a key role in sexual behaviour (Hook, 2004) and thus also in the spread of HIV, however, these (and other) individual factors are shaped by a person's social context and is thus only part of this extremely complex problem.

A number of different beliefs exist surrounding the spread of HIV. Dennis Altman (cited in Valentine, 2004), for example, states that societies are prevented to respond effectively to the HIV epidemic due to prejudice and stigma which are being disguised as morality, tradition, and religion, while President Thabo Mbeki, according to Mbali (2002), denies the causal link between HIV and AIDS. In the remainder of this chapter I will attempt to convey the experiences and perceptions of the participants regarding the possible causes of the spread of HIV within their community.

4.2 Discussion of the findings

4.2.1 "…laws which are given to us…" (Culture of power-rule and fear)

According to Steve Biko (1971, electronic version) "the most powerful weapon in the hands of the oppressor is the mind of the oppressed". A characteristic of the community in which the participants live are the power-relations, which can be defined as the relations between groups or individuals in a hierarchically structured society (Campbell, 2004). Traditional cultural practices, including gender-role expectations, hierarchical structures, power-relations, et cetera form a very important part of this community's day to day life.

In this hierarchically structured community individuals have different levels of access to wealth, political influence, and symbolic respect and recognition. Many people feel that their needs and views are not respected or valued by those in charge and that there is no manner in which they can contribute or participate in decision making activities, be it in the context of the family, school or neighbourhood. As Mr. D said *…if it's me* [referring to those who formulate and impose the laws] *and my law can be accepted…*

The 'instruments of power' involved in community life described by Gaventa (cited in Dalton et al, 2001) is evident in this community. Resources that can be used to bargain, reward, and punish are being controlled by the chief and his *indunas*. The sangomas (or traditional healers) also have control over many resources and can communicate directly with the ancestors (or forefathers) who in the end are seen as the most powerful in the chain of control. Within the household setting it is the husband who has control over the resources.

The channels for citizen participation in community decisions are under the control of the chief. As Mr. D said *…chief is the one that are going to ask you…* A member of the community (especially a younger member) may only suggest or say something if he / she is asked to respond by the chief.

Community decisions are made by the older men in the community, whilst the *induna* co-ordinate the meetings where decisions are made, as Mr. D said

> *And to the community the important words it can… comes from the induna when we have the meeting. So when we have the meeting it's important because he's the one who's leading all the community, but from the chief. So, because the chief is far from here the words of the induna is the important words. So, you find that even when we start he's the one that is going to… we are at a home and then they will have to welcome us and even when we close, like when now we are having a discussion of something there in the community maybe it's the time of… when the rain have come, so we want to plough first we stop the induna is going to beat the koedoe horn he said 'for now, this rain is just to make the last stem of the mealies to be rotten we are not ploughing' so and then when the other rain comes so he can beat the koedoe horn again, he said 'now we can start ploughing' so where we're going to reap our mealies.*

The definition of a public issue or conflict is shaped by either the chief's, the *induna's*, or the older men's interpretation of the issue at hand and the issue will be handled in a manner they see fit. In many African societies, as in this one, personal disputes are seen as a public issue that has to be resolved with the help of the community (Fanon, 1963). Mr. D, for example, explains how a problem between him and his wife will be handled.

> *So, first thing they will go to the induna and tell him that we have a problem of this lady and her husband, so they will call me and then they call the men to go there. And then they sit down speaking with me…*

HIV/AIDS tends to flourish in marginalised social groupings (Barnett & Whiteside, 2002), which include those with the least access to economic power (i.e., access to money and paid work), political power (i.e., access to formal political influence), and symbolic power

(i.e., access to recognition and respect from other members of society). It is unlikely that the individuals in these marginalised social groupings will have power or influence to promote the development of a health-enabling environment (Campbell, 2004). Inequality resulting from social and economic health determinants has long been recognised as the cause of differences in health levels across gender and socio-economic standing (Craddock, 2000; Leon & Walt, 2000; Turshen, 1991). It is thus just as important to look at the social, cultural, economic, political, gender, and environmental factors as it is to look at the biological factors when attempting to find solutions or devise strategies to combat the spread of HIV (Kalipeni et al., 2007). There is a definite need for the natural and social sciences to join forces to effectively tackle HIV/AIDS in Africa. HIV spread and prevention are both enabled and constrained by the wider social context within which communities are located. Here particular emphasis can be placed on the unequal power dynamics (Campbell, 2004) within the community – particularly the relationships between men and women, between rich and poor, and between accepted leaders and those who are not.

4.2.1.1 Gender relationships

A large body of work (e.g., McFadden, 1992; Schoepf, 1988; Shefer, 2003; WHO, 1994) view gender inequality and men's perceived sexual and economic superiority to women as central to HIV infection. Women's power inequalities make them, according to the feminization of poverty theory, especially vulnerable to HIV infection (Shefer, 2003). In a patriarchical culture men are seen as dominant in the family as well as society at large (Boonzaier, 2003). The community in which the participants live is established around such patrilineal lines. The men make the important decisions for their families and the community. Men are seen as more intelligent and superior to women. Women have to respect and accept men's decisions. As Ms. P said *…you must take your husband as he is your parent. Don't say nothing to your husband, you must stay with him. And if he told you something don't put another words which is going to make a problem.* A woman should always listen to either her husband or father. When asked whether a man may at times listen to the views of a woman Ms. P replied laughing, *No, they can't. Just because they say they are the head of the family always*.

This power dynamic between men and women also occur in their sexual relations and is an example of how the spread of HIV can be enabled. The discourse of power, influence whether or not people practice safe sex (Collins, 2003). Men are seen as powerful and thus have the right to decide what happens in a relationship. They can, for example, put themselves and their partners at risk by having multiple sexual partners and by their refusal to use condoms. According to Ms. J *in our culture we are allowed to have – if you are a man – you are allowed to have maybe two wives and wives did not allow to have two husband. So that… you find that if the husband have got two wives sometimes he go outside and he want to find another girlfriend. So that's why we find that they spread the HIV*.

Several factors work together to produce the perceived male power, as well as women's willingness to accept their decisions and behaviour. In this community (as in many others) women are more likely to be unemployed, to be less educated, and to have fewer and worse paid employment opportunities. They are therefore many a time dependent on a man (or men) and thus forced to tolerate their behaviour (whatever that behaviour or the consequences thereof might be). Particular ideas about masculinity also support the discourse of male power. The idea that men cannot help having multiple sexual partners due to their uncontrollable drive for sex, or that a man has to prove his 'manhood' by having many children and therefore has the right to object to the use of condoms are but two of the ideas surrounding masculinity (Collins, 2003). However, as an increasing body of literature on men and masculinity (Cornell, 1995; Foreman, 1999; Morell, 2001) has shown, not all men practice the same 'type' of masculinity and many different constructions of male power exist.

In general women are seen as objects of men's sexual urges and women view sexual behaviour in terms of men's sexual needs and urges. Ensuring man's pleasure is experienced as an expression of commitment and love from a woman. Ms. P, for example, said that *… by the sex they say that if you are having a husband, maybe you are alone there from your husband, and then he say to you you must… I have to find another woman just because you are one here, I'm not satisfied about you, for what you*

are doing for me here. So he want to take another one. You have to say 'Yes, you can take him'…

Condomless sex is seen as more pleasurable and it is thus expected of a woman, in order to satisfy her male partner. When asked why the community members do not want to use condoms Ms. J answered *The other people they say they don't eat the banana with the peel on* and *they say it's not nice to use something, without using their own flesh*. The only time when a woman may ask her husband to use a condom is when she has concrete prove that he has been sleeping with other women.

> *If you know that you are only one… you will… have sex without condom. If you… see that that man he have got maybe two or three girls you… you are allowed to use the condoms.*

According to an article in the Mail and Guardian (2006, April 5) the pressure women face to have unprotected sex and the belief that men are entitled to sex are enormously underestimated. Willig (1999) found that maintaining trust in a relationship requires strict censorship about what is communicated between the individuals and evidence of trust is offered by having unprotected sex. Requests for using a condom can be interpreted as a sign of infidelity or that the person making the request is HIV positive. Ms. J, for example, noted that *…the most for the women. If they told the men that if you want to sleep with me you can use the condom, so he would like to know why you said we can use the condoms. Maybe me you… I've got another husband and you find that it's not true. It's because the men they go outside most*. Moore and Oppong (cited in Kalipeni et al., 2007, p. 1017) found that men prefer not using condoms as "pressing economic deprivation and other considerations such as the desire to have children, to assure social standing and fulfilment, supersede the remote potential of infecting their spouses". The pressure women face to have unprotected sex and the belief that men are entitled to sex and cannot help having multiple sexual partners are enormously underestimated. The structural gender inequalities and culturally condoned male sexual behaviours and sexual practices is harmful to both men and women. The HIV/AIDS

epidemic harbours strong potential, both in respect of transforming gender relations and in supporting greater democratic participation:

> The paradox offering promise is that, although the nature and severity of its impact is a consequence of inequalities of power, AIDS can serve as a leveler of conflicting interests. Both rich and poor are among those afflicted. If women are most vulnerable, men are not spared. AIDS threatens the future by claiming the lives of the young. In this sense the epidemic exerts a strong persuasive influence, illustrating the illusory nature of any vested interest in maintaining a status quo, which can bring harm to, so many (Baylies & Bujra, 2007, p. 196).

Attempts to alter power relations are likely to be resisted by those in positions of dominance if such attempts threaten their position of relative privilege and access to resources (Baylies & Bujra, 2007, p. 194). According to Silberschmidt (2001) men do not give up their male privileges, and certainly not in situations of poverty and disempowerment. According to Baylies and Bujra (2000) the way forward in the fight against HIV/AIDS could be to build on women's existing organizational skills and practices.

In the Mnisi tribe men prefer to be in control of their wives at all times. They do not trust their wives and believe that their wives can bring bad luck over their house or to their person. This was substantiated by Mr. D, *because there is no one that is controlling her, but when I'm controlling her and say 'at four o'clock I want you to be home'… So she can go and find another man, but if she don't show you maybe you see by the sun that here there is something vision on my eyes… you will not find it but you can find it later* and *the men said when you have a wife, maybe you are… it's a cherry that you are jollying with her and then you are on working, when she do something wrong at home when she is busy jollying there at home you'll find you are getting injury where you are; because of her there at home*.

Research (e.g., Miles-Doan, 1998; Schornstein, 1997) has shown that the lack of access to assistance from social institutions puts constraints on the options that poor women have. The problem of the spread of HIV may be aggravated by socio-cultural and religious inhibitions that prevent educated mothers from giving meaningful sex-education to their pre-adolescent and adolescent daughters (Mbugua cited in Kalipeni et al., 2007). The female participants indicated that they believed women have the right to make their own decisions and to refuse sex should a man object to using a condom. It is, however, clear that women's social position within the community is not equal to that of men and that, even though women believe they have the right to say 'no' to a man, they would rarely act on this belief. The fact that the woman has been paid for (labolla), although it does not constitute an actual sale, puts her in an inferior position (Junod, 1966). Baylies and Bujra (2000) also found that women find it very difficult to challenge men's power and negotiate about sex, as "[u]nequals cannot negotiate" (p. xii).

Adult members of the community are taught about sex, HIV and AIDS by nurses and social workers while the youth learns most of what they know from their friends. Only girls are taught about sex by their mothers, fathers never speak to their sons about these issues.

> *More especially the mother she can teach her at home. Actually, she is giving them the advice that when you see this you'll have to do this then when you see this you have to do this. So we men uh… you find that my father can't tell me that 'my son you will have to do this', because they know that to us men it's difficult… actually the mother have no problem, but father he can't teach a man and my mother he can't… she can't teach me that 'son while you have a… a wife or when you see this at the girl that you are staying with her you will have to do this'. No. It's only the mother that are telling the girls that 'you will have to do this and this'*

In some instances the culture of male power is not as strong as it used to be and Mr. D, for example, acknowledged the role his wife plays, *so, helping with my wife for now we*

have this and this what can we do while we are doing, because you can't work alone at home meanwhile you're not one, so you'll have to get advice with your wife that for now we are doing this and for now we are doing this. Women's power have also increased in that they are able to decide whether or not they want to become pregnant as most women now have access to oral contraceptives, which they can take without the knowledge of their husbands or boyfriends. Mr. D indicated that *they've made that a woman they have to go and do the prevention so that they mustn't get pregnant*.

4.2.1.2 Relationships between rich and poor

> [H]e's a beggar fighting, in his poverty, against rich men powerfully armed. While he is waiting for decisive victories, or even without expecting them at all, he tries out his adversaries until they are sick of him.
>
> (Fanon, 1963, p. 20)

Being poor may well be the "principle cause of human misery" (Singer, 1993, p. 220). Socio-economic status brings forth a difference in power, especially economic resources, and opportunities. According to Campbell (2004) many of the social factors shaping individuals' health-related behaviour are linked to the unequal distribution of political and economic power.

People who are poor often lack adequate food and shelter, as well as education and health which keep them from leading the kind of life wealthier people value. The poor are extremely vulnerable to illness and economic displacement (Thelen, 2003). They are also, more often than not, treated negatively by institutions in society. Mr. D said that they do not have access to quality health care and therefore *she can stay… take maybe two months or three months without seeing that she is HIV. So she is going to do the sex with the other boys where it's the time where she's spreading also*.

Ms. P explained what a hard time she experienced when her daughter became pregnant: *I always used to take my own money and use it to help her when she's*

pregnant and also when she have a child. I have to buy for her all clothes for that kid and also when she go to the clinic, sometimes they need money there I have to take my money and go there. Having an extra mouth to feed when you are the sole breadwinner for your entire family puts immense strain on the caregiver as well as on everyone else in the family.

Education is very important to the people of the Mnisi tribe. They admire any person who has some sort of qualification. Those without an education or with a lower level of education will accept that which a qualified person tells them. Mr. D, for example, said that *because when she talk with that bones* [referring to the sangoma] *she said saguma, which means you accept what she's saying you are going to accept, because you don't know nothing*. Most individuals want to study and work, but as Mr. D said *I see that to be a teacher I'd need money*. Ms. J, when asked what she used to dream of becoming when she was a young girl, answered that *If I'm still a child I would like to go to school and also to the church. So if I went to the school and I finish my matric I want to go to the tertiary school and I want to be a nurse, because I want to help the people at the clinic.*

Within poor communities violence and crime are prominent (Thelen, 2003) fixtures of everyday life. Mr. D said *But you can kill sometimes…* and *that's why when a man or a woman die, nowadays you will find that they said this man it is killed by somebody or they can tell you that's your neighbour that is killing you. They say that your children – all of them – they are working nicely so you are the important man, so that's why they are jealous. So it's where you'll have to go to the other place where you can find the really sangoma than the one that have made you that thing so that you can alive.* Ms. P explained how a person could go about to bring harm to another. … *if there is someone who's enemy to you he… they can find someone who lives with you there at your family. Saying 'o…' maybe it's a book they can come 'have you seen Ms. P's book?' and if he don't know what he's going to do with my book or whatever to do they can give him… and then there to the sangoma they are going to take some medicine and… if they came with it again back to you, if you touch it that book you are going to find that maybe*

you are going never see anything again. Your eyes will be blind you can't see it. Or else whether they want you to be dead they are going to find a clothe for you, more especially panty. It's dangerous for us. If they find the panty they are going to cut a little piece under it and then they're going to put in some medicine, busy talking about your name also your surname and then you will start to be ill and then from there there is no cure of that and then you are going to die like this…

As violence is so prominent in many poor communities this forms a big part of their every day lives. Fanon (1963) said that when one knows only violence, this is what one will use to stop violence against one self and one's family. Mr. D articulated how he would go about stopping crime in the community if he could have an input in the laws and how they should be executed.

> *And if I saw that crimes it's not stopping so I can bring back the law of eye for an eye. If maybe you come to the other home, maybe you kill somebody, by… let's take you want to steal… is your car or something that he want steal at your home and then when you came out he shoot you. Even me I can use that law that eye for an eye, if you have kill and then you're killed. Because if you don't kill that man who have killed even tomorrow he's going to kill because he is not afraid*

The power relation between rich and poor often becomes a power relation between men and women as men are more likely to be employed, to be more educated, and to have better paid employment opportunities than women have. Men show their 'power' by sleeping with many women. They also use their money to buy alcohol and drugs to show others how 'powerful' they are.

> *And there is a tablet that they can use to so that they are boosting themselves so that you can manage to sleep with five or six girls per day and that's the other thing that's spreading HIV also, because the men is using money and the ladies are running after money… because the ladies*

> *are running after money and the men are looking for the woman so that they can share their pocket… When they saw that this lady is drunk and then they follow her at the back. After that they rape…*

4.2.1.3 Relationships between accepted leaders and those who are not

> [I]ndividual change is most likely to come from projects in which people collaborate not only to change their own behaviour but also to understand and challenge the social circumstances that place their health at risk.
>
> (Freire cited in Hook, 2004, p. 335)

As previously mentioned, the Mnisi tribe believes in the principle of *Ubuntu*, which is "an ethic or humanistic philosophy focusing on people's allegiances and relations with each other" (Wikipedia, 2008d, p. 1), the respect people have toward each other. Within the Mnisi culture, as in many other African cultures, respect for older people and the ancestors is of utmost importance – if you show respect to others, you will also be respected. According to Mr. D *respect is a good thing to the people even if you are not here at home you will have to respect. So keeping respect is good, because they will… everywhere you will walk in the community of at the other community you will hear the people speaking about your name, that there is a home of Mr. D of there is this home of who he… that children they are having respect to the people*.

Educated individuals are respected and looked up to for answers to problems. It is very important to the Mnisi people to ensure that their children get the best education they can afford to give them. They see it as an investment, not just for their children, but also for themselves.

> *And I know that my children, when they have passed, they will learn for their own job that they can get money, so that… the money that I have*

> *helped them they will help me also then use that money. And I know that if they can get that job that money that I have loose they will close*.

Most African leaders are in a position to influence political and social thinking surrounding issues of HIV and AIDS (Loosli, 2004). Unfortunately these leaders do not always want to acknowledge the magnitude of the HIV/AIDS epidemic. This is evident when one hears president Mbeki saying, “we could not blame everything on a single virus” (cited in Horton, 2000, electronic version). Makgoga, the president of the Medical Research Council of South Africa, said that Mbeki’s comments were “absurd… and a form of national denial” (cited in Butler, 2000). Justice J. Cameron, a South African High Court judge living with AIDS argues that “in my own country, a government that in its commitment to human rights and democracy has been a shining example to Africa and the world, has at almost every conceivable turn mismanaged the epidemic” (cited in Horton, 2000, electronic version). Baron and Byrne (2003) found that it is important for a person to form attitudes about issues, persons, objects or groups, as this is the manner in which people organise and interpret social information. Attitudes are formed mainly through the process of social learning, many of a person’s views are acquired in situations in which he / she interacts with others or merely observe their behaviour (Baron and Byrne, 2003), genetic inheritance also plays a small part in one’s formation of attitudes (Waller, Kojetin, Bouchard, Lykken, & Tellegen, 1990). The behaviour and vocalisations of African leaders are observed and respected (and thus copied) by many of their supporters. Although this can be used to the advantage of many people it has unfortunately been mismanaged and misused by many individuals in leadership positions. Many examples of South African leaders mismanaging the disease can be found in literature (e.g., Butler, 2000; Horton, 2000; Obisesan, 2007).

The prevalence of HIV/AIDS among South African men, between the ages of 30 and 40 years, is 25% and even higher for men in younger age groups (Mail & Guardian online, April 5, 2006). Despite these statistics Jacob Zuma, while serving as head of the National AIDS Council, said that he had unprotected sex with an HIV positive woman, as he knew the risk was ‘minimal’. He also said that he showered after intercourse as a

precaution against contracting the virus (Obisesan, 2007). In a press conference Mr. Mbeki held that he does not know anyone living with HIV or anyone who has died of AIDS (BBC News online, September 26, 2003) distancing himself from a large part of the South African community. Health Minister Manto Tshabalala-Msimang advocates that a diet of vegetables and garlic can help to combat the disease (Obisesan, 2007) thereby discouraging individuals from using ARV's and leading them to the belief that eating healthily will cure them from HIV and / or AIDS. According to Mark Heywood, spokesperson for the country's main AIDS lobby, the Treatment Action Campaign (TAC) "their (referring to Zuma and Mbeki) utterances and general disposition to the fight against HIV/AIDS are suspect" (cited in Obisesan, 2007). More examples of the influence leaders have can be found in the interviews. Ms. J indicated that most of the people in the community believe that only a sangoma (who is seen as a leader in the community) can heal them from HIV and that the pills they receive at the clinic will make them sicker. When asked why, if people know and understand the consequences of unsafe sex do they still not use condoms, Ms. P answered *they* [referring to the health practitioners and community leaders] *are saying that it's God who have give us. You'll find that HIV on the food which we buy from the shops, so it's not for the intercourse what we are doing here which make us to find HIV*.

The chief, his *indunas* and the older men in the community represent the state and the law in the Mnisi tribe. Ms. P said*…also when there is a meeting it's that induna who is going to say 'I have found something there at the chief' so all the community must know all what he had find it there at the chief* and Ms. J, when asked whether it is important to listen to the older people, said *if they say 'this one it will not right' you can listen them and if you don't listen them you will be in trouble*.

The members of the community are taught from a young age that bad things will happen should they not abide by the laws of the culture and should they not comply with the requests of their ancestors (the 'people' with the highest level of leadership). As an example Mr. D explained the traditions surrounding the planting of corn:

> *[W]hen the rain have come, so we want to plough first we stop the induna is going to beat the koedoe horn he said 'for now, this rain is just to make the last stem of the mealies to be rotten we are not ploughing' so and then when the other rain comes so he can beat the koedoe horn again, he said 'now we can start ploughing' so where we're going to reap our mealies*.

When asked what will happen if a member of the community decided to start planting before he / she has received the go-ahead from the induna, Ms. J answered, *they will come to you and say 'why you plough the field and it's not the time for the ploughing'… because they agreed that if you plough before the other people they plough there will be no rain again*. The individual planting before the others will thus be responsible for the suffering of the entire community for the entire year ahead.

Sangomas (or traditional healers) play an enormous role in the everyday life of the Mnisi people. Mr. D explained the role of the sangomas in the community during the interviews.

> *So the sangomas that's the people that they always help us while we are aliving in life, because you'll find that maybe I'm ill and then when they took me to the doctor they find that it's not the sick that is the natural sick… So there is where I'm going to meet with the sangoma, the ancestors… because that's the people that they use the joint of the animals. Or sometimes you can look also while you're at home, because they use something they find in the oversea; it's like snakes they use it even on the tortoise. They find some bones there and then they use it to profect [prophesize] that… So, after that he's going to give you the medicine that you can use at home, for what you want… that traditional healer their forefather that have gave him that job to do it.*

According to Ms. J: *the sangoma if you have got a problems at the home you can go to the sangoma so they can tell you what's happening to your house and the traditional*

healer, if you are sick you can go there so they will give you some medicines so you will use it. Women are taught that they have to go to the sangoma as soon as they find out that they are pregnant. This will, for example, ensure that the baby stay healthy and that he / she is delivered at the right time. Mr. D said the following regarding this issue:

> *And sometimes they have to go to the sangoma – giving her the medicine that the… actually they are helping, because nowadays the people… there's some people that they do something that are not good to those who are having a pregnant. You find that instead of giving birth on 9 month you pass there until to 10 or 11 months. So that's the one people's they're traditional healers. Maybe they have hate our home so, they can do that… So that's why I said they have to go to the sangoma and then they vaccinate her that even if they come with that things that's not alright it must be alright, that pregnancy, that mustn't make the abortion*.

After the birth of the child the mother has to once again go to the sangoma to ensure the health of the baby.

> *So, when she gave birth they took that… they have to take that child and then there is some medicine that they have to give the child – traditional medicine, using the trees*.

Sangomas are believed to be able to give people medicine to use to get rid of a problem or to kill their enemies, and to then use the deceased's spirit to work for him / her. Mr. D, for example, explained how he will go about getting rid of a person whose job he wants and also tells what happened to him when somebody was angry with him:

> *[M]aybe I want to… you… to chase another one here. So I go to the traditional healer and then I said 'here I have a problem', maybe I want to be a manager or a vice so I said 'here I have uh… five hundred just do for me a favour to… I want take that one there to be off on that chair'… so*

he's going to give me the medicine and said to me 'go and take this medicine when you arrive there at the kitchen or at the gate where you know that that person is always walking and then you can throw that medicine on the ground… She will start hearing something as is a thorns that have digging inside her hands, so from there it's where that thing is going to make a pain. And then she try some means that that pain can leave. Maybe you see the hand after that one day the hand becomes swollen so… and when she go… even her, because when the hands can be swollen and then it goes inside sometimes it can kills you if you stay and say 'I will see I will see'.

I remember when I'm ill they said they have used that thing from August until December I was staying in the owner of that school, to the traditional healer, because it have started from the leg and then get inside beating here where my… where my heart is beating and then from there I stay without going to the toilet and then that's why have went to the traditional healer. At night they will tell you that maybe they have taken your spirit. Actually they do something that they take your spirit and then you still alive, meanwhile you are dead. They said there is a place where there is a dead body where you are not really dead. When they bury you they said they have buried a stomp there it's not you, because of the medicine that they have. It's a strong medicine that they have. I don't know that where did they find, but they have that thing. It's what's happening. They said that people at night they are weeding the grass in the field. Sometimes they… what they reap the mealies in the field. Actually they take that people and then put in their field so that they can work there.

Many people affected with HIV/AIDS turn to traditional healers and traditional medicine for help as they are culturally more accepted, less expensive, and more available than ARV's (Bodeker, Carter, Burford, & Dvorak-Little, 2006). The participants commented on whether sangomas (traditional healers) are able to cure HIV/AIDS. Ms. P noted that

some of the sangomas led the community members to believe that they are able to cure HIV and AIDS. Ms. J said that some of the traditional healers will, although they cannot test for HIV, tell you that you do not have HIV/AIDS in order to sell their medicine to you. Mr. D said that some of the sangomas will tell you that they will try to help you while others say they know how to cure HIV/AIDS he also said that when you are *lucky* the ancestors will cure you from HIV/AIDS. Mr. D acknowledged that, …*because we are not the sangoma…*, he will listen to and believe what the sangoma is telling him.

Although there are growing concerns about unsafe practices and claims of traditional cures for AIDS, traditional health practitioners can play an important role in offering treatment for opportunistic infections and to deliver AIDS prevention messages to rural areas (Bodeker et al, 2006).

“In early modern Italy, fear of disease and the disease of fear (paura) became inextricably intertwined, within a world of bewitchment, malevolent forces, and the almost daily threat of unexplained pains or sudden death” (Bynum, 2002, p. 535). According to Van Dyk (2001) in Africa witchcraft is believed to be the causal agent in HIV transmission and AIDS. Belief in the power of witches provides individuals with ‘answers’ they understand. Community members are, however, very scared of being bewitched and will therefore not tolerate anybody who appears to be or has been shown to be a witch. Mr. D explained what used to happen with people believed to be witches.

> *That sangoma where you have visit he’s going to tell you all and if there is one who there amongst you, the one that he is a… a witch they will going to paint her or him… So he tell you that ‘you are a witch’ and they beat a cross on your forehead. And then when you come back, they all they came back… They stand one by one telling us that me I’ve hear when they say this and you find that it’s… there is a lot of problems. And from there it’s where you find that long ago they were killing some people, burning the people, they said ‘you are a witch’, they burn him with the petrol.*

According to Fanon (1963, p. 43) "… the so-called pre-historic societies attach great importance to the unconscious". The people from the Mnisi Tribe, as many African tribes, accept dreams as a way of communicating with the ancestors. The ancestors will communicate with an individual in a dream. Should the individual need more information he / she will go to a sangoma who will assist him / her in understanding what the ancestors wish to communicate. Ms. J explained it as follows:

> *You find that if you have sleeped at night you find you have dream your grandfather or your grandmother, so they told you what you can do. And if you do it it will be fine… . If you go to the sangoma and you said 'when I sleeped at night I have dream my grandmother or grandfather', so they will tell you they want this and this. So if you can go and make it you find that you'll be fine or you have never dream it again, if you made that things that they wanted you to do it*.

As soon as an individual knows what the ancestors wanted to communicate to him / her immediate action has to be taken in order to satisfy the needs and wants of the ancestors. Mr. D clarified this during the interviews.

> *Even when I'm slept at night you can find that maybe I'm dreaming my grandfather who have died long ago… they will lead you that this money 'we want you to buy the cattle', 'we want you to did this and this'. So, every way they will channel you is what you'll have to do, because if you find that maybe they said 'buy the cattle' and then you take that money and you buy the car you find that within a year you can maybe kill four cars, because you will roll sometimes you beat the trees. So, when you walk around to the sangoma they said 'the thing the money that you have got you are not using the money the way they have told you', so… which means you will have to follow the instruction of your forefather, what they are saying*.

When asked what one should do if the ancestors asked you to buy cattle for them and you did not have the finances to do so, Ms. J answered that *you will make plan to have the money to buy that cattle*, because if you did not obey them or provide in their whishes your fate will be dire. Even the sangomas will obey the ancestors as the ancestors can take away their 'powers', rendering them unable to act as a sangoma. The individuals of the Mnisi community have a constant awareness of the presence of their ancestors. As mentioned above, the ancestors' wishes should always be satisfied, but despite this they should also always be made to feel proud of their living relatives.

4.2.2 "…People are running after money…" (Culture of poverty)

> For this same people, poverty-stricken yet independent, comes very quickly to possess a social conscience in the African and international context of today… Now, the fellah, the unemployed man, the starving native do not lay a claim to the truth; they do not say that they represent the truth, for they are the truth.
>
> (Fanon, 1963, p. 38)

Socio-economic status brings forth a difference in power, especially economic resources and opportunities. The Mnisi community is comprised mainly of poor individuals and households. Rising unemployment works to worsen poverty and inequality in the community. The participants all indicated the need to alleviate the most basic needs of the people in the community. According to Maslow's hierarchy of needs (Moore, 2003) people will first work toward satisfying their most basic needs before they will satisfy their need for safety, et cetera. Mr. D explained how the families in the community are suffering without the basic resources any person needs for survival.

> *Sometimes at the back you find that after two years you lose that children, because she's not eating and the children need to eat so that they can grow well without getting sick like that*.

Without money food cannot be bought and without a sufficient water supply food cannot be produced by the community members to provide in their own needs. As Mr. D said *so you find that you have no money to go ahead*.

When asked what she will give to the community and its members should she become president Ms. P answered *I will give a people work, just because now the… the people are stealing more and more just because they are sitting here at home and then when they are just walking here they also remember for what they are going to do 'let us go and steal there at the café, so that we can find money' and maybe they can go to kill the people there, thinking that they have to find money to help themselves. But I can give them work and then when they're working they will forget to go and do something wrong*. Mr. D indicated that he would make sure that everybody have adequate access to water, he would create jobs and fight crime; while Ms. J wants to reduce the number of teenage pregnancies, build schools and provide food, water, and housing for everyone in need.

Poverty was not associated with ignorance of the mechanisms of transmission in the early days of HIV transmission. Butler (2000, p. 1445) holds that although "biomedical models of AIDS correctly emphasise the importance of HIV transmission, the spread is dependent on factors such as behaviour, knowledge, education, attitudes, and the availability and affordability of medication and medical advice".

A causal relationship is not necessarily indicated by the association of poverty with increased HIV prevalence, but poverty may increase one's susceptibility to HIV/AIDS (Fenton, 2004). According to Butler (2000, p. 1445) "poverty is neither necessary nor sufficient for an individual to contract HIV infection or AIDS", but he feels that "it may be necessary for an epidemic on the scale currently witnessed by parts of sub-Saharan Africa". However, Halperin (2001) says that although it cannot be denied that poverty has contributed to the spread of HIV one should not come to the simplistic conclusion that "poverty is what causes AIDS". Coovadia (cited in Horton, 2000) holds that although poverty exacerbates HIV/AIDS, it is "not the basic cause".

Poverty is, however, one of the key factors leading people to behave in a manner which expose them to the risk of HIV infection (United Nations, 2005). Poverty also exacerbates the impact of HIV/AIDS. Non-poor individuals can readily be pushed into poverty through the experience of HIV/AIDS – poverty and HIV/AIDS are interrelated (African Studies Center, 2003). This interrelatedness has been substantiated by Butler (2000, p. 1445) who holds that the cause of the link between HIV/AIDS and poverty is probably bidirectional: “the economic consequences of epidemic disease help to trap populations in further poverty and disease”.

Poverty and economic opportunity, or the lack thereof, have commonly been cited as important contributors to the AIDS epidemic (e.g., Butler, 2000; Fenton, 2004; Halperin, 2001). Bloom et al, (2002) found that there is a positive correlation between HIV prevalence and poverty at the global level whether measured by gross domestic product per person, income inequality or Human Poverty Index. The role of poverty and economic deprivation in the transmission of HIV is complex and manifests through migration, gender, and cultural politics (Kalipeni, Oppong & Zerai, 2007). Poverty alleviation programs are increasingly being implemented in sub-Saharan Africa by international development agencies and donors with the goal of reducing the prevalence of HIV (O’Farrell, 2001). Kalipeni and Gosh (cited in Kalipeni, Oppong & Zerai, 2007) found that even when men have knowledge about HIV/AIDS and prevention strategies they still continue to engage in risky sexual behaviour. Even when HIV/AIDS awareness is high people personally tend to think they are not at risk (Mail and Guardian online, April 5, 2006). Community-based economic ventures that promote economic security (and reduce circular migration and thus keep families intact) should complement the usual strategies (e.g., the ABC approach (USAID, 2006) which holds that Abstaining from sexual intercourse, Being faithful to one partner and correct condom use are behaviours that can prevent and reduce the likelihood of HIV transmission).

The participants indicated a number of ways in which the need for money and resources can force people to behave in a manner they might not have, were it that they had basic resources at their disposal. Fulfilling immediate needs for food, water, and shelter seem

to be a greater priority than the potential long-term consequences of unsafe sex (Hlatshwayo & Stein, 1997). People have various degrees of freedom to change their identities and associated high-risk behaviours. A woman, for example, whose sexual partner assists her in supporting herself and her children, will have less freedom to refuse sex with a condom-resisting partner than a woman who can support her family on her own (Campbell, 2004). Women might also improve their economic situation by having concurrent partners (Shelton, Cassell, & Adetunji, 2005) and thus concurrent sources of income to support her and her children. Mr. D reported that women sell their bodies for money and for lifts to and from the places they need to be – taxis and busses cost money – he also said that, in his opinion, this is how HIV is spreading.

> *…girls and the boys around the corner they are doing sex during the day where it's a place where are very busy, but they are not afraid of the people they are just using. The ladies want money and then the boys they help themselves and they don't want to know if this man is not having HIV or AIDS… Actually, the thing that is making this… that is doing this… to spread the HIV and AIDS that's the money... They are looking for the money, running for the money, selling themselves…You know the one who's having HIV he like sometimes he's having money and then our children or wives here in our area, many people nowadays they likes money, so maybe he's having a car, you find him waiting on the station he's going Acornhoek say lift him, you go with him and then he start to propose and then he accept what he's saying.*

As the community in which the participants live is of low socio-economic standing, with very few work opportunities, men and women leave their homes in order to find employment elsewhere. Many a time employment can only be found in a big city far from home and everything and everyone he / she knows. Studies have shown that migrant workers often participate in high risk sexual behaviours during the times they spent away from home and that the infection rate among such workers is high (United Nations, 2005).

> *Because nowadays if you look our culture the people are running after money. Men in the minings and workings, everywhere there's jobs, you'll find that there is a ladies that they have wait for the men when they get paid… they are going there to do what they are selling themselves so that they can get money. And then according… when they do that they, they want money, they forget that they will get HIV… one lady she can sleep the one day with three boys, there when we are working.*

The person that leaves home looking for employment undergoes individual changes and also changes the family characteristics. Couples are separated and individuals that spend a long time away from their regular partners are more likely to engage in casual sex (United Nations, 2005). When a person working far from home, who at times engage in casual sex, comes back to his / her regular partner the partner is also at risk of infection. In turn the partner might engage in casual sex while his / her working partner is not home, and so the disease is spread in the community. Mr. D and Ms. J respectively had the following to say:

> *From here she climb on top of the big lorries, running with them. They don't know how is that man or how is what… And then he is going to share it here at home. So it's where you'll find that it's spreading all over the places around our community.*

> *Yes, it's a problem, because if the men go to the work and you found that there is another girl and he sleep with them and when you came here and they have never used a condom and when you came here and sleep with his wife it will be transmitted the HIV.*

It also often happens that women cannot find employment even in big cities and is then forced to prostitute themselves in order to get money to provide food for her family. Mr. D explained how even people with tertiary education struggle to find work and then have to resort to desperate measures.

> *Some they have the low education, but some they… many of them have learned in school, but because they saw… You can see now you can have the… maybe you are coming from the training and then you don't find the job, because there is no job nowadays. So some others they have went…maybe they go Pretoria, Nelspruit when they come back they said 'check my friend how I'm are, there where I'm are you can get money as long as you do this and this' so at the end of the month they go some there and then when she arrive there, maybe she find a piece job and then she get another man… And then it's like when you find that I'm having a wife and then she's working to the other place, when she's there she's not staying she's doing something wrong that is not right to me… After that even me I'm going to spread it. It's how the HIV and AIDS we spray here in our local area*.

Giving birth to a child and registering him / her at the Department of Home Affairs gives a poor South African women the right to receive a grant of R210 per child each month – *we find the money from the government*. A child cannot be fed, clothed, and schooled with this amount of money, but to a person who has absolutely no income and no means of looking after herself and her family, having a baby simply to receive the grant money might look like a viable option. As soon as a child can walk he / she also play a role in the household, helping with the chores. They can, for example, fetch water (which is often situated quite some distance from the house) and wood and they can clean in and around the house. Ms. J, when asked what she would do if she could do anything for the community, said *in our community I can help the people to say if like the ladies if they are not married they will not allow to have the pensions for the child, because you find that all the children they have got the baby because they know that they have got some money from government. So I can make the plan that the people they can find the job and I can make the people that they are not going at school without the money. They can go to the school*.

In a poor community the children have nothing extramural to do after school and often become sexually active at a very young age. Ms. J said that she wish there could be a centre where children could go after school, because *if they are playing they will no time to go at the road. Sometimes you find that if they… the school is out the children they went to the road and the car they will take it to the… the children, so if they are playing there's no time to go and sit on the road*. The children are often picked up at the side of the road and then paid for sex. In houses where there is no money this might seem like the only solution for a child to find money for food.

People, who have been tested for HIV and have been found to have AIDS and a viral load of less than 400, also get grant money from the state as they are unable to work. These individuals are also provided with healthy food, food that a family might not have were everyone healthy.

> *Because I heard the other one they saying that on the radio tell us that when you are having AIDS or HIV you have to get food that can help you so that the AIDS mustn't go high. Actually you will have to eat many fruits at that time… And they give you maybe pension [referring to government grant] so that you can alive. I saw many of them, those they said they're having HIV/AIDS, they are getting pension and support themselves, while they get another food from social work*.

Families and households are the worst affected by the burden of HIV/AIDS as they are the primary units for coping with the disease and the consequences that might follow. If the breadwinner is the infected person in the family, the family will suffer financially due to a loss of income and increased medical costs that will have to be paid. It has been shown that AIDS-affected households often make a rapid transition into either poverty or extreme poverty (United Nations, 2005). Children from AIDS affected households often have to drop out of school in order to either find a paying job or to help with labour at home. Many children are orphaned by the disease – left to fend for themselves. The participants articulated the problem as follows:

> *[I]t's a problem to the other people because the one that is having AIDS, you'll find that he is the one that he will need support to each and everything that he do or she do, she will need support and intensive care is needed to a person like that one. And then, even if there is something she want to do, you will have to assist him*.

> *[I]t's a problem, because the other people they will die and there's… they've got some babies they have got no one to take care of that babies, so it will be a problem.*

It has been found that in communities with a low socio-economic standing the use of alcohol and the prevalence of violence is extremely high (Dalton et al., 2001). Mr. D said, *Your aliving for drinking, smoking, so nothing for your future*. Due to excessive use of alcohol people regularly fight with each other, the fights often end up with one or more individuals bleeding. Ms. J expressed her thoughts about the excessive use of alcohol and the subsequent fighting as follows:

> *[T]hey fight; always if they've got… they have drink the beers… they drink a lot, because you found that maybe someone… the other at six o'clock they went to the tavern to have some drinks early in the morning, without eating food… for the fighting always… like the men when they have already drank you found that they fight with someone and the blood come out and someone come and help us, you find that they touch that blood, maybe I've got something in this hand so the blood come inside, so maybe he's got an HIV so it will be transmitted*.

The excessive use of alcohol also leads to the rape of many women. Unfortunately it is usually the excessive use of alcohol by the woman that leads to her being raped. It also happens that men buy drinks for the women in order to get them intoxicated, with the intention of raping her. Mr. D explained how drinking often leads to rape.

> *And the other thing that's the rape… when you go to the bottle store or hotels you will find the young girlies. At night, maybe twelve o'clock at night, what's going to happen when she leave there, maybe two boys or three boys they go with her and then on the way they rape her, they share with that lady… because she is drunk and then she don't know who is she because she was enjoying there in the bottle store… maybe there is a girl that you maybe you suppose that if I can find this lady and then you find that you are failing to get her when you talk with her and then… and she's the one that are drinking he… the man can say 'this one I'm going to find her, because she is drinking, I'll buy her drinks and then I know that she like to drink'. He buys the drink… So, it's too overpowering them, that beer, and then it's the time for that boy when he saw that oh that lady is drunk, so he can do as he pretend to help her so that I can take you home meanwhile he know his aim, so on the way he do what he will want to do.*

As mentioned earlier individuals who are perceived to be leaders are highly respected and having an education and qualifications automatically put you in this category. Individuals who have never had the opportunity to finish school or to go for tertiary training will easily believe whatever a highly educated person tells them. Everyone wants such respect and most of the individuals in the Mnisi tribe want to study in order to have better employment opportunities. This is unfortunately not possible for most of the people.

The ancestors and their wants and needs are of utmost importance to the Mnisi people. Should they ask for money or possessions the individual to whom the request was made will have to find a way to do what they want. Many a time community members have to borrow money to do this, putting themselves and their families into debt. Mr. D explained how the ancestors might come to a person to request certain things.

> *[H]e [referring to an ancestor] said 'I want wife' of 'I want the cattle' of 'I want the house'. So we'll have to build the house of the ancestors. And*

> *then where you'll first go to the traditional healer looking that where can we build that house for that man… So they will tell you that you'll have to build that house and then when it's finished… so we'll make the beer the local beer where you call… maybe your relative, so you come there and then you sit down beating the drums there. So, getting there inside and said 'here is your house'… they will lead you that this money 'we want you to buy the cattle', 'we want you to did this and this'. So, every way they will channel you is what you'll have to do…*

Should an individual visit the sangoma and he / she does not have the amount of money the sangoma requests for his / her help, the individual will also have to borrow money in order to get the sangoma's help. The participants indicated that one will have to first put money on the ground for the sangoma before he / she can tell you what the ancestors want or what the causes of your problems are.

Mr. D indicated that *people are running after money*, but without money none of a person's basic needs can be fulfilled. Should this then not be the first level of intervention? Poverty alleviation should be a priority, but together with this, people should be educated on the use of their resources.

4.3 Discussion and Conclusion

HIV crosses social, physical, and cultural, cross cultural, ideological, economic, political, religious, moral, legislative, and international borders. The virus affects people all over the world, rich and poor as well as young and old. Most of all it disproportionately affects those individuals and groups of people who already face social and economic disadvantages. The risk of being infected by HIV, as well as the impact of the epidemic on individuals infected and / or affected, differ significantly depending on one's personal, social, and environmental circumstances.

The HIV/AIDS epidemic has its roots in a series of complex processes including the micro-dynamics of human sexual desire, as well as the macro-dynamics of gender, economics, and politics. Addressing the challenge to stop the spread of HIV will thus require the co-operation of a wide range of sectors, as it is too complex a problem to be solved by a single constituency.

Mkhize (2004, p. 423) holds that "[p]eople are stratified differentially by factors such as access to power, economic wealth, and other opportunities. These divisions, often assumed to be 'natural', involve various forms of domination". She is also convinced that domination is established and maintained through processes of violence, political exclusion, economic and sexual exploitation, and cultural alienation.

In this chapter the research findings were discussed in some detail. Through the information obtained during the interviews and observations two cultures that are influencing the spread of HIV in the Mnisi tribe were identified. These two cultures were (1) The culture of power-rule and fear, and (2) The culture of poverty.

In the culture of power-rule and fear particular emphasis was placed on the unequal power dynamics within the community – particularly the relationships between men and women, rich and poor, and accepted leaders and those who are not. The interrelatedness of poverty and the spread of HIV was the main focus point in the culture of poverty. The transmission of HIV is influenced by factors such as oppression, poverty, discrimination, and illiteracy. These factors are in turn, affected by surrounding social, economic, and political environments in which individuals find themselves. Power-relations is a dominant characteristic of the community in which the participants of this investigation live, these power-relations are most dominant in the relationships between men and women, and rich and poor individuals.

Due to both biological differences and gender inequality, women and girls are particularly susceptible to contracting HIV. Women make up 57 per cent of HIV infected adult individuals in sub-Saharan Africa and it has been estimated that women aged 15

to 24 years are nearly three times more likely to be infected than their male counterparts (UNAIDS, 2004). Many women in the Mnisi tribe face economic, cultural, and social disadvantages, which increases their vulnerability to HIV infection. In the patriarchal society of the Mnisi tribe, men are seen as dominant in the family and women lack power in their relationships with men. Due to their inferior position, women find it difficult to negotiate condom-use with their male partners, which make them more susceptible to contracting HIV from their regular partner.

HIV/AIDS affects all people, but in general its impact has disproportionately affected individuals with the lowest level of economic and social resources. Poverty also exacerbates the impact HIV/AIDS has – it has been shown that poverty and HIV/AIDS are interrelated. Socio-economic status brings forth a difference in power, especially economic resources and opportunities. Individuals from the Mnisi community are mostly poor and rising unemployment works to worsen poverty and inequality in the community.

Poverty is one of the key factors leading individuals from the Mnisi tribe to behave in a manner which expose them to the risk of HIV infection. Poverty alleviation programmes are increasingly being implemented in sub-Saharan Africa with the goal of reducing the prevalence of HIV. However O'Farrell (2001) is of the opinion that the alleviation of poverty alone will simply divert attention away from biological risk factors which may be the determining influences that drive high-prevalence HIV epidemics. He also states that the relationship between HIV and poverty is complex and that poverty-reduction policies, by itself, are not likely to succeed in reducing the number of new HIV infections. Community-based economic ventures that promote economic security (and reduce circular migration) should complement the usual HIV prevention strategies, as awareness and knowledge of HIV/AIDS is not enough to change individuals' sexual behaviour.

As mentioned, the community in which the participants live is of low socio-economic standing and there are very few job opportunities within close vicinity to their homes.

Individuals from the Mnisi tribe thus often leave their homes to find employment in the cities (where risk behaviour occurs frequently). The United Nations (2005), however, is of the opinion that if adequate support networks are in place, exposure to new environments may reduce an individual's risk by increasing his / her exposure to information and to better services and care. This may very well be true, but due to the lack of employment opportunities in the Mnisi tribal area many women are forced into prostitution as a last desperate attempt to provide in the needs of their families. This then puts them, as well as their spouses or regular partners at high risk of getting infected by HIV. Women are also having babies in order to qualify for government grants, thereby increasing the amount of people suffering as a result of poverty.

The findings agree with Baylies and Bujra (2000) when they hypothesised that the success of strategies to confront the spread of HIV rests on the recognition of the power relations that exist within a community. HIV/AIDS is a powerful political issue, traversing with social divisions of gender, class, post-colonial-relationships, and global economics (Joffe, 1999; Van der Vliet, 1996). It is also a painful personal experience, partly because of the social and political dynamics which underlie it and which assists to create the assorted experiences of loss, stigmatised identity, and material lack that accompany it (Gibson & Swartz, 2004). An increase in the economic and political power of women relative to men and of poor people relative to wealthier ones may bring about the social changes needed to promote health-enabling communities (Campbell, 2004).

After completion of this investigation I have to agree with the findings of Kalipeni, Oppong and Zerai (2007, p. 1015), who concluded that "HIV/AIDS in Africa cannot be stemmed until issues of sexuality, empowerment, and vulnerability as well as social, gender, and economic inequities are addressed in meaningful ways at both local and global levels".

Chapter 5 discusses the limitations of the study, makes recommendations for practice in future research and concludes the study by discussing how the findings can be used to the advantage of the Mnisi tribe.

CHAPTER 5

CONCLUSION

> One thing only I know, and that is that I know nothing.
>
> (Socrates cited in Gaarder, 1995, p. 58)

> Thought is no longer theoretical. As soon as it functions, it offends or reconciles, attracts or repels, breaks, dissociates, unites and reunites. It cannot help but liberate and enslave. Even before prescribing, suggesting a future, saying what must be done, even before exhorting or merely sounding an alarm, thought, at the very level of its existence, in its very dawning, is in itself an action – a perilous act.
>
> (Foucault cited in Hook, 2004, p. 1)

5.1 Introduction

In this chapter the limitations of the study are discussed, recommendations are made, and the study is concluded.

5.2 Limitations of the study

A qualitative approach was appropriate for this study, but led to some limitations. As convenience sampling was used to find the participants for the investigation the information obtained may not be representative of all the individuals in the Mnisi tribe. This may also be the case due to the small sample size and the relatively small amount of interviews held with each participant. Using a sample of three participants one cannot make valid assumptions or draw conclusions about an entire culture.

In cases where translators were used, the translated questions and answers might not have been translated to have the exact same meaning it had in English and those translated to English might not have had the exact same meaning as in Tsonga. The answers obtained from the questionnaire might thus not be representative of the HIV/AIDS knowledge of the Mnisi tribe as a whole.

Observations provide rich and complex descriptions of what actually happens between individuals within different situations and can be carried out with little community disturbance. It is, however, very subjective and one tends to focus on certain aspects and neglect others. There might therefore be information that I 'missed' during the investigation which might lead to further insight into the cultures that are present in the Mnisi tribe. The coding and analysis of the interviews were also done using subjective interpretations and existing literature which may lead to the same problem the analysed data was, however, presented to and discussed with the participants (member checks) to improve the credibility of the findings

A limitation to the communication of any study of any kind is that writing has a reductionistic function and it is therefore impossible to convey everything that happened during the interviews and observations to the reader. The reader can also never be aware of all the texts that was used, or played a part in the construction of this specific text.

5.3 Recommendations

The information provided by this study, in combination with previous research findings, could be used to implement community / culture specific strategies in the Mnisi community in order to combat the spread of HIV. Examples of what I mean by community / culture specific strategies is strategies that would increase the economic and political power of the Mnisi women relative to the Mnisi men and of poor individuals and families relative to wealthier ones. Although knowledge alone cannot stop the

spread of HIV it is a starting point to individuals' willingness to protect themselves from contracting the virus. Using the sangomas or traditional healers, who are seen and respected as part of the community leadership, to educate individuals on issues surrounding HIV and AIDS may prove more productive than using individuals from other cultures that speak different languages and have different experiences and values. In order to implement successful interventions it is, however, advised that further research into the specific needs of community members in different age groups should be done. Mr. D, Ms. J and Ms. P are all between 37 and 40 years of age and might therefore experience their circumstances in a similar manner, which could be different from the experiences of either younger or older individuals.

Further research on the Mnisi tribe's culture and the different cultures that have, over the years, formed within the community should be conducted in order to investigate specific cultural effects on the spread of HIV in the community. The findings of the research should then be used to implement an intervention programme that would be culturally appropriate and acceptable to community members.

5.4 Conclusion

People's health related behaviour is shaped by social factors, which are linked to the unequal distribution of economic and political power. This power is often held by a small group of educated and / or wealthy men. The challenges surrounding HIV in the Mnisi tribe are numerous. Social conditions, habits, and the rules of patriarchal communities are complicated issues to address. Certain aspects of cultural practices can facilitate the spread of HIV. Lucius Phaiya (cited in Loosli, 2004, p. 4) argues that "(t)here is no valid excuse for continuing with these customs? What is a custom for if it stands to kill you? What logic lies in clinging to it? It is high time we reviewed some traditional practices".

The efforts of public health interventions have been dented by beliefs that drive cultural practices. The risks linked to these practices should not be trivialized. Communities should be involved in addressing beliefs, concepts, and rituals that puts individuals into danger of HIV infection. Centuries' practices and beliefs will not be changed within a short period of time; it is a long-lasting endeavour, which should be undertaken at every level, that is household, community, provincial, and national. Community leaders should become more involved in development of strategies that will enable sexual attitudes to be modified. Particular attention should be paid to the gender relations in the community. The community members should be encouraged to gather and reflect on solutions and the implementation thereof. Culture should be seen, and used, as a resource that can strengthen the fight against HIV/AIDS. Acting on people's attitudes and their motivation are not mere formality, it will take time and continuous endeavours. Awareness rising is not enough; an attempt has to be made to transform not just rituals, but also values, and attitudes.

Prevention of HIV/AIDS must be the mainstay response to the epidemic within the Mnisi community. Intervention programmes that whish to decrease the rate of HIV infection is most effective when an appropriate combination of interventions are tailored to the specific risk factors of a community (United Nations, 2005). These programmes should also be accessible to everyone in need. Government needs to improve the effectiveness of their strategies; knowledge gaps between different segments of the population needs to be closed and antiretroviral treatment should be accessible to all individuals who need it. Responses to HIV/AIDS need to take contextual circumstances, that may increase an individual's vulnerability to contracting the virus, into account. According to Anderson (cited in Horton, 2000) a vaccine remains "the only hope for the long term", but until such a vaccine has been manufactured, the prevention of individuals being infected by HIV should be the foundation of every intervention programme.

The future of HIV/AIDS is in no way predetermined. The response of individuals, families, communities, nations, and the world, today and tomorrow, will determine the

eventual course of HIV/AIDS (United Nations, 2005). Although the effect and affect of HIV and AIDS on the Mnisi tribe and its individuals have been devastating and have left many weary “this weariness of the heart is the root of an unbelievable courage” (Fanon, 1963, p. 20). By using and building on this courage and inner strength of the Mnisi tribe and individuals the fight against the spread of HIV can be victorious.

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APPENDIX A

Participant Information Leaflet and Informed Consent

Participant Information Leaflet

March 2007

Dear Participant.

My name is Marié Joubert-Wallis and I'm currently a student at UNISA. In order to complete my studies successfully I have to do a research study and write a dissertation on my findings. I am interested in the effect of cultural beliefs and behaviours on the spread of HIV and this will also be my focus for my dissertation.

You are invited to volunteer for this research study. This information leaflet is to help you to decide if you would like to participate. Before you agree to take part in the study you should fully understand what is involved. If you have any questions please do not hesitate to ask me to explain or elaborate on any statement. You should not agree to take part unless you are completely happy about all the procedures involved and unless you feel that you have a good understanding of what the study entails.

This study aims at investigating the Shangaan people's cultural beliefs and traditions that might act as contributory factors to the spread of HIV among the Mnisi tribe members. The main objective for this research is to identify and evaluate the pervasiveness and influence of Shangaan cultural beliefs, myths and behaviours, on the spread of HIV within the Mnisi tribe. More specifically, its objectives are to:

1. Determine whether and to what extent Shangaan cultural beliefs hamper or help efforts to contain the spread of HIV;
2. Identify the cultural factors that influence the spread of HIV within the Mnisi tribe; and to
3. Explore the interactions among the identified factors.

During the study you will be interviewed a number of times (not exceeding 15 times). Each interview will take approximately one hour to complete. You will be asked about your views on the influence of the Shangaan culture on the spread of HIV in the Mnisi tribe. This will include your views on the customs, beliefs and behaviours of your people, i.e., the people of the Mnisi tribe.

Please note that your participation in this study is entirely voluntary and you can refuse to participate or stop at any time without prejudice. You can also withdraw your consent at any time, before, during or at the end of the interview.

You may feel uncomfortable about answering some of the questions as sexual behaviour and HIV/AIDS are sensitive issues. If indeed you feel uncomfortable with answering a question, you may decline to answer.

As incentive for participating in the study, you will receive R500 as soon as my final report has been compiled. In order to qualify for the incentive you should have participated in at least three interviews.

The interview will take place in private. A Dictaphone will be used in order to capture the interview. I will then use the captured information for further analyses. All information obtained is strictly confidential and the only people who will have access to the recorded interview will be my supervisor, the examiners and myself. Results of the study that may be reported in scientific journals will not include any information which identifies you as a participant; you are thus guaranteed to remain anonymous.

Informed Consent

I hereby confirm that I have been informed by Marié Joubert-Wallis about the nature, conduct, benefits and risks of the study. I have also received, read and understood the Participant Information Leaflet regarding the study.

I am aware that the interviews will be recorded and that the results of the study will be anonymously processed into a study report.

I may at any stage, without prejudice, withdraw my consent and participation in the study. I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.

_____ _____

Participant's signature Date

_____ _____

Marié Joubert-Wallis Date

APPENDIX B

General questions on HIV and AIDS.

What do you know about AIDS? *(Answer true or false)*

Number	Statement	True/False
1.	HIV is caused by AIDS.	
2.	AIDS damages the body's defence system.	
3.	There is no cure for AIDS.	
4.	People with AIDS often die from serious diseases.	
5.	STI means Standard Time in Light of day.	
6.	Someone can have HIV or a STI and have no symptoms (i.e., not know it).	
7.	There is no way to protect yourself from AIDS and STI's.	
8.	An example of an STI is gonorrhoea.	
9.	It is difficult for women to get AIDS.	
10.	If you are strong and healthy you can't get HIV/AIDS/STI.	
11.	AIDS and HIV infection is the same thing.	
12.	HIV/AIDS can be cured by having sex with a virgin.	
13.	You can get AIDS from a mosquito bite.	
14.	Women will be safe from HIV if they take a contraceptive pill.	
15.	You can get HIV by kissing.	
16.	If a couple are both HIV positive, safer sex is unnecessary.	
17.	TB causes AIDS.	
18.	During the window period you will test HIV negative even if you are HIV positive.	
19.	Eating healthily will prolong your life if you are HIV positive.	
20.	Eating healthily can cure HIV.	

Total ☐