

Discourses of health, sexuality and gender in the H360° HIV/AIDS education portal on MXit.

Mareike Annette Kramper - KRMMAR012

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COMPULSORY DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

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Signature: _____ Date: 22.11.2012

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Abstract

The widespread adoption of mobile communication by South African teenagers is playing an increasing role in their formation of identities and construction of knowledge. This dissertation uses feminist critical discourse analysis as an explanatory framework in order to investigate what types of discourses around HIV/AIDS emerge from queries submitted to the mobile application H360°, which is an educational portal on MXit, South Africa's most popular messaging platform. These queries are analysed in order to identify how gender and other power relationships inform young people's discourse on MXit. This approach gives insights into how South African teenagers construct discourses about HIV/AIDS knowledge within an environment where unequal power relationships reflect gender, race and class divisions. In the face of such dynamics, attempts to halt the spread of the disease have so far proven ineffective.

The H360° platform employs language that shifts away from medical discourse and appeals to a young target audience. Although the H360° platform attempts to challenge the power asymmetries inherent in clinical discourse, these are in fact reinforced in certain ways through the hierarchical power structure implicit in the design of the Q&A section of H360°. Users of this online platform cannot communicate with each other, and only submit queries to be reviewed by H360° administrators. The structure of the Q&A section on the H360° educational platform relegates young people to the role of questioners, while experts provide the 'answers'. Thus, the Q&A section on H360° produces a uni-directional top-down structure, missing out on the opportunity to facilitate dialogue with and between young people, and thus missing a vital component of effective HIV/AIDS intervention campaigns.

Analysis of the queries that were submitted reveals how discourse about HIV/AIDS is situated within a complex network of power relations which is reflected in the H360° users' concerns and in their wording of queries. Discourses relating to unequal power relations co-exist and overlap along multiple dimensions, including gender, power, race and medical knowledge. These all play a role in discourses about HIV/AIDS. This suggests that, in order to effectively address knowledge about HIV/AIDS, intervention programs need to consider the important role of discourse and to address issues of discourse explicitly in their strategies.

Chapter 1: Introduction

The uptake of mobile phone usage and mobile internet has increased throughout South Africa (World Wide Worx, 2012; Goldstuck, 2012 in Shapshak, 2012). Cell-phones have achieved a status of fashion accessory, especially amongst the youth (Bosch, 2011). While, in the past, cell-phone ownership was only affordable to a few, some degree of mobile internet access has become attainable by all social classes through recharging pre-paid airtime on an ad-hoc basis (Bosch, 2011). The devices also allow for maintenance of relationships, while mobile internet in particular creates a new channel to seek information of personal concern. Although a growing number of educational projects adopt mobile strategies centred around the popular MXit instant messaging platform (Butgereit et al., 2012; Donner, 2012, Ford & Botha, 2010; Kreutzer, 2009, Vosloo et al., 2009) questions around usage and reception patterns remain.

The H360° portal on MXit is an online educational portal which allows youngsters to participate in discussions, ask questions and comment on issues around HIV/AIDS. Since the epidemic affects almost 11% of South Africans (Statistics SA, 2011), HIV/AIDS intervention campaigns are of utmost importance to avert the spread of the disease. While more than 30 million people have died as a result of HIV/AIDS worldwide (Avert, 2012), “[a]pproximately one-fifth of South African women in their reproductive ages are HIV positive” and among children between 0 and 14 years in 2011, around 63 600 new HIV infections were estimated (Statistics SA, 2012). The number of HIV infections increases every day leaving South Africa, with a total of 5, 38 million people infected with the virus in 2011 (Statistics SA, 2012). Although the disease is not curable, HIV infection can be prevented and treatment therapies can prolong the outbreak of AIDS in a patient. These strategies, however, rely upon a well-informed public. Media campaigns play an important aspect in creating knowledge around the disease.

This mini- dissertation aims to explore how knowledge about HIV/AIDS is shaped by discourse, and in particular investigates the discourses used by young women who discuss love, sex/sexuality, and health matters on the H360° portal, and in particular through its Q&A section. A critical discourse analysis reveals interpellation processes inherent in discourses and ideologies that, in turn, influence the construction of a gendered identity. Established health institutions enforce particular power and gender relations. The H360° project is an interesting platform to study exactly because it is an attempt to bypass the more formal discourses around health and health decision-making processes and allowing young people to ask questions. It attempts to create an accessible and user-friendly atmosphere, both visually and linguistically. I argue that this does not automatically translate into a brave new world of equitable and just power relations, in which young people have access to

information and their health and sexuality decisions are based solely upon a rational evaluation of all the available information.

This study investigates how power relations and gendered discourses might impede HIV/AIDS media intervention programs by showing the relationship between knowledge and discourse, and the ways discourses about HIV/AIDS may foster race and gender inequality.

Research Question

This dissertation will examine how unequal power relationships are expressed in users' discourses on the H360° HIV/AIDS educational portal on MXit, with particular focus on race, gender and clinical discourse. In particular, I investigate which key discourses should be considered in the design of future HIV/AIDS education projects.

Connelly and Macleod (2003) illustrate the importance of evaluating social aspects of the HIV/AIDS epidemic from a critical discourse angle. The same argument is echoed by McGregor (2003: 3), who argues that "discourse and language can be used to make unbalanced power relations and portrayals of social groups appear to be common sense, normal, and natural when in fact the reality is prejudice, injustice, and inequalities". Arguably, the social impact of the HI virus is largely maintained and negotiated by the mass media. Every individual receives and interprets messages differently. Mediated information is filtered by layers of different discourses around health which people have internalised. People express their knowledge around health and new discourses emerge. Since the HIV/AIDS epidemic is the first one within the information age (Connelly and Macleod 2003), it finds itself high on news agendas, due to its newsworthiness and global impact. Media assert a high amount of control in defining, creating and shaping information, but appear mostly to apply their power in a way that creates a threatening picture of the HI virus and people affected and infected by it (Connelly and Macleod 2003; Sontag, 2002).

In South Africa, the current academic landscape in media studies does not efficiently take into account how the media contributes to the formation of discourses around love, health, and gendered identity amongst young South African women (Bosch, 2011). A whole range of studies focus on MXit generally, and how this mobile application informs and influences South Africans in everyday interactions (Bosch, 2011; Bremmen, 2011 Ekine, 2010; Donner, 2010; Goldstuck, 2009; Walton, 2009; Van Heerden et al., 2010; Kreutzer, 2009; Butgereit et al., 2012; Vosloo et al., 2009).

While it is clear that a growing body of literature is emerging, only a few have adopted a feminist perspective to show an awareness of gender (Bosch, 2011).

Discourse is characterised as “a group of statements which provide a language for talking about [...] a way of representing the knowledge about [...] a particular topic at a particular time” (Hall, 2001:72). Also, language contributes to the formation of a sexual identity, as for example, gender is a social construct (Butler, 1990).

Within a patriarchal context, gender-based discourses strengthen unequal power-relationships and are negotiated amongst others through the media (Baker, 2010; Tamale, 2011; Van Zonen, 1994, Lazar, 2005, Wodak, 2005). This process not only reinforces discourses that underpin gendered inequalities, but also maintains HIV/AIDS related stigma and impedes the uptake of HIV/AIDS intervention programs (Pattman, 2002; Sontag, 2002; Tamale, 2011).

I employ a critical analytical approach in order to reveal discourses that relate to unequal power relations, whether medical, political, or gendered. The focus is on how young South African women make use of mobile media in order to educate themselves around health and matters related to sexuality. As “[the] cultural dimension of sexuality [...] shows that sexuality discourses have a social function and [...] inform gender identity” (Ntseane and Preece, 2005:356), I investigate the discourses that relate to the subjective construction of a female sexual identity in order to understand how HIV/AIDS might form part of everyday conversations.

Through analysis of qualitative data derived from the H360° mobile application, media usage patterns reveal how young people use the media to air their concerns. My analysis also shows how these discourses contribute to the impediment of health awareness and gendered equality. Indeed, under the umbrella of medical discourse, many discourses surface which counteract discourses that support informed behaviour practices. The findings of this project reveal how discourses co-exist with one another. Different communities create and negotiate diverse discourses around HIV/AIDS on a day-to-day basis. In order to create informed HIV/AIDS intervention strategies, discourses that relate to traditional or indigenous health therapies need to be recognised and included so that counter-strategies can become effective and the spread of the virus can be impeded (Ntseane and Preece, 2005).

This dissertation uses several theoretical approaches in order to create an outcome that represents a feminist perspective. Together, feminism and critical discourse analysis can challenge and reveal gendered power-relations which foster and reinforce patriarchal social structures (Cameron, 1997,

1998; Lazar, 2005; Wodak, 1997, 2005; Coates, 1997; Talbot, 2000). Indeed, “feminism recognizes the organizing of the social world by gender” (Brayton, 1997:1). Social structures are evaluated and reinforced through dominant interpretations of patriarchal theorising, thus reinforcing gendered stereotypes that devalue the status and agency of women in society. Dominance can be defined “[...] as the exercise of social power by elites, institutions or groups, that results in social inequality, including political, cultural, class, ethnic, racial and gender inequality” (van Dijk, 1993: 249). By this measure, which takes feminist research into consideration, the negotiation of discourses around unequal power relationships and discriminations based on gender are reinforced through ideologically charged power structures embedded in everyday interactions (Wodak, 2005).

Unequal relationships are produced, underlined and maintained by social arrangements. Subtle, but complex institutional contexts, such as the mass media, the church, educational environments or the government, reinforce hegemonic ideas and belief systems overpowering women’s agency (Lazar, 2005).

Repressive discourses around sex/sexuality form part of daily discourses in South Africa which mostly targets women as the inferior gender. “Sex and gender go hand in hand; both are creatures of culture and society, and both play a central and crucial role in maintaining power relations in our societies” (Tamale, 2011:11). Through discursive practices, such as communicating messages that maintain patriarchal ideologies, women are exposed to harm and control over their body. Social meaning is inscribed in the female body which leaves her as the inferior and controlled gender in society. Through repressing the subject of sex and sexuality in public domains, gendered roles are negotiated and seen as taken-for-granted realities. Silencing education around sex and sexuality contributes to stigma and maintaining stereotypes associated with gendered roles. Moreover, violation and assault becomes part of a discourse on sex and sexuality that is marked by silence in a patriarchal context.

MXit and Cell Phones

MXit Lifestyle (Pty) is a South African company which started off in 2005. MXit is a South African instant messaging application that is developed to run on mobile and computer platforms. The mobile application is free to install and because of its easy and cheap access it is South Africa’s most popular online network (Goldstuck, 2010, 2012). The MXit portal allows users to communicate through Mobile Instant Messaging (MIM) with each other. The application is JAVA based and can be installed on most cell phones that can connect to the internet (Bosch, 2008). The company uses

Instant Messaging (IM) to connect people on a global basis through low-cost and immediate communication application. Whereas SMS (Short Message Service) is rather cost intensive, Instant Messages only cost between 1 and 3 South African cents. Instant Messages are sent immediately to the sender, while email might only arrive to the aimed receiver with delay (Butgereit, 2008). Because computer-based internet is not affordable to a majority of South Africans, mobile internet is popular amongst the youth (Bremmen, 2011; Walton, and Donner, 2012; Goldstuck and Wronski, 2011). This might help explain that MXit remains the most popular messaging network application with approximately 10-million active users (Goldstuck and Wronski, 2011).

Although only 10% of South Africa's population has access to a landline or computer-based internet, a growing number of South African's teens and adults are browsing, chatting, exchanging information on online platforms (Walton, 2010; Walton, and Donner, 2012). Social networks, such as Flickr, The Grid, or MXit make it possible to share and connect with peers and other network browsers through mobile phones. Many South Africans use mobile social sites to create an identity within their community through social media networks (Walton, and Donner, 2012). New technology and the liberalisation of the media is part of the current South African political and economic landscape, and especially women have made use of new media to reach out, connect and inform themselves about matters of individual concern (Posel, 2004).

Despite MXit's popularity, little research has been performed on the growing social media platform and its effects on users (Chigona and Chigona, 2009). The media eagerly report on MXit, mostly focusing on parent's complaints and worries about MXit's lack of safety regarding surveillance of exchanged content by their children. Parents also complain that MXit distracts pupils from their school work, thus emphasising and contributing to distorted pictures of MXit in the media. However, research on how teenagers use and engage with the medium or how MXit influences the construction of knowledge or discourses is missing (Chigona and Chigona, 2009). Although research on usage patterns is lacking, many social projects involving MIM (Mobile Instant Messaging) show that the MXit platform can function as an educational space for South Africans (Bosch, 2008; Butgereit, 2008; Nitsckie and Parker, 2009; Walton, 2010).

Many aspects of mobile internet, such as mobility, inexpensive access, or anonymity, contribute to its growing membership and effective approach to communicate messages of social relevance (Bosch, 2009; Bremmen, 2011; Chigona and Chigona, 2009; Chigona et al. 2011; Walton and Donner, 2012). According to a South African research project that was conducted in 2010 (World Wide Worx, 2011), 39% of urban and 27% of rural users are now using mobile internet. In terms of social sites,

MXit gains the highest attention amongst users above 16 years (29% of urban users and 19% or rural users). Followers use it for maintaining, creating or connecting to peers within their community, or to gain knowledge around topics that are of personal concern. Bosch (2009), as well as Nitsckie and Parker (2009), emphasise the idea that participants can use MXit to raise issues within a confined space that they would normally not bring up within their community. Topics such as drug addiction problems or questions around HIV/AIDS are often silenced in communities as people fear being stigmatized by their peers (Nitsckie and Parker, 2009).

The African Pulse and H360°

This dissertation focuses on the H360° instant messaging application that is accessible through MXit. H360° was an educational portal launched on the online network site MXit by the non-governmental organization (NGO) 'The African Pulse' (TAP) at the end of 2010. H360° was an educational project connecting students and teachers in 1,000 schools in Europe with 500 schools in Southern Africa. H360° was designed to be interactive through cross-cultural communication in order to raise awareness, collaborate young people to work together to learn about HIV/AIDS. The project provided resources and online learning material so that teachers were able to integrate the project and HIV/AIDS education into the curriculum. According to the organisation, collaborative work between schools worldwide was a significant tenet in the development of TAP as an organisation, so that consciousness towards activism could be raised (Final Report, HIV360, June 2012).

TAP was funded by several national and international organizations and closed down prematurely in May 2012. H360° was developed to be accessible from both mobile phones and desktop internet via the websites Rafi.ki and H360° (<http://www.v3.rafi.ki/>, Figure 2, below), and MXit (www.mxit.com). H360° remains accessible via MXit, but the website merged with Kidogo, a similar South African non-profit-organisation (<http://rafiki-kidogo.blogspot.com/>, below Figure 3), into a blog. H360°'s main focus is to inform and educate South African youngsters about health related matters in order to initiate behaviour change and create awareness around HIV/AIDS. This is done through allowing users to log onto and participate in games and quizzes, raise questions and concerns, or get informed about sex/sexuality and HIV/AIDS related matters.



Figure 1: Mobile Interface of H360° on MXit

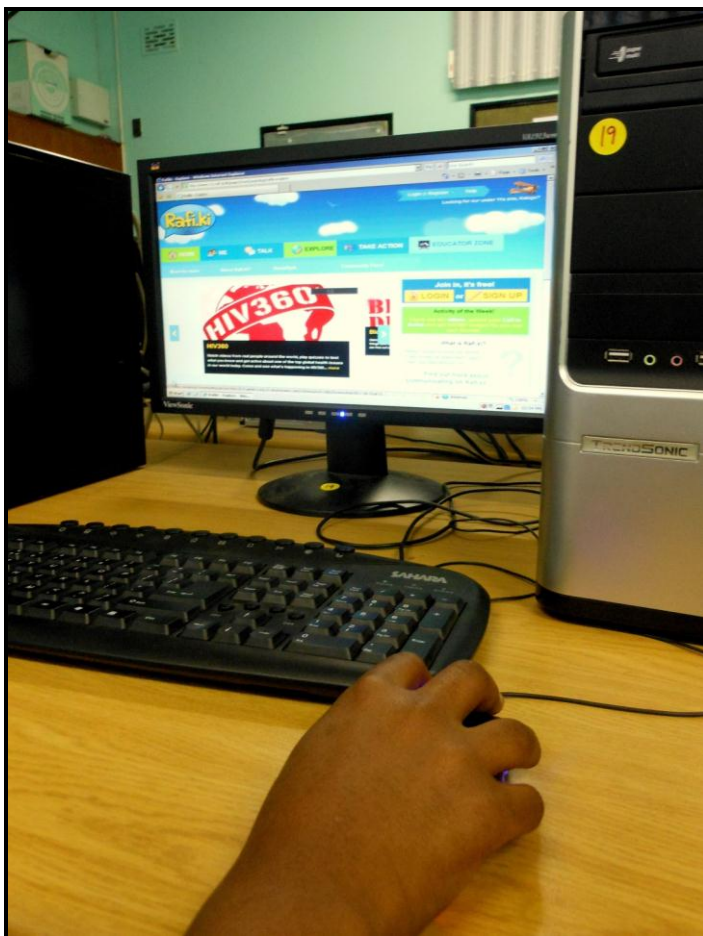


Figure 2: Original Rafi.ki website with H360° (<http://www.v3.rafi.ki/>)

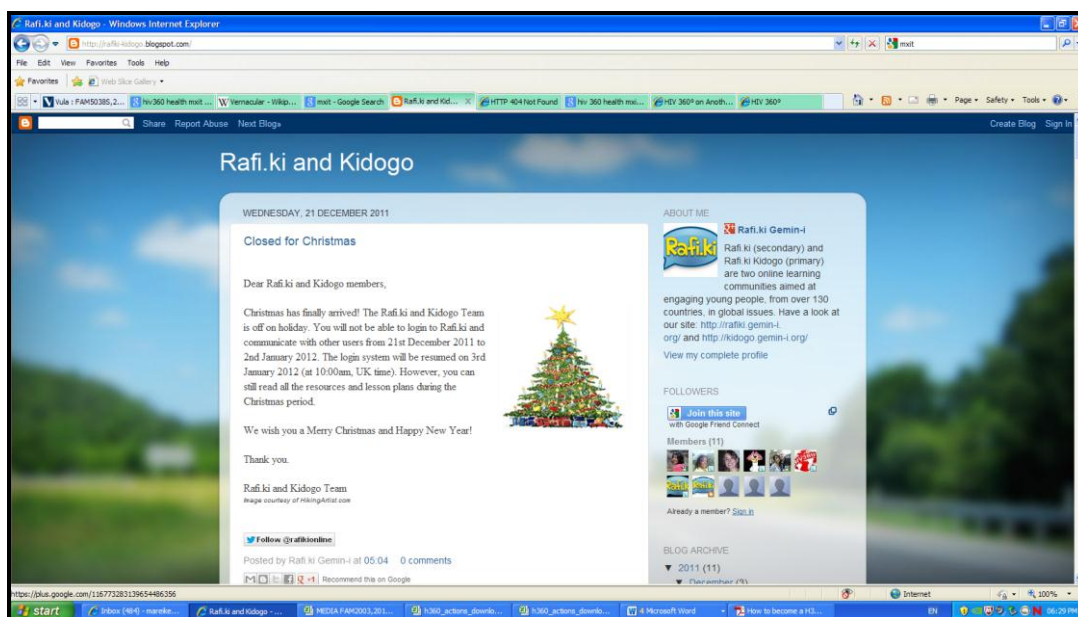


Figure 3: New Rafi.ki and Kidogo website (<http://rafiki-kidogo.blogspot.com/>)

Once MXit users have registered for the H360° application, users can navigate onto the Q&A link and then use this section to raise issues of personal concern (Figure 4, below). The questions are answered by the project administrators at H360° according to the demand of a specific topic (Figure 5, below). The platform also offers different sections where people can get informed about certain issues or partake in actions, such as sharing their experience of going for an HIV/AIDS test under the section 'Testing Experience'. The platform also offers spaces where people can take part in actions collectively. 'Pledge' is a page that urges users to pledge to do a good deed, for example buying groceries for an elderly woman in their community. 'Be a Beacon' or 'Heart of Action' are sections where people can upload a story of how they can be of service to their community or environment. 'Speak2Someone' includes helpline numbers for people who want counselling or further medical advice. H360° also offered a chatroom in 2011. This service was removed from the platform after a few months, because monitoring the chats was not financially sustainable for the organisation. The nature of the mobile application allows users to access the H360° portal anonymously. This feature contributes to a safer environment for people in need of advice or support to talk about issues of a sensitive nature, such as sexual identity, abuse, health awareness or addiction problems (Butgereit, 2008; Nitsckie and Parker, 2009).

THINK

H360 Info

- 1) **NEW!** 360 Q&A
- 2) **NEW!** Millennium Development Goals
- 3) Ur body, ur immune system and HIV
- 4) HIV: Signs, symptoms & stages
- 5) Treatment
- 6) Peer Pressure & Sex
- 7) Speak 2 Someone
- 8) The Real Test

H360 Quizzes - **More things to Think about!**

- 9) Immune system quiz
- 10) **NEW AND IMPROVED!** Take the HIV Quiz
- 11) Am I at risk of getting HIV?
- 12) Feroza's story

LINK

Xchange & Share

- 13) **NEW!** H360 Mover Xchange
- 14) **NEW!** Calls to Action...
- 15) Be a Beacon
- 16) Tell others about your testing experience
- 17) What matters to ME...
- 18) Can culture contribute to HIV?

CAMPAIGN

H360 Movers

Figure 4: Navigation page of H360° on MXit



See the Answers

Thanks for all your questions. We take your questions seriously and easily find what you're looking for.

- 1) Top things to remember about HIV
- 2) Questions on What is HIV&AIDS?
- 3) Questions on how you get HIV
- 4) Questions on how HIV works in your body
- 5) Questions on how to prevent HIV
- 6) Questions on Stages, signs & symptoms
- 7) **NEW!** Questions on Treatment for HIV
- 8) Questions on Living with HIV
- 9) Questions on Choices about Sex
- 10) Read Older Q+As
- 11) Questions on pregnancy and HIV

Figure 5: Answer page Q&A on H360°

During the month of April 2011, when I started to analyse the queries posted to the Q&A section, a total subscription of 36,736 registered users for H360° had been captured. In other words, only four months after its launch in November 2010, the H360° portal had attracted many users from around the world. Through their interactive mobile portfolio, the educational project grew enormously.

	2010 November (Launch)	2011 March	2011 April	2012 May
No. of reg users	469		36,736	59, 766
Total Visitors				305 374
Unique Visitors (per month)		18 407		11 173
Total Page Views		204 921		136 881
Visits duration for the month to date (average time spent)		294 secs / 4.9 minutes		376 secs / 6 minutes
Pages per visit (monthly)		4.62		6.51
Visitors Q&A		1 158		1 288
Viewed by 11-16 yrs		12 631		13 540
Viewed by 17-18 yrs		13 239		19 986
Viewed by 18+		49 080		102 716
Pages viewed by female		119 007		85 077
Pages viewed by males		85 372		51 123

Figure 6: Comparative statistics from H360°

The intended audience of H360° are youngsters between 11 and 16 years. According to the final report by TAP, the project started off with 469 users in November 2010 and ended with 42 434 users in this age group (Final Report, HIV360, June 2012). In total H360° had 305 374 visitors and 59, 766 registered users of H360° on Mxit since its launch in November 2010 till the end of May 2012 (Final Report, HIV360, June 2012).

The last monthly report that MXit published for the H360° fundraisers was in May 2012. In March 2011, H360° had 18 407 unique visitors on H360° on MXit, but this monthly total went down to 11 173 by May 2012 (Final Report, HIV360, June 2012). The marked decrease in unique visitors could be attributed to the drying up of financial support for the portal, and hence less new content, or perhaps to fewer MXit users.

In March 2011, a total of 204 921 page views were reported. In May 2012, H360°'s total monthly page views had gone down to 136 881. Although the total number of page views went down, visitors appear to have lingered longer on the individual pages: In March 2011 a user would stay on H360° for 294 seconds / 4.9 minutes on average and view 4.62 pages per visit. In May 2012, each user spent around 6 minutes per visit to H360° and viewed an average of 6.51 pages.

The Q&A section is the focus of this mini-dissertation. In March 2011, 1 158 users made use of the Q&A forum. In comparison, 1 288 users visited the forum in May 2012. So, even though overall participation was declining, the numbers on the Q&A forum did not shrink. Overall, the Q&A section was the most popular page on the H360° forum (Final Report, HIV360, June 2012).

In March 2011, the report indicates that 12 631 pages were viewed by teens aged between 11 and 16 years, 13 239 views came from 17 to 18 year old participants, and the majority of pages were viewed by users aged 18 years and older. Although H360°'s target audience is between 11 and 16 years, most of the H360° users are older than 18 years, according to the data they provide to MXit, which may not be entirely accurate (360° Monthly Report, March 2011). The latest report from May 2012 indicates that 13 540 pages were viewed by users between 11 and 16, youth between 17 and 18 accounted for 19 986 page views, while 102 716 pages were visited by users 18 years and older (H360° Monthly Report, May 2012).

H360° usage statistics are also quite interesting in relation to gender, although gender on MXit is also self-declared and thus not necessarily reliable. In March 2011, 119 007 pages were viewed by female members, compared to 85 372 by males. It appears a majority of H360° users are female: In March 2011, women accounted for 58% of the 204 379 total page views (360° Monthly Report, March 2011). As with the age gap, this predominance of female members appears, unaffected by declining total numbers of H360° users. By the time of the latest monthly report, May 2012, women stood for 85 077 page views compared to 51 123 pages viewed by men (360° Monthly Report, May 2012).

Throughout the research project, the project manager of H360°, Jean,¹ provided invaluable assistance, such as providing data or including me in focus group discussions at schools. She also supervised me as an intern with the company in 2011. Jean explained how important it was to provide information to the users and to answer individual questions by H360° users (personal communication, 30 June 2012). Despite the widespread availability of information about HIV/AIDS, she explained that there was still a huge need for interaction with young people, as “people still ask those questions”. Furthermore, many queries received on H360° show that the “info is not getting through to the people” because the “same questions are asked over and over again”. She believed that knowledge was lacking amongst the general population, perhaps because of the level of denial of the problem, that people were “scared to own it and admit that it’s [HIV/AIDS] real”.

Of particular concern to Jean were the many questions revolving around pregnancy, asked by women of a very young age. She said they had found that teenagers as young as 13 are desperate for help, and that rape and violence are major issues for the H360° users. She also mentioned that the trend towards more emancipated women was evident, but that, at the same time, there was little room for men to explore and express their new role within this changing environment. In her opinion, the new democratic landscape empowers women, but does little to provide guidance for men. Instead, men remain stuck in gender roles fostered by apartheid’s conservatism. In Jean’s opinion, hegemonic masculinities struggle to adapt to the new political landscape and this results in sexual violence and increasing numbers of HIV/AIDS infections.

Subsequent to my involvement on the project, the Rafi.ki and Hiv360 websites have both closed down due to the withdrawal of a major donor. Hiv360’s mobile application H360 continues to operate via MXit, even though the websites are no longer active (H360° project manager, personal communication, 30. June 2012).

Chapter 2: Discourse and Sexuality

Discourse is communicated through written, visual, or oral texts. A dominant discourse is channelled to the subordinate group by authoritative institutions, such as the school, church or the government. Society interprets messages sent by the dominant group as “self-evident truths” (van Dijk, 2000), thus not contesting those messages, as they are interpreted and internalised as common sense (Artz, 2003). In turn, “discourse (the words and language we use) helps shape and constrain our identities, relationships, and systems of knowledge and beliefs” (McGregor, 2003:3). If this is how

¹Not her real name in order to preserve anonymity of the participant

dominant groups retain their position, the flipside is that the voices and opinions of the marginalised group tend to be dismissed as unrelated, wrong or without substance (McGregor, 2003).

Through the constant repetition of ideas, a certain hegemonic viewpoint is negotiated within society and consequently seen as a common-sense and taken-for-granted reality (Gramsci in Bates, 1975). Discursively enabled power-imbalances, sexualities, or stigma manifest themselves in the minds of individuals through the repetition of such patterns (Cameron, 2001). Discourses that relate to social hierarchy, gendered power relationships, stigma, and treatment and prevention options of HIV/AIDS are unveiled through the analysis of discourses communicated through written messages on the H360° forum.

This must be done within the sphere of critical discourse analysis, in which “[...] reality is understood as constructed, shaped by various forces” (Cameron, 2001:124). McConnell-Ginet further explains that “[...] what gets naturalized in discourse tends to be the common-sense beliefs of dominant groups” (1988 quoted in Cameron, 2001:126).

Discursive practices are linked to the exercise of power by an institution of authority, such as the media, political leadership, church or the economy. Those powers define the discourses which represent that social structure through the negotiation of selection, segregation and domination (Foucault, 1980). According to Foucault, those principles apply to every society, as “ [...] the production of discourse is controlled, organised, redistributed, by a certain number of procedures whose role it is to ward off its powers and dangers, to gain mastery over its chance events, to evade its materiality” (Foucault, 1980:49). Messages are sent to the public through the media and as a result, the audience absorbs and internalises them. Those messages become the ‘norm’ and people identify themselves according to those rules (Baker, 1998). Furthermore, people enact those roles which are given to them by the controlling organisation, thus creating relationships around those discursive conventions (Buckingham and Bragg, 2003). Those forms of behaviour are visible amongst particular groups in society, such as online chat rooms or online communities. “Individuals come to speak as particular kinds of subjects – to speak themselves into being – through speaking the discourses that enable the particular institution” (Lee and Poynton, 2000:5 quoted in Spencer, 2011: 119). Discursive norms and rules are communicated within communities around a certain topic, thus discourse is redistributed.

Discourses are manifest through both talk and text. A critical approach searches for textual cues that suggest certain ideological perspectives, and reveals how power relations are enacted through discourse. Power is wielded through the dominance of one party over the other. If the inferior party

is not able to speak up, an imbalance of power is created (Cameron, 2001). This imbalance of power is represented through discourses that relate to gender, stigma and sexuality. For example, when the mass media silence dissident voices in news reports, such as people who are affected by HIV/AIDS, an imbalance of power is created, thus contributing to the increase of discourses reinforcing stigma towards HIV/AIDS (Connelly and Macleod, 2003).

Connelly and Macleod (2003) explore how HIV/AIDS has been constructed by the daily South African newspaper *Daily Dispatch* from 1985 to 2000. The researchers focus their discourse analysis on the metaphorical framework of war to illustrate how the media contributes to the personification of HIV/AIDS and its subsequent construction of the virus (and the people affected) as the enemy. The study portrays how the media has created the virus “as the ‘Other’, as a dark and threatening force” through the selection of linguistic techniques, such as wording or metaphors (Connelly and Macleod, 2003:1). Connelly and Macleod argue that the discourse around HIV/AIDS is comparable to that of the discourses surrounding cancer, both using the language of war around it (2003). Overall, their findings show strong undertones of racism and gendered power relations. Their study is an excellent example of how the choice of words contributes to the manifestation of discourse amongst the population.

Religion and Disciplinary Power

HIV/AIDS is highly stigmatised in society. Religious discourse influences the discourse about the disease, because it is sexually transmittable (Sontag, 2002; Tomaselli, 2009). Therefore, people reach out for assistance or information through other avenues, such as online or mobile media. Online communities serve as a safe and anonymous space to ‘confess’ or gain knowledge about topics that are normally stigmatised or deemed as immoral.

Sexual health and sexuality is just such a place where ideologies converge. According to Foucault (1981), religion reinforces unequal relationships through its hierarchical power structure (Deacon, 2002). Deacon explains that Western discourses emphasise that certain truths can only “[...] be found in relation of human beings to themselves” (2002:93). The origin of those principles seem to stem from expressions by the oracle of Delphi, ‘Know thyself’ or ‘In the inward man dwells truth’, as articulated by St. Augustine (Foucault, 1987b: 131 and Taylor, 1989: 129 in Deacon, 2002:93). Indeed, individual introspection remains crucial: “It would not be an exaggeration to suggest that it was on the basis of this obsession that Western scientific values, political forms, moral customs and economic practices have come to dominate the rest of the planet” (Deacon, 2002:93). In this way,

Christianity morphed into 'a confessional space' where a bond between doctor and patient became the main ingredient in order to function. "The confession had unfolded within a power relationship of dependence on the (at least virtual) presence of another acting as an authority" (Foucault, 1981a: 61 quoted in Deacon, 2002:108). This involved a hierarchal power relationship in order to strengthen and to *normalise* this relationship (Deacon, 2002). Within this 'confessional space', the church converted 'sin' into an illness and thus sexuality gained attention as an aspect of social discipline (Deacon, 2002). "[S]exuality was postulated as a fundamental 'cause of any and everything', and 'the limitless dangers that sex carried with it justified the exhaustive character of the inquisition to which it was subjected'" (Foucault, 1981a: 65–6, quoted in Deacon, 2002: 108). The emphasis is on sharing thoughts rather than actions, and even more so on intentions. Confession is said to have therapeutic aspects, by shedding light onto the inner truths. Christianity turned "[...] everything that couldn't be expressed into a sin" (Foucault, 1988b: 48, Deacon, 2002: 96). Discourses around HIV/AIDS are influenced by these forms of religious reasoning, particularly if sexual relationships occur outside marriage, as the disease is sexually transmissible and therefore, in Christian discourse, associated with something sinful.

Foucault argues that through the formation of unequal power relations, the discipline of amplifying and generalising belief-systems, identity-constitutions or knowledge production are intertwined with the exercise of power (Deacon, 2002). Traditionally, those discursive conventions were defined by the elite in order to discipline others, but afterwards distributed towards the populace. Foucault identifies certain techniques for upholding and constantly delivering those conventions, such as "confession and ascetic conduct, faith and empiricism, and self-reflection" to pursue "western political rationalities in the form of combined totalization and individualization technologies" (Foucault in Deacon, 2002:89). The exercise of power stems from the pastoral belief structure, which entailed that the elite has the right to know the actions of people and the knowledge over the 'self' of each individual, implying "a knowledge of the conscience and an ability to direct it" (Foucault, 1982:214 quoted in Deacon, 2002:94).

Clinical Discourse, Language and Power

Power dynamics inherent in responses to sexual health and sexuality can also be informed by linguistic factors. Deumert (2010) analysed the role of clinical power structures in relation to multilingualism in health care facilities in South Africa. The *Patients' Rights Charter* published in 2002 by the Department of Health outlines the rights and responsibilities of patients. However, almost

two decades after the end of apartheid “[...] levels of access to care and health still vary significantly according to population group (‘race’) and socio-economic status” (Deumert, 2010:53). The findings of her study demonstrate that linguistic barriers play an integral aspect in the lack of sufficient health service among patients. She refers to this as the concept of ‘unproductive patient – provider interactions’. On top of communication barriers, the public health sector faces enormous shortages in areas such as medication, staff or facilities. Her examinations demonstrates that although South Africa is socio-economically and politically organised according to democratic principles, “[...] linguistic barriers between English/Afrikaans-speaking providers and isiXhosa-speaking patients are a deeply entrenched structural feature of the public health system, and significantly impede the provision of equitable and effective health care” in the Western Cape, South Africa (Deumert, 2010:53). The South African government outlines that, isiXhosa, Afrikaans and English should all be provided in public clinics and hospitals, but her analysis demonstrates that the implementation fails.

Foucault (2003 [1973] in Deumert, 2010) analysed the concept of the *clinical gaze* between medical doctor and patient which means that visual inspection reveals the truth about an illness through critical inspection of the physical body. However, the *clinical gaze* needs to be combined with verbal communication in order to generate a diagnosis. This relationship creates power dynamics between the patient and doctor, as the patient reveals physical and emotional truths to his/her superior.

Deumert (2010) explains that the doctors she interviewed stressed the importance of language for accurate and effective treatment therapies. However, this tenet was absent from English-speaking doctors in everyday interactions with isiXhosa-speaking patients. The doctors reflected rather openly about “[...] the dire consequences of medical treatments without communication” (Deumert, 2010:56). The *clinical gaze* fails to establish a coherent diagnosis of a physical illness if meaningful verbal communication is lacking. Rather, the *clinical gaze* alone takes power over the patient’s physical body. Thus, “the patient becomes an object of examination rather than a participant in his or her own well-being” (Deumert, 2010:57).

Deumert’s research uncovers how communication between patients and medical staff (excluding nurses) often fails to provide efficient medical support because they do not speak a mutual language (2010). She explains that hospital workers were very critical about whether they were able to provide efficient health care, due to the ecology of languages prevalent in the health care facilities.

Another important finding is how traditional African conventions of respect are omitted by white medical doctors in basic everyday interactions. For example, in her study a white medical doctor called out an elderly patient by his ‘name of work’ which is “[...] associated with out-group contact,

labour exploitation/oppression, and the invisibility of African heritage” instead of his African name (Deumert, 2010:57). Traditional interactions valued by African people, such as forms of address or introduction are signs of respect; therefore the doctor’s behaviour is highly stigmatising and reproduces the racist legacies of South Africa’s colonial and apartheid era in present time. This is only one example of how communication failure contributes to skewed power relations between staff and patients. Deumert (2010) recorded examples where lack of communication resulted in misdiagnosis or wrong drug therapies. IsiXhosa-speaking patients who were able to express symptoms in their own language were relaxed and pleased, but if consulted in English felt ‘robbed’ in participating “[...] in any decision-making concerning their own bodies” (Deumert, 2010:58). This medical environment creates a foundation of oppressive medical discourse in the public domain. People are scared and fear to ask questions, as most knowledge ‘suppliers’ of health are white English-speaking doctors.

These asymmetries in the health care sector are also reflected in the H360° architecture, as many users speak a different language in both settings, but the platform is an exclusively English speaking environment. Likewise, the structure of the information flow replicates that of the doctor-patient relationships outlined by Deumert (2010): information flows in a top-down structure on H360° in that users ask questions for experts to answer, perhaps inadvertently reflecting the power structure visible in established medical health facilities.

Cultures of Sexualities

A dominant discourse is passed on to a subordinate group by authoritative institutions. In return, this group accepts those beliefs and value systems and sees them as common-sense (Foucault, 1978). Foucault (1978) argues that the discourse around sexuality has been marked by repression since the Victorian era. Before that, the discourse around sexuality and conduct were experienced as direct, frank and with little secrecy (Foucault, 1978:3). The Victorian regime, however, negotiated a dominant view of repressed, restrained, mute and hypocritical sexuality, a view which is still present in some contexts until today. The theorist argues that, under the Victorians, “[o]n the subject of sex, silence became the rule” (Foucault, 1978:3). The Victorian regime changed the discourse around sexuality and moved it into the home (Foucault, 1978). The married couple “[...] enforced the norm” that sexuality is practiced solely as an act to reproduce and laid down the rules: in their bedroom (Foucault, 1978:3). Foucault analyses the relationship between power and sex in terms of

'repression' and argues that the one who speaks openly and prudently about it is aware of the subversive nature of his arguments and thus, "places himself to a certain extent outside the reach of power" (Foucault, 1978:8). Foucault argues that there was no space given for any debate around sexuality. For example the discourse practiced at that time entailed that "children had no sex" and that "[...] it was forbidden to talk about it [...] although they came to show evidence of the contrary" (1978:4). This kind of repression is firmly anchored within society and operates as a link between power, knowledge and sexuality. Discursive practices such as these rests upon historic-political conventions which are constantly presented and negotiated through the media and authorities. Repression towards the subject of sex/sexuality is visible in countries that are influenced by this dominant discourse.

Historically, female pleasure was seen as intrinsically asexual or alternatively seen as entirely sexual objects. The discourse around women's sexuality was medically controlled and referred to as 'hysteria' of female sexuality (Foucault, 1978). It is against this backdrop that in current societies, women's sexuality is discussed as inferior in dominant discourses around sexual pleasure and that discourses co-exist and reinforce unequal gendered relationships (Foucault, 1978). Women are portrayed as inferior or framed as objects of desire through institutions of power, such as the media or other hegemonic apparatuses. Dominant patriarchal ideologies shape the construction of female subjectivity and conscious sex/sexuality and health behaviour. Women experience power and regulation over their bodies. We are living in a patriarchal society where women are suppressed and discourse around sexuality is silenced and seen as a taboo topic (Tamale, 2011:5). Women are the victims of dichotomized thinking: "Both formal and informal education in the main promotes learning in dualism and absolute truths, such as right and wrong, good and bad, moral and immoral, inclusion and exclusion and male and female" (Tamale, 2011:5). Through historical causation and social structures, patriarchal principles have gained the upper hand and are communicated towards society and can thus influence the construction of discourses around HIV/AIDS and gendered identities.

In contrast to the drastic discursive implementation, these days the media and consumer culture are held responsible for moral and social decline. Buckingham and Bragg argue that with the rise of the internet and new media technologies "[...] there is no longer a clearly defined consensus on moral issues" (2003:11). Nonetheless, dominant discourses of childhood 'innocence' perpetuate public rhetoric which claims "[...] children are growing up much too soon" and that "[...] children are prematurely 'sexualised'" as a dominant discourses (Buckingham and Bragg, 2003:11).

According to Buckingham and Bragg (2003), a more open-minded approach towards educating the youth on sexuality can be discerned amongst social and educational critics. Those with more liberal views “[...] seem prepared to justify the availability of sexual information in the media on the grounds that it represents a greater degree of openness” (Buckingham and Bragg, 2003:4). On the other hand, it is interesting to note that that right-wing players object to open sex talk in public, as it supports the “[...] loosening of sexual boundaries and the subsequent ‘loss’ of children’s innocence” (Buckingham and Bragg, 2003:4).

Nowadays the term ‘sexuality’ refers to “the general quality or capacity of human beings to behave, feel and think in sexual ways” (Cameron and Kulick, 2006:2). Sexual identity refers to the ‘orientation’ or ‘preference’ of a human being. Sexuality can be associated with how human beings perform or feel or in which way individuals express their sexual preferences. Buckingham and Bragg note that “the formation of sexual identity is a complex process – that it is unstable, insecure, always ‘under construction’” and cannot simply be reduced to direct media effects leaving the young person with no agency (2003:14).

Overall, Buckingham and Bragg (2003) depict a shift in attitudes towards sexual behaviour in the UK, which has become more liberal over the past 50 years. In the South African context, Posel (2005) argues that the politicization of sexuality is the most revealing marker of the new democratic landscape in South Africa. Since the demise of the apartheid regime in 1994, “[...] issues of sexual practice, sexual identity, violence, and varieties of desire, have been incorporated into the wider discourse of democratic rights in the post-apartheid era” (Posel, 2004:55). Within this new context, the renegotiation of identity not only exists in relation to class or race, but also sexuality. “[C]onsumption is closely coupled with sex, making for the overt sexualisation of style, status and power” (Posel, 2005:131).

Even if the repression and exclusion of sexuality from public debate was a hallmark of the Victorian era, remainders of those discursive rules are still visible within society. In South Africa, for example, talk around sex and sexuality was removed from the public throughout the apartheid era. At present, sex talk receives more attention within the media landscape in South Africa (Posel, 2004). The demand for sexual education by the population, especially women, is proved through the participation in, for example, public media debates or online chat rooms (Posel, 2004). On the other hand, traditional taboos which restrict young people from discussing sexual matters with their elders persist (Rudwick, 2008). Although education on sex and sexuality takes place more frequently today

in South Africa, this education is not neutral, and draws on existing discourses about gender and sexuality.

Ntseane and Preece (2005) highlight the importance of engaging with behavioural practices and values of different communities when implementing HIV/AIDS educational strategies. The authors base their findings on a study they conducted in Botswana and stress the importance of engaging with discourses that are specific to an ethnic group (Ntseane and Preece 2005). In order to understand diverse cultures of sexuality and the creation of discourse thereof, social behaviour monitoring, cultural and educational research need to form an integral part in framing educational strategies for HIV/AIDS.

The authors argue that one way to address the issue of HIV/AIDS pandemic is through an understanding of people's cultural practices around sexuality. Indeed, "ascertaining the sexual culture of any such community is a central research task for effective health communication, because all communities are differently structured" (Dowsett, 1999:228 in Ntseane and Preece, 2005:347). The research by Ntseane and Preece (2005) addresses how women interpret and reinforce unequal gender power relations within their community. The article also points out how heteronormativity informs the role of hegemonic male identities in this community, leaving women inferior and thus reinforcing gender inequality. The study reveals that women's sexuality is dismissed and regarded as irrelevant by men in that context. Women's practices are shaped by traditional customs and conform to the dominant ideologies in order not to disrupt the 'traditional order'. This is what my earlier discussion of Foucault (1978) hinted at: People who assert unchallenging behaviour have internalised a form of self-regulation, also known as 'disciplinary power' (Ntseane and Preece, 2005:348). People watch their own behaviour, as if they were surveyed by an omnipresent gaze and try to control it in order to conform to a dominant discourse. "By policing themselves in this way people are taking away their own will to resist by internalising as 'common sense' certain rules and norms" (Ntseane and Preece, 2005:348). The researchers say that, "[...] the repression of women's individual agency hinders women from challenging the risky practices of their male partners and puts them in a hegemonic position of 'desire' to maintain the status quo of their sexual behaviour" (Ntseane and Preece, 2005:348). Women are more highly subjected to HIV infection in the context of this community. Therefore, women have been identified by HIV/AIDS intervention programs in Botswana as a potential resource for addressing behavioural change: "The use of women's hegemonic understanding is embedded in social interactions and the extent to which space for alternative discourses has to be found" (Ntseane and Preece, 2005: 348).

Culturally and socially determined practices influence the construction of sexualities and discourse around HIV/AIDS and need to be investigated in order to create behavioural change. Public discourse refers to this information as subjugated knowledge. According to Foucault, “[...] subjugated knowledge exists outside the dominant discourse and is seen by authorities as irrelevant and disregarded as delegitimated knowledge” (Ntseane and Preece, 2005:349). South Africa consists of diverse cultures which assign different meanings to practices and behaviours. Dissimilar indigenous discourses around health education and sex/sexuality all play a part in creating knowledge around HIV/AIDS. Therefore, traditional health practices form part of the South African cultural landscape and need to be considered in order to create awareness towards HIV/AIDS prevention and treatment options, and should start from within the communities and different groups of people who create discourse discourses around the disease. According to Ntseane and Preece (2005), common values and behavioural practices inform the adoption of HIV/AIDS discourses by specific communities. The role of indigenous and traditional healing and prevention methods and cultures of sexualities all contribute to the creation of discourses and knowledge around the disease.

Online Sexualities

With the rise of new media, South Africans have come to enjoy access to the internet. The traditional notion of a public sphere has been replaced by a networked publics (Benkler, 2006). This web-based public sphere allows people to participate in a particular online community to exchange their interests. The availability of such many-to-many communication does not automatically translate into a more just or equitable society. Networked communication is subject to the same discursive constraints which characterise other forms of communication. Foucault points out that each social context imposes certain discursive practices and that “[...] each discursive practice implies a play of prescriptions that designate exclusions and choices” (Foucault, 1980:199). Within each of those niche public spheres, power is redistributed and discourses communicated and practiced (Castells, 2007).

Sex, Consumption and Gendered Identity

Western ideologies often play a role in the construction of sex and sexuality within a patriarchal context. Unequal gender roles contribute to the formation of discourses that hamper HIV/AIDS awareness. Control, discipline, and punishment all formed part of a public discourse that

constructed the concept of sex/sexuality in the apartheid era. Gendered identities were constructed during that time and remain continuous and visible in society until today: “The apartheid state assumed that all households conformed to the Westernised two-parent family norm where fathers and mothers fulfilled stereotyped gendered roles” (Salo, 2006:177). As a ‘reward’ for conforming to ideological principles, child welfare grants were only paid out to mothers and public houses were only provided to families that adapted to the social structure of a ‘traditional’ family (Salo, 2006). Thus, gendered roles were negotiated by the former government of South Africa which contributes to the perception of women as caregivers and their gendered role in the domestic space.

Gender inequality forms part of a patriarchal discourse. However, “power relations are most effective when they are not perceived as such. Gender often operates through the unquestioned acceptance of power” (Kabeer, 2005:14). Thus, women who internalise an inferior status, will not speak-up when being abused, because that would be considered outside of their range of options. This behaviour could be seen as a conscious decision in the matter, agency through passivity, but is “[...] really based on the denial of choice” (Kabeer, 2005:14). Hegemonic male identities operate within the same parameters, by using the internalised discourse of their superior status to abuse women. An inferior status in a patriarchal community exposes women to harm and reaching for emotional or psychological assistance can be considered as outside their realm of possibilities, especially if financial or communal support is not in place.

In the late 1980s, Judith Butler (1990) aimed towards destabilising the fixed concepts of masculinity and femininity and the idea that sex is gendered through culture. Whereas sex has historically been the domain of scientists through biological research, the concept of gender has been attributed to cultural and social conventions. Butler (1990) objects this idea and moves away from heteronormative reasoning by investigating that women are not solely natural and pure, but are influenced and shaped through science based on a heteronormative origin, thus, their identity is shaped along those aspects.

Society determines that the sexed body is binary, either female or male. Butler (1990) argues that feminist theory has reinforced a concept of feminism around ‘woman’ which closed down possibilities to create an own identity based on individual freedom and agency. Early feminist movements refused the idea that the body is biologically determined, and said that the body is a construction built on culture and personal characteristics. However, Butler (1990) argues that this theory is in fact an oxymoron, as there was no space given for an individual to develop liberally or difference to emerge, as those traditional feminists said that the body is built upon a cultural

foundation of a sexed body. Conventionally, a person characterises one's identity along those binary concepts of male and woman. Rather, Butler (1990) argues, gender should be seen as more fluid and that those attributes are interchangeable from each context and different times. Butler (1990) says that the binary concepts of sex, male and female, are an effect of gendered identities (feminine or masculine). This in turn, generates constant comparison and longing for the other gender (Butler, 1990). Foucault claims that the cause is often the effect of a historical process (1978). Therefore, the development of gender differences is restrained through constant comparison to another gender. The assumption that gender is caused by sex thus needs to be re-evaluated (Butler, 1990). Butler claims that in order for gender identities to develop freely this cycle needs to be disrupted (1990). This way gender can act as a continuum, flexible and not linked to a historical, scientific or cultural concept. It is in light of this that my research interrogates how gendered discourses are linked to the construction of knowledge around HIV/AIDS.

Gendered discourses are communicated by institutions of power which construct belief systems around performed gendered behaviour and subsequently slow down HIV/AIDS awareness. The government, church, school or the media are instruments which negotiate ideological principles through various techniques. Foucault (1978) explains that discourse takes shape through *polymorphous techniques*, thus, belief systems are channelled to the society through different apparatuses taking on different shapes according to certain contexts. Ideals about conforming to a gendered identity through consumption are delivered through western discourses. Salo conducted ethnographic research in Manenberg, a predominantly coloured and Afrikaans speaking township in an area in Cape Town, South Africa, also referred to as the 'Cape Flats' (2006). The researcher investigated how young people create their identity in relation to gendered-perceptions around female and male, but also in relation to global cultural ideas, practices and products (Salo, 2006). In this community, consumption is seen as "[...] the quintessential act of modernity is shaped by local histories of modernity, and local forms of social stratification that are rooted within the rupture from tradition" (Salo, 2006:175). Although members of this community consume global products, Salo (2006) argues that the identities that emerge from that context differ from those where those ideals are originally produced. Hence, given the context of apartheid, Western negotiation of hegemonic practices or ideals about masculinity or femininity are received and internalized by South Africans and filtered through an ideological mind of the past.

Race, Identity and Gender

South Africa has been highly influenced by dogmatic and repressive discourses around the topic of sex and sexuality (Posel, 2004). African countries were influenced by European discourses around sex and sexuality through colonialism. Through missionary work and colonial administration, dominant and repressive ideals and belief-systems were exported to the colonised countries. Not only gendered roles were enforced by colonial powers, but also racial categories were legislatively reinforced. Categorising people stemmed from scientific research that was conducted in the 18th century and acted as “evidence gathering” to discursively normalise binary categorisations of race (Baker, 1998). The moral, the intellectual and ‘nature’ became grounded in the deployment of scientific techniques which were used to create ‘data’ about ‘race’”(Gould, 1981 in Baker, 1998). Physical features were attributed towards a certain race and labelled as standard. Through *normalising* social hierarchies based on physical anatomies a discursive context *allowed* participants to evaluate social conditions within those racial parameters ‘objectively’ (Baker, 1998). The interpellation of this discursive convention lasted and remains influential in discursive practices in current societies by reinforcing violation not only based on race, but also on gender (Moffett, 2009). Hence, people remain influenced by socio-historical discourses which constructed identities according to political parameters.

Moffett explores how sexual violence in South Africa is linked to discourses that demonise black men and harden racial barriers (2009). Moffett puts forward a different explanation than one that is racially inflected, by arguing that “[...] contemporary sexual violence in South Africa is fuelled by justificatory narratives rooted in apartheid practices that legitimised violence by the dominant group against the disempowered, not only in overtly political arenas, but also in social, informal and domestic spaces” (2009:155). Hence, sexual violence was reinforced through the social structures of the apartheid regime and remains part of the lived realities of many South African women nowadays (Moffett, 2009).

The apartheid system classified South Africans into four groups – black, coloured, Indian, and white – “with legislation maintaining physical segregation and impacting on the socialisation and identity formation of the members of each group” (Bosch, 2008:187). Since 1994, democratic legislation has contributed to the renegotiation of identity within South Africa. Narunsky-Laden further notes that “the racialised discourse of identity that underpinned the apartheid state continues to inform, shape and constrain how new identity options, spanning individual and social senses of ‘selfhood’, are currently being mediated and enacted on post-apartheid South Africa” (2008: 124). Bosch (2008)

explains that racial identity is constantly negotiated within South Africa. At present, identity re-negotiation centres not only around race, but also on culture, class or sexuality.

Language serves as a social boundary within the creation of discourse, but also contributes to the formation of (sexual) identity. Through language, users participate in online chat rooms; they submit comments, questions or facts about themselves to negotiate and maintain an identity. Cameron and Kulick illustrate that “language-using is ‘an act of identity’” (2006: 3). Sex for human beings is not merely something we do, but also something that we reflect and represent ourselves upon. Each sex attributes certain characteristics and internalizes those forms of behaviour as ‘me’ – “[...] that is, gender does not *feel* like a performance of an accomplishment to the actor, it just feels like her or his ‘natural’ way of behaving” (Cameron, 2001:171). Thus, people identify themselves through behaviour or communication, as discourses are internalised and enacted as *normal*.

Cameron (2001) identifies the positioning of viewers ‘asymmetrically’, because one party determines the exchange of content. “Language using is among the social practices through which people assert their identities – who they are or take themselves to be – and distinguish themselves from others who are ‘different’” (Cameron, 2001:161). Each society constructs discourses around gender differently and context applies different gendered attributes to each sex.

Discourses that relate to unequal relationship between genders are largely perpetuated and maintained through the media, but also through social and cultural reasoning. Fiske, for example, has deconstructed “a myth that women are ‘naturally’ more nurturing and caring than men, and thus their natural place is the home raising the children and looking after the husband” (1990: 89). It would appear that gender performances construct and reinforce gender discourses.

Cameron discusses whether male dominance is a result of hierarchical gender relations or stems from the cultural context of those genders which leads toward a patriarchal system (2001). Shaw conducted a study of speech behaviour in a British courtroom (2001 in Cameron, 2001). Her findings include that women are less powerful within the institutional system in discussion, and deduces that women in that context are “[...] disempowered by comparison with men” (Shaw, 2001 cited in Cameron, 2001:167). Shaw explains that the behaviour of women not to take action stems to large extent from how status equals power and dominance over situations (2001, in Cameron, 2001). Another reason why women avoid certain situations results from the belief that certain behaviours are connected to masculinity. Thus, her study shows how discursive practices are manifested in society both through action and inaction.

Cameron agrees with Shaw, and explains that “[...] women tend to prefer a co-operative, consensus-building style of discourse, whereas men tend to be more comfortable with competition and conflict” (2001:168). The origin of subordinate behaviour within public contexts might stem from a specific socio-economic background of femininity, such as the domestic sphere. “[W]omen in heterosexual couples have responsibility for the conduct of talk, but it is men who ultimately control its direction” (Cameron, 2001:163). According to Brown (2001), an inferior position is maintained through the avoidance of conflict with the dominant player. This theory can be applied throughout the hierarchical order of discourse formation, from the dominant elite of a society and subordinate citizens to the day-to-day interaction between genders in private gatherings. Therefore, people tend to establish discourses according to heteronormative parameters which in turn influence the construction of knowledge around topics such as HIV/AIDS. Women’s sexuality is seen as inferior and ‘sinful’ in discourse around pleasure and sexuality. Also, women are often blamed as the carrier of the virus, therefore demeaning women’s pleasure (Brennan *et al.*, 2005). Repression easily accompanies knowledge production if fear becomes part of the process.

Stigma

Fear is often a product of stigma, a discourse media often feed into when dealing with HIV/AIDS. Stigma can be defined as “[...] as a dynamic process of devaluation that significantly discredits an individual in the eyes of others” (Aggleton *et al.*, 2005:9). HIV-related stigma is multi-layered. Visual and print media has been shown to reinforce already prevalent pictures of the disease by using language “[...] that suggests that HIV is a ‘woman’s disease’, a ‘junkie’s disease’, an ‘African disease’, or a ‘gay plague’” (Aggleton *et al.*, 2005:9). This is problematic, as people who are affected by HIV/AIDS need support and advice, something the media and welfare institutions are thought to provide. Moreover, morbid pictures and false information negotiated by the media contributes to discriminate and rouse fear and anxiety amongst the populace. Sontag (1989) observes that “AIDS is widely perceived as a plague; like syphilis during the Renaissance, it is seen as “a disease that (is) not only repulsive and retributive but collectively invasive” (quoted in Bird, 1996: 48). Clearly, HIV/AIDS discourse that includes aspects of stigma impedes health awareness to raise consciousness. It is thus imperative to interrogate discourses performed on H360° for traces of stigma.

In the early stages of reporting on HIV/AIDS, the illness was framed explicitly around ‘promiscuous females’ or ‘sexually active males’ (often gay) within societies. This served to create a distance to the illness and to assign “the role of the contaminated other” to those infected (Bird, 1996: 51). The

media contributed to those pictures and manifested those in the minds of societies, which contributes to the presentation of discourses around stigma, and the labelling of women as the transmitter of the disease. Still, as Tomaselli puts it, “the real disease is that of denial, aimed at preventing stigma (individual, communal, national, continental), a social condition that hampers policy and clear thinking” (2009: 582).

The distorted media image of HIV/AIDS can partially be explained by the very nature of commercial mass media. News reports reinforce and reflect social concerns in order to construct newsworthy material (Bird, 1996). The fact that the media rely on fearful emotions in order to reach high circulation can be linked to the assumption that media and news are filtered by media organizations out to make a profit and often favouring a certain political agenda (Herman and Chomsky, 1988). According to Bird (1996), tabloid newspapers, as part of our culture, use emotions to reach people and gain profit, with little regard to report ethically or objectively (Bird, 1996). Because the media gain such an important status within society, fair and accurate reporting is an imperative to battle the stigma of HIV/AIDS in order to avert the disease (Swanepoel *et al.*, 2007; Ridgard and Spurr, 2005; Collinge, 2005).

Within certain communities, women are often blamed for being the carrier of the virus, although academic and scientific work argues the opposite (Brennan *et al.*, 2005). The role of stigma and the dependency of women on their men in a patriarchal society are closely linked. Brennan *et al.* (2005) mention that if women avoid prevention such as testing out of fear of the stigma attached to being sick, the first step of generating behaviour change is hampered. The socio-economic dependency of women on men in certain African communities contributes to the inferior status of the woman. Furthermore, women are often blamed by the community if someone falls ill (Brennan *et al.*, 2005). Hence, a discourse that connotes a gender-based perspective reinforces misleading pictures around HIV/AIDS.

Not only are women blamed as carriers of the virus in certain communities, but news reports have tended towards picturing women as the carriers and perpetrators of the disease. Bird (1996) analysed the US news coverage of CJ in the early 1990s. CJ was a woman who claimed to have AIDS and initiated sexual relations with men to deliberately infect them, supposedly because of her anger and wish for revenge against men. She was characterized as “a predator, an abnormally promiscuous woman” (Bird, 1996:50). The story turned out to be a hoax, an urban legend and a “cautionary tale for men” (Bird, 1996:50). Through rumours and alleged statements of people, a snowball-effect created the story of a ‘sexual mass murderer’. This anecdote illustrates how folklore can create

stories that reflect and reinforce anxieties felt by a society. News reports like this feed into the stigma and amplifies fear and anxiety within societies. Like folklore, news “is a cultural construction, a narrative that tells a story about things of importance and interest, and reflecting and reinforcing cultural anxieties and concerns” (Bird, 1996:44). The CJ story is an example of how news media contributes to negotiate stigma about HIV/AIDS and the redistribution and manifestation of discourses. Thus, in order to understand and reveal discursive practices communicated by an online community, the complex nature of how discourse is put into practice through various channels and conventions need to be taken into consideration.

Foucault defined ‘problematization’ as “not the representation of a pre-existing object, or the creation through discourse of an object that does not exist. It is the totality of discursive and non-discursive practices that brings something into the play of truth and falsehood and sets it up as an object for the mind” (Whyte, 2011: xxiv). Thus, my research aims to reveal discourses that are communicated by members of the online community H360°. The platform is accessible throughout the whole of South Africa, and different discourses are present in posts to the platform. Collectively these will give insight dominant discourses prevalent amongst South Africa’s youth. In this way, the connection between the exercise of power and discursive practices can be drawn together, as discursive practices form the basis for every discourse. “Discursive practices are characterized by the delimitation of a field of objects, the definition of a legitimate perspective for the agent of knowledge, and the fixing of norms for the elaboration of concepts and theories” (Foucault, 1980: 199). Hence, the way sexuality and sexual health is conceptualised and problematized on H360° can be deconstructed as discursive practices through critical discourse analysis.

Chapter 3: Rationale of Methods

I obtained the data for this mini-dissertation from the Q&A section on the H360° platform. The methods I used to sample and analyse the queries are explained and detailed in the following chapter.

Overview

My overall methodological approach was qualitative and text-based (Fairclough et al., 2011). Critical discourse analysis focuses on overall patterns and commonalities of knowledge and allowed me to identify the linguistic and discursive ways in which social relations of power are exercised and

negotiated by users of H360°, as they go about phrasing queries on the site. As Fairclough et al., explain:

“So discourse, may, for example, be racist, or sexist, and try to pass off assumptions (often falsifying ones) about any aspect of social life as mere common sense. Both the ideological loading of particular ways of using language and the relations of power which underlie them are often unclear to people. CDA aims to make more visible these opaque aspects of discourse as social practice” (2011:358).

I conducted a quantitative content analysis for a pilot study (Kramper, 2011) in order to determine the most common concerns expressed by users of H360°, this indicated the complexity of coding data, and revealed how several discourses could surface in one short query (Kramper, 2011). After selecting my sample of queries I examined them individually and labelled them to identify key discourses that users of the Q&A section drew upon when phrasing their inquiries about HIV, sexual health, and sexuality in general.

The prominence of gendered discourses in the comments led me to explore feminist critical discourse analysis as a methodology and theoretical approach. This approach helped to explain the prevalence of discourses suggesting unequal power relationships between genders. Because HIV/AIDS is such a sensitive and stigmatised topic in society, ethical implications were considered throughout the research process. Given the fact that this research draws on feminist methodology where possible, I reflect explicitly on how my own social background informs the research process. This helped me to enhance the transparency of the research process, to highlight the importance of self-reflexivity and to emphasise the importance of women’s narratives to increase awareness of gender equality (Brayton, 1997).

Nonetheless, the sample is relatively small and non-representative and, owing to the properties and architecture of the H360° platform, the individual queries are decontextualized. The analysis does demonstrate salient discourses around HIV/AIDS on the H360° platform.

Collecting Q&A queries

As part of an internship opportunity with ‘The African Pulse’, the NGO that initiated H360°, I was permitted access to the mobile platform’s Q&A section. With the assistance of the H360° administrators, I downloaded 1070 queries from the H360° mobile application as data to be analysed

in this mini-dissertation. These comments were posted by users through the Q &A interface of the H360° portal and were not available to outside users of the mobile platform. The messages were uploaded between 17.12.2010 and 20.04.2011 on H360°. To create a more manageable sample of text for qualitative analysis, I selected a random sample of 500 of these queries for further study.

The NGO uses the H360° forum to upload content and engage users in HIV/AIDS related topics in order to create awareness and initiate behaviour change. Thus, the data consists of comments and questions that H360° users ask about love, relationships, sex/sexuality and health, mostly concerning HIV/AIDS. Moreover, the posts give information about demographic data, such as location, gender or age. This demographic data is derived from Mxit profile data (which relies on self-reported age, gender, location etc.). Mxit profiles are often used for identity play (see e.g. Walton, 2010) and thus are not entirely reliable. The entries are signed with a timestamp which records the users' first access onto the portal and the time when the question was uploaded. Although users from twenty different African countries accessed the H360° portal, I only included queries which were posted by users whose profiles identified them as South African women.

Research suggests that young women use mobile media "to perform their socialised and racialised gendered identities" (Bosch, 2008, 2011), whereby self-representation and sexuality forms an important aspect in creating this online identity (Bosch, 2011). Therefore, the data that forms part of my mini-dissertation is relatively decontextualized, as the basic demographic data provided in Mxit profiles gives only minimal contextual information about the users.

Thirty four of a total of 500 queries are analysed in detail in relation to the key discourses which my initial coding identified on the platform. The reported age of the users who posted these queries ranges between 13 and 31 years. Seven of the users' profiles did not specify their age.

Critical Discourse Analysis

This project employs the methodological approach of critical discourse analysis (CDA), focusing on discourses of stigma, disease and unequal power relations in the H360° users' queries.

CDA is an analytical methodology "that primarily studies the way social power abuse, dominance, and inequality are enacted, reproduced, and resisted by text and talk in the social and political context" (van Dijk, 2001: 352). Critical discourse analysts strive towards uncovering hegemonic influence that is negotiated through power dominance by a social hierarchy.

The decontextualized queries from the Q&A feature of H360° do not allow for more in-depth study or discussion with the young people who posted them. Nevertheless the queries are revealing of young people's discourse in South Africa. However, before discussing the findings in detail, we first need to get a clear understanding of the methodological framework.

Fairclough (cited in McGregor, 2003) identifies three areas that should be considered when analysing written or spoken discourse. Firstly, one should address the language of the comments, such as grammar, choice of words or expressions (such as metaphors, analogies, or wording) (McGregor, 2003; Blommaert and Bulcaen, 2000). The second area of analysis are the broader social processes and power relations and viewing "discourse-as-social-practice, i.e. the ideological effects and hegemonic processes in which discourse is a feature" (Blommaert and Bulcaen, 2000: 448). A third analytical principle relates to social interaction of the text but this study is not able to analyse the social meaning or practices in which the queries were given meaning, as the data did not provide any background information about the participants or their social interactions.

I chose CDA as a qualitative methodology over a quantitative approach in order to investigate discourses around HIV/AIDS through analysing messages of an online portal. I am interested to unveil social arrangements that reinforce unequal power relationships by means of analysing queries that related to sex/sexuality and health. Fairclough et al. pose that "[CDA] openly and explicitly positions itself on the side of dominated and oppressed groups and against dominating groups" (2011:358). Through analysing discourses around HIV/AIDS, cultures of sexualities and information on gendered and social identities can inform valuable knowledge of how discourses around HIV/AIDS are produced and communicated. CDA allows messages to be studied from an analytical perspective that takes into consideration the broader social context of where the information flow took place. Therefore, CDA provides "[...] a sophisticated theorization of the relationship between social practices and discourse structures and wide range of tools and strategies for close analysis of actual, contextualized uses of language" (Lazar, 2005:5). Furthermore, a feminist approach was considered entailing that feminist critical discourse analysis seeks to understand the relationship between power, gender and ideology in texts. Also, feminists have always been interested in the connection between language and oppression, as "[...] women occupy negative semantic space within language" (Kitzinger and Wilkinson, 1995:166). Therefore, blending together CDA and feminism "[...] can produce a rich and powerful political critique for action" (Lazar, 2005:5).

Because we interpret texts according to our socio-economic and historical condition, the comments and questions that the H360° users upload can give information on how dominant media messages

influence interpretation and understanding of messages that the South African youth are exposed to. However, “[...] instead of attempting to say what power is, we must attempt to show how it operates in concrete and historical frameworks, in the sense of ‘By what means is it [power] exercised?’ and ‘What happens when individuals exert (as they say) power over others?’” (Foucault, 1982: 217 quoted in Deacon, 2002:91). Certain rules and conventions surrounding health awareness and sexuality exist within every country. The complex historical and social context of South Africa influences the renegotiation of identity in South Africa. Power relations between class and gender, sexuality and the transformation of identity are dominant issues within the media landscape.

CDA can reveal power relations that are communicated in written or spoken texts (McGregor, 2003). “CDA focuses on how social relations, identity, knowledge, and power are constructed through written and spoken texts in communities, schools, the media, and the political arena (Luke, 1997 in McGregor, 2003:3). A critical approach to discourse seeks “to link the text (micro level) with the underlying power structures in society (macro sociocultural practice level) through discursive practices upon which the text was drawn (meso level) (Thompson, 2002 in McGregor, 2003:3). Thus, the comments and questions that are posted by H360° users are situated within a broader social context that needs to be taken into account. South Africa’s social context rests on a complex set of power relations influencing the understanding of social messages around sexuality and health. Socio-economic and historical factors influence the interpretation and the subsequent internalisation of messages. Socio-historical conditions, such as South Africa’s legacy of apartheid influences the construction of discourse and knowledge around health differently by various communities.

According to McGregor, “[d]iscursive practices refer to rules, norms, and mental models of socially acceptable behaviour in specific roles or relationships used to produce, receive and interpret the message” (2003:3). Those discursive practices are influenced by both implicit or explicit rules and conventions on how to behave, think, and act in any given context. Each social context is influenced by guidelines, expectations and conventions, thus, laying a ground of anticipation and expectation on how to behave and act. This dissertation was limited in identifying how the queries related to discursive practices as the analysis was constrained by only a certain amount of background-information provided through the demographical data. This aspect could be explored in future investigations on how people engage in discursive practices.

The aim of my research was thus to employ a critical analytical approach to reveal dominant discourses on the H360° forum which relate to medical and traditional informed treatment and prevention discourses, manifested and shaped by unequal power relations. The findings are

important in revealing hidden meanings and misunderstandings about discourses on sex/sexuality and health awareness in order to reveal how they support the status-quo and initiate counter-discourses amongst particular communities where discourses are negotiated on a day-to-day basis.

Given the limited demographic information available about the users who posted queries, and the context in which the queries were posted, interpreting the data raises many difficulties. With this in mind, this dissertation looked specifically for discursive evidence of unequal power relationships, stigma, disease, love, sex/sexuality or gendered relations.

Although this project is limited in various aspects, the outcome of this study is meant to strengthen knowledge around mobile users' understanding around HIV/AIDS, as dominant discourses can be identified through careful analysis.

Approach to textisms

The comments on the H360° platform are texting messages in English (see Deumert & Masinyana, 2008; Walton, 2010). I present each query along with its 'translated' form, thus including both the original MXit textisms and a more formal register.

Research Ethics and Informed Consent

To a researcher, ethical principles are important, especially when dealing with a sensitive topic. "It is important for qualitative researchers who work with vulnerable populations to ensure that research is conducted in the most ethical way possible" in order not to expose the participant to harm inflicted upon them through their community (Ensign, 2002). To avoid exposing informants to harm in such a context is of utmost importance. This responsibility towards research participants raises several complexities for researchers who investigate online communities and online discourse (Knobel, 2010).

Given the fact that a collection of queries were given to me for analysis, I was not able to approach individual users or to inform them further about my project, and I approached the analysis primarily as a discourse analysis. As the queries from the Q&A section did not link to any background information or contact details of users who contributed queries, I was also not able to conduct follow-up interviews to interpret and cross-check the data with the posters. Moreover, the participants log-in anonymously and are encouraged not to reveal any private information to other

users. To further protect the identities of the users who posted queries, this research project will not reveal any private information, such as the nickname they use to log in to the forum.

H360° participants were made aware through an alert banner that their comments and questions were recorded and could be used to develop the content of the website. The difficulty remains that users are not appropriately informed about to what extent their queries are used for further research. People might be made aware of the fact that their comments and questions are reviewed for development purposes, but the users do not assert any agency over the unfolding process of the interpretation of the data. If I would have been able to cross-check my analysis with the participants, possible misunderstanding or misinterpretations could have been corrected by the participants immediately.

Feminist Methodologies

Given the limited demographic information available about the users who posted queries, and the context in which the queries were posted, interpreting the data raises many difficulties. With this in mind, this dissertation looked specifically for discursive evidence of unequal power relationships, stigma, disease, love, sex/sexuality or gendered relations.

I make use of feminist theory and appropriate 'masculine' theory developed by Foucault (1978) to strengthen a subjective outcome by means of a critical discourse analysis. Moi understands 'appropriation' as "[...] a critical assessment of a given theory formation with a view to taking it over and using it for feminist purposes" (1991: 265). From a critical perspective, it is important to consider 'who says what' and what are the underlying power interests communicating and creating a message a particular way. "Feminist theory is critical theory; feminist critique is therefore necessarily political" (Moi, 1991: 265). Therefore, this research dissertation uses critical discourse analysis and combines it with feminist research to raise political awareness and in order to uncover discourses that impede work to stop the spread of HIV/AIDS.

From a feminist perspective, my role as a researcher is a central issue to consider throughout the research process. My own socio-economic background defines the scope of analysis and influences the focus of the subject matter. Hence this dissertation acknowledges subjectivity to create transparency by making visible the limitations accompanying the research process, such as collecting data, or focus of analysis.

The argument develops in relation to comments submitted by female users and how they articulate and express concepts around sex/sexuality, health and relationships. Thus, this project bases its theoretical framework on Brayton's (1997) epistemological principles of feminine research which centre around women and their way of expressing concerns or ideas.

Brayton (1997) highlights three principles that differentiate feminist research from traditional research which contribute to the appropriation of the methodological approach. Firstly, "[Feminist research] actively seeks to remove the power imbalance between research and subject" (Brayton, 1997:4), thus this research is going to use an approach that highlights the authority of the participants throughout the study and serves the interest of women. Secondly, a feminist approach "[...] is politically motivated and has a major role in changing social inequality" (Brayton, 1997:4). This research project uses a feminist approach to reveal how unequal gendered power relations contribute to misinterpretations around health issues which not only impede the uptake of HIV/AIDS, but also reinforces patriarchal and conservative belief systems which violate women's identities. Lastly, a feminist researcher "[...] begins with the standpoints and experiences of women" (Brayton, 1997:4). My research is firmly grounded in the principle of female subjectivity, not only through its reliance on feminist literature, but also in its use of stories about women, including my own, as well as the qualitative data gathered from female participants on the H360° platform.

Brayton argues that "[k]nowledge of women's lives have been absent or constructed from the perspectives of men" (1997:6). Fausto-Sterling (1993) explains that from an epistemological perspective medical and scientific data is valued higher in society due to an overarching patriarchal discourse. The knowledge created around orthodox medical treatment is shaped by male ownership, thus limiting women's influence and treatment options, as most research is grounded in empirical data based on male bodies (Fausto-Sterling, 1993). Media scholars, such as Bosch (2011), and Bragg and Buckingham (2011) support this argument by arguing that in order to generate findings explaining social behaviour, qualitative research is a useful methodology in comparison to numerical scientific research.

An additional principle in feminist methodology is brought forward by Brayton (1997) and revolves around "taking women and gender as the focus of analysis" (1997:7). This research explores how women construct the concept of sexuality in a context that is highly influenced by social structures that enforced gendered power relations. Through revealing those inequalities and shedding light onto those powers, space is given to female subjectivity and empowerment arises. The comments that are submitted by young women onto H360° demonstrate how gendered inequality is socially

linked to a patriarchal discourse. The ability to relate individual experiences to structural conditions can in itself have a liberating effect (Brayton, 1997:6). Thus, using women's stories and how we articulate and express them, not only reveals inequalities, but also raises consciousness.

HIV/AIDS is included in this dissertation as a discussion point, thus examination that takes qualitative research, more specifically gender-based research, as a grounding principle is imperative to develop HIV/AIDS intervention programs (Pattman, 2002). Through in-depth research on how women construct and express concerns around sex/sexuality and health, strategies are made more effective by taking into account how people who are affected by the disease produce and articulate discourses around HIV/AIDS.

Limitations

This dissertation applies critical discourse analysis, but is limited in several aspects from developing a coherent discourse analysis (Louwse, 2005). The data analysed for this project allows interpretation from a linguistic and rhetorical perspective, but there are limits on this analysis, because no interactions between the researcher and the informants took place. Therefore, many questions remain unanswered about the H360° queries. I was only able to access the queries and interpret them in relation to basic demographic information, such as the user's age, country, gender or a timestamp of the user's log in and date they posted a query. This situation lends itself to the unconscious tendency towards "[...] imposing interpretations on data to fit their own ideological presuppositions" (Widdowson, 1995 cited in Cameron, 2001: 162).

Given the fact that this project is limited to one language, it cannot accurately represent the many languages and vernaculars that form part of the cultural landscape of South Africa. Furthermore, I was not able to engage in a dialogue with any of the participants of H360° which constrains my research further, because from a feminist perspective, throughout a research process a constant interaction between subject and researchers is of utmost importance in order to create an outcome that represents the participants as ethically as possible (Brayton, 1997). However, an advantage of the study is the combination of women's issues in relations to new media technologies, which is a rather unexplored field in the social sciences.

Transparency is an important aspect of qualitative research, but the data in discussion did not include aspects that would allow deeper interpretation, as the data for analysis did not comprise of any information about the socio-economic or cultural background of the participants. I was not able to conduct interviews or check my interpretations in follow-up interviews which normally strengthen findings from a qualitative perspective. Although I was not able to conduct in-depth research from an ethnographic or interview-based approach, through a self-reflexive engagement with the data, the findings of this dissertation give valuable insights into how people create knowledge about health and sexuality amidst an array of available discourses. Media communications often miss out on incorporating a two-way dialogue in order to understand how an audience receives messages. By creating awareness of the discourses that shape MXit users 'understanding of the disease, health communications campaigns and media strategies can take into consideration the importance of power relationships and perceptions of HIV/AIDS among young adults.

Discourses are communicated and perceived according to the receiver's socio-political and economical background, thus, "the 'right' interpretation does not exist whereas a more or less plausible or adequate interpretation is likely" (Fairclough, 2002, Wodak and Ludwig, 1999 in McGregor, 2003:3). Rather, my own socio-economical conditioning and the context of analysing the data from a textual perspective infers the interpretation of the data. In addition, I tried to distance myself from interpreting the data, rather focusing on the thematic discourses that emerged.

Owing to the limited scope of this mini-dissertation I was not able to address every discourse that I encountered, and instead concentrated on discussing the most influential discourses in relation to knowledge construction around HIV/AIDS.

My Personal Response Influencing the Research Process

In order to conduct research grounded in feminist principles (Brayton, 1997) I need to account for the integral role played by my own social background as a researcher. Therefore, the following section serves to contextualise my own experiences in relation to the experiences suggested by the H360° data.

Tompkins explains the essence of the dichotomy that I have been facing since I started my Masters research, "[t]he problem is that you can't talk about your private life in the course of doing your professional work" (1987:169). Tompkins refers to the dilemma between the critical academic and the private self and infers that "[t]he public-private dichotomy, which is to say the public-private

hierarchy, is a founding condition of female oppression” (1987:169). The more I dive into feminist texts, the more my academic conditioning seems to surface which directs me towards subjectivity.

Throughout the research process I found myself more and more drawn towards a subjective approach which is an integral part in feminist studies (Brayton, 1997). I decided to include my personal response into the dissertation, as I realised that my own socio-economic and private background influenced the process. Feminism recognises objectivity as a social construct. Therefore, being self-reflexive about one’s work is an important aspect to consider whilst dealing with people. According to Denzin, “[r]eflexivity, however, is not an option. The trick is to balance the subjective with the inscriptive and to continue to produce texts that brings news from one world to another, understanding that at some level a reflexive poetic informs all that we write” (1994: 223). After more than a year of analysing and engaging with the data and conducting research, the process has been more complex and demanding than first anticipated.

Not only did the methodological approach of discourse analysis challenge my academic mind, but also the topic under discussion changed my perspective towards objective research. The more I engaged with the data, the more I became involved in the process and in the concerns of the people. I started to question whether I was able to distance myself from my own feelings and standpoints as a woman whilst analysing and selecting queries for discussion. After almost eight years of studying and working in the media, my critical mind started to question the concept of objective analysis. I started to branch out into other disciplines, such as anthropology and gender studies, and in that process I started to realise that objectivity is a term that needs to be evaluated critically. All the more so, as “it is impossible not to be reflexive because essential reflexivity is a part of language - an integral feature of all discourse” (Denzin, 1997:217). Also, the more I researched subjectivity and how personal experiences seem to influence other scholars, the more I wanted to include subjectivity into my dissertation.

“Every time I have tried to do a piece of theoretical work it has been on the basis of elements of my own experience: always in connection with processes I saw unfolding around me. It was always because I thought I identified cracks, silent tremors, and dysfunctions in things I saw, institutions I was dealing with, or my relations with others, that I set out to do a piece of work, and each time was partly a fragment of autobiography” (Foucault, 2000A: 458 in Davies et al, 2004: 364).

Therefore, this paper combines critical discourse analysis with a subjective perspective in order to create transparency towards the research process, as my personal conditioning largely affected the topic and the queries selected for discussion.

I remain sceptical towards writing about my personal background. For one, I am scared I might not satisfy the standards my supervisors expect from me and that my work will not be regarded as valuable from an academic perspective. Secondly, I fear opening up and talking about my personal space, although I know that my experiences are part of my body and to some extent inseparable from my writing, and therefore have influenced the whole research process.

Reading Denzin encouraged me to understand that the dilemma I have been facing is something that is collectively experienced by academics, as “a division between the personal and the scientific self falsely presumes that it is possible to write a text that does not bear the traces of its author” (Lincoln and Denzin, 1994: 578 in Denzin, 1997:218). But “of course, this is an impossibility because all texts are personal” (Denzin, 1994:578). Therefore, the following section outlines my subjective approach that inspired my Master’s dissertation.

Subjectivity allows the researcher to be more aware of how social conditioning informs the analysis of data, as the researcher herself is influenced by various discourses and in turn creates discourse. According to Brayton, feminist research emphasises a subjective perspective (1997). My own discourse about HIV/AIDS is quite removed from that of the participants. Not only was I born a different country but also my academic background privileges me as a researcher and therefore I am at risk in ‘over-interpreting’ the data.

I was born in Hamburg, Germany and came to South Africa around six years ago. I came to South Africa to find out more about myself, as being ‘mixed-race’ confronted me with many questions since I was a child. My mother had to leave South Africa at the age of 24 because of political reasons; and at the same age I decided to explore the country I had not seen since I was a child. I only remembered the beauty of it in vague pictures carefully stored in my heart since my last visit. After a few years of living here and calling this place my home, I sometimes wonder whether the beauty of this country is not a natural mechanism masking the atrocities happening behind this appealing veil. I have experienced a few traumata which, I cannot deny, have made an impact on my academic focus.

Thanks to a falsely positive HIV test I was led to believe that I was HIV positive for eight days. This incident happened a few years ago, after I became severely ill and had to admit myself into a private

hospital in Cape Town. Another experience occurred that made me face the disease again two years after that. I was on Anti-Retro-Viral treatment for many weeks after a sexual assault. Hence, my view towards the topic cannot be condensed to be objective. My academic background taught me to be objective, but over the past two years my whole being started to feel helpless and I decided to use the experiences and channel them into creating consciousness towards health and gender awareness. Also, the fact that the H360° project closed down prematurely, strengthens my desire to shed light onto this area of media education, as it holds valuable information to strengthen HIV/AIDS media initiatives. I have empathy with the H360° users that continue to log onto the platform and ask for advice by submitting queries. The queries are personal messages which contain emotions and personal dilemmas which become visible through topics that are raised. At the moment, the future of the platform is not guaranteed, although the service is in high demand.

Some people who know about my experiences commented on it and questioned whether my dissertation topic was a solely therapeutic exercise. I am well aware that my personal conditionings made an impact onto my study, but I also found that a dearth of personal narratives is visible in South African media studies which does not emphasise how HIV/AIDS research is a highly sensitive subject which needs to be approached from a personal angle and emphasises constant interaction with people affected by the disease. Therefore, I started to investigate how I could combine my personal experiences and link these with media studies in order to create an outcome that will benefit a larger group of people. In order to reach people and generate behaviour change, it is imperative that health education through the media receives higher attention, especially given the fact that socio-economic conditions continue to impose gendered inequality and impede HIV/AIDS awareness.

Further Research Suggestions

Insider perspectives are essential to understanding how discourses around sex/sexuality are framed by specific communities. In order to create media educational strategies it is important to recognise how different communities construct cultures of sexuality. As Ntseane and Preece argue, “[...] in order to change existing discourses for sexual behaviour in particular communities it is necessary to find a way of changing those discourses from within those communities” (2005:349). How people in diverse cultural settings identify and create their understanding of sex/sexuality and HIV/AIDS should be observed from the socio-cultural and political context where the text occurs.

Further research is needed to give more insight into how people construct discourses around health and sexuality in everyday interactions. Therefore an ethnographic approach that investigates *how* and *why* teenagers use mobile media in specific ways should play a key role in future research. It is important to understand how people make use of media information and then apply it in everyday practices (Cain, Schensul and Mlobeli, 2010). This could be achieved through triangulation of methodologies, such as in-depth interviews, surveys, and ethnographic fieldwork.

Another suggestion for future research would be to analyse how mobile media contributes to empowerment of women. Violence based on race or gender is a complex and deeply-rooted concern in patriarchal societies. In this context, it is important to analyse how women perform agency by using mobile media to inform themselves about health and sexuality. It is needed to question how agency is performed in technological development (Emdon, 2008), so that women's agency is understood, acknowledged and taken into consideration, so that women's social identity is strengthened and awareness towards empowerment arises.

Ntseane and Preece advocate for HIV/AIDS intervention strategies that take into account "[...] localised social relations and value systems" (2005:347). The Q&A section is not a community where people are able to engage and see each other. The information flows one-way towards the users. "Communications from within communities [...] are key to ensuring behavioural change" - to engage with social values and structures rather than disrupting them (Ntseane and Preece, 2005: 348). Therefore, an ethnographic study that entails engaging with teenagers in everyday practices and to talk about HIV/AIDS and mobile media education would be an important approach to understand how different teenagers from different communities construct knowledge about HIV/AIDS.

Deumert (2010) approached her highly sensitive research on multilingualism in South African health care facilities through different methodological approaches, such as interviews, ethnographic observations and staff interviews serving empirical data. This research study is one example of how triangulation of different methodologies creates deeper insights into a research topic. An ethnographic approach is imperative to gather data not only about what people talk about, but also *how* they express themselves through body language, or other forms of non-verbal communication within a given environment. Spatial relations inform the process, as different locations make people behave in different ways. Therefore, my research dissertation could be seen as a foundation for further research, as it provides information around discourses that inform young South Africans around knowledge production towards HIV/AIDS and sexuality from a discursive angle.

Chapter 4: Discussion and Findings

In a pilot study (Kramper, 2011) conducted during my research methodology training in 2011, I identified some key areas of concern, as expressed by users who posted to the Q&A section on H360°. These concerns included (i) how infection took place, (ii) how to prevent transmission of the HI virus, and specifically prevention of mother to child transmission, (iii) a desire for better understanding of the interaction between the immune system and HIV, (iv) the symptoms and treatment of AIDS/HIV, and (v) testing procedures. More general questions included queries about pregnancy, sex and sexuality, and sexual abuse. My pilot study found that these were thus the main areas of concern to users who posted queries in the portal.

Further analysis of the 500 queries sampled for the purposes of this mini-dissertation showed how queries were underpinned by various discourses which shaped and constituted users' knowledge about HIV/AIDS and sexuality in general, notably discourses and knowledge about gender, sex/sexuality, power in intimate relationships, medical knowledge, hygiene, and religion. Thus queries are not simply a matter of users requesting information, but are shaped by various unequal power relationships.

The following discussion will analyse these discourses and show the role that they play in relation to queries about HIV/AIDS in the Q&A section of H360°. Owing to the feminist perspective which informed my analysis, I focus on discourses reflecting unequal power relations, such as medical or gendered relationships. Discourse analysis also reveals the role of other forms of knowledge in impeding the fight against the disease. Various competing discourses relating to HIV/AIDS co-exist. For example, discourses that relate to medical knowledge connect to belief systems that are rooted in traditional views of health and hygienic everyday discourses. Discourses of stigma, cure, prevention and treatment methods all form part of the larger framework of discourses about HIV/AIDS knowledge. The following analysis will show how such discourses are present in the queries posted to H360°.

Metaphorical thinking is particularly important in understanding the role of stigma in shaping attitudes towards people affected by the disease. Clatss and Mutchler explore HIV/AIDS as a symbolic representation, as "[...] images are marshalled and deployed, through metaphor (consciously or unconsciously), in the service of moral and ideological agendas" (1989:105).

Euphemisms and dysphemism are metaphorical expressions that control the relationship between disease and language. A dysphemism ('speaking offensively') or euphemisms ('sweet-talk') are used as substitutes to refer to something unpleasant or less offensive (Allan and Burrige, 2006:31). The relationship between euphemism and dysphemism is based on motivation of feelings, for example fear, anger, hatred or contempt. "[D]ysphemism is the opposite of euphemism and, by and large it is tabooed" (Allan and Burrige, 2006:31).

This chapter also considers the ways in which the architecture of H360° itself shapes discourse structures on the platform. H360° allows users to upload queries onto the forum, thereby participating in discourse. People join groups or communities in order to create "[...] a sense of belonging and security" (Dimbleby and Burton, 2007: 103). The communication that takes place within the space of a group or community functions to hold the community together (Dimbleby and Burton, 2007). In the case of the H360° portal, a limited sense of group or community identity was created, as a result of the peculiar structure of the MXit application, as will be discussed in more detail in this chapter.

Clinical Discourse

People with a status of authority in society, such as medical doctors, have the power to negotiate discourse around diseases, because of their historically established status as discourse agents (Foucault, 1993). Foucault analysed the theory that medical institutions historically shaped discourse relating to 'madness' and explains that in the age of HIV/AIDS his work can be applied to 'modern' medical discourse as it could give "[...] a perspective on how to adapt and direct the power exercised by medical, quasi-medical, and moral experts in the time of the AIDS epidemic" (Foucault, 1993: 199). A discursive convention entails that people who are affected by the disease internalise terminologies that are presented to them, as they rely on 'expert' information. The architecture of H360° promises access to expert or therapeutic discourses, but does not keep this promise, as a two-way dialogue is not sustained through the asymmetrical structure of the Q&A.

H360°'s mobile presence adopts an informal register and textisms characteristic of MXit use (Vosloo, 2009; Walton, 2010) to invite young MXit users to share and participate in discussion of issues around HIV/AIDS and sexuality. As Figure 7 reveals, through this appropriation of youthful linguistic conventions, the platform tries to shift the discourse away from a purely clinical or scientific register.

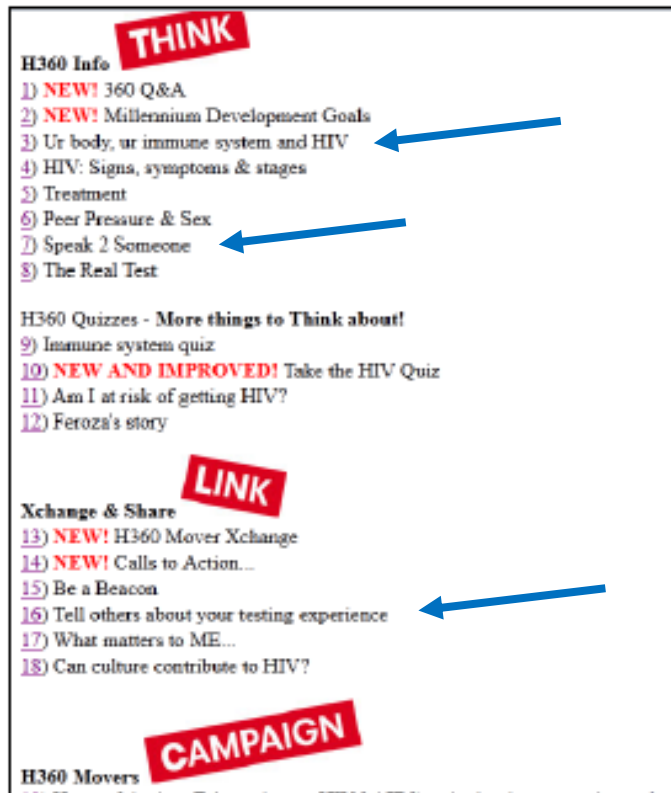


Figure 7: Navigation page of H360° on MXit

However, Figure 7 shows that H360° invites participation on the mobile application site by concurrently appropriating informal and rather formal registers of language use. On the one hand, a teenage voice is simulated through textisms such as 'Ur body' instead of 'Your body' or 'Speak 2 Someone' instead of 'Speak to Someone' on the H360° mobile interface (above Figure 7). On the other hand, the voice from a person of authority, such as a medical practitioner or an adult, is reflected through using more formal registers (for example spelling out words such as 'Tell others about your testing experience' (above Figure 7)). This inconsistency establishes different voices speaking to the users.

The medical discourse around the disease reflects the clinical power structure in that it limits communication between doctors and patients in health facilities. H360° thus promises to break the gatekeeping power of health workers and their prejudices by allowing users to ask questions through the Q&A section.

The Q&A section of H360° is a misnomer. The abbreviation assumes that there is an answer section on the platform. However, the questions are filtered and only a small percentage of the posted

queries are given answers, and queries are prioritised according to the highest demand regarding a certain topic. According to the project manager of H360°, around 75-100 queries of a total of 1.200 were addressed monthly (personal communication, 30 June 2012). So, only a fraction of the total number of queries are selected and addressed accordingly.

The H360° platform is used for a great deal more than factual informational queries about health. My analysis suggests that some people tended to associate the platform with a 'confessional' space. Hence it is useful to consider the role of confessional discourses in constructing sexuality. Techniques such as the facilitation of confession, were implemented through institutions of authority, such as educational or medical settings or the church, in order to enable individuals "to open up entirely to its director – to unveil to him the depths of the soul" (Foucault, 1981d:238 quoted in Deacon, 2002:94). People conform to ideologies that are internalised, otherwise believe that they transgress the 'norm'. For example, users approach the platform to release emotions or to 'confess' highly complex circumstances and dilemmas, as in the following examples:

1. "Im a 13 year old black girl nd i have a 21 year old boyfriend, he,s recently told me that he,s been using drugs and now im so confused, i love him and im realy nt prepared 2 dump him or anything like that, what can i do to help him? And is it wrong 2 date someone way older than you, even though u love them?" – Woman, Cape Town.

["I'm a 13 year-old black girl and I have a 21 year-old boyfriend. He recently told me that he uses drugs and now I'm so confused. I love him and I am really not prepared to dump him or anything like that. What can I do to help him? And is it wrong to date someone who is way older than you, even though you love him?"]

In the above query, the person seems to be confused and needs affirmation of her love relationship. She asks, whether it is "wrong 2 date someone way older than you" therefore implying a 'norm' of what is socially and morally 'acceptable'. Also, drug abuse is highly stigmatised and sensitive topic among the public. Presumably, that is why the user tries to reach for help through this mobile application, as the platform promises an alternative and anonymous way to health and sex/sexuality in comparison to medical discourse. Unfortunately, the platform did not fulfil this promise of being an alternative to medical discourse. In the first place, as explained above, most users who posted queries received no answers to their individual questions. In the second place, the architecture of the H360° portal enforced asymmetrical discursive relations. The H360° administrators had the power to shape the discourse on the platform, as they alone had the ability to provide answers, and they chose which questions are selected for publication. This is reminiscent of other forms of

mediated confessional such as the 'agony aunts' commonly found in newspapers and magazines. As the NGO explained to users on the Q&A forum:

"Thanks for all your questions. We take your questions seriously and try to respond to as many as possible. There are naturally a lot of the same questions so we have grouped the answers by topic so you can easily find what you're looking for" (H360° on MXit, 2012).

Thus in the H360° portal, the users posted comments or questions, but like magazine readers' letters to agony aunts, their posts were initially only visible to the administration, and the majority remained unanswered. The comments and questions were all reviewed by the managers who had complete editorial control over what was published.

Just as religious confession encouraged people to construct their identity and sexuality in relation to certain categories of 'sin', the structure of the H360° portal also imposes a particular categorisation on the discourse. The answers which were provided to users in the Q&A section were categorised according to the following topics (as depicted in Figure 7, above):

- 'Ur body, ur immune system and HIV';
- 'HIV: Signs, symptoms and stages',
- 'Treatment',
- 'Peer Pressure & Sex'.

Sub-topics included information about anti-retro viral therapy; the different stages of HIV/AIDS; the relationship between peer pressure and HIV; how to stand up against peer pressure; information about the immune system and HIV; and information about 'cures' or drug resistance.

The above set of topics left out many issues that might not have been as frequently raised, but which may be greatly important to some people. Many questions relating to teenage pregnancy, sexuality, discrimination based on race or gender, stigma or fear were not addressed. Nonetheless, content on the platform was developed according to issues raised in the questions. This asymmetry empowers the administrators of the platform as they have access to ask the Q&A queries while the users remain isolated from one another.

Some users protested the lack of a visible response to their queries as follows:

2. “Well this is ol a lie coz i askd a question 20days ago bt u neva replyd.” (20 year-old female user from East London)

[“Well, this is all a lie, because I asked a question 20 days ago, but you never replied.”]

The asymmetry in the architecture further assumes that the NGO has all the ‘answers’ and that users only have ‘questions’. This structure reinforces a power relation, as it is visible in other discourses on this platform, and also reflects the clinical power structure visible in public health facilities in South Africa. H360° users seemed to wish to connect in particular communities to talk about issues that are of shared concern and to develop relationships with one another.

3. “Hi thr im nt hiv bt i jst wna tel da ple wh0 hve it its nt the end of the wrld u js nt wri wht the ple say man js life ur live nd i luv u all mwa(x).” (14 year-old female user from South Africa)

[Hi there, I’m not HIV positive, but I just want to tell the people who have it that it’s not the end of the world. Just not right what the people say man. Just live your life and I love you all. [Imitates sound of kissing and icon for kiss] (x)]

The above ‘query’ is not in fact a query, but rather suggests that this H360° user may have intended to use the space of communication to create a sense of belonging and unity so that other people do not feel alone with their concerns (Dimpleby and Burton, 2007). Also, the user seems to gain authority by negating the power of HIV (‘not the end of the world’). In this context, the user used the space to initiate a positive and affectionate (‘mwa(x)’) discourse. Nonetheless, most of the H360° users submitting comments on this platform make enquiries, thus conforming to their allocated role as questioners and reflecting the asymmetries of clinical discourse:

4. “My father has been on arvs 4 2yrs,now they say he has liver damage.what can we do the doctors arent being straight with us.pls be honest!”
– Posted by a 27 year-old woman.

[My father has been on ARVs [Anti-Retro Viral treatment] for two years. Now they say he has liver damage. What can we do? The doctors aren’t being straight with us. Please be honest!”]

This query reveals the power relations inherent in clinical discourse, since the doctors seem to either withhold information or the family was not properly consulted. Deumert (2010) investigated how

health care facilities struggle to provide efficient service. Due to shortage in staff and medical supply people often leave hospitals with very limited information about their situation.

Under the umbrella discourse of medical-scientific information, discourses emerge which are associated with treatment, prevention methods, but which are in fact culturally and socio-historically shaped. The following comment shows how medical discourse competes with other discourses that relate to treatment and prevention methods, but are strongly rooted in everyday perspectives on health and belief systems:

5. "Im h.i.v. .i realy want to have a babey.can i fal pregnant.ive been positive 4 3 years and in dat tym ive neva used a condom with my partner bcoz i want to fal pregnant.the hospital told me dat i have a cist in my womb i dnt undastand,my man tels me dat da mother of hes child is using zulu blackmagic to make me sick and i dnt undastand anyof this.im so confused i dnt have any1 to talk to or trust.i dnt knw wat to do.i want to speak to a counselor bt i dnt have the means.my man is black bt im wite/mixed race so im nt so sure about anythng.wat must i do .im also a prostatute.i hpe dis is confidential.plz help.lost.suicidal gel.tanx." – 22 years old, woman, Durban.

[“I’m HIV. I really want to have a baby. Can I fall pregnant? I’ve been positive for 3-4 years and in that time I’ve never used a condom with my partner, because I want to fall pregnant. The hospital told me that I have a cyst in my womb. I don’t understand. My man tells me that his mother is using Zulu blackmagic to make me sick and I don’t understand any of this. I’m so confused and I don’t have anyone to talk to or trust. I don’t know what to do. I want to speak to a counsellor, but I don’t have the means. My man is black, but I’m white/mixed-race so I’m not sure about anything. What must I do? I’m also a prostitute. I hope this is confidential. Please help. Lost suicidal girl. Thanks”.]

Different discourses around health co-exist with each other in this query. It not only indicates confusion, distrust and shame, but also shows desperation around what to believe and confusion regarding the truth of competing clinical or traditional explanations of her predicament (a ‘cyst in my womb’ versus ‘Zulu black magic’). Medical discourses around health are thus influenced both by traditional and indigenous knowledge in relation to treatment and health options.

The woman seeks medical help, thus a medical discourse informs her behaviour options. However, the comment also indicates distrust in the medical authority, as her visit made her more ‘confused’ about her situation, perhaps to the point of being ‘suicidal’. Again, a clinical discourse and its

inability to provide sufficient health communication become visible in this comment; the woman remained distressed after her visit to the hospital.

Query 5 also suggests that the woman fears stigmatisation if her concerns (or perhaps her occupation as a sex worker) were to be made public. This suggests that some users valued the ability to ask their questions in private, uninhibited by the possibility of being subjected to stigma, which is present even among health workers. Indeed, some queries from H360° users suggest that they experience harsh treatment and possibly discrimination in their interactions with doctors, nurses, and clinic staff, as suggested by the following user query:

6. “It is good to have nurses at our local clinics that still have short tempers to hiv persons at clinics?” – 24 years-old, Halfway House.

This comment shows how stigma and hierarchical power relationships inform discourses around HIV/AIDS, even in the context of clinical interactions with staff at a medical institution. Stigma towards people affected by HIV/AIDS is in fact reinforced by authorities who have the power over knowledge.

Stigma

The reference to judgement and discrimination by nurses with ‘short tempers’ in Query 6 discussed above reveals powerful stigma at work in everyday discourse. The query signifies an unequal power relationship at play as it shows how power is exerted by staff of medical institutions. Horn refers to HIV/AIDS as “a stigmatised condition” (2010:25). Stigma about illness and prejudice based on race or gender is largely supported through discursive practices presented by authorities, which guarantee the uptake of those beliefs (Chigona and Chigona, 2009). Using metaphorical register to refer to the disease is part of a discourse that reinforces stigma. The figurative language creates terminology that displaces people affected by HIV/AIDS and produces unequal power relations. Stigma is therefore characterised by tabooed topics. Indeed, “this power of taboo keeps language users from avoiding the forbidden concept and compels them to preserve or violate it” (Fernández, 2008: 96).

Haupt et al. argue that, “[s]imply communicating dry scientific evidence in media messages is insufficient [...]” (2004:28). Not only is the media responsible for accurate reporting on HIV/AIDS so that the battle against stigma can be supported, but also social scientists need to pay attention to discursive power and existing discourses so that generalizations about HIV/AIDS positive people can be averted. One example of how discourses of HIV/AIDS feed into the stigma of HIV/AIDS is visible

through the wording of Hasnain's (2004) article on the socially inferior role of women in African societies. Hasnain (2004) reports on important information, such as cultural factors preventing women from adopting initiatives such as the 'prevention-of-mother-to child-transmission' program (PMTCT). The formal discourse of knowledge about treatment decision making is impeded by people in authority who use language which reinforce stigma. The language Hasnain employs connotes discourses of 'othering' which further feed into the stigma around HIV/AIDS (2004). Hasnain uses the terminology of 'high-risk' groups and furthermore explains that "in Africa everyone is at risk" (Hasnain, 2004:78). This wording is ethically inaccurate as society as a whole is affected by the epidemic (Walker et al., 2004). Thus, discourse that is negotiated by people of authority, such as media scholars or health institution all contribute to how discourse about the disease is constructed in the public.

An example of how a H360° user has internalised similar terminology around 'risk calculation' as Hasnain (2004) employs is visible in the following query by a 19-year-old female user from Johannesburg:

7. "Can u get hiv when lets say a girls has 2 sexual parnter and she has unprotectedd sex with both is there also a high risk."

["Can you get HIV when let's say a girl has two sexual partners and she unprotected sex with them, is there also a high risk?"]

A discourse that creates detachment towards a possible infection rate resonates in this comment. The commenter uses language to create a distance towards the disease by shifting from the vague and generalising second person 'Can u get hiv' to the socially distanced third person 'she has unprotectedd sex', and at no stage does she refer to herself. This type of discourse allows users, through the use of language, to create an imagined distance towards an infection. Metaphorical thinking that produces stigma resonates in discourses about HIV/AIDS. Indeed, "AIDS is strongly linked to sex and death, and both of these, to a lesser or greater extent, are regarded as taboo topics in most social groups" (Horne, 2010: 25). Language, 'Othering' and stigma all form part of discourses that contribute to the construction of discourses around HIV/AIDS. The following query shows how metaphorical thinking is internalised:

8. "How long can a teenager live with hiv"
-Posted by a 17-year-old female South African.

This comment reveals how 'mortal' pictures of the disease are communicated and manifested in discourses around the illness.

Since HIV/AIDS is pictured by the media and other institutions of authority as a 'sinful' and 'mortal disease', people are scared to open up about the disease and take responsibility. Discourse serves to redistribute responsibility and to create an imagined distance towards the disease. The linguistic convention of a metaphor is often employed in order to manage the contact with the disease. "When we talk about 'high' morals, 'falling asleep, or the 'lower' classes we are talking metaphorically and using the same metaphor each time: [...] it acts as the vehicle for a variety of social experiences" (Fiske, 1990:93). Also, whilst employing metaphorical speech, "[t]hinking in terms of 'stages' is essential to discourse about AIDS" (Sontag, 2002:107). HIV/AIDS stages are often referred to as the following by medical discourse: the window period, HIV positive, symptoms of illness more frequent and finally AIDS (Taylor, 2001). Weiss refers to HIV/AIDS as a 'staged disease' that can "[...] unfold from latency (HIV seropositive [...]) to death. To get AIDS is to be revealed as a member of a certain 'risk group'" (1997:457). Therefore, metaphors around the disease become 'normalised' and become part of a discourse around HIV/AIDS. Thinking metaphorically in terms of 'stages' is visible in the following comment:

9. "I wana knw dat wat is an exact tym when a person c h/she is positive". – Posted by an 18 year-old woman from Johannesburg.

["I want to know what is the exact time when a person can see that he/she is HIV positive?"]

The author of Query 9 alludes to physical symptoms that mark a visible outbreak of disease. The person may be distressed about her own well-being or perhaps that of another person. However, her wording displaces the subject away from herself or a loved one, by referring to 'when a person can see that he/she is HIV positive'.

Language creates discourses and with discourses realities are created. People employ metaphors to create a 'picture' of the disease in order to manage and process interactions with it.

10. "Is it true dat hv worms@small holes which we cnt c with our naked eyes?" – 25 year-old woman from Johannesburg.

["Is it true that HIV has worms and small holes?"]

A dysphemism is used in this context and describes the virus as something that is made up of 'worms' and 'small holes'. Using metaphorical language resorts speakers to use dysphemism in order "[...] to talk about people and things that frustrate and annoy them, that they disapprove of and wish to disparage, humiliate and degrade" (Allan and Burrige, 2006:31). Using metaphorical speech eases the process to engage and to overcome fears that are collectively associated with the illness. Society contributes to the manifestation of 'mortal' pictures of the disease, thus, people feel the need to invent symbolic images in order to cope with effects of the disease (Sontag, 2002).

Figurative language shape the ways we think about problems and the types of solutions we investigate. Those pictures become normalised and distributed amongst society, by either word-of-mouth or the authorities, such as media entertainment, political debate, or medical conduct. Thus, discourses that relate to people who are infected by the disease are often characterised by metaphors and the grouping of people as 'Others'.

Stigma is reinforced through constant repetition and vocabulary that frames the disease as something 'deadly'. People are scared to be connected to the disease and the stigma attached to it, so figurative language is used which creates an imaginary distance from it. The displacement also serves to create a 'deadly' picture towards 'others' who are infected, thereby reinforcing stigma. 'Identifying' a person through physical symptoms forms part of a stigmatised discourse, as people who are sick are labelled as 'others'.

The following query shows how a dysphemism is employed:

11. "Does aids kill u?" – Posted by a 13 year-old woman from Cape Town.

The above comment connotes a possible infection as an immediate death sentence. The selection of words is a subconscious practice that enables discourses to operate and to be negotiated.

Fear is also a major factor that influences the construction of discourses around HIV/AIDS. Repression and anxiety seem to affect the production of knowledge around the disease. Thus, the wording of comments and questions confirms that discourses that relate to stigma and mortal pictures prevail amongst society. Using fear as a means to control interaction with HIV/AIDS often leads to classification and stigmatisation of 'others'.

Discourses that relate to testing procedures and uncertainty of voicing their opinion co-exist with stigma:

12. “My boyfrnd keeps having sex wit me en knw i want us 2 have a hiv test am afraid he myt thnk am infectd”. This comment was posted by a 20 year-old South African woman.

[“My boyfriend keeps having sex with me and now I want us to have an HIV test. I am afraid he might think that I’m infected”.]

In this query, the woman implicitly denies responsibility for having sex with her boyfriend ‘My boyfrnd keeps having sex wit me’ – this is possibly because she does not have the power to refuse, or it may merely be a way to deny her own (potentially stigmatising) desire and sexuality. A patriarchal discourse is further apparent, as the young woman fears losing her partner if she raises the issue of testing for their HIV status. People who are infected with the virus often get blamed for their infection as it “[...] is sometimes understood as the fault of someone who has indulged in ‘unsafe’ behaviour” (Sontag, 2002: 111). Thus, people avoid testing or forego treatment as they fear being blamed for contracting the virus or (as in this case) being suspected of having it.

13. “How can i now my statues without going 2 the clinc?” – Posted by a 26 year-old woman.

[“How can I know my status without going to the clinic?”]

The motivation for this query is not clear, but the wish to avoid the clinic visit may reflect the stigma of going to the clinic. According to Mills (2004), “[...] fear of HIV/AIDS-related stigma affects people’s ability to accept and access services from clinics and home-based carers in South Africa” (in Deacon, 2006:421). Therefore, the stigma that is attached to clinical discourse is multi-layered.

A 20 year-old woman contributes to the H360° portal with this comment:

14. “How can a man who have HIV got to have a normal child?”

The woman addresses the concern of family planning whilst being HIV positive but also suggests that HIV positive children (and people) are not ‘normal’. Discourses that enable patterns of stigma or fears of being ‘abnormal’ are issues that need to be addressed through authorial institutions, such as the media, the medical environment or the government.

Discourses that include fear of being excluded or ‘abnormal’ need to be addressed in order to prevent the spread of the disease, as through repression people are not able to identify with the illness. Only if people *feel* positive about their HIV status and demonstrate strong mental awareness, informed and healthy decisions can be made and counter-discourse can become effective.

Another example of how stigma is internalised through discourse is visible in the next comment:

15. "Why do they still allow people living with the hiv virus to have babies?"

- This comment was posted by a 31 year-old South African.

This comment shows that the user is influenced by discourse that relates to stigma and denial, as the word 'allow' indicates a form of infantilisation, which suggests that HIV positive people's reproductive capacity should be kept under control.

People who are infected with the disease are often blamed for contracting it. Sontag explains that "[t]he metaphor implements the way particularly dreaded diseases are envisaged as an alien 'other' [...] and the move from the demonization of the illness to the attribution of fault to the patient is an inevitable one" (2002: 97). Several posts on the portal suggest that education is needed to inform users about PMTCT (prevention-of-mother-to-child-transmission) programs. The MXit forum allows women to access information about individual concerns, such as pregnancy issues. Furthermore, the discourse around stigma needs to be addressed through correct medical education, as false pictures lead to the assumption that people who are infected by the disease are "dangerous others" and not worthy of a dignified life (Sontag, 2002:113). According to Cain et al., "[...] HIV interventionist needs to identify the appropriate language for sexual communication given the participants and the message" (2011:476). Therefore, discourses around transmission need to be addressed to actively counter beliefs that stigmatise people on grounds of physical or social attributes.

Hygienic Discourse

The media relies on novelty and spectacles in order to circulate. Possible HIV/AIDS cures or prevention methods are hyped by the media which in turn influences discourses to flourish that are not medically sustained (Haupt et al, 2004). An example of how an authorial figure might influence public discourse around HIV/AIDS prevention and treatment would be the case of the mediated debate on South Africa's current president Jacob Zuma and his alleged affair with an HIV positive woman. Zuma was accused of raping a woman and in his court case he explained that, after having sex, "I wished to take a shower because it is one of the reasons that would minimise the risk of contracting the disease", a statement which created a furore in the press (S v. J. Zuma [Tr.] at 1007 in Skeen, 2007: 39). Zuma's statement reflects a hygienic discourse, as contracting diseases is often

related to cleanness and a sanitised environment. Therefore, taking a shower might imply to 'wash-off' and to 'clean' oneself from possible germs.

The fact that Zuma's statement became part of a discourse around HIV/AIDS may relate to the president's influential status as a political figure which gives him a great amount of power in shaping a discourse. Alternatively, it may show how widespread the hygienic discourse is which associates cleanliness with health, and disease with dirt, or a state of being unclean. Hence, by normalising a discourse people interpret actions and thoughts according to 'common-sense' beliefs within the public arena. The mediated debate translated Zuma's statement into "HIV prevention by showering" (Suttner, 2009) and the discourse around Zuma's testimonial remained contested in the public domain (Hammett, 2010).

16. "So if u dont knw ur patners status the u have unprotected sex with him/her n him/her being hiv+ and after the sex u take a bath wil u be affected?"

– Posted by a South African woman in 2011.

["So, if you don't know your partners status and you have unprotected sex with him/her being HIV positive and after sex you take a bath, will you be infected?"]

Despite public critiques of Zuma's comment, the hygienic discourse surfaced in several H360° queries. Whether the political affair of Zuma influenced the construction of young people's understanding is not assured, but it seems inevitable to include those concerns in order to raise awareness towards discourses which obstruct critical health awareness."

A number of comments on the H360° platform suggest the influence of Zuma's trial case on public discourse and the resonance of his statement with existing everyday beliefs. Nonetheless, Zuma might be as much a symptom of this discourse as its source.

(Gendered) Power Relations

The H360° queries reveal discourses that relate to gender inequality and gendered power relations, as it reflects the discursive formation of normalising gendered behaviour in a dominant discourse.

Discourses that relate to gendered power relations form part of daily conversations in South Africa and hamper the control of the disease. Informed decision making is largely based on social

conditioning which normalises gendered behaviour and leaves women as the inferior and controlled gender in society. Gendered behaviour contributes to power relationships between men and women. This in turn hinders HIV/AIDS awareness from becoming part of a public discourse that promotes independent and informed decision making. The content of the messages show that women face abuse and that their well-being is lowered in relationships. This behaviour is influenced by discourses which promote male supremacy. Discourses take shape and the following comment shows how sexual violence forms part of the social landscape:

17. "How do you tel a person that vorce you to have sex no".

This question was posted onto the portal by a female user from East London.

["How do you tell a person that forces you to have sex to say no?"]

The freedom to say 'no' is limited by violence and unequal gender relations. From a feminist point of view, her message is important as it informs knowledge construction from a female perspective and contributes to knowledge about women's experiences. The H360° platform centres on health awareness. However, people use also this platform to reach for help and support to disembark from abusive relationships. The above comment portrays how a woman is using the platform to express her concern. The question is written in the second person; hence the wording connotes a perceived distance and perhaps disavowal of her own experience. While she may be trying to find help for someone else it seems more likely that she is hesitant to take ownership of her situation. In addition the question highlights the woman's 'no' pitted against physical force, perhaps even the forcefulness of rape.

Repressing and silencing issues around sex and sexuality, public discourses accept and normalise gendered roles. Those 'realities' contribute to structural violation and the internalization of gendered roles that represent women as inferior in patriarchal societies.

Discourses which contribute to the disempowerment of women are practiced throughout society. Although women can use media and health institutions to empower themselves, many women are sexually and emotionally abused. According to Moffett , "[t]he high rate of rape in particular is also fuelling South Africa's HIV/AIDS pandemic, a major stumbling block to the functioning of the new state and a vibrant civil society"(2006:130). Several comments on the H360° portal show how many women experience abusive relationships and are in need of advice in order to resist rape or deal with its consequences:

18. "What do i do if i get forced to have sex with someone?"

– Posted by a 21 year-old woman.

19. "I was rapd and nw am losin ma weight.is possible am hiv pos."

- 15 year-old woman from Pietermaritzburg

["I was raped and I'm losing my weight. Is it possible that I am HIV positive?"]

The H360° platform allows people to participate in discussions about sensitive topics that were previously legislatively repressed. The discourse around an inferior woman was constructed by the previous government and remains partly visible today. Moffett poses the theory "[...] that sexual violence in post-1994 South Africa is fuelled by justificatory narratives that are rooted in apartheid discourses" (2006:132). In the previous government, unequal power relations were reinforced and hegemonically maintained through the "[...] complex racial and sexual economy premised on the subordination of black women [and] sought to shape the understandings and social definition of rape in a way which excluded any sexual activities on their part being defined as rape" (Moffett, 2006: 139). Therefore, a discourse around power relationships and discrimination not only based on race, but also on gender was created by the former government and because South Africa remains a country that has "the worst known figures for gender-based violence for a country not at war" discourses around sexual violence influences the negotiation of HIV/AIDS discourse (Moffet, 2006:129).

Although discrimination based on gender forms part of a discourse around women and sexuality, discourses which communicate sexual awareness are finding a larger audience in the new democratic landscape (Posel, 2004). Through the empowerment of women, informed decisions around sexual behaviour can be raised. As a consequence, informed decision making contributes to discourse relating to prevention and treatment.

20. "Well im 16 and i want to have sex...what can i do to prevent myself from getting pregnant after unprotected sex?"

From a clinical perspective, the above comment represents a certain level of confusion. After unprotected sex, if fertilisation has occurred, the zygote begins to develop and a pregnancy is considered to have started from the last menstrual period. Nonetheless, the person may be requesting information about post-conception contraception, such as the 'morning after' pill, which prevents implantation.

The syntax of the person changes, as she says “i want to have sex...” but then uses the phrase ‘after unprotected sex’. Either this comment indicates wish-fulfilment or means that unprotected sex is not a problem, or the author might already have had unprotected sex and now wants to take post-conception contraception. Whether the person had sex or not is not important in this context; the main point is the fact that the person is 16 years old and wants to inform herself about sexuality and her reproductive processes.

Posel (2004) demonstrates that more women, like the one who posted the statement ‘I want to have sex’ (see Query 21, above), are gaining interest in workshops and education around health in South Africa. Whereas women under the former government were “[t]ypically silent and unquestioning [...], black women’s growing knowledge of sexual issues and recognition of new rights to sexual assertiveness, sexual pleasure and the right to resist male sexual advances, are seen to undermine established norms of sexual authority, and destabilise the very bedrock of masculinity” (Posel, 2004:61). These emerging cultures of sexualities need to be explored and considered whilst drafting HIV/AIDS intervention programs.

Therefore, discourses that obstruct health and sex/sexuality need to be examined and countered so that information around sex and sexuality can enter public discussion. For example, if ‘silence’ or stigmatisation contributes to a discourse around sex in a certain community, people are unlikely to speak up about their concerns in this respective context.

Religion and Repressive Discourses

Knowledge around HIV/AIDS is highly influenced by various discourses and in particular by religion, as several comments and questions from the H360° platform connote a religious discourse.

Queries are framed using metaphors and symbolic language that connote religious discourse. The discourse around HIV/AIDS stigmatises people who have HIV/AIDS, as the virus is sexually transmittable and (according) to religious discourse sex before marriage is ‘sinful’. Therefore, if people engage in premarital sexual relationships, they are likely to be blamed for contracting the illness. Also, from a religious perspective ‘abstinence’ is promoted and forms part of the discourse around sex/sexuality and HIV/AIDS. From this perspective, sex before marriage is a taboo topic and silenced. People who have internalised a religious discourse and do have sex construct the discourse around HIV/AIDS from a religiously informed perspective, therefore likely to feel ‘guilty’ or ‘ashamed’ of their behaviour. People do have sex, but the fact that religion plays an integral part in

discourses around education and health, and discussion about premarital sexuality is not included, therefore removes education around prevention and treatment of HIV/AIDS from a religious discourse. The discourse around HIV/AIDS from a religious perspective is characterised by binary oppositions, such as good or bad. Therefore disciplinary action is performed by people who have internalised a religious discourse through silencing or suppressing issues deviating from the dogma. Relationships are evaluated from a heteronormative perspective in Christianity; therefore homosexuality is not only stigmatized but highly immoral.

In South Africa, religious discourses about women's sexuality are often influenced by Christian notions of virginity or 'purity'. This discourse stigmatises feminine sexuality and sexual activity as sinful, and applies double standards to women's sexuality, viewing it perhaps as more transgressive and sinful than men's, and setting up a binary opposition between 'virgin' and 'whore' as visible in the following query:

21. "Does it make a girl a whore if shes not a virgin anymore?"

- Uploaded by a 19 year-old woman.

A binary opposition between 'whore' and 'virgin' resonates in the above query. Binary thinking reinforces stigma and stigmatise sexually active people, and women in particular, because of double standards which punish women for being sexually active, while sexual activity may be a positive trait affirming masculinity for men. This type of discourse contributes to the fact that people silence issues around sex/sexuality, as they fear being labelled as a 'whore'.

Controlling the construction of sex/sexual identities through silence and relocating education around sex/sexuality towards the church, a repressive discourse mushroomed which suppressed any deviant form of behaviour or action as a 'sin' which deviated from heteronormative principles. The following example challenges or questions discrimination based on sexuality:

22. "I wnt 2 knw y plls hate gays?" – Posted by a 19 year old woman from Pietermaritzburg.

["I want to know why people hate gays?"]

Posel argues that the South African reluctance to confront sexuality and HIV makes sense because it "[...] is to be expected from a society long accustomed to the secretion of sex to the margins of public debate and exposure, banished by a potent mix of moral/cultural taboos and politico-legal prohibitions" (2004:61).

One of these taboos is masturbation which was often seen as a sinful sexual activity according to Christian discourse. The following comment resonates with traditional bans on masturbation (which Christianity associated with sinful sexuality):

23. “Does fingering yourself daily when you desire get you infected or pregnant?”

– 21 year-old woman from South Africa.

This question is particularly reminiscent of confessional discourse, in that the woman confesses to frequent masturbation but fears some form of punishment such as pregnancy or infection. Not only is the woman worried about contracting a disease or getting pregnant, but it seems she is concerned that performing this sexual activity will lead to some unwanted consequence such as infection or pregnancy. This may also be the reason that her query displaces the action onto ‘you’ and away from herself. The fact that masturbation is associated with sinful behaviour stems from the moral regulations implemented by religious, medical and social purity discourses in the 18th and early 19th centuries in Great Britain (Hunt, 1998). This antimasturbation movement was communicated through medico-moral literature which was “[...] full of dire warnings about the consequences of self-abuse” (Hunt, 1998:576). This hegemonic negative judgement of masturbation remains influential in certain popular discourses relating to sexuality. Some users challenged this dominant perspective in their queries:

24. “What wrng if m doing marstubation?”

– Posted by a 26 year-old woman from Johannesburg.

[“What’s wrong if I’m masturbating?”]

Many queries show how discourses that repress sex/sexuality are internalised and regulated by a grounding religious belief system. If actions, thoughts or even intentions deviate from the dogma, it is equated with ‘sin’. As such, actions are evaluated through a religious discourse. Dogmatic principles that are internalised can influence the construction of what is ‘morally’ acceptable. Mohlakoana explains that “[t]he placement of discussions about sexuality and gender in the church context results in protection and advancement of ideas, even where “morality” continues to serve as a basis for judgement” (2011:86).

25. “Should married couples refrain frm using protectn during sex?”- Posted by a 20 year-old woman from Durban.

[“Should married couples refrain from using protection during sex?”]

The comment is intriguingly framed, as the word 'protection' is euphemistic and does not specify the type of protection. Is the woman referring to condoms or the contraception pill? Either way, the woman is interested in protection methods in conjugal relationships by referring to married couples in general. The discourse that informs her query possibly connotes a religious undertone, as being in a married relationship the discourse around protection changes for her. However, living in times of an epidemic, fear might be associated with not using STD (sexually transmitted diseases) protection.

Religion is an instrument that controls the construction of sex and sexuality through upholding a power relationship. Religion asserts discursive practices which characterise practices as 'good' or 'bad'. Certain comments, such as the following one, draw on religious discourse where disease is seen not only as evidence of or punishment for sin, but is in fact the embodiment of evil spirits or a 'demon'.

26. "Is it true dat HIV/AIDS isnt't just a disease. , its a demon?" – posted by an 18 year old woman from East London.

["Is it true that HIV/AIDS isn't just a disease, it's a demon?"]

This question shows how culturally shaped discourses contribute to misconceptions, and adds to stigma, objectifying and 'othering' HIV/AIDS (Bird, 1996). Describing the disease as a 'demon' acts as a vehicle to express an emotion. In this context, a dysphemism is used which reinforces stigma towards people who are infected with the disease. "An infectious disease whose principal means of transmission is sexual necessarily puts a greater risk to those who are sexually more active – and is easy to view as punishment for that activity" (Sontag, 2002:112).

Discourses relating to patriarchy are presented by the media and also widely internalized by people, and as a result, pictures of what is the 'norm' are reinforced (Baker, 1998). According to Buckingham and Bragg (2003) a discourse around prematurity influences society, therefore this platform serves as a social space to renegotiate this discourse.

27. "Why do girls have sex at such a young age and love to talk about to everyone about what they did to the guy and what the guy did to them while having sex?"
–Posted by a 17 year-old woman.

The discourse around teenagers engaging in sexual relations is highly contested and influenced by a religious discourse. H360° thus represents an alternative space to an orthodox discourse which represses the fact that teenagers and children have sex. People who have internalised a religious

discourse might associate pre-marital sex as a 'sinful' behaviour, and therefore often feel ashamed or guilty when engaging in sexual activities outside wedlock. Also, women might feel forced to live up to expectations imposed by men who ask for conjugal rights from their sexual partner, thereby neglecting their own well-being and the importance to connect to their body in order to construct an informed and healthy sexual identity in relation to the needs of her female body. So, in order for women to create a strong relationship to their body, awareness of gender-based inequality and informed decision making needs to be communicated and internalised by women.

Pressure for young women to embark on sexual relationships and suppress emotional awareness is apparent in comments such as the following:

28. "Wat if im nt ready 4 sex&ma partner wnts sex bt u r afraid 2 loose hm whn u dnt wnt 2 hv sex?" – 17 year-old female user from Cape Town.

["What if I am not ready for sex and my partner wants sex but you are afraid to lose him when you don't want to have sex?"]

The question implies that the woman is worried about 'losing' her man, and this particular wording places the responsibility on her (rather than, for example, phrasing it differently in terms of him 'abandoning' her). This comment, like many others therefore represents how a patriarchal discourse is internalised. The comment also reflects a discourse which connotes an obligation towards sexual interaction, as the person fears that she will lose her partner if she does not agree to it. The comment shows that the woman internalised a discourse about prematurity which entails the awareness of what it means to be "ready 4 sex", but she expresses that she feels pressure as she is "afraid 2 loose hm". The idea of being "ready 4 sex" is also often used in Christian discourse as a justification for waiting until marriage to have sexual intercourse. Finally, her query implies an inferior status in relation to her partner, as she is not able to express her sexual choices without the fear of consequences.

The following comment suggest a discourse around prevention methods that is grounded in belief systems that reinforce violence based on gender:

29. "Is it wrong to have unsafe sex with a virgin?"
– Posted by a 15 year-old woman.

The person seems to be influenced by different discourses. The way the person framed the question is very interesting, as she uses discourses of 'safety' (referring euphemistically to sex without a

condom as 'unsafe sex') and wishes to know whether having sex in this way as a virgin deviates from what is believed to be 'right' or the 'norm'.

31. "Is it possible for kids under age maybe 6-8 having sex, to get infected by hiv if one has it n dont use a condom".

- This comment was posted by a 14 year old female teenager.

["It is possible for kids under the age around 6 to 8 years who have sex to get infected by HIV in one has it but does not use a condom"]

The above queries are chilling and may have some connection to practices which are linked to the belief in a 'virgin cleansing myth' where children or infants are raped in the mistaken belief that it will cure a man from HIV infection (Jewkes et al, 2002).

Discourses around Prevention and Treatment

Discourses around prevention and treatment methods are strongly linked to traditional or indigenous healing methods. The above mentioned 'virgin cleansing myth' is one example of how traditional communication created a discourse around alternative healing methods, but is also grounded in gendered power relations and violence. Fiske explains that "[a] myth is a story by which a culture explains or understands some aspects of reality or nature. [...] A myth, for Barthes, is a culture's way of thinking about something, a way of conceptualizing or understanding it" (1990:88). Myths are shaped through culture and correlate with a chain of events which creates a myth in the end (Barthes in Fiske, 1990). The following comment by a 14 year-old female H360° user is an example of how this myth still has currency:

32. "Dose seep'n with a virgn crue adis/hiv?"

["Does sleeping with a virgin cure hiv/aids?"]

The comment includes many aspects of discursively shaped beliefs. This comment shows that the myth around the 'virgin cleansing myth' is active (if not necessarily credible) in the minds of young South Africans. Furthermore, the medical discourse is defied, by using cultural belief systems as a way of explaining or treating the illness. Cultures of sexualities vary in relation to context, and in this context an alternative healing method seems to inform the discourse.

People might prefer traditional discourses around HIV/AIDS over medical explanations in order to reduce their own distance from the knowledge system in which the disease makes sense. Many comments objectify the disease, or explain treatment and prevention methods through mythological concepts. Fiske explains that “myths mystify or obscure their origins and thus their political or social dimension” (Fiske, 1990:89). The content of the questions show that metaphors, such as dysphemism and euphemisms form part of the structure of the discursively shaped text.

Several posts on the Q&A forum relate to discourses which try to explain, through metaphors and rumours, treatment and prevention methods. The following post is an example of such discourse:

33. “I recently heard that in some country they have cured a man with HIV so does that mean they have the cure and will it be used in all countries?”
–This comment was posted a 20 year-old female South African.

Traditions and social backgrounds contribute to various interpretations of HIV/AIDS prevention and treatment methods. Media campaigns are required to take into consideration the diversity of languages and cultural traditions within this country in order to implement social change effectively. “Effective HIV and AIDS communication involves providing relevant and meaningful information accurately, consistently, reiteratively, and repetitive using multiple methods, mediums, and languages including vernacular” (Haupt et al., 2004:26). This way, discourses that work against medical science can be formed and take effective action in countering the disease. The following example shows how different discourses influence HIV/AIDS knowledge:

34. “Is hvin sex wit a prson who hs int cut their 4skin dangerous?” This comment was uploaded by a 17 year-old woman in the end of 2010.

[“Is having sex with a person who has not cut their foreskin dangerous?”]

This comment demonstrates how different discourses around health influence each other. The woman has internalised a discourse that frames the HI virus and, by implication, all sex as unsafe, ‘deadly’ and ‘dangerous’. The query may also refer to the fact that circumcision can reduce chances of HIV infection.

Racial Discourses

The former South African government wielded enormous legislative power over South African civilians, which traumatized them to such an extent that it is still visible in the current society. “Sex across the black-white racial divide was forbidden, and miscegenation intensely stigmatised” (Posel, 2004: 54). The next comment signifies an internalised discourse around repressed sex/sexual behaviour:

35. “can i have sex with a white doctor?”- This comment was posted onto the H360° portal by a 19 year old female participant.

The question shows how the woman is influenced by different discourses in order to construct her sexual identity. On the one hand, the woman is concerned about how her sexual desire might breach ethical norms forming part of public discourse. On the other hand, residues of racial prohibitions and segregation are expressed through her commentary.

Discourses that continue to reinforce racial inequality are communicated in societies. “Although [South Africa] has changed in profound ways, many features of the apartheid era persist: material inequalities and poverty continue to shape everyday life; race and class continue to define neighbourhoods, and ‘integration’ is a sought-after but limited experience for the young” (Bray et al, 2010). Hence, the online platform provides a space for people to air their questions and concerns in order to overcome repressed and internalised discourses that formed part of the cultural and political landscape of South Africa.

The following question also addresses the question of racial associations between HIV/AIDS and black South Africans:

36. “why we many blacks die of aids alwayz” – 16 year-old male user from Cape Town.

This member of H360° communicates a discourse that relates to race, which has been socially and historically shaped. Furthermore, the wording of this comment generalizes about the infection of a group of people, as it is often noticeable in discourses around infectious diseases (Sontag, 2002). “Every feared epidemic disease, but especially those associated with sexual license, generates a preoccupying distinction between the disease’s putative carriers (which usually means just the poor and in this part of the world, people with darker skins) and those defined – health professionals and other bureaucrats do the defining” (Sontag, 2002:113). A picture of people who are more ‘likely’ to get infected is negotiated by institutions of authority, such as “white heterosexuals who do not

inject themselves with drugs or have sexual relations with those who do” (Sontag, 2002:113). Thus, creating a divide between groups of people, feeding into stigma and classification results in discourses which represents one group of people as more healthy and ‘less likely’ to get infected.

An interesting point to mention is that many users referred to themselves as “Im hiv” or “Im hiv+” indicating that they conflate their identity with the disease (Butgereit, 2007; de Tolly and Alexander, 2009). Therefore, HIV/AIDS is part of young people’s discourse; however, every context is shaped by different discourses and knowledge around the disease and therefore needs to be addressed accordingly.

The queries on H360° are influenced by large bodies of knowledge that are communicated in public; therefore, every query seems to be built on different discourses around HIV/AIDS. Different discourses emerge and co-exist with each other. Salient discourses are identified that contribute to the production of knowledge and discourse around HIV/AIDS by H360° users. Unequal power relationships are expressed through discourses around HIV/AIDS resonating discourses of religion, race, unequal gender relationships and clinical discourse. A discursive formation is perceptible which produces a discourse around HIV/AIDS that connects people affected by the disease with sinful, mortal and fearful pictures, thereby stigmatising people affected by HIV/AIDS. As Goldin phrases it, “[f]ears of the consequences of open discourse and self-identification have created a silence that threatens all of us” (1994:1359). This gains further complexities in the South African context, where a racial discourse informs the construction of power relationships by connecting the disease to a particular ethnic group of people, thereby stigmatising people and reinforcing ‘mortal’ pictures of the disease.

Chapter 5: Conclusion

Although based on a limited number of decontextualized queries, the H360° mobile project shows the need for an awareness of discourse in HIV/AIDS education in several ways. This dissertation reveals the urgency of the need for information and understanding by young South Africans but also the intertwining of knowledge with desire and identity. From a critical point of view, the discourses that emerged on the platform reflect the dire need for information, not only for people who are reaching for help, but also to clarify and negotiate information and knowledge about informed behaviour choices relating to health. The amount of traffic that was reported via the H360° mobile application is evidence for the demand for a space to air concerns, comment or ask questions of private importance. On the H360° platform itself, the Q&A section is the most visited page by mobile users (Final Report, HIV360, June 2012). Although the name Q&A is a misnomer, the traffic on the page supports the argument that people have questions and want to talk about HIV/AIDS.

The H360° platform, as an online network, embraces characteristics that have not been explored academically to a very large extent. Given the structural dimensions of the H360° platform, people participate in order to contribute or to gain knowledge about health. The Q&A does not meet the criteria for a public sphere where discourses about HIV/AIDS are negotiated and communicated. People are able to comment, submit stories or ask questions, but not to discuss or deliberate among themselves. Nonetheless, the H360° platform provides a safe space removed from the stigma-filled environment which characterises much of South African public discourses. By contrast, on the MXit portal, users are only able to ask questions which are not publically accessible, and cannot interact with one another. Thus, it is a huge advantage of the platform that it allows anonymous access to knowledge about sex/sexuality and health.

New technologies create new spaces to communicate, share and represent discourse and power. The queries analysed show the close relationship between discourse, power and knowledge, as argued by Foucault (1979). The platform therefore does represent an alternative approach to medical discourse that is communicated in the public and through health institutions. However, the asymmetrical structure of clinical discourse is also present in the architecture of the H360° platform. The users conform to their roles as the receiver of messages whilst the administrators control the flow of information. This asymmetry reflects the architecture of health institutions, as the 'knowledge supply' remains in the hands of an authority, thus shaping its discourse. Thus, this dissertation employs Foucault's (1979) concepts around the relationship between power and knowledge. The authority of H360° administrators allowed them to define and select answers despite new technological phenomena where power is distributed amongst members and participants via

online networks: “[P]ower relations, that is the relations that constitute the foundation of all societies, as well as the processes challenging institutionalized power relations are increasingly shaped and decided in the communication field” (Castells, 2007:239).

Close analysis of the queries also showed how discourses are re-negotiated in everyday interactions. Teenagers are not passive consumers, but rather create knowledge and construct reality according to discourses they are exposed to (Buckingham and Bragg, 2011). The media, or religious or cultural beliefs might affect the construction of a picture around HIV/AIDS, but many factors shape the production of discourses around HIV/AIDS.

The discourses that are present on the platform are all influenced by power relations, such as medical, gendered or racial discourses. Given the social context of an online platform, a discursive structure is encoded in its architecture, but is also shaped to some extent by its users. The kinds of questions asked reveal several dominant discourses that co-exist with unequal power relationships, such as medical and gendered relationships and identities. Discourses that are expressed on the H360° online education portal reveal the importance of relationships and identities. Through the analysis of comments and questions, this dissertation identified key discourses which may be hindering the efforts of HIV/AIDS intervention programs to raise awareness. Discourses which promote safe and informed behaviour options need to be presented by institutions of authority and to address discourses of inequality in order to implement behaviour change around sexuality and health.

Although the media might contribute to an understanding of how people construct their knowledge around HIV/AIDS, many discourses influence the negotiation of a reality in relation to HIV/AIDS from various socio-political or economical angles. Discourses emerge which relate to health, sex/sexuality, gendered relationships and prevention and treatment options around HIV/AIDS. Therefore, the findings reflect diverse discourses that relate to HIV/AIDS and are internalised by many young South African women.

The queries on H360° support the argument that gendered behaviour is normalised within a heteronormative discourse around health and that health education is ineffective when it conflicts with people’s indigenous or traditional discourses around sexuality and HIV/AIDS.

This dissertation included a feminist theoretical approach to highlight the importance of female subjectivity as key to counteracting the spread of the disease. Therefore, knowing how people construct their sexual identity in a time where HIV/AIDS affects millions of people worldwide is

important to counter the spread of the disease. This dissertation aims to serve as a foundation for further research, for example to analyse how discourses are re-enacted and communicated in everyday settings. Also, the findings are of importance in order to design new platforms such as H360°, or to construct theoretical and practical frameworks and to initiate HIV/AIDS campaigns that promote discourses around collective activism and informed behaviour choices.

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