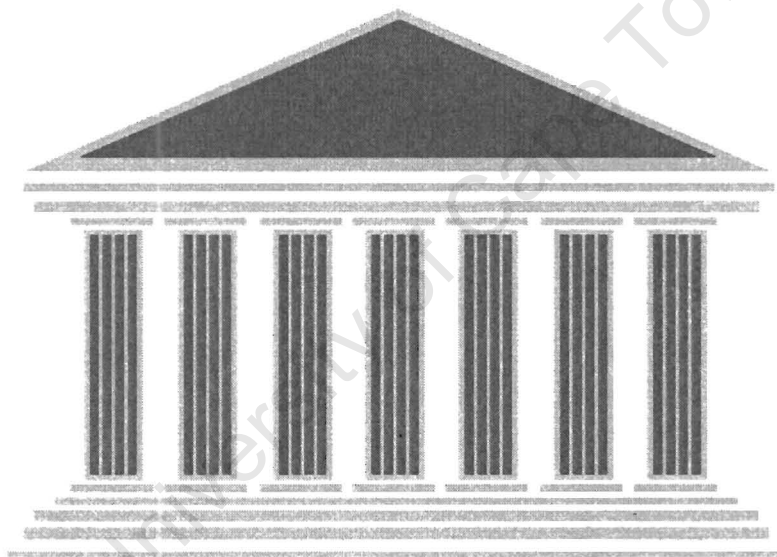


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Socio-cultural beliefs concerning sexual relations, sexually transmitted diseases and HIV/AIDS amongst young male clients at a Gugulethu STD clinic.

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Abstract

This dissertation documents the importance of cultural beliefs, knowledge and attitudes of black male youth in relation to intervention strategies designed to combat HIV/AIDS. I argue that socio-cultural and economic conditions are a major influence on the attitudes of youth towards HIV/AIDS and STDs in Gugulethu. Young men and women's ill informed sexual behaviour has contributed to the spread of the STDs and HIV/AIDS in Gugulethu.

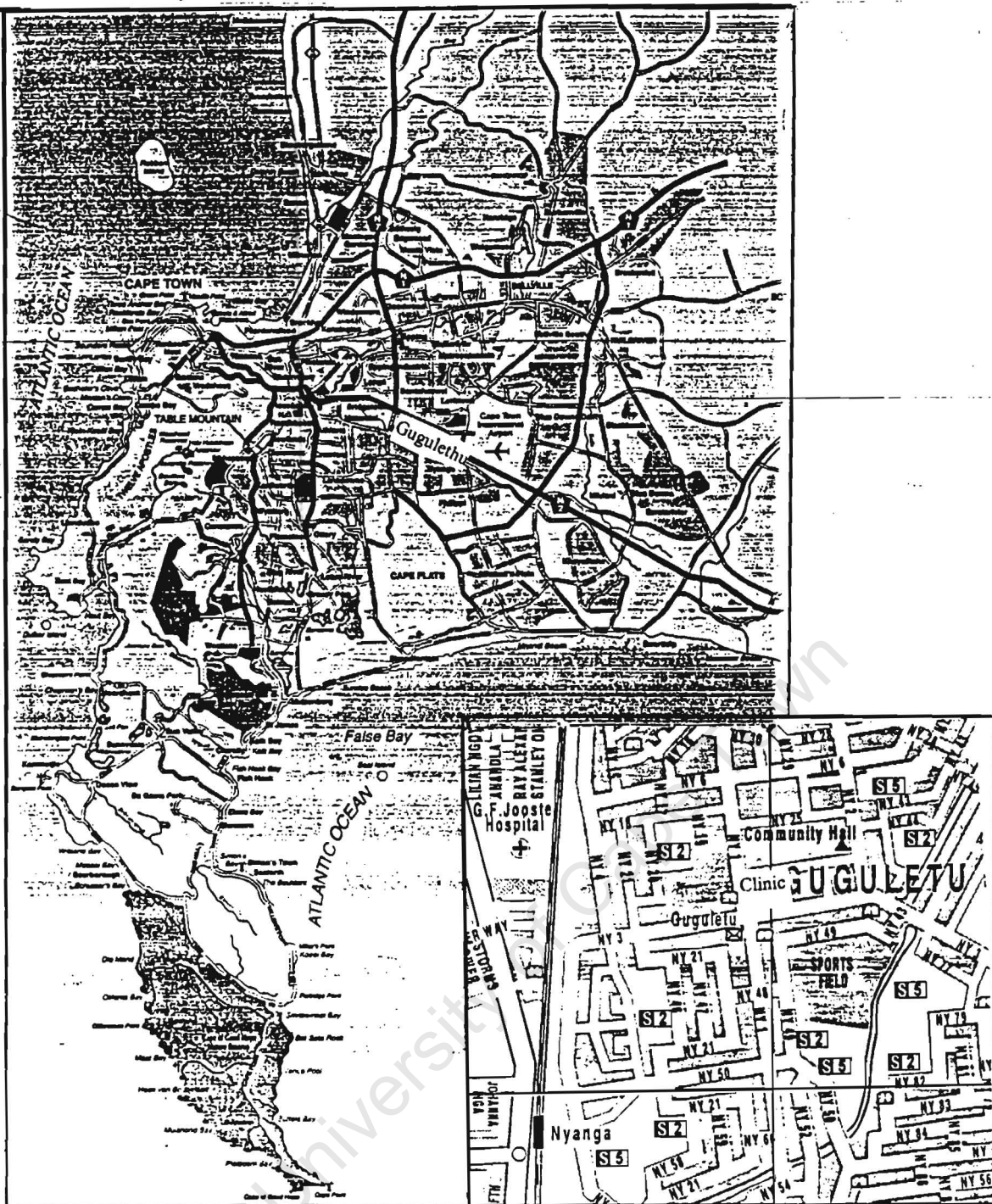
The main findings of this research reveal that: (1) levels of knowledge about HIV/AIDS and STDs amongst different groups in the community are uneven; (2) youth sexual relations and behaviour are the determining cause of HIV/AIDS spread in Gugulethu; (3) the inability of social institutions to communicate knowledge about sex has deprived youth access to crucial information about caring for their health; (4) Traditional medicine is often preferred by males as a mode of STD treatment, despite the availability of western biomedicine at local clinics. Lastly ignorance, denial, prejudice and discrimination have been detrimental to the fight against the spread of the disease, because HIV/AIDS spread has been blamed on the immoral behaviour of others by a society that continues to live with the scourge of the disease.

List of abbreviations and acronyms

AIDS	Acquired Immune Deficiency Syndrome
CBOs	Community Based Organisations
DOH	Department of Health
DOTS	Directly Observed Short Course Treatment
HIV	Human Immunodeficiency Virus
MRC	Medical Research Council
NAPWA	National Association of People Living with AIDS
NIAID	National Institute of Allergy and Infectious Disease
SABAAC	South African Beyond Aids Awareness Campaign
SAMA	South African Medical Association
SAMJ	South African Medical Journal
STDs	Sexually Transmitted Diseases
TB	Tuberculosis
UNICEF	United Nations Children's Fund
VTC	Voluntary Testing and Counselling
WHO	World Health Organisation

Table of contents

Acknowledgements	i
Abstract	ii
List of abbreviations	iii
Table of contents	iv
Map of Gugulethu	vi
1.0 Chapter I	
1.1 Introduction	1
1.2 Objectives of the study	5
1.3 Background of Study: HIV/AIDS pandemic in South Africa	6
1.4 The youth as a target group	7
1.5 Research settings	11
2.0 Chapter II	
2.1 Research methods and data collection	22
2.2 Sampling	23
2.3 Non –scheduled structured interviews	23
2.4 Follow-up interviews	24
2.5 Focus group discussions	24
3.0 Chapter III	
3.1 HIV/AIDS and anthropology	26
3.2 Literature review	26
3.3 Conclusion	34
4.0 Chapter IV	
4.1 Findings	36
4.2 Conclusion	57
5.0 Chapter V	
5.1 Conclusion	60
5.2 Recommendations	62
5.2 List of references	66
5.3 Sample questionnaire	70



Cape Metropole maps (1997/8) showing the Western Cape and the location of Gugulethu. Insert is the Cape Town street index (1998) which shows Gugulethu clinic and Nyanga train station, which is also a transport interchange. The clinic is located next to the community hall and is a 10 minutes walk from the station.

Chapter one

1.1 Introduction

South African debates on the HIV/AIDS epidemic have tended to concentrate on whether poverty is the major factor in the transmission of the disease. Given the history of South Africa with its repressive apartheid laws that impoverished the majority of people, it is not surprising that HIV/AIDS has become a powerful metaphor for poverty and social injustice in the post Apartheid State. In this thesis I examine some of the relationship between poverty and cultural practices that influence risk of HIV infection among youth in poor communities, as compared with other privileged classes in South Africa. It is also clear that like TB or diabetes, HIV/AIDS has become a fatal disease for the poor and a chronic illness for the rich that is shown in the social and geographical spread of HIV related deaths.

My research documents beliefs, fears and practices pertaining to HIV/AIDS and STDs amongst young men in the township of Gugulethu in the Western Cape. It analyses what the youth report about their sexual behaviour and discusses the particular ramifications of male sexuality for women's health and social status in Gugulethu. The social construction of masculinity and peer pressure negatively influences male sexual behaviour and promotes risky sexual activity.

The thesis also shows that males are the dominant partners in relationships, and that it is the males who decide on whether or not to use condoms. Women have little say or no say

in this matter because either they do not have the necessary skills to negotiate for condom use or they do not want to lose their male partners to other women. Males generally believe that it is their right to enjoy sex with multiple partners and are oblivious for the fact that this put them and their partners at risk of contracting HIV.

In the first chapter, I present the background of the study and discuss the rate at which the HIV/AIDS epidemic has spread in South Africa and try to show why the Western Cape has experienced escalating HIV/AIDS cases since 1999. I also discuss my research settings and the reason that Gugulethu was particularly identified as place of study. I also discuss various myths on the origins of HIV/AIDS, which hinder attempts to slow down the infection rate in South Africa. In South Africa, as in Europe or America the AIDS epidemic has provoked racial and xenophobic accusations against foreigners who are often blamed for the spread of the disease.

I also argue that the information on HIV/AIDS is difficult for black youth to access because of the following: a) their parents do not have the necessary information; b) clinic staff though better informed tend to be hostile and judgmental and are shunned by youngsters; c) schools and the media are not educating the youth about HIV/AIDS even though they are better placed to influence youth behaviour. These factors contribute negatively to youth behaviour and understanding about HIV/AIDS and they should be looked at very carefully in order to curb the spread of the disease.

In Chapter II, I discuss the methods I have used in order to collect data for this study. This involved the use of open-ended questionnaires, interviews and focus group discussions. My informants consisted of male and female youths between the ages of 15 and 35, who were selected from clients at a STD clinic. My focus group consisted mainly of circumcised and uncircumcised males from Gugulethu. The limitations and problems that I encountered during my research in this chapter are also discussed.

In Chapter III, I argue that the anthropologist's ability to study and observe human behaviour in different socio-cultural contexts is crucial for: a) understanding the various reasons behind the rapid spread of the disease; b) suggesting solutions and; c) facilitating effective information sharing across cultural boundaries. It is important to know how people think, interpret and understand the cause of HIV/AIDS and STDs in Gugulethu so as to suggest ways of curtailing the spread of the disease. An anthropological study such as this one may help to increase our understanding of people's behaviour.

Chapter IV presents the ways in which youths depict what they do in their sexual and social relationships. I found that their perceptions relating to HIV/AIDS are greatly influenced by peer pressure. Although there is a high level of knowledge amongst members of these groups on how HIV/AIDS and STDs are contracted and transmitted, little or no effort is made to put this knowledge into practice. Generally, the individuals in my study engage in unprotected sex, and in the process, risk their lives because of their desires to experiment, achieve social, emotional, financial support and most of all gain acceptance by their peers.

The complicated categories used to define sexual relations between males and females in Gugulethu have specific meanings and imply many obligations that influence the behaviour of the youth. For example males do not use condoms with their “fulltime partners¹” due to culturally constructed notions of lovers that can be “trusted” and those that cannot. Fulltime partners are considered to be unlikely to carry STDs as opposed to “casual partners²”, who are often blamed for different afflictions. “Fulltime relationships” are characterised by unprotected sex that puts both male and female partners at risk of contracting STDs, including HIV. Without this act of faith, the relationship loses its meaning.

In the final section of chapter IV, I discuss the different therapeutic methods of treatment, the traditional and bio-medical modes with particular attention to which method, is preferred. I describe traditional medicines that are believed to heal infections, and in particular those regarded as cures for HIV/AIDS. The belief in traditional medicine’s ability to cure AIDS is another significant obstacle towards fighting the disease as people are more likely to take risk when they believe that there is a cure.

In conclusion, I argue that the fight against HIV/AIDS in South Africa is a continuing battle that requires positive, radical and collective efforts from policy makers, social institutions, as well as members of communities. More research needs to be done so as to devise sustainable means that will help in curtailing the spread of the disease.

¹ “Fulltime girlfriends” are the girls that males consider regular, loyal and trusted partners with whom they need not use condoms, on the assumption that they may enjoy exclusive sexual access.

² These are partners that the youth sleep with for sexual purposes only, initially there is no emotional attachment but some of these relationships become regular.

At the end of the thesis I make recommendations on how current policies should be modified to deal more effectively with HIV/AIDS and STDs.

1.2 Objectives of this study

Due to young people's sexual behaviour and practices, HIV/AIDS and STDs cases in Gugulethu are increasing everyday. Thus it is important to know the factors that contribute to young people's beliefs, understanding and attitudes toward HIV/AIDS and STDs. The study aims at investigating these factors so as to come up with specific effective areas of intervention that need to be addressed in order to curb the spread of HIV/AIDS and STDs.

The objectives of my study are to:

- determine the mode of STDs transmission amongst youth in Gugulethu;
- investigate the factors behind male sexual behaviour;
- determine the attitudes of the male youth towards condom use and HIV/AIDS and STD prevention; and
- suggest better ways to prevent the spread of the HIV/AIDS in Gugulethu.

In the first section I will provide an overview of the current state of affairs in South Africa and discuss various factors that lead to the rapid and escalating HIV/AIDS cases in the country. I will also look at youth culture and behaviour in the Western Cape as the main cause of the spread of HIV/AIDS and other STDs with more emphasis on Gugulethu youth.

1.3 Background of study: HIV/AIDS epidemic in South Africa

South Africa has one of the highest HIV/AIDS infection growth rates in the world and in 1999 it was estimated that more than 3 million South Africans out of a population of 40.5 million were infected with the disease. In 2000 these figures had increased to 5 million, with 1700-2000 people being infected everyday. (Department of Health, February 2000). This scenario has prompted the government together with other major role players such as NGOs, and CBOs, to establish measures and programmes like the HIV/AIDS Consortium, HIV/AIDS strategic plan and Beyond HIV/AIDS Campaign to prevent the spread of HIV/AIDS. The government has focused its plan on the youth, as the priority population group for HIV/AIDS intervention.

The primary goals of the plan are to reduce the number of new HIV infections (especially among youth), and reduce the impact of HIV/AIDS on individuals, families and communities.

The following general strategies will be stressed:

- (a) An effective and culturally appropriate information, education and communication (IEC) strategy;
- (b) Increased access and acceptability to voluntary HIV testing and counselling;
- (c) Improve STD management and promote increased condom use to reduce STD and HIV transmission; and
- (d) Improved care and treatment of HIV positive people or people living with AIDS to promote a better quality of life and limit the need for hospital care.

The strategic plan is structured around the following areas:

- (e) Prevention
- (f) Treatment, care and support
- (g) Human and legal rights
- (h) Monitoring, research and surveillance

The plan mentions youth as the target for research and intervention. Uganda, which has been a leading example in the fight against AIDS in Africa, proved that focusing the anti-AIDS campaigns on the youth could reduce the spread of the disease. According to available sources in Uganda the rate of HIV prevalence among 15 to 19-year-olds has dropped from 38 percent in 1991 to 7.3 percent in 1996. The results of a survey that was conducted in South Africa (KwaZulu/Natal) in 1991 amongst people of the same age group (15-19), results proved that instead of decreasing, the rate of HIV/AIDS increased rapidly within a space of six months from 1.6 % to 3.6 (SABAAC, <<http://www.aidsinfo.co.za/>>10.08.2000).

The intervention programmes in Uganda were all-inclusive and involved role players including social scientists, religious and educational institutions. The focus was on teaching the young people in primary school the importance of abstinence and waiting for right partners before engaging in sex. Uganda and other countries in Africa have long passed the stage of the epidemic that South Africa is in. South Africa still faces the difficult task of preventing the spread of the disease especially among the youth.

When the disease was first reported in South Africa gay men, sex workers, and migrant

workers were identified in as “high risk groups” (Ncayiyana, 1998, 88:3). Such labelling may have created a false sense of safety since in reality all groups of people are at risk if they practise unprotected sex. The youth, for example has become the focus of many HIV/AIDS researches, and all indications are that they are vulnerable to the disease because of their sexual practices, as they perceive recreational sex as part of having fun.

Young people between the ages of 15 and 35³; represent the most sexually active group, in South Africa as elsewhere in the world. This therefore puts them at “highest risk” of contracting the disease from unprotected sex whether they are gay or straight. In this thesis I argue that youth constitutes a special category of people with specific socio-economic and cultural problems. Young people’s sexual behaviour is characterised by new desires, passion and experimentation.

Most people in their early and late teens are in a stage of sexual exploration and striving for acceptance by peer groups. South African youth are enticed to engage in sexual activities in the early stages of their adolescent lives. Older men also target young girls whom they perceive to be less likely to be infected or are at low risk of contracting HIV/AIDS. Such young women receive financial and material favours, in exchange for sex. Peer pressure, the influence of the global media and the breakdown of forms of social control, contribute to making youth sexual behaviour particularly risky.

³ I have used the ANC definition of youth as people between the ages of 15-35 for simplification’s sake.

The global media has enhanced what is referred to as the “generation revolution.” Genres of music such as *rap*, *hip-hop*, *kwaito*, magazines, movies and television all prompt the youth to party, drink and have sex. The youth are exposed to violence and drugs and have few positive role models in their own communities. Their role models are the *amagintsa*, the “popular guys” that are known to rob people and steal cars to make a living. Young men admire them because they dress well, drive beautiful cars, wear expensive jewellery and have many girlfriends. *Amagintsa* are very popular in many townships in Western Cape, including Gugulethu because of their lifestyles.

According to statistics based on antenatal clinic attendance, the Western Cape was the province with the fewest numbers of HIV/AIDS cases in 1999. However, STDs infection generally, are escalating rapidly everyday and this is bound to result in higher HIV infection as well. In 2000, the Western Cape was reported to exhibit the highest seroconversion rate, suggesting that it would catch up with other provinces in their HIV/AIDS numbers (SAMJ, 88:285-290). The table below illustrates my argument about the increasing HIV numbers in the Western Cape.

Table 1.0: Percentage HIV infection in antenatal clinics by province (1999)

Province	Percentage of mothers HIV	
	1998	1999
KwaZulu/Natal	32.5	32.5
Mpumalanga	30.0	27.3
Free State	22.8	27.9
North West	21.3	23.0
Gauteng	22.5	23.9
Eastern Cape	15.9	18.0
Northern Cape	9.9	10.1
Northern Province	11.5	11.5
Western Cape	5.2	7.1

In response to the escalating HIV/AIDS numbers, the Western Cape Department of Health “recognised the importance of stepping up its efforts to stop the spread of HIV/AIDS. Health personnel aimed at distributing 1.7 million condoms to increase safer sex but exceptional team work and staff enthusiasm saw them distribute more condoms than their target with 2.7 million condoms made available city-wide. The city also increased its ability to attend to sexually transmitted disease by ensuring that quality service, with qualified nurses in attendance was offered at every clinic at every working day”(The City of Cape Town, 2000:5).

Despite the increased distribution of condoms, the Western Cape is recording escalating numbers of people infected with HIV/AIDS. The number of condoms distributed does not guarantee the reduction of the spread of HIV/AIDS and STDs or increased usage of those condoms as some of the condoms would be used and others wasted. The procurement and use of condoms also depends on individual choices and increased distribution does not necessarily mean increased use of condoms.

Meyer’s (1999:16) study of condom fate in South Africa argues that little research has been conducted on the fate of condoms that have been distributed to the public because the intentions of condom procurers vary from individual to individual. Condom distribution, coupled with other intervention strategies and sustainable research on condom fate and usage, treatment of STDs, could hold the key to the prevention of the spread of HIV/AIDS. Although the city of Cape Town has distributed huge numbers of condoms, their usage in the townships is minimal as my data reveals. Consequently there are still growing numbers of STDs cases in Gugulethu.

1.4.0 Research Setting

My research was undertaken over a period of 6 weeks from the 3rd April to the 19th May 2000 while I was an intern at the HIV/AIDS Directorate of the Department of Health in the Western Cape based in Cape Metropolitan. The council already had a project underway studying the control and prevention of STDs and TB, which focused on black community clinics in the areas of Gugulethu, Nyanga and Brown's Farm.

My earlier involvement with High School youth and HIV/AIDS in Khayelitsha in 1999, as part of a medical anthropology project, stimulated my interest in conducting this research. I was able to gain access to various NGOs (like WolaNani "Embrace" Centre and NAPWA-which are based in Cape Town), and governmental organisations such as the Department of Education. My experience with these organisations gave me the foundation, interest and exposure that I wanted in terms of the practical and theoretical aspects of HIV/AIDS research. As part of my internship, the Cape Metropolitan Council asked me to write a report based on my anthropological research.

The terms of reference required me to conduct research on males with STDs (gonorrhoea, syphilis and chlamydia and genital herpes) including those who were HIV positive. I was also required to investigate why black males in the townships were reluctant to use condoms. Interviewing HIV and TB clients, however, was difficult due to time constraints and various ethical issues like confidentiality and gaining of interviewees' confidence, thus the research was limited to STD clinic clients only.

Hunt (1989:11) argues, “fieldwork involves gathering in depth data about the meaning structures, moral codes, and social behaviours of particular cultural groups and individuals, who compose their membership. It is characterised by intensive interaction between researcher and the subjects.” As a result of my constant visits to Gugulethu, I developed a rapport with some of my key informants, and we decided that it was appropriate to meet in other places instead of the clinic. This meant that Saturdays were the ideal days for these discussions and different places were used for our meetings during their free time. As a Xhosa speaking man, I was able to win the confidence of my informants, especially those in my age group, as they were able to talk to me openly.

People reveal different facets of themselves under different sets of circumstances, making it essential to see group members in different situations, not just during formal interviews. Agar (1980:70) argues “ethnographer associates with people over a long period of time because, it takes a while for people to accept your role and begin to accept you.” People are more comfortable being interviewed in their own spaces than they would be in offices or clinics. That is why I suggested meeting them in different places.

As a result,

- a) My informants became more open and relaxed in my presence and developed trust and;
- b) We met when it was convenient to interview rather than the on the day in which they attended the clinic for treatment and STD screening;
- c) Students and those that were employed who could not come to the clinic during

weekdays arranged week-end interviews; and

- d) The stigma associated with constant visit to the clinic, and was removed and;
- e) I was able to speak to other males with STD histories in the community.

Extending my research site beyond the clinic setting proved to be of great help because I gained the confidence of the group as well as other people in Gugulethu as I made constant visits to the area. Parents, relatives and friends of my informants who were willing to help locate the informants allowed me into their homes there by allowing me to extend my study beyond the limitations of the clinic setting.

1.4.1 The Gugulethu case study

The NY 1 Community clinic was chosen as a base from which to reach the rest of the township. I reported to the project co-ordinator in the Fezeka Municipality offices and attended meetings and discussions on Aids Memorial Quilt and Youth, HIV/AIDS and a Video project. The NY 1 Community Clinic is in Gugulethu, Xhosa for “Our Pride”; and a residential area situated 15-20 km from the metropolitan centre of Cape Town. It is one of the areas where black African migrant workers were placed under repressive apartheid laws. They were confined to compounds and hostels according to their ethnic affiliations and their places of origin.

Racial segregation was the order of the day until recently and under apartheid people were classified according to the colour of their skin, denied access to resources, education, employment and human dignity. Apartheid regulations also set up various townships for urbanised “coloured” people and the “black” Africans. As more migrant workers and their families came to the urban areas, the more the townships could not accommodate people which resulted in building of shacks in the yards and later the formation of informal settlements (Phampallis, 1991).

Today Gugulethu consists of three major residential areas, which are divided into nine subsections. There are three types of housing systems; brick houses, hostels and the informal shack settlements where the bulk of the African population still live. These are the unemployed and poor, who have no access to running water, sanitation or electricity in their homes. Ironically most of these informal settlements are named after the prominent people that played a pivotal role in the liberation of the country such as Oliver Tambo, Nelson Mandela, Joe Slovo and Chris Hani.

The population of Gugulethu is made up mostly of people that are unemployed, poor and with low level of education. The majority of the people are from the rural parts of the country like the former Transkei and Ciskei. The few who are gainfully employed are involved in unskilled and semi-skilled labour with only a few involved in high-income skilled labour as the table below shows.

Table 1.1 Number of /African and household heads, employment, unemployment, and education statistics of Gugulethu.

Age	Status	Males	Females	Total
15-60+		25,648	29,268	54,916
	Employed	6,337	7,254	13,591
	Unemployed	4,103	4,548	8,651
	N0 school	2,319	2,202	4,521
	Grade 1-11	2,734	3,805	6,539

Source: (Statistics SA, Census 1996: <<http://www.statssa.gov.za>>)

The language predominantly spoken by the population in Gugulethu is IsiXhosa, with few minorities speaking Zulu, SeSotho, SeTswana and few other South African languages.

Table 1.2 Descriptive Geographical areas by first language of household head.

Gugulethu	Isixhosa	IsiZulu	Afrikaans	SeSotho	Others
Barcelona	1,511	-	14	6	-
Europe	1,540	8	11	4	3
Kanana	1,354	5	6	6	4
Kick	2,652	4	4	1	5
New Rest	1,975	7	22	30	2
Phola park	849	-	6	-	-
Tambo Sq.	587	5	-	2	-
Waterfront	1,077	-	-	-	1
Total	11,545	26	73	49	15

Source: (Statistics SA, Census96: <<http://www.statssa.gov.za>>).

Most of the people in Gugulethu are from the Eastern Cape, everywhere you go you⁴ would hear people calling each other *mkhaya* (homeboy/girl). There were street vendors selling fruits, vegetables and uncooked meat at their stands. Informal taxi drivers using their private vehicles to transport people and operate only within and around Gugulethu while unemployed people young and old stood in front of their shacks and homes passing time. Others played games or listened to local and international music blaring from loud speakers connected to old car radios. These people could not afford fees charged by expensive private clinics and hospitals, and used the public clinic facility when they require medication and treatment.

1.4.2 NY 1 Community Clinic (An overview)

The first day in the field was spent visiting nine clinics in the area under study. I introduced myself to health workers and the head sisters that were responsible for running the clinics. The second day involved settling in the Gugulethu NY1 clinic and to familiarise myself with the clinic staff. I was given orientation in different sections of the clinic. The clinic serves as a multi-functional health facility, and it is mostly used by the residents around the area for family planning, immunisation of children and for directly observed treatment short-course (DOTS) for people with TB. There are usually long queues in every section of the clinic and people are often turned away and asked to return the next day because of the shortage of staff.

⁴ This is how Xhosa people refer to each other if they come from the same rural area.

The majority of clients visiting the clinic for treatment were females, and the male-female attendance ratio was 1:5, through out the period of my fieldwork. On the second day (4 April 2000) there were 45 females as compared to only 13 males. The lower turn out of males was in part because some of them disregard the clinic and visited traditional healers instead.

Doctors visit the clinic only once or twice a week, as they visit clinics in other areas as well. The pressure on the doctor's time was eased somewhat by the presence of medical students from the University of Western Cape Pharmacy department. Some of the patients were referred to these students in the absence of doctors. There was only one nurse and one male volunteer responsible for counselling of the clients. I described the lack of resources and pressure on qualified medical personnel's time to show how directly poverty leads to diminished or non-entitlement to health. I will now look at the problems of misinformation and myths about HIV.

1.5 Myths of the origin of HIV/AIDS in Gugulethu

There are many unfounded myths all over the world about the origins of HIV/AIDS.

Acquired Immune Deficiency Syndrome (AIDS) – was first reported in the United States in 1981 and has since become a major worldwide epidemic. AIDS is caused by the human immunodeficiency virus (HIV). By killing or impairing cells of the immune system, HIV progressively destroys the body's ability to fight infections and certain cancers. Individuals diagnosed as HIV positive are susceptible to life-threatening diseases called opportunistic infections, which are caused by microbes that usually, do not cause fatal illness in healthy people (NIAID, <http://www.aegis.com/>, 21.08.2000).

This is the scientific theory but many people still do not understand the scientific and biological transmission of the disease. The medical fraternity have not been helpful with their green-monkey theories and racists' fascination with exotic African, Haitian sexual practices.

The green monkey theory has it that HIV came from the green monkey's blood, which is used in circumcision rituals in Central Africa. Others say that the virus was transmitted from a monkey to a hunter who was preparing its meat. There is also the myth that HIV was invented in US laboratories for biological warfare purposes, but it got out of control (Dossier, 1990; Crewe, 1992). There is no clear understanding of the origin of the virus though, one theory suggests that it originated from a contaminated polio vaccine, given to children in central Africa in the 1950s. However, this theory has subsequently been disputed, as the vaccine was considered not to have properties that could lead to the virus (UNDP, 2000, 3:2).

HIV was once considered to be a virus that was transmitted between gay men and was referred to as a “gay plague”. Intravenous drug users were identified as being vulnerable to the risk of the disease because of exchanges in contaminated syringes. Later it was found that heterosexuals were also vulnerable to the disease through the exchange of body fluids.

Farmer (1992:58) in his study of HIV/AIDS in Haiti argues that “blame, the search for accountability, accusation and racism, have shaped both responses to AIDS and the epidemiology of a new virus.” HIV/AIDS has been associated with marginalised groups and has led to discrimination. Farmer describes how Haitians were marginalised and blamed in America. They were considered to be the carriers of HIV/AIDS. A similar process was happening in apartheid South Africa, where black Africans were blamed for the spread of HIV/AIDS (Crewe, 1992).

Even in post apartheid South Africa, HIV/AIDS is considered to be a disease that is spread by foreigners, and is one of the driving forces behind attacks on immigrants even in Gugulethu. Matilda, a 26 year old unemployed woman, has been dating one partner for the past 5 years and comes from Queen’s Town in the Eastern Cape. She has lived with her boyfriend in the same shack for the past 2 years. According to her:

*Amakwere-kwere*⁵ (foreigners) were the ones who came with AIDS. If you can

⁵ Amakwere-kwere is a word used in the township to refer to Africans who are from other parts of the continent.

still remember we didn't have these problems before they arrived. Girls are talking about how good *amakwere-kwere* are in sex. They also spend a lot of money on sex, knowing that they are spreading the disease all over the township infecting unsuspecting individuals. We don't want these people here in Gugulethu. I think they should have sex with "their own" otherwise they are going to destroy many young lives.

In Gugulethu the majority of these foreigners stay in the Kick⁶ hostels and the informal settlements of Tambo Square. There are many informants that share Matilda's view and it shows that in the township people have a perception that *amakwere-kwere* are the ones who caused the spread of the disease in Gugulethu. It seems to me that people want to make "others" scapegoats for their dangerous lives. This also shows that people are also distancing themselves from HIV/AIDS as if it is a disease that will infect those that are having sex with foreigners not them. It is this kind of understanding and thinking that leads to people to engage in risky sexual behaviour.

1.6 Conclusion

In this chapter, I have shown that the rate of HIV/AIDS transmission is growing rapidly in South Africa especially in the Western Cape despite government efforts to curtail the spread of HIV/AIDS. The plan that has been put forward by the South African government has focused on youth as the main category in its quest to combat the spread of HIV/AIDS. Learning from the experiences of other countries, like Uganda, could also

⁶ Kick is name given to one of the hostels in the area that were previously use by migrant workers, but now they serve as permanent accommodation for families.

help to avoid the devastating impact of the disease on the South African population.

I concur with Meyer that the number of condoms distributed does not guarantee the reduction of the spread of HIV or increased usage of condoms. I also argue this is an area that still needs intense research in the South African context, as we still do not know how condoms are used.

I have also discussed that black youth are a special category that is at risk of contracting the disease, because of the socio-cultural and economic situations that shape their daily lives. Sexual relations between males and females are often based on material gain and peer acceptance. There have been unfounded myths about the origins of HIV/AIDS, which could hinder the action that should be taken to prevent the spread of HIV/AIDS. Blame and discrimination of certain racial groups have clouded the response to HIV/AIDS. In South Africa people blame *amakwere-kwere* for the spread of the disease instead of focusing on their own practices. In the next chapter I will discuss methods that I have used in order to collect data and some of the problems that I encountered during my six weeks in the field.

Chapter Two

2.1 Research methods and data collection

In this chapter I discuss the methods that I used to collect my data and the limitations and difficulties that I experienced in the field. I collected my data through interviews with STD clients, whilst they were waiting for the doctor in the hall as well as when they were at their homes. I was unable to do participant observation, as most anthropological research would require. I could not spend enough time to observe and or monitor my respondents' daily behaviour. Achola and Bless (1988:88) argue "there are many possible ways of gathering information directly from participants if such information cannot be obtained from observation." I could only conduct interviews, which meant asking questions directly from my informants.

Initially I planned on a systematic random mode of selecting my interviewees by choosing each and every fifth person in the queue. I also wanted to achieve an equal distribution of male and female participants. However, most females refused to be interviewed, for reasons I thought had to do with my not being a doctor or a nurse. I felt that they would have been willing to participate if I was a female, as males were willing to take part in the study. Achola and Bless (1988:83) argue, "throughout the process of data collection the problem of persuading participant to co-operate with the researcher is ever present...participants have the right refuse openly to take part." I decided to interview those that were available and willing to participate voluntarily because I did not have enough time to try other approaches of soliciting for data.

2.2 Sampling

I managed to interview 68 clients that consisted of 53 males and 15 females, some before and others after they had been treated. I conducted the interviews in such a way that they did not interrupt the normal flow of the clinic service. My sample size represented the views of clients at the NY1 STD clinic. Although it was supposed to consist of informants that were between the ages of 15 to 35. I also interviewed five that were below 15 years, which shows that the youth contract STDs in the early stages of their sexual activity.

2.3 Non –scheduled structured interviews

I conducted non-scheduled structured interviews with male and female clients. The interviews took 20 –25 minutes and the answers were written down in Xhosa and later translated into English at home. Since the respondents were approached from the queue I had to finish before their consultation turn came. There was not enough time for the interviews in the clinic during the busy hours which is one of the reasons that I decided to conduct follow up interviews. The reason that I also interviewed women was because I wanted to use their views to compare with that of male. Achola and Bless (1988:88) argue, “there is a need for more specific and detailed information which can facilitate comparison of the reaction of different participants. In this case the interviewer has a precise goal and the type of questions to be answered by all interviewees are fixed.” The female interviews in my study also helped in determining similarities and differences between male and female understanding of HIV/AIDS and STDs.

3.4 Follow up interviews

In order to determine whether the clients understood the counselling and STD screening that was provided by the clinic staff, the results were issued a week after the person had been given treatment. I conducted interviews with 33 clients who agreed to be interviewed for the second time. The interviews also served to establish whether there could be any reported changes in their sexual behaviour and attitudes towards HIV/AIDS and STD after they had obtained their results. The interviews involved asking interviewees about their sexual behaviour after they have visited the clinic. The interviewees reported to be using condoms during the taking of treatment period. After the pain or discharge is gone they immediately revert to their old ways of unprotected sex.

3.5 Focus Group Discussions

The discussions were held in Xhosa and the key points were written down and translated into English at home. I had two different sessions with my groups over two weekends and each discussion lasted for three hours. I had discussion sessions with male clients whose ages ranged from the age of 15-30 to establish the socio-cultural factors behind their sexual behaviour. I decided to divide the informants into two categories, the circumcised and uncircumcised males. The reason for this was to establish which group was more likely to contract STD and HIV and which group should be focused on for intervention. This would help in determining the kind of information on sexual issues that is available to those that have and have not been through initiation schools.

I considered the following factors during the focus group discussion so as to obtain as much information as possible

The demographics: age, sex, occupation and social status-whether the clients were (men *amadoda* (men) or *amakhwenkwe*:⁷ (boys).

The informants' understanding and knowledge of HIV/AIDS and STDs and their ability to translate that knowledge into practice.

I also considered my clients' STD histories, number of partners they have had and the type of relationship they were involved in.

I asked whether the clients discussed about STD and HIV/AIDS information with parents, friends, teachers, health workers and community STD and HIV/AIDS counsellors, and their clients' preferred therapeutic mode of STD treatment.

The questions that I asked were to make sure that the informants were familiar with issues of sex and sexuality before going into discussions. There were many other issues that were raised in the discussions without losing the content and main purpose of the study. I would have also collected enough information in the field but the six weeks was inadequate.

⁷ *Amadoda* (men) and *amakhwenkwe* (boys), refers to circumcised and uncircumcised males respectively. (A Xhosa way of determining the cultural status of an individual in the society).

Chapter Three

3.1 HIV/AIDS and anthropology

In this Chapter I discuss the socio-economic, cultural and political factors that influence risk to HIV. In agreement with scholars like Ralph Bolton (1986), Judith Head (1992) and Paul Farmer (1990, 1992), I argue that poor people are more likely to be affected by HIV/AIDS than wealthier people because of the lack of access to various resources, drug treatments and living conditions that promote immune suppression. For Gugulethu in particular, I argue that social forces and peer influence play a major role in determining male and female youth behaviour, which puts them at risk of contracting HIV. Sexual relations based on faith may lead to risk taking behaviour of the youth characterised unprotected sex with multiple partners. Finally I argue that social institution like families, schools and churches have failed adequately to educate and inform the youth about HIV/AIDS and STDs let alone to install a strong sexual morality.

3.2 Literature review

Various multidisciplinary sources such as sociology, psychology and anthropology were consulted for this research. These include MA theses by DaCruz (1999) and Maphekula (1996), Government publications and AIDS policies documents, NGO pamphlets, newspapers, magazines and Internet sources.

The literature on HIV/AIDS mainly focuses on condom use or gender and power relations. Most researchers present African women as passive individuals who have neither agency nor shared understandings in relation to sex with men.

The anthropological literature has focused on exotic African culture and its peculiarities as the cause of the spread of HIV/AIDS in South Africa and the rest of the continent (Webb, 1997).

More political approaches have highlighted the effects of underdevelopment and poverty as factors contributing to the spread of HIV/AIDS (Crewe (1992); Farmer (1990; 1992)).

In South Africa, anthropologist Lerclerc Madlala (2000), in her study in Durban highlighted the socio-economic dependency of women on men and how this increases women's vulnerability to HIV/AIDS. I have explored all these anthropological perspectives and support and contradict some of them, as they do not apply to my context. My own thesis focuses on the shared sexual relations and categories used by both males and females in Gugulethu that put them at risk of contracting HIV/AIDS. I argue that these categories have specific meanings and obligations attached to them that influence male and female youth behaviour.

I argue that male dominance in sexual relationships does not offer protection against HIV/AIDS or even reduce the risk of infection. Whereas some women allow males to dominate and dare not suggest the use of condoms, others do not use condoms because they simply want to have children. My report presents the different understanding of HIV/AIDS amongst my informants and shows how this knowledge is likely to be translated into sexual behaviour.

My starting point is that HIV/AIDS is a disease that is spread in relation to human behaviour, driven by socio-economic and cultural conditions. By drawing the link between these factors anthropologists are more likely to have insight on the reason behind the spread of HIV/AIDS amongst a certain groups of people.

Poor people are mostly affected by HIV/AIDS, as some of their countries are characterised by unstable nation-states where war, immigration, unemployment, poverty, lack of adequate health care facilities and weak infrastructures are the order of the day. In these countries people are also exposed to diseases like malaria, TB and STDs. Head (1992:16) argues “malnutrition, bilharzia, malaria and measles, among other diseases of poverty, all weaken the immune system and hence the individual’s capacity to fight off new infections.” These diseases, which are a result of poverty and squalid living conditions, are immune suppressants that make it easy for other infections to attack the body.

The reality is that even with advanced technology and funds in rich countries, there is no cure for HIV/AIDS. But unlike poor people, wealthier people have good food, clean water and stronger immunity. In addition they have access to drug treatments that are able to prolong their lives. These anti-retroviral drugs like (Zidovudine (AZT), Didanosine (DDI) and (D4T) are used in cocktail therapy (Evian, 1993:202). They have made HIV more or less a chronic illness for rich people living with HIV/AIDS. These drugs are very expensive and unaffordable for people in many third world countries, where the disease is expected to have devastating effects on their populations.

A political landmark court bid by 39 pharmaceutical companies to stop the South African government from importing and producing cheaper generic drugs was concluded on 19th of April 2001. The government was granted permission by multinational pharmaceutical companies like Glaxo Wellcome, Bristol-Myers Squibb, and Boehringer Ingelheim, to provide cheap drugs for HIV positive South Africans.

The Treatment Action Campaign (TAC), an organisation fighting for HIV/AIDS treatment, regarded this as a victory for HIV positive people as well as for small pharmaceutical companies wanting to produce generic varieties of the drugs. ANC political activist and TAC spokes person, Zachie Achmat also urged the government to immediately deliver anti-retroviral drugs especially AZT to pregnant women and syrups for the newly born (a month after delivery) to reduce the risk of mother to child transmission. This would benefit millions as South African has the largest number of people living with HIV or Aids, 4,7 million, or about 11 percent of the population (UNDP, 2000:2,3).

The link between poverty, underdevelopment and HIV/AIDS is a problematic and complex one. However, it is clear that poor people with few resources are more likely to be infected with the disease and thereafter more likely to die than rich people because of not being able to access health information, healthy living environments or buying available drug treatments. I think concentrating on poverty only will not curb HIV/AIDS spread, as there are other important factors. The key to the understanding of the spread of HIV/AIDS is to look at the sexual practices and how both males and females understand sex and the relations that influence them to engage in risky behaviour.

The language of AIDS has come to associate the disease with death and immoral sexual behaviour giving the importance of sex in human reproduction and relaxation little significance. Bolton's (1992:297) study of sexual behaviour in the USA, argues "the reason that the epidemic is so difficult to deal with is the fact that HIV transmission exists, precisely in the context of some of the most meaningful and emotionally charged experiences of human life, indeed in the very experiences that are life giving." Bolton also gives six circumstances under which HIV is transmitted namely:

- From mother to child—breast-feeding or prenatal, an intimate act, which is a symbol of love.
- From donor to recipient – in the life sustaining context of the gift of blood in transfusion.
- Between individuals –in the shared ecstasy of sexual encounters.
- In the bond of those who share in chemically induced ecstasy.
- The ritual of manhood and or womanhood –such as scarification which creates bonds of solidarity and identification between generations or within them.
- In the bond of caring represented by physician/patient relationships.

Such practises as mentioned above are increasingly associated with illness and death due to the presence and spread of HIV/AIDS. One often ignored but very important HIV potential transmission route that Bolton mentions is circumcision ritual, which is important for two reasons.

Firstly these rituals involve the use of tools that are often unsterilised and can be contaminated with the virus. Rituals like circumcision, which are practised by different groups in South Africa including the Xhosa, and other rituals of scarification are potential HIV/AIDS transmission routes that could also be factors in the spread of the disease if precaution measures are not taken.

Secondly these rituals are vital in Xhosa and other societies as they determine the status and behaviour of individuals as a member of a group. In her study of circumcision among AmaXhosa, Funani (1990:20) argues “circumcision usually signifies the formal admission of the individual into his group or the achievement of a certain status, thus fixing his social position, rights and status.” For young boys circumcision leads to manhood status and community acceptance. It also indicates the right to sexual pleasure and freedom from parental control as well as power over young women and boys. It paves way to marriage, fatherhood and the responsibility that this entails.

Mager (1997:7) suggests “circumcised bodies signalled a change in personality, manliness and identity. Circumcision signified masculine identity and male power, constructed over and against boys and women...it remained the touchstone of Xhosa masculinity.” Members of different age groups controlled sexual relations, and premarital sex was not very common among the youth with girls having to undergo *ukuhlolwa*⁸ every three days, which made it difficult for youth to practice penetrative sex.

⁸ *Ukuhlolwa* is the process of checking girls' virginity by older women of a family or kinship. A girl had to maintain her virginity so that she would not bring shame upon her family on her wedding night.

In contrast to the more recent situation described by Mager, Mayer's (1980:34) study of tradition and transformation among the Xhosa people in Ciskei suggests that the Xhosa were hit by a "sexual revolution" where the youth lost their sexual ethics, including the enforcement of the traditional non-penetrative technique prescribed for unmarried lovemaking *ukumetsha*.⁹

Today penetrative sex is the order of the day and boys use sex as a way of proving to their peers that they are men by having sex with multiple girlfriends in order to avoid being called *izishumane*¹⁰ and laughed at. This pressure from peers that encourage youth to engage in multi-partner relationships appears to have replaced custom and fear of elders as main influence on young people's sexual behaviour.

In gender terms males now have greater control over women's sexuality and have power to decide when or how to have sex in relationships. Although females have information on HIV/AIDS and STDs they are not well equipped when it comes to negotiating for non-penetrative sex or use of condoms. It seems that negotiating sex or condom use is not just about asserting masculine authority, because women can influence their own and men's behaviour if they have the relevant cultural experience and skills.

⁹ *Ukumetsha* is a Xhosa word, which refers to non-penetrative sex and lovemaking.

¹⁰ *Izishumane* refers to boys or men who do not have girlfriends, their peers usually laugh at such people.

Another factor which is a major social problem in Gugulethu is unemployment as some of my informants spend most of the time sitting next to their houses with little or nothing to do. Alcohol consumption is very high and many of my informants go to shebeens to enjoy themselves, especially on weekends. This is where the males meet their friends for drinks and fun and pick up girls. As Evian (1993:9) has noted “with few opportunities for leisure and entertainment, sex frequently combined with alcohol, used as a substitute, as a means to “transcend” the mundane and the daily struggle and to gain, however fleeting, a sense of pleasure, comfort, intimacy and even belonging.”

People use drugs and alcohol in order to forget about their day-to-day realities, which are characterised by a lack of belonging, association and comfort. The use of alcohol blinds individuals or casual partners temporarily from the risk of contracting STDs.

To avoid contracting the HIV/AIDS and STDs it is important that condoms are used and they have been the core of HIV/AIDS campaigns in South Africa and other countries. In order for condoms to be effective as protection devices they require regular and correct use to help to prevent unwanted pregnancies and transmission of STDs. Condoms are not the only means to prevent the spread of HIV/AIDS, however, some writers have suggested abstinence as a better way to prevent the spread of the HIV/AIDS.

Bender's (1991:231) study of adolescent sexual behaviour in America argues “instead of the insistence of condom use it would have been more to the point to equip parents with appropriate knowledge needed to educate their children with the necessary skills on the values of abstinence.” Bender's suggestion is probably inappropriate for South Africa for two reasons.

Firstly many parents do not have the necessary knowledge regarding HIV/AIDS. Even if they have the information, some do not have sufficient time to sit down and have conversations with their children. In our society, parents should not be the only ones responsible for the children, as other social institutions should play a major role in HIV/AIDS prevention. In my study I found out that parents do not discuss sex with children due to cultural barriers that do not condone discussions in such subjects and others do not have the necessary information. I also found out that at school there is no sex education taught to students because of the current curriculum.

Secondly, it is difficult to teach the youth that are already sexually active to abstain because of peer pressure and other social forces. In a study conducted on sexually active adolescents in Massachusetts, Benjamin Bowser and Gin Wingwood established that 98% out of 100 interviewees preferred using condoms to abstaining from sex (1991:231). My informants share the same view that they preferred using condoms to abstaining from sex.

2.3 Conclusion

In this chapter I have shown that that poor people are mostly affected by HIV/AIDS because they cannot afford life extending drug treatments, as compared to wealthier people. Sex in human reproduction is obviously very important, however because of AIDS has come to have moral implications. Its association with death and immorality has overshadowed its purpose of life, pleasure and affection.

Circumcision and other scarification rituals could also facilitate the spread of the disease if shared tools are not sterilised. Ritual experts will need to modify their practices in response to the HIV threat. The transition from boyhood to manhood also poses its own problems as young men consider having multiple partners as part of the status of being men and they want to impress and be admired by their peers.

Finally I have suggested that another hindrance to the control of HIV/AIDS is the fact that parents do not equip children with HIV/AIDS and sex education as some still do not understand the nature of HIV/AIDS. In the next chapter I am going to discuss the findings of my study and show the social and cultural factors that work to disempower young people and hinders attempts to reverse the impact of HIV/AIDS.

Chapter Four

4.1 Findings

In this chapter I present heterogeneous responses given by my informants concerning their understanding of HIV/AIDS. Table 2.0 below summarises the responses given by my male and female informants to questions on sexuality and condom use.

Table 2.0 Interviewee's responses

Total no of clients interviewed N=68	Males		Females	
	N=53	%	N=15	%
Clients who were familiar with HIV & its transmission	38	71	13	90
Those who did not know how it is transmitted & were not sure	15	29	2	10
Clients who contracted STDs through heterosexual sex	53	100	15	100
Clients who do not use condoms	48	92	12	80
Clients who have multiple partners	50	95	3	15
Clients who believed to have contracted STDs by having sex with full time partners	5	10	12	80
Clients who contracted STDs by having sex with casual partners	49	92	3	15
Clients who contracted STDs during sex while drunk	21	40	2	10
Clients who initiate decisions for condom use	52	95	2	10
Clients who argue that condoms are not reliable and can break during sex	46	90	9	65
Clients who argue that condoms are meant for people who do not trust their partners and they promote promiscuity	39	73	11	75
Clients who consulted traditional healers before coming to the clinic	15	29	0	0

Source: field data, 2000.

The low rate of condom use proves the lack of support for the anti-HIV campaign based on condoms use amongst my informants. Condom use does not guarantee protection from HIV infection and males and females alike agree that condoms are meant for people who do not trust their partners and also cause people to be promiscuous even though the men in particular are not committed to one-partner sexual relationships.

In response to questions about why male clients had multiple partners and did not use condoms, the following are some of the responses they gave. A 17-year-old male informant, Khwezi, who was a grade 11 student living with his mother said:

I don't think it is normal to have one girl because it is not nice to eat one kind of food everyday, you have to change your menu. What I am saying is, there are lots of girls in Gugulethu, if you can look in the street you can see there is plenty to choose from. Any normal, good looking and smart guy can have as many girls as he wants.

21-year-old Mfanelo, who is a student at the local technical college and shares a house with fellow students from outside Cape Town, concurs with Khwezi:

All my present and former girlfriends know that I have or had other girls because that is the first thing I tell them. They know that there is no one without a girl or boyfriend these days. These *babes*¹¹ don't like guys who are not involved because they will think there is something wrong with him or he does not know what to do when it comes to sex. In our house if you always come with one girl every time, whereas other guys come up with different girls they will laugh and consider me a one girl- man or *isishumane*.

¹¹ *Babes* is a word used by guys to compliment young and beautiful girls of the same age as theirs.

Kwezi and Mfanelo clearly value multiple partner relationships. From my other discussions, most young people share their views. According to Mfanelo, should one have sex with the same girl, their peers laugh at them. Although both are aware that HIV/AIDS exist, they do not act responsibly, because they are afraid of being humiliated. They want to show their peers that they can have as many females as they wish because it is their right as males.

The number of partners that one has, does not on its own mean that one is unsafe, however, as has already been shown, the use of condoms is considered just “uncool” as being faithful to one sexual partner. It is also the males who decide on the use of condoms, as females often do not have say in this regard. The main factor disempowering young women is their fear of losing their partners. The following cases show the dominance of males in relationships, which also put them and their partners at risk of HIV/AIDS.

Xola, a 27-year-old male informant who explained that he was only dating one girl because of fearing HIV/AIDS argued that:

I am the one who decides when to have sex and a girl must wait till I am ready otherwise if I am not, there would be no sex. Using condoms depends, because sometime I use it and sometimes not. I usually use them when I want to have a long night of lovemaking, only in the initial stages then afterwards I can continue without it. Maybe my girlfriend will eventually ask me for a condom but that would be funny and unusual for a female to ask that from me, it will be like taking over my role as a man.

Thus condoms are used for enhancing his sexual performance and not protecting him from infection. By having only one sexual partner he has taken steps to limit his chances of infection.

Confirming Xola's male centred view of sex is an 18 year old female high school student Nomonde, who said that the reason she did not use condoms was because her boyfriend did not want to use them, and they had never tried even though she knew that he had other partners.

I know that my boyfriend has other partners and we are supposed to use condoms, but I can't ask him because he will go to others and in that way I will lose him. He tells me that he uses condoms when sleeping with them and that I do not have to worry about contracting disease.

Young females seem to have accepted the fact that their male partners dictate matters and that men are the ones responsible for decision making in the relationships, including if or when to use condoms. Apart from women's powerlessness another reason behind this situation is the question of trust, between people who are in love. Leclerc Madlala's (2000:3) study found out that the youth regard sex as necessary, natural and an expression of love and the suggesting of condom as a sign of mistrust. Most of my informants express views on the importance of trust in their partners for maintaining their relationships.

Trust is an important aspect of relationships and trusting one's partner is demonstrated by having unprotected sex. Trust therefore leads to non-use of condoms, as it is associated with intimacy, love as well as the desire to satisfy each other sexually. Most of the female

interviewees said that they want to indicate that they trust their partners, or they do not want to show that they do not trust them. Their definition of trust is based on faith and assumptions that one cannot betray or infect the other with disease. It also confirms the gender inequality inherent in the relationship they engage in. Condoms, in short, are deemed useful for casual sex and meant for used with untrustworthy partners. The following examples show my informants' understanding of "trust" in their relationships.

Goods, a 21-year old grade 11 male student, has had four full time partners in two years. He has had sex with all four of them using condoms and after knowing them for a while, he decided not to use condoms. He told me that:

Condoms can be used in the early stages of the relationship just to show her that you do not know her properly and her sexual background. When you get used to each other and trust each other and you still continue to use condoms the girl will think that you don't trust her or she would also think that you are sleeping around.

In a similar view Noni, a 21-year-old female, who was a first year student in Peninsula technikon and has had three boyfriends in 2000, said that:

When you use condoms it shows that you do not trust your boyfriend or else you are like telling him that you are having other relationships, so you are not worth trusting. Condoms also give a wrong impression that you are encouraging your partner to sleep around.

Thus both men and women associate condoms with casual sex and unprotected intercourse is seen to be associated with intimacy and trust rather than power relations.

The steady or full-time relationships create specific contexts that facilitate risk-taking behaviour and therefore a potential for STD and HIV transmission. If condoms are proposed by one partner-male or female, that indicates that the partners do not trust each other and their relationship would be based on mutual suspicions thereby, putting it in jeopardy. Condoms are usually used with casual partners but considered appropriate with fulltime partners. Ironically, this suggests that people engage in casual sex with partners they do not trust are more likely to use condoms and thereby reduce their chances of infection.

My informants' understanding of trust is based on faith and the period that one has known his/her partner. I was unable to completely understand how my informants differentiate between trusting fulltime and casual partners. Initially they would use condoms with them and after a while resort to unprotected sex, as they become more acquainted with these partners, even though they meet them in *sheebens* and parties where they usually search for sexual partners. In part this may have been a transition from a casual to a steady relationship and the question of trust to knowledge of each other's HIV status is not often a concern as the youth are sometimes under the influence of alcohol.

Alcohol consumption is another factor that contributes to risk taking behaviour, as the following interviews will show.

Sipho, a 20 years old grade 11 student and 1999 "Mr Personality" in his school, told me that he has had sex with many girls that he met in *sheebens* without using protection.

It is very easy to get a girl from *esilotin i* (sheeben) when you are drunk, especially if you have money and buy her these ciders (Hunters Dry) they like, after that the girl is yours. You will both get drunk and go to sleep together without a condom and forget that there is AIDS.

Concurring with Siphso was a 30-year-old male, Zakhele who worked in a local liquor store and he said that:

The guys *esimokololweni* or *esilotini* know which girl is *ngca*¹² then you get tempted so you want to experience that by yourself knowing that there are no strings attached you only wanted to feel her like others. You have to make sure that you have money otherwise, others who are prepared to spend money and buy her drinks will take her.

When Zakhele and Siphso say they want to “taste” the girls mean that they only want to have sex with them, for fun (*ukumwina*¹³). It also shows that they want pleasure from these sexual encounters. Their desire for instant pleasure as well as negative attitude towards condom use that are reinforced by their peers result in frequent and dangerous sex involving the exchange of male and female sexual fluids. Casual relationships are often based on physical rather than emotional attraction. Courting sometimes starts in the sheebens and through exchanges and buying of drinks people end up sleeping together.

¹² *Ngca* refers to something that is beautiful and delicious. In this context it refers to a girl who is able to satisfy males in bed by giving them pleasure that they seek in sexual intercourse. This is considered to be a learned behaviour, which girls acquire through experience.

¹³ *Ukumwina* is when a male has bought a female some drinks so that he can go and sleep with her. This also indicates that the guy “won” the girl despite the competition and the presents of other male pursuers.

Hunt's (2001:8) study of sexual relations in Mandeni and Isithembe informal settlements in KwaZulu/Natal suggests that sexual relations linked to material transactions set the terms for often violent and coercive relationships. Like wise, the girls in my study returned favours by sleeping with the males who bought them the drinks. If they were to refuse to have sex there could be serious confrontations, which could lead to physical harm. Such one nightstands may develop into more regular partnerships and by some method of selection, "casual partners" could also become "fulltime time" partners.

There is a lot of competition amongst females to go out with the "best males"¹⁴ in the community by offering themselves sexually. Some young women demand things in return for dating particular guys. Leclerc Madlala (2001:2) argues "the notion and practice of reciprocity and gift-giving is a pivotal feature of sexual relations that has been documented in most parts of Africa. "Gifts for sex" is a practice that expresses itself most strongly in premarital and extra-marital relationships."

Aviwe, an unemployed 22-year-old female technikon graduate said:

Tell me what are you going to do with a man who is not working and especially if you are both not working, who is going to support you? If you have to introduce that person to your parents he must be smart and well dressed so that your parents know that you are in good hands. That is the kind of men you have to cling to even though tomorrow you can lose him to other women if you do not care for him.

¹⁴ Best males are determined by material possession like smart clothes, money, and car including popularity.

Sexual relations for financial gains like this case of Aviwe are quite common. However, since the majority of my informants were scholars there were other factors and reasons for being involved in sexual relations rather than for financial gain and an example of this is the practice of having *ioutie*¹⁵. The important thing among my female informants is knowing that the males regarded them as “full time partners, something that they can be proud of that brings dignity and respect among their peers.

Informants like Looks and Jongi were involved in relationships that span from 2 months to 2 years which, they refer to as full time or steady relationships. Informants explained how they understand and chose fulltime girlfriends but it remains an area for further research, as it is very subjective.

Jongi, a 21 year old, self-employed male who sold fruits and vegetables in his shack at home said that:

If a girl you are dating is yours after sometime you may stop using condoms. If you had been dating for about a year or longer, any girl that you may date should know her as your first preference of “full time partner.”

¹⁵ *ioutie*, plural *amaoutie* are young uncircumcised males between 15 and 18 years who dress smart at school and good looking. Dating them is not for financial reasons or about material possessions. He may be a young boy who excels at school in sport or in his studies that is fancied by most young girls at school.

Looks, a 19 year-old grade 10 student who was staying with relatives in Kick Hostels said that:

Sometimes you may have many girlfriends *amapholi*¹⁶ (new) and you have to choose the one you like. She has to be beautiful, and then you can make her your *560 or fasty*¹⁷ (full time partner), the one you could be seen in public with. This would be your lady and you do not have to use condoms with her because you would make her *akuthembe*¹⁸ trust you. The remaining girls would be your casual partners or *amataken*¹⁹ and you could also allow them to date other guys as long as you know that you would use a condom with them.

This is clearly the male chauvinist understanding of relationships. The physical appearance of a partner is important, for example, beautiful girls are often preferred and their sexual history is not often put into consideration as long as one is beautiful outside.

The categories of *amapholi* and *amataken* determine who to use condoms with. There is no real difference. It all depends only on the decision that is made by the males. The males consider females clean even though those partners could be STD carriers. The only way to know that a partner is safe is when both partners undergo an HIV test but this is not the preferred method for building trust.

¹⁶ *Amapholi* is the plural of *ipholi*, which refers to girls you have recently started dating and had not slept with yet. Although they might not be virgins they are still regarded as "new."

¹⁷ *560 or fasty* is a township way of referring to fulltime partners. *Girls usually use fasty and the guys commonly use 560* as part of townships language difference between guys and girls.

¹⁸ *Ukuthemba* is to trust someone with your life and involves trusting someone not to infect you with disease.

HIV testing informs people about their serostatus, as well as that of their partners. By knowing each other's status and remaining loyal to one another, the chances of contracting or infecting others with the disease decrease. There are however contrasting views concerning testing as it poses psychological and emotional challenges. The following examples show the difference in people's views concerning HIV testing and these views show different understanding of their knowledge about testing which can be attributed to their access to adequate information.

Chris, a 22 year old employed male, who is a taxi driver and still living with his parents and four siblings said:

It is better not to know your status because what usually kill people is not AIDS or HIV, it is knowing that that you have the disease. It is then that they gradually become thin, and eventually die because of the emotional pain. People will notice and start pointing fingers at you when you are walking on the streets, your girlfriends, friends would avoid you so, I think it is better because no one can tell when you don't know it yourself. There could be many people who do not know and they are still leading normal life with no one laughing at them.

Similarly, Litha, a 30-year-old male, employed as a bus ticket inspector and married with two children, said:

Taking that test is like you want to know how much time you have in order to live because once you know, *iyakutya ngaphakathi*²⁰ (it eats you inside), its better when you do not know although you will infect others if you do not use protection. There may be more people with the disease who still do not know that

¹⁹ Amataken or *take-away* refer to female casual partners that one only see for the purpose of having sex. There is no male equivalent.

²⁰ *Ikutya ngaphakathi* means that the disease is destroying your internals and gradually making you thinner and thinner.

they have it but they do not worry about something they do not see. If you know that does not help because you are still going die anyway, because there is no treatment for the disease, so I don't approve of taking the test.

Portia, a 24 year-old employed female informant who lived with her boyfriend said that she took the test when she was pregnant with her second child and the results were negative. In her view:

I think it is wise to take the test because it is then that you will know that you are infected and then you start to lead a better life. Taking the test does not mean that you could always be positive but it is a very big decision that requires people to be tough psychologically. If you know the type of life you had been leading then that gives you serious reason to be concerned but then if you know that you had been faithful then I think you should give it a try although even faithful partners could get it from their unfaithful partners.

Gcinile, a 16-year-old grade 9 student, had not been tested and did not consider the possibility of doing so. It was the first time that he has had a STD, and the third time he had sex with a girl he considered his full time partner. They both attended the clinic because the nurses recommended that he brings his partner along for treatment.

In his view:

The only time that I can test myself is when I see that my health is deteriorating and there are signs that I may have the disease because, believe me I know them. However since I know that people die of Aids it is better that you test yourself because the very person that you think is "clean"²¹ may be the one that infects you with the disease. If you are faithful you may even know the person who could be

²¹ A clean person is considered to be HIV/AIDS free.

the potential carrier and it is best to first test yourselves, especially if it's a new person but, I have not taken the decision yet. Should people know that you are positive they would laugh at you and you may even lose some of your friends.

Evidently, people know the value of HIV testing but in the context of their daily lives find it potentially too destabilising to carry out.

Two women I spoke to Portia and Fundile, argue that knowing one's status prevents people from infecting others, and can help people to live better and healthy lives. Others like Chris and Gcinile argue that knowing one's status leads to people giving up hope. They also consider that should a person be diagnosed HIV positive it, could result to immediate illness or death. There is also a fear of being rejected and discriminated against by peers and community. One informant, Litha, thinks that rejection is due to the stigma that is associated with HIV/AIDS.

The stigma that is associated with HIV/AIDS leads to prejudice, discrimination and rejection of those who are infected with the disease. A prominent example is that of Gugu Dlamini, an AIDS activist who was stoned by members of her community after she revealed her positive status (Mayburg, 1997). Incidents like this hinder the likelihood of people getting tested because of the fear that they will be rejected, attacked and victimised in their own communities. People living with HIV/AIDS are still discriminated against in South Africa. I asked my informants what they think about people with HIV/AIDS and whether they know of any person that is HIV positive. These were their responses:

Phiwe, a 26 year old employed male, who was in the clinic for TB treatment together with his 21-year-old brother Sanele, said:

There are many cases of people who die in a very strange and bizarre ways but you will never hear in their funerals the cause of their death. Families cover these facts so that they do not become embarrassed in the community. Usually it's the young people who die of things like pneumonia, TB and other causes except accidents. If you could notice that for the past 4 months we have had more funerals for youth than for old people, which was not always the case because usually, it is old people who die of natural causes.

Kleintjie, who was 28 years old and unemployed argued that:

People do not usually disclose that their relatives, friends or close neighbours are HIV positive because they know that people in the community talk about people's problems in *sheebens* and through rumours things spread very fast.

The reason for hiding this is that people will blame the parents for not rearing and disciplining their children properly, or say that the children have been prostitutes or sleeping around, and people do not forget you when something horrible happens, but forget when you have done something good.

The community does not accept the fact that people are dying of HIV/AIDS related complexities, and that the disease does exist. Talking about HIV/AIDS would ensure that the youth not yet infected by the disease would be able to negotiate safer sex. Although the youth have information about HIV/AIDS and STDs, they do not put their knowledge into practice. Unfortunately people do not acknowledge AIDS related deaths because of moral reasons. They even bury their loved ones during weekdays, because of the shame that is associated with the disease.

The media is attempting to teach the young people the necessary skills related to sex and HIV/AIDS through programmes initiated by the government in conjunction with Lovelife. The primary goal of Lovelife is to positively influence adolescent sexual behaviour to reduce teenage pregnancy, sexual transmitted disease and HIV/AIDS (HIV/AIDS and STD Directorate, 2000:9).

When asked about whether the programme is an effective communicative tool, my informants generally had positive views about it but highlighted cultural conflict on sexual matters.

Luvo, a 17-year-old grade 10 student who liked watching television after school said:

It is an educational and informative programme, which allows us to open up about our bodies, sex, teenage pregnancy and AIDS and other disease and many other issues related to youth. I think it is a good programme for those youth that are around Johannesburg line because there is no way that they will go to the rural areas. I do not know how they choose their presenters but you always see the same faces that you see on TV everyday.

Simphiwe, an 18-year-old grade 12 student, concurred with Luvo,

I have seen the programme on TV and we were discussing about it at school with my friends. My view is that it will be an embarrassment for me to talk about what I do, so the rest of South Africa can know. I rather keep that information to myself because when asked how many girlfriends I have, I have to lie and say one, whereas I know that there are many, things like that. The youth that are in that programme are those who are in the multi-racial schools and who can talk English very well. I do not see how it is going to help people like me who are not allowed to talk openly about such issues with our parents.

The arguments presented above by my informants show that the programme does not cater for all youth because of the limitation of its audience. If such programmes are not reaching the youth as they are intended to, the escalating of HIV/AIDS cases would increase. Youth would still consult traditional healers, as this mode of STD treatment is becoming popular in Gugulethu. People believe that illness or STDs can be contracted through the use of witchcraft. Treatments of such STDs are believed to be effectively done using traditional medicines. I am not convinced that television producers pay attention to these realities.

There is a belief amongst the youth that traditional healers are able to cure STDs and even HIV/AIDS. "In all human societies beliefs and practices relating to ill health are a central feature of the culture. Often these beliefs about the origin of a much wider range of misfortune including accidents, interpersonal conflicts, natural disasters, crop failures, and theft or loss) of which ill-health is only one form" (Helman, 1994:7). There is a belief in the effectiveness of traditional medicine in the treatment of diseases, which are caused deliberately through witchcraft by jealous partners. The clinic is used as an alternative for treatment by some of the interviewees, especially by males as they believe in traditional healers.

Traditional healing involves the use of traditional herbs that have been obtained from *ehlathini*²² (forest) by *ixhwele*²³ (healer) in order to make herbs to heal diseases and

²² *Ehlathini* is the forest, which is believed by *amachwele* to be a holy place where their ancestors live.

²³ A Xhosa word to refer to herbalist (specialises in medicine, can be learnt from father to son-the key is to know the environment and different kinds herbs and animal parts essential for healing.

ailments. This is a healing method that requires knowledge of indigenous herbs, and is still used in many part of the country. In Gugulethu, there are several vendors and stores that sell these medicines.

My informants argued that there are diseases that traditional healers can treat which medical doctors and nurses cannot. They also preferred going to traditional healers instead of biomedical doctors because of common belief about the causes of illness they share with traditional healers. Maphekula's (1996) study on the psychological explanation in HIV/AIDS and the relationship between nurses or counsellors and their clients argues that "counsellors explanations are medical and objective with passive notions of bodily process, while clients explanation reflects subjective, personal experiences with conditions attributed to active human agency, supernatural and natural power."

Although nurses and doctors could share the same cultural values and norms as part of a broader community, their therapeutic mode and understanding of the cause of ill health differ from that of their clients. Nurses' understanding is derived from the biomedical domain whereas the clients' is derived from the traditional mode of treatment, which they share with traditional healers.

To summarise, below are the views that my informants gave concerning traditional healers and why they prefer them instead of the biomedical clinics:

There are STDs that traditional healers can heal that doctors cannot heal. For example *igcushuwa* (STD referred to as syphilis in biomedical terms). My informants argue that *ubumdaka* dirtiness/pollution stays inside and resists biomedical treatment and requires traditional medicine for *ukuyikhupha* or getting rid of puss from the penis and leave it completely healed.

People can afford to pay and access traditional healers in their communities. They can pay the healer only when they have money and sometimes they get traditional medicine for free. Healers know that they are using natural herbs that they can access anytime. They also live in the same community as their traditional healers, whereas they found it difficult to go to hospitals and as they are far and always asked for money even when they are in pain and needs help.

Healers share the perceptions, norms and values about the cause of illness and disease with the people. For example if a client *iqhaniwe*²⁴ or infected with an STD goes to a healer, he or she will know what the problem is with the client whereas the nurses will not understand and try to explain things in their biomedical view with the use of medical jargons, which are not understood by clients. Lastly healers give support and privacy to the clients and their families, as they know them closely as clients and members of the community.

There is an understanding that STDs are caused by partners who deliberately infect their partners by *ukuzibamba* or *ukuziqinisa*²⁵ (holding themselves) during intercourse so as to infect them with *ubumdaka* (dirtiness). This is a form of bewitchment, which is usually practised by girls on their partners.

The following example shows the different conceptions about the causes of STDs among clients. Jerry, a 27 years old unemployed male informant said that:

If your *drop*²⁶ cannot be healed in the clinic then you must know that you got it *ngababom*²⁷ (deliberately) from the person you had intercourse with. That means the girl has other intentions of making you suffer if she has something against you. The only place you can go to is the traditional healer so that you can get medicine to heal yourself and advise you on how to avoid similar incidents and give you medicine to protect you from that STD in the future.

According to this definition, when a man has been infected deliberately or sometimes by mistake, it means that the girl has “tightened herself.” Usually the women are the ones who are said to be able to practice this form of witchcraft. A number of reasons for the malicious act on the part of the women that were suggested included:

Ukukhweleta/umona is (jealousy) from a partner who does not want her boyfriend to sleep with other women. This form of affliction is usually done to partners so that if he sleeps with another woman his penis *ayivuki*²⁸ (does not become erect) and they cannot

²⁴ Qhaniwe or ukuqhanwa is a Xhosa word, which refers to someone who has been infected with an STD.

²⁵ *Ukuzibamba* or *ukuziqinisa* refers to the process whereby a girl has tightened her buttocks so that a male could not ejaculate. This is believed to be practised by girls who want to infect their partners with STDs.

²⁶ *Drop* refers to the puss or discharge that comes from the penis when a person has gonorrhoea.

²⁷ *Ngababom* in Xhosa means doing something deliberately with the intention to harm.

²⁸ *Ukuvuka* is when the penis becomes erect and the opposite is *ukungavuki*.

have sexual intercourse. The penis *iyavuka* (fully functional), when the afflicted has sex with the partner with the jealous partner who had afflicted him.

Ukungaqheli (inexperience) on the part of the girl if a girl is not used to doing. Virgins are also believed to infect people if they hold themselves but not deliberately.

Girls are believed to get used or enjoy sex, after three or four encounters even so they have to hide the fact that they are enjoying sex an issue, which I will explain in details in the following paragraph.

When girls had been forced by their boyfriends against their will or engaged in sex without arousal (where there was no foreplay). This act of force is however, not regarded as rape as both male and female share the same views that males are entitled to sex as I have highlighted before. There are many cases that had been reported in magazine about males preferring *ukoma*²⁹ (dry sex). If a woman *umanzi* (wet), which is what naturally happens, she is considered to be *isifebe* or sleeping around. Lastly when girls want to *ukunqanda ukumitha* (avoid pregnancy) so that *angachanwa* or get impregnated.

Should a person suffer from one of the above-mentioned afflictions there are some traditional medicines or herbs that believed to treat such contamination or STDs.

²⁸ *Ukoma* opposite of *ubumanzi* is the dryness of the female genital, which many males prefer. However this means that there is often no foreplay before sex, which could result in painful intercourse for women.

The first and highly rated one is African potato (Hypoxis plant or *inongwe*)³⁰. There is a belief amongst the people in the township that it can heal or cure HIV/AIDS and other STDs and is commonly sold by street vendors. Although the contents of the plants are considered to boost the immune system of an individual its curative effects have not yet been established.

Another medicine is called *umxube wegazi* or blood mixture which people believe that iyakhusela (it decreases the likelihood of contracting disease). This mixture of traditional herbs which is taken over a period of two weeks and thought of as a vaccine that should be taken immediately so that the body can resist any STD. Once someone has cleaned his contaminated blood, a key concept in the Nguni notion of pollution, s/he is cured of that particular STD. However, this does not apply to the treatment of HIV/AIDS.

There is also *ukucima*, which is the method of using the syringe filled with traditional medicine as a laxative so as to get rid of the infection that has been contracted through sexual intercourse. The traditional healer or the client at home administers the medicine, and it is prepared by first cooking and allowing it to cool before being used. The belief in the effectiveness of some of these medicines has led to people also believing that there are traditional medicines that could also heal HIV/AIDS. Although some people know that there has been no cure for HIV/AIDS as yet, there is still continuing use of these medicines to treat other STDs.

³⁰ This plant which is found in KwaZulu /Natal and the former Transkei (*inongwe*-Xhosa/Zulu name used in the townships to refer to the African potato) has been used by traditional healers for the treatment variety of ailments and virus infections to sexually transmitted disease.

4.3 Conclusion

In this chapter I have shown that despite the fact that levels of awareness that AIDS exists are high amongst males in Gugulethu, it is still difficult for them to change their behaviour because of cultural, sexual beliefs that do not allow them to adopt new and safer lifestyles. Power dynamics and gender roles play a major role in the dominance of males in their relations with respect to decisions on sexual behaviour taken by them. As my focus group has shown the information and sex education in the initiation schools should change as they promote risky behaviour that contribute to the spread of HIV/AIDS. Males are encouraged to engage in unprotected sex for the reason of getting pleasure and in the mean time becoming vulnerable to HIV/AIDS, especially those who sleep with girls when their wounds are not completely healed.

The youth are also involved in short term relationships which span for few months up to a year and it is in this relationship that they choose their full time partners. The trusting of full time partners increases the chances of exposure to STDs simply because it is based on unprotected sex.

“Fulltime relationships” are based on faith and trust and therefore condom use is not encouraged in such relationships. My informants’ definition of trusts however is based on faith and merely knowing an individual well, and does not guarantee faithfulness from both either party. Sometime condoms are used with casual partners but in most cases, it seems even casual one-nightstands involve unprotected sex as partners are too drunk to care, or powerless to resist the dominant anti-condom sexual paradigm of the township.

Risky behaviour is heightened where intimacy develops and casual partners are no longer considered disease carriers. In some cases risky behaviour is exacerbated by sexual relations that enable gift taking for sex and in other instances, the assurance of social support for being involved with a particular individual in the community.

The difference between “casual” and “full time” partners is difficult to make as the youth change relationships in a short period. In other words it becomes an individual decision to use or not to use a condom and which person becomes regarded to be a fulltime or casual partner. Alcohol and sex are a common recreation that people use to escape their harsh or boring living realities. Sexual encounters are often characterised by unprotected sex with casual partners or strangers when individuals are concerned only with having fun.

Voluntary HIV testing was not favoured or even properly understood by the youth as the majority considered that knowing their status would hasten the development of terminal illness. HIV positive people fear having to face discrimination and victimisation from their communities. The stigma that has been associated with the disease leads to discrimination and non-acceptance by the community as people with family members who have died of the AIDS related complexities still deny the causes of their deaths.

Television and radio programmes directed at youth and sexuality like “*Scamto*” were not reaching many youths in Gugulethu. Some of the youth have a strong faith in the effectiveness of traditional medicine in healing STDs, and other disease, and some of the medicine is believed to be able to cure HIV/AIDS.

Men were more likely than females to use traditional medicine in order to treat STDs especially those that were considered to be deliberate or attributed to witchcraft. The clients had the same, shared understanding concerning the causes of illness with the traditional healers. Some of the males considered the clinic as another therapeutic option for treatment when traditional medicine has not been effective in curing a particular STDs or disease.

Finally, the battle against HIV/AIDS should be approached from the socio-cultural level because it difficult for people to understand the seriousness of HIV/AIDS. As long as there are people who still believe that there is a cure HIV/AIDS, they will continue to engage in risky behaviour. As my study aims at helping in the understanding the reasons behind the youth's behaviour the next chapter will draw the final conclusions and make recommendations on what could be modified in the current HIV/AIDS policies and campaigns so as to reverse the spread of HIV/AIDS epidemic.

Chapter Five

5.1 Conclusions

The findings of this thesis are that it is the youth behaviour that is the determining cause of the spread of HIV/AIDS in Gugulethu. Condom distribution which has been the core emphasis of the South African AIDS campaigns does not guarantee the use of those condoms as many end up wasted as already been shown by previous research (Mayer, 1998). I have answered some of the reason that lead to non-use of condoms. I found out that condoms use is a subjective issue that depend on individual decision and is not based on the serostatus of an individual. I have also looked at the complexities of sexual relations that do not allow the use of condoms. In Gugulethu the most common reason that I found from my informants is that condoms are not used when having sex with partners that are believed to be “trustworthy” or “full time partners”. My informants think that they are safe from HIV/AIDS, but that is all in their minds as they switch partners frequently and practising unsafe sex.

Although levels of HIV/AIDS knowledge are high amongst males and females, they do not put their knowledge into practice. My informants know how HIV is contracted, transmitted and the ways of preventing transmission but tend to conduct their sexual activities based on myths and beliefs that pay no regard to this knowledge. I think they do not take the danger posed by the disease seriously as they continue to practice risky sex. Some of them, although, having STDs like gonorrhoea and syphilis think that it is still not possible to get HIV/AIDS which is a dangerous assumption as HIV share most of the transmission route with other STDs.

I have also highlighted some of the socio-cultural and economic factors that contribute to youth risky sexual behaviour which are unemployment, alcohol consumption and inaccessibility of health facilities and information. These are some of the many complex issues that need to be addressed before any progress could be made in the curtailing HIV/AIDS.

I also believe that social institutions have played a minimal role in combating HIV/AIDS. Some parents do not discuss sex with their children and in most cases it could be that they do not have the necessary information and adequate time to discuss HIV/AIDS with their children. Even if such discussion were held the youth would still want to experiment on their own because of peer pressure and curiosity. Although there is a policy on HIV/AIDS in education the school curriculum still does not cover sex education in the classroom where it would have been easier to educate the children given the lack of such information at home (South African Curriculum 2005:2000). The media also does not address and promote some of the fundamental aspects of prevention that could be useful and be understood by black communities like the traditions of *ukuhlolwa* and *ukumetsha*, which I think should be reintroduced in our societies.

Some of the males preferred traditional mode of therapeutic treatment to western biomedicine and this result in low male turn out rate in the clinic. The difference in terms of understanding between the clinic staff and the clients in their beliefs of the causes of illness and diseases clearly suggest a major cultural divide. Some of the traditional medicine is believed to be able to cure HIV/AIDS, which could be the reason why risky sexual behaviour makes it difficult to curtail HIV/AIDS.

5.2.0 Recommendations

In the light of the of the above conditions a number of policy recommendations could be made in the following areas, so as to come up with effective and decisive means to curtail the spread of the disease.

5.2.1 Sex education – family vs. school

As parents have failed dismally to adequately educate the youth about sex and their bodies the role of the school should also be that of sex education. Young people should be taught about the right ways to use and dispose condoms, whereby they have to check the dates and how to properly use them so that they do not break during sexual intercourse. This kind of information could be conveyed in local clinics, schools, through the media and traditional institutions like initiation schools.

5.2.2 Safer sex

Programmes of prevention should also focus more on abstinence and there should be rewards like medals, virginity certificates that are offered to young women who abstain from sex until they are more than 18 years old. The youth should also be taught of the other ways to make love besides having penetrative sex, such as the traditional Xhosa way of *ukumetsha*. Some communities already organise groups so that young women are inspected-*ukuhlolwa* by female elders in order to restrain them from having sex until the right time. This could be expanded to include all young people and promote the responsible use of sex in mature relationships.

The youths that are already sexually active should be encouraged to undergo VTC so that they know their serostatuses, together with their partners. They should also be encouraged to undergo VTC test before sleeping with every new partner especially if they intend to have a long-term relationship otherwise they should frequently use condoms. They should be taught to have responsible attitudes towards others. Those that are already positive should be taught not to infect but help and inform others that are not positive.

5.2.3 Youth culture

As the youth sexual behaviour and culture involves penetrative and non-use of condoms it is important to help them change their choices and adopt more cultural sexual practices. Peers should also be motivated to play a more positive role so that the youth stay away from alcohol, drugs and risky sex. It is also important that programmes like *Scamto*, a youth and sexuality programme that was broadcast by ETV-on Thursday at 6:05 p.m. are introduced at community level, by having discussions initiated by peer facilitators in the communities, this will enhance to actively participate in such programmes.

There should be HIV/AIDS youth counsellors like respected members of the community, volunteers from local communities who the youth are familiar with. Those people should be sexually active and speak the same language as the youth. Example of this is the sportsmen against crime on (*Mabaleng*-sports programme- where sport stars voice their views on HIV/AIDS). In Gugulethu a person like 22-year-old Andile Sixaba, who is a

prominent football player for Ajax Cape Town and Bafana Bafana can be a suitable example to the youth because of his background before becoming successful in his soccer career. There should also be community-based programmes organised by schools and churches like drama, dance that will educate the youth about various HIV/AIDS and STDs related issues and communication skills so they could concentrate on other activities, which could keep the youth busy during weekends.

5.2.4 Education, health and finance

More resources should be allocated to establish community-based organisations that will focus on prevention and education about HIV/AIDS and promotion and fundraising should also be encouraged and sponsored. More money should also be put on programmes of prevention that are directed at young women empowerment and assertiveness training.

Sheebens should be provided with free condoms in their toilets whereby the owners would be responsible for making sure that people always have access to these free condoms. *Kwaito* musicians, soccer stars and other entertainers ought to be invited to perform and educate the youth about HIV/AIDS and their bodies in the sheebens, where young people congregate.

I also think that there should be programmes offered by the government and NGOs to train more health counsellors to help in the shortage of staff that I highlighted. Traditional healers should be educated about HIV prevention and condom use and people from the community should be trained so as to provide home-based care. Finally, for future research more resources should be made available for anthropologists to conduct more research on HIV/AIDS.

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Appendix I: Sample Questionnaire

The following questionnaire was handed to all the clients that were interviewed and to the individuals in the focus group to determine their views. The questions were transcribed from Xhosa to English.

1. What do you know about the terms STDs and HIV/AIDS and how are they contracted?
2. Did you know that HIV is a sexually transmitted disease?
3. What can you do to prevent contracting HIV or STDs?
4. Do you use condoms and (if not why?) are there other reasons?
5. What could be the reason that you have STD and have you had any previous encounters with the disease?
6. How many partners do you have and does your partner know that you have a STD?
7. Do you discuss sex with your partner/s, parents, friends, teachers, health workers, community HIV/AIDS, listen or watch HIV/AIDS, STD and sex related programmes in the media?
8. Do you have access to condoms in your community (besides the clinic)?
9. Have the nurses explained to you why they have taken your sample?
10. What does it mean when your results say that you are reactive or non-reactive?
11. Is there anywhere besides coming to the clinic, that you can receive treatment for STDs? If yes please, tell me where and how?
12. Do you believe in traditional medicine? If yes why?
13. Do traditional healers know or advise people about HIV/AIDS and STDs. Do you think they have a cure for HIV/AIDS?
14. Do you think that traditional healers have a role to play in the prevention of the spread of HIV and what role can they play?