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**Deafhood and Exclusion: A Study of Deaf adolescents' perceptions of
loveLife's HIV and AIDS communication campaigns.**

by

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*A minor dissertation submitted in partial fulfilment of the requirements for the award of the
degree of Master of Philosophy in Development Studies.*

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DECLARATION:

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

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ABSTRACT:

The South African government, in conjunction with a number of non-governmental agencies, has created a number of public awareness interventions to combat the HIV and AIDS scourge. Despite efforts to ensure that all communities get the information they need, some communities still face challenges when trying to access information. This thesis examines d/Deaf adolescents' perceptions of current *loveLife*'s HIV and AIDS campaigns. In particular, the research conducted focused on participants' perceptions around issues of access to *loveLife*'s HIV and AIDS campaigns. Data was collected through a questionnaire survey, a focus group, individual interviews and a HIV and AIDS campaign design task. The findings reveal that, firstly, the participants are aware of what *loveLife* is and what they aim to do, and; secondly, participants have very limited access to *loveLife*'s print and television campaigns. Based on these findings I argue that this limited access is due to conceptualisation of communication primarily with respect to hearing communities. This in turn leads to the exclusion of d/Deaf communities from the fight against HIV and AIDS.

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ACRONYMS:

AHRTAG	Appropriate Health Resources and Technologies Action Group
AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress
ARVs	Antiretrovirals
AZT	Azido-thymidine
CBO	Community-based Organisation
D&HH	Deaf and Hard of Hearing
DeafSA	Deaf South Africans
DMF	Dimethylformamide
DoE	Department of Education
DoH	Department of Health
FBO	Faith-based Organisation
gB	groundBREAKER
GCIS	Government Communication and Information Services
HIV	Human Immunodeficiency Virus
IAAF	International Association of Athletics Federation
ICC	Intercultural Communication Competence
IDC	Inter-Departmental Committee on AIDS
LO	Life Orientation
MNC	Multinational Corporation
NACOSA	National AIDS Coalition of South Africa
NAFCI	National Adolescent-Friendly Clinic Initiative
NGO	Non-governmental Organisation
NSP	National Strategic Plan 2007 - 2011
OVC	Orphaned and Vulnerable Children
PANSALB	Pan South African Language Board
PMTCT	Prevention of Mother-to-Child Transmission
PSAs	Public Service Announcements
R&D	Research and Development
SABC	South African Broadcasting Corporation
SADC	Southern African Development Community
SA MCC	South African Medicines Control Council
SASL	South African Sign Language
SLED	Sign Language Education and Development
SSA	Sub-Saharan Africa
StatsSA	Statistics South Africa
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
TAC	Treatment Action Campaign
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USA FDA	United States of America Federal Drug Agency
VCT	Volunteer Counselling and Testing
WHO	World Health Organisation

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CHAPTER 1: INTRODUCTION

Sub-Saharan Africa (SSA) is the epicentre of the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) pandemic. According to Pridmore and Yates (2006: 2), HIV and AIDS is the leading cause of death in the Southern African Development Community (SADC). Statistics South Africa (StatsSA, 2010: 6) estimated that in 2010, 10.5% of individuals aged between fifteen and forty-nine years are HIV positive. This is an increase from 10.3% in 2009. Gouws & Abdool Karim (2005: 48) argue that there is evidence that the epidemic is levelling off. Research conducted by Shisana, Rehle, Simbayi et al (2009: 31) corroborated this. The search for innovative ways to prevent the spread of the disease and mitigate its effects needs to continue. These solutions, which must do more than simply disseminating information, must target everyone.

Media platforms, namely television, print and the internet, are being increasingly used to disseminate public health information. *loveLife* uses these platforms primarily to promote HIV-free living for the country's adolescents. This thesis aims to explore Deaf adolescents' perceptions of their access to *loveLife*'s campaigns. In particular, this thesis is concerned with Deaf adolescents' perception of the manner in which *loveLife* presents sexuality-related information in their campaigns. The lack of research on the sexual socialisation of Deaf adolescents influenced the decision to focus on this group. *loveLife* is one of the most notable responses to the country's HIV and AIDS epidemic. It is for this reason that *loveLife*'s campaigns form the basis for this research. The decision to utilise *loveLife* as the basis of this research was also influenced in part by the near complete absence of the portrayal of Deaf individuals within its campaigns, and the media in general.

This chapter will begin with a discussion of *loveLife*'s communication strategies and the organisation's key programme elements. This will be followed by a discussion of disability in relation to HIV and AIDS and reproductive autonomy. The chapter will then go on to outline the impact of Deafhood on health literacy. The research question and objectives will be presented after this discussion. The chapter will end with a brief description of the organisation of subsequent chapters.

1.1. *loveLife*'s Communication Strategies:

As a non-governmental organisation (NGO), *loveLife* promotes HIV-free living amongst South African teenagers. It was launched in 1999 with the South African government's support. It also garners support from international organisations such as the Bill and Melinda Gates Foundation and the Henry J. Kaiser Family Foundation to mention a few. The project's target audience ranges from twelve to seventeen years old. Coulson (2001: 3) noted that *loveLife*:

“combines high-powered media awareness and education with the development of adolescent-friendly reproductive health services and other outreach and support programmes for hard to reach youth in poor communities.”

loveLife has incorporated issues of sexuality and relationships as well as healthy living into its communication strategies.¹ These are issues, which Kelly (2004: 47) highlighted, as the two principle areas around which HIV and AIDS programmes should be developed. Launched in 2006, the *HIV – Face It* campaign sought to break the cycle of HIV infection. This campaign adopted a holistic lifestyle approach to get individuals to examine their personal risk. The campaign aimed to mitigate the disease's effect at three levels. Firstly, the campaign mitigates the disease's effects prior to infection. This was in a bid to prevent further infection. Pridmore & Yates (2006: 44) noted that *loveLife* prevention messages advocate for the reduction of sexual partners as well as consistent condom usage. Short, punchy statements deliver these messages. This is undertaken in the hopes that individuals will change their behaviour accordingly. Secondly, *loveLife* hopes to mitigate the effects of the disease post-infection. Programmes that help individuals deal with their HIV-positive statuses ensure *loveLife* accomplishes this aim. *loveLife* hopes that these programmes also assist individuals deal with the HIV-positive status' of others. Thirdly, *loveLife* aims to mitigate the effects of the disease post-parental death. At this level, *loveLife* assists children to deal with their loss and increased poverty.

loveLife's 2007 communication strategy was predicated on the following five key features of

¹ See Appendix A for a time map of *loveLife*'s communication strategies.

the love life generation: (i) future-focused; (ii) gender-equal; (iii) committed to sexual change; (iv) entrepreneurial, and; (v) body-wise. This is expressed by *loveLife* (2007c: 4) as the:

“got ambition; power-to-decide, and; don't-want-HIV generation!”

The campaign aimed to disseminate key information along these tenets. With respect to the “got ambition” aspect, *loveLife* (2007c: 24 – 35) provided information on balancing life, the nature of love, puberty and being true to one's self. *loveLife* (2007c: 36 - 53) also provided family planning information, equal relationships and living with HIV. The provision of information on HIV testing; condom usage, and; circumcision pertains to the third element of the love life generation.

Overall emphasis is placed on the future. A future one can be part of by being: future-orientated; committed to gender equality and social change; entrepreneurial, and; body-wise. *loveLife* (2007: 2) states the love life generation is also characterised by passion, determination and not wanting HIV.

1.1.1. Key Programme Elements

i. Multimedia Campaigns:

The multi-media component of the campaign is comprehensive. This ensures wide coverage throughout the country. The use of television, print, outdoor media, the internet and email ensures maximum exposure of the message. In its entirety, *loveLife* media aims to prompt informed discussion and behaviour change. The intense television public service announcements (PSAs) and series are broadcast across the three South African Broadcasting Corporation (SABC) stations. The thirteen-part annual television show is called *S'camto groundBREAKERS*. According to *loveLife* (2004: 11), their radio campaigns reach 97% of the country's households. PSAs are also broadcast across the sixteen SABC radio stations. The programmes are broadcast across only eleven of the radio stations. All the content is

broadcast in each of the eleven official languages. It bears mentioning that young people produce and present some of the radio programming.

The youth magazine, UNCUT, forms part of the campaigns print component. This lifestyle magazine has a monthly print run of approximately six hundred thousand copies. The magazine is distributed via the Independent Newspaper group.² Additional copies of the magazines are distributed in various *loveLife* sites, as well as schools and clinics. The magazine is published in both English and Afrikaans. It has a wide target audience, which ranges from twelve to twenty-five years. In addition to the magazine, *loveLife* produces and distributes HIV and AIDS and sexual health educational material for young people and their parents. This level of targeting information is carried through to the website content. The site has youth, parent and corporate portals. *loveLife* (2004: 12) does note that internet access in South Africa remains limited. The internet and email components do add an element of interactivity to the whole campaign.

The outdoor media campaign houses utilise both print and television. Billboards and signage spread *loveLife*'s messages. Outdoor televisions at select taxi ranks across the country are also used to broadcast PSAs and programmes. *loveLife* also broadcasted their PSAs in local cinemas, namely Ster Kinekor. They utilised popcorn boxes to spread their messages. The multimedia campaign does not stand alone. The activities of the groundBREAKERS and gogoGetters support the multimedia campaign.

ii. loveLife Programmes: gogoGetters and groundBREAKERS

The *gogoGetters* programme provides organised support and capacity building to older women, affectionately known as *gogos* (grandmothers). GogoGetters are leaders and support workers. In the HIV and AIDS era, and as Harrison (as cited by *loveLife*, 2007a: 1) argued, *gogos* have had to step up as a “stabilising influence in the lives of young people.” They also recruit other older women to widen the network. Working alongside the *gogoGetters* are the *groundBREAKERS* (gBs). According to *loveLife* (2004: 14), they are at the forefront of all

² The Independent Newspaper Group includes newspapers such as The Star and Pretoria News in the Gauteng region, and; the Cape Argus, Cape Times and The Daily Voice in the Western Cape. It has a wide readership, spanning from the working class communities to the middle and upper class communities.

loveLife's activities. gBs are full-time volunteers who are trained and equipped with motivation and leadership skills. They form a national youth volunteer service corps. The gBs are aged between eighteen and twenty-five years old. With their aid, a multi-media campaign with nationwide community-level outreach and support programmes for the youth is rolled out. They are responsible for the mobilisation of twelve to seventeen year olds through various *loveLife* style programmes until they graduate. Each gB recruits five volunteers, known as *Mpintshis*. *Mpintshis* assist gBs to graduate participants. *loveLife* (n.d.: <http://www.lovelife.co.za>) note the extensive use of role modelling and peer interaction to effect behaviour change within their programmes. The aim is to get *Mpintshis* to live a 'loveLifestyle'. This lifestyle renders one fit, healthy, and able to deal with and talk about (peer) pressure. *loveLife* (n.d.: <http://www.lovelife.co.za>) hopes that the gB experience gives “real experience to the *loveLifestyle* concept”. It needs to be said that there has been at least one Deaf gB to date.³

iii. Y-Centres:

These centres are also referred to as *loveLife* Hubs. They are multipurpose youth centres located in over seven hundred of the poorest communities⁴. These centres provide recreation and skills training as well as sexual health education. The aim is to foster the positive social development of the youth in these various communities, by providing voluntary counselling and testing (VCT) services. These VCT services are provided within clinics that were created as part of the National Adolescent Friendly Clinic Initiative (NAFCI). This initiative was launched in conjunction with the Department of Health (DoH). It is a drive to ensure that adolescent health services are available in South Africa's five thousand public clinics. The peer component of this venture, spearheaded by the gBs, seeks to encourage youths to use the clinic services.

Y-centres also house a radio station and computer training facilities. The centres also offer recreational activities such as dance and basketball. Additional elements are developed in conjunction with the community.

³ This young man was profiled in an article titled 'The Right Sign', *UNCUT*, May 2009, Issue 67.

⁴ See Appendix C for a map illustrating the distribution of *loveLife* programmes across South Africa.

iv. Additional Elements:

Additional elements of *loveLife* include the *loveLife* Games, *loveLife* franchise and *ThethaJunction*. The *loveLife* games offer *loveLife* a platform for face-to-face interaction. The impetus behind the *loveLife* games stems from the increasing acknowledgement of the value of sports to health and wellbeing. *loveLife* (2007b: 2) notes that:

“[b]enefits include the physical expression of fitness and wellness and its associated rewards, shaping and realizing of personal goals, and creating a non-intimidating environment for discussion of healthy sexuality.”

The *loveLife* franchise is a network of more than one hundred community-based organisations (CBOs), faith-based organisations (FBOs) and youth organisations. Collaborating with these organisations broadens *loveLife's* outreach at the local level. Lastly, *Thethajunction*⁵ is a toll-free sexual helpline offers teenagers and parents counselling services.

It is important to note that there are many responses to the epidemic. The Department of Health (DoH) in partnership with various agencies such as Soul City⁶ has embarked on a number of other public health communication initiatives. Atkin (2001: 57) identified three types of communication campaigns. First, awareness campaigns aim to create recognition of a topic. They also provide cues on what should be done and when. Instruction campaigns provide ‘how to do it’ information. Lastly, persuasive campaigns give people reasons to adopt the preferred behaviour. Each message is framed according to what is already known about the disease, and whether the aim is to promote prevention or treatment.

⁵ *Thetha* is an isiXhosa word that literally means ‘speak’.

⁶ The Soul City project was started in 1992. It is the longest running multimedia project in the country. According to Coulson (2001: 2) its target audience is comprised of Black and Coloured South Africans aged between sixteen and sixty-five years. The project's print media and adult education components complement its television and radio life skills series. Soul City's (unkown: online) OneLove HIV and AIDS campaign, promotes serial monogamy. The project also runs a PhuzaWize campaign. This campaign promotes responsible drinking. It also promotes the creation of alcohol-free zones to reduce the incidence of alcohol-induced violence.

1.2. South African Deaf Communities

In 1995, according to the Central Statistical Service (as cited by Government Communication and Information Services (GCIS), 1998), four million people were Deaf or hard of hearing (D&HH). The World Health Organisation (WHO) (as cited by DeafSA⁷, 2009: 2) argued that one in ten children born in South Africa have some degree of hearing loss. In poorer communities, this loss is often detected when a child is between the ages of six and eight years. This raises a number of questions about who can be called Deaf. Is adoption of a “Deaf identity” the determining factor?

Meador & Zazove (2005: 218) argued that the distinction between the Deaf and hard of hearing is one that needs to be maintained. This is because the conflation of these two communities has had a profound negative impact on the health and well-being of the profoundly Deaf. In maintaining the distinction between the Deaf and those who are hard of hearing, who then are the Deaf?

Hagemeyer (1992, as cited by Baker, 1999: 123) demarcated the Deaf population into nine sub-populations. Using the same categorisations, I divided the South African Deaf population into the following nine subpopulations:

1. Those whose first language is South African Sign Language (SASL).
2. Those who can communicate in SASL and English or Afrikaans.
3. Those who are hearing-impaired and communicate primarily through speech (for example, English, Afrikaans, isiXhosa, etcetera).
4. Adults who became deaf later in life. They were able to hear normally and may have acquired speech before hearing loss occurred.
5. Those who lost their hearing later on in life as part of the natural aging process.
6. Those who communicate primarily through gestures, miming and their own signing systems. They do not communicate in English, Afrikaans or SASL. This may be due to the fact that they were denied access to education, SASL or Deaf culture at an early

⁷ Deaf South Africans (DeafSA) was formerly known as the South African National Council for the Deaf (SANCD).

age.

7. Those with residual hearing, who can hear with the aid of hearing aids and describe themselves as hard of hearing.
8. Those who are both deaf and blind.
9. Those who are fully conversant in signing or with Deaf culture because their parents, children or other family members are Deaf. These individuals have normal hearing.

The categorisations above are based on language differences. Baker (1999: 123) contends that such differences are an insufficient basis for grouping. This may be true, but it is evidence of the Deaf population's heterogeneity. Such heterogeneity needs to be factored in, particularly when making decisions about what to teach about HIV and AIDS and to whom. Mirzoeff (1995: 57) argued that the boundaries delineating these subpopulations should not be seen as impermeable. Populations overlap and are constantly changing. For example, there are specific groups such as Deaf gay men, Deaf drug users, Deaf prisoners, and etcetera. What challenges does this present for public communication campaign designers? What challenges does this present for the Deaf individual seeking information?

- **A Note on Big 'D' Deaf and little 'd' deaf:**

In the literature, the little 'd' deaf is used to refer to individuals who experience their deafness primarily as a (hearing) loss. These deaf individuals choose to limit their contact with signing communities. The big 'D' Deaf refers to individuals who do not experience their deafhood as a loss. These individuals view themselves as members of a language minority. Ladd (2003: xviii) notes that little 'd' deaf individuals are sometimes referred to as little 'h' hearing individuals by big 'D' Deaf individuals.

1.2.1. Disability, HIV & Reproductive Autonomy:

Hanass-Hancock & Nixon (2009: 1) note that there are two fields relating to disability and HIV. The first field examines the episodic or permanent disabling effects of HIV and its treatment on previously healthy individuals. In this field, the term 'disability' is also used in relation to disability grants. This is in instances where an individual is unable to work due to

a chronic illness. Campaigns utilising data drawn from this field alone resulted in, and as Myhre & Flora (2000 as cited by Noar & Zimmerman, 2008: 226 – 7) found, early HIV and AIDS campaigns that were not directed at specific groups of individuals. This was despite the observation that the virus seemed to be present in specific (high-risk) groups. This resulted in the causes of AIDS being related to 'risky behaviour'. Fee & Krieger (1993: 1478) argued that this resulted in:

“all members of the potential risk groups were seen as potentially contagious; from there it was a short step to perceive these populations as 'responsible' for AIDS”.

Groups not seen to be partaking in or thought to be incapable of participating in 'risky' behaviour were considered to be at minimal risk of contracting HIV. These low-risk groups include disabled communities, namely Deaf communities. Research concerned with people with existing disabilities and their vulnerability to HIV and AIDS makes up the second field relating to disability and HIV. This field seeks answers to questions such as “why are they at higher risk of infection?” The present research lies in this field as it is concerned with Deaf adolescents' knowledge of HIV and AIDS, which provides insight into the extent of their vulnerability to infection.

Hanass-Hancock (2009: 4) outlined a number of studies that point out that people with disabilities do consider themselves vulnerable to infection. Shisana et al (2009: 36) estimates the prevalence rate for people with disabilities is 14.1%. Groce (2003: 1401) notes that only a few studies have been conducted on the effects of HIV on individuals with impairments. Sait et al (2005: 192) argued that in addition to viewing impairment as a form of weakness, two other processes occur. First, is the infantilisation of disabled individuals. The disabled are viewed as perpetual children. Second, is the desexualisation of the disabled body. The underlying assumption stems from what Harlan Hahn (as cited by Thomson, 1997: 25) labelled *asexual objectification*. The assumption is that disabled individuals are not sexually active. Hanass-Hancock (2009: 5) cited a study conducted in South Africa that revealed that people with intellectual disability had their sexual debuts between the ages of fourteen and sixteen years.

The lack of sex typing of disabled individuals is a form of exclusion and control. Popplestone

(2005: 139) noted that:

“disabled people are almost by definition disqualified as desirable”.

Sait et al (2005: 196) argued that physical disability is thought to render an individual unable to meet societal ideals of beauty. Conversely, mental disability may render an individual physically acceptable but incapable of making judgements such as negotiating safe(r) sex. This is used to justify and increase acceptance of the sterilisation of young disabled women. Discourses promoting the infringement of disabled individuals' reproductive rights focus on the unborn child's interests. Berer (2002: 7) stated that:

“Sex is a universal form of human behaviour, and getting pregnant and having babies is an almost universal experience for women.”

This was the case until the advent of the eugenics movement during the late 19th and early 20th centuries. Hubbard (1997: 187) argued that the eugenics movement had two aims. The first fell under the 'positive eugenics' banner. This phase of the movement encouraged those considered 'fit' (read well-to-do) to have many children. The second fell under the 'negative eugenics' banner. This phase aimed to prevent those deemed 'unfit' from having any children. Hubbard (1997: 189) noted that the broad definition of this grouping included individuals suffering from epilepsy, sexual perversion and feeble-mindedness. The disabled were also lumped into this group. Hubbard (1997: 187) further argued that these groups of individuals ended up being treated as a “form of pollution”. Ladd (2003: 160) noted that in addition to the negative eugenics movement, genetic engineering scientists have joined the movement. With respect to Deaf individuals, they are trying to locate the “deaf gene”. According to Ladd (2003: 160), this has been presented as the final solution in the quest to be entirely rid of Deaf people.

The question of reproductive rights is a question of autonomy. It is a question of who has a right to say what can and cannot be done to one's body. This autonomy is not awarded to disabled individuals. Hanmer (1985: 93) noted that reproductive oppression results in some women being forced to have children they do not want. Other women are denied the right to have children altogether. This is done through either forced sterilisation or simply denying

them access to sexuality-related information. This is compounded by the fact that 'sexuality' as a concept is difficult to define. Padgug (1999: 16) noted that it is often described and not defined in terms of its spheres of operation. These spheres lie within the private (home) sphere.

Charlton (2002: 32-3) argued that disabled individuals are further controlled and taught their place in society through various forms of labelling and symbols. These measures of control include so-called handicapped rooms, 'special' schools and physical restraints including sedation. A second assumption is that disabled individuals are unlikely to use drugs. Groce (2003: 1401) does point out the existence of research that disputes this. The research also outlines that individuals with impairments experience higher threats of rape and violence than previously thought. Coombe (2002: 10) further noted that the idea that Deaf children are at low risk of infection often translates into the notion that they cannot get infected. This places them at greater risk for being used for 'cleansing' rituals and consequently at greater risk for being infected with HIV.

1.3. Impact of Deafhood on Health Literacy:

The lack of compulsory hearing screening of newborns in South Africa contributes to delays in language acquisition by d/Deaf infants. According to DeafSA (2009: 3), the resultant language deficit is one that Foundation Phase teachers are not equipped to help the Deaf child overcome. This is further complicated by the fact that (SASL) is not a subject that Deaf learners can study. This is despite the fact that SASL is the language that they have the most access to. Mirzoeff (1995: 57 – 8) argued that this discrepancy can be explained in part by the fact that communication continues to be conceptualised primarily in relation to hearing individuals. The effects of this and the subsequent delay in language acquisition on health literacy remain largely unacknowledged.

Meador & Zazove (2005: 219) argued that D&HH individuals, when compared to hearing people, possess less knowledge on healthcare and preventative medicine and interventions. Simply put, many D&HH individuals are health illiterate. Kalichman (2008: 330) defined health literacy as a:

“constellation of skills that include the ability to use printed, and verbal information for following medical and healthcare directions and improving health, such as reading and comprehending prescription bottles, dosage instructions, and appointment reminders.”

Poor health literacy has been associated with poorer health and greater likelihood of hospitalisation. This is due to the limited understanding of one’s illness. Health literacy should not be conflated with education level. Education, or more specifically literacy skills, has been identified as key to understanding health information. The American Medical Association (1999 as cited by Kalichman, 2008: 329) argued that even adequate literacy may be insufficient for understanding unfamiliar material such as consent forms and health instructions. Baker et al (1997 as cited by Kalichman, 2008: 329) described three ways in which poor literacy hampers a patient's ability to follow verbal and/or written dosage instructions.

Firstly, treatment adherence is decreased by the inability to read prescription labels. Patients need to remember verbal instructions given by doctors and pharmacists. The likelihood that memory errors will disrupt treatment adherence increases. Second, low literacy renders individuals less likely to use written reminders and other systems to ensure treatment adherence. Third, patients with low literacy may not understand the full effects of non-adherence on their health. The fear of stigmatisation further decreases the likelihood of treatment adherence. Each of these factors applies, perhaps not equally, to treatment adherence by Deaf individuals.

These factors must be accounted for, particularly in the conceptualisation of public communication campaigns that target the Deaf. To improve health literacy levels the Department of Education (DoE) developed the Life Orientation (L.O.) curriculum. Kelly (2004: 29) argued that Zambia and Uganda are clear examples of education's contribution to the fight against HIV and AIDS. In both countries, education interventions led to a decrease in prevalence rates amongst young people. In South Africa, the curriculum has had less success. Ahmed et al (2006: 622) argued that the L.O. curriculum has had limited success. Pridmore & Yates (2006: 95) argued that this is because the national curriculum is inaccessible to many young, affected people. This is why Ahmed et al (2006: 629) argued that

issues around language access and literacy levels must be addressed in relation to the use of media to access out-of-school, orphaned and/or disabled youth. Kelly (2004: 41) argued that the issue of language accessibility is more pertinent with respect to children who are no longer in school and/or Deaf adolescents. They attributed this to contextual factors that make it difficult for teachers to teach sex education effectively. Mukoma et al (2009: 40) attributed this to the lack of knowledge and/or understanding by adolescents of the community level factors that affect their vulnerability to infection. For Deaf adolescents, their sex education is further hampered by some teacher's lack of proficiency in SASL and the use of unfamiliar terminology.

Deafhood adds particular weight to the choices that a Deaf individual makes with respect to his/her health. The first is with respect to access to health care facilities in the socio-cultural sense. The inability to communicate like and with the majority of the hearing population, particularly healthcare workers, needs to be taken into consideration by campaign designers.

1.4. Deaf Communities: Disabled Communities or Cultural & Linguistic Minorities?

Whisman (1993) asked: "Who is a lesbian anyway?" Most homosexual women do not fit into the available definitions of the term *lesbian*. Snitow (as cited by Whisman, 1993: 59) argued that in certain times and places, the boundaries of lesbian identity need to be maximised. Expanding the ways to be lesbian minimises the identity. At other times, it is necessary to maximise the identity by "limiting" the ways to be lesbian. This has the effect of letting the identity control you. The same can be said of disability. Popplestone (2005: 138) agrees that disability, like gender, is a social construct. It is a term that was created by "experts" to collectively refer to individuals who cannot perform actions, such as hearing, speaking or walking, in the social world. Who counts as disabled, varies as with all other constructs with time and place. The boundaries of identity based on disability can thus be minimised and maximised when the occasion calls for it.

Pre-1970, deafness was viewed as an inability to use part of one's body. It was viewed as a

disability. Mirzoeff (1995: 69) argued that many individuals like Maxime du Camp⁸ hold the medical view of Deafhood. This pessimistic view considers those born Deaf as “defective”. Morgan (2008: 6) argued that this view pathologises Deaf people by focusing exclusively on the hearing loss or impairment. The focus is also on rehabilitating the Deaf through surgical procedures. This is despite knowing that the profoundly Deaf cannot benefit from hearing aids or lip-reading. Those who undergo surgery and are not rehabilitated are deemed *oral failures* within this model.

Popplestone (2005: 129) notes that some prefer the term *impairment*. It originates from the social model of disability, which was first developed by Oliver (1990). Within this model, the term *impairment* is used to refer to the physical problem. Popplestone (2005: 129) notes that within the social model *disability* is seen as a function of a society that does not cater for people with different abilities. At the heart of the matter is the issue of access.

The social model is not without its limitations. The social model identifies the problem as society's inability to accommodate individuals with impairments. For the model's proponents, once this is fixed then there will no longer be disability. Popplestone (2005: 129) argued that many individuals with impairments feel as though their bodies are being disregarded. The reality is that once the disability is removed, the impairment will continue to exist. There will be day-to-day challenges experienced only by individuals with impairments. Able-bodied individuals will not experience these challenges. Impairment will also continue to be seen as a form of weakness within ablist societies.

Despite bargaining for their rights within the Disabled Rights movement, Stevens (1998: 102) argued that Deaf individuals are not disabled. They are, and should be treated as, a linguistic and cultural minority. Ladd (2003: 15 – 6) advocates the viewing of Deaf communities as language minorities who occupy dual categories. Some of their issues relate to non-hearing. Others relate to language and culture. The culturo-linguistic model propounded by Ladd (2003) refuses the disability label in relation to the Deaf. Ladd (2003: 166) argued that although constructed as such, Deaf issues, unlike disability issues, are not only about access. The collectivist cultural value seen in Deaf communities accounts for this difference. Ladd

⁸ Maxime du Camp (8 February 1822 - 9 February 1894) was a French writer, journalist and photographer.

(2003: 167) pointed out that Deaf discourses promote the upliftment of not only the individual, but also the entire community. To this end, Deaf discourses promote the establishment of schools for the Deaf. This is in contrast to disability discourses, which call for the disabled to be accommodated within mainstream schools. Ladd (2003: 168) notes that Deaf individuals:

“who do associate with the disability movement are those who see themselves as primarily deafened or hard of hearing (or as Deaf people might have it, 'hearing disabled').”

Second, Ladd's (2003) model also refutes the idea that hearing impairment is relevant to cultural membership. Hearing impairment is considered secondary to hereditary cultural influences. Stevens (1998: 103) noted that:

“[m]ost people who were born deaf or became so early in life and who grew up as part of the Deaf Community see themselves as fundamentally visual people, with their own visual language, social organisation, history, and mores – in short, with their own way of being, their own language and culture.”

One of South Africa's most notable campaigns promoting the prevention of HIV and AIDS transmission within the adolescent population is run by *loveLife*. As it is one of the most notable responses to South Africa's HIV and AIDS epidemic *loveLife*'s campaigns were selected as the basis for this research. It is not the longest running multimedia project in the country though. This accolade is given to the Soul City Project.

1.5. Research Question:

The present research stemmed from a hearing person's attempt to imagine Deaf teenagers making sense of *loveLife*'s television campaigns. The following questions will be the focal point:

Do Deaf adolescents think their Deafhood impacts on their access to HIV and AIDS information produced by loveLife? In what ways?

The research was guided by the following objectives:

- (i) To describe the perceptions of HIV and AIDS for these Deaf teenagers.
- (ii) To identify what these Deaf adolescents know about HIV and AIDS.
- (iii) To identify the main sources of HIV and AIDS information for these Deaf teenagers.
- (iv) To describe the processes through which sexuality communication takes place within these particular Deaf communities.
- (v) To describe the young people's views of the manner in which HIV and AIDS information is communicated within *loveLife* campaigns.
- (vi) To identify the different strategies *loveLife* employs to cater for Deaf adolescents in their campaigns.
- (vii) To describe Deaf adolescents perceptions on the nature and adequacy of their inclusion in *loveLife* campaigns.

On the basis of this, I aim to further probe the relationship between deafness and health literacy.

1.6. Organisation of the Dissertation:

The remainder of the dissertation is organised as follows:

Chapter 2 will outline the literature upon which the current research is based. It begins with a discussion of the objectives of public communication. . It will then go on to outline particular challenges faced by public communication campaign designers. These challenges come in the form of community-level factors that have the potential to either increase or decrease one's susceptibility to HIV infection.

Chapter 3 describes the design of this study and the methodology used to conduct the fieldwork. This chapter will discuss in detail how the questionnaire was constructed as well

as how the interviews were conducted. The aim of this chapter is to contextualise the interviews, which form the central components of this thesis. In addition to this, the chapter will briefly outline the characteristics of the sample and challenges encountered. The chapter will then end with a description of the data analysis procedures for analysing both the questionnaire and the interview responses.

Chapter 4 presents the responses to the questionnaire and interview questions collected. The chapter will then go on to present the findings drawn from these results and discuss them at great length.

Chapter 5 contains comments and recommendations for further research in this area. The main findings of the research will be summarised first. These results will then be interpreted with reference to the literature reviewed in Chapter 2. The chapter will also outline the larger significance of the findings and make recommendations for further research.

CHAPTER 2: LITERATURE REVIEW – CHALLENGES TO PUBLIC HEALTH COMMUNICATION

Pridmore & Yates (2006: 3) contend that SADC governments have failed to provide schooling to the most vulnerable children – girl children and orphans. Their argument is based on evidence indicating that these children are unable to identify the community-level factors that increase their susceptibility to HIV and AIDS infection. These community-level factors – in their various guises – present one of the challenges to public health communication. The purpose of this chapter is to identify the environmental factors that affect one's vulnerability to infection. The chapter will also discuss the significance of contextual factors such as socio-economic status and culture on an individual's assessment of his/her susceptibility to infection and knowledge of HIV and AIDS. The chapter will end by arguing for the need for the utilisation of theories that contextualise individuals as the basis upon which public communication campaigns are created. The chapter begins with a reconceptualisation of public communication.

2.1. Public Health Communication: A (Re-)Conceptualisation

loveLife is a non-governmental organisation whose core function is to design public communication campaigns on HIV and AIDS. Public communication campaigns can be defined, firstly, in terms of their objectives. Paisley (2001: 4) argued that this:

“focuses on one group's intention to change another group's beliefs or behaviour”.

In this light, it is a strategy of social control. Paisley (2001: 6) argued that this heuristic definition is in no way a judgement of the creator's motives. 'AIDS language', if one may call it that, is so pervasive and powerful that certain communities have been excluded from the fight against HIV and AIDS altogether. Those left out are those who have already been excluded from participating in wider society. Young (2000: 41) argued that these marginalised communities experience material deprivation and/or extermination. Marginalisation as a form of oppression is carried out under various guises that render the afflicted powerless. Language is one of these guises. The Appropriate Health Resources and

Technologies Action Group (AHRTAG)⁹ (1997 as cited by Stevens, 1998:99) noted that:

“[b]y language, we mean [...] how our methods of communication reflect our community's culture and how we relate to each other.”

Paisley (2001: 5) argued that public communication is defined, secondly, in terms of the methods campaigners employ to disseminate the message. This process definition is of particular significance to this research. Campaigners use billboards, radio, television and print as well as various forms of mini-media such as cell phones to spread the message. In this case, it becomes a question of *access*. Coulson (2001: 1 – 2) argues that mass media has the potential to reach all South Africans with approximately 99% having access to radio, 75% television and 7% read newspapers. Do Deaf communities have access to these messages? If yes, how much access do they have?

It is not necessarily the case that the issues Deaf communities face in making sense of HIV and AIDS awareness campaigns are particular to these communities alone. Groce et al (2006: 1) argued that the issues faced by members of Deaf communities are at times similar to those of their hearing counterparts. At other times, the issues faced by Deaf communities relate to language and culture. Mazrui (1990, as cited by Ndoleriire, 2000: 273) argued that culture functions as a mode of communication. The first assumption is that identity is constituted in interaction, specifically communicative action. Thus, identity is dynamic, multiple and diverse. Second, culture and identity are intricately linked. In this instance, culture is viewed as a symbolic repertoire within which individuals can come up with actions and outcomes of interaction. That is why Parker (2001: 167) argued that public health communication should not only aim to change behaviour. The cultural setting in which the ‘risky’ behaviour occurs should also be taken into consideration. Airhihenbuwa & Obregon (2000: 12) argued that this way, campaigners can:

“promote the positive, recognise and affirm the existential, and contextualise the negative.”

Translating all messages into SASL or simply adding subtitles to television public service announcements (PSAs) is not the solution. Morgan (2008: 3) argued that translation does not

⁹ Now known as Healthlink World.

necessarily give rise to meaningful, connected communication. Many nuances within the original language are lost in translation. Morgan (2008: 7) further argued that certain nuances, such as social mores relevant to healthcare, simply cannot be expressed in another language. This is because no words or expressions exist for them in that language. This is the case for English and Sign Language. That is why we are more than likely to fail to get HIV and AIDS messages across meaningfully to the Deaf through mere translation.

Groce et al (2006: 2) argued that educated Deaf individuals have lower literacy levels than their hearing counterparts. Ladd (2003: 9) notes that many Deaf children leave school with the reading average of an eight year old. This means that they can only understand tabloid headlines. Consequently, information that is presented through advertisements in print media and captioned television PSAs is inaccessible to Deaf adolescents. This is because, as Stevens (1998: 102) argued, print advertisements and PSAs target those who can hear and read a spoken (oral) language. For many Deaf individuals, a spoken language is their second language. Their first language is a visual one. This means that the message they obtain from print media and captioned television advertisements is incomplete and ambiguous.

2.1.1. Problematising Current Conceptualisations of Communication:

An equal challenge to public health communication is the manner in which 'communication' is conceptualised. Ndoleriire (2000: 269) illustrated the communication process as follows:

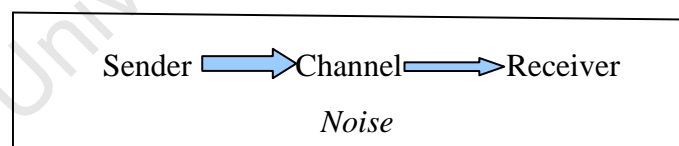


Figure 1: Communication Process

This illustration, in many respects, oversimplifies the communication process. It is nevertheless useful. Of particular significance to the current research is the method through which the message is transmitted. That is the *channel*. The channel can be in the form of a letter or a radio and television advertisement for example. Also of significance, is the *noise*. Ndoleriire (2000: 269) argued that this noise comes in the form of socio-cultural practices and physical noise in the form of people talking around the receiver. Individuals differ in a myriad of ways. Most of these differences are often at odds with the campaigners

assumptions. They function as *noise*. This *noise* distorts the message, resulting in miscommunication.

Fullinwider (1996: 3) argued that multicultural education can mitigate the effects of *noise*. The definition of culture used is of particular significance. Does this definition include gender? Class? Ethnicity? Sexual preference? (Dis)ability? Or is culture defined only in terms of common beliefs and habits? Moon (1996: 74) argued that in the 1980s the term *culture* was stripped of its heterogeneity for two reasons. Firstly, there were calls for Social Science to utilise methodologies that are more rigorous. Secondly, emphasis was placed on the need to define *culture* in terms of *nation-state*. From hence, *culture* was viewed only from this Western perspective. It is then assumed that the disease means the same thing to everyone. In addition to this assumption, Kincheloe & Steinberg (1997:4) argued that this monoculturalist standpoint explains phenomenon at the individual level. Moreover, a monoculturalist stance enables one to speak of Deaf and other communities in an essentialist manner. From this perspective, Deafhood, like “race” as Erasmus (2008: 187) argued, would be treated as though it is “all determining, fixed and immutable”. This makes Deafhood everything. Dimensions like gender, class and politics are all removed from the picture. The sole focus on Deafhood results in the decontextualisation of the individual and his/her experiences. This necessitates the reconceptualisation of public communication as a form of intercultural communication. In so doing, campaign designers can then:

“acknowledge, respect, tolerate, and integrate cultural differences.”

These and other differences will be discussed in subsequent sections of this chapter.

2.2. Contextual Factors:

Wallack & Dorfman (2001: 389) summed up one of the fundamental flaws of public communication campaign strategies as follows:

“[public health communication] systematically ignores a wide range of social forces that influence health and focuses on personal choice. Thus, flaws are identified and remedied at the individual level, leaving important contributing factors unchanged.”

Poverty, inequality and, culture are all contributing factors that need to be acknowledged and changed if the disease is to be effectively tackled. There are two dominant understandings of the manner in which contextual factors impact on the HIV and AIDS pandemics trajectory. On the one hand, AIDS is viewed as a disease of poverty. On the other, AIDS is viewed as a disease of inequality. Together these views, which will be outlined below, take us a step closer to obtaining a holistic understanding of the disease.

2.2.1. AIDS – A Disease of Poverty:

In order for a disease to flourish, the disease agent and a host are needed. Yet not everyone who is exposed to the virus becomes infected. This hints at the existence of contextual factors that either facilitate or hinder the virus' transmission. In the case of HIV and AIDS, an impoverished environment facilitates its transmission. As Iliffe (2006 as cited by Nattrass 2008: 8) argued, poverty is “an effective incubator” of the virus. That is why AIDS is referred to as *a disease of poverty*. Head (2009: 4) noted that the former homeland areas in particular have the worst vital statistics. This does not mean that only poor people get infected with HIV and AIDS. It is used to refer to the observation that wealth, or rather the lack thereof, determines one's susceptibility to infection.

Statistics South Africa (StatsSA, 2010: 4) estimates that South Africa has a population of 49 991 300. Of these:

“the poorest 20% [account] for less than 1,5% of income (based on income from work and social grants).”

(StatsSA, 2005: 2)

The poorest individuals reside in densely populated areas referred to as townships. A significant proportion of these township residents are Deaf. Usdin (2003: 79) noted that these areas lack basic services, such as refuse removal, clean water and adequate sanitation. Mukotsanjera (2008:10) noted that these areas have higher prevalence rates than the low(er) density urban areas. In her book titled *AIDS and the Ecology of Poverty*, Stillwaggon (2006) outlines how such impoverishment, characteristic of the conditions the majority of hearing

and Deaf Africans live under, increases susceptibility to infection by a myriad of communicable diseases. Impoverished surroundings are characterised by, amongst other things, high food and economic insecurity and violence. Economic insecurity is the basic determinant of access to: shelter; healthcare; education (including health literacy), and; nutrition to mention just a few. Morris & Potter (1997, as cited by Stillwaggon, 2006: 7) argued that of these, nutrition is:

“the most important determinant of susceptibility to disease because of its impact on both the protective barriers (skin and mucous membranes) and on immune response at the cellular level”.

The impoverished communities in which a large number of Deaf individuals reside means that they have no food security. To this end, they do not receive adequate nutrition, placing them at an even greater risk of infection with communicable diseases.

2.2.1.1. Limited Access to Healthcare:

The lack and complete absence in some communities of basic and supportive infrastructure remains the biggest challenge facing the healthcare sector. In the rural areas particularly, individuals have to walk long distances to access medical care. That is if they can access these resources at all. Berer (1999: 8) stated that:

“[g]lobally, access is first and foremost about political geography and the differential in wealth and resources between North and South [...]. However, access to health is also about the divide between rich and poor within each country, and how much – or how little – governments are doing to reduce that gap.”

Universal Access (as cited by Day & Gray, 2008: 310) identified the three dimensions of the term 'access'. The first of these is *availability*. This encompasses physical access, economic access and socio-cultural access of quality services. *Coverage*, which is the second dimension, was defined by Universal Access (as cited by Day & Gray, 2008: 310) as:

“the proportion of the people needing an intervention who receive it”.

The final dimension is *outcome* and *impact*. This is defined in terms of behaviour change as evidenced by lower infection or higher survival rates in each community. The South African health system fairs poorly on all three dimensions. This is because, and as Schwärtlander et al (2001: 1) noted, the unequal distribution of resources did extend to the healthcare system during apartheid. Head (2009: 3) noted that the apartheid government's preference for vertical programmes led to the improvement of health services in specific communities. Facilities in poorer communities were and continue to be under-resourced and under-staffed. Kehler (2007: 27) argued that these clinics are also prone to run out of drugs, have no water, sanitation and/or electricity. The public health system was already over-extended when the HIV and AIDS epidemic struck. This was due to the TB epidemic. Stillwaggon (2006: 59) labelled TB as the:

“most lethal and prevalent infectious disease in history”.

TB is the most common opportunistic infection amongst HIV-positive individuals. It increases the rate at which HIV transitions to AIDS and eventually death. Stillwaggon (2006: 59) went on to argue that HIV “promotes the activation of latent TB”. TB is, to a lesser degree than HIV and AIDS, stigmatised. This is because it has become closely associated with HIV and AIDS. TB treatment non-adherence is high because of this stigma. Non-adherence is more likely as individuals feel better before the six-month treatment period is over. Once an individual feels better, s/he stops taking the medication. This has resulted in a rise in the number of patients with drug resistant forms of TB.¹⁰

The TB prevalence statistics are only often broken down to show prevalence within the various racial and/or income groupings. The number of individuals within Deaf communities who have been afflicted by TB remains unknown. We also do not know how prevalent drug resistant forms of TB are within Deaf communities. This lack of statistics is a result, in part, of the lack of health facilities tailored specifically for Deaf individuals. This in turn means that with respect to Deaf communities coverage, as defined above, is poor. Drug resistant forms of TB can be expected to be at high levels within Deaf communities because they are

¹⁰ There are two types of drug-resistant TB. The first is **multi-drug resistant TB (MDR-TB)** is a type of TB that is resistant to at least two of the best first line anti-TB drugs known as *isoniazid* and *rifampicin*. The second type of TB is **extensively drug-resistant TB (XDR-TB)**. It is relatively rare. To qualify as XDR-TB, a strain that is resistant to first-line drugs and at least one of three injectable second-line drugs.

unable to access treatment. In instances where they do gain access, treatment adherence will be poor because instructions are given to them or as in most cases a hearing relative, orally.

The limited nature of Deaf individual's access to healthcare highlights the element of inequality that characterises pandemics. It is not the case that Deaf individuals are completely denied access to healthcare services. The issue is that they do not have adequate access. It is also not the case that Deaf adolescents are not taught about HIV and AIDS at all. There are organisations that are working to improve the HIV and AIDS literacy of Deaf individuals. One such organisation is the Sign Language Education and Development (SLED) project. This organisation is working with the DoE to develop books and DVDs on HIV and AIDS to be utilised during L.O. in schools for the Deaf. According to information on their website (<http://www.sled.org.za>) SLED also trains teachers of the d/Deaf. Their aim is to ensure appropriate classroom practices that lead to the development of SASL and written language literacy. This literacy is based on *sight* not *sound*. The activities being undertaken by SLED are in line with the findings in a study conducted by Bisol, Sperb, Brewer et al (2009). In their study, Bisol et al (2009: 17) found that it is imperative that school based instruction be improved. This involves presenting health information to Deaf adolescents in an appropriate manner. Doing so would vastly improve the levels of HIV and AIDS knowledge amongst Deaf adolescents.

Sencity is another organisation that is working towards improving HIV & AIDS literacy within Deaf communities. Sencity is a multi-sensory project for d/Deaf, hard of hearing and hearing individuals. Unique events, during which the emotion of the music and information is conveyed to d/Deaf individuals through the other four senses, are held. The organisers of Sencity events (n.d.:<http://www.your-sencity.com>) argue that they achieve this with techniques such as vibrating dance floors and Sign dancers.

2.2.2. AIDS – A Disease of Inequality:

Mukotsanjera (2008: 10) argued that women, namely Black¹¹ women, are disproportionately

¹¹ The term Black is used broadly in this thesis to collectively refer to the racial and cultural groups classified as (Black) African, Coloured and Indian in South Africa's recent past.

affected and infected by HIV. Seekings & Nattrass (2006: 52) attributed this to the disruption of traditional structures by rapid urbanisation. These structures regulated the most mundane aspects of everyday life. Social and economic upheavals disrupted African gender relations. Coupled with gender inequality, the unequal distribution of wealth makes women more vulnerable to infection. Gouws & Abdool Karim (2005: 61) noted that in general, women have higher rates of infection. They also have higher rates of infection at a younger age. Women care for the sick. They are blamed for bringing HIV into the home and community. The longer-term migration of men to the cities, ill health and death of their breadwinners left women in rural communities needing to provide for their families. This burden has made sex a part of the economy for many poor people. At times, women have to provide irrespective of the personal cost. Denise (as cited by Usdin, 2003: 37) a Namibian sex-worker said:

“I am not happy with what I do but I have to do it because I must survive. I must keep my children alive. Some days there is not even bread at home; then I have to go out and earn money. My father was a fisherman until last year when he got a stroke and was laid off. My husband died last year. I know it [sexwork] is illegal in Namibia but I have no choice; there is no other income.”

In writing about men-who-have-sex-with-men (MSM), Niehaus (2005: 87) argued that sex became a part of the economy because colonialism and forced celibacy on the mines made non-reproductive sex more 'valuable'. This was spurred by the delinking of a man's wealth and/or status from the number of children he had. The workplace (mine compounds) and jails provided new sites within which the masculine identity could be renegotiated. Niehaus (2005: 87) contends that these new identities cannot be equated to the “modern gay personhood”. Mineworkers did have access to (female) sex workers to release their sexual tension. These relationships did not offer the men intimacy, domesticity or the comforts of home. Niehaus (2005: 92) argued that the men preferred male-male sexual relationships. These relationships presented a lower risk of contracting disease. The young men who assumed the roles of mine wives had financial motives. Niehaus (2005: 94) notes these young men also got to do less strenuous work on the mines. Others, especially newcomers in jail, were physically coerced into performing the roles. For those in prisons, the male-wife got protection, extra food, cigarettes, dagga and/or some money.

A combination of physical attraction, emotional rapport and financial calculation motivates sexual relationships. Epstein (2007: 76) argued that in southern Africa the financial prospects appear to be the main motivation. This has given a rise to phenomenon known as *transactional sexual relationships*. Epstein (2007: 76) defined transactional sexual relationships as relationships in which:

“women expect gifts of cash or consumer goods from boyfriends”.

Women and men in such relationships often engaged in concurrent relationships. Epstein (2007: 55) argued that *concurrency* accounts for the high HIV prevalence rate in SSA. Concurrency is the practice of engaging in sexual relationships with more than one person at a time. Overlapping relationships are identified as the primary cause of the high rates of HIV transmission within the model of concurrency. Epstein (2007: 55) maintains that concurrency is more dangerous than serial monogamy. This is because it links people in a giant web of sexual relations. The ideal conditions for the spread of HIV are created. What matters, according to Epstein (2007: 59) is the network itself and not the behaviour of any particular individual. The underlying premise is that if one person in the web contracts HIV, then everyone in the web is placed at high(er) risk. Examples of such webs in the African context are polygamous marriages and transactional sexual relationships.

Jewkes et al (2004 as cited by Head, 2009: 7) noted that these transactional sexual encounters are either once off or regular. These encounters are to be differentiated from sex work. This is because, as Epstein (2007: 78) argues, the gifts and money are not seen as payment for services rendered. Swidler & Watkins (2007: 156) argued that transactional relationships should be viewed as an extension of the kinship system. They offer women a social security net. The shift from communalism left women unable to rely on their extended family. Poulsen (1995: 37) argued that migration increased the social and economic impoverishment accompanying individualisation. It became difficult for individuals to fulfil obligations, particularly to extended family. Botchway (2004: 2) argued that migration also eroded traditional institutions resulting in the further weakening of kin relationships. Poulsen (1995: 36) notes that individualism rendered customary law ineffective by changing individuals' values. In so doing, it changed their interpretation of customary law. This in turn, made customary law inadequate and difficult to apply. Women lost a myriad of their traditional

rights as well as some of their power and agency. Transactional sexual relationships provide women with a way to fill this gap. Commodities such as accessories and clothes are important to the definition and expression of the self. Dolby (2001: 65) noted that within South African schools, “race” or rather racialised identities are constructed through discourses of taste. Transactional sexual relationships also provide men with a sense of self-esteem and power.

Transactional sex is thought to be riskier for both parties than sex work. Jewkes et al (2004 as cited by Head, 2009: 7) found that women in these relationships are more likely to be HIV-positive. This is irrespective of the number of partners they have had. Usdin (2003: 37) argued that their increased vulnerability is the result of their heightened tolerance to unfaithfulness. These women are also more likely to find additional concurrent sexual relationships. Transactional sex is often intergenerational. Young women are often engaged in sexual relations with older males. Mercer et al (2009 as cited by Shisana et al, 2009: 2) argued that their vulnerability is increased by the heightened unequal power dynamics. The inequality is further heightened when the younger individual in the relationship has a disability.

Popplestone (2005: 131) noted that the more visible an individual’s disability is, the less sexually desirable they are deemed to be. The sexual marginalisation of individuals based on their disability is linked to their social marginalisation and consequent downward mobility. In part, this factor leads Deaf adolescents to enter into risky sexual relations and tolerate unfaithfulness within their relationships. Their desire to be seen as sexually attractive will result in them entering into relationships with little regard of the consequences. These relations may or may not be transactional in nature. Deaf adolescents are placed in a more precarious position than their hearing counterparts are because they in an even lesser position to negotiate safe(r) sex. Secondly, the inability of community workers in police stations and hospitals to sign means that Deaf adolescents will experience greater difficulty laying charges of rape against perpetrators and obtaining the relevant health care. This contextualisation of Deaf individuals is necessary as it uncovers additional factors that make them more vulnerable to HIV infection.

2.2.3 The Sexual Socialisation of Black African Adolescents:

Parker, Barbosa & Aggleton (2000: 1) argued that it is vital for non-university categories and classifications of disease to be acknowledged. These categories are often more flexible. Usdin (2003: 46) noted that communities structure sexual encounters in terms of: who one can have sex with; what ways sex can happen, and; the circumstances under which it occurs. Ultimately, multiple sexual realities are created. It then becomes necessary to question terms such as 'promiscuity' for example. Coleman (1997: 217) argued for the need to question the judgements we make about other people. To this end, we need to interrogate the significance Western worldviews have attached to the disease in Africa.

Harrison (2008: <http://www.tandfonline.com/doi/full/10.08013691050701775068>) argued in contrast to Epstein (2007: 85) that it is not the case that African youth do not possess romantic ideals. Discourses of love and romance are shadowed by the stigma and secrecy accompanying discourses of adolescent sexuality in Africa. Botchway (2004: 1) noted that in Africa parents do not occupy the front seat in the sexual socialisation of their children. In traditional African societies, this process is undertaken in initiation schools. It is during these ceremonies that young men are taught the societal sanctions on premarital sex. Although no age is specified, male initiates tend to fall between the ages of fifteen and twenty-five years. After three weeks, his family and the community welcome *umkwetha* (male initiate) during a ceremony akin to a graduation ceremony. During this ceremony, *umyalo* takes place. This is the part of the ceremony where advice about adulthood is given to *umkwetha*. The men and women invite the young man to sit with them. In these advisory sessions, the young man is taught the meaning of *ubudoda* (manhood). The idea that coming of age comes with greater responsibility and accountability is stressed. It is also emphasised that one's actions now have a greater implication for the family unit. These sentiments are not overtly expressed. This is typical of what Weaver (1994: 46) termed high context cultures. In these cultures, shared communication does not require things to be stated explicitly. A lot of cues are dropped. For example, the young man is advised to continue treating his mother with respect. It is implied that he must treat all women with respect.

The responsibility accompanying the transition to adulthood weighs heavily on young men. Swartz & Bhana (2009: 24) writing about teenage fathers stated that:

“it would seem that these [teenage tatas] felt a strong sense of shame more in keeping with breaking family and cultural bonds, and with upsetting the foundation of strong mutual respect and trust in the traditional family.”

The secrecy and stigmatisation shrouding adolescent sexual intercourse makes it difficult to transmit HIV and AIDS related information in these communities. Sexually active young men and women will not divulge they are. In turn, and as Botchway (2004: 14) argued, they will not go out and seek sexual health information and services. Traditional practices encourage the delay of sexual debut. Brown et al (2001 as cited by Shisana et al 2009: 1) noted that in South Africa, the age of sexual debut is between eighteen and twenty years for girls and fifteen and twenty years for boys. Variables such as location, (dis)ability, and, school attendance lead to variations in these estimates. According to Shisana et al (2009: 1) the age of sexual debut as a variable needs to be accounted for in prevention efforts. Calculating the age of sexual debut allows for an estimation of the age at which individuals become at risk of infection. This calculation will help tailor the campaign messages at levels appropriate for the developmental stage that children will have reached. This is particularly pertinent when tailoring information for children with impairments, who may develop later than children without impairments may.

2.2.4. The Meanings of AIDS:

Afrikaaner Invention to Deprive us [Black Men] of Sex

This is what the acquired immunodeficiency syndrome (AIDS) came to be known as by some anti-apartheid activists and individuals residing in the townships. The virus had had the most devastating effects in the townships. As its visibility increased, the disease was given more labels. The medically sanctioned definition of the disease is not the one that prevails. This definition was drawn in 1983 when the HI-virus was discovered.

A discrepancy exists between the way a disease is and the way it is understood. In biological terms, *HIV* is a virus, which attacks the immune system. *AIDS* is a broad term referring to the illness associated with infection by HIV. Treichler (1999: 357) argued that the term 'AIDS' is

not just a label for an illness. The virus' action within the body is not the only thing that individuals have to deal with. Those infected and affected need to deal with the social signification attached to the disease. Socially, an HIV-positive status is said to be an indicator of promiscuity. It is also said to be punishment for sin. HIV-positive individuals are stigmatised and shunned based on such signification. The process of signification accounts for the discrepancy between the disease and the manner in which it is understood. Shefer (2004: 204) defined signification as the:

“use of signs or, more accurately **signifiers** (that is, spoken or written words) to make meaning of the world through representation of concepts or ideas (that is, **signifieds**). The relationship between signifiers and signifieds is arbitrary”.

To illustrate the arbitrary nature of this relationship, Shefer (2004: 204) uses the word 'cat'. For most individuals this word conjures the image of a four-legged creature with fur, whiskers and a tail. Through repeated use, this signifier has stuck. Any other word could be used to represent that creature. Post-structuralists argue that we can use a different concept to understand what seems to be the same object or phenomenon. This has ramifications for the manner in which we experience HIV and AIDS as real. Patton (1990: 55), speaking of AIDS, stated that the reduction of all symptoms to one pathology (AIDS) results in the disease being forced to correspond to the body. In this case, the virus is forgotten and the body or individual “becomes AIDS”. For this reason, Treichler (1999: 370) argued that disease as an immaterial and linguistic reality has *real* consequences for those affected and infected.

The HIV and AIDS epidemic is an epidemic of many meanings. Individuals have to deal with the disease *and* the meanings attached to it. Fee & Krieger (1993: 1477) argued that:

“perhaps more than any other disease, acquired immune deficiency syndrome (AIDS) offers a complex and vivid example of the ways in which people create multiple, contested explanations of health and illness.”

Charlton (2002: 25) argued that the signification attached to any disease is culturally informed. Popular significations serve to further isolate already marginalised groups. We know that within a number of communities, HIV is heralded as a punishment for sin namely

in the form of deviant sexual practices. In isiXhosa, AIDS is referred to as *isifo sikaGawulayo* or *qhoks* in township slang. These terms invoke notions of promiscuity linked to pre-marital sex and homosexuality. Popular conceptions and misconceptions of the disease also serve to inform one's assessment of personal risk. As Kalichman et al. (1993: 292) argue that association of a disease with a particular group that one is not part of, gives rise to a diminished sense of personal risk. To what extent does the misconception that HIV infects the 'other' contribute to negation of personal risk? What informs the processes that give rise to the attachment of these and other meanings to the disease? Do these meanings differ between hearing and Deaf communities? If yes, how?

Little is known of the manner in which the sexual socialisation of Deaf adolescents is undertaken. Even less is known of the meanings ascribed to HIV and AIDS within Deaf communities. Do they differ from the meanings ascribed to the disease by hearing communities? This additional factor needs to be accounted for by campaign designers when conceptualising campaigns. Doing so will result in the contextualisation of the individual and consequently, the creation of relevant and effective campaigns.

2.3. Conclusion:

A number of socio-cultural and economic factors influence one's susceptibility to infection with HIV and AIDS and/or a number of other communicable diseases. These present significant challenges to public health communication. In particular, these factors call into question the basing of public health communication strategies solely on individualistic models of behavioural change. Theories that contextualise the audience, in this case Deaf adolescents residing in a township, need to be used to conceptualise public communication campaigns.

Paisley (2001: 14) outlined three other problems for public communication in the 21st century. First is the issue of public distrust. Paisley (2001: 17) outlined the media's contribution to the criticism of public officials, public agencies, corporations and other powerful entities. A prime South African example of this is the *Mbeki Controversy*¹². Second,

¹² Also referred to as the *Mbeki-AIDS saga*.

is the episodic nature of issues. Paisley (2001: 17) notes that there are quite a number of prominent issues on the national agenda. The more persistent issues are subject to fatigue and regain their place on the national agenda when new research or advocates become known. Third, is the rise of issue literacy. Paisley (2001: 19) argued that social problems are re-framed as a literacy to gain people's attention. This is also in part acknowledgement of the complexity of the issues and the need for more than just posters to address them.

Health is a multidisciplinary concept. That is why Ross & Deverell (2004: 203) argued that epidemics should be examined and tackled using a multidisciplinary approach. Such an approach would make it possible for contextual factors such as poverty, culture and impairment to be accounted for. In order for this to be achieved, it is necessary to view public health communication as intercultural communication. This view of public health communication will allow cultural differences between the sender (campaign designer) and the receiver to be acknowledged. Acknowledgement of these cultural differences will lead to the incorporation of these differences in public health communication campaigns. This in many respects goes beyond linguistic accommodation. This is because the information about diseases and the manner in which they should be combated put forward is culturally specific. This (culturally specific) information can then be disseminated through the various media platforms.

Such an approach will allow Deaf communities to join the debate around the disease and how HIV and AIDS prevalence rates can be lowered within Deaf communities. In addition to opening up discussions on HIV and AIDS to Deaf communities, the increased access to information will lead to higher numbers of Deaf individuals going to be tested. These (more) accurate and up-to-date statistics will provide a clearer picture on the number of d/Deaf individuals who are infected, and; will provide greater insight into the extent to which the disease has affected Deaf communities.

CHAPTER 3: RESEARCH METHODOLOGY

The previous chapter outlined different conceptualisations of AIDS. The chapter then went on to provide an overview of the literature. The chapter concluded with the notion that public health communication must be reconceptualised as a form of intercultural communication. Doing so would allow Deaf communities to join the fight against HIV and AIDS, and contribute to finding solutions that would mitigate the disease in their communities.

This chapter outlines the methodological choices made prior and during to data collection. The fieldwork was conducted from November to December 2010 in one of Johannesburg's townships. Townships, often referred to as locations are under-developed, high-density urban areas. Due to the small size of the Deaf community and the sensitive nature of the topic under discussion, neither the school's name nor the names of the participants will be revealed. This is to ensure that the participants' identities are protected. It suffices to say that the school is classified as a school for children with special needs. It caters for Deaf and Hard of Hearing children. The majority of its pupils reside within the township in which the school is situated.

3.1. The Research Process:

This section will detail the sample's characteristics; how the sample was selected, and; how the data was collected.

3.1.1. The Sample:

The issue of accessibility to Deaf adolescents played a key role in the selection of a school as the location for the fieldwork. This decision was also taken because the children were exposed to the L.O. curriculum and had access to HIV and AIDS and sexuality-related information through the school nurse. The school setting was ideal as it provided a pool of potential research participants:

“who were born deaf or became so early in life and who grew up as part of the Deaf community see themselves as fundamentally visual people, with their own visual

language, social organisation, history, and mores – in short, with their own way of being, their own language and culture.”

(Stevens, 1998: 10)

Nineteen (19) participants – eight (8) girls and eleven (11) boys – took part in the study. The participants were aged between fourteen and eighteen years. The average age of the participants was seventeen. One of the participants was fourteen years old. Five participants were aged 16 and below. Most of the respondents (42%; n = 8) were in Grade 9. The biographical information, broken down according to sex, is presented in Table 1.

Table 1: Biographical Information of Participants stratified by gender

Variable	Number	% of Sample	Average Age
<i>Gender</i>			
Female	8	47.4	17
Male	11	52.6	17

i. Access:

Obtaining access to children classified as having special needs may involve a lengthier process than obtaining permission to access children without special needs. This is because of the perception that children with special needs – irrespective of the nature of their impairment – can be taken advantage of and/or placed in harm’s way during research as a result of their inability to (fully) comprehend the situation. Deaf adolescents are also classified as children with special needs. Their ability to understand the nature of the study is not hampered by any deficiencies in their mental capacity. Their ability to understand is hampered when the information is not provided in their first language, SASL. To counter this, a first language SASL interpreter was used to introduce the study to the participants and explain their roles as participants.

Access to the school and preliminary access to the pupils was obtained from the school principal. Permission also had to be sought from the parents as well as the participants.

Consent forms introducing the study were given to parents and participants.¹³ Once all the relevant permission slips had been signed and returned, I had access to the participants during school hours. I did not observe the participants interacting outside the school environment with the greater community.

ii. Sampling Procedures:

Purposive sampling was used to select the participants. Babbie & Mouton (2001: 166) note that purposive sampling is also referred to as judgemental sampling. It is a non-probability sampling method. This sampling method allows the researcher to utilise his or her knowledge of the population as well as the research aims and processes to select a sample. This method was used for two related reasons. Firstly, this sampling method was used because of the nature of the Deaf population. Although the Deaf population is large, majority of the individuals within this population are hard to reach. The first issue that influenced the sample selection was access. Secondly, sample selection was influenced by the decision to use a questionnaire during the first phase of the data collection process.

The use of a questionnaire format and my own use of English meant that participants had to be able to read and write English. This, in addition to requirement that the participants fall within the fourteen to eighteen years age, made a school the ideal pool from which participants could be drawn. This raises a number of challenges for the attainment of a representative sample and avoiding essentialism.

Purposive sampling has its advantages, but it does not yield a sample that is representative of the study population. That is, the:

“aggregate characteristics of the sample [will not] closely approximate those same aggregate characteristics in the population.”

(Babbie & Mouton, 2001: 172)

¹³ See Appendix D for consent forms.

In this respect, there is not the claim that the results obtained through this research are generalisable to all the d/Deaf communities. In sum, the results obtained through this research only apply to the sample. The findings will provide insight into current HIV and AIDS communication strategies and provide additional avenues for further research.

3.1.2. Data Collection Techniques:

The research was guided by the following aims:

- (i) To describe the meanings of HIV and AIDS for these Deaf teenagers.
- (ii) To identify what Deaf adolescents know about HIV and AIDS.
- (iii) To identify the main sources of HIV and AIDS information for these Deaf teenagers
- (iv) To describe the processes through which sexuality communication takes place within these particular Deaf communities.
- (v) To describe the young people's perceptions on the manner in which HIV and AIDS information is communicated within *loveLife* campaigns.
- (vi) To identify the different strategies *loveLife* employs to cater for Deaf adolescents in their campaigns.
- (vii) To describe Deaf adolescents' perceptions on the nature and adequacy of their inclusion in *loveLife* campaigns.

To accomplish these aims, this research was conducted from an interpretivist position. A qualitative approach would enable the researcher to obtain an in-depth understanding of social phenomena. This understanding will be based on the participant's point of view. To obtain the participants' views, several data collection methods were utilised. Data was collected through a questionnaire survey, a focus group interview, individual interviews and, a group exercise. Each of these methods of data collection will be discussed in detail shortly. The utilisation of more than one data collection method is referred to as *triangulation*. These three data collection methods were utilised to obtain information from the adolescents. This information would provide elaborate descriptions of the activities from the participants' point of views.

The data collection phase should be viewed as a sequence, with one step leading to the next.

The discussion will show the links between the different steps in this sequence.

i. Questionnaire Survey:

Description and Motivation: The process of drafting the questionnaire began once the research question and objectives had been formulated. Questions that related directly to the research objectives as well as filter questions were drawn up. The questionnaire was checked to ensure that, firstly, responses to the questions were mutually exclusive; secondly, to ensure that instructions within the questionnaire were clear, and; thirdly, to ensure that there were no double-barrelled questions.

Once the necessary changes had been made, two staff members at the school in which the research was going to take place reviewed the first draft of the questionnaire. Changes to the format of the questionnaire as well as to the structure of some questions were made. This revised questionnaire contained seventeen questions. With the exception of one, all the questions were closed-ended questions¹⁴. These questions were pre-coded. That is, they were coded before the fieldwork was conducted. The coding process also involved devising methods to deal with missing data. The open-ended question was coded after the fieldwork had been completed. An additional seven questions requesting biographical information, namely age, gender, “race” and, grade, were placed at the end of the questionnaire. These questions provided information about the sample group.

The utilisation of a questionnaire was fuelled by the desire to collect some of the information in a standardised format. This decision was also influenced by the fact that the researcher already knew all the possible answers to the questions. The questionnaire survey was designed to gather information to answer the following questions: What do Deaf teenagers know about HIV and AIDS? and; from where/whom? In particular, the questionnaire was designed to give rise to information, which would achieve the second and third aims, namely:

- To identify the main sources of HIV and AIDS information for these Deaf teenagers
- To identify what the participants know about HIV and AIDS.

¹⁴ The final questionnaire is attached in Appendix E.

Administration: Once the second draft of the questionnaire had been completed, it was piloted with eight (8) (out of a possible 50) Deaf adolescents from the same school. This phase highlighted the need to utilise an interpreter to administer the questionnaire. An interpreter was used to, firstly, ensure maximum understanding of the questions, and; secondly, some of the terms that may or may not have been familiar to the participants. For example, during the piloting phase it became apparent that the participants were unfamiliar with the term 'anal sex'. This term was used in question thirteen, which asked: *Do the following factors make a person vulnerable to infection?* To ensure that respondents were able to answer this question, in the final administration of the questionnaire, the interpreter described the act instead of simply naming it. The only other changes that were made were to the layout of the questionnaire. This was done to make the questionnaire more 'user-friendly' so to speak.

During the final administration phase eleven (11) (out of a possible 120 pupils, minus the eight who were in the piloting stage) students volunteered to fill in the questionnaire. None of the students who participated in the piloting phase participated in this stage. The interpreter – a native Sign Language speaker – would sign the questions and responses (in the case of closed questions) and the participants would then fill in the appropriate spaces on their respective questionnaires. The administration of the questionnaire in Sign Language overcame any issues related to the written format of the questionnaire.

The need for confidentiality led to the decision to let the participants fill in the questionnaires themselves. Meador & Zazove (2005: 219) noted that the use of interpreters by doctors, usually a family member means that conversations between the practitioner and patient are not private. Hanass-Hancock (2009: 5) also notes that a number of studies highlight the inability of VCT staff and other health officials to communicate with Deaf people. This results in the compromising of their confidentiality.

In this case, the interpreter was a staff member who was familiar to and trusted by the students. Even though they trusted the interpreter and often sought his assistance, it was decided to let the students fill in their own questionnaires. This was a bid to ensure that all the information provided in the questionnaires remained between the researcher and the respective participants. These and other ethical considerations will be addressed in a subsequent section of this chapter.

ii. Focus Group:

Description & Motivation: Four open-ended questions were drawn from the questionnaire responses. In this regard, the focus group was semi-structured. The four questions that were used to steer the discussion and draw it back to the focus area where necessary:

- a. What role do you think media plays in your lives?
- b. When you hear the term HIV and AIDS, what comes into your mind?
- c. What does *loveLife* do?
- d. Why do you find it difficult to talk to your parents about important things, for example sex?

The desire for rich and more detailed information necessitated the convening of a focus group following questionnaire administration. This decision was also influenced by the desire to develop my own understanding of the participant's perceptions of HIV and AIDS, as well as *loveLife's* HIV and AIDS communication campaigns. However, a focus group was used in lieu of individual interviews because a group discussion would enable the participants to (visually) share their experiences. Morgan (1997 as cited by Babbie & Mouton, 2001: 292) noted that focus groups also allow the researcher to "observe a large amount of interaction on the topic in a limited amount of time". This was crucial since this phase of the data collection process was used to collect information that leads to the fulfilment of the following aims:

- To describe the meaning of HIV and AIDS for these Deaf teenagers.
- To describe the processes through which sexuality communication takes place within these particular Deaf communities.
- To describe the young people's perceptions on the manner in which HIV and AIDS information is communicated within *loveLife* campaigns.
- To identify the different strategies *loveLife* employs to cater for Deaf adolescents in their campaigns.

Administration: Six (6) (out of the possible nineteen [19]) participants were selected to participate in the focus group following questionnaire administration. The criterion for

selection into the focus group was that they had completed the questionnaire survey – either during the piloting or final administration stages. A second criterion was a willingness to participate in the focus group. The group, which was composed of three boys and three girls, convened for two and a half hours. There were opportunities for me to follow-up on some of the comments made after the discussion during non-formal discussions when I needed further clarification.

The interpreter served to facilitate the dialogue and the group processes. Babbie & Mouton (2001: 293) attributed this role to the interviewer. The need to observe the group dynamics as they explored and shared the meanings of the topic together influenced the decision to use a focus group. The focus group also afforded me the opportunity to see the power dynamics at play between the participants themselves firstly. Secondly, it afforded me the opportunity to see the power dynamics at play between the interpreter and the participants. Third, it also made me even more aware of the dynamics at play between the interpreter and myself. Lastly, and of equal significance, during the focus group I was able to ask respondents to elaborate and clarify their responses as needed. This probing enabled me to check the accuracy of my understanding of what had been said.

Extensive notes were taken during the discussion. These notes formed part of the data in addition to the discussion, which was recorded and transcribed shortly after the interview. Rather, what was transcribed was the information that was relayed by the interpreter. The difficulty faced at this stage of the research process was ensuring that what was transcribed was exactly what the participants had said. This is a difficulty faced when content is translated from one language to another. In this case, it was particularly more difficult because of the vast differences in grammatical structure between SASL and English. Many words and grammatical markers are not expressed in SASL but are present in English. Similarly, SASL utilises a lot of facial expressions and body movements, which are lost once translated into English. To this end, a number of ideas that were emphasised by the participants might have been lost in the transcription process.

iii. Individual Interviews:

Description & Motivation: A number of open-ended questions were drawn from the questionnaire responses. During the preparation process, a number of probing questions were also drawn up. These ‘sub-questions’ would be used to elicit more information from the participants. The information collected during this phase of data collection would help the researcher achieve the following aims:

- To describe the meaning of HIV and AIDS for these Deaf teenagers.
- To describe the processes through which sexuality communication takes place within these particular Deaf communities.
- To describe the young people's perceptions on the manner in which HIV and AIDS information is communicated within *loveLife* campaigns.
- To identify the different strategies *loveLife* employs to cater for Deaf adolescents in their campaigns.

Individual interviews were conducted with volunteer participants, to allow each participant to speak for him-/her-self. As Babbie & Mouton (2001: 289) noted, each interview was:

“essentially a conversation in which the interviewer establishes a general direction for the conversation and pursues specific topics raised by the respondent.”

(Babbie & Mouton, 2001: 289)

The individual interviews also gave the participants the opportunity to ask questions they may have been too shy to ask in front of their peers during the focus group.

Administration: Seven (out of a possible nineteen) pupils agreed to be interviewed. Participants in this phase of the research had to have participated in either the questionnaire and/or focus group phases of the research. The second criterion was the willingness to participate. Individual interviews were conducted with four boys and three girls. Each interview lasted for approximately one hour.

The interpreter conducted the individual interviews in the absence of the researcher. The decision to conduct individual interviews was based on the need for further insight into participants' perceptions of HIV and AIDS. The interpreter took extensive notes during each interview. The interpreter who was interviewing then transcribed each interview immediately after the interview had ended. The transcripts were then shared with the participants to ensure that the transcripts reflected the participants' sentiments. Once this process had been completed for all the interviews, the transcripts and notes were then sent to the researcher.

iv. Task: Campaign Design

Description & Motivation: Four participants (out of a possible nineteen) were selected to complete the task. Only four participants were selected to take part in this last step to ensure that there would be ample time for the participants to discuss each of the campaigns at great length. The participants were all in grade twelve and had an average age of nineteen (19). The group consisted of three girls and one boy.

The task involved conceptualising an HIV and AIDS print campaign aimed at d/Deaf adolescents.

- To describe the processes through which sexuality communication takes place within these particular Deaf communities.
- To describe the young people's perceptions on the manner in which HIV and AIDS information is communicated within *loveLife* campaigns.
- To identify the different strategies *loveLife* employs to cater for Deaf adolescents in their campaigns.
- To describe Deaf adolescents perceptions on the nature and adequacy of their inclusion in *loveLife* campaigns.

The task created an opportunity for the participants to discuss *loveLife*'s current HIV and AIDS campaigns in greater depth. The task helped stimulate discussion by, first, getting the participants to create the kind of HIV and AIDS campaigns that they felt were needed. In so doing, the task got participants to think about what current *loveLife* campaigns were lacking

and how they could be improved.

Administration: The interpreter also conducted this task in the absence of the researcher. The task was conceptualised by the researcher and detailed instructions regarding how to conduct the task were given to the interpreter. To begin the task, the interpreter explained what the task entailed and how it would be undertaken. Then the participants were given blank sheets of paper and pencils. Once the participants had finished conceptualising their campaign, they then had to present their concept to the rest of the group. The interpreter had to ensure that the following questions were answered:

1. Is it a television, newspaper/magazine or poster (print) campaign?
2. What is happening?
3. What message is it sending about HIV/AIDS?
4. How is it different from *loveLife's* campaigns?

The three other participants also had the opportunity to ask the presenter questions and/or provide him/her with feedback regarding their concept. During this presentation and feedback session, the interpreter also took extensive notes. These notes as well as the task sheets were then sent to the researcher.

i. A Note on Reactivity:

The presence of the researcher and the staff member could have an effect on the type of data that was elicited from the respondents. The data could have been influenced by the phenomena known as *reactivity*. The term reactivity refers to the alteration of behaviour in reaction to the realisation that one is under observation. It presents as either the Hawthorne effect, experimenter bias, or; the Pygmalion effect. Behaviour can change either positively or negatively. That is, behaviour can become more destructive or better for example. These changes also arise in a bid to conform to the researcher's, and in this case the staff member's, expectations. As a result, reactivity poses a threat to the internal validity of the research. Babbie & Mouton (2001: 122) argued that reactivity makes it difficult to establish conclusively that the meaning attributed to the interview content is the real meaning of the content.

The absence of the researcher during this phase of the data collection process was considered to be advantageous. The researcher's absence was thought to increase the internal validity of the research by diminishing the influence of the researcher's presence on the responses given by the participants. This (reactivity) could not be controlled for in this research to the extent that it is controlled during blind experiments. In the present research, reactivity was accounted for, and, diminished through the use of more than one method of data collection. This was coupled with the writing of extensive field notes to yield a nuanced description of activities and the topic from the participants' point of view. Triangulation enhanced the validity and reliability of this qualitative research project. It offered a means through which checks can be performed on the data to ensure that the findings were indeed drawn from the data.

Strategies of credibility were also used to counter for reactivity. These strategies included prolonged engagement. Both the staff member involved in the interview processes and I spent lengths of time with the participant before and after the research process began. Babbie & Mouton (2001: 277) noted that this allows for us to establish a rapport with the participants and for data saturation to occur. These mechanisms ensure the credibility of the data. This in turn negates the possibility of participants saying that teachers are their primary source of information because a staff member was involved in the interview process.

3.2. Ethical Considerations:

The issue of informed consent presented the first ethical consideration. This issue must be dealt with in all research settings. This is irrespective of the nature of the research. This issue is pertinent in relation to children. The issue becomes even more pertinent when the research involves children classified as having special needs. To ensure that the participants were aware of what the study was about and that they could withdraw their participation at any time a process of linguistic accommodation was undertaken. Oral and written information, in this instance the informed consent forms, were reconfigured to make them more intelligible to the participants and a number of parents/guardians who were Deaf. This was in part an acknowledgement of the fact that their first language was not spoken English. Consent was

also sought from the children's parents/guardians because their children are classified as having special needs by health practitioners and the Department of Education.

The second issue is that of confidentiality and the related issue of anonymity. This was overcome in two ways. Firstly, pseudonyms were used to identify the participants as opposed to using the participants' real names. Secondly, by letting the participants fill in their own questionnaires. Allowing participants to fill in their own questionnaires ensured that only the researcher and the participant had access to that information. The information derived was not divulged to anyone else in any form other than this report. A number of other ethical considerations are to be found in the relationship between the researcher and the researched. In particular, the focus of this section lies on the possible impact that the research and research process could have had on the participants.

The sensitivity of the topic under discussion also added extra weight to concerns around confidentiality and anonymity. There was a fear amongst the participants that their responses would be divulged to teachers and/or parents. This may have made participants apprehensive about giving information that may become known to either their parents and/or teachers. This was dealt with through repeated reassurance of the participants. I also made an undertaking to keep the staff member I was liaising with up-to-date at each stage of the research process. Participants were given opportunities throughout the research process to ask questions pertaining to the research or provide feedback on the research process as they arose. The research was perceived to have minimal, if any negative impacts on the participants even though the topic under discussion was sensitive in nature.

3.3. Data Analysis:

This section details the procedures used to analyse the data.

3.3.1. Questionnaire Data:

First, responses to the open-ended question were coded. Second, all the data was entered into a Microsoft Excel spread sheet; checked and cleaned. This phase of data analysis primarily

involved the quantification of the number and percentage of respondents who selected particular responses for each question.

Descriptive statistics were drawn from this data. These statistics help us describe single variables such as age and gender. The data was summarised using averages, namely mean, median and mode.

3.3.2. Focus group & Individual Interviews Data:

The first step in this phase of the research process encompassed sorting the data into more manageable forms. The aim was to uncover regularities and themes informed by the research aims, which would then be interpreted.

The focus group transcripts and notes made during the interviews were read and re-read in order to familiarise myself with the content. Additional notes were also made on the data. Key themes within and across the interviews were identified. Data was initially sorted into categories that were informed by the research aims. The categories had been identified when the research objectives were being specified. The categories were:

- The meanings attributed to HIV and AIDS by the participants
- Participants' knowledge of HIV and AIDS
- Primary sources of HIV and AIDS information for Deaf adolescents
- Sexuality communication within Deaf communities
- Participants' views on *loveLife* campaigns
- Strategies used by *loveLife* to accommodate Deaf adolescents
- Deaf adolescents' perceptions of the extent of their inclusion in *loveLife* campaigns

The data was then regrouped, through a process of selective coding. Strauss & Corbin (1990 as cited by Babbie & Mouton, 2001: 500) defined selective coding as:

“[t]he process of selecting a core category, systematically relating it to other categories, validating those relationships, and filling in categories that need further refinement and development.”

After the core category had been identified, other categories are drawn from the data. The data analysis phase ‘concludes’ with the drawing of a relation between the core category and sub-categories. The task data was grouped in relation to the aim(s) of the campaigns. That is, task data was analysed in terms of whether the campaigns aimed to: (i) raise awareness; (ii) provide ‘how-to’ information, and/or; (iii) provide information on why one should adopt the preferred behaviour.

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CHAPTER 4: RESULTS AND DISCUSSION

The results obtained from the data collected will be presented in this chapter. The results will be presented in line with the key objectives of this research. This will be followed by a discussion of the results. Each discussion will link the findings to the theoretical perspectives outlined in the literature review. The chapter will then end with a summary of the findings and a discussion thereof.

4.1. Results:

The results presented in this section were obtained from questionnaire responses, individual interviews, the focus group and the task.

4.1.1. Participants' knowledge of HIV and AIDS: Facts and Myths

4.1.1.1. Participants' knowledge of HIV and AIDS: Results from the Questionnaire

For questionnaire item 3.6. the respondents had to indicate if they felt they had enough information about HIV and AIDS. Five (5/19) respondents disagreed with this statement. Two (2/19) respondents strongly agreed with this statement. Four (4/19) respondents strongly disagreed with this statement. Two (2/19) participants agreed with this statement. One (1/19) participant was undecided. Two participants (2/19) indicated that they needed more information.

Ten (10/19) of respondents stated that HIV is a virus that causes AIDS. Five (5/19) respondents responded that this was false and the rest stated that they did not know. Ten (10/19) of the respondents were aware that an individual needs to take 100% of their prescription medication once they begin treatment.

Nine (9/19) participants acknowledged that the HI-virus does weaken the immune system. Mother-to-child transmission (MTCT) was identified as one of the primary causes of HIV transmission. Breastfeeding was not identified as a mode of transmission of the virus. Neither

were unprotected anal sex and the sharing of needles. During the piloting phase of the questionnaire design process, it was established that the participants were unfamiliar with the term 'anal sex'. In the final administration of the questionnaire and during the focus group, the interpreter would first describe what anal sex is in lieu of naming the act. Overall, the participants exhibited fair knowledge of the causes of HIV and AIDS as well as its prevention and management.

The participants were then asked to indicate if a number of statements in question 9 were true, false or they did not know. The responses to each of the statements are presented in Table 2 below.

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Table 3: Responses to question 9

	True	% of sample	False	% of sample	I don't know	% of sample	Totals	
							n	%
HIV is a virus that causes AIDS	10	53%	5	26%	2	11%	17	90%
An HIV+ individual needs to take every prescription of his/her ARVs	10	53%	5	26%	2	11%	17	90%
HIV weakens one's immune system leaving a person unable to fight off opportunistic infections.	9	47%	4	21%	3	16%	16	84%
Anyone can get infected with HIV	11	58%	4	21%	3	16%	18	95%
You cannot become infected through sharing cups, plates or cutlery with someone who is HIV+.	10	53%	6	32%	2	11%	18	95%
HIV is passed on through infected blood and bodily fluids.	11	58%	4	21%	1	5%	16	84%
It is possible to be reinvested with HIV.	12	63%	4	21%	2	11%	18	95%
There is more than one strain of HIV.	11	58%	2	11%	3	16%	16	84%
HIV can be passed from mother to child in-utero.	14	74%	3	16%	1	5%	18	95%

For a number of the statements above, the number of responses do not add up to 100% (n = 19). Two factors account for this disparity. Firstly, some respondents may not have selected an answer for a particular question. That is, the data may be missing. Secondly, the participants may have selected more than one response for a particular question/statement.

Mother-to-child transmission (MTCT) was not identified as one of the primary causes of HIV transmission, with only six (6/19) of the respondents selecting it. Breastfeeding was also not identified as a mode of transmission of the virus. Neither were unprotected anal sex and the sharing of needles.

- *Access to Condoms:*

In response to a question on when condoms should be used, twelve (12/19) of respondents stated that condoms need to be used with each sexual encounter. Four (4/19) respondents argued that condoms should be used when one has more than one sexual partner at a time or if they are unaware of their partner's status. Only two participants, both male and female, stated that condoms should not be used at all during sexual intercourse.

Five (5/19) of participants indicated that they did not have easy access to condoms. The remaining fourteen (14/19) indicated that they did have easy access to condoms. In response to question eight, which asked: "*Where can you get condoms in your area?*" twelve (12) of the respondents indicated that they got condoms from the clinic. Five (5/19) of respondents indicated that they obtained condoms from the shop. Three (3/19) of respondents indicated that they get their condoms from friends.

Question 10 asked the respondents what the acronym 'ABC', which was used extensively in earlier campaigns, represents. Four (4/19) of respondents knew that it stands for Abstain, Be faithful, use Condoms. Two (2/19) of respondents stated that this acronym did not mean anything and it was just the first three letters of the alphabet. The same number of respondents indicated that the acronym stands for "abstain before condomising". Only one of the respondents indicated that the acronym stands for "always be careful".

In response to a question asking whether male circumcision lowers HIV infection risks for either or both sexes, five (5/19) participants responded that circumcision lowers infection risk only for men. Another five respondents (5/19) stated that male circumcision reduces a woman's risk of infection. Three (3/19) respondents said that circumcision lowers risks for both men and women.

- *Assessing personal vulnerability:*

Question 11 asked which age groups were the most vulnerable to infection. Participants indicated that the fifteen to twenty-four year age group, within which most of the participants fall into, was the most vulnerable to infection. Questions relating to personal vulnerability revealed that the majority (12/19) of the respondents were not concerned about HIV and

AIDS in relation to themselves. Five (5/19) participants were concerned about HIV and AIDS in relation to themselves. These participants were also concerned about the disease in relation to an immediate family member.

Question 13 asked respondents to select the factors that make a person vulnerable to infection. Age was identified as a factor that made an individual more vulnerable to infection. Peer pressure, gender, drug and/or alcohol (ab)use, unprotected vaginal, and, unprotected anal sex were not identified as factors that increasing vulnerability.

4.1.1.2. Participants' knowledge of HIV and AIDS: Results from the Focus Group

Some of the participants had indicated in the questionnaires that they did not have enough information about the disease. During the focus group, one participant stated that he would like more information on ARVs because:

“I don't know how the pills work but I know that you have to take them and ... you need to make a lot of changes in your life, like... you must not drink [alcohol] and smoke anymore”.

- *Access to Condoms:*

As was indicated in the data from the questionnaire, participants reiterated that they get condoms from the clinic, shop and/or their friends. To this, one participant added:

“[o]nce in a while if I walk into a [public] bathroom with condoms and there's no-one around, then I'll grab a few for myself.”

Part of the discussion focused not only on access to condoms but on which condoms they had the easiest access to. It bears mentioning that the participants only had access to male condoms. The girls did have access to male condoms. However, male friends facilitated their access to these. The girls also chose not to carry condoms around. A female participant said:

“girls can't carry condoms, you just can't. People will think you are sleeping around [with more than one boy] and you don't want people thinking that [.....] when people start talking

and staring at you even your boyfriend will end up not believing you and he'll also think you're sleeping around.”

The following was said of female condoms:

“I've only ever *really* [emphasis in original] seen female condoms one time ... maybe two times at most...”

Another participant added:

“If they [female condoms] work just as well [as male condoms] then why aren't they as easy to get? [...] even if I was to get one, how would I use it? You are never shown how to use it ... such demonstrations are done for the male one”.

The discussion then turned to the frequency with which condoms should be used. Two respondents in the first phase of data collection had indicated that condoms should never be used during sexual intercourse. In response to a similar question during the focus group, a female participant said:

“it's not okay to use condoms. Why should you when you are married and starting your family? If you're not married then you shouldn't be having sex [...] you *must* abstain” (emphasis in original).

- *Assessing personal vulnerability:*

The questionnaire data revealed that only a small number of participants were concerned about the disease in relation to themselves. During the focus group, participants were asked why that was the case. One participant stated he was not concerned about the disease in relation to himself because:

“I don't do anything that could leave me infected [...] I'm always careful but my friends, on the other hand, do take chances”.

The interpreter probed what precautions they took to ensure they did not catch the virus. One participant said:

“you must not sleep with someone who has the virus...you just know when someone has it [the virus]... you can see, they'll look sick and thin. You just need to make sure that you don't touch things that they have used, like cups and spoons.”

This attitude was true for more than half the focus group participants even though they had seen someone suffering from HIV and AIDS. The youngest participant in the group said:

“I watched someone very close to me suddenly get very sick [...] but at the time I did not know what was wrong. Nobody wanted to tell me what was wrong. Eventually I figured it out and asked my cousin who confirmed it was AIDS [...] now I always wonder whose next”.

Another participant added:

“I also wonder who's next in my family, except I was told from the beginning what was wrong with my uncle. I could see that everyone in my family was getting ready for the worst but, thankfully he's still alive”.

The issue of circumcision was brought to the fore during the focus group. A male participant stated that:

“at least guys who have been circumcised don't have to worry about catching the virus [...] they are protected so they don't have to worry if they don't have condoms or anything”.

This quote reveals a link between perceptions of personal vulnerability to HIV and misconceptions of the disease. This and other misconceptions will be highlighted further in the subsequent section.

4.1.1.3. Participants' knowledge of HIV and AIDS: Results from the Individual Interviews

The individual interviews revealed that the participants did want a lot more information on the disease than had been indicated in the questionnaire and focus group. Participant A5

noted that the information they had received thus far “doesn’t help”. Participant A5 furthered stated that:

“there should be more pamphlets and the books so that I can study”.

The individual interviews also revealed that participants harboured a number of misconceptions about the disease. In response to a question pertaining to the difference between HIV and AIDS, participant A7 said:

“it [HIV] starts from water and then it will be blood. It means your blood will be watery, it won’t be thick”.

In response to the same question, participant A5 stated that:

“when you are HIV-positive you don’t want to disclose, you just want to keep quiet and not tell anyone [...then...] they’ll die [...] after nine months or one year”.

In response to a question on how to prevent being infected with HIV, participant A7 stated:

“You cannot protect yourself from AIDS because it’s there, it won’t be finished.”

4.1.2. Meanings attributed to HIV & AIDS:

4.1.2.1. Results from the Focus Group:

A myriad of meanings attributed to the disease were expressed during the focus group. One participant said:

“HIV is a just disease [...] a person can live with it for a long time if they do what their doctor tells them”.

Another participant diverted the discussion back to notions of promiscuity with the following statement:

“You get the disease as a punishment [...] you would have done a lot of terrible things in your life to get it and die. Maybe you were sleeping around and then you catch the disease as your punishment [...] if you live don't misbehave then you won't get it [HIV]”.

- *Risky Behaviour Defined:*

Heterosexual behaviour was identified as a key driver of the disease. At the collective level, risky behaviour was identified and attributed to:

“girls, who have many boyfriends [and] have [unprotected] sex with them”.

Individual perspectives varied slightly from this as follows:

“it's not only about using or not using condoms; these girls don't know how to behave. They always go out late at night and sometimes they even sneak out of home”.

A second participant added that risky behaviour occurs:

“when you know that you are not well but you go and have sex with other people”.

4.1.3. Sources of sexuality-related information for Deaf adolescents:

4.1.3.1. Results from the Questionnaire:

The primary source of information identified by the participants in the questionnaire responses was the Life Orientation teacher. The school nurse and friends were identified as secondary sources of sexuality-related information.

- *Home: Parents & Guardians:*

Ten (10/19) of the participants strongly agreed with the following statement: “I struggle to talk to my parent/guardian about anything significant”. Two (2/19) participants agreed with

this statement. Six (6/19) participants strongly disagreed with this statement. The rest of the participants (3/19) disagreed with this statement.

4.1.3.2. Results from the Focus Group:

The focus group participants also indicated that they did not speak to their parents/guardians about anything significant especially sex. During the focus group, one participant said:

“my parents and I do not have that kind of relationship. We talk about this and that but I could never ask them about sex [...] it would be such an uncomfortable discussion. Even more so for my parents than me I'd imagine since their signing is not that good either.”

Another participant added:

“I don't even talk to my parents that much so starting a conversation about sex with either of my parents is going to be hard. I guess I have to wait for the day that they bring it up”.

The participants got the bulk of their information on HIV and AIDS at school.

- *School: Teacher*

During the focus group, participants did contend that teachers were their primary source of HIV and AIDS information. Participants did reveal that the limited nature of their interaction with the teacher meant they could not ask questions on the things that they had heard outside the classroom. One participant stated that:

“we spend so much time talking about and asking questions about what is in the textbook, to make sure that we understand everything so that we can pass our tests and exams. We are not left with any time to ask questions about what we hear from our friends”.

Another participant said:

“it would be strange to ask the teacher lots of questions about sex. It's like asking my mother or my father. I couldn't do it, so I just listen to what the teacher says and then after class I ask my friends to explain or for more information.”

- *School: School Nurse*

The school nurse was identified as the second source of information in the questionnaire responses. In the focus group, one participant said:

“the nurse is always around. If you need to ask a question, she's easy to find. Also she's nice [...] and you can trust her. She won't tell or laugh at your questions.”

- *School: Friends*

One participant stated:

“at least I can talk to my brother and ask him questions about sex and stuff when I am at home. Also he brings it [sex] up whenever he hears something new.”

The same participant went on to add that:

“but like me he doesn't know everything [...] so I must always ask someone ma'am [teacher] or someone else if what he said is true”.

- *Access to Youth-friendly Health Services:*

“[H]ow do I even begin trying to ask my mother to come with me to the clinic because I need an HIV test? You know we can't go for these things first, because the clinic needs permission from our parents. Even if I was to get that permission, what's the point when the nurse is just going to talk to my mother and not tell me what is going on in my body?”

This question was posed by one participant in response to a question about how often they go for HIV tests. A second participant added:

“when I'm sick I attend the clinic with my mother and she must explain what's wrong with me, sometimes the nurses don't do anything more than listen to my mother and take my temperature [...] then they give my mother some pills and we go home. Nobody even tries to ask me what's wrong”.

A third participant stated:

“it's definitely easier to go the school nurse than to go to the community clinic..... but when it comes to HIV tests though, you still need to get your parents' permission so in the end it's never your decision it's your parents”.

The findings illustrated that accessing health services outside the school environment was said to be more difficult for the participants.

4.1.3.3. Results from the Individual Interviews:

During the individual interviews, a number of the participants noted that they obtained the bulk of their information from the class-work books and portfolio files the teacher provided.

4.1.4. Perceptions of *loveLife*'s HIV and AIDS campaigns:

4.1.4.1. Results from the Focus Group:

Of all the mediums that *loveLife* utilises to disseminate their messages, the participants stated that they only had limited access to television and print content. Radio is the one platform that the participants stated outright that they had no access to at all. In response to questions about *loveLife*'s television public communication campaigns specifically, a participant said:

“every once in a while I come across one of their advertisements. The only reason I know that it's their advertisements is because I have seen their logo a few times and my brother explained what they did.”

A second participant said:

“I have seen some of their adverts on TV. [...] they're usually very colourful but the pictures go by so quickly and so does the writing on the bottom – which is so small too – that I don't get a chance to even figure out what it's all about or what they're trying to say.”

When asked who the participants thought was *loveLife*'s target audience, one participant said:

“for the most part I think the [*loveLife*] adverts are aimed at people our age but at the same time it's not for us [Deaf teenagers]”.

The participants said that *loveLife* could make their television campaigns more accessible to d/Deaf adolescents by:

“at the very least [...] using an interpreter or better yet have a Deaf boy or girl as the central figure in the advertisement”.

4.1.4.2. Results from the Individual Interviews:

Participants in the individual interviews also expressed frustration at their inability to access *loveLife*'s campaigns. Participant A3 was asked if any information she obtained from television subtitles was useful. The participant said:

“I don't understand also the words that are being written there”.

Participants A1 had not “thought about” how *loveLife* could ensure that their campaign messages reached Deaf adolescents.

4.1.4.3. Results from the task:

The task gave the participants an opportunity to think about what *loveLife* could do to make their campaigns more accessible to Deaf adolescents at greater length. The participants produced mainly print campaigns. As C3 noted of the poster in figure 1 below:

“the posters will ensure that people will have as much information as possible”.

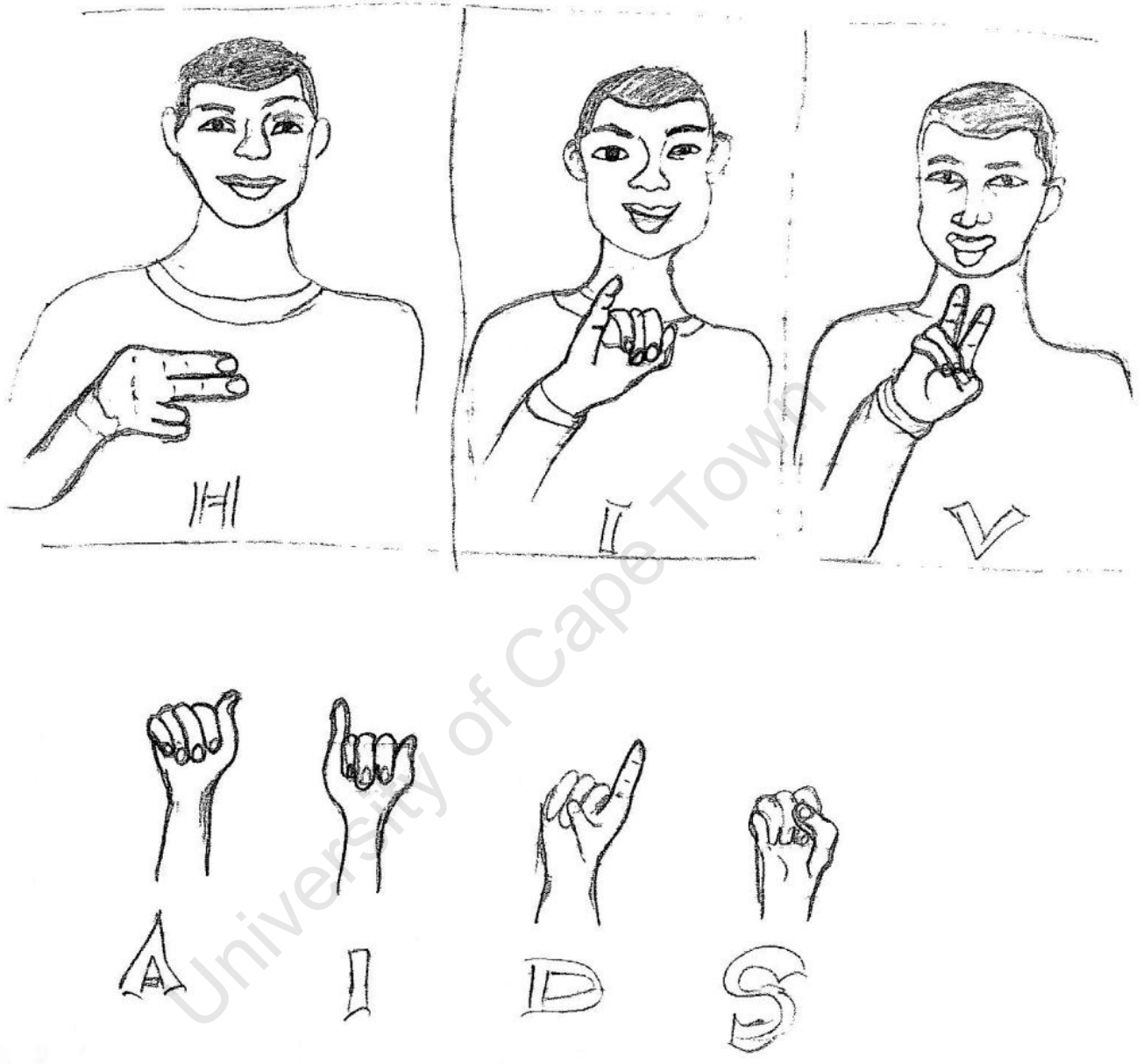


Figure 2: Possible HIV and AIDS print campaign

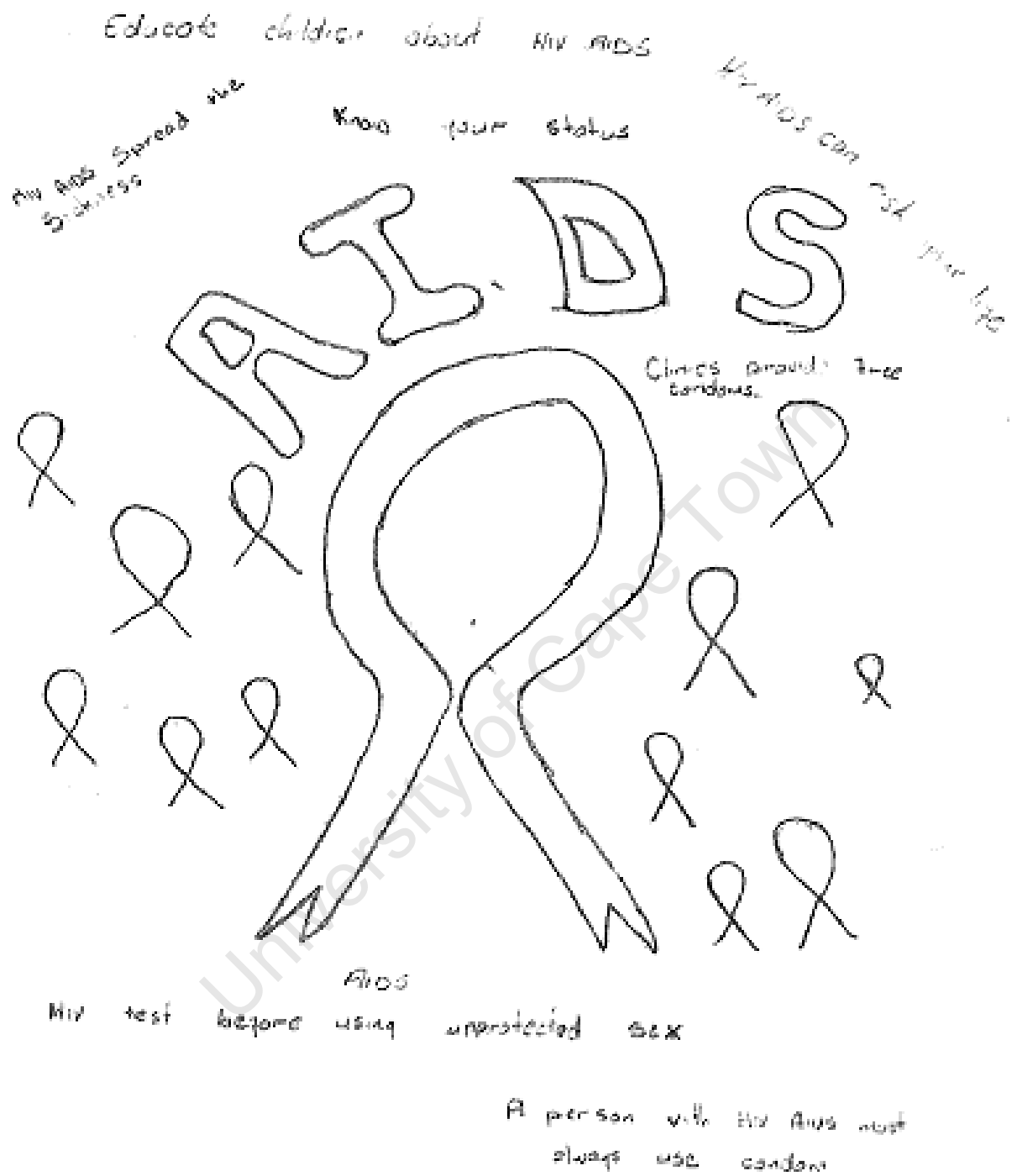


Figure 3: Ribbon Poster – HIV and AIDS print and/or television campaign

4.2. Discussion of Findings:

4.2.1. Sources of sexuality-related information for Deaf adolescents:

The study sought to identify the main sources of sexuality-related information for the participants. The questionnaire data revealed that the Life Orientation teacher and the school nurse were the primary sources of HIV and AIDS information for the adolescents. This means that the school was the main location in which participants received HIV and AIDS information.

Although teachers and the nurse were identified as the primary sources of information, friends were identified as being the most forthcoming with information during the focus group and individual interviews. The identification of teachers as the primary source of sexuality-related information could have been because of the fact that a staff member assisted in the interview process. However, this possibility was minimised through the various strategies used to mitigate reactivity. Friends were also identified as being the most open to discussion and debate on the issues of sexuality and HIV and AIDS. It is important to note that the term 'friends' was also used to refer to (hearing) siblings. Information provided by friends was not thought to be as reliable as that obtained from the school nurse and teachers. Reliability of information was correlated with age and stature in the community. The older an individual was and the more respected they were within the community, the more reliable their information was thought to be. Friends, on the other hand, held no stature within the community and although the participants sought information from them, they did not trust it completely. Each source of sexuality-related information was deemed to have different levels of credibility by the participants. This criterion, however, was not the primary determinant of which source to utilise for information. The overarching factor influencing this choice is accessibility.

Botchway (2004: 14) argued that adolescents do not go out of their way to seek information. In accordance with this notion, the study highlighted that the participants rely on those who they have immediate and the most access to for sexuality-related information – teachers and nurses. This finding supports Botchway's (2004: 14) assertion, as children spend most of

their time at school. At the time that the focus group convened, none of the participants had yet engaged in sexuality-related discussions with their parents and/or guardians. Hearing siblings remained the primary source of information in the home sphere. One participant attributed the failure to speak to her parents about sex to her parent's inability to sign. The implications of these findings for the sexual socialisation of Deaf adolescents are grave.

Pridmore & Yates (2006: 3) argued that governments have failed to provide schooling to its most vulnerable children. Amongst the children that the government has failed are d/Deaf adolescents. Although the South African government has made great strides to provide schooling for children in most communities, they face another challenge. This challenge, as noted by Ahmed et al (2006: 622), is posed by the inadequacy of the Life Orientation curriculum. Pridmore & Yates (2006: 95) went on to argue that many children could not access this curriculum. The focus group and individual interviews data revealed that, for the participants, discussions within the classroom centred on what was contained in the school curriculum. This finding is particularly troubling. The participants' went on to express discontent at the limiting of their interaction with the teacher to Life Orientation classes. The participants do not have many opportunities to ask questions beyond the scope of the curriculum to which they have very limited access. The finding that the school nurse is a primary source of information provides evidence of the possible inadequacy of the country's Life Orientation curriculum. The need to ask the nurse for information highlights that the participants are also unable to access the curriculum.

4.2.2.1. The influence of contextual factors on Deaf adolescents' identity and sexual socialisation:

Initially, the commonly shared inability to speak to parents and/or guardians revealed in both the questionnaire and focus group data sets appears to be a nothing more than a communication problem. Data from the individual interviews revealed that the issue ran deeper than that. This is particularly true for the home sphere.

i. SASL as a source of tension in the home:

Usdin (2003: 43) argued that communities determine in how, with whom and when sex can happen. In a number of South African communities, these sexual realities are determined by African traditions. Many African traditions stipulate that a child must be raised according to the customs and traditions of his/her father's culture. In the absence of the father, the child is raised in accordance with his/her mother's traditions. This includes learning to communicate in his mother's or father's home language.

It is difficult for many parents to accept their children's Deafhood. This reluctance to accept that a child is Deaf stems in part from the fact that the impairment is often diagnosed later on in the child's life. Until a diagnosis is made, the inability of Deaf adolescents to speak to their parents' language is often perceived as a failure on the part of the child. Once a child is 'diagnosed' as Deaf, parents continue treating their child(ren) as if they were hard of hearing. Amongst poorer Black African parents, this acceptance rarely reaches the point where they seek help and learn SASL. Once the children begin formal school and adopt SASL as their first language, tension arises in the home. The tension revolves primarily around the loss of the family's traditions if the Deaf child does not learn his/her home language. On another level, the conflict centres on the child's and to a lesser extent the parent's identity.

ii. Deafhood as a source of tension within the individual:

Discussions on sexuality and rites of passage that began in the focus group continued in the individual interviews. The focus group data revealed that participants were eager to go through the rites of passage as dictated by their fathers' or mothers' traditions. The individual interviews data revealed that this decision was based primarily on their desire to be viewed as adults. The data revealed that not all the research participants based their identities on their participation within a Sign Language minority group. Put differently, some of the participants made the decision to base their identities on the culture, and not the language, which they had the most access. Some participants identified themselves as Tswana- and Sotho-speaking for example, as dictated by *their*, that is, their fathers' cultures. Other participants had adopted SASL as their first language. To this end, it is necessary to make the distinction between little 'd' deaf and big 'D' Deaf (d/Deaf) when referring to the participants in the remainder of this thesis.

This finding demonstrates the complex interplay between language, culture and identity. It also illustrates how identity is constituted in communicative interaction particularly between parents and their children. This is irrespective of how limited this interaction is. Participants were well aware of the manner in which the transition to adulthood was accomplished within their, that is their father's respective cultures. It is important to note that for a couple of the participants whose fathers were absent, they stated that they still had to go through the rites of passage as dictated by their father's cultures. This was irrespective of the fact that their mothers and/or guardians had raised them in accordance with different customs.

iii. The sexual socialisation of Black African adolescents:

Botchway (2004: 14) argued that sexually active male adolescents will not go out and seek sexuality related health services and/or information, especially from parents. Botchway (2004: 1) further noted that, in Africa, parents are not responsible for the sexual socialisation of their children. The finding that the participants have not and are unable to speak to their parents about sex is not surprising when viewed in this regard. Girls and boys seek sexuality-related information from their aunts and uncles respectively. This is problematic on two fronts. Firstly, and as Seekings & Natrass (2006: 52) argued, rapid urbanisation has disrupted traditional structures. This means that d/Deaf adolescents do not have easy and direct access to their aunts or uncles should they have any questions. This is assuming that these relatives can sign. Since adolescents are unable to ask their parents for information, they have to ask their hearing siblings. These siblings may or may not have the answers. Secondly, leaving the sexual socialisation to relatives possibly residing in another homestead is equally as problematic. At best, their signing is rudimentary. This means that a communication 'breakdown' hinders the transmission of information through the culturally sanctioned channels.

The focus group data showed that the younger male participants are concerned by the fact that they did not fully comprehend the initiation process. This was due in part to the 'communication breakdown' that prevents information from being effectively passed on through culturally sanctioned channels. It is also due to the secrecy, noted by Harrison (2008:

<http://www.tandfonline.com/doi/full/10.08013691050701775068>), that shrouds not only the initiation process but adolescent sexuality discourses as a whole. The participants argued that it was at these initiation schools that their sexual realities would be shaped and reinforced. To this end, they were worried that *ukhanki* (the teacher) would not know sign language. This would mean that they could possibly miss out some important teachings - teachings that they may not have access to again once they went back home. That is, unless they have older siblings who have been to initiation school and can fill in what they missed. There appears to be, as Popplestone (2005: 131) argued, fear of sexual marginalisation because of one's disability.

4.2.2. Infantilisation & HIV and AIDS knowledge:

The first research objective was to describe the participants' perceptions on HIV and AIDS. The focus group and individual interviews data sets revealed that HIV and AIDS mean many (different) things to the participants. The data also revealed a discrepancy between the way the participants understand the disease, its modes of transmission and its effects on the body. Shefer (2004: 204) attributed this discrepancy to the process of signification. Their understanding of the disease, and consequently the meanings attributed to the disease, is particular to their socio-economic positioning. The permeation of a number of myths and misconceptions held by hearing communities is indicative of the extent to which the participants have been influenced by their socio-cultural and economic contexts.

The participants' socio-economic positioning is intricately linked to their positioning as children with special needs. The signification attached to their impairment serves to restrict the participants' movement. This signification is in the form of the 'children with special needs' label. This classification – and the consequent grouping of d/Deaf adolescents with children with physical and/or mental impairments – results in the limiting of the spaces in which these children can move about in freely. The data revealed that the classification of d/Deaf adolescents as 'children with special needs' and/or disabled served to restrict participants' movements within their community. In the case of the research participants, their parents and/or guardians primarily undertake the restriction of their movement. This restriction serves to reinforce the notion that Deaf adolescents are children.

It is partly for this reason that the participants were eager to go through the rites of passage as dictated by their fathers' traditions. The ability to hear and communicate verbally that some of the participants' siblings possess results in these hearing siblings being (un-) consciously treated as though they are more intelligent. In the same manner, they are assumed to be more mature. Participants were aware of the responsibility that a culturally sanctioned transition to adulthood came with. They welcomed this responsibility, as it would accompany changes, however slight, to their positioning in society.

The participants did not examine the extent to which their treatment as infants contributed to their limited access to HIV and AIDS related information and their negation of personal risk. Sait et al (2009: 36) noted that disabled individuals are viewed as perpetual children. The assumption that Harlan Hahn (as cited by Thomson, 1997: 25) referred to as asexual objectification accompanies this notion. The participants did not feel that their treatment as children, and consequent asexual objectification, was linked to their Deafhood.

The participants also did not examine the extent to which their association of the disease with certain groups of people contributed to their negation of personal risk. Kalichman et al (1993: 292) argued that the attachment of meanings to the disease results in the association of particular outgroups (and their associated behaviours) with the disease. The participants did not perceive their negation of personal risk to be related to the misconceptions they held about the types of individuals who were at (greater) risk of infection.

Gouws & Abdool Karim (2005: 61) noted that, generally, women have higher rates of infection. This supports Epstein's (2007) contention that AIDS is a disease of gender inequality. The findings also provided evidence of the fact that although the participants are able to identify the behavioural drivers of HIV and AIDS, they do not fully comprehend the socio-economic and cultural drivers of the disease. The lack of acknowledgement of the fact that some boys are also promiscuous supports this finding in part. The participants did not examine the extent to which promiscuous boys and men contributed to the spread of the disease. The participants attributed the spread of the disease to promiscuous girls. The participants also did not examine the extent to which gender inequality, in particular, has resulted in women being disproportionately affected by the pandemic.

The participants did add one further dimension to the notion of AIDS being a disease of inequality. Although, very few participants expressed concern about the disease in relation to themselves, they were aware that their inability to access information, from *loveLife* amongst other sources, was detrimental to their health and in some respects discrimination. This discriminatory practice was (un)consciously being carried out in favour of the able-bodied. In particular, this discriminatory practice is being carried out in favour of the hearing.

4.2.2. Perceptions of *loveLife*'s HIV and AIDS campaigns:

The questionnaire data revealed that participants did not have access to youth centres. The focus group data supported this. This data set also revealed the fact that participants were aware of *loveLife* and the services they offer. The data from both data sets revealed that participants were unable to access *loveLife*'s services and the messages carried in their campaigns. The overarching perception was that *loveLife*'s campaigns were targeting adolescents; however, there was no attempt to ensure that d/Deaf adolescents had access to the messages. These sentiments did not hamper the participants' efforts to gain more information about the disease with the assistance of their hearing friends. In some instances, it spurred participants to find out "what all the fuss is about" (female participant).

The data from the task revealed that it is possible to tailor campaigns to target d/Deaf adolescents as well as hearing adolescents. This is not to say that tailoring campaigns for d/Deaf adolescents will not have its own challenges. At the very least the data from the task highlights that the creation of HIV and AIDS campaigns targeting d/Deaf adolescents is worthy of consideration. The clarity and simplicity of the messages their print campaigns carried made it accessible to both d/Deaf and hearing adolescents. *loveLife*'s attempt at linguistic accommodation encompasses the use of subtitles. The notion of limited access to *loveLife*'s campaigns was carried through in the discussion of *loveLife*'s television campaigns. Although they do have limited access to television, the participants cannot utilise this or any other media platform to obtain sexuality-related information. Groce et al (2006: 2) theorised individuals with lower literacy levels do not read newspapers and magazines. The findings highlighted that the media, namely television and newspapers, were not utilised by the participants to obtain HIV and AIDS-related information. None of the participants had

access to *loveLife's* campaigns. With particular respect to television, it was also not utilised to obtain information because of the fast pace at which subtitles flashed across the screen. Stevens (1998: 102) argued that PSAs target those who can hear and read a spoken language. Subtitles are a transcription of what is being said. Campaign designers do not attempt any linguistic accommodation. This means that the message received by the d/Deaf viewer is vague and incomprehensible. A lot of unfamiliar and culturally specific terminology and nuances are utilised in *loveLife's* campaigns. These are drawn from spoken (oral) language. The conceptualisation of communication primarily in relation to the hearing populations results in d/Deaf adolescents not being identified as members of the target group.

Ndoleriire (2000: 269) argued that socio-cultural factors function as *noise*. This *noise* distorts messages resulting in miscommunication. The liberal views expressed in *loveLife* campaigns and in the L.O. Curriculum are often at odds with the conservative messages passed through culturally sanctioned channels. In the end, the adolescents get mixed messages. Another significant limitation associated with the television campaigns is its lack of feedback mechanisms, particularly for d/Deaf adolescents. Hearing adolescents are able to provide and receive feedback at the Y-centres and through *ThethaJunction*. d/Deaf adolescents do not have this opportunity.

4.3. Conclusion: The love life generation - Can d/Deaf teens be a part of it?

The discussions in the preceding sections have brought a number of key issues to the fore. These issues culminate in the exclusion of d/Deaf adolescents from the fight against HIV and AIDS. d/Deaf adolescents are denied membership into the *love life generation*. They are also denied the opportunity to engage in discussions about HIV and AIDS and its effects on d/Deaf communities with their hearing counterparts.

loveLife utilises a number of channels to disseminate their messages. Of these, radio is the one media platform that d/Deaf participants have no access to at all. The participants get their information from their teachers, friends and the school nurse. Their knowledge of *loveLife* does not extend beyond the recognition of the organisation's logo. A lack of knowledge of *loveLife* and its activities does not mean they cannot be part of the *love life generation*. The

participants' low levels of commitment to the promotion of a gender-equal society do exclude them from participating in the *love life generation*. This is in spite of the fact that the participants do possess a fair amount of information on HIV and AIDS. Put differently, they are therefore 'body-wise'. The participants' non-commitment to the drive for gender-equality is evident in their attribution of the blame for the virus' spread on women alone. This line of thinking places the responsibility to halt the virus' spread solely on women. Women are placed in the position of having to control not only their own sexuality, but that of men as well.

Second, having been classified as 'children with special needs' they have been stripped of their power-to-decide what happens to them and their bodies. The problem with the "children with special needs' and 'disability' labels is that it lumps a wide array of individuals with various impairments under one umbrella. The effect of this is that individuals with physical impairments like d/Deaf adolescents are treated in the same manner as adolescents with varying degrees of mental impairment. Ultimately, these adolescents – irrespective of the type of impairment they have – are treated as children and incapable of reasoning soundly. As Erasmus (2008: 187) noted in relation to "race", their impairments are treated as though they are "all determining, fixed and immutable".

Lastly, by virtue of their negation of personal risk, the participants cannot gain membership into the *love life generation*. Being a member of this group involves the affirmation and examination of one's personal risk. The participants have not done so.

At a more fundamental level, campaign designers have denied the participants membership because no linguistic accommodation was undertaken. For the most part, *loveLife* does not attempt to accommodate the d/Deaf linguistically. Most of their television campaigns do not contain subtitles. Those that do contain subtitles, cater for an audience that can hear and speak an auditory language. The grammatical structure used for the subtitles is that of spoken English not SASL. Furthermore, the subtitles cater for individuals with the average reading level of most Hearing teenagers. The fact that the subtitles flash by quickly complicates this further. Most participants said that they got nothing from these advertorials. Those few participants who were able to pick up fragments of the subtitles ended up receiving a confusing message.

The campaigns the participants conceptualised during the task overcame these limitations by incorporating bold pictures and sign language. The campaigns utilise less wording and contain a simple, clear message that the average learner can comprehend. The campaigns are accessible to both the average d/Deaf and/or hearing learner. Furthermore, the campaigns also teach hearing adolescents Sign Language as campaigns contain Sign images in addition to subtitles.

The notion that d/Deaf adolescents have been denied membership into the *love life generation* is supported by the fact that it was only in the North West province where d/Deaf participants were sought for the *loveLife* games. For the rest of the year there are no attempts to include Deaf communities in *loveLife*'s activities and campaigns. The reasons given for this ranged from a lack of resources to a lack of communication skills.

Wallack & Dorfman (2001: 389) noted public communication campaigns such as those of *loveLife* fail to acknowledge a number of wide-ranging factors and focus at the individual level. It is in campaign designers' ability to 'choose' whether or not to include Deaf adolescents in their activities that it is visible that the power lies solely in campaign designers hands. Deafhood is a factor that needs to be accounted for as it has significant implications for the choice of communication channels that must be used to disseminate campaign messages.

CHAPTER 5: CONCLUSION

This study highlights the difficulty d/Deaf adolescents face when trying to obtain sexuality-related information in general as they do not have access to youth-friendly healthcare services. This study has shown that the participants feel that their Deafhood is used to control their movement, behaviour and their access to sexuality-related information. This thesis has served to highlight that this group of Deaf teenagers, and possibly others in similar socio-cultural and economic environments, have been (un-) consciously excluded from the fight against HIV and AIDS. This has been achieved through the almost exclusive utilisation of cultural references drawn from hearing communities in the mass-media communication. The d/Deaf participants have no, or at best, very limited access to these references.

This chapter will outline a number of research gaps that were brought to the fore by this current research.

5.1. Avenues for Further Research:

A number of findings that extended beyond the objectives of this research were made. These findings have highlighted a number of possible research avenues.

Firstly, research could be conducted into the possibility of increasing Deaf children's access to health services outside of school by utilising those who teach children with special needs as support staff in community clinics. A finding made during the preliminary research, supports this. *loveLife* had no SASL proficient volunteers in its centres. According to Sekgobela:

“as an organisation that relies largely on volunteers they are faced with a skills limitation [...] as yet we have no volunteers who can interpret into sign language. This makes it difficult to target Deaf adolescents. It is only possible when they are working with individuals with the skills, for example the Sencity project.”

(Interview, Sekgobela, June 2010)

Employment of teachers and nurses working within schools for the d/Deaf would greatly increase d/Deaf adolescents' access to sexual and reproductive health services outside the school environment.

However, participants' reluctance to visit centres outside of school were not driven solely by the inability to communicate with those working within these centres. A fear of violation also drove these feelings. Feelings of vulnerability and fear of violation were expressed by the participants, in particular the girls. One of the respondents stated that:

“you just go to school and go back home. You can't be walking around alone after school. No-one around you understands sign....so if you were to get into trouble [...] robbed or something like that and need help, no-one will understand. It's best to stay in places that you know you're safe in.”

Secondly, the specific areas in which the Life Orientation curriculum falls short can be investigated. One aspect of the research could look at the extent to which participants, specifically children with impairments, are familiar with terminology used in learning material. Further research needs to be conducted with particular reference to children who have much lower reading skills and are out of school. This research would possibly uncover if campaign designers would have to cater for them differently to Deaf adolescents who are in the right grades for their ages.

The non-utilisation of parents and/or guardians as sources of sexuality-related information is due in part to the some parents' inability to sign. One participant expressed her frustration as follows:

“it's hard to say what is on my mind when it's just my father and I alone in the house. He cannot sign so he spends the greater part of our time together making gestures I do not understand. When I sign, it is clear that he does not understand me at all [...] I end up giving up and walking away.”

Not all the participants experience this frustration. Some participants disagreed stating that:

“my [parents] can sign. My mother started taking sign lessons when I started school. We kind of learnt together [...] we understand each other very well when we sign but I still wouldn't ask her about sex”.

This reluctance to speak to parents about sex stems from traditions, which place the responsibility of sexual socialisation of adolescents on aunts and uncles. In some instances, this is the duty of initiation school teachers. Initiation school teachers are also another underutilised resource. A third avenue of research would explore the possibility of initiation school teachers collaborating and working with community clinic nurses to disseminate sexuality-related information to adolescents since they have

experience. Furthermore, they are the culturally sanctioned avenues through which such knowledge can be imparted to adolescents. This means that community members will put up very little, if any, resistance to their young(er) children being taught about HIV and AIDS.

Lastly, research on the specific effects of infantilisation on the assessment of personal risk by d/Deaf adolescents could be undertaken. One participant contended that:

“I can’t wait until I come back a man, [and] then my parents will have to stop treating me like a child”.

This quote highlights the possible link between infantilisation and the minimisation of personal risk by participants. Future research can examine the extent to which these two are correlated.

5.2. Conclusion:

The manner in which this study was conceptualised limited the scope of the research. Time constraints served to limit further the scope of the research. To this end, a number of issues that came up during the research process provided insight into possible avenues for further research. The list presented above is not exhaustive. The list merely highlights a few issues that could shed further light to the themes identified in this study. The existence of these avenues for research points to the existence of significant gaps in our literature. This research has gone some way towards offering insight into the children’s perceptions of their Deafhood as a factor that excludes them from gaining access to information via *loveLife*’s media campaigns. Research in the fore mentioned avenues combined with this research could give rise to new and inclusive methods of public communication. This will undoubtedly have the effect of including more marginalised communities in the fight against HIV and AIDS.

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University of Cape Town

APPENDICES:

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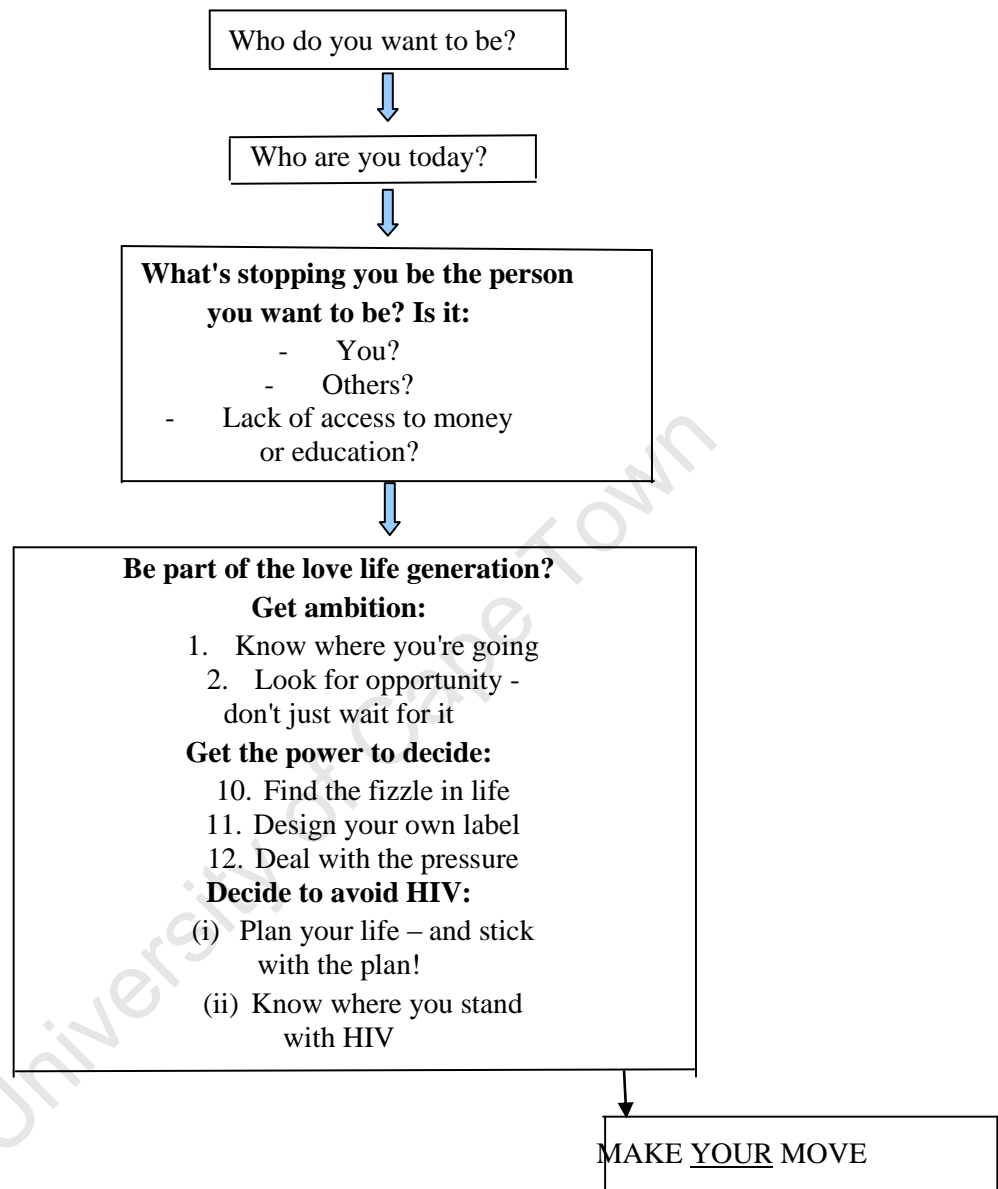
Appendix A: *loveLife*'s Communications Strategy

Year	The Problem	<i>LoveLife</i> 's Response
1999	We South Africans aren't talking about the HIV epidemic	Talk about it
2000	We aren't connecting HIV and sexual behaviour	It's about sex
2001	We aren't connecting HIV and their future	HIV: The future ain't what it used to be. Motivate a new HIV-free future.
2002	We are not taking personal nor collective responsibility	Shape values of responsibility, love, dignity and respect.
2003	We know about the ABC, but telling people to ABC does not address the drivers of high risk behaviour	Tackle the drivers of high risk behaviour – coercion, peer-pressure, sex for money
2004	In our minds, we need to connect drivers to high risk behaviour	Focus on high risk behaviour
2005	Our actions are shaped by our attitudes – personal and societal	Focus on attitude to self and to others – a new generation; a new way of thinking.
2006	Enough! Why aren't some people hearing us? We need a wake-up call.	Make the call – HIV: Face It! Show what facing up to HIV means for young people.

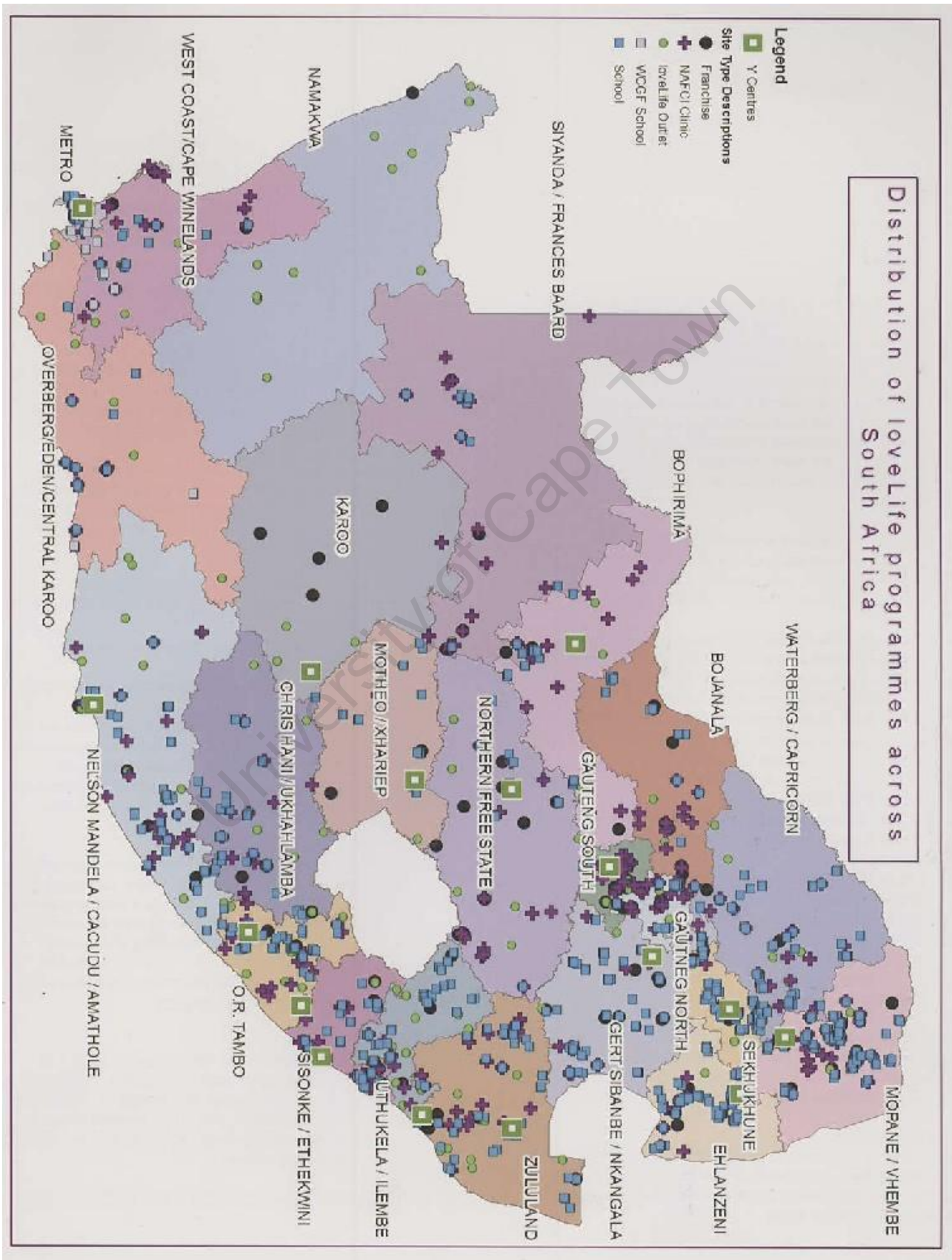
(Source: *loveLife*, 2007: 1)

Appendix B: Communication Flow

The love life generation: Make your move.



Appendix C: Distribution of *loveLife* Programmes across South Africa



Appendix D: Consent Forms

Introduction to the Study: Parents

Dear Parent/Guardian,

I, Nobukhosi Ngwenya am conducting a study that aims to explore your children's views on sexuality and HIV and AIDS communication in the media. Interviews will be held among some of the adolescents aged between fourteen and eighteen years of age. The research process will begin with the distribution of a questionnaire. It will then be followed by interviews that will last approximately an hour long. The interviews will be audio-recorded and notes taken at the same time but without revealing the names of any of the respondents. The information will be analysed and used to write a thesis that will be submitted to the University of Cape Town's Department of Sociology in partial fulfillment of a Masters Degree. The report will also be provided to the Principal of Sizwile School, *loveLife*'s Communication's Manager and the research participants and their parent/guardian if possible.

All the information will be handled with confidentiality. I, Nobukhosi Ngwenya will be the only one who will have access to all the information collected. During the research process, your child will be free to respond or decline answering any question. They can also withdraw from the research process at any time without giving any explanation. Please be advised that upon receiving your consent, I (Nobukhosi Ngwenya) will enter into a confidentiality agreement with your child.

Your child's participation in this study will help me to get valuable information on their perceptions of mass media campaigns in South Africa. This information will also be important for researchers, health and education development workers, adolescents and you the parents. I am therefore requesting permission for your child to take part in this research. If you agree, please read carefully through the attached consent form and sign it.

Thank you for your assistance.

Nobukhosi Ngwenya

Parents Consent Form:

I/we have been informed that this study is collecting information on adolescent's views regarding mass media communication on HIV and AIDS. All the information collected from the questionnaires and the interviews will be handled with the utmost anonymity and confidentiality. Only, Nobukhosi Ngwenya will have access to this information. I/we have also been informed that our child is free not to answer questions without a need to explain. My child is also free to withdraw at any time. The audiotapes will be deleted and transcripts destroyed when the University of Cape Town has accepted the final report.

Date: _____

Signature: _____

Introduction to Study: Participants

Hie, I am Nobukhosi. I am studying at the University of Cape Town. I am studying what you think of *loveLife's* HIV and AIDS campaigns. As part of the research I need you to fill in a questionnaire. I will also want to speak to a number of you who are aged between fifteen and eighteen years. I want us to discuss HIV and AIDS, namely where you get your information about it from.

When the research has been completed, I will make the findings available to you, your parents or guardians, school and my university if possible.

Our research activities will last not more than one and a half hours at a time. They will be arranged at a time that is convenient for you.

We will record some of our discussions using tpe recorders. These recordings will be kept in a secure room and will not be shown to anyone without your permission.

Some sensitive questions may be asked but you are free to answer or refuse to answer any question.

I am giving you this information to see whether you would like to take part in this research. You are free to make your own choice, and if at some point you do not want to continue, you are free to at *any* time without giving a reason. You will not be punished for this.

I have also given this information to your parent or guardian to make sure that she/he agrees that you take part.

If you have any questions, please feel free to ask me.

Participants Consent Slip:

I agree to participate in the questionnaire and interviews for this research project. I understand that I am not being forced to do this, and that I can leave at any time if I dont want to continue. I know I will not be punished for this. I understand that the researcher (Nobukhosi Ngwenya) will not tell anyone about personal things that we talk about in the interviews.

I understand that if at all possible feedback will be given to my community on the results of the completed research.

Signature: _____

Date: _____

Appendix E: Questionnaire

1. Do you think HIV affects the following people? Please circle your answer.

- | | | | |
|----------------------|-------|------|----------------|
| 1.1. yourself | [Yes] | [No] | [I don't know] |
| 1.2. a family member | [Yes] | [No] | [I don't know] |
| 1.3. your friend(s) | [Yes] | [No] | [I don't know] |
| 1.4. your community | [Yes] | [No] | [I don't know] |
| 1.5. your country | [Yes] | [No] | [I don't know] |

2. Where do you get information about HIV and AIDS from? *You can tick more than one.*

- Parents
- Life Orientation Classes at school
- Nurse/Doctor
- Friends
- Media. *Please specify:* _____
- Other. *Please specify:* _____

3. Next to each of the statements presented below, please indicate whether you Strongly Agree (SA), Agree (A), Disagree (D), Strongly Disagree (SD), or are Undecided (U).

- a. I am willing to be sexually active when I am married. [SA] [A] [D] [SD] [U]
- b. I am willing to be sexually active when I am sure I have the right life partner. [SA] [A] [D] [SD] [U]
- c. I am willing to be sexually active when I am in a long-term committed relationship with someone I love and trust completely. [SA] [A] [D] [SD] [U]
- d. I am willing to be sexually active is when I am in a relationship. [SA] [A] [D] [SD] [U]
- e. I am willing to be sexually active at anytime as long as we both agree. [SA] [A] [D] [SD] [U]
- f. I know enough about HIV and AIDS. [SA] [A] [D] [SD] [U]

4. When would you use condoms during sexual intercourse? *Please tick one.*

- All the time
- Only if you have more than one sexual partner
- Only if you do not know your partner's status
- Only if you are not a virgin
- Never

5. Next to each of the statements presented below, please indicate whether you Strongly Agree (SA), Agree (A), Disagree (D), Strongly Disagree (SD), or are Undecided (U).

- 5.1. I can talk to my parent/guardian about anything. [SA] [A] [D] [SD] [U]
- 5.2. I can talk to my parent/guardian about most things. [SA] [A] [D] [SD] [U]
- 5.3. I can talk to my parent/guardian about some things. [SA] [A] [D] [SD] [U]
- 5.4. I can talk to my nurse about some things. [SA] [A] [D] [SD] [U]
- 5.5. I can talk to my teacher about some things. [SA] [A] [D] [SD] [U]
- 5.6. I find it difficult to talk to anyone about personal things. [SA] [A] [D] [SD] [U]
- 5.7. I struggle to talk to my parent/guardian about anything significant. [SA] [A] [D] [SD] [U]
- h. I struggle to talk to my parent/guardian about anything. [SA] [A] [D] [SD] [U]
- i. I cannot talk to my parent/guardian about anything at all. [SA] [A] [D] [SD] [U]

6. Do you have easy access to condoms?

- Yes
 No

7. Please circle one box to complete the sentence below.

I seek advice from my parent/guardian:

- [Often] [Usually] [Sometimes] [Seldom] [Never]

8. Where can you get condoms in your area?

- Clinic
 Shop
 Youth centre
 Friends
 Other. Please specify: _____

9. Next to each of the statements presented below, please indicate whether you think they are true, false or you do not know.

9.1. HIV is a virus that causes AIDS. [True] [False] [I don't know]

9.2. An HIV-positive individual needs to take every prescription of his/her ARVs.
 [True] [False] [I don't know]

9.3. HIV weakens one's immune system leaving a person unable to fight off opportunistic infections.
 [True] [False] [I don't know]

9.4. Anyone can get infected with HIV. [True] [False] [I don't know]

9.5. You cannot become infected through sharing cups, plates or cutlery with someone who is HIV-positive.
 [True] [False] [I don't know]

9.6. HIV is passed on through infected blood and bodily fluids.
 [True] [False] [I don't know]

9.7. It is possible to be re-infected with HIV. [True] [False] [I don't know]

9.8. There is more than one strain of HIV. [True] [False] [I don't know]

9.9. HIV can be passed from mother to child in-utero.
 [True] [False] [I don't know]

10. What does the term ABC stand for?

- It is just the first three letters of the alphabet
 Abstain, Be Faithful, Use Condoms
 Always Be Careful
 Abstain Before Condomising

11. Which age groups are the most vulnerable to infection? *You can tick more than one box.*

- Newborn – 14 years
 15 – 24 years
 25 – 34 years
 35 – 44 years
 45 – 54 years
 55+

12. Does male circumcision lower the risk of HIV infection, for:

- Men [Yes] [No]
Women [Yes] [No]

13. Do the following factors make a person vulnerable to infection?

Age	[Yes]	[No]
Peer pressure	[Yes]	[No]
Gender	[Yes]	[No]
Drug (ab)use	[Yes]	[No]
Alcohol (ab)use	[Yes]	[No]
Unprotected vaginal sex	[Yes]	[No]
Unprotected anal sex	[Yes]	[No]

Other: Please specify _____

15. What do you consider risky behaviour?

16. Do you consider yourself vulnerable to HIV infection?

[] Yes
[] No

17. How is HIV transmitted? *You may tick more than one box.*

[] Through sharing of cups and cutlery	[] Through kissing
[] Unprotected vaginal sex	[] Through sharing of needles
[] Through infected blood products	[] Unprotected anal sex
[] Mother-to-child transmission	[] Through breastfeeding

Biographical Information:

- i. Age: _____
- ii. Date of Birth: dd/mm/19_____
- iii. Gender: [Male] [Female]
- iv. Ethnic group: [Black] [White] [Indian] [Coloured]
- v. Which part of Johannesburg do you live in? _____
- vi. What grade are you in? _____
- vii. What is the highest formal educational level you hope to complete?
 - [] Senior Phase
 - [] FET (Grades 10 -12)
 - [] University
 - [] University Postgraduate
 - [] Tertiary other than university (College/Technikon/ABET)

THANK YOU VERY MUCH FOR COMPLETING THE QUESTIONNAIRE.

University of Cape Town