PART III: VOICES OF THOSE RESEARCHING THE INTERNATIONAL CONTEXT

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12. THE HIV/AIDS PANDEMIC IN SOUTH AFRICA

Cultural constraints and education

INTRODUCTION

An estimated 5.5 million South Africans out of a population of 46 million are infected with HIV (UNAIDS, 2006). The virus is, however, unevenly distributed among the various population groups in South Africa. The disease is most prevalent among the black population, almost six times as frequent as among the second most affected population group, namely, the coloured. What is even more alarming is the steady increase in the prevalence rate among the blacks in South Africa, in a context of decline amongst other population groups (Chirambo, 2008: 144).

The seriousness of this situation can be illustrated by projections indicating life expectancy with or without AIDS, figures that will affect black people the most. According to UNDP and the US Bureau of Census (Chirambo, 2008: 147) the life expectancy projections for South Africa without AIDS in 2010 is 68.3 and with AIDS 35.5 years of age. The counter factuality of these figures notwithstanding, they nevertheless signal a bleak future, if interventions fail to make a difference.

The consequences for the economy with a decreasing labour force are difficult to predict in detail, as are the consequences for the education system, when as many as one third of the teachers are HIV positive. However, it is undeniable that the future consequences are very serious, indeed.

Since the prevalence rate is much higher among blacks than other population groups, one aim of this chapter is to discuss some of the challenges in dealing with HIV/AIDS by situating the issue contextually and culturally.

There are a number of conceptual issues that arise from the literature on cultural values, and on cultural values and HIV/AIDS. The most significant is an essentialist orientation in the use of the term 'culture' or 'traditional culture' to signify African culture. It is not always clear in the South African research context the extent to which difference in the behaviour of adolescents, for example, can be attributed to aspects other than a narrow definition of the terms. It would seem that some studies compare the behaviour of adolescents using language or ethnicity as key variables without considering that these are not always indicative of the practices from which the group is drawn (see e.g. Wood & Jewkes, 1998 and Tillotson & Maharaj, 2001). Other studies infer that the results are indicative of a

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specific culture's values (for instance, LeClerc-Madlala 2001, 2002; Breidlid, 2002). As has been noted in relation to the Xhosa culture:

> There is a sense that despite the intertextuality and dialogic exchange between various value systems, the indigenous cultural values are retained, not only as a means of social cohesion, or as a kind of low-key cultural resistance, but as a fundamental element of Xhosa identity construction (Breidlid, 2002: 43).

While it is acknowledged that tradition is often subsumed in modern practices and vice-versa, tensions can exist where communities are still very traditional and youth are influenced both by tradition and modernity, thereby making it difficult for the youth to navigate their way within social and cultural practices that are fluid and sometimes contradictory (Breidlid, 2002). This difficulty notwithstanding, this chapter suggests that cultural practices impact seriously on the spread of HIV/AIDS in Southern Africa and that various intervention programmes have been largely inefficient in halting this development, since they have not taken cultural factors into consideration and since the interventions have often been put across in a culturally insensitive language. Admittedly changing cultural practices is very difficult, even in the face of this serious pandemic.

A number of South African studies acknowledge explicitly or implicitly the importance of cultural context in the efficacy of intervention programmes. Cohen (2002), for example, suggests that cultural aspects present serious constraints in the attempt to fight the pandemic (besides socio-economic circumstances) and Archie-Booker, et al. (1999) states that HIV/AIDS prevention education must be responsive to culture, in order to be effective.

However, not only is the impact of cultural beliefs on sexual behaviour, negotiation and change not always clearly spelled out, but also, the use of cultural knowledge in intervention programmes seems more or less absent. The reason for this may be the sensitive nature of HIV/AIDS as a disease that invokes issues of sex, sexuality and disease that many communities struggle with, due to aspects of class, ethnicity and gender. In South Africa, a nation striving to achieve a national identity across former differences, such discussions may also be deemed politically incorrect. The seriousness of the pandemic means, however, that such cultural and political considerations must be approached more creatively in an attempt to design more efficient strategies.

The chapter explores first the so-called Caldwell hypothesis that African sexuality is different from Eurasian sexuality. It proceeds to discuss more specifically cultural sexual traits in Africa, with a particular emphasis on Southern Africa and the myths surrounding the prevention of HIV/AIDS infection among certain population groups. Third, the South African government policies on HIV/AIDS are explored, focusing particularly on the ideological and cultural content of strategies linked to prevention programmes. Finally, the chapter explores the role of education as a site for knowledge transmission and queries to what extent the correlational link between knowledge and behaviour is addressed in educational intervention programmes.

CULTURAL CONSTRAINTS IN FIGHTING HIV/AIDS

Cohen's (2002) suggestion that there are serious cultural constraints in fighting the pandemic is an important point of departure for the following discussion.

The Caldwell hypothesis

While there is a danger of projecting age-old western stereotypes and prejudices onto African cultures, there is also the risk of evading the whole topic of African sexuality and simply talking of preventative measures that are often Western in approach and origin. Caldwell, Caldwell and Quiggin argue that "there is a distinct and internally coherent African system embracing sexuality, marriage, and much else, and that it is no more right or wrong, progressive or unprogressive than the Western system" (Caldwell, et al., 1989: 187).

According to Caldwell, et al. (1989) there are certain elements of African cultural practices with a bearing on sexual behaviour, which may have adverse consequences in the age of HIV/AIDS. According to these researchers, aspects of sexual behaviour are not placed at the centre of African moral, religious and social systems, nor do such systems sanctify chastity (Caldwell, et al., 1989: 194).This is in deep contrast to the focus on sexual behaviour and chastity and the tremendous solemnity regarding sex in large segments of the Euro-North American population. The impression is that attitudes towards the sexual act are simple and straight-forward, and that virtue is related more to "success in reproduction than to limiting profligacy" (Caldwell, et al., 1989: 188). Reproduction is, according to Caldwell et al. (1989) a central element in indigenous African religion. Thus it is argued that the touchstone of the contrast between Eurasia and Africa is not male, but female sexuality (Caldwell, et al., 1989). These researchers state that:

> A pragmatic attitude exists in Africa toward the latter, with a fair degree of permissiveness toward premarital relations that are not blatantly public, and a degree of acceptance that surreptious extramarital relations are not the high point of sin and usually should not be severely punished (Caldwell, et al., 1989: 197).

There is no indication that either female premarital chastity or male sexual abstention has been supported by religious sanctions. Moreover, the claim is that many African societies admire risk-taking, especially dashing behaviour by young men (Caldwell, et al., 1989: 224-225).

Sickness and death are most often not considered natural events, but ascribed to evil spirits and breaches of taboos and are, therefore, explained, not in the behaviour that led to them, but in relation to who or what caused the sick person's misfortune. When the risk of contracting HIV/AIDS is recognised within this framework of understanding, Caldwell finds that "even many who recognise the role of infection and pathogens believe they are merely the intermediary mechanisms... In these circumstances there is little point in avoiding the one type of infection only to find that the malevolent forces settle for another mechanism" (Caldwell, 1999: 11). The situation is aggravated by the commonly held belief that

one's time to die was decided long ago, or that they will die in the not too distant future anyway. "Some men practicing high-risk sex say that, if the latency period is a decade, they are not worried because they are likely to die of something else in such a long time" (Caldwell, 2000: 10-11).

By linking this lack of cautiousness about one's health to what she terms as "non-HIV life expectancy" Oster (2007) finds that responsiveness to risk awareness corresponds to the length of life expectancy without HIV/AIDS. The assumption is somewhat problematic, however, given the figures above showing the huge gap in life expectancy with and without AIDS.

Caldwell's thesis of African sexuality has been contested, most notably by Ahlberg (1994), who claims that Caldwell, et al. (1989) has left out all data suggesting that "there was moral restraint attached to sexuality in Africa" (Ahlberg, 1994: 223). Ahlberg (1994: 230), by referring to the Kikuyu culture, shows how taboos and regulations "were extensively used in the maintenance of good conduct" in terms of sexual discipline. Other African communities had similar regulations (Krige, 1968; Evans-Pritchard, 1965). As Epstein states:

> Just as anywhere else, sexual behaviour on the (African) continent is governed by strict moral rules. They may not be the same as Western rules – polygamy and other forms of long-term concurrency are considered acceptable to many people – but they are rules all the same (Epstein, 2007: 146).

This is in line with Mbiti (1969) who also claims there was no anarchy in terms of sexual norms. Sexual offences were taken very seriously:

> When adultery is dealt with it is seriously dealt with…Fornication, incest, rape, seduction, homosexual relations, sleeping with a forbidden 'relative' or domestic animals, intimacy between relatives…all constitute sexual offences in a given community (Mbiti, 1969: 147-148).

While traditional sexual mores in many communities were highly regulated, Ahlberg (1994) claims that during colonialism, "sexuality was dramatically transformed, from a context where it was open but kept within well defined social control and regulating mechanisms, to being an individual, private matter surrounded largely by silence" (Ahlberg, 1994: 233). This led to the existence of two distinct moral systems, "neither of which has much authority over sexual behaviour" (Ahlberg, 1994: 233). Accordingly, there are no simple mechanisms to discipline deviant sexual behaviour or to enforce traditional sexual norms.

SEXUAL PRACTICES AND MYTHS IN SOUTHERN AFRICA

While knowledge of traditional sexual regulations is important, particularly in designing alternative intervention strategies, the contemporary sexual practices discussed below are extremely problematic in combating the HIV/AIDS pandemic, whatever the underlying causes for such practices are.

Nattrass acknowledges that sexual culture in Southern Africa is an important dimension relating to the AIDS pandemic (Nattrass, 2004: 279). According to her

"gender inequality, sexual violence, a preference for dry sex, fatalistic attitudes and pressures to prove fertility contribute to a high-risk environment" (Nattrass, 2004: 26-27). LeClerc-Madlala is more specific in her discussion of cultural sexual practices by referring to the Zulu sexual culture which is "underpinned by meanings which associate sex with gifts and manliness with the ability to attract and maintain multiple sex partners" (LeClerc-Madlala, 2002: 31-2). This clearly contributes to the spread of HIV. LeClerc-Madlala goes on to characterise the Zulu culture in terms of:

> gender inequity, transactional sex, the socio-cultural isoka of multiple sexual partners, lack of discussion of both men and women to accept sexual violence as 'normal' sexual behaviour along with the 'right' of men to control sexual encounters, and the existence of increasingly discordant and contested gender scripts (LeClerc-Madlala, 2001: 41).

Other problematic cultural traits refer to the practice where young women form sexual liaisons with older men for financial advantage and where sex is a currency by which African women and girls are frequently expected to pay in a desperate situation; "there is no romance without finance".

Nattrass refers to Zambia where women, educated about the virus, nevertheless offered sex during a famine because they would rather die of AIDS than of hunger (Nattrass, 2004: 27). This means that they may be more exposed to contracting diseases, thus making them vulnerable to HIV infection. This is particularly so in relationships based on exchange or money, because it is under such circumstances young women have little power to insist on condom usage (Kelly & Ntlabati, 2002: 52).

Added to these cultural sexual practices are the myths surrounding the disease and its possible cures. While some myths are harmless ("African potato cures AIDS"), others are critically dangerous to the spread of HIV; particularly the myth that having sex with a virgin or a baby is curative. Moreover, misconceptions that HIV can be caused by witchcraft weaken intervention strategies, as well as the current debate about whether forced sex is rape or simply sex[1] (Mandela, 2002: 82). These myths and misconceptions have sprung out of cultural beliefs that are nurtured by an indigenous epistemology based on magic and supernatural phenomena and explanations. Such myths are associated with the reported increase in child rape and the sharp increase of HIV among young girls. The strength and pervasiveness of these myths and misconceptions is, however, disputed (Nattrass, 2004: 141).

The socio-economic situation

Poverty poses another challenge to combating the pandemic. According to UNDP, South Africa is becoming increasingly unequal (UNDP, 2003), and "more people were living in poverty in 2002 than 1995" (Chirambo, 2008: 147). Statistics show that provinces with higher levels of poverty also have higher levels of HIV/AIDS, and this correlation shows the "relevance of including poverty as a contextual

variable in any social science discussion of the epidemic" (Chirambo, 2003: 147). To the extent that women's sexual behaviour is a product of economic circumstances, interventions at the level of individual behaviour and sexual culture are unlikely to be very successful. Therefore, the link between poverty and sexual behaviour poses another major challenge for AIDS interventions.

Sexual culture, ethnicity and education

The cultural sexual practices referred to above are often associated with Black African culture, and are, if Caldwell et. al. (1989) are anything to go by, different from Euroasian sexuality. Nattrass (2004) questions this difference by referring to a qualitative study by Marcus (2002). Marcus found that it was usual among white university students in South Africa to engage in multiple partnering (both serial and concurrent), as well as casual sex for its own sake (Marcus, 2002). Marcus' research notwithstanding, there seems to be no study on white sexual behaviour in South Africa, which makes the link between cultural sexual practices and the spread of HIV. Moreover, the link between myths, magic and HIV/AIDS does not seem at all to be prevalent among the white population. Pointedly a district survey in the Western Cape Province (Nattrass, 2004: 27) carried out at 374 facilities, involving the testing of 5,964 people, revealed that the black townships of Gugulethu and Nyanga had a prevalence rate of HIV of 28.1 per cent and Khayelitsha 27.2 per cent, far above other districts in the Western Cape. While the prevalence of HIV follows ethnic lines, it is worth noting that the prevalence also seems to follow income groups and education levels. Both Gugulethu/Nyanga and Khayelistsha are townships with relatively low income and education levels, thus upholding the view referred to above of a correlation between poverty and the escalation in HIV rates. While African households in the Western Cape Province have an average annual household income of R 33,449, white households averaged R 165,320 in the same Province (UNDP/UNAIDS, 1999: 33). According to Nattrass, and since malnutrition and parasite infection increase HIV susceptibility, there is good reason for assuming our previous contention that poverty is a breeding ground for the spread of HIV in sub-Saharan Africa (Nattrass, 2004: 29).

Levels of education are also noted to be an indicator of HIV infection. A national survey of South African youth reported that there were lower reported levels of sexual activity among better educated youth. Those with tertiary educational qualifications had lower rates, and "those in high skill bands have relatively low levels of HIV infection" (Nattrass, 2004: 30).

Government policies and strategies

Inadequate responses by most African governments have no doubt contributed to and are still contributing to the AIDS pandemic. The often conflicting messages by the Presidency in South Africa has resulted in messages about infection not being taken seriously, thus weakening the impact of intervention programmes. The defensive reaction by the government to criticism of its HIV/AIDS policies limited

the possibility of engaging with and improving on the government's capacity to implement policies. This stance has been detrimental to the government in that opportunity was missed to obtain evaluative input, which may have led to improvement and better implementation of the nation's AIDS policies.

This notwithstanding, the South African government's policies regarding the pandemic are changing at a slow, but steady pace. In *HIV/AIDS Emergency: Guidelines for Educators* the government acknowledged that the HIV pandemic is an emergency that would have serious consequences for the education sector. "If the current rate of infection does not slow down, by the year 2010 one in every four people in the country will have HIV. In ten years, the disease will have made orphans of three –quarters of a million South African children" (DoE, 2000/2002: 4).

The Guidelines also acknowledge that the disease is spreading so fast "mainly because many South Africans, especially men, are careless about their sexual behaviour…This means that the death rate from HIV/AIDS is still climbing rapidly among men and women of all ages, especially among sexually-active people" (DoE, 2000/2002: 4). The document warns that "unless we take the necessary precautions any one of us may contract HIV". The Guidelines concur with statements by other researchers early on that acknowledge the role of social and economic circumstances in the increase of HIV-prevalence.

> HIV/AIDS is a new disease that was not there when our old customs were created. The arrival of HIV means we have to make some changes to our culture because if we do not make these changes very large numbers of our young people may die and we may do so as well. Changing the rules about discussing sex does not mean that our culture will be threatened. There is much more to our culture than codes and practices relating to sex. In fact, cultures change all the time. That is how it survives…We need to adapt our customary attitude toward sex and talking about sex, because the lives of our spouses and partners, our children, and those in our care, depend upon us (DoE, 2000/2002: 12).

The message in this document also refers to aspects of religious beliefs that are detrimental as regards the present HIV pandemic. The religious taboo of discussing sex openly in the families is questioned, since information about sex is said to be vital in containing the disease. Moreover the message stresses the moral aspects involved: "…The threat of HIV does not mean to discard our moral code. A strong and clear moral code was never more necessary" (DoE, 2000/2002: 12). This emphasis on the moral aspects is important in a situation where the government's HIV campaigns have been criticized for being too technical and too modern in their approach.

Strategies to combat the pandemic are varied. The question is to what extent the strategies to combat the disease take into account how cultural practices, not only impact responses to intervention programmes, but also the extent to which the implicit and explicit messages they attempt to convey are received.

The HIV/AIDS/STD Strategic Plan for South Africa 2000-2005 (GoSA, 2000: 16) calls for "an effective and culturally appropriate information, education and

communications (IEC) strategy." This notwithstanding, implementation of the plan seems, to a large extent, have focused either on the use of condoms or on improving access to and the use of male and female condoms, especially amongst 15-25 year olds (GoSA, 2000: 19).

The ABC strategy that prioritises A for abstinence, B for Be faithful and C for condom use has been criticised in South Africa by some quarters for paying too little attention to abstinence and faithfulness and too much reliance on condoms, especially with regards to the allocation of resources, both in terms of funds spent on the purchase and distribution of condoms as well as the funds spent on promoting them.

The reason for the focus on condom distribution is not necessarily due to a sexual liberation ideology, but more likely due to the acknowledgement that changes in sexual behaviour are both time-consuming and very difficult, and that "safe" sex is an urgent priority, even if deeply-rooted sexual practices (other than condom use) are not changed. Questions about the cultural appropriateness of such an approach are often not in question, particularly when a common response amongst youth is: "Using a condom is equivalent to eating a banana with the peal on."

The new *HIV/AIDS and sexually transmitted infection (STI) Strategic Plan* for South Africa (the NSP 2007-2011) expands on the above and emphasises the gender problem and human rights protection. It is a comprehensive plan intended to address the multiple challenges across a wide range of sectors, including "areas of prevention, treatment, care and support; human and legal rights; and monitoring, research and surveillance…" (Chirambo, 2008: 142).

HIV/AIDS and education

According to a 2005 survey by the HSRC (Human Sciences Research Council, 12.7 per cent of teachers in South Africa are HIV-positive. This corresponds to the national statistics, and is confirmed by very high teacher absenteeism (Chirambo, 2008). The regional variance of teacher absenteeism also correlates with the different rates of prevalence of HIV in the various provinces, i.e., teachers from KwaZulu-Natal and Mpumalanga have the highest prevalence rate in the country. According to Chirambo (2008) this corresponds with the national statistics, and is confirmed by very high teacher absenteeism. The regional variance of teacher absenteeism also correlates with the different prevalence rates in the various provinces, i.e., teachers from KwaZulu Natal and Mpumalanga have the highest prevalence rates in the country.

In *The HIV/AIDS Emergency: Guidelines for Educators* (DoE 2000/2002: 5) educators are given a special responsibility along the lines of an ethical model: "Educators must set an example of responsible sexual behaviour. In so doing, they will protect their families, colleagues, learners and themselves." The role of the teacher is not, however, without its challenges. Few, if any, studies have been done on the role of teachers in HIV-prevention programmes. Are teachers willing and able to teach? Can they teach about sex, sexuality, and disease in the public space of the classroom without fear of repercussions from school authorities and

communities? What is their attitude and do they in fact position themselves? What is their moral position on teaching HIV/AIDS education? These questions are not explored in AIDS education literature and thus make the assumption about an easy fit between teachers and the curriculum unsustainable.

According to a national review in South Africa of more than 10,000 women under 50 years, teachers commit a third of all rapes in South Africa (Jewkes, et al., 2002) thus putting doubts on their capacity to, not only teach about sex education to children, but also about their position of authority as role models over their children's lives. If teachers are sexually abusing children, this is made all the more drastic in that "South Africa's 443,000 educators constitute the largest occupational group in the country. At least 12 per cent are reported to be HIV positive" (Coombe, 2000: 6). This means that in excess of over 40,000 teachers are HIV positive. To give credence to these fears, Hickey (2002: 45) states:

> Schools, particularly in rural areas, can be a breeding ground for the disease by providing opportunities primarily via sexual relationships between male teachers and young girls. Reportedly the measured infection rate amongst young women between age 15 and 19 rose from 12.7% in 1997 to 21% in 1998.

The DoE (1999: 14) states that "educators may not have sexual relations with learners or students" suggesting a political will to confront teachers who abuse their position and those entrusted to their care. Questions do remain about the consequences for such offences and whether or not punishment is always meted out.

Educational intervention strategies

According to Baxen and Breidlid (2004), some studies (e.g. Wood et al, 1997; Levine and Ross, 2002) have sought to examine and gain some understanding of what knowledge, attitudes and practices (KAP studies) those participating in the educational endeavour (teachers, youth, and adolescents) carry. Often these studies have as their main outcome recommendations towards the development of "effective" prevention strategies for those perceived as "most vulnerable", which in many instances, are youth between the ages of 14-24.

There is very little co-ordinated information on what South African youth know about reproductive health. Judging from some of the studies, some South African youth have a very sketchy understanding of reproduction, puberty and sexually transmitted diseases (Wood et. al., 1997). However, Kelly (2000), in a study commissioned by the Department of Health, found that youth had good access to accurate HIV/AIDS information, and were regularly exposed to such information.

Even though Kelly's research might be true in some instances, the educational intervention programmes have not, it seems, been able to effect a positive correlation between knowledge and behaviour. It seems, therefore, some South Africans are constructing their sexual identity and ideas about safety from infection in a complex, discursive space where competing knowledge systems co-exist to produce and reproduce conflicting messages about risk, contraction and infection.

In an attempt to examine ways of increasing the possibility of behavioural change, Wight (1999) found in his study that learner-driven classes do not work as well as teacher-driven ones. Wight argues that there are severe limits to the efficacy of pupil empowerment in sex and HIV/AIDS education. Skinner (2001), however, found that educators were seen as out of touch with youth. He described this as another factor distancing youth from scientific information and making them inclined to look to alternative sources of knowledge.

Although a number of studies describe South African cultural beliefs that have a bearing on sexual behaviour, it has been noted that few studies investigate the intersection between either cultural context or cultural beliefs, and intervention programme efficacy.

The emphasis on intervention and prevention programmes (giving youth more knowledge) referred to above seems to be underpinned by reductionist views of the association between knowledge and behaviour. This view creates a dissociation of the interface between sexual identity, education and HIV/AIDS. More importantly, what it leaves unattended is the deeply complex nature of the social, contextual and cultural discursive fields in which youth receive and interpret the HIV/AIDS messages and how they understand, experience and use this knowledge in the face of or while constructing, performing and playing out their sexual identities.

Louw (1991) argues that the medical model which favours information on safe sexual practices, especially condom use, has had some results, but "it has been shown that information and education campaigns (as in the case of tuberculosis) do not stop the spread of a disease; medical information is not enough in the long run" (Louw, 1991: 101). He favours an ethical model as a long-term strategy that might have the desired effects of reducing infection among youth. Such a response does, of course, raise questions about whose ethics and what ethical framework might be applied in a complex context like South Africa. Questions may be posed, therefore, about productions and interpretations of morality and its inclusion in prevention programmes in a context where its constructions are often open to transformation.

The interface of tradition and modernity has had an impact on some cultural practices with detrimental effects. This has resulted in an underplay of the traditional social support-systems in terms of sexual norms and behaviour; aspects that, in some communities, remains intact. Ahlberg's (1994) reference to positive sexual norms and practices in traditional African communities noted earlier in this chapter is important knowledge in strategic discussions of the pandemic. Therefore, under-communication of these in discussions of intervention strategies to combat the pandemic can be seen as a factor contributing to HIV/AIDS-intervention inefficiency.

CONCLUSION

Cultural practices are not static. Sontag (1990) suggests that the ways in which we understand HIV/AIDS is, therefore, more indicative of our broader societal discourse of politics and economy than of any salient features of the disease itself. Sexual practices alone cannot explain the virulence of the spread of AIDS in Africa.

The combination of cultural, socio-economic factors and biomedical factors together with unsafe sexual practices produce fertile ground for the spread of HIV.

Prevention programmes can thus not be limited to certain sectors of society, i.e., education or health, but must address the multiplicity of areas that critically impact upon the spread of HIV and AIDS. Moreover, these interventions must transcend a mere economistic and technical discourse and take into account the deeply ingrained cultural factors and practices among the various groups in a complex South African society. While cultural essentialism should be discarded, interventions must acknowledge and identify cultural and contextual aspects which, it has been noted, clearly play an important and sometimes detrimental role in the negotiations and decision-making with respect to sex.

Further, it would be important to examine the interface between discourses of tradition and modernity in the development of more appropriate intervention strategies that could lead to behaviour change. Such a space would encourage discussions about, for example, how modern concepts of women's behaviour are juxtaposed with traditional conceptions of male sexuality. When HIV/AIDS is blamed, for example, on the "modern" behaviour of women, and when control is reasserted over women's bodies in virginity-testing through the contemporary reinvention of traditional practices, this is the expression of an anxiety over the relationship between tradition and modernity.

The failure of modernist interventions to achieve behavioural change makes it urgent to explore the extent to which traditional processes, practices, dynamics, structures, and networks within communities are under-reported and under-utilised as resources to support or facilitate behavioural change. There is a sense that reference to traditional norms and values stands a better chance of being accepted and adhered to than alien, modernist interventions which so far have been met with massive, if not tacit resistance on the behavioural level. Interventions devoid of any acknowledgement of cultural and contextual specificity may be those that would have detrimental consequences for success in reducing the effects of the pandemic.

Undoubtedly the AIDS pandemic is threatening the democratic foundation of the new South Africa.[2] As Steinberg states:

> A new democracy is an era of resurging life. Sex is the most life-giving of activities. That a new nation's citizen's are dying from sex seems to be an attack on ordinary people's and a nation's generative capacities, an insult too ghastly to stomach (Steinberg, 2008: 6).

Former president Mbeki has re-echoed these sentiments in his conspiracy theories about the disease, and the former Health Minister Manto Tshabalala-Msimang has rightly been accused by scientists and grassroots activists for her unconventional and very controversial support for beetroot and garlic as treatments of AIDS. The myths that the former Mbeki government have spread about the disease have probably reinforced the stigma attached to it. The medical fact that the disease is most pervasively spread through sexual contact is not easily accepted, and as has been noted earlier in this chapter all kinds of mystical explanations are given to explain the occurrence of the disease. "Some people have maybe sent a demon to

have sex with me: a demon with HIV. That is why I am scared to test. I think I will test positively" (Steinberg, 2008: 15).

People are afraid of testing because people with AIDS are in many ways ostracized, particularly in the rural villages. As Steinberg maintains "where there is AIDS, there is blame. It is said in the villages that the virus was hatched in laboratories to be let loose on blacks until whites become an electoral majority" (Steinberg, 2008: 6). And since people are scared of being tested, they are not making use of ARVs that might really improve their life situation substantially. Therefore some people prefer to die with the disease rather than to come forward to get help with the disease. There are stories of people dying of AIDS just a few yards away from clinics with ARVs.

While Mbeki failed to make ARVs widely available, the new Health Minister, Barbara Hogan, has indicated a radical change in the authorities' attitudes to ARVs and to the pandemic in general. Stating that the government policies over the past ten years have failed, Hogan has promised to step up the fight against HIV/AIDS in a country where life expectancy has fallen to 52 and where more than half of all public hospital admissions are AIDS-related and more than one quarter of the national health budget goes to fighting the disease. Acknowledging the widely accepted cause-effect relationship of the disease, Hogan has also appealed to the scientific community to come with better tools to fight the disease.

This is indeed good news. As one commentator put it "health has been rescued from the madness of lemons, garlic and beetroot, which are now restored to their role as nutritious fruit and vegetables, liberated from being the weapons of mass destruction that Manto (Tshabalala- Msimang, the previous health minister) had made them" (Mail & Guardian, 2008).

While the new policies of the government are welcomed, the situation will not change overnight. The former government's denial policies have naturally impacted on the common man's perception of the disease, and research shows, that even if knowledge about the disease is available, behaviour change is slow to come. Cultural practices and perceptions are still a great obstacle to behaviour change, and the one-size-fits-all modernist interventions do not seem to address the issues in an adequate way. Time has come to look at how information is transmitted about the disease.

The question thus arises as to if the message is diffused through the most appropriate channels, and in a culturally sensitive way. The various transmitters of knowledge need to address this issue, and most probably differentiate the interventions according to the various recipients in the country (Breidlid & Kadalie, 2009). As Steinberg has shown (2008), medical expertise intervening in the rural villages might often face a credibility problem as they invade the rural space without necessarily having the cultural knowledge necessary to communicate with the population. The schools seem in many ways to face a similar problem, not being able to convince the pupils that knowledge about the disease has to be translated into behavioural change.

As the government now seems to be entering a new and more productive phase in the combat of HIV/AIDS, it is important to emphasize that it is not only a matter of spreading ARVs more evenly across the country or discovering more effective

vaccines against the disease, but also of analyzing ways of diffusing the message of the pandemic in such a way that people both start a process of behavioural change as well as taking advantage of the drugs now made available to them without experiencing stigmatization and ostracisation.

NOTES

[1] These beliefs seem to be fairly pervasive within certain ethnic groups, where forced sex is not seen as coercion. The longer the relationship, the more "right" a male has to demand sex from the "submissive" female. Should she resist, he has the cultural "right" to beat her into submission. Cultural systems carry immense gender inequalities.

[2] The last part of this chapter is partly excerpted from J. Baxen and A. Breidlid, "A hermeneutic understanding of HIV/AIDS in South Africa: epistemological and methodological implications." In Baxen and Breidlid (eds.) (2009). *HIV/AIDS in Sub-Saharan Africa: Understanding the Implications of Culture and Context*. Cape Town: UCT Press Cape Town: Juta Press.

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