
‘Diseases come from girls’: perspectives of male learners in rural KwaZulu-Natal on HIV infection and AIDS

Reshma Sathiparsad and Myra Taylor

Abstract

The rapid spread of HIV, particularly among young people, is a source of concern across disciplines focusing on HIV risk reduction interventions. Research indicates that while adolescents have knowledge about sexually transmitted infections, including HIV and AIDS, this knowledge does not necessarily translate into safe sexual behaviour. Such realisation calls for a move beyond knowledge-based approaches to exploring how youth experience, make meaning of and respond to HIV and AIDS. This article describes research conducted with a sample of rural male learners on their perspectives of the behaviour of men and women in relation to the spread and the prevention of the disease and perceptions of their personal risk for infection. An analysis of the discourses of the learners is presented and arising from this, implications for prevention are suggested.

Introduction

HIV/AIDS is one of the critical problems facing women in developing countries in the twenty first century (Chirambo and Caesar, 2003; Wood, Maforah and Jewkes, 1998; McFadden, 1992). Many Sub-Saharan African nations already report more new infections among women than among men (UNAIDS, 2002). A national survey in South Africa of 11 904 youth aged 15–24 revealed that 75 per cent of HIV zero-positive individuals were aged 20–24 years, 95 per cent were African and 77 per cent were female (Reproductive Health Research Unit (RHRU), 2004). KwaZulu-Natal had the highest prevalence of HIV infection at 14.1 per cent, followed by the Eastern Cape with 12.8 per cent. The report concluded that gender inequalities are a major driving force behind the spread of HIV, in that physical violence, the threat of violence and the fear of abandonment prevent women from negotiating condom usage or leaving relationships that are physically unsafe (RHRU, 2004). An earlier study by the South African Demographic and Health Survey (Department of Health, 1998) reported a high rate of teenage pregnancy (35.1 per cent) in the 15–19 year age group, indicating that many

young people do not practice safe sex, behaviour which places them at risk of HIV/AIDS. A later study by Reddy, Panday, Swart, Jinabhai, Amosun, James, Monyeki, Stevens, Morojele, Kambaran, Omardien and Van den Borne (2003) of the South African Medical Research Council was conducted in twenty-three secondary schools selected from each of the nine provinces in which 10 699 learners participated. The total sample consisted of 54 per cent females and 46 per cent male, of which 79.5 per cent were Black, 9 per cent were Coloured, 8.9 per cent were White and 1.4 per cent were Indian, while 1.3 per cent fell into the 'other' category. The majority of the sample (78.7 per cent) was between the ages of 14–18 years inclusive. The study revealed that nationally 9.8 per cent of the learners felt that they were forced to have sex. Of the total sample, 28.8 per cent reported that they used condoms during sex. These findings point to the need to further explore issues relating to masculinity, gender violence and sexual behaviour.

The AIDS epidemic has led to an examination of what sex and sexuality mean in their socio-cultural contexts, the construction and interpretation of sex and sexuality, both in public and private, and the relationships between health, disease and sexual behaviour (Lamprey and Gayle, 2001; Nattrass, 2004). There has been a growing realisation that gender inequality lies at the centre of the international HIV epidemic (Foreman, 1999; Cornwall and Welbourn, 2002; Mirsky, 2003). HIV/AIDS is increasingly being recognised as a gendered disease (UNIFEM, 2005), impacting on women but requiring an understanding of the role played by, and the construction and performance of, masculinity in driving this epidemic (Pattman, 2005; Ramphela, 2002). Morrell, Moletsane, Abdool Karim, Epstein and Unterhalter (2002) draw attention to the extent to which patriarchal power impacts on rates of HIV transmission, particularly amongst girls, via coerced sexual intercourse. Coerced sex increases the vulnerability of young women, in particular, as it is less likely to be protected and often more physically traumatic than consensual sex.

Biologically, women have a greater susceptibility to HIV infection and other sexually transmitted diseases (Schoub, 1999). Coercive sex itself is more likely to lead to trauma or abrasions which can facilitate the transmission of HIV (WHO, 2004). Foreman (1999) reflects on the different circumstances in which both sexes contract the disease. He maintains that women are vulnerable to HIV because they have limited opportunity to protect themselves; men are at risk because they refuse to do so, often deliberately, because "that is how men are expected to behave" (Foreman, 1999, p.xi).

These views resonate with those of Harris (1995, p.10) who states that the concept 'masculinity' refers to "beliefs about how men ought to behave and are constructed at different levels in society and in the minds of individuals". Notions of masculinity generated by the media, teachers, historians, parents, priests and public figures dominate how men think about themselves. Because men in a particular country with common cultural histories may receive similar notions about how to behave, these common understandings of masculinity constitute dominant cultural norms and patterns of masculinity promoted within national boundaries. Such widely accepted male notions of masculinity underpin the behaviour of millions of men across the globe.

Globally and more specifically in Africa, women living with and at high risk of HIV infection have borne the brunt of persistent and deepening forms of economic and social inequality. Zierler and Krieger (1997) claim that in the United States social inequalities lie at the heart of HIV infection among women. Economic deprivation and discrimination on the basis of race, class and gender are interwoven with risk of HIV/AIDS. Although women at high risk of HIV infection are aware that condoms can prevent transmission, they are unable to insist on the use of condoms because of their economic dependence on men. This dependence robs them of the choice of whether or not they have sex, or whether a condom is used (Selikow, Zulu and Cedras, 2002; Zierler and Krieger, 1997). Many women express feelings of powerlessness, low self esteem, the lack of a voice and the inability to effect risk reduction decisions or behaviours with their partners. Mirsky (2003) reported that women were less likely to use condoms when they needed men for social status or when teenage or younger women were sexual with older men.

Even women who want to resist do not have enough leverage to refuse having unprotected sex because such women are wives, poor mothers, sex workers and/or rape victims. Disempowered rural women often run the risk of being infected by husbands returning from the city who refuse to wear condoms (Ramphela, 2002). Morrell *et al.* (2002) contend that the risk of HIV infection amongst women is increased because men set the terms of intimacy. Further complicating the issue, according to Tillotson and Maharaj (2001) is the common belief in Sub-Saharan Africa that having sex with a virgin can cleanse one of HIV. Men may seek out young partners believed to be virgins to free themselves of the virus

There is clearly a need for engagement with the fundamental issues of sexuality and power that lie at the heart of improving sexual and reproductive well being (Cornwall and Welbourn, 2002; Redelinghuys and Van Rensburg, 2004). Willig (1999) suggests that in order to understand people's actions, we need to know what they mean. Investigating meanings underlying behaviour may be useful in understanding and interpreting the high HIV statistics among youth. This article contributes to such an understanding by exploring male learners' views on sex and HIV/AIDS. This is one component of a study exploring perceptions of gender violence and masculinity amongst rural KwaZulu-Natal male learners.

Research methodology

A descriptive study was conducted in Ugu, one of the eleven districts in KwaZulu-Natal which, although it has the largest population (9.4 million) is one of the poorest of South Africa's provinces, with over 80 per cent of the population being isiZulu (Statistics SA, 2003). This study is of particular relevance given the findings of the Reproductive Health Research Unit (RHRU, 2004) that 41 per cent of HIV positive youth live in rural areas. Ugu was selected as being similar to other disadvantaged areas in the province. Rural communities in KwaZulu-Natal lack basic services such as electricity, water and access to clinics. Churches and small shops selling food dot the landscape, but Ugu North offers few services other than schools and a limited number of clinics. Schools are under-resourced and poorly equipped. In such communities, many adults are illiterate, unemployment rates are high (estimated at 40 per cent), and there are few opportunities for school leavers even after 12 years of schooling (Taylor, Dlamini, Kagoro, Jinabhai, Sathiparsad and De Vries, 2002). There are no tertiary educational training institutions in Ugu offering opportunities for further training for school leavers.

The study sample was male learners attending public high schools in the district who each participated in three focus group discussions held on consecutive weeks at each of three schools. These schools were randomly selected from a list provided by the Education Department. Ten grade 11 learners were randomly selected from each school's class lists and invited to participate in the study. There were no refusals. During the group discussions which focused broadly on gender violence, HIV and AIDS were mentioned by the learners as an area of concern. The shift from focus groups to individual

interviews enabled us to explore this aspect further while providing interviewees with confidentiality in respect of their responses. From each of the discussion groups, four learners were invited to volunteer to participate in in-depth interviews which took place on two consecutive weeks with each interview lasting approximately ninety minutes. The interviews were conducted by an experienced isiZulu research assistant in his mid-twenties who was able to relate to and communicate well with the learners. The twelve male learners, all isiZulu first language speakers, were aged between 16–24. As suggested by Henning, Rensburg and Smit (2004), the interviewer was given clear instructions not to react to responses of the learners in any way that was likely to influence their responses. This was essential as reactions on the part of the interviewer such as disapproval, surprise, shock or a strong challenge might have hindered or stifled honest responses. However, it is also possible that the interviewer, as a young male, may have influenced responses. With the permission of the learners, all interviews were tape-recorded. These twelve individual interviews provide the basic data for this article.

The open-ended interview schedule explored learners' perceptions about HIV/AIDS (knowledge about the disease, transmission, prevention of HIV, decision making about sex and gender issues). The schedule was developed in English, and translated into isiZulu to enable the Zulu speaking research assistant to facilitate the groups with ease by avoiding the need to translate from English to isiZulu during the sessions. It was then piloted to check for clarity. The interviews explored personal experiences of respondents arising from the discussions relating to gender violence and HIV/AIDS. An interview schedule was used, which enabled the interviewer to probe responses where relevant. The transcripts were translated and transcribed by the interviewer and the data were analysed manually by the researchers. The themes from the interviews were identified and explored, and the underlying discourses were analysed. Barker and Galasinski (2001) see discourse as a regulated way of speaking that defines and produces objects of knowledge, thereby governing the way topics are talked about and practices conducted. In fact, for Hall (2001) the term 'discourse' refers to the entire process of social interaction around a text. A social constructionist framework was used to guide the analysis. This framework, according to Patton (2002), holds that the world of human perception is not real in an absolute sense, but is shaped by cultural and linguistic constructs. However, this does not mean that it is not perceived and experienced as real by real people. Using the social constructionist perspective, we attempted to explore the learners' perceptions, explanations and beliefs, as well as the consequences of their constructions for their

behaviours and for those with whom they interact. In keeping with the aims of this study, Henning *et al.* (2004) and Patton (2002) remind us that the analysis should move beyond language and speech to include meanings in relation to behaviours, conceptions, values, events and social patterns.

The study received ethical clearance from the Ethics Committee at the Nelson R Mandela School of Medicine, University of KwaZulu-Natal. Permission was obtained from the KwaZulu-Natal Department of Education and Culture and the principals of the schools, and written informed consent was obtained from parents and learners.

Discussion of the findings

The family circumstances of the youth in the sample varied. Of the twelve learners that were interviewed, four lived with both parents while five lived with their mothers only (two of their fathers were deceased and in the other three cases, the parents were separated). One learner whose parents were separated, lived with his father. In two cases, both parents were deceased and the learners lived with other family members. In most instances, family income was derived from employment by the father and/or the mother. Where there were no parents, learners were supported by family members who were in employment or received state pensions.

The findings in respect of the youth and their views with regard to the transmission of HIV/AIDS are presented. Particular emphasis is placed on the responses of four learners with regard to 'whether the role of women influences the spread of HIV/AIDS', 'whether male behavior change can influence the spread of the virus', and 'whether the learners thought that they were at risk for HIV/AIDS'. The views of these four learners are representative of the views of the twelve learners interviewed, and indicate some of the discourses underlying the current HIV/AIDS epidemic that prevention programmes need to address. For purposes of anonymity, the names of the youth have been replaced with pseudonyms.

Women's responsibility for the spread of HIV and AIDS

The discourses relating to HIV/AIDS among the rural learners were clearly gendered. In the interviews, the major discourses of diseases, stigmatization and blame were identified. Women's infidelity and 'indiscipline' in the form of loose sexual behaviour were suggested as major contributors to the spread of HIV. A recurring theme in the interviews is well reflected in one learner's contention that "*It would be a person of skirt that would bring the virus*". These male participants suggest an active female sexuality in comparison with the stereotypical representation of females as passive, submissive and asexual. The majority of the learners made some reference to their fear of the diseases that girls carried. Several learners explained how men "*end up getting the disease*", implying that they had no active role in acquiring it. This can perhaps be seen in the light of LeClerc-Madlala's (2001) explanation that among Zulu speaking people, narratives of blame are framed within a common discourse on female sexuality. While acknowledging that the female body is the site of male sexual pleasure, women's bodies are associated with notions of danger, disease and the ability to weaken men and bring all sorts of danger to society. These beliefs draw on long-established notions of pollution associated with sexually active women and their bodies (LeClerc-Madlala, 2001; Ngubane, 1977). Sexual intercourse is also considered to be polluting to a milder degree because of the seminal emissions, and related secretions such as menstrual blood and vaginal discharges are viewed as reservoirs of HIV "germs" (LeClerc-Madlala, 2001). While the *Concise Oxford Dictionary* (1990) defines disease as "an unhealthy condition of the body (or a part of it) or of the mind, illness, sickness", Ngubane (1977) explains that in Zulu, the word *isifo* has a different connotation and applies to disease manifested by somatic symptoms, to various forms of misfortune, and to a state of vulnerability to misfortune and disease.

The discourses that follow further highlight the perspectives of the learners regarding the role of women in spreading HIV and AIDS. Although not all male learners subscribed to this view, many of them saw women as driving the AIDS epidemic.

Moses: [Women spread AIDS because] they are people who are unable to control and respect themselves. . . . If one comes with a beautiful car, whether that person is using a condom or not, she does not care. . . . If you look at the rate of people with AIDS in South Africa, women are the most people who suffer from it.

Jacob: A beautiful person attracts people. She attracts strongly. There is no one that does not like a beautiful girl. So in that way it can be able to spread, because once you (the woman) has HIV/AIDS, you must try to discipline yourself. Yes, they sleep around, isn't it? Too much and that is the thing that will make them get HIV/AIDS. These people go places in a strong way.

Nkosi: [Women play a big role in spreading HIV/AIDS because] maybe she is involved with people and she sleeps around with them and not even checks what kind of people they are and she finds herself having HIV/AIDS.

Dumisane: [Women reject men (in their love relationships)] and thereafter go for other men . . . get AIDS . . . and then go forward for another affair and then get AIDS again. Then AIDS keeps on spreading and AIDS spreads on and on. She then becomes something useless and an AIDS toy and when she knows that she has AIDS, she decides to spread it to other people.

As noted earlier, these learners attribute the spread of HIV/AIDS to women's careless behaviour such as the inability to control themselves, being beautiful and attractive, having multiple sexual partners, and deliberately spreading the virus. By implication then, additional pressure is placed on beautiful women to discipline themselves. Although this evidence does not suggest that all boys have the same view about HIV transmission, male responsibility and female culpability, it does exemplify male hegemony and the power relations implicit in these discourses. Connell (1995) explains that hegemonic masculinity legitimates patriarchy, which guarantees the dominant position of men and the subordination of women. These are high status forms of masculinity which, in many societies, have been constructed as those masculinities that demonstrate 'normal' masculine behaviour by which boys and men can be measured, by themselves and others, to determine the extent of their 'manliness'.

Authors such as Whitehead and Barrett (2001) and Hearn (1998) claim that the common feature of dominant forms of contemporary masculinity is that manhood is associated with having some sort of power. The equation of masculinity with power conforms to and justifies domination of men over women and the valuation of males over females. However, in these discourses, the learners seem to attribute some power in the form of the "power to infect" to women, referred to by Barker *et al.* (2001) as negative power, that is, the power to destroy. Furthermore, for the learners it is power that has a stigma attached to it and requires some distancing from and rejection of the carrier, that is, the woman. AIDS as a gendered illness implies that women have overstepped patriarchally defined moral boundaries, as signified by their inability to control themselves (LeClerc-Madlala, 1999) These discourses

confirm Strebel's (1997) observation that the control of seemingly deviant sexuality is seen as a solution to the AIDS problem, evident in Moses' assertion that the 'out of control' behaviour provides a rationale as to why more women in South Africa suffer from HIV and AIDS. The contradiction here, as pointed out by Leach, Fiscian, Kadzamira, Lemani and Machakanja (2003), Mirsky (2003), LeClerc-Madlala (1999), Rweyemamu (1999) and Wood *et al.* (1998) is that in reality, it is often women who are frequently coerced, forced or beaten into sex by male partners who control sexual encounters and refuse to wear condoms. Despite this observation, women, irrespective of their behaviour, seemingly cannot escape being blamed for the spread of the disease. Henning (2004) makes reference to 'meaning making' whereby attaching a meaning that absolves men from responsibility, results in a comfort zone for men. They then do not need to engage in the arduous task of behaviour change.

Dumisane's description of a woman with AIDS as being useless and an AIDS toy further confirms the socialisation of these rural learners, the stigmatization associated with the epidemic, and the reduction of women to a plaything only worthy of being discarded after use. The woman's decision to spread the disease seems to have a genocidal connotation that requires no participation or agreement from another party. A majority concern amongst the learners was the infidelity of women which contributed to the spread of AIDS. One of the learner's explained how AIDS may be spread at school:

Yes, it does happen that when one is in relationship with someone who sexually misbehaves and she goes to another school and falls in love with someone with AIDS. Then she will come back to him who sexually behaves well. He will meet (sexually) with her and gets AIDS.

This discourse reinforces the 'them' (*who sexually misbehaves*) and 'us' (*who sexually behave well*) highlighted by Barker *et al.* (2001). The oppressor-victim discourse which surfaces here reflects the dominant cultural construction of male innocence. The discourse is silent on the fact that multiple partnerships for both men and women constitute risky sexual behaviour. The acceptability and promotion of multiple partnerships for men are highlighted by Koenig, Lutalo, Zhao, Nalugoda, Kiwanuka, Wabire-Mangen, Kigozi, Sewankambo, Wagman, Serwadda, Wawer and Gray (2004), Jewkes, Levin and Penn-Kekana (2002), Selikow *et al.* (2002), Becker (2000), and Mc Fadden (1992). Implicit in this discourse is the perception that males are the victims of female infidelity and that the prevention of HIV therefore rests largely on female behaviour change.

Men's behaviour change and the prevention of HIV/AIDS

There was disagreement about the role of males and their capacity to change as evidenced in the following quotes:

Moses: Yes, that may also happen. You find that one has been sexually behaving well in a relationship, then he starts to change, for example, walking at night, coming late and so on.

Jacob: No, . . .it is just that I don't know how they can change. . . .I don't think there is a man that does not love a woman. . . once you let him taste, he will want it all the time. I don't know how they can change. HIV/AIDS is something that is always there.

Nkosi: Maybe men can be changed, but changing men will not stop women. They can still make men get HIV.

Dumisane: Males do have a role, though it is not that high. They use condoms and try to limit the spread of AIDS.

Jacob's comments clearly reflect the objectification of women as the sex provider, a view that surfaced in research with youth conducted by Leach *et al.* (2003), Becker (2000), Wood *et al.* (1998) and Buga, Amoko and Ncayiyana (1996). In analysing this part of the text, we borrow from Wendy Hollway's (2001) 'male sex drive discourse' which seems apparent here. According to this discourse, men's sexuality is directly produced by a biological drive, the function of which is to ensure reproduction of the species. The above discourse (once *you let him taste, he will want it all the time*) confirms Hollway's (2001) contention that it is natural for men to be seen as sexually incontinent and out of control. In these discourses, the hegemonic positioning of the males in relation to females who are expected to be submissive highlights the perception of the role of women as sexual providers. Such positioning is replicated in Tanzania (Rweyemamu, 1999) where one man offered the view that because it is God's plan for men to dominate women, no woman is allowed to decide when to have sex. In fact, God created a woman primarily to service a man, thus reinforcing men's agency and the reality of male power.

Although the above comments make some marginal reference to men having some role to play in limiting the spread of HIV, it is noted though, that the dominant discourse still centres on women as the carrier of the disease who can infect men with HIV. These findings are contrary to those of Willig (1999)

who, in her analysis of American heterosexual male and female adult talk about sexual activity, found that sex was viewed as a male preserve and women were positioned as the innocent victims of HIV infection. Women were constructed as sexually naïve while men were viewed as being promiscuous and sexually experienced. In our study, men were viewed as passive receptors of a deadly disease while putting their survival skills in the form of sexual release to the test. The clear message as articulated by Nkosi was that even if men changed their behaviour, the behaviour of women still placed them at risk of the disease. Whether the silence on the prominent role played by men in the spread of HIV is due to ignorance, entrenched cultural beliefs or a form of learned denial is not clear. Our sense is that these responses are probably due to a combination of these factors.

Comments made by Moses imply that for him, behaviour change for a man would mean a shift from present good behaviour towards bad, HIV/AIDS causing behaviour. The belief that men are AIDS-free in respect of transmission seems to be implied, which confirms LeClerc-Madlala's (1999, p.217) assertion that "the possible association between men and HIV/AIDS remains, metaphorically, inconceivable". The paradox here is that most studies on women and AIDS point to women being the main victims of the epidemic (Dorrington, Bourne, Bradshaw, Laubscher and Timaeus, 2001; UNAIDS, 2004). Foreman (1999) argues that men's failure to protect themselves and their partners makes them responsible, or even to blame, for the HIV/AIDS epidemic.

Although Dumisane claimed that men used condoms, a quantitative survey by Taylor *et al.* (2002) who studied 901 secondary school learners in Ugu North, the rural area in which this research is located, revealed that although 64.8 per cent of the learners viewed the threat of acquiring HIV/AIDS as discouraging multiple sexual partners, 16.5 per cent still indicated that they would want to have many partners. Of the 256 sexually active learners, only 33.5 per cent of males and 10.1 per cent of females reported always using condoms.

Personal risk of infection with HIV/AIDS

Moses: I can get it because of the people I am staying with if they will fail to control themselves. Then she (girlfriend in Johannesburg) comes here and cheats me and then she kisses. . . and then we are tempted to have sex. At the end, I have got it this way, whereas I have abstained for four years telling myself that I am grand. [In fact Moses has two girlfriends.]

Jacob: Yes. Maybe there are babes on my side and they are busy two timing me and I come with a kiss and have sex with her. Then I get it like that.

Nkosi: Me? Not at all. . . You see brother, I first look at the girl that I want and how she is conducting herself.

Dumisane: I don't use a condom and I don't want to know my status. This is going to cause stress for me and also mixed with other things.

These discourses place the responsibility for the youth's risk for HIV squarely on women, echoing the negative power referred to above by Barker *et al.* (2001). Moses, who has two girlfriends with whom he is sexually active, claims that he could be at risk because *others* (women) are out of control, indicating his selective visioning of this issue. Dumisane's endangering the lives of others by not using condoms seems to be of little consequence to him except that knowing his status might cause *him* stress. This statement contradicts his earlier claim that men use condoms, and is viewed in relation to his contention that "*she (a woman) decides to spread it (AIDS) to other people*". The belief that women cause AIDS appears to be so deeply entrenched that the youth seem to see no reason *to reflect on and review their own sexual behaviour*. It is evident that for these youth, advertising campaigns, social marketing and promotion of condom use to prevent HIV/AIDS infections, has failed to change risky behaviour (Strebel, 1997). In the midst of the HIV pandemic in KwaZulu-Natal, responses of this nature call for alternative strategies to facilitate behaviour change. This requires a better understanding of the power dynamics that persuade men to continue to engage in unsafe sex and the defensive techniques at play that result in these perceptions and consequent sexual behaviour.

To prevent HIV, one of the learners suggested that in addition to boys using condoms, mothers should talk to their female children and discipline them. "*If she goes to a person that is calling, she has already failed to control herself.*" Herein lies the double-bind for women arising from widely accepted concepts of masculinity – while females are expected to accede to men's sexual demands, such submission may warrant criticism in the form of labels such as 'slut', 'loose woman' and 'whore', as evidenced in studies by Selikow *et al.* (2002), Becker (2000), and Wood *et al.* (1998).

Despite the youth's suspicion about the infidelity of girls, Bankole, Singh, Weug and Wulf (2004) found that among sexually experienced 15 to 19-year-

olds in Sub-Saharan Africa, larger proportions of men than women had two or more partners in the past year, more than 40 per cent of men in some countries and fewer than 10 per cent of women in almost all countries. On the issue of HIV/AIDS, these authors highlighted that traditional social values condoned promiscuity among men while undermining women's ability to protect their sexual and reproductive health. Adding weight to this argument, Foreman (1999) confirms that over a lifetime men have considerably more partners, which means that they have more opportunity to contract and pass on HIV.

Implications for prevention

In this study, although the boys were very clear that they were at risk of HIV, they did not see it as their role to implement safe sex and appeared to be trying to avoid the blame. Although the literature indicates mens' culpability in spreading the disease, this study confirms that men still perceive women to bear the main responsibility. Other studies (Koenig *et al.*, 2004; Selikow *et al.*, 2002; Harrison, Xaba and Kunene, 2001; Nzioka, 2001; LeClerc-Madlala, 1999; 2001) suggested the tendency of young men to position themselves as not at risk for HIV/AIDS, and therefore see no need to implement safe sex. The emphasis is, however, placed on preventing women from spreading diseases, and this encourages stigmatization as AIDS is generally perceived as the outcome of deviant and promiscuous behaviour. This has broader implication in that instead of receiving sympathy and support, people with AIDS may be blamed, feared and avoided (Pattman, 2005; Strebel, 1997). Shifting such notions must be prioritised in preventive intervention.

Sex education is understood to refer to the process by which ignorance in relation to sexual matters is dispelled. More recently, the reduction of sexually transmitted diseases in general and HIV transmission in particular has become another key objective in sex education (Willig, 1999). We support Willig's (1999) contention that changes in individual sexual behaviour require shifts in discourses surrounding sex and sexuality. It is essential that more emphasis is placed on building relationships between the sexes to change perceptions about the need for male domination and to promote gender equity. These include perceptions of male rights to sexual decision making and the provision of gifts for sexual favours. Female rights to insist on the use of condoms must be recognised. This means that to be effective, sex education may have to challenge those social structures which support limiting and oppressive sexual discourses.

This study highlights misinformation amongst the youth regarding sexual relationships and the spread of HIV. However, simply providing information on protection against ill-health is often insufficient to change behaviour (Foreman, 1999). HIV prevention educators could provide counter narratives to challenge a hegemonic masculinity that views female sexuality as dangerous and diseased and their own sexual behaviour as uncontrollably biologically driven. Condom promotion must be accompanied by knowledge regarding prevailing power relationships, sexual patterns and the context within which sexual and reproductive decisions are made. A supportive approach is advocated where men and women have opportunities to dialogue, in addition to HIV transmission, issues such as self confidence, intimacy, respect, mutual fidelity, and alcoholism. Cornwall and Welbourn (2002) caution that changing what people *know* may have no impact on what they *do*. Adding weight to this argument, Wood *et al.* (1998, p.235) state that the “knowledge leads to action” model which forms part of the HIV/AIDS prevention campaigns tends to overlook the realities of power dynamics, including the gender inequities which structure heterosexual relationships. Strebel (1997) and McFadden (1992) identify two major hurdles in addressing AIDS, namely, the firm entrenchment of patriarchy, and poverty which leads to the economic dependence of women. Economic deprivation, a sense of hopelessness and forced rural-urban migration for work may encourage young men to turn to traditional forms of aggressive masculinity as a means of acquiring power and self esteem. Priorities must, therefore, be given to fundamental changes in power relations between men and women, as well as different notions of sexuality. To do this, there would have to be a focus on women’s differential positioning in society, their lack of access to economic resources which leads to their financial dependence on men, and thus to difficulty in insisting on safe sex. What seems to be required is a shift beyond individual behaviour change to approaches that tackle contextual factors such as poverty and discrimination.

Schools, being sites where young people congregate, are viewed as ideal venues for HIV risk reduction interventions with youth. Morrell *et al.* (2002) and Strebel (1997) emphasise that to achieve sustainable behaviour change, school-based HIV risk reduction interventions must consider the central role of gender in their design and implementation. This could include eliminating damaging stereotypes, encouraging gender sensitivity and creating more gender equitable relationships. Our findings also point to a need to develop interventions which, in addition to providing knowledge, must focus on skills development and behaviour change. Materials are needed to facilitate open

discussion of sex and sexuality, and to enhance awareness of alternative constructions of love and sexual practice, including abstinence. Schools need to provide safe environments within which adolescent males and females can be encouraged to explore male exertion of power over women especially in sexual relationships. Interventions must also be appropriate to the needs of rural school learners, particularly the socio-cultural contexts of views of rural adolescents. Educators play a crucial role given the extensive contact time with learners, and equipped with training pertaining to HIV and AIDS, can provide considerable support in strengthening prevention efforts.

Talk about sex and sexuality is still taboo in many African families and communities, and the stigma attached to the disease often leads to isolation of the infected person. Consequently, a strong discursive practice of silencing has emerged, accompanied by denial, fear and further uncertainty. Involving parents in educational institutions and exploring creative ways of including parents and other adults in sex education programmes will draw attention to the reality of HIV and AIDS. Encouraging 'let's talk about sex' discussions among parents and children may help to demystify sex and sexuality, and reinforce ideas about responsible sexual behaviour. HIV and AIDS must be viewed as a community issue with men and women sharing the responsibility for sexual behaviour and its consequences.

In our research, although in the minority, some alternative responses provided spaces for possible shifts in attitudes with regard to sexuality and HIV/AIDS. Along with their strong assertions about women spreading AIDS, some youth admitted to men having a role to play in prevention. Further exploration of this aspect is likely to lend some direction to the development of interventions. It is felt that maximum use should be made of opportunities to encourage alternative forms of talk about sexuality, encourage gender equity, provide safe sex education, and promote healthier relationships. In conclusion, we endorse the views of Cornwall and Welbourn (2002) that creating safe spaces for young people to articulate their needs and concerns, discuss the changes they would like others to make in their attitudes and behaviours, and develop a critical analysis of how to resolve their concerns, will certainly make a difference to youth and to society.

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Note

This research was funded by South Africa Netherlands Research Programme on Alternatives in Development (SANPAD).

Reshma Sathiparsad
School of Social Work and Community Development
University of KwaZulu-Natal

sathipar@ukzn.ac.za

Myra Taylor
Department of Community Health
Nelson Mandela School of Medicine
University of KwaZulu-Natal

taylor@ukzn.ac.za