You can’t eat the sweet with the paper on
An anthropological study of perceptions of HIV and HIV prevention among
Xhosa youth in Cape Town, South Africa

By
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**Abstract**

South Africa has the biggest HIV epidemic in the world and the HIV rates among youth are especially alarming. In 2016 there were 110 000 new cases of HIV among 15 to 24-year-olds\(^1\).

The aim of this study is to describe and analyse perceptions of HIV and HIV prevention among Xhosa youth in the township of Langa, Cape Town. In order to study this, I focus on the organisation loveLife and their employed peer educators called groundBREAKERs (gBs). To gain knowledge on what fuels the HIV epidemic in this setting I will examine their thoughts and notions of HIV/AIDS, sexuality and sexual behaviour in relation to the information that is available to them. Examining the socio-cultural context of HIV/AIDS is important to understand the spread and why HIV is not declining sufficiently in response to HIV preventative efforts.

This thesis is based on ten weeks of fieldwork at loveLife’s Y-Centre in Langa. The material was gathered through semi-structured interviews and participant observation. To analyse the drivers for the spread of HIV among Xhosa youth an analytical tool of gender roles, with a main focus on masculinity, has been utilized.

**Title:** You can’t eat the sweet with the paper on – An anthropological study of perceptions of HIV and HIV prevention among Xhosa youth in Cape Town, South Africa.

**Keywords:** HIV, HIV prevention, condom attitudes, Xhosa youth, loveLife, gender inequality, hegemonic masculinity, ulwaluko.

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\(^1\) UNAIDS AIDSinfo [http://aidsinfo.unaids.org/] [2018-01-14].
# List of acronyms and abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
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<tr>
<td>ARVs</td>
<td>Antiretrovirals</td>
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<td>gBs</td>
<td>groundBREAKERs – young persons working for loveLife</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>NGO</td>
<td>Non-governmental Organisation</td>
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<td>NPO</td>
<td>Non-profit Organisation</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>STD</td>
<td>Sexually Transmitted Disease</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>Y-Centre</td>
<td>Youth Centre</td>
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# Terminological definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td>Choice</td>
<td>Free governmental distributed condoms (now re-branded as Max)</td>
</tr>
<tr>
<td>Epidemic</td>
<td>Disease outbreak in a particular region</td>
</tr>
<tr>
<td>Incidence</td>
<td>Newly diagnosed cases of the disease within a certain time period</td>
</tr>
<tr>
<td>Mpintshi</td>
<td>Volunteers working for loveLife</td>
</tr>
<tr>
<td>Pandemic</td>
<td>Disease outbreak that is not limited to a specific geographic region (can be global)</td>
</tr>
<tr>
<td>Prevalence</td>
<td>Prevalence is the actual number of cases alive with the disease</td>
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Acknowledgements

First of all, I wish to express my sincere gratitude to loveLife and the Y-Centre in Langa for letting me conduct this research there. And above all, a big thank you to the groundBREAKERs for participating in this study.

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Last but not least, I would like to thank my family. Jens, thank you for your immense support throughout these years. When the finish line seemed distant you always kept me on track. Amandine, my chocolate praline, you are the greatest source of joy. I love you.
List of cited informants

The groundBREAKErS

Andisiwe    female, 25 years, responsible for Debate.
Lungile      male, 22 years, responsible for Sports and Recreation.
Nwabisa     female, 19 years, responsible for Arts and Culture.
Thulani      male, 23 years, responsible for Media Ys.
Vusi         female, 20 years, responsible for Living my Life.
Xolela       male, 23 years, responsible for the Clinic.
Zizipho      female, 21 years, responsible for Making my Move.

Others

Siyabonga    programmes manager at loveLife´s Y-Centre in Langa.
# Table of contents

1. Introduction ..............................................................................................................1
   1.1 Introduction and research objective ..................................................................1
   1.2 Background to HIV in South Africa .................................................................3
   1.3 A gendered epidemic .......................................................................................6
   1.4 Outline ..............................................................................................................7

2. Theoretical framework ............................................................................................8
   2.1 Introduction to anthropological HIV/AIDS research ........................................8
   2.2 Gender in anthropology ..................................................................................11
   2.3 Definition of masculinity and masculinity as manhood acts ............................12
   2.4 Becoming a Xhosa man (indoda) through ulwaluko ........................................13

3. Ethnographic research methodology ......................................................................21
   3.1 Fieldwork .........................................................................................................21
   3.2 Methods for data collection .............................................................................24
   3.3 Practical and ethical matters ...........................................................................28

4. loveLife and HIV prevention ..................................................................................31
   4.1 About loveLife ...................................................................................................31
   4.2 The groundBREAKERs – peer motivators .......................................................33
   4.3 HIV information from loveLife .........................................................................35
   4.4 Information from other sources .......................................................................37
   4.5 How the groundBREAKERs work to prevent HIV ............................................38

5. Perceptions of reasons for the spread of HIV ........................................................41
   5.1 Not talking about it ..........................................................................................41
   5.2 “People don’t want to get tested” .....................................................................46
   5.3 HIV myths .......................................................................................................49
   5.4 Spreading HIV on purpose .............................................................................50
   5.5 Multiple partners .............................................................................................53
   5.6 Alcohol and drugs cloud your judgement .......................................................55
   5.7 You can’t eat the sweet with the paper on .......................................................56
   5.8 Condom is a modern thing – what did our forefathers do? ..............................61
   5.9 Sugar daddies ..................................................................................................68

6. What could stop the spread of HIV among youth? ..................................................70
   6.1 Preach ..............................................................................................................70
   6.2 Distribute condoms – make them fun ..............................................................72
   6.3 The scientists have to invent a cure .................................................................73

7. Concluding discussion ............................................................................................75

Bibliography ...............................................................................................................82
1. Introduction

1.1 Introduction and research objective

Acquired immunodeficiency syndrome (AIDS) represents a group of conditions that occur as a result of severe immunosuppression related to human immunodeficiency virus (HIV) infection. HIV/AIDS is an incurable medical condition and a complex global pandemic. Although significant strides have been made in the last thirty years to stem the devastating effects of HIV/AIDS, it continues to be one of the leading causes of infectious disease deaths in the world. (Oxford Bibliographies)

The last sentence in the quote above captures what made me interested in and determined to conduct research about HIV in the first place. I wanted to gain knowledge about what mechanism fuels the spread of HIV to understand why the preventative efforts to this day have not been sufficient. As of 2016, there were approximately 36.7 million people living with HIV/AIDS globally, with a significant majority residing in sub-Saharan Africa (UNAIDS 2017a:6-7). The spread of HIV has declined globally since the early 2000’s. However, the decline is occurring at a slow paste; in 2015 the global number of newly infected reached approximately 1.9 million whilst in 2016 an estimated 1.8 million people were newly infected with HIV globally (UNAIDS 2017a:6). HIV and AIDS have been labelled as ‘development problems’ by the World Bank (1999). And, UNAIDS (2004) notes that HIV is unique in being both an emergency and a long-term development issue. I find that social anthropologist Hansjörg Dilger describes an understandable juxtaposing for this: “The presence of the disease has affected local and household economies, gender and kinship relations, religious expression and organization, concepts of life, death and healing and the organization of social, cultural and political life in sub-Saharan Africa in general” (Dilger 2010:3).

As already mentioned, the sub-Saharan region is the most affected by HIV, but there is especially one country that stands out here, and that is South Africa. The country has the largest HIV epidemic in the world seen to absolute numbers. In 2016, one third of all new infections in the region were to be found here (UNAIDS 2017b:105). With this in mind, I got curious to learn more about HIV and HIV prevention in a South African setting. I was especially interested in youth and how they are being affected by the epidemic. The HIV rates amongst youth in South Africa are alarmingly high. In 2012 the prevalence of HIV among youth aged 15-24 was 4.4% in the Western Cape (including Cape Town). Nation wide, the rates were at 11.3% in urban informal areas. There is significant higher HIV prevalence amongst black Africans than other racial groups (HSRC 2012:42, 2017-11-28)
According to researchers, youth in South Africa are said to have sound levels of knowledge regarding sexual health risks (see for example Campbell & MacPhail 2002, Skinner 2001). Yet, there are particularly high levels of HIV amongst youth in South Africa compared to other countries. In 2016 there were 110 000 new cases of HIV among youth aged 15-24 nationally. Compared to 120 000 new cases in both 2015 and 2014 (UNAIDS AIDSinfo). Looking at these numbers, it seems evident that there has been no distinct decline in the incidence of HIV among youth in South Africa in recent times. This made me want to learn more about what preventative efforts are being executed to stem the epidemic in this age group. And, not only that, I also wanted to know how youth relate to these efforts and how they make sense of the epidemic. Through the non-profit organisation loveLife, South Africa’s largest HIV prevention initiative for young people, I was able to conduct fieldwork and gain insight in how they work, what they stand for and what they promote. I wanted to learn about what is being done to reduce the incidence of HIV among youth, especially among black youth, since they are the most affected by the epidemic in South Africa. I also wanted to examine what information youths are receiving concerning HIV, both from loveLife and from other sources. Though, the primary research subject in this thesis concerns Xhosa youth, and how they perceive and relate to HIV, I wanted to acquire knowledge about the reality Xhosa youths are living in today in the Cape Town area. I believe that an understanding of young peoples experiences with, and, social responses to HIV/AIDS is crucial to understand why the spread of the virus is declining so slowly. As anthropologist Merrill Singer (2009) emphasise, “… anthropological research in Africa has improved our understanding of local HIV-related beliefs, behaviours, attitudes and emotions – knowledge that is of critical importance in making changes that matter in responding to HIV and AIDS” (ibid.:385).

The aim of this study is to describe and analyse perceptions of HIV and HIV prevention among Xhosa youth in the township of Langa, Cape Town. In order to study this, I focused on the organisation loveLife and their employed peer educators called groundBREAKERs (gBs). To gain knowledge on what fuels the HIV epidemic in this setting I will examine their thoughts and notions of HIV/AIDS, sexuality and sexual behaviour in relation to the information that is available to them. The purpose is to uncover and understand some of the underlying mechanisms that affect how youth relate and respond to HIV/AIDS in an urban South African context. Examining the socio-cultural context of HIV/AIDS is important to understand the spread and why HIV is not declining sufficiently in response to HIV preventative efforts (like loveLife’s).
Research questions:

- What are the perceptions of HIV/AIDS among the youth (groundBREAKERs) involved in loveLife?
- What are the mechanisms behind the spread of HIV among youth? What factors are driving the epidemic?

1.2 Background to HIV in South Africa

The first AIDS cases in South Africa were reported in 1983 (Walker et al. 2004:12). The epidemic came in a turbulent political period during the time of apartheid that lasted between 1948-1994. Simplified, apartheid can be explained as a political ‘White supremacy system’ of institutionalised discrimination and racial segregation with the intention of creating a ‘White Christian national state’ (Christopher 2001:68). Through its systematic racial segregation, the apartheid regime divided people and created systems of structural violence that prioritised and benefitted the ‘White’ minority in all aspects of society. Disproportionate rates of the resources went to the departments that were serving the ‘White’ minority, leading to the break down of the infrastructures for non-whites. For example, did the apartheid healthcare system restrict access to healthcare for ‘Blacks’ and the quality-of-care standards were often ignored (Brauns & Stanton 2016:23). The same applied for the educational system, the non-white education departments were grossly underfunded, there were not enough teachers, but also, they were unqualified, which resulted in unequal access to education and unequal learning outcomes for non-whites (Sayed & Kanjee 2013:7).

South Africa has a historically high prevalence of HIV that is accounted by multiple factors, one of them explained by the migration that occurred under apartheid where men had to leave their homes to seek employment, for example in the mining sector. These men were not allowed to bring their wives and families with them. It is therefore suggested that migrant workers developed multiple sexual networks that included partners in urban or mining areas as well as back home (Squire 2007:29). Walker et al. reason that “[t]he long-term separation of migrant men from their wives and families, along with the ever-present dangers of mining work and other high-risk, low-paid jobs (such as in foundries), helped foster aggressive masculinities and sexualities among migrant labourers. These in turn have contributed massively to the rapid spread of HIV” (Walker et al. 2004:64). The sexual violence by men in South Africa has roots in the colonial and apartheid

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5 These thoughts were firmly rooted in the colonial era. South Africa was first settled by the Dutch East Indian Company in 1652 and then occupied on a permanent basis by the British in 1806 (Christopher 2001:9).
6 The apartheid regime created four racial categories: Africans (or ‘blacks’), coloureds, Indians and whites (Dickinson & Deutsch 2009:7)
7 Structural violence is defined by Abdi (2011) as: “social, economic, political and psychological relations of domination, exploitation and exclusion among and within individuals and groups” (ibid.:694).
past and its structural violence. Piot (2015) states that apartheid left men “[d]eprived, disenfranchised, and for a long time without rights” and suggest that this led to some of these men becoming violent among themselves, and also, that they “imposed on their women and often their children an exacerbated male domination” (ibid.:41). Furthermore, he states that “AIDS in Southern Africa demonstrates that the deleterious effects of discriminatory and oppressive societies, like apartheid, can last well beyond their formal abolition. Historic events like conflict and displacement create oppression in hearts and minds and mark families in the deepest spheres of human relations, including in the intimate domain of sexual relations” (Piot 2015:41).

**The Government’s response to HIV**

From a political perspective, the response to the epidemic has been described by some scholars as painfully slow. For a long time, the Government failed to lead a national response to the epidemic. President Nelson Mandela (1994-1999) had to deal with the legacy after apartheid and was “faced with the urgent need for reconciliation and nation building which took precedence over the need to accord AIDS the necessary priority and commitment” (Abdool Karim 2005a:35). Whilst, subsequent President Thabo Mbeki (1999-2008) is known for his HIV denialism; in 2003 he declared that he knew of no one who had died of HIV (Washington Post, July 30 2003 in Squire 2007:40). When antiretrovirals (ARVs), drugs developed to maximally suppress the HI-virus and stop the progression to AIDS, came out on the market, the Government refused to provide people with a HIV-positive status with them. And, according to Squire: “In 2000, the government voiced the possibility that ARVs were useless remedies being imposed on Africa in economically ruinous and potentially racist ways” (Squire 2007:36). It wanted to find an African solution to avoid dependency of multinational pharmaceutical corporations. It is important to point out that, it was not only the Government that was reluctant towards ARVs, rather, “ARVs seemed to many developed-world funders and NGOs to be prohibitively expensive and complex for the developing world, requiring sophisticated and unending treatment regime, and extra infrastructure, medical capacity and training” (Squire 2007:34). However, the tide turned and in 2003 the Government announced a national antiretroviral roll-out plan. And, in her research, Squire found that by 2003-2004 all her research participants could access ARV treatment in the Western Cape area (Squire 2007:41). Yet, messages from the Government have over the years continued to contribute to HIV confusion. Current President, Jacob Zuma (2009-today) got accused of rape in 2005, by a woman he knew had an HIV-positive status. In trial, he admitted having sexual intercourse with the woman but claimed it was consensual. He also disclosed that he had not used a condom, but explained that he had taken a shower afterwards to minimise the risk of contracting HIV (BBC 5 April 2006).
HIV in South Africa today

South Africa is today Africa’s economic and political major power, and an important player for peace, security, integration, and development on the African continent. Although South Africa is preceding in terms of development in relation to other African countries they are still wrestling with major challenges, HIV/AIDS being one of the biggest hurdles. “South Africa has the largest HIV epidemic in the world, with 19% of the global number of people living with HIV, 15% of new infections and 11% of AIDS related deaths” (UNAIDS 2017c). The illness is threatening the country’s development, social structure and growth. In 2016, 7.1 million people estimated to be HIV-positive in the country, with a total population of almost 57 million people (Worldometers), which shows that more than one in eight carries the virus. Out of these 7.1 million HIV-positive people, it is believed that 1 million are unaware of their HIV-positive status (UNAIDS 2017c). “HIV prevalence rates in South Africa are strongly correlated with race, gender, employment, income, and education. Prevalence rates are lowest among whites and Asians, slightly higher among Coloreds, and highest among blacks, including when controlling for socioeconomic differences” (Horton 2005:116). If left untreated, life expectancy is 9-11 years after initial HIV infection (UNAIDS 2007).

Today, antiretroviral therapy (ART) is recommended for everyone infected with HIV in South Africa (UNAIDS 2016). ART is a life long treatment that demands medication adherence, which means that you must take your ARVs every day and exactly as prescribed. “Adherence to an HIV regimen prevents HIV from multiplying and destroying the immune system. Taking HIV medicines every day also reduces the risk of HIV transmission” (U.S. HHS 2017). With medical adherence, life expectancy has today reached ‘near normal’ (The Antiretroviral Therapy Cohort Collaboration 2017).

1.3 A gendered epidemic

The HIV/AIDS epidemic in Southern Africa is mostly driven by the distinctive and dramatic interaction of sex, gender and power relations. (Walker et al. 2004:59)

A very striking fact about the HIV epidemic in South Africa is that more women than men are HIV-positive. Statistics show that young women are far more exposed to HIV than young men. Numbers from 2016 showed that the national prevalence among young South African women aged 15-24

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years were 10.4% compared to 4.0% for men in the same age span. The same year there were 77,000 new cases of HIV among young women and 33,000 new cases among young men (UNAIDS AIDSinfo). Young women’s disproportionate infection rates in South Africa are generally explained through the physiological factor of easier susceptibility during heterosexual intercourse. In Abdool Karim (2005b) we find an estimation that HIV transmissions from men to women are seven times greater than vice versa (Abdool Karim 2005b:245). The difference is also explained through a range of social factors, including women starting sexual activity at a younger age, having sexual relationships with older men whose longer sexual histories give them more likelihood of infection. Marriage also exposes women to older men with whom they are unlikely to practice safer sex. Domestic violence and women’s lack of power to negotiate safer sex also play a part, and contribute to the disproportionate infection rates of young women. This is the result of the power structures in the country where men are superior to women. Walker et al. elucidate that women are found to be submissive to men, as they should be well-mannered. They strive to please men all the time, not only in the wider community but also in their relationships (Nduna et al. 2001:9 in Walker et al. 2004:31-2).

Sexual abuse and rape is indisputably frequent in South Africa (see CSVR 2009), and, as Vincent points out: “Research findings indicate that physical assault, rape and coercive sex have become the norm in male-female relationships in South Africa and that it is very difficult for young women to protect themselves against unwanted sex” (Vincent 2008:436). Sexual coercion may actually be seen as a normal part of ‘love’ relationships by some (see for example Outwater et al.:2005, Wood & Jewkes 2001, Squire 2007:27). In a role play as described in Walker et al. (2004) youth did not see forcing a girl to have sex as rape. They thought of rape as an attack by a stranger. The role play indicated that boys did not see girls saying no as an option. And, “they used biology (the male sexual urge) to justify men having sex on demand” (Walker et al. 2004:32). The research also revealed that: “Coercive sex happens so frequently that it has come to be seen as normal and is even accepted as part of having sex by both girls and boys” (Walker et al. 2004:56). Not only that, they also shed light on the fact that girls are often afraid to speak about this type of violence because they are not supposed to be having sex in the first place (ibid.). It is of importance to point out here that violence against women is a crucial factor in the HIV epidemic. And, as Walker et al. show, it is not possible to negotiate safer sex practices in abusive relationships (ibid.:17).

Because more women than men are HIV-positive they are the scapegoats for being the spreaders of the disease, which can be seen as a paradox. According to Squire, women are stigmatised as responsible for getting and transmitting HIV through promiscuity (Squire 2007:15). Yet, in contrast to this, many scholars point at gender inequalities as one of the core drivers of the

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11 Due to the physiological differences, where the contact area of the female mucous membrane is much greater than that of males.
HIV epidemic in South Africa. It is suggested by Walker et al. (2004) that men drive the HIV/AIDS epidemic and that “… masculinity is a critical area of inquiry when it comes to understanding the course of the AIDS pandemic in South Africa. The combined effects of common male behaviour, such as having multiple sexual partners, exercising control over women, engaging in coercive sex, violence between men, and the use of alcohol and drugs, are a large part of the problem” (ibid.:59). Thereby, I have chosen to use theoretical perspectives on gender roles, and particularly on hegemonic masculinity, for my analysis of the drivers for the spread of HIV among Xhosa youth, thus the main focus will lie here, and not on theories on femininity.

1.4 Outline

After this introduction follows a theory chapter that will go through some of the previous anthropological HIV/AIDS research, the theoretical tools that will frame my empirical findings and how masculinity is constructed in Xhosa culture. I will then shed light on the methodological research methods utilised in this thesis in chapter three, where I also elucidate my positionality as a researcher. From there, we move on to the first empirical chapter, here I describe how loveLife and the groundBREAKERs work to prevent the spread of HIV among youth, I also go through the HIV information that has been available for the gBs. In chapter five my empirical findings will be presented along with their analysis. Here I will go through the reasons for the HIV epidemic from the gBs point of view. Then, chapter six follows where the groundBREAKERs present suggestions of how they think HIV preventative efforts should look like. Lastly, a concluding discussion will follow where I highlight my main findings in relation to the theoretical framework and the work of other scholars.
2. Theoretical framework

In this chapter I start off by exploring anthropological and social science research within the field of HIV, from the outbreak in the 80’s until present day. I will then clarify how anthropologists have understood the concept of gender, and after this, I will define masculinity and ‘manhood acts’. Lastly, I will present how Xhosa males are transformed into real men through ritual circumcision.

2.1 Introduction to anthropological HIV/AIDS research

During the first years of the HIV/AIDS pandemic anthropological and social science research tended to concentrate on risk groups, risk behaviours, and prevention. At first risk groups became highlighted and HIV/AIDS was identified with certain social groups (gay men, injecting drug users, and prostitutes). Walker et al. explain that:

This allowed those who did not belong to these ‘high risk groups’ to imagine that they were immune from infection. If you weren’t a prostitute, didn’t do drugs, and were straight you thought you were not at risk. Understandings of AIDS was strongly influenced by moral judgements. Minorities of the margins of society were often blamed for the spread of the disease. Those who were infested were believed to be the victims of their own immoral and antisocial behavior. And these perceptions added to the stigma attached to AIDS. (ibid. 2004:12)

Because HIV, in the first place, was associated with these traditionally stigmatised groups the discourse surrounding the topic has never been neutral (Dilger 2010:1, Nguyen 2010:24, Herdt 1987:1). After some time anthropologists helped influence a shift in the overall HIV/AIDS literature away from an emphasis on ‘risk groups’ to ‘risk behaviours’. These anthropologists drew conclusions from their own research and stressed that empirically bounded ‘risk groups’ did not exist. By 1989 it was clear that the AIDS epidemic in the Southern African region was mainly heterosexually transmitted (Walker et al. 2004:12). Moreover, anthropologist also helped to clarify that gender is an important aspect when it comes to risk behaviour. Gender identities and specific patterns of male/female interaction play significant roles in the construction of risk behaviours (Singer 2009:381). For example, men who perpetrate partner violence are more likely than other men to engage in HIV risk behaviours, and as a result of this, more likely to be HIV positive (Dunkle 2006:2108). Men’s violence against women makes women more exposed to HIV than men. Women are at a higher risk of acquiring HIV than men and this vulnerability is a result of gender inequality (Boesten & Poku 2009:12, de Bruyn 1992, Thege 2009). There are also economic and cultural factors to this. Many women lack options for supporting themselves and therefore feel
compelled to stay with a male partner. Because of this economical dependency many women have a hard time negotiating and practising safe sex. A refusal to participate in unsafe sex may mean the withdrawal of material support leaving a woman and her children with no alternative means of survival. A woman’s socioeconmic status and lack of power makes it difficult for her to negotiate safe sex (Boesten & Poku 2009:11, Thege 2009, de Bruyn 1992, Schoepf 2004:131).

Eaton et al. identified that “HIV risk behaviour is influenced by factors at three levels: within the person, within the proximal context (interpersonal relationships and physical and organizational environment) and within the distal context (culture and structural factors)” (Eaton, Flisher & Aarø 2003:149). I find that Deutsch and Dickinson (2009) capture these three different levels well when they explain sexual behaviour:

Preventing infection requires individuals to address and change the least manageable of human behaviours. For HIV infections is, for most, a question of sex: sexual behaviours that infection starkly exposes. Sexual behaviour is embedded within beliefs about gender, faith, status, morality, identity, and more. Preventing infection, or coming to terms with being HIV-positive, requires individuals to take responsibility for themselves. Yet, this is not straightforward. Their actions and the actions of others with whom they coexist are enmeshed within a web of social understandings and responsibilities that can neither be ignored nor thrown out wholesale. The social worlds that we inhabit are shaped by the past as well as our own actions. (ibid.:3)

Above, Deutsch and Dickinson show the complexity that HIV preventative efforts need to relate to, when advocating for a change in (sexual) behaviour. Now, many scholars have stressed that the use of the terms ‘risk groups’ and ‘risk behaviours’ stigmatise people and blame individuals. Among them are Walker et al., who argue that: “Neither [term] takes into account the overriding importance of social context and how life circumstances and environment substantially shape one’s risk of infection” (Walker et al. 2004:61). More recent anthropological research has shifted focus from looking at risk groups and behaviours to instead focusing on HIV/AIDS as a social reality in a specific social and cultural context. Many anthropologists are today interested in examining how this social reality is being modified, transformed and challenged by the presence of the disease (Dilger 2010:1). Jackson (1991) points out that an HIV or AIDS diagnosis may mean very different things for different individuals (ibid:30). Similarly van Woudenberg argues that: “Traditional values and cultural concepts related to dealing with disease always play a role in coping with HIV and AIDS, and peoples subjective understanding of their own illness always goes beyond physical or biomedical explanations” (van Woudenber 1998:23). Castro and Farmer (2005) emphasise that diseases have a social course, that pathology is embedded in social experience. Van Woudenberg and Dilger are on the same path, and claim that the meaning HIV/AIDS gets for a person reflects
that individuals’ personal experience and knowledge of the perceived cause of the infection, which will also influence the manner this person will cope with the disease (van Woudenberg 1998:30, Dilger 2010:7). Another relatively new factor that has changed how people perceive an HIV diagnosis are the antiretrovirals. Today an HIV diagnosis is not necessary a death sentence.

**Global responses to HIV – the biomedical model**

Since the beginning of the epidemic, anthropologists have contributed to better understandings of cultural beliefs and local practices that place people at risk for HIV/AIDS, advocated for equitable access to care and treatment, and promoted culturally appropriate strategies for prevention. More recently, anthropologists have also critically analyzed the complex relationships of power between global multilateral organizations, influential donors, governments of resource-poor countries, and local communities, and their impact on global HIV/AIDS projects. (Oxford Bibliographies)

Walker et al. (2004) explain that, throughout the world, a biomedical or scientific model has dominated explanations of the causes and treatment of HIV/AIDS. “In this medical system the cause of the disease is a virus, and the focus of prevention and treatment the individual patient. The biomedical model lies at the heart of most AIDS research, intervention and education programmes in South Africa and internationally” (ibid.:91). Furthermore, Dickinson and Deutsch (2009) point out that:

Early responses to AIDS assumed that knowledge about HIV/AIDS would be sufficient to change beliefs and bring about behavioral change (UNEFPA 2002). This assumption promoted *top-down or vertical communication programs* that disseminate information from centers of expertise to target audiences. In short, the assumption was that information = knowledge = belief = behavior. […] The general failure of such programs, evidenced by continued HIV infection and persistent stigmatization of those with the disease, has prompted a rethinking of such communication strategies. (ibid.:5-6).

However, loveLife seem to navigate from the biomedical model in their HIV preventative strategies. They use peer education as a means of changing attitudes in youth, with the aim that it will in turn lead to behavioural change. Their mission statement is: “To promote social activism for healthy living, active lifestyles and HIV consciousness among young people; through: –Advocacy – Information, education and awareness campaigns –Healthy living and behavioural change interventions –Youth development programmes” (loveLife 2017a). loveLife’s working strategies will be further described in chapter 4.

2.2 Gender in anthropology

Gender has been a key concept within the discipline of anthropology for a long time. Here, sex and gender are understood and defined differently. Anthropologist Verena Stolcke (1993) explains what derived the distinction between the two:

The analytic concept of ‘gender’ is meant to challenge the essentialist and universalist dictum that ‘biology is destiny’. It transcends biological reductionism by interpreting the relationships between women and men as cultural constructs which result from imposing social, cultural and psychological meanings upon biological sexual identities. As a consequence, it became necessary to distinguish between ‘gender’ as a symbolic creation, ‘sex’ which refers to the biological fact of being female or male, and ‘sexuality’ which has to do with sexual preferences and behaviour. (ibid.:20)

One of the pioneers in the anthropological study of gender was Margaret Mead who critiqued the assumption that biology determines male or female traits or roles. In her work *Sex and Temperament in Three Primitive Societies* (first published in 1935) she demonstrates how cultural conditioning affects the meanings for masculinity and femininity (Mead 1963: viii-ix). Another influential study that focuses on the cultural imagery of masculinity, is for example *Guardians of the Flutes* (first published in 1981) by Gilbert Herdt. This is one of the most well known anthropological studies on masculinities due to its sexual and scandalous content where Herdt discloses ‘ritualized homosexuality’ within manhood initiation rites in Papua New Guinea (Herdt 1994:239). Another anthropologist who has written about masculinity is David Gilmore who in his *Manhood in the Making* (1990) is on the search for what it means ‘to be a man’ in different cultures around the world. Is there a global archetype of manliness? he asks (ibid:3). Gilmore aims to answer this question through a cross-cultural study of manhood and masculinity in different countries.

There are plenty of anthropologists who have studied gender. Here, I have mentioned a few to show some of the perspectives on gender that have been studied. However, gender has also been studied in other disciplines. In this thesis I will use a definition on masculinity and a concept of ‘manhood acts’ that stem from sociology.

2.3 Definition of masculinity and masculinity as manhood acts

One researcher that is highly influential in the study of gender is Raewyn Connell, who sees gender as a social relation within which individuals and groups act (Connell 2009:10). In her book *Gender in World Perspective* (2009) she reason that:
Gender, like other social structures, is multi-dimensional; it is not just about identity, or just about work, or just about power, or just about sexuality, but all of these things at once. Gender patterns may differ strikingly from one cultural context to another, but are still ‘gender’. Gender arrangements are reproduced socially (not biologically) by the power of structures to shape individual action, so they often appear unchanging. Yet gender arrangements are in fact always changing, as human practice creates new situations … (ibid.:11)

What Connell is saying is that being a man or a woman is not a pre-determined state. It is a becoming, a condition actively under construction. One is not born masculine, but rather has to become a man (Connell 2009:5). According to Connell, masculinity can briefly be defined as “a place in gender relations, the practices through which men and women engage that place in gender, and the effects of these practices in bodily experience, personality and culture” (Connell 1995:71). Furthermore, her standpoint is that there are multiple forms of masculinity in each society at any given time. Connell developed a concept of hegemonic, subordinate, complicit and marginal masculinities and established how they relate to each other (see Connell 1995:76-81). “At any given time, one form of masculinity rather than others is culturally exalted”, this is the hegemonic masculinity (Connell 1995:77). Hegemonic masculinity embodies the currently most honoured way of being a man, it requires all other men to position themselves in relation to it, and it ideologically legitimise the global subordination of women to men (Connell & Messerschmidt 2005:832). However, Mfecane (2016) points out that Connell’s (1995) model of masculinities represents patterns of masculinity in the Western gender order, therefore, he argues that it is not applicable universally (Mfecane 2016:209). He contends that in Xhosa culture masculine hierarchies are based on circumcision status (ibid.:210). The hegemonic masculinity here is “primarily achieved by having a traditionally circumcised penis” (ibid.:208). Whereof, “the most subordinated forms of masculinity in Xhosa gender order are uncircumcised adult men and medically circumcised men” (ibid.:210).

Furthermore, I will in this thesis use sociologists Douglas Schrock and Michael Schwalbe’s concept of masculinity as ‘manhood acts’. They define ‘manhood acts’ as: “the identity work that males do to claim membership in the dominant gender group, to affirm the social reality of the group, to elicit deference from others, and to maintain privileges vis-à-vis women” (Schrock & Schwalbe 2009:289). They argue that “[f]or an individual male to enjoy the benefits that derive from membership in the dominant gender group, he must present himself to others as a particular kind of social being: a man. … To be credited as a man, what an individual male must do, in other words, is put on a convincing manhood act (Schwalbe 2005). This requires mastering a set of conventional signifying practices through which the identity “man” is established and upheld in interaction” (Schrock & Schwalbe 2009:279).
In section 2.4 below I will shed light on ulwaluko, the customary rite of passage from boyhood to manhood that Xhosa males have to go through to transform into men. As stated by Connell above, one is not born masculine, but rather has to become a man. Here, I suggest that ulwaluko should be understood as a ‘manhood act’ as defined by Schrock and Schwalbe (2009), as showed by multiple researchers (e.g. Vincent 2008, Ntombana 2011, Mavundla et al. 2010). And that being an indoda man is the hegemonic masculinity as argued by Mfecane (2016).

2.4 Becoming a Xhosa man (indoda) through ulwaluko

As seen, many scholars have pointed out gender inequalities as one of the main drivers of the HIV epidemic in South Africa. Men’s violence and dominance over women makes women more exposed to HIV infection. Since unequal gender roles play an important role in the incidence of HIV amongst youth I will in this section explore how these are manifested through Xhosa masculinities. Let us look at what it means to become a man, an ‘indoda’, within Xhosa culture. This will be done through a literature discussion since my own material is very limited, although, it will be brought up in section 5.8, thus an explanation is needed to contextualise hegemonic masculinity to better understand the narratives of the informants.

Ulwaluko

Xhosa notions of masculinity centre on the practice of ulwaluko, the customary rite of passage from boyhood to manhood undertaken by boys aged 18 years and older (or rather, the legal age is set to 18, however, the most common age span for boys to undergo the rite is between the ages of 15 and 25 years) (Vincent 2008:433–4). Ulwaluko involves ritual male circumcision, and is among the most secretive and sacred of rites practised by the Xhosa people. Women and uncircumcised men are excluded from obtaining knowledge of male initiation rites since initiates are precluded from discussing the intricacies of the rites with non-initiates; it is frowned upon to talk of male circumcision. As a result, detailed accounts of the practice itself are rare (Vincent 2008:433, Ndangam 2008:212): “Maintaining secrecy is related to the sacred nature of the practice and is constructed by many as a way of safeguarding the ritual from those who may want to dishonour it” (Magodyo et al. 2016:7). Annually, approximately around 10,000 Xhosa males are circumcised in the Eastern Cape (Vincent 2008:433).

Despite the secretive nature of ulwaluko, there are multiple scholars who have studied the phenomenon. Few have undertaken ulwaluko themselves, but one who has is Sakhumzi Mfecane (2016), currently enrolled at the Department of Anthropology and Sociology at the University of the Western Cape. His and other scholars findings will be further described in the section below.
Ulwaluko – the ritual in short

Ulwaluko entails ritual circumcision where the foreskin is severed off by a traditional surgeon using a knife. The initiate is expected to stay completely still and quiet during the procedure, since, as Ndangam puts it, “[t]he overt pain of circumcision in the bush is perceived as both a reflection and embodiment of male power and bravery” (Ndangam 2008:218). When the procedure is done the initiate is supposed to exclaim “Ndiyindoda!” [I am a man]. This declaration marks a shift in his social status, he is no longer considered a boy. However, he must go through the rest of the rite to be fully regarded as a man, an indoda (Mfecane 2016:206-7). Circumcision is followed by separation from society for a period of three to six weeks. During the separation period, the initiate lives in a secluded temporary lodge together with other initiates and a designated guardian. Here, he receives instruction about being a man from the guardian and other initiated male youths (Mfecane 2016:204). In excess of this education, the initiates also undergo physical training to overcome difficulties and pain, to cultivate courage, endurance, perseverance and obedience. These experiences are meant to equip them mentally, physically, emotionally and morally for adulthood (Ntombana 2011:636). Yet another skill that is being taught is a secret new language that serves as a proof of manhood. As only circumcised men know the language, a man can prove that he has been initiated by speaking it (Mavundla et al. 2010:932).

Instructions in being a man

The Xhosa view is that initiation is necessary to make the transition from the stage of irresponsibility (boyhood) to the stage of responsible manhood (Ntombana 2011:635). In a study by Magodyo et al. (2016) the researchers found that most participants expressed that character development is one of the central aims of the ritual. In their article on how ulwaluko constructs masculinities they describe that:

> The teachings and mentoring instil good moral values and adult roles and responsibilities. A sense of identity and belonging, decision-making, problem solving, self-control, leadership skills, knowledge of traditional ritual and ceremonial proceedings, working hard, self-reliance, and endurance is cultivated during and after the transition. In addition to these attributes, the ‘ideal Ulwaluko man’ is expected to be responsible, selfless, and respectful to family, elders, and society at large. (Magodyo et al. 2016:7-8)

These attributes can be seen as ‘manhood acts’ (Schrock & Schwalbe 2009) as they construct how an indoda man should act, as Mfecane (2016) also shows. Apart from the topics mentioned above,

13 Their sample included seven Xhosa men between the ages of 19-32 from a university in Cape Town.
sexual themes are also typically a part of the education the initiates receive. These cover sexual taboos, instruction in sexual mores, the proper control and expression of sexuality, as well as marriage and familial responsibility (Vincent 2008:433). However, Vincent remarks that “traditional and community leaders are in wide agreement that historical mechanisms for the sexual socialisation of youth have largely broken down. The role that circumcision schools once played in this regard has been eroded, to be replaced by the emergence of a norm in which circumcision is regarded as a gateway to sex rather than as marking the point at which responsible sexual behaviour begins” (ibid.:432). Furthermore, she argues that while traditionally the initiation rite was a communal responsibility, it is today more of an individual project in the experience of many. She states “what was once an overarching message of responsibility and control has transformed into a focus on the right of access to sex as a primary marker of manhood. This has occurred in the context of a society in which multiple sexual partners, with or without consent, is thought to be an incontrovertible male right” (Vincent 2008:443). Vincent stresses that “[i]n theory, older men in the community could provide positive role models and reinforcing instruction but violence and sexual coercion of young women is rife among older men too as is seen, for instance, in the common practice of ‘sugar daddies’ in which girls exchange sex with older men for money, clothes, food and other presents” (ibid.:437). Ntombana’s (2011) research point in the same direction, he claims that the ulwaluko guardians introduce inhuman teachings as well as alcohol and drugs. One example of such a teaching is that “when an initiate graduates, he must sleep with a woman who is not his girlfriend to supposedly remove the bad luck acquired during the initiation” (Daily Dispatch 2006, in Ntombana 2011:636). Ntombana contend that this view perpetuate rape and the abuse of women (ibid.).

Again, as stressed by Vincent (2008), what the initiates learn in the process of becoming a man has transformed from an induction into a world of communal adult ties to more individualistic centred practices. When it comes to the mores and ‘manhood acts’ of being responsible and respectful towards other people, research show that initiates seem to quickly lapse into pre-initiation behaviour (Wood & Jewkes 1998:34). Magodyo et al. found that “[t]he participants constructed their exposure to the teachings as ambiguous and open to interpretation. Participants reflected that some of the teachings about what it means to be a man were unclear and vague to them and that some of the teachings conflicted with their realities” (Magodyo et al. 2016:7). This is sometimes explained as being a result of boys going for ulwaluko too early or for the wrong reasons, such as to compete with peers rather than being ready for the transition into manhood (Vincent 2008:437). Other reasons include that circumcision school is short-lived and without follow up, and that the newly initiated men lack positive role models (Vincent 2008:437, Magodyo et al. 2016:3). Wood and Jewkes suggest that the slight effect the traditional initiation teachings has on initiates is a result
of an overall decline of elder patriarchs’ influence over young men that has been documented (by Mager 1998 for example). It is suggested that the shift occurred during the 50’s where young men began asserting new masculinities that were excessively aggressive. “This brought about a widening gulf between the cultural ideals of elders and the practices of the youth” (Wood & Jewkes 2001:331). It is also important to point out here that “[y]oung male participants in traditional initiation rites are products of a society in which sexual socialisation has been disrupted by broader social ruptures in family and communal life effected by apartheid and wider global forces for change” (Vincent 2008:442).

Suggestions have been made to try to come to terms with these problematic issues of ulwaluko. Ntombana (2011) emphasises that “there is a need to regulate the whole practice, including the roles and responsibilities of the guardians” (ibid.:638). He proposes that the guardians “should be recognized as informal educators within the initiation practice, and a curriculum should be developed comprising issues that should be taught in the initiation schools” (ibid.).

The importance of ulwaluko

… there are numerous reports of botched circumcisions as well as hospital admissions resulting from various complications ranging from poorly performed operations to gangrenous penises and even death because of infections. During the circumcision seasons the morbidity and mortality rates increase among young men. (Mavundla et al. 2010:932)

Despite the evident dangers of the practice, young Xhosa men seem today no less eager to be circumcised than their forefathers. They are aware from a young age that initiation is regarded as an inevitable part of life since it is the only route to the acquisition of hegemonic masculinity and the rights that go along with being communally approved as an adult man (Vincent 2008:433, 440). Again, ulwaluko could in itself be seen as a definition of a ‘manhood act’ as Schrock and Schwalbe (2009) define it: “the identity work that males do to claim membership in the dominant gender group, to affirm the social reality of the group, to elicit deference from others, and to maintain privileges vis-à-vis women” (ibid.:289) as also showed by Mfecane (2016), Mavundla et al. (2010) and Vincent (2008) amongst others. After the completion of the ritual, the initiate is reintegrated into the community and officially regarded as a man, an indoda. This allows him to actively participate in community discussions and rituals. Now, he has also earned the right to marriage and can start building a homestead, or in the case of a heritage, he can now inherit property (Ntombana 2011:635, Ndangam 2008:212).
There are a lot of social pressures for young Xhosa men to undergo ulwaluko. In their study\textsuperscript{14} Mavundla et al. (2010) found that most participants indicated that the main reason they underwent the initiation was due to fear of social rejection. The participants reported feeling pressured by the community at large, their families, their peers and also by women (ibid.:934). According to Vincent, other self reported motivations include avoiding being ridiculed and harassed, pressure from older people to maintain tradition, and foremost, the desire to gain respect (Vincent 2008:438). The participants in Mavundla et al. study “associated the lack of social acceptance with being uncircumcised or having failed the manhood test of ritual circumcision. Failing the test occurs when the ritual does not follow the prescribed traditional steps or a taboo is violated, such as hospitalization. In the broad sense, the participants revealed that uninitiated individuals were ostracized from their communities” (Mavundla et al. 2010:934). Furthermore, Mfecane also states that: “[m]any amaXhosa boys are forced to undergo ulwaluko against their will because of fear of the violence and social ostracism that may follow if they undertake medical male circumcision or remain uncircumcised” (Mfecane 2016:212). Uncircumcised Xhosa males and medically circumcised males are referred to as “boys”, irrespective of their age or social status. They are also given other derogative labels, and, expressions such as ‘inkwekwe yinja’ (the boy is a dog) is often heard, which implies that “anyone who is not circumcised is not regarded as a human being in the community; the person who has not gone through initiation, has no moral standards” (Ntombana 2011:635). “[T]he most subordinated forms of masculinity in Xhosa gender order are uncircumcised adult men and medically circumcised men” (Mfecane 2016:210). As can be seen, there is no easy way to skip ulwaluko and medical circumcision is for most young Xhosa males not regarded as an option.

**Hegemonic masculinity and dominant male sexuality**

Men drive the HIV/AIDS epidemic, and gender inequality, violence and sexual coercion all contribute to the spread of the disease. Masculinity takes many different forms and can be extreme, ranging from gangster to father and caregiver. So in order to comprehend and curb the epidemic we need to understand men’s sexual behaviour. (Walker et al. 2004:20)

According to the research, being an indoda is generally characterised by dominance and oppressive practices towards other masculinities. As shown, ulwaluko gives indoda men power in society, and, this is also manifested through how they relate to sexual relationships. In her article, Vincent argues that indoda men interpret their newly accomplished rights as to include the right to sex. Thereby,

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\textsuperscript{14} Their study was based on 14 newly initiated Xhosa men between the ages of 15-20, from East London, Eastern Cape.
they actively use the fact of a male being uncircumcised to limit his access to women. This is also exemplified in Mavundla et al. where one of their informants explained that initiated men “[t]hey forcefully take away your girlfriend because men claim that a boy cannot be in love with a beautiful or any ordinary girl” (Mavundla et al. 2010:936). The risk of physical violence for uninitiated males is imminent in situations like these (Wood & Jewkes 2001:320-1, Vincent 2008:44).

There also exist male competition over sexual partners between initiated men, that also often results in violence. Wood and Jewkes (2001) found in their research of masculinities among Xhosa youth in a township in Eastern Cape that multiple sexual partners was a defining feature of ‘being a man’. The actual number of partners acquired was important in their positioning among male peers, since having many girlfriends shows status which leads to other men starting to respect you (Wood & Jewkes 2001:321). “Competition for sexual partners, either in the form of struggle for possession or ‘revenge’ for a ‘stolen’ girlfriend, often resulted in physical violence …” (ibid.:320-1). However, not only did they find that indoda men are violent towards uninitiated males, and between themselves, they also found that men act out towards females.

**Men’s violence against women**

Wood and Jewkes research revealed violent male practices such as assault, forced sex and verbal threats, to be a common feature of young people’s sexual relationships (Wood & Jewkes 2001:318). According to their study “most reported violence was associated with girl’s rejection of male ‘proposal’ to become involved in a ‘love affair’, their actual or suspected sexual ‘infidelity’, their attempts to end relationships, their sexual refusals, their acts of resistance to boyfriends attempts to dictate the terms of the relationship, and their efforts to undermine their boyfriend’s sexual success with other women” (Wood & Jewkes 2001:319). Wood and Jewkes (2001) research also demonstrates that the young men in their study were intensely invested in their sexual partnerships. They found that notions of ‘successful’ masculinity were constituted through sexual relationships with girls and deployed in struggles for position and status among male peers. ‘Successful’ masculinity was defined in terms of the number of sexual partners, the choice of main partner (and her sexual desirability to other men), as well as his ability to control girlfriends (ibid.). The controlling strategies of men over women included the attempt to dictate the terms of sex with their partners; coercive and physically forced sex, and assault to enforce sexual co-operation were particularly common manifestations of violence in youth relationships (ibid.:326). Most controlling strategies revolved around men’s perceived need to control the sexual behaviour of their girlfriends and these were frequently enforced through threats of, or, actual assault (ibid.:324). Wood and Jewkes (2001) draw a parallel between how young men relate to their sexual partners and historical ethnographic descriptions of traditional bridewealth systems [lobola] which include an idea of
exchange and female duty. Thus if a girl accepted a male ‘proposal’ to love, she would be expected to have sex whenever he wanted in return for gifts, money, being visited frequently and taken out to social events. “Thus sexual refusal on the part of girls, which contradicted this ‘contract’ as well as challenging dominant ideas about (male) sexual entitlement in relationships and female sexual availability, was an important catalyst for assault and was seen (by some men) to legitimise the ‘taking’ of sex, by force if necessary” (ibid.:327). Furthermore, their male informants expressed suspicion regarding girl’s motivations for refusing sex; “[...] you must have sex, or he’ll get suspicious that you are having an affair” (ibid.).

Young women are not without agency

It is important to point out here that young women are not mere passive victims but are rather navigating in this social sphere. As Outwater et al. (2005) stress, “the tendency to speak of women's powerlessness is unduly simplistic and fails to take account of the range of coping strategies and social support networks that women have constructed to deal with their day-to-day life challenges” (ibid.:147). Moreover, they also state that women are “people with power who can and do make decisions and have strategies even when sometimes their actions are only at the micro-level” (ibid.). Wood and Jewkes are also pointing out that young women are not without agency, since, as exemplified by them, young women tend to chose men with means so that they can access material resources (Wood & Jewkes 2001:323). This makes sense in a high unemployment context, such as the one in South Africa, where young women have fewer economic options than men (Squire 2007:28). Furthermore, young women tend to favour indoda men over others. This is partly because uninitiated men are seen as unable to commit to a serious relationship since they cannot get married (Mavundla et al. 2010:935). But also, women do not want to be in a relationship with someone who gets mocked (as uninitiated males do), and, indoda men tend to have more access to resources since they are prioritized over uninitiated males (see Vincent 2008:441).

This chapter has shed light on the importance of ulwaluko within Xhosa culture and how the initiation rite affects the social structures when it comes to how indoda men relate to uninitiates (both male and female). The following chapter will focus on how this study was conducted.
3. Ethnographic research methodology

This chapter describes the field in which the data was gathered for this study, and also how the informants were acquired. How the research was conducted will be discussed in detail as well as which methods were utilised in the process. I believe that transparency is key here, since, who the researcher is affects how you are perceived in the field, and also, how the informant relate to you. Here, I will also go through how I relate to my empirical findings.

3.1 Fieldwork

I conducted ethnographic fieldwork at loveLife’s youth centre (Y-Centre) in the township of Langa between February and April 2014. The Y-Centre in Langa has been operating since the beginning of the 2000s. Langa is a small township (3,09 km²) with approximately 52,400 residents (Census 2011) located 20 minutes outside of Cape Town’s Central Business District, South Africa. The majority of the inhabitants in Langa are Xhosa-people with a background and family origin from the Eastern Cape. The majority of the residents are unemployed and youth unemployment is very high. It is estimated that 50% of South Africa’s youth are unemployed (WEF 2017:36). However, the situation is likely even worse in less privileged communities and townships than what the general national rate indicates.

Arriving in the field

My first contact with loveLife in the field was at their office in Observatory, Cape Town. I had scheduled a meeting with a person whom I thought would be my local supervisor, since it was with her I had established email contact whilst planning the research project. And also, she was the person who gave me a green light to study HIV prevention through loveLife. However well on site, after having waited almost an hour in the reception, this person came to greet me and introduced me to the rest of the staff at the office. She then told me that she was leaving for Johannesburg in a short time, and that she would be away for the majority of my stay. Therefore, she introduced me to a colleague of hers that actually worked at the Y-Centre in Langa, and not only at the office in Observatory as it turned out that my anticipated supervisor did. The colleagues name was Siyabonga and she worked as programmes manager at the Y-Centre in Langa.

Shortly after being introduced to each other the two of us sat down and had a meeting. Here, Siyabonga introduced me to the work of loveLife and I then got the opportunity to present my research questions. She started of by explaining that loveLife is a NPO (non profit organisation) that focus upon youth leadership and the decrease of HIV amongst youth in the age span of 15-25 years.
But that the target group in the schools are aged 12-19 years. Siyabonga explained that loveLife started as a response to the challenges in society. The incidence of HIV was high in South Africa due to teenage pregnancy, rape, violence and sexual exchange, she explained. But also that factors such as gender stereotypes where girls are more passive, low self esteem amongst youth, and societal drives such as poverty influenced the spread of HIV among youth. Siyabonga then continued by elucidating how loveLife looked at these root problems and then established different programmes that are designed to address all these challenges. Here, she went through the programmes in detail, but to summarize, some of the programmes are focusing on personal development (how to pursue goals, carriers, dreams etc.) whilst others are more oriented on practical skills such as computer training. Whilst wrapping up the meeting we decided that she would introduce me to the Y-Centre in Langa straight away, so a few minutes later we were sitting in a car with the loveLife logotype, on our way to my first visit in the field.

The Y-Centre was buzzing with activity upon arrival. It was the birthday of one of the groundBREAKERs and the other gBs and loveLife staff were all busy preparing a surprise party for the birthday girl named Thandokazi, she had been away on training and had therefore not arrived yet. Siyabonga had brought cake and some of the gBs were busy cooking in the kitchen. They had all contributed money to make the party possible. After a while we went out to buy meat and soft drinks. Siyabonga drove me and two of the gBs to a combined restaurant and meat shop, where they bought the meat. We had to wait a while on site to have it prepared and barbecued. Meanwhile, without notifying me, Siyabonga had taken off to collect the birthday girl at the airport. There I found myself, in a meat shop with two complete strangers, in a township that I had never been to before. This was a bit of a reality check and I felt like I had dived head first into fieldwork. I was clueless to where I was located, other than that I was somewhere in Langa. When the meat was ready we left the shop by foot to continue the shopping spree to buy soft drinks, and after that we slowly moved towards the Y-Centre again. Even though, admittedly, I had no clue where we were heading at that moment.

Whilst waiting for Siyabonga and the birthday girl Thandokazi to show up I tried my best to make small talk with the groundBREAKERs, however, they seemed very shy and the response was slim. Every time I said something or asked something it was like all of them waited for someone else to reply or they would just talk over my head in Xhosa. They exclusively spoke Xhosa among each other and I could not follow a thing of what they were saying. I felt the anxiety creeping up on me and I started to question if these people spoke English at all. And I wondered, how will these ten weeks turn out when the groundBREAKERs seem so unwilling to communicate with me. Then Thandokazi arrived which caused the sound level to increase exponentially. This marked the start of

15 Thandokazi was the one gB who declined taking part in this study. Therefore her name will not appear in my research.
the celebration and the groundBREAKERs began to plate the food. It did not take long before I was handed a plate with a chicken wing and two slices of white bread by a woman who worked as a household technician at the Y-Centre. Here, my first dilemma occurred. I had to decline the food since I am a vegetarian with no desire what so ever to eat meat. What a great impression I am making here, I thought to myself. Saying no to food in a context where a lot of people go hungry and struggle to put food on the table. And also, saying no to their efforts of showing hospitality. However, I did not seem to offend her, I understood the situation to mean more food for her and the others. However, I cannot verify this. By now I had also developed a severe headache due to all the new impressions and the high sound level, and, I thought to myself that the ten weeks in the field could have started better. However, as time went on it was revealed that the gBs could speak English and they got more and more communicative and comfortable with me the more time I spent with them.

After the first day I had to find my way to the Y-Centre on my own. “Mendi!” I shouted from the back of the taxi. It had taken me a few days to learn what to shout when I wanted the taxi driver to stop as close as possible to the Y-Centre located on Mendi Avenue. Initially I was saying “circle!” thereof, having to walk further. It only took me a couple of minutes to walk the straight road leading to the Y-Centre. Whilst entering the premises a distinct smell would hit me, it reminded me of a gymnastics room and of old gymnastic clothes. The interior of the Y-Centre was quite worn, the paint was flaking off the walls here and there, and there were too little furniture and other equipment to make the space a welcoming environment. It soon became clear that the Y-Centre’s glory days were long gone. My initial plan before entering the field was to interview youth (loveLife’s target group) coming to the Y-Centre. However, I had to rethink my planning because upon arrival I noticed the lack of attendance of the target group. The only ones who came to the Y-Centre were children who wanted to use the facility to play pool and sports. For some reason, the Y-Centre failed to attract its target group. My second plan was then to join the gBs in the schools where they worked. But then it became evident that they had not been able to get the school sessions started yet since, as I was told, some of the groundBREAKERs from the previous year had misbehaved, hence leaving some of the principals unsure of whether to accept the outreach work of the gBs or not. When the school sessions were finally initiated I realised that the gBs and the learners spoke solely Xhosa with the exception of a few English words here and there. This meant that I could not participate during class nor interpret how the students related to what the gBs said. I therefore decided that the gBs would be my main informants since they were easily accessible and also youth themselves.

The groundBREAKERs – my informants
During the time of my field study there were eight gBs working at the Y-Centre in Langa, five young women and three young men. One of the female gBs declined participating in this study, thus, it is based on the data collected from the remaining seven. They were between the ages of 19-25 years since the age limits for becoming a gB are between the ages of 18-25 years. They shared the same ethnicity, they were all Xhosa with a family background from the Eastern Cape. Some of them were born in Langa whilst others had moved there at a young age to attend school. All of them stayed with family members in Langa, except for Xolela who now stayed in another township with his older brother. Some of them had applied to become a gB themselves whilst others had been recruited by the programmes manager Siyabonga.

3.2 Methods for data collection

First of all, I would like to clarify that this is an abductive study. In this thesis I have started off by exploring my empirical findings, then searched for suitable theories with the aim to provide the most likely explanation for, as in this case, the mechanisms that fuel the spread of HIV among Xhosa youth.

As emphasised by Haig (2005) an abductive methodology “endeavors to describe systematically how one can first discover empirical facts and then construct theories to explain those facts. Although scientific inquiry is often portrayed in hypothetico-deductive fashion as an undertaking in which theories are first constructed and facts are then gathered in order to test those theories, this should not be thought of as its natural order” (Haig 2005:371). Furthermore, he claims that:

In fact, scientific research frequently proceeds the other way around. The theory of method described here adopts this alternative, facts-before-theory sequence, claiming that it is a search for the understanding of empirical phenomena that gives explanatory theory construction its point. With this theory of method, phenomena exist to be explained rather than serve as the objects of prediction in theory testing. (ibid.)

Before entering the field I read a lot of research on HIV, however, it was not until after I had processed my empirical finding that I felt like I could comprehend what theories made sense in this context, and, that I felt were likely to guide me in the pursuit to answer my research questions. In an abductive study the benchmark lies within the empirical material, however, you move back and forth between the empirical material and the theoretical frameworks. There is an interaction between the theoretical perspectives and the empirical findings. But let’s take it from the beginning. The two main methods used in this research were participant observation and semi-structured interviews.
**Participant observation**

As avowed by most cultural anthropologist, “[p]articipant observation fieldwork is the foundation of cultural anthropology. It involves getting close to people and making them feel comfortable enough with your presence so that you can observe and record information about their lives” (Bernard 2011: 275). A legacy within the discipline of anthropology has been to “go native”. Traditionally this meant that the researcher would conduct fieldwork in a remote setting over a long period of time (preferably extending more than a year). “Going native” also includes learning the local language, living in the same village as your informants, participating in their rituals, festivities, and every day routine. As Malinowski puts it, proper conditions for ethnographic fieldwork, “consist mainly in cutting oneself off from the company of other white men, and remaining in as close contact with the natives as possible, which really can only be achieved by camping right in their villages” (Malinowski 2007:47).

However, to conduct participant observation as a methodology, you do not necessarily have to take it that far. Gold (1958) suggests that there are four different research roles to be found here, where the degree of participation is what differentiate these categories. On the one end of the scale we find the: ‘complete participant’, who operates covertly without the knowledge or consent of the research participants. Here the researcher takes on a role as an insider, and could for example start working in a factory to learn the working conditions of the employees. Then we have the ‘participant-as-observer’, here both the researcher and the informants are aware of the field relationship. The fieldworker develops relationships with the informants through time, and spends more time and energy participating than observing. After that, we find the ‘observer-as-participant’, which is a role that the researcher takes on when there is only time for one-visit interviews. Here, only formal observations are done, leaving out informal observations and participation of any kind. And, lastly there is the ‘complete observer’, who observes what goes around him/her without any social interaction with the informants. Here, the researcher is eavesdropping and studying people without them knowing it (Gold 1958:219-222).

The majority of the time in the field I spent hanging out with the groundBREAKERs at the Y-Centre during regular working hours. I also took part of Mpintshi (volunteer) training where the groundBREAKERs were educating other youth to function as “change agents and cultivators of healthy attitudes and lifestyles among their peers and the broader community” (loveLife 2017b). I joined three of the gBs to their designated schools on two separate occasions. One time I went with Nwabisa to the high school where she was working, and on another occasion I participated in the class Zizipho and Vusi held in a primary school. I also spent some time in the waiting room of the loveLife health clinic, where I was able to view how Xolela worked. He had a calendar with
enlarged photos of severe cases of STDs to show the youth whilst they were waiting in line for their turn to see the nurse. I also took part in the weekly Friday festival that was held at the Y-Centre. Here, rap battles and dance contest would be held and prizes would be handed out in the form of water bottles and plastic wristbands etc. There were also different sport events on the court of the Y-Centre quite often where I would take part as an observer. In general I spent most of the time in the field observing, rather than participating. Therefore, I would like to claim that my role as a researcher ended up somewhere in between the role of a ‘participant-as-observer’, and an ‘observer-as-participant’.

As claimed by Bernard (2011), “[p]articipant observation involves going out and staying out, learning a new language (or a new dialect of a language you already know), and experiencing the lives of the people you are studying as much as you can” (ibid.:276-7). In this sense, it is clear that I did not conduct participant observation as a ‘participant-as-observer’, which is what his description above is referring to. I did not stay in Langa during my fieldwork, I ended up staying in the most privileged part of Cape Town with a majority of wealthy white people from all over the world, since this was the only accommodation I was able to find on a short notice. Neither did I spend time in the community outside of the Y-Centre, nor did I share in any other aspect of the groundBREAKERs lives outside of work. I did not take an active part in the work and duties of the groundBREAKERs either, rather, my role as a researcher in this study was always on the spectator bench. However, the fieldwork sparked a desire for a more embodied experience. I wanted to explore how it is to work with these types of questions myself. Thus, upon arrival back in my home country Sweden I took part in a similar initiative here called Colour of love. This is a safer-sex initiative aimed at reducing sexual transmitted diseases (STDs) among youth. To work as a Colour of love introducer you first have to take part in a full days training where you learn about STDs and dialogue based methods of how to approach people. You are then able to work at Colour of love campaigns that are organised at festivals and other events that attracts a lot of youth. The messages they are promoting are: “keep the good feeling”, by practising safer-sex (using condoms) you do not have to worry about STDs, thus, can keep the good feeling. And also, they advocate for youth to take on responsibility and “get tested regularly”. With this experience, I can now reaffirm that it takes courage to approach strangers with the intention to talk about sex, condom usage and HIV prevention.

**Interviews**

During my fieldwork at loveLife I conducted individual semi-structured interviews with the groundBREAKERs. A semi-structured interview is open ended, but follows a general script and covers a list of topics (Bernard 2006:210). To guide me through the interviews I had a set interview
guide with the questions I wanted more information on (see the appendix). However, I also allowed
them, or myself, to drift away into other topics or discussions. Since, semi-structured interviewing
“… demonstrates that you are fully in control of what you want from an interview but leaves both
you and your respondent to follow new leads. It shows that you are prepared and competent but that
you are not trying to exercise excessive control” (Bernard 2006:12). The interview questions that I
will shed light on in this thesis are the following: “What have you learned from loveLife?”, “How
do you work as a groundBREAKER?”, “How do you work to prevent HIV as a
groundBREAKER?”, “What are the reasons for the spread amongst youth?”, and lastly, “What are
your thoughts on HIV prevention? What needs to be done?”. In this thesis, I am following the line
of Forsey (2010) who states that: “[i]nterviews, regardless of setting, can enable us to locate the
biography of the individual, and groups of persons, in the broader cultural domains in which they
live. Consequently, we should be able to link their personal story to the broader context and issues
we are seeking to describe and analyse in the formal reports of our research data” (ibid.:568-9).

I also conducted two unstructured interviews with Siyabonga, the programmes manager at
the Y-Centre. And, one unstructured interview with the two nurses working at the loveLife health
clinic. All interviews were tape recorded and transcribed. I also had a lot informal conversations
with all of the loveLife staff at the Y-Centre which included the groundBREAKERs, the
programmes manager, a janitor, and a household technician. There were also two volunteers from
another organisation that spent their time at loveLife, I never understood what they were assigned to
do there, as they did not share any of the working tasks with the groundBREAKERs. Hanging out
with these people broaden my knowledge of Xhosa society in Cape Town. Except HIV prevention
related topics I also learned about lobola (bridewealth), ritual male circumcision, marriage, the role
of the man and the role of the women, damages (the payment a man has to do when he impregnates
a female that he is not married to) etc. During fieldwork I would carry with me a field diary in
which I would sometimes write down thoughts, reflections or findings. And also, at the end of each
day, when I got back to where I was staying, I would try to summarise the day in the field in it.

3.3 Practical and ethical matters
Starting with the practicalities, all mentioned research by other scholars in this thesis is from South
Africa, unless otherwise stated. Another thing to point out here is that the groundBREAKERs
sometimes used the terms HIV and AIDS unisonally like they meant exactly the same thing and are
interchangeable. They are not, but to keep it simple and comprehensive here, HIV (Human
Immunodeficiency Virus) is a virus and AIDS (Acquired Immune Deficiency Syndrome) is the
sickness state you end up in if the HI-virus is left untreated.
Throughout the study process ethical considerations have been taken into account. The topic of this study is of sensitive nature and the participants are asked to talk about personal experiences and of how they relate to HIV. Therefore, pseudonyms have been used to protect their identities. Here, I would also like to add that I never asked the groundBREAKERs regarding their HIV-status. However, some of them conveyed their status to me freely.

**Positionality**

When it comes to positionality I experienced the benefit of being an outsider in this context. The legacy of apartheid is still alive and the division between people of different colour and background is vivid. I believe that me being white opened a lot of doors that might have remained locked if I was not. This is a topic that could be discussed in all immense, however, I would just like to acknowledge here the phenomenon of ‘white privilege’, which amongst other things includes that white people have greater access and move around easier in different types of places and spaces. For further reading, I recommend Jemima Pierre’s book *The predicament of Blackness* (2013) where she explores the significance of whiteness for Ghanaian people. In South Africa xenophobia (regarding people from different African countries) is a huge problem, and, as I learned in the field, Nigerians are the ones who are the most discriminated against. Had I been Nigerian, I am sure I would have encountered more hurdles in the field. With this said, I am not claiming that I was served everything on a silver platter in the field. Rather, I had to navigate through a lot of difficulties, as we all do whilst conducting fieldwork.

One of the biggest hurdles was to navigate in Cape Town as a foreigner without a car. I had to rely on commuting with taxis (minibuses). Here, I always stood out as being the only non-local on board. These taxis tend to get robbed from time to time. Luckily nothing like that ever happened to me. It would take me approximately two hours in total from door to door, so I would spend four hours a day travelling. By car the same journey would have taken 22 minutes single way. I could not stay too late at the Y-Centre either, since, after 5 p.m. very few people staying in Langa had errands in town. It would therefore take ages for the taxi to fill up and leave. Sometimes I had to sit and wait in the taxi for 1.5 hours whilst the sun would go down and drunks would approach me due to the unusual sight of a white woman sitting without company in a taxi at that hour of the day. The problem here was mainly the lack of bus stations. The taxis fill up at the taxi rank and then they only stop when someone wants to get off. This meant that I had to walk all the way to the taxi rank at the end of each day in the field, whilst, during rush hours multiple empty taxis would pass me by on their way back to town. However, I could not ride with them since this is not how the system works. To walk to the taxi rank took approximately 15-20 minutes and here I felt like a burden to

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16 There are four racial categories inherited from apartheid in South Africa: Africans, coloureds, Indians and whites (Dickinson & Deutsch 2009:7).
the groundBREAKERs since someone always had to walk with me to the taxi rank. I was not allowed to walk alone, since, as the gBs stated it, “you are a walking ATM”. This was a bit problematic since I had to leave before the end of the gBs working hours, and also, the only ones who wanted to walk me there were Nwabisa, who stayed close to the taxi rank, and Xolela who commuted as well. To conclude, these commuting problems resulted in less time spent in the field than I had anticipated. However, I also gained a lot of insights by using taxis for transport rather than driving there myself. More often than not the other passengers would start talking to me, asking me what I was going to do in Langa and where I was from. Some of them also let me know what they thought about loveLife when they heard that I was studying HIV prevention there. Their reactions would often not be very positive, one woman blurted out “what are they doing there, really?!”. It was very interesting to hear what the outside community thought about loveLife, especially since there was no interview session, but ordinary conversation with people who brought up the subject themselves.

Yet another aspect that had both positive and negative implications was that I was almost the same age as the gBs (I was turning 25 that year). In hindsight, I believe it was a massive advantage in relation to the topic of this study. As will be disclosed later on in this thesis, HIV and sex is not a topic that is easily spoken about in this context. And, especially not over the generations, so I believe them being able to relate to me as a peer – to a certain degree – was beneficial. On the other hand, being within the same age span also implied that some of the gBs saw me as a potential partner. Thus, it happened on a few occasions that some of them would drop a line with the intention to try to hit on me. This was only done in innocent ways, never causing any real problems. However, it was something I always had to keep in mind and relate to. On several occasions I also ended up in other strange situations, for example when the gBs and the programmes manager at the Y-Centre would ask me for improvements, and about what I thought about their work. This put me in a strange position since I was not there to evaluate their achievements.

To conclude this section, I would like to make clear how I relate to the data collected and portrayed in this thesis. Here, I would like to emphasise that I find that it is not my role to validate the verity of the information the groundBREAKERs shared with me. What I am interested in are the narratives of the gBs and how they relate to HIV and HIV prevention. With this stated, it could happen that I am reinforcing myths in this thesis. As will be seen later on, one of my findings indicates that people are spreading HIV on purpose. This is something that is impossible for me to verify through research. However, this is how the gBs perceive it. Hence, this might or might not correlate with reality.

**Definitions**
Some of the terms used in this thesis need to be explained. I request that you keep these clarifications in mind throughout the thesis: By ‘youth’ I refer to people within the age span of 12-25 years. Since, within this span we find loveLife’s target group, 12-25 year olds. Note also that most statistical measures and survey research on youth are made on people between the ages of 15 and 24 years, since this is the defined age span for youth set by the United Nations (UN 2013:1). Thereby, all the mentioned statistics on youth by UNAIDS and HSRC are based on people aged 15-24 years. Secondly, when we are talking about ‘sex’ (as in sexual activity) we mean penetrative heterosexual vaginal sex, nothing else. What must be pointed out as well is that gender identities have not been taken into consideration in this thesis. By male I mean a person with a penis, and by female I mean a person with a vagina. And, when we are talking about condoms, we are referring to “regular condoms”, not female condoms.
4. loveLife and HIV prevention

This chapter starts off by going through the objective of loveLife and how they are operating in their HIV prevention. After this, follows a description of the groundBREAKERs working tasks. I will then move on and explore the information that is available for youth regarding HIV and HIV prevention. What are they learning when it comes to HIV prevention? And, from where are they getting the information? Lastly, I will go through how the groundBREAKERs work as peer educators to decrease the spread of HIV among youth.

4.1 About loveLife

loveLife is a non-profit organisation (NPO) launched in 1999 as an HIV prevention initiative. It was born out of a collaboration between several South African non-governmental organisations (NGOs) together with the South African government, with its primary funding from the Henry J Kaiser Family Foundation. During the course of the years loveLife has broaden its objective and is now aiming at strengthening youth, for them to reach their full potential. They acknowledge that youth face a lot of societal ills that put them at risk. These include poverty, lack of education, youth dropping out of school, lack of information and knowledge, lack of parental care, teenage pregnancy, unemployment, gender-based violence, substance and alcohol abuse, and HIV infection among others (Siyabonga, the local programmes manager at Langa Y-Centre). On their website loveLife problematise two of these topics; the amount of youth dropping out of school and youth unemployment. They state that: “At Grade 7 there are about 1.7 million young people in schools nationally but by the time they get to Grade 12 that number is about 600 000 – that’s two thirds lost along the way. Post Grade 12 into universities it’s another 100 000 that make it” (loveLife 2017a). They also shed light on a report on Global Risks 2014 by the World Economic Forum that estimated that more than 50% of the youth between the ages of 15 and 24 were unemployed. Therefore, loveLife points out that, “you have a large number of young people who are unskilled, semi-skilled or who have no ability to be productive and have no sense of future: That is a big calamity for the country” (loveLife 2017a). loveLife are trying to address these issues by promoting ‘positive lifestyle’, ‘positive sexuality’ and ‘responsible decision making’ for youth. Their strategic objectives are to: reduce new HIV infections among young people, reduce teen pregnancy, keep young girls in school and to improve employment opportunities for young people (loveLife 2017a). Their means of reaching youth include: youth centres (Y-Centres), communication campaigns, incorporating broadcast, print and outdoor media, a telephone helpline, and the bi-monthly newspaper Uncut. There are also community based clinics at the Y-Centres with nurses that deal with contraceptives,
HIV-testing (rapid test), sexual transmitted diseases (STDs) information and testing. Though, the most prominent method of reaching youth that they are utilising is peer to peer education, these peer motivators are called groundBREAKERs (gBs). There are a total of 22 Y-Centres in the country, all placed in marginal communities, where the gBs are based. The gBs work with outreach where they implement loveLife’s programmes in schools. According to Siyabonga, the programmes manager at the Y-Centre in Langa, these programmes are looking at the root problems, hence are designed to address the societal challenges mentioned above. The loveLife programmes will be further described in section 4.2, where I will go through the positions of the gBs.

Critique against loveLife

Over the years, loveLife has been criticised by different scholars. One of them being HIV researcher Kylie Thomas, from the English Department of the University of Stellenbosch, South Africa. First of all, Thomas critiques the name ‘loveLife’ since she means that it implies that you should love yourself and others enough to not ‘get’ infected: “According to the logic of this conception of people living with HIV/AIDS, it is those who do not ‘love life’ that become infected with HIV and who grow sick and die of AIDS. In calling on people to take responsibility for their own sexual practices, health and knowledge of their HIV status, prevention campaigns, perhaps inadvertently, often place blame on HIV-positive people for their infection” (Thomas 2004:31). Furthermore, Thomas also problematises loveLife’s use of slogans such as “you are free to choose your own future”. She claims that: “That can only ring hallow for those who are struggling to survive. It is becoming increasingly true that a good life, a healthy life, is indeed something that comes at a price the majority of people living in South Africa cannot afford to pay. By focusing its prevention efforts on effecting change in behaviour at an individual level, the loveLife campaign elides the multiple socioeconomic factors that are determining factors in the spread of HIV” (Thomas 2004:30). Yet another of loveLife’s shortcomings brought up by Thomas is that they in their campaigns have pictured young confident women with slogans like “too smart for just any body” as to paint a picture of female sexual autonomy. Here, Thomas is pointing out that this image would only make sense in an imaginary realm where female are free to choose when and how to engage in sexual practices. Whilst in reality young females in South Africa are particularly vulnerable to HIV transmission due to the unequal power relations that exists (Thomas 2004:33). Another scholar who has critiqued loveLife is Warren Parker, Director of the Centre for AIDS Development (CADRE). In 2003, he argued that loveLife was stating numbers and statistics without making references to any sources (Parker 2003:5). And, that they were trying to measure the decline in HIV without having a statistical baseline (ibid.:7).

17 CADRE is a South African NPO.
Looking at loveLife’s website today, it is evident that they are still showing numbers without referring to where they got the information from. As they write: “At Grade 7 there are about 1.7 million young people in schools nationally but by the time they get to Grade 12 that number is about 600 000 – that’s two thirds lost along the way. Post Grade 12 into universities it’s another 100 000 that make it”, without making a reference to where they found the information (loveLife 2017a). This indicates that the issue Parker (2003) sheds light on still remains.

4.2 The groundBREAKERs – peer motivators

The assignment as a groundBREAKER is to reach out to your peers within the community you are living in to spread information aimed at reducing the incidence of HIV among youth. But also, to promote healthy lifestyles in general. The gBs do so by working at the Y-Centre in Langa as well as giving lectures at schools in the community.

The gB, my work, is to change attitudes. That’s what I was hired, or chosen, to do. To talk HIV, preach HIV, maybe sing it. As long as people are going to hear what is right. What is right and also to hear what is not good for their health or their lives or their immune system. So as a gB, my work is to encourage the youth of Langa to stay away from the wrong things, which are the things that are happening around the hood. That’s my work, to encourage and motivate. – Xolela

Zizipho had a similar line of thought regarding the assignment as a groundBREAKER. She expressed that they are supposed to “teach the kids how to live life and how to take ownership of their life and make right decisions. To motivate the kids in any way possible”. Before the gBs started their work at the Y-Centre and in the schools they went through a ten days learnership programme in a town called Wilderness located five hours away from Cape Town by car. This training was held together with all the other gBs from the Cape Town region. During the training they received a lot of information regarding HIV/AIDS and they were educated in HIV prevention and topics related to this. They were taught about loveLife and how their programmes work. loveLife has implemented several different programmes to reach out to young people nationwide with the aim to teach them resilience, healthy living and HIV consciousness (loveLife 2017a). The programmes at Langa Y-Centre were at the time of my field study: ‘Cyber Ys’, ‘Media Ys’, ‘Arts and Culture’, ‘Sport and Recreation’, ‘Making My Move’, ‘Living My Life’ and ‘Debate’. Each gB was responsible for one programme each, except for one of them who was responsible for the clinic at the Y-Centre instead. They all received training in the different programmes to be able to take on

responsibility for any of the programmes if needed (except for Media Ys and Cyber Ys since they had yet another training camp at another occasion). The gBs also got trained in debating, public speaking and how to handle a class of student as well as and how to give lectures. As mentioned, the gBs working method is peer to peer education where they go to schools and give lectures at ‘Life Orientation’ class:

When we did the facilitation skills and everything we were told to stage the myths and the facts so that whatever one person in the crowd think is a fact we expose as a myth. Doing the face to face where the interaction goes on gives them [the students] a platform to ask questions and for whatever doubt in their mind to be settled because now they receive the answers. So HIV is something that exists, if you have multiple partners you are at risk of getting HIV, if you don’t use protection you are at risk of getting HIV and all that information. So when we go to schools we give them the information and they can pick our brains as much as they can or they want, all to get the answers they want and then they make their own informed decisions. Which is why we have the programmes like “Living My Life” which does not speak about HIV but speaks about personal development, like, yourself. There is another topic that I love a lot that is called “Who am I”. We have these sessions about who are you, what do you want in life, your values, your beliefs and everything in order to somehow persuade them into making the right decisions for themselves. – Nwabisa

Examples of topics they bring up in class include peer pressure, low self esteem, sexual transmitted infections (STIs) and sexually transmitted diseases (STDs), male circumcision, how to talk about sex with your parents, how to talk about sex and condom usage with your partner, teenage pregnancy etc. Nwabisa illustrated that: “In high schools we talk about everything. We talk about domestic violence, we talk about relationships, healthy and unhealthy relationships. We talk about communication with your parents, how to approach them and ask about whatever you want to talk to them about. We talk about substance abuse, carrier choices. Mainly what we want to do is to encourage them into developing into better people”. The gBs have loveLife textbooks that they use as guidelines of how to plan and carry out their lectures at the schools. They are assigned to work for loveLife during a calendar year (January to December) and in exchange they get a monthly paycheck of R1200\(^1\) as well as working experience and a good reference to the resume.

### 4.3 HIV information from loveLife

When interviewing the groundBREAKERs regarding what information they had received concerning HIV and AIDS from their employer loveLife their answers were quite consentaneous which did not come as a surprise since they received the same training. To summarize, they described how they had been profoundly educated in what HIV and AIDS are, different ways of

\[^{19}\text{R1200 equals 737 SEK [2017-12-02].}\]
getting and transmitting HIV, how you can protect yourself from getting HIV, how HIV proceeds from the time of infection to full blown AIDS if untreated, how to treat HIV with ARVs, and how the gBs could pass on this information to other youth through peer to peer education.

First and foremost, the gBs lined up the common knowledge. That is to say, that the best way to stay HIV negative is to either abstain from sexual relations with others or to condomize at all times, and that masturbation is the safest way of having sex. They all stressed the fact that there is treatment to HIV but that it is not curable, “HIV is killing” as Andisiwe put it. When it comes to how HIV spreads all the gBs mentioned unprotected sex with someone who has an HIV-positive status as the greatest risk factor. Some of them also mentioned mother to child transmission. As Andisiwe explained: “There is no age limit to HIV, you can get it at any age and if you are pregnant you can minimize the chance of transferring the virus to your newborn during birth by taking ARVs and then by choosing to either breastfeed or give the baby formula, not both”. Nwabisa elaborated further on this and said: “You can infect your child with HIV during birth and by breast feeding, not the milk necessarily but when the child bites the mothers nipples and she starts to bleed. When the child is born the child will test positive for the next eight months because the child will still have the mothers anti bodies in their blood. When they start producing their own anti bodies that’s when you get the correct answer if they have HIV or not”. Other ways to acquire HIV, mentioned by the gBs, were to share the same needle [injecting drugs] or toothbrush with someone with an HIV-positive status since they might bleed when brushing their teeth. Some of them also exemplified how HIV does not spread: “it doesn’t spread by you using the same spoon” said Vusi. And Nwabisa asserted that: “If you would have to infect someone using saliva it would be buckets and buckets with saliva for someone to drink in order for them to get infected. And you cannot receive it from mosquitoes”.

When it comes to preventative methods and what had they been taught regarding how to decrease the spread of HIV within the younger population all the gBs adverted the importance of condom usage; either condomize or abstain. As Nwabisa explained: “Using the injection for pregnant prevention is not going to prevent you from getting HIV. So for all the STDs and all the STIs, the HIV and the AIDS, there is only one thing that can prevent it and that is the condom. So that’s what I learned from loveLife. The only way to prevent HIV/AIDS is by using a condom” – Nwabisa. Other things mentioned by the gBs included getting tested, and for people with an HIV-positive status to take their ARVs. Lungile expressed that: “You can prevent HIV by using a condom and prevent HIV by getting tested before having sex with another partner. By not using someone’s [tooth]brush. If you are going to touch someone’s blood you must wear gloves. You must eat treatment, ARV, you must eat ARVs to reduce HIV”. Furthermore, Lungile also pointed out that having one partner [serial monogamy] can decrease the spread of HIV. Another one who stressed
the importance of people with an HIV-positive status to take their ARVs was Thulani. He clarified that:

HIV/AIDS is a virus, not just a disease or a flue. It needs to be treated and it is not curable, even thought you tell yourself that you are going to eat pills and eat pills and then when I feel good, like when I feel like my body is in shape I am going to leave those pills. It’s not like TB [tuberculosis] or flue where you treat it and the flue just goes away and TB where you get the treatment for like six months and after that six months the TB is gone. HIV is always there, if you get it you get it. It stays in your body so you got to drink the treatment, you got to eat the pills until you eventually die or something. Because when you have got HIV, yeah you can live for many years, but eventually it is going to change into AIDS. HIV has got stages until it gets to the AIDS itself, that’s what I was taught.

Furthermore, Xolela explained that: “You cannot die by AIDS, you die by opportunistic diseases which are TB [tuberculosis] and diarrhoea and other STIs which are not good”. Vusi, in turn, pointed out the importance of taking care of yourself and your health:

They [loveLife] say that even if you are taking the pill, you are not preventing HIV. You are just preventing yourself from getting pregnant. HIV is not written on your forehead. Anyone can have it, but you have to take care of yourself. Take care of your body, take care of everything with you, because no one wants to be ill. And you know, once you have that HIV you want to spread it to other people because you feel bad about yourself. And, you have it until you die. So, you must be able to take care of yourself now while you are still young. If that guy says no condom, say OK that’s fine, then there is no sex.

Vusi then concluded by saying that we should not treat people with HIV and AIDS in a different way, nor should we judge them. “They are the same as other people, it’s just that they have HIV and AIDS”. Here, I would like to flag what Vusi proclaims above, when saying: “you know, once you have that HIV you want to spread it to other people because you feel bad about yourself”. This is a subject that several of the gBs mentioned during the interviews. To exemplify further, when I asked Zizipho about what she had learned from loveLife she said: “To condomize at all times. Because you don’t want to tell people to abstain, rather condomize at all times. If the boyfriend or girlfriend says no condom, no sex. Don’t pressurize yourself. The main prevention would be condom, condomize at all times. If a partner says – let’s sleep without a condom, it is your right to say no. If there is no condom then there is no sex. Because people outside are very selfish and some people are just sleeping around just to spread HIV. Most people are doing that, I know of someone who is doing that”. “Why?” I asked her. “She says that she doesn’t want to die alone” Zizipho replied. I find this topic very interesting and it will be further elaborated in section 5.4.
4.4 Information from other sources

When discussing what kind of information regarding HIV the gBs have encountered from other sources than loveLife it became evident that this topic is not as widely spoken about as I had first imagined. The sources of information the gBs mentioned here included school, TV, radio and friends. Regarding school, they expressed that their experiences were that the HIV education they received there did not go into detail. Xolela shared that: “In schools we don’t actually [get] taught everything about AIDS. They just give us, – use a condom in order for you to not have HIV and abstain if you don’t want to be infected. HIV is a virus which affects the human immune system. That’s what they give us in school. Here at loveLife they get into detail which was good”. Yet another source of information the gBs referred to were the clinics. Zizipho accentuated that she had only received information regarding HIV from the clinics:

In clinics, they do talk about HIV. That’s the only place I have heard about HIV. In schools they don’t go into detail. You get more information once you go to the clinics. Or once you are a victim of that particularly disease. People are still not HIV educated, you don’t learn about the different stages and how to take the ARV until you are HIV-positive. The general information is very basic.

To conclude, the messages the gBs had come across from other sources than loveLife were mainly to either condomize or to abstain. Or, if the target group would be younger children they would only discuss that you can get HIV by touching someone’s blood, using the same razor or the same needle. According to the gBs, they would not mention that it is a sexual transmitted infection. Thus, doing so would imply that they were discussing sex, and this could be misunderstood as encouraging children to engage in sexual activities. Zizipho problematised this by drawing from her own experiences of working as a gB in a primary school: “Some principals feel like once you speak about HIV/AIDS you are saying to the kids that they must go and have sex. So, for me I don’t like to talk about HIV/AIDS, especially with the young ones” – Zizipho. This leads us to take a closer look at how the gBs work preventative against the spread of HIV.

4.5 How the groundBREAKERs work to prevent HIV

The gBs use verbal communication to reach loveLife’s target group (youth aged 12-25 years). They stress the importance for youth to condomize and to get tested. And, they aim for the youth to take
informed decisions. Lungile exemplified how he is working to prevent the spread of HIV among youth:

I am now preaching out, telling them about HIV. HIV is dangerous because while you are still having HIV, you can still have AIDS. And AIDS can kill. And still, they must use a condom. Condom is there to protect. I know that they say to me that condoms can break, I say – it’s fine if it breaks, you can hear if it breaks so you must stop. So you can put on another condom. I say that – if you are going to have sex, you must use a condom. But it’s not a must, if you don’t want to use a condom, it’s your choice. But if you [do] not use it you must know your partner, your partners status. The other thing is, even if you use a condom you must go to the clinic and get tested.

Vusi advocated for similar things as Lungile:

I don’t force them but I offer them to come and test. And always using condom when they are having sex. If the guy doesn’t want it, then there is no sex. Yes, we can preach those things, they won’t listen to us. You can say – always test, but those children won’t listen. But we try by all means to make them come to the clinic. First, and then second distribute the Choice even though they don’t want it. Make them know that you must use a condom every time you have sex.

What Vusi is indicating here is that from her experience, it is hard to reach youth with loveLife’s message. However, she then continued and said that as long as one person in the crowd is listening, and has in his or her mind that they must use condoms, a change has occurred. Furthermore, the gBs consolidate the information they are giving by connecting it to real life examples (or what could be real life examples). Nwabisa declared that:

I tell the truth, I tell people facts about it [HIV]. I always tell them that there is always a reaction for every action. You can’t eat a lot of greasy food and not expect to get sick, or get diabetes or anything. You can’t smoke and not expect lung cancer, you can’t use drugs and not expect to get some kind of mental illness. You can’t have unprotected sex and not expect to get some kind of STD or STI. So I tell them facts, once you don’t use a condom you are at risk of getting HIV and that might impact your future in a huge way. You might be positive or you might be negative but also we have seen people make the mistake ourselves. You can walk behind someone and when they trip you know that the step that they tripped on you are going to walk over, so we don’t need to make the same mistake in order to know the consequences of it. There are people who are retarded, mentally ill, because of drugs. There are people who have HIV because they have had so many ‘sugar daddies’. We know these stories, we see it every day, so I tell them what happens in reality. I am not going to sugar coat things in to so you can live a longer life with HIV, yes you can live a longer life but it is better to prevent than to cure. Actually it is not curable, so to treat. I stage facts, and scare the hell out of them. – Nwabisa

20 Choice was a free governmental distributed condom. Now re-branded as Max.
Furthermore, Thulani gave an example of how he tries to encourage youth to use condoms:

Guys tend to get girls just to sleep with them and then move on. And then don’t you think that when you have gone to a party, and then you meet up with a guy, that you don’t even know, don’t you think in your mind that maybe that guy is HIV-positive? Maybe he is not. I don’t even know him. Even though we don’t judge, that question should come into your mind. That, this person, we met in a party, obviously what we are going to do is just sleep [have sex], and then I will never see him again and he will never see me again. So, why don’t I use a condom? That’s the examples that I make.

When asking the other gBs what they thought had to be done to make youth condomize, both Andisiwe and Xolela expressed that they had to try to convince the youth to use condoms. Andisiwe said:

Convince, tell the benefits of using condom. You will see on their faces that they are convinced but when they go out and meet their partners they forget everything and just think that lady from loveLife is trying to confuse me. We are telling them that if you use condom this and this will happen, and if you don’t you are going to be in this danger. There are a lot of dangers, you can get pregnant, HIV-positive, and there are a lot of STIs.

And, Xolela declared: “The only thing we should do is to talk to them because we can’t force them. Talking to them would be a good idea in a way. I don’t see any other way man, because loveLife is all about changing lives, changing attitudes of individuals. Which is what we are doing as groundBREAKERS”. The gBs expressed that they sometimes felt that the youth did not listen to what they were trying to mediate. They explained that what kept them motivated in these situations was the thought that at least some individuals would take in the information and make meaning of it, and, hopefully also make use of it. And, as Andisiwe put it: “To hear it from different people, this can reduce HIV. To hear one thing from different people”.

Let us now move on to explore the groundBREAKERS thoughts and notions of the reasons for the spread of HIV among youth.
5. Perceptions of reasons for the spread of HIV

In this chapter I will shed light on my empirical findings. I wanted to examine how the youth that are living in these surroundings themselves perceive what mechanisms there are that are fuelling the spread of HIV among youth. I wanted to know how do the groundBREAKERs relate to the HIV epidemic? And, how do they explain it? What are the reasons for the spread of HIV among youth in their experience? The gBs mentioned a lot of things here: stigmatization, having multiple partners, that youth are not using condoms nor getting tested, to name a few.

Many of the subjects they brought up are intertwined and it is sometimes hard to separate the one from the other. However, I have tried to categorize my findings in different sections below.

5.1 Not talking about it

The thing is that no one wants to tell no one about his HIV. It’s your right to voice out or to keep it as a secret. – Lungile

The gBs described sex as a subject that is not easily spoken about within their community. From loveLife’s side, they encourage youth to discuss sex and condom usage with their partner(s) before it gets too heated. Is this something that youth do? I asked the gBs. Nwabisa seemed doubtful: “I don’t think so. It comes from our background, from our parents that the man takes over in the bedroom and that’s that. They don’t discuss it because sex is this sacred thing, this thing that must be hidden. So, I don’t think we are more open about sex. Personally I find it difficult to communicate with my partner about sex because I am not used to that. I was never taught to do that”.

Thulani expressed himself in a similar way: “HIV and sex, when it comes to the penis and the vagina and how the procedure happens most guys seem to – aa-aa, don’t talk about that. Which is another problem because if you are at school you are there to learn”. As can be seen from this, the gBs were themselves also struggling to talk to their partners about sex even though they work with these types of questions. There is a difference between talking about sex with an educational purpose and talking about the same topics with a partner. Though, as Thulani indicates, it is not easy to educate youth either:

You see, the problem is one could have HIV in the family and the family would not talk about it, amongst the family. They try to hide it away. The main point of what is happening, even our parents are ignorant in a way, to not tell us that your father or your uncle is HIV-positive, that’s why he is drinking this [medication]. If we are told by our families, that’s where we will ask – how does one get HIV? And, – I have heard about
HIV here and there, but I want to be sure. Since education starts at home, many children tend to believe that I need to hear something from my mother or my father before one outside my family can tell me. That’s another way of being ignorant that many people use out there. So, if we come as groundBREAKERs and talk to youngsters about this and that, even though they are listening, if it doesn’t really happen in their family or they haven’t really noticed what’s happening, they will take it as – na-ah, these people are just joking. – Thulani

Here, it becomes evident that when the older generation do not speak about HIV nor AIDS they actually create unwritten rules that the younger generation in their turn pick up and adopt. Since the older generation signal that these topics are taboo. Thulani is problematizing this above where he says that parents are not open with their (or others) HIV status. They do not even share their status within the family, which makes children experience no connection to HIV at all. Since, as Thulani shows, children tend to only accept what their parents have enunciated. Skinner (2001) also found that the respondents in his research experienced difficulties in talking about sex, just as Thulani and Nwabisa stress emphasised: “The problem of providing education about AIDS is compounded by the difficulty that most respondents reported in talking about sex generally, and especially to any person from a different generation. Sex predominated by issues of shame, together with the obvious associations of sex with power and status. It is only amongst peers that sex is spoken about, and even here there appears to be a restricted dialogue” (Skinner 2001:13).

Fear of being labelled as an HIV-positive person

The gBs stated uniformly that it is rare that people with an HIV-positive status are open with their HIV status. Thulani declared the situation quite explicitly by stating that “nobody has it [HIV] in a way because nobody is sharing it”. Xolela explained that: “People are dying in society. … Few of them who have passed on have talked about it. And, they know that they are HIV[-positive], that’s why they are dead now. …. So most of us here in the hood die of HIV21, but, we say it’s TB [tuberculosis]. We don’t say it’s HIV, because it is a big thing in a way, a big thing in our country”. I then asked Xolela: “Why is it like that do you think?”. “Because every individual in that family they will be appointed as one of the HIV victims” he answered. He then continued: “Because in a community we talk. People talk, everyday people are gossiping. And if I am from that family who has just lost their soul, and I am passing by, they will say – he got HIV also, because his brother or sister died of HIV. So, we are saying that. So, if I get sick they say – he got it [HIV]. That’s the thing, that’s why we don’t say it” – Xolela. He then went on: “They just say it like that. They say it’s a family thing. – Don’t talk about them, those ones they got HIV and AIDS. They say that, which is not good”.

21 I believe he is referring to AIDS here.
Seen from the description above there is a great fear of being labelled as an HIV-positive person. People are trying to avoid being talked about, and, they are apprehensive of being judged. I believe that this stems from a fear of being rejected by others. Thulani pointed out that: “It’s not easy for one to go up and say to people – I am HIV-positive, because people tend to tease one and people tend to call them funny names. – Hey there is that HIV-positive one, go and sit there with the friends that are HIV-positive! So that is going to hurt ones feelings, so it’s better for you to keep it inside. Even though it’s not the healthiest way of living with HIV”. Looking at these statements, I find that there might exist a connection to why parents are reluctant to speak about HIV in general, and, especially to share their own HIV-positive status. If, it is accurate as Xolela describes, that HIV is a “family thing” where all family members will be labelled as “HIV-victims” if the word comes out that one person from that family has a positive status. Then, not speaking about it might actually be seen as a protective mechanism to avoid bringing discredit, not only over yourself, but also over the family. If so, this suggest that the parents are trying to protect their family members by keeping quiet. Even though this might be counterproductive and lead to HIV denialism among youth as explained by Thulani above.

When discussing this topic with Zizipho she confirmed that people do not talk about their HIV status. “People do not talk about their status at all” she claimed. When I asked her why? she said: “I think that some people don’t want their private business to be known by others because some people will laugh about you having the disease. Some people find it hard to open up to a lot of people”. “But doesn’t this make people living with HIV feel very lonely?” I wondered. Zizipho then responded:

I think so, you feel very lonely. You feel lost in your own world, it’s traumatizing. I think once you got the disease, I don’t think that’s anyone’s business, as long as you personally accept that you are HIV-positive. Then, I think you can live a better life. Or, tell your family members that you are now an HIV-victim, other people don’t need to know about your status. What I have seen here in the country is that the only time people tell their status is when they join the support groups. Now they are starting to feel free because the other people know what she or he is going through.

Again, seen from this, people are afraid of what other people would say and do once they find out that you have an HIV-positive status.

**It is an insult to ask someone about their HIV status**

When asking Zizipho if people who are aware of their HIV-positive status are open with it when they get a new sex partner? she answered: “Some tell, some don’t. Some say that they are afraid that their partner will run away just because they are living with the virus. I don’t think the other person
can stop loving you because you have the virus. I mean, no one plans to get HIV”. There are several underlying reasons to why people are reluctant to discuss HIV. Yet another one of them is that it would be seen an insult to ask someone regarding their HIV status. I had a very interesting conversation with Xolela about this where he said:

We as HIV preachers, or maybe I can say the people who are talking about HIV. We say – please don’t judge anyone with HIV or bully someone you think has HIV. So, the moment a person is having sex without a condom he or she knows that this person is not HIV-positive. That is what is running through their head, because the people who are talking about HIV said – please let us not judge others. And also there are rights, rights to not judge anyone, which is human dignity. Do not say she is HIV so I should not talk to her or anything. So that is the thing, maybe people think of not using condom. They do not use it because they see a girl and say okay she is not HIV-positive, so I don’t want to use a condom because I don’t see any.

Here, Xolela got silent. “But you do not see HIV” I blurted out. “Yeah, that is the thing. We do not see it. And we do not want to say it to people who we have just met now – are you HIV? I cannot ask that because I will be insulting her in a way”. “When can you ask that question then?” I asked him. “I cannot ask that question” he declared. “But if you are in a relationship, shouldn’t you know?” I continued. “I do not have to ask her” he said. “I can say, – please can we go and test? I don’t need to ask – are you HIV-positive? Because that is an insult in a way. I have to try to convince her to go with me and test. So, you convince her to go and test and see what is happening, and if she is negative or positive I should support. That is the only thing we need to do, not to ask”.

The discussion above expose what a complex reality youth are navigating in when it comes to acquiring information regarding their partners HIV status. It is not as simple as to just ask. As an outsider this might be hard to comprehend at first, however, it seems evident that most youth find it difficult to discuss HIV status due to multiple reasons. And, even if it would be easy to ask about someone’s HIV status, they could still lie or be unaware of their status.

Nobody dies from AIDS

To conclude this section, people seem unwilling to talk about HIV in general, and in particular to disclose their own HIV-positive status. The same applies in event of death, HIV is not spoken about here either. As Xolela pointed out above: “So most of us here in the hood die of HIV, but, we say it’s TB [tuberculosis]”. To exemplify this further, a variation on the same theme was portrayed during the interview with Vusi where she told me that she used to have an older sister. This sister
got pregnant and had a baby. She then got ill, and when the baby was five months she passed on. And two days later the baby passed on as well. Vusi told me that she had not been aware of her sister having an HIV-positive status. And, she had not had the chance to travel to see her new born niece. She told me that she was communicating with her sister and that everything was fine, then, this just happened. It was only after the funeral that Vusi learned that her sister and the baby were carrying HIV and where she was told the story of why they died. Vusi then quickly changed the subject and started to tell me about her current family situation, clearly not comfortable going deeper into the subject due to its sensitive nature.

These findings corroborate Stadler’s (2003) research from South Africa. He found that “… AIDS is almost never talked about at funerals. To do so is “embarrassing”, for unlike cancers and heart disease, AIDS deaths are shameful…. The silence and secrecy surrounding the case of death leads to talk of AIDS in the “corners of the funeral”, as gossip and rumor. It is through these oral forms that cultural meanings of AIDS are produced and reproduced” (ibid.:362). And, Walker et al. give understandable reasons to why people prefer to keep their HIV-positive status to themselves, when they remark that: “Large-scale fear of AIDS, misinformation, popular mythology, and the legacy of mistrust left by apartheid have created an environment highly unsympathetic to those infected and living with AIDS” (Walker et al. 2004:102). It seems evident that silence is a dominant response to HIV. Ban Ki-moon, former Secretary-General at the United Nations, expressed in an opinion in Washington Times that: “… One of the biggest hurdles for our global response to AIDS is psychological. That is the stigma factor. To greater or lesser degrees, almost everywhere in the world, discrimination remains a fact of daily life for people living with HIV” (Ban Ki-moon in Washington Times 2008-08-06). Furthermore, he continued by stating that: “[Stigma] is a main reason why too many people are afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it, or taking easily available precautions. Stigma is a chief reason why the AIDS epidemic continues to devastate societies around the world” (Ban Ki-moon in Washington Times 2008-08-06).

5.2 “People don’t want to get tested”
To get to know your HIV status you must get tested. Is this something that youth do? I wondered. This is of course something that differs from person to person. To quote Xolela: “There are ones which [have] never ever tested, there are ones who [have] already tested, there are those who test often”. When asking the gBs what the most common would be they unanimously answered not getting tested at all. Xolela pointed out that: “There are many people who are not testing. That is
why we need to convince, not to judge or ask – are you HIV?”. Zizipho said that she could not understand why people would not get HIV-tested. “People don’t want to get tested, I don’t know why” she said. She then continued by telling me about a conversation she had with a friend: “I’ve got a friend of mine, when I say – let’s go get tested, she gets so angry. The other day I said – you have to be [HIV-]positive because the way that you are acting says something else.” She nearly bit my head off. I couldn’t understand why she was like that. At least you can live a better life, not dying, than not knowing how sick you are”.

Seen from the information I received from the gBs it seems like few youth talk about sex, condoms, and HIV, and that few ask their sexual partners regarding their HIV status. “Few people ask – do you know your status? People do not go with their partner to test” stated Andisiwe. “You can go alone and if you find out you are [HIV-]positive you don’t tell anyone. You continue to sleep with him because you think you got it from him. Maybe she didn’t even get it from him” she continued. When asking Thulani if it is common that people in a relationship go together to get HIV tested he replied: “No it’s not common. Because guys tend to believe that HIV is not for them”. I asked him to elaborate and he continued:

I think they don’t want to get tested because they think that the nurse is putting the HIV into them. Because, as they are living they are not noticing the HIV inside, because they don’t even know the symptoms. So one will say – I’m not HIV-positive, even before entering the clinic. Some of them don’t want to give in to the fact that HIV is there and it’s alive and it’s killing people. They are very ignorant.

“But why?” I wondered. “I’m not sure why. Maybe it’s because it hasn’t happen to one of their family or relatives yet, for them to realise that HIV is here and I want to know about it. Or, it has happened but he has that mentality that, the word that says never. He uses that word that, it will never happen to me. It’s maybe that, that’s why people don’t want to get tested” he said. After pausing for a moment Thulani then continued:

That one is a difficult one because our cultures and the things we get taught tend to clash because we as the pride people, we tend to hold on to the beliefs of our cultures. So when stuff like these come out we don’t even listen sometimes. Because HIV is there and people do know that HIV is there but they are scared to come and test because they think that when you come and test the nurse is putting the HIV inside you. – Thulani

Above, Thulani is referring to a myth where it is said that the nurse is injecting the patient with HIV whilst taking the HIV-test. In the next section, 5.3, I touch upon this subject a bit further. Thulani

22 Indicating that the friends behaviour pointed in this direction.
also mentions that as Xhosa they tend to hold on to the beliefs of their culture, this topic will be further demonstrated in section 5.8 below. But first, let us go through more reasons behind why youth do not get tested, other than fear stemming from myths like these.

**Fear of knowing your HIV status**

One day I joined Nwabisa to a high school where she worked as a groundBREAKER. I had imagined that I would be able to follow what she and the pupils were talking about but unfortunately they spoke almost solely Xhosa. But, what stood out was that the class was very engaging and interactive. When I later asked Nwabisa what they had discussed during class she told me that they were discussing HIV testing, and she had asked them why people are not getting tested? Their response had been that people are too scared to get tested. That they do not want to know their status. The students had also revealed that they feared that the nurse would be rude. And, expressed that they feared that the nurse would be an acquaintance to their parents, and if so, that the nurse would tell their parents about their status. So, lack of trust towards the nurses was one reason why the youth felt reluctant to go and get HIV tested. Here, it seems evident that people are not getting tested due to fear of knowing their (positive) status. They would rather not know than facing the consequences of other people finding out. Returning back to Xolela’s explanation that it is an insult to ask someone regarding their HIV status, and his suggestion that people should rather go to get HIV tested together instead makes little sense in a context where a lot of people avoid getting tested because they do not want other people to find out. Would not testing together with a partner rather be experienced as worse that testing on your own? When it seems evident that most people want as few people as possible knowing their (positive) HIV status.

**Andisiwe’s story**

Andisiwe shared her own story with me and described that she had never done an HIV test before joining loveLife: “I used to hear what loveLife said before, but I never used condoms. The nurse asked – do you use condoms? and I said – no. – Why? she asked. – I don’t like it, I said”. Andisiwe took a short break, and then continued: “From the ten days [loveLife] training I came back saying – aa-aa, that was wrong, and I have been risking for many years. Being a gB changed me”. When Andisiwe came back from the gB training she took an HIV test at the loveLife clinic. She explained that she felt that she now had to know her status. I asked her if she felt scared for the result? She just shook her head and said that “I don’t even understand myself, because normally when people are testing for HIV they are nervous and they are shaking, but I took it lightly”. She then continued describing that she was not nervous at all. “I just told my self, if it happened it happened. There is nothing I can do”. The test results came back negative, she did not carry HIV. Even so, I took the
opportunity to ask her: “What do you think your reaction would have been if it came back positive?” Andisiwe answered: “I am not going to cry. Not here. Maybe I can cry when I get home. I would be very down and when the others would ask – what’s wrong? I would say – I can’t say”.

“So, you would not tell people?” I asked. “It is your choice” she answered. “But what would people normally do, would they tell it or..?” I asked. “People do not want to tell. Even when they take their HIV treatment, they hide. They don’t want people to know, they keep quiet. The counsellors say that you should say it because to keep quiet will eat you inside”.

I find the discussion above very interesting and also quite telling, maybe even in a broader sense. Andisiwe explicitly shares that she used to hear loveLife’s message before, but that she was not particularly affected by it. It did not make her change her behaviour, she never used to use condoms because she did not like it, as she explains. She also reveals that she was unaware of her HIV status and had never taken an HIV test until she started to work at loveLife (at the age of 25). And, in the end, she expresses that she would not have shared news of an HIV positive status with the other gBs.

**More females than males get tested**

According to research, more females than males get HIV tested (HSRC 2012:xl). Stadler (2003) explains this by the “natural gender difference”. He alludes that women come in contact with health clinics more than men due to the fact that they are the ones getting pregnant. He illustrates that: “In the current setting, young women tend to have had the most exposure to HIV/AIDS information. Pregnant women are routinely tested for HIV and syphilis, and receive pretest and posttest counselling. … in contrast, men are regarded as “matter out of place” in clinical settings, particularly family-planning services” (Stadler 2003:361). Maybe it would be a good idea to implement HIV testing for fathers in connection to when the pregnant mother is tested? If they were offered HIV testing it would at least serve as a reminder for men to also get tested.

**5.3 HIV myths**

HIV myths circulate because the ones who are positive do not talk. They don’t share their stories. – Andisiwe

My intention is not to reinforce mythogenesis but since the topic came up during several of the interviews, I will here share what was conveyed by the gBs. With Nwabisa, the subject came up when we discussed that sex is a topic that is difficult to talk about. I wondered: If sex is a subject that many youth feel uncomfortable talking about, how does this then affect how HIV is spoken
about? Since HIV as a sexual transmitted infection has a direct connection to sexual activity. Nwabisa explained that:

I think people are frightened, people are scared. They are intimidated and I think it all started with the fact that HIV is transmitted through sex and sex to us is that thing we talk about behind closed doors. Now, knowing that someone has gotten a disease through sex, is a huge deal. And some people they label you as a whore or something because you are now diagnosed with HIV. A lot of people don’t want that, so they create things.

“They create what?” I wondered. “They create myths and stigma. I think people get very intimidated and scared. They don’t want to believe, so they become delusional in a sense” she continued. I have already presented one myth; that the nurse at the clinic injects the patients with HIV when HIV testing, thereby making the patient HIV-positive. I believe that an underlying mechanism that fuels this myth stems from the fact that before you develop AIDS, you do not necessarily feel ill. In the initial stages you can feel perfectly healthy whilst carrying the HI-virus. So, when a person that is, self-reported, as healthy as one can be gets an HIV diagnosis, it does not seem too far fetched to explain the “newly acquired” HIV-positive status with the assumption that it must have been the nurse who gave you the virus in the first place. As Thulani pointed out above, in section 5.2, “as they are living they are not noticing the HIV inside”. “What other HIV myths are there except for the nurse injecting you with the virus?” I asked Thulani. He answered that:

If I am HIV-positive I can sleep with a virgin and I could be cured of HIV. Many people don’t know that HIV doesn’t have a cure. Its been said on TV, everyone is talking about HIV not having a cure, but it’s within the people who are ignorant. Because if I have HIV, and one comes to me and says that – to cure HIV you will have to sleep with a virgin, obviously what’s ringing in my mind is that I will have to sleep with a virgin. If I don’t cure HIV I will die, so another way of curing HIV is sleeping with a virgin. So, that will run in his mind – I will have to get a virgin, I will have to get a virgin. And once he gets one, even though that person is not a virgin, even though he is not sure, once he sleeps with one he will think he is cured. Many people are educated with HIV and what is happening with HIV, but they are too ignorant in a way. They don’t want to say – yes this is happening. And that, I don’t know why. – Thulani

The virgin myth seems to be a long lived one and it was also mentioned by Nwabisa. She said that some people believe that “HIV can be cured by raping a virgin or having sex with a baby, actually raping a baby”. She also brought up some other myths: “Some people don’t believe that HIV exists. That it’s something made up to scare people. And also that holy water can cure HIV. When we discuss this with people we don’t discourage them. We tell them okay, drink your holy water but also take your medication. And also, that you can infect someone with HIV by using witchcraft, that
some witchdoctors can put HIV inside you”. Yet another myth that Xolela had heard was the one saying that “if you sleep with a girl without a condom, go to a shower and shower the AIDS away”. This last myth stems from President Jacob Zuma’s statement during the trial where he was accused of rape. As already mentioned in the introduction, he confirmed that he had had unprotected intercourse with a woman that he knew had an HIV-positive status, but explained that he had taken precautions by showering afterwards. Clearly, announcements like these can have widespread effects and create myths that lives on for decades. The fact that the government initially denied HIV created a ground for myths to thrive and to be fortified.

5.4 Spreading HIV on purpose

When discussing the virgin myth with Thulani I asked him regarding the scenario where someone would have sex with a virgin to cure HIV. Would they have another test after the act to check their status or would they be assured that they were cured? His answer slid into another topic namely spreading HIV on purpose, something that several of the gBs brought up:

Most of the time it’s those people who are ignorant in a way, because they know that HIV is not cured by a virgin. But, he will try it because he got it from someone and he wants to spread it in a way. Because when one gets HIV most people say – I am not going to die alone. Because they know that HIV is a death row in a way. If you get HIV, even if you treat it, eventually you are going to die. People tend to say – no I am not going to die alone, because I don’t even know where I got this HIV from, so I might as well spread it. Not that they don’t know that HIV needs to be treated, and that HIV doesn’t need to be spread. They are just doing it for the fun of it, and for the fact that they are angry, because they don’t know who they got it from. So, one is saying, – I am not going to die alone, I am not going to die alone! And then you go and approach a girl, and then you go and sleep with that girl. Even one round of sex, once your fluid goes into that girl, then it’s enough for you. Then you look for another one, and you keep spreading the thing until the feeling inside you tells you that now it’s fine for me. Because you don’t know who you got it from so you might as well spread it. – Thulani

When this topic came up during the interview with Xolela, I asked him why people are spreading HIV on purpose? He replied: “Because they say – I got it from a person, I have to give it to a person. I can’t have it alone”. “Why do they say that?” I wondered. “Because they are scared they are going to die. They don’t have information about it, they just say – OK, I’m HIV-positive now, I have to spread it so that they can also be HIV-positive. Others are maybe angry, I’m not sure”. “So they don’t want to have HIV alone?” I repeated. Xolela answered:
We think that, I also think that. Because living with the fact that you are going to die, is not an easy thing in a way. When I’m walking in the road, I see that people who are [HIV-]negative are walking, just like me. So why ain’t I give them that, the virus? Which is, you can give them the virus, and you know OK, I am going to die with my soldiers. Which are the ones you spread HIV to. I agree with the fact that it’s, you don’t have to die alone. Because you didn’t get it alone, you were not alone at the time you got infected. So, it should be 50/50. It’s not a good thing to die with someone or affect someone with the disease. It’s terrible, big time.

Lungile suggested the same thing, that people are spreading HIV because “no one wants to be infected alone”. And also, that people get angry with the one who transmitted the virus, even though they might not know who they got it from. Even so, they spread it further because “it can’t only be me”.

In an article, anthropologist Jonathan Stadler (2003) sheds light on a rumour where beautiful girls are said to seduce as many men as possible with the purpose of spreading HIV. He then continues by recalling an occasion where he spoke to a young HIV-negative man. The man had just taken an HIV-test which came back negative. Even though this man had just tested negative, he expressed that he was afraid that he would not stay HIV-negative. He said: “they will rape my girlfriend and then I will get AIDS. People are very jealous” (Stadler 2003:365). According to Stadler this statement resonates with the moral economy of witchcraft. “Witches are motivated by jealousy of the good fortune of others. Similarly, those who are HIV-positive resent those who are not and will intentionally infect them” (ibid.). Stadler points out that this presents a construction of risk that shifts the focus beyond the behaviour of the individual, to rather encompass social relations and context. Here, risk is no longer controllable by the individual, but is ultimately determined by others; no matter what you do to protect yourself, others will destroy you (ibid.). This makes sense if we connect this to the mentality Xolela is describing above: “I got it from a person, I have to give it to a person”, “it should be 50/50” – Xolela. And, as he is portraying: “When I’m walking in the road, I see that people who are [HIV-]negative are walking, just like me. So why ain’t I give them that, the virus?”. Which indicates jealousy. I believe that the sensation of “no matter what you do to protect yourself, others will destroy you” that Stadler is describing stems from HIV being especially intimidating since it is invincible in many aspects, in comparison to many other infections. Take the flu for example, which gives clear symptoms. If someone in your surrounding would have a bad cold you would notice, and you would thereby be able to keep away from that person to avoid getting the flu yourself. But, since you cannot tell if a person carries HIV or not, this makes HIV this danger that is lurking around the corner. Especially in a context where having multiple partners is common. And, not to forget, in a context where sexual abuse and rape is frequent. Now, let us again return to the rumour of beautiful girls spreading HIV. I find that this correlates with what I
indicated in section 1.3 A gendered epidemic, where I showed that women are being scapegoats in the HIV epidemic. As one could ask oneself, why was it not a beautiful man who was said to seduce with the purpose of spreading HIV? This rumour even got strengthened by getting broadcasted on local radio (Stadler 2003:365). Here, I would suggest that blaming the spread of HIV on the opposite sex is a ruling technique for men to consolidate their power over women. Therefore, I propose that this could be interpreted as a ‘manhood act’.

Furthermore, the phenomenon of spreading HIV on purpose was researched and described by anthropologist Suzanne Leclerc-Madlala already 20 years ago. Her findings elaborate what Stadler has pointed at above, she describes that:

Having an HIV seropositive status confirmed was believed to be a most horrible thing for the person concerned because it would cause him/her to “do awful things,” things informants claimed would go beyond the realm of normal activity. … To be infected with the HIV/AIDS virus, or even to suspect that one might be, was said to set into a motion of a whole complex of behavioral changes that are played out in the sexual arena. Rather than resigning oneself to a future of protected sex or no sex at all, a confirmed HIV seropositivity might precipitate a quite opposite response. (Leclerc-Madlala 1997:368-9)

Leclerc-Madlala explains that: “Young people express a desire to share the burden of disease, and this is believed possible by spreading the virus to others” (Leclerc-Madlala 1997:369). Just as Xolela indicates above, where he suggest that people spread HIV because they are “scared they are going to die”. Leclerc-Madlala discloses that: “They share a philosophy which says, “If I don’t have a future (now because of AIDS), then I will try my best to ensure that others don’t have one either”” (ibid.:371). Leclerc-Madlala displays that this might actually stem from and be explained by South Africa’s history: “It is possible that a strong sense of peer group affiliation, forged during their years in South Africa’s war-ravished townships, may help to explain the youths’ desire to pass the HIV/AIDS virus on to others. By spreading the virus one is sharing the burden, the anger, the hopelessness and ultimately the death. It is no longer an individual problem but a shared group problem” (Leclerc-Madlala 1997:371). She indicates that this is a way for youth to respond to the epidemic that is not completely powerless nor passive. And, this could be understood as a coping strategy: “Comfort may be found in this epidemic through knowing that one will be facing his/her fate with many others” (ibid.:376-7). Or, as Xolela expressed it: “dying with your soldiers”. To conclude, I would like to shed light on one of Leclerc-Madlalas (1997) conclusions that I find very intriguing: “To adopt preventative measures would seem to make little sense against a social response of sharing the virus, sharing the burden of disease, sharing the destiny” (ibid.:377). At first, I found this statement quite controversial but then again, on a second thought, I believe that
she could actually be on to something here, since this is also what the groundBREAKERs indicate. Now, whether people are spreading HIV on purpose or not would be very difficult (if not impossible) to ensure by research. For now, we can only take into consideration peoples accounts. Yet, what could actually be analysed is statistics of the number of youth that are getting tested, since this would then also show how many youth that are in fact not getting tested, which would indicate if it is correct to assume that people do not want to know their HIV status.

5.5 Multiple partners

It is spreading because we don’t want to have one partner, we are not faithful to our partners. We want to have more different partners. – Lungile

During the interviews with the groundBREAKERs it became evident that having multiple partners simultaneous seems to be a common feature of adolescence, for both females and males. However, the focus was usually on guys having multiple sexual partners. Nwabisa explained the connection between having multiple partners and proving that you are a real man:

There is also a lot of stigma around that, if you are proven to be a man. If you are proven to be the man, you have to have multiple partners. It’s also something along the line of peer pressure, because once you have one girlfriend then your friends will consider you a wimp because you only have one girlfriend and you are only having sex with one person so you are good for nothing. Things like that needs to be addressed, which also goes along the lines of the topic that I spoke of, ‘Who am I’, when we do those sessions, we address things like that. If you know yourself and if you are confident enough then you won’t need a friend to manipulate you or persuade you to do something that you are not comfortable with. I think it is a habit that we took from our parents and their parents, that it is OK to have a little side kick on the side. I think it’s something most of us young people have experienced and have seen and that’s why we find no problem with having so many sexual partners because my mum is not going to say anything about it because to her it is nothing. And I never talked to her about these things so I can do it, like, no one is going to judge me. – Nwabisa

Nwabisa sheds light on a number of interesting points here. First of all, she states that to prove that you are a man, you should have multiple partners. This statement stands in line with what researchers have found. As already mentioned, successful masculinity as described by Wood and Jewkes, among others, is defined by having multiple partners (Wood & Jewkes 2001:319). Nwabisa then goes on and says that males are considered as wimps and as good for nothing if they do not have multiple partners. I believe that the right of access to sex is a primary marker of manhood, as brought up by Vincent, is connected to this (Vincent 2008:443). As showed in the introduction,
coercive sex has become a common feature of youths sexual relationships. Male dominant sexualities makes it difficult for young women to protect themselves against unwanted sex, and if we follow Nwabisas line, it seems like males are considered as wimps if they do not accomplish acquiring multiple partners. This suggest that it also exists a certain expectation and pressure on young men to have multiple sexual partners. Moving on, Nwabisa is then referring to the older generation and how the younger generation have seen how they behave and is now taking after. I find it comprehensible that the younger generations takes on behaviours that the older generation has justified. This will be further elaborated on in section 5.8.

After the statement seen in the quote above, Nwabisa continued: “I have had friends that have been in a serious relation for about four to five years but their boyfriends have cheated on them countless times. It is actually normal, it’s normal for me, for my boyfriend to cheat on me and for me to take him back and wait for him to do it again. And for me to even know who he cheated with and for me to know who his side girlfriend is” – Nwabisa. Again, as explained by Wood and Jewkes, the actual number of partners acquired is important for males, since many partners shows status and thereby leads to other males start respecting you (Wood & Jewkes 2001:321). Are girls cheating just as much? I asked Nwabisa. “I think girls cheat just as much” she replied. “You said earlier that a dude is a wimp if he’s not sleeping around but is it the same for the girls?” I continued. “No, it’s not. Sometimes you wouldn’t even tell your friends that you have two boyfriends because it’s going to be like (draws her breath out of surprise) – what are you doing? But things are changing and maybe five years ago it wasn’t normal but now it’s normal for a girl to cheat. It’s nothing that is a surprise. It depends on the type of company you keep” Nwabisa answered. “What happens if your boyfriend finds out that you are cheating on him? What will he do?” I asked. “Normally he will dump you. It’s just us girls that will stay, when a guy finds out he will dump you” she said. “Why do girls stay?” I asked her. “I don’t know. I think maybe it’s because they think the guy is going to change. There are various reasons why girls stay. Maybe they are so in love and hope for a miracle, I don’t know” she responded. Wood and Jewkes, amongst others, suggest that physical and psychological violence is a common feature of young peoples sexual relationships and that most cases of violence reported was associated with females actual or suspected infidelity. They also found that girls attempt to end relationships may result in violence, so maybe part of the answer to why girls stick with unfaithful guys is to be found here (Wood & Jewkes 2001:318-9). Research supports that females also have multiple partners, however, due to reasons such as the one mentioned above, the risk of being exposed to violence, it is not spoken about to the same degree as males having multiple partners (ibid.:334). Also, males and females seem to have multiple partners for different reasons. For males it is a question of status and pride whilst for females it seems to be more connected to increasing your possibilities of acquiring benefits, such as material resources.
When talking to the gBs they often used the words girlfriends and boyfriends in plural and they also mentioned “first girlfriend/boyfriend” as in favourite girlfriend/boyfriend in relation to “side girlfriend/boyfriend”. Why do you get a second girlfriend/boyfriend if you are happy with the one you have? I asked Thulani. He responded that: “I don’t know how to put it, but we as guys we would probably say that I can’t drink water every day. I will have to drink juice or coke or... That’s what’s happened with us guys”. The topic of multiple partners seems to be connected to the topic of what is learned during ulwaluko (Vincent 2008:443, Wood & Jewkes 2001:19-21, Daily Dispatch 2006 in Ntombana 2011:636), therefore, it will be further explained in section 5.8.

5.6 Alcohol and drugs cloud your judgement

When I asked the gBs what the reasons for the spread of HIV amongst youth are, they pointed out alcohol and drugs as great risk factors. As Nwabisa put it: “The reasons for it spreading amongst the youth are a lot of us believe in one night stands, a lot of us get wasted when we get drunk. We blame it on the alcohol”. Thulani followed a similar line of thought:

Alcohol and drugs are the reasons for the spread. Using alcohol or using drugs, they tend to make you think that doing stuff is cool. And most of us as the youth, when we use these things we tend to not look at the issues of not using a condom and making sure that my girlfriend is prevented from any kind of disease. We don’t take that into consideration. Because when I am drunk the only thing I think of, is, as a young person, if I go into a room with a girl, the only thing I think of is having sex. No matter if there is a condom, no matter if there is no condom. I will think about having sex. – Thulani

Xolela had a similar thought and expressed that:

We drink, and we don’t use condom. It is only that which spread HIV with alcohol included. Alcohol is like, OK, we have sex, and we don’t use condom. That’s the only thing. Because we are going out, partying, and meet a girl. And then tomorrow, we don’t know that girl, maybe you know her but you ain’t gonna follow up on her. You go to Khayelitsha or whatever party, doing the same thing. Then you don’t follow up on it, it’s constantly spreading in the community.

Andisiwe had another angle on alcohol and its complex of problems. She saw, from a female perspective, how alcohol makes girls more vulnerable. She said that people should stop using alcohol and drugs because “when you are drunk people will take advantage of you and you don’t know what you are doing”. Her concern is validated by research from southern Africa, Kalichman et al. confirm an association between alcohol use and sexual risks for HIV. In their research men
were found to be more likely to drink and engage in higher risk behavior, whereas women's risks were often associated with their male sex partners' drinking (Kalichman et al. 2007:141). As mentioned, it is difficult for young women to protect themselves against unwanted sex, and, probably even more so under the influence, as Andisiwe points out.

5.7 You can't eat the sweet with the paper on
From the understanding of the gBs most youth do not use condom. I have already touched upon this subject in some of the sections above but let us take a closer look. Why are youth not using condoms even though they are both easily accessible and free? The Governmental distributed condoms called Choice, that is today re-branded as Max, are available for free at the Y-Centre and at the health clinics. When I asked Andisiwe if she thought youth are using condoms? she said: “I don’t think so, they just take condoms here and then throw it away. Youngsters don’t like condoms. They say you don’t get the real thing if you use a condom. – You can’t eat a banana with the peel on, you have to take off the skin before you eat. You have to take off the plastic before you eat the sweet”. This notion of “you can’t eat a candy with the paper on” was mention by all of the gBs. According to Lungile this is something that youth are saying, both girls and boys. Why don’t they like Choice? I asked Lungile. “They say it stinks. And, it can break” he responded. The other gBs referred the same things, namely that Choice has an unpleasant odour and that it is too oily. At one point, I opened a Choice myself out of curiosity to experience what the gBs were talking about and I can confirm their insights. The first thing that hit me was the smell and then it stood clear that the condom was drenched with an oil based lubricant. My hands got covered with the smelly oil just from taking out the condom from its package. This made me understand better why I would often see unopened Choice condoms laying around in the corner of the streets together with pieces of trash and dirt from the road while walking to the taxi rank in the afternoon on my way home.

When I talked to the female gBs they all claimed that it are the guys who have the most negative attitude towards condom use. And, that it is more common for girls to trying to negotiate condom usage. Nwabisa expressed that: “Guys actually hate condoms, some of them, most of them. I don’t know why, some of them say it is uncomfortable or whatever. It’s normal that the girl would have to debate with him, trying to convince him to use a condom. It’s normally girls that want to use it. Some girls don’t, I’m not saying all, some girls don’t”. Andisiwe shared the same experience: “The people who have a problem with the condom are the guys, they really don’t like the condom. They say it takes time that thing. You can’t eat a banana with the peel on”. What Andisiwe is referring to here is that condom is a threat to sexual pleasure. This can also be seen in Skinner’s research, he found that: “Students generally complained that condoms ‘disturbed’ sex. The
important point is that the experience of sex as an immediate reality was considered far more important than the future threat of AIDS” (Skinner 2001:18-9). He also adds that: “Physical needs rapidly overpowered their knowledge of protection, and excuses were made for not using condoms” (ibid.:21).

Returning back to girls and their difficulties in negotiate condom usage. Nwabisa made an example of a situation where it would be hard for a girl to stand her ground: “Sometimes it is because this guy that you are dating is the cool guy, the it dude, every girl wants him. So, now once you ask him to use a condom it is going to be weird because you are even surprised why he is with you. You cannot negotiate things like that, because you feel like he is too cool, he is going to ditch you if you want to use a condom” – Nwabisa. When I asked Vusi what the reasons for the spread of HIV among youth are she answered: “They are just careless. They are just doing what their boyfriend is saying they must do. If the boyfriends says – I want it without a condom then you just say yes”. But aren’t people afraid of HIV? I wondered. “They don’t seem to be afraid, it’s like they, it’s not for them. It’s for others” she answered. “So they have this thought that no, it’s not going to happen to me?” I repeated. “It’s not going to happen to them” she asserted. “But what if it happens, what are they going to say then?” I asked. “They would just get frightened then, otherwise they don’t mind it, because no one seems to be more focused on HIV, especially the young ones. It doesn’t seem like they can have it or they will have it” Vusi continued.

I find that Walker et al. (2004) explain in a comprehensive way how sex is connected to sociality, power and the context which one is in. They emphasise that:

Sex is social – whom we have sex with, how and where we have sex, our views about sexual morality and even the objects of our sexual desire are not necessarily individual choices. The environment which we live influences the extent to which we are able to control these choices. Sex is also about power – who initiates sex, who makes the decision, who decides whether or not to wear a condom. These decisions are contested because relationships between men and women are unequal. In order to make sense of the AIDS epidemic we need to look at the social context and power dynamics that inform sexual behaviour, and understand sexual relationships and gender inequalities between men, women and children. (ibid.:22)

From what the gBs are describing, girls are clearly submissive in relationships, this stands in line with what researchers have found, as argued by Walker et al. in the introduction, women are submissive to men and strive to please them not only in their relationships but also in the wider community (Nduna et al. 2001:9 in Walker et al. 2004:31-2). And, as brought up in the introduction and in chapter 2, boys do not take no for an answer. So, as Vusi explains, “If the boyfriends says I want it without a condom then you just say yes”. There seems to be little for girls to oppose guys.
And, as Skinner (2001) puts it: “Because women have to ask their male partners to use a condom, they do not have direct control, especially in a highly patriarchal context” (ibid.:26). The power relations here are unequal which has to do with the masculinity ideals where guys dictate the terms of sex with their partners since this is a feature of successful masculinity as explained in chapter 2 (Wood & Jewkes 2001:326). As Nwabisa mentions above, you are afraid he will ditch you if you suggest condom usage. And again, as described by Wood and Jewkes (2001), there is an impending risk of violence for girls if they try to dictate the terms of the relationship (ibid.:319).

Another big issue here is that youth do not perceive themselves as susceptible to HIV, as brought up by the gBs here and in section 5.2. This is also confirmed by statistics: In a national survey from 2012, 39.6% of respondents aged 15-24 years believed that they were ‘definitely not going to contract HIV’ and another 39.6% that they were ‘probably not going to get HIV’. Which suggests that a large majority of respondents (79.2%) believed that they were not at risk of acquiring HIV (HSRC 2012:88). The most common reasons for respondents believing they had a low risk of contracting HIV included: faithfulness to one partner (32.0%), trust in that partner (22.5%), abstaining from sex (21.3%) and using condoms (19.2%) (ibid.:xxxvii). Peltzer and Kanta’s (2009) research also support this, they found that Xhosa indoda men aged 16-25 years felt knowledgeable about HIV, and, did not see themselves as susceptible to HIV (ibid.:92).

**We play with fire even though we know that we are going to get burned**

There are also other reasons why youth do not use condom. Nwabisa had an interesting input here:

> It [HIV] also spreads because the youth is informed but some of them are close minded, in their own little box. We chance everything, once I tell that you can use an injection to prevent pregnancy and you can use a condom and you can get tested, they think okay, I am going to use the injection to prevent pregnancy and I am going to get tested with my partner. And then that makes it OK for us to not use a condom. Not knowing that your partner might be having other partners, and then they become stubborn and close minded by thinking that you are the only one. I am not saying that every man cheats but you never know. So yeah, we try to find the little mouse trails out of everything in order to run away from using the condom. That is why it spreads so much amongst the youth. Even though, as my mum always says, they were never informed about anything, we know about everything. We are taught in schools about everything. Teachers talked to us about sex and everything. Even though it’s happening [HIV is spreading], we still test the water. We want to see, it’s like we are little kids who want to play with the fire even though we know that we are going to get burned.

From what the gBs shared, it seems quite rare for couples to use condoms. Above, Nwabisa is pointing out that once a girl is using the injection to prevent pregnancy she has that part sorted out, she does not have to worry about getting pregnant. Which from my understanding, makes it easier
to neglect condom usage. Furthermore, Thulani explained people’s lack of interest in condoms with the fact that life is full of uncertainties, and, you never know when you are going to die anyway. The only thing you can be sure of is that you are going to die, sooner or later:

I wish I could change ones mind set to just listen and stop being ignorant. Because HIV is alive and it is there, no matter where you go or what you do. And people are just being ignorant in such a way that they don’t care. If they carry it, or if they don’t carry it, they don’t care. Because they know that one day they will die, even if they die from HIV or even if they die from anything. They know that one day they will die. And some of them use that, they put that mentality in their mind and they use it in such way to ignore some other serious stuff. Because since he knows he is going to die, he doesn’t care if he gets HIV or if he doesn’t get HIV. Because he is going to die eventually. So I don’t care even if I die tomorrow, because I don’t know, I might go out of this door and go out to the gate and someone will come and stab me for any reason. – Thulani

Seen from this, HIV is not prioritised when there are more immediate risks to handle. As Thulani points out, you might just as well getstabbed when you leave your house. So, when there are more acute problems or threats to take into consideration, preventative measures against HIV just does not end up high on the list. Leclerc-Madlala stresses that also “[…] socio-cultural and economic factors may override fears and concerns about unprotected sex and the possibility to acquiring AIDS. These include pressure from both partners to prove fertility, culturally-conditioned lack of decision-making power, economic dependence on men, and having sex for social acceptance and affirmation of love” (Leclerc-Madlala 1997:376). Some of these factors brought up by Leclerc-Madlala I find connected to women and them being submissive, such as culturally-conditioned lack of decision power, which has been explored above already.

**Not using a condom as a sign of true love**

There is also a symbolic dimension to not using a condom that Andisiwe shed light on. She stated that: “The girls don’t have big bones to use condom. To them it is proving how the guy loves you. If he loves you he wont use a condom, if he is he has someone else”. Here, not using a condom is interpreted as an affirmation of love and as an ensuring that you are the only one. The findings of Skinner (2001) point in the same direction: “The issue of trust was advanced as an argument against using condoms. This was then extended to the discourse on love: if you loved and trusted someone you didn't have to use a condom. It was interesting that one of the major arguments for serial monogamy, i.e. love and trust, was now being given as an argument against another safer sex behaviour, namely condom usage” (ibid.20-1). “Furthermore, wanting to use a condom could imply that you do not trust your partner or you think that they have an STD or AIDS. ‘The main reason is that of trust. Sometimes they think you want to use a condom because you do not trust
them. To them using a condom is an insult” (Skinner 2001:20). Skinner (2001) also elucidates another reason to why youth are reluctant to condom usage, he found that:

A distinct problem involving condom usage was that it had implications for the youth in relation to their perceived sexual image. Wanting to use a condom reduced a person’s status and raised fears of rejection. Condoms were associated with STDs and AIDS, or with people who sleep around and so are at risk. To get that label or even to be associated with it is very detrimental and would certainly reduce a person’s sexual and social status in the community. (ibid.:19)

At the time I joined Nwabisa to a high school they were discussing condom usage amongst other subjects, and I recall that one of the guys in the class explained how he used condoms with all of his sexual partners except with his first girlfriend. He seemed very pleased with this and I got the impression that he wanted recognition for it. However, Nwabisa tried to explain that the youth should use condoms with all their sexual partners. The discussion was vivid, but unfortunately I was not able to take part in what was said there and then due to them speaking mainly Xhosa. What he said regarding his condom usage did not make sense for me at the time, at first glance, for an outsider, it might be seen as a paradox how not using condoms is understood as an act of love and as a way of showing concern in this context. To hear that people only use condoms with partners who they are not that close with in relation to their first girlfriend due to these reasons confused me, but in the light of this it all comes together. A very interesting point connected to this, as Skinner’s research found, is that there seem to exist competing knowledge systems simultaneous. He illustrates that: “Competing knowledge systems relating to means of protection were also found. A number of respondents indicated that trust in their partners was a defence against contracting HIV. This concept is difficult to interpret, given most of the respondents had more than one partner” (Skinner 2001:11). Trust in their partner was also a factor mentioned in the HSRC report from 2012, where most respondent answered that they saw the risk of them acquiring HIV as slight (HSRC 2012:xxxvii). Here, I would like to stress the importance of what Baxen and Breidlid concluded regarding this, they point out that: “… it would seem that even when readily available, ‘knowledge’ does not necessarily protect teenagers because some South Africans are constructing their sexual identity and their safety from infection in terms of competing knowledge systems (Skinner, 2001) and within contexts that produce, reproduce and send conflicting messages to the youth” (Baxen & Breidlid 2004:16). I find that this aspect is crucial to constantly keep in mind whilst trying to explore why the HIV incidence is declining slowly. The more we learn about the reality the youth are navigating in the more pieces of the puzzle we find.
5.8 Condom is a modern thing – what did our forefathers do?

There are also reasons to why youth are not using condoms that are rooted in historical explanations where the condom is seen as a modern thing. Nwabisa illustrated this by reporting that:

Some people don’t want to use condoms because it doesn’t give pleasure. Some people don’t use condoms because they feel it doesn’t fit or its painful when you put it on. Using a condom is an urban thing, it’s a modern thing. What did our forefathers do? Why should black people be using condoms when our forefathers didn’t use those things? I actually had a conversation with a guy about this. He said it’s something that came nowadays and that we are sat into the urban life apparently, and that there is no such thing as HIV.

I believe that this is connected to the circumstances in the beginning of the HIV epidemic, HIV came “out of the blue” in a way. It is something that is invisible in many aspects. You do not notice when it infects you, nor can you tell if someone has an HIV-positive or negative status by looking at them. This makes it hard for people to relate to HIV, since it is hard to grasp. As Skinner stress, people tend to want to see a disease to comprehend it, before altering their behaviour (Skinner 2001:10). And also, some are wondering what the origin for HIV is. Where does it come from? It seems like a piece of the puzzle is missing here. As Lungile expressed himself: “It’s a virus but no one knows where it comes from. I am still trying to find more information about that, I am still asking”. Skinner (2001) demonstrates that:

Scientific explanations of HIV have two major weaknesses that undermine the credibility of the information: namely, uncertainty about the origin of the disease, and lack of clearly identifiable symptoms. Most respondents found it difficult to believe that a disease as devastating as AIDS could have no history and no visible symptoms for most of its life cycle. The key argument, "How come it did not affect my fore-fathers who had many sexual partners?" was felt to be unanswered. (ibid.:12)

Since the HIV pandemic happened in the 1980’s it is a modern phenomenon. The fact that HIV did not exist among their Xhosa ancestors has harboured a seed of doubt in some. Which, as mentioned, affects how some relate and react to HIV. Yet another explanation to why youth are not using condoms has it origin in the view of sex as a natural act. As mentioned earlier, our forefathers did not use condoms and unprotected sex has been a natural thing since the beginning of humanity. Thulani pointed out that:

Let me be specific, when you are talking about HIV you have to talk about sex. And then sex is a big issue for us youngsters because we tend to ignore HIV just because we say sex is, it taste nice or it is good for us because we love it, and it is natural. Most of
the youngsters say it is natural for a vagina and a penis to cling. Once a month or twice a month or trice a month. So, some of them don’t use a condom. – Thulani

Again, Skinner (2001) presents similar findings in his research: “There is a perception about what is ‘natural’ or ‘unnatural’. Sex is perceived as a natural, enjoyable experience, into which ‘unnatural’ phenomena should not be introduced” (ibid.:18). As mentioned in section 5.7, condom can be experienced as a threat against sexual pleasure. Above, Nwabisa also mentions that there exist a notion of – our forefathers did not use condoms so why should we? I believe that the confusion here can be derived from what Breidlid explains, that: “While it is acknowledged that often tradition is subsumed in modern practices and vice-versa, tension can exist where communities are still very traditional and youth are influenced by both tradition and modernity, thereby making difficult the challenge of navigating their way within social and cultural practices that are fluid and sometimes contradictory” (Breidlid 2002 in Baxen & Breidlid 2004:20). Here, I must add an emphasis on the role of the ancestors for Xhosa people. According to my informants, ancestors play an important role in the lives of Xhosa people (see e.g. Ainslie 2014), no matter if they are modern or traditional, they have a strong bond to their ancestors. This will be demonstrated below where Xolela describes ulwaluko.

**Ulwaluko: Keep the legacy and bring us babies**

As we saw in the theory chapter, the ulwaluko ritual is crucial in the construction of hegemonic masculinity for Xhosa males (Mfecane 2016). It is through ulwaluko that the boy evolves into a man, an indoda. I have argued that ulwaluko intrinsically can be seen as a ‘manhood act’ as Schrock and Schwalbe (2009) define it, since it is the only route to acquisition of the hegemonic masculinity (Vincent 2008:440, Mfecane 2016). While conducting the interviews with the groundBREAKERS I never explicitly asked about ulwaluko, since I knew that it is surrounded with secrecy and that it is frowned upon to talk about with non-initiates. Thus, my ethnographic material is very limited, and I draw heavily on other sources here when discussing ulwaluko. However, the conversations slipped into the subject during the interviews with both Thulani and Xolela. With Thulani it happened when I asked him regarding multiple partners. I asked if he experienced that it is common for guys to have multiple girls? He answered that it is very common for guys to have multiple partners due to girls loosing their reproductive ability at some point. Thulani said:

Yeah, it is very common. Since for girls, when they reach the age of 30 or around 30-35 the reproductive system of a lady, there become complications there. Mainly because [they] are using the needle, after effects of the needle can damage your womb. Guys tend to think, – yeah we don’t have a womb so nothing is going to get damaged for us. So, guys think that when girls reach a certain age, nothing is going to be produced. But
for us, our sperm produces even after that age. Even after we reach 60 we can still produce babies. So that’s what guys put in their mind. That when girls reach a certain age their reproductive system is not going to work in a healthy way so why have one girl? Even at a young age, some of them, their reproductive systems don’t work in a healthy condition. So why not have many? Because I am a guy, I used to think that too. Why not have many girls? Than have one person who in five-six years to come, is not going to give you a proper baby?

Here, I responded: “But then you say that sex and making babies are like the same thing? But I mean sex for pleasure. Because men have a lot of partners here for what I have heard, and even though you are married or in a serious relationship guys are seeing other girls if he can, so that’s more of a structural mind set of the guy? I don’t know if society here expects men to be faithful or if its so common to ...”. Here, Thulani interrupts me and says:

According to our culture we go to the bush23, we go for circumcision, in our way in our culture. And, what you get there make one do certain things that are out of line. Because our society don’t expect us to be faithful in a way. So, many guys tend to get hold of that information that they get there, and use it. They don’t say, – go for many girls, but they say, – bring us babies. In a marital status kind of way. So, some of them get that information and then they use it, embrittle it, because this was said. It was not said in such a way that go and cheat and have 100 girls for you to feel like now I am doing what was said to me. But, they use it in a way that is not said to them. They take over advantage of the situation that they have, and when they need a girl they just think OK this should happen.

“Isn’t that like a clash from one point, the traditional side, make babies, and then modern society where almost every girl here takes the needle for contraception so there wont be any babies?” I asked Thulani. He explained:

No, it’s not a problem for youth. Young people, not only from here but from all over the world, or from various countries, they tend to think that when girls use the needle it prevents them from HIV, it prevents them from STI and STDs. But they don’t know its only the baby. Whereas the youth don’t have a problem with not getting a baby, they don’t have a problem. All they want is the pleasure and the sex, that’s all. So that’s why I am saying that around here, since we go to initiation and all that stuff, they use that information that they get there to their advantage. When they see girls they think of sex and pleasure, that’s all they think about. They don’t think about babies, that’s why we have those who make babies and run away, they don’t want to take care of the babies. So that’s practically what happens.

Here, I wanted to make sure that I understood Thulani so I asked him again: “Yeah but still, why do you think they have multiple partners? If they don’t want to make plenty of babies?” He answered:

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23 The expression “going to the bush” refers to ulwaluko.
That’s pleasure sweetie. Pleasure. Because you get one girl and one guy. The guy wants the girl because the girl is too curvy. And then you find out that when they meet, to probably have sex, the girl doesn’t please the guy in a way that the guy wants, I put it that way because us guys like to be pleased. We don’t just want to have sex, but we want to be pleased in our way. So, if you don’t please me in my way that I like, if, let me put it plain for you to understand, if you don’t do the styles that I want you to do, then you are not what I am looking for. Then I am going to the next person.

I continued: “Yeah but I mean, if you have a relationship with a girl you like, and she is good in bed but then you have other girls outside the relationship. Because that happens a lot too?” Thulani answered:

Yeah, it happens. That one goes to the sense of, we as guys we would probably say that I cannot drink water every day. I will have to drink juice or coke or.. that’s what happened with us guys. Even though you have your girl and you like her and there is no problem with her, you tell yourself that you cannot drink water every day. You have to have something that has another chemical, that does things a different way. Because juice does not taste the same as water.

The quote above is very symbolic, however, I think Thulani’s message stands quite clear. He describes how men expect to be sexually pleased, and that if they are not, they move on to the next person. Here, the sexuality of men seems to stand over the sexuality of women and as found by multiple scholars, men tend to dictate the terms of sex with their partners (Wood & Jewkes 2001:326, Walker et al 2004:20, Squire 2007:27). As showed in the introduction, Walker et al. stress that males use biology (the male sexual urge) to justify having sex on demand (Walker et al. 2004:32). And as explored in the theory chapter, Vincent claims that “multiple sexual partners with or without consent, is thought to be an incontrovertible male right” (Vincent 2008:443). The dominant male sexuality also makes women submissive since, as brought up by Nwabisa in section 5.7, girls are afraid of suggesting condom usage, due to fear that the guy will then leave her. Or as brought up by Vusi in the same section, “[Girls] are just doing what their boyfriend is saying they must do. If the boyfriends says – I want it without a condom, then you just say yes”. It seems to be a viscous circle where the submissiveness of women is fuelled by these dominant sexualities that also fortifies the same submissiveness. As stated by Connell, “Gender arrangements are reproduced socially (not biologically) by the power of structures to shape individual action …” (Connell 2009:11). These constructs of dominant male sexualities help males claim membership in the dominant gender group and they also make sure that males maintain privileges over women, hence they are ‘manhood acts’. As stressed by Wood and Jewkes, successful masculinity is, among other things, defined in terms of men’s ability to control women. And, these controlling strategies include their attempt to dictate the terms of sex with their partners (Wood & Jewkes 2001:319, 326).
In the previous sections, Thulani also described how indoda men are taught to “bring babies”, which I understand as an exhortation to ensure the survival of the Xhosa people. However, Thulani express that this message has been modified by men to instead function as an excuse to have multiple partners, and not only that, but also to justify it. This stands in line with what Vincent stresses in her article: “The role that circumcision schools once played in this regard has been eroded, to be replaced by the emergence of a norm in which circumcision is regarded as a gateway to sex rather than as marking the point at which responsible sexual behaviour begins” (Vincent 2008:432). Having multiple partners can also be understood as a ‘manhood act’, since it, as explored, fits every point in Schrock and Schwalbe’s (2009) definition of a manhood act. To refresh your memory, they define a ‘manhood act’ as: “the identity work that males do to claim membership in the dominant gender group, to affirm the social reality of the group, to elicit deference from others, and to maintain privileges vis-à-vis women” (ibid.:289). As already brought up in section 2.4, Wood and Jewkes found that multiple sexual partners was a defining feature of ‘being a man’. The actual number of partners acquired was important in their positioning among male peers, having many girlfriends shows status and other men start respecting you (Wood & Jewkes 2001:321). Skinner’s research point in the same direction, he found that: “Lifetime monogamy was not considered as a possible choice by any of the youth interviewed. Even the option of serial monogamy was responded to with doubt, especially by the males. This appeared to arise mainly out of a culture of male dominated sexuality, where promiscuity is a point of pride and status. The more partners a man has the more he is respected and considered to have power in the community” (Skinner 2001:13-4).

With Xolela, the conversation slid into ulwaluko when I asked him about HIV preventative operations. I expressed that: “… circumcision, they say that it might decrease the risk of STDs?”. Xolela answered: “I don’t know much about this medical thing because I don’t feel comfortable talking about it”. “You don’t feel comfortable?” I repeated. “But, has not loveLife forced you to listen to these kinds of ...” Xolela interrupts me and says: “Yeah, I have listened to it. But they understand that we males, especially Xhosa, we are not comfortable talking about it and we have told them. They know” – Xoela. I then continued: “What are you not comfortable talking about? Circumcision?” Xolela responded: “Yeah, this medical circumcision. It’s not working for us. I am the Xhosa, I went to initiation school in the Eastern Cape. [If] I am here [at loveLife] preaching about medical circumcision, people will throw words on me when I walk pass them. I would loose my dignity”. Here, Xolela explains that as a gB he has a neutral stance: “On this one I say, if you feel like going to the hospital it’s fine, you can go. But, if you feel like going to the bush then you can go, it’s fine”. Yet, he was not comfortable advocating for medical circumcision. I then asked Xolela regarding circumcision (referring to ulwaluko), and how he anticipated the future of it?
wanted to hear his thoughts on for how long Xhosa males will get circumcised? Did he think that at some point one generation would stop performing it? He answered: “I believe it will never stop”. “Because it is so deep into the culture?” I asked. “Yeah. We are different here in the country and we have the royalty, which are our kings, those who have passed on. So, we are keeping the legacy of Xhosa and keeping the legacy of our ancestors. I have to do it because my grandfather and my grandmother ...” Here I, unfortunately, disrupt Xolela and ask: “And your kids will do it?” “Yes”, he replied. “Because if you are an ‘old boy’ you are getting disturbed in the brain here, my culture beliefs that. Once you become man then you focus because it is not easy to be a man. So that’s maybe why we think we should do that [ulwaluko]. To be strong, and keep the legacy”, he responded.

I ended up interviewing Xolela twice, what has been said until now stems from our second interview. The time ran out in our first interview when Xolela told me about some life changing events, gangsterism and prison life. Here, during our first interview he also demonstrated the importance for Xhosa people to practice their culture. He told me that he used to have a very poor health when he was younger, and explained that this was due to the fact that his family neglected him. Xolela grew up with his grandparents in the Eastern Cape and he expressed that their love was not enough to also include him, they did not love him like a son. Neither did they make any sacrifice for him, for example, did they not slaughter animals for him, which according to Xolela is essential for the prosperity and good health of children. However, when they finally did and he ate the meat and drank the blood, and talked to the ancestors, he got well again. Xolela explained that: “You must do your culture otherwise your children will get sick when they grow up. Family is important, even if you do not get along, you must get along when it comes to practicing the culture”. He then continued and said: “We believe that if we do not do culture it will affect us. It is happening, people get mad out there because they are not doing their culture”.

Seen from this, ulwaluko is deeply rooted in Xhosa culture. And, as Xolela is portraying, if you do not practice your culture, it will not only affect you but also your children in the future. Furthermore, he points out the importance of successfully undergoing ulwaluko, when he says that “if you are an ‘old boy’ you are getting disturbed in the brain here, my culture beliefs that”. To clarify, by ‘old boy’ he means a male that has reached, or exceeded by far, the age for undertaking ulwaluko, who has not done it or has not successfully finished the rite. As explored in section 2.4, being a “boy”, or an ‘old boy’ is irrespective of the males age or social status. Xolela explained that: “If you go to the hospital [during ulwaluko] you will loose your manhood title. They will call you names, it is a stigma in a way”. He then continued and said that: “Then you cannot attend certain rituals, you cannot negotiate lobola [bridewealth]”. Here, I asked him if there is a hierarchy? “Ranking?” he responded. “Yeah, like the boss ...” I said, when he interrupted me and stated that:
“There is no boss there, it is just the way we talk things. And the way we do things”. “But there is a ranking because boys [uncircumcised males] are lower?” I continued. “It is like boys don’t count” Xolela replied. “Yeah exactly” I said. “They are not lower, they don’t count. They don’t show up in the picture”, he concluded.

Here, Xolela clarifies how ulwaluko as a ‘manhood act’ secure the dominance over others, being an indoda man is the hegemonic masculinity, as researchers have pointed out (e.g. Mfecane 2016, Mavundla et al. 2010). And as explained by Ntombana (2011) “anyone who is not circumcised is not regarded as a human being in the community; the person who has not gone through initiation, has no moral standards” (ibid.:635). Therefore, it is only indoda men who are given certain rights, such as the right to negotiate lobola, or to inherit property (Ndangam 2008:212, Ntombana 2011:635).

5.9 Sugar daddies

When discussing the reasons for the spread of HIV among youth with the groundBREAKERs the phenomenon of ‘sugar daddies’ came up. However, my ethnographic material on this is very limited, thus I cannot make too strong conclusions.

‘Sugar daddies’ are men who provide their partners with material resources in exchange for sex. Typically the ‘sugar daddy’ is considerable older than his partner, however this does not have to be the case. Yet, a parameter that is always present in these types of relationship is an imbalance of power, where the ‘sugar daddy’ has the dominant role. Nwabisa exemplified these power structures by stating that: “It [HIV] also spreads amongst the youth because we have what we call ‘sugar daddies’, where this older guy provides for you, buys you everything and you don’t have the platform to negotiate safe sex because you know that this guy is buying you. So who are you to tell me about condoms?”. When discussing ‘sugar daddies’ with Xolela he came to the same conclusion as Nwabisa, but also pointed out how poverty affects girls in several negative ways. He said:

[‘Sugar daddies’] is happening, but you know dating an old guy is violating a girls rights in a way because the old guy will supply money that expect more, expect to sleep with that girl. If that girl wants to use condom the ‘sugar daddy’ will say – no I don’t want to use a condom. If the girl is saying no then ‘sugar daddy’ will pull out response of money. Then she will feel like – who’s gonna give me money now? OK, I should go back, then get affected [by HIV]. Also, poverty is one of the things which pull them to ‘sugar daddy’, because ‘sugar daddy’ will supply food to the home. And prostitution is also one of the things which spread HIV amongst youth. Youth are getting tired of going to school, so they go to sell their bodies. We don’t use condoms, other costumers use

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24 Here it is important to point out that women are not without agency (as discussed in the end of section 2.4), and as Leclerc-Madlala explain, there can be a “mutual exploitation” in these relationships (see Leclerc-Madlala 2008:20).
condoms, some will not. So you get HIV there. Those are the things which affect the spread.

These sexual patterns where young females have relations with much older men (intergenerational relationships\textsuperscript{25}) makes them more exposed to HIV since these men usually have been sexually active for quite some time and thereby also have had several partners (Leclerc-Madlala 2008:18).\textsuperscript{26} It is suggested that intergenerational relationships and the phenomenon of ‘sugar daddies’ is one of the reasons for the disproportionate HIV rates between males and females in the same age span (ibid.). In section 2.4 where I explore how indoda men are created, I shed light on how Wood and Jewkes draw a parallel between the way young men relate to their sexual partners and historical ethnographic descriptions of traditional bridewealth systems [lobola] which include an idea of exchange and female duty. They explain that if a girl accepted a male ‘proposal’ to love, she would be expected to have sex whenever he wanted in return for gifts, money, being visited frequently and taken out to social events (Wood & Jewkes 2001:327). There seem to be a similarity regarding the power structures between the partners in a traditional bridewealth system and in a ‘sugar daddy’ relationship.\textsuperscript{27} Maybe the phenomenon of ‘sugar daddy’ relationships has developed from the traditional bridewealth system in this context? I will not immerse further into the subject here. Rather, to conclude, is seems like the new hegemonic masculinity ideals of indoda men and the ‘manhood acts’ expected from them, such as dominant male sexualities in different forms, create a breeding ground for HIV to spread among youth (Walker et al. 2004:59, Vincent 2008:436, Wood & Jewkes 2001).

Concluding notes
As can be seen in this chapter, the factors that contribute to the continued spread of HIV among youth in this setting are many. The nexus is complex and intertwined with sociobehavioural, cultural, political, historical and economical factors. In the next chapter I will explore how the groundBREAKERS think of HIV prevention and what they believe must be done to reduce the incidence of HIV among youth.

\textsuperscript{25} “[A]ge-disparate relationships generally refer to those in which the age gap between partners is 5 years or more. Intergenerational or cross-generation relationships usually refer to relationships with a 10-year or more age disparity between partners” (Leclerc-Madlala 2008:18).

\textsuperscript{26} Studies from southern Africa (Kenya, Zambia and Uganda) show that the larger the age differences the greater the association with unsafe sexual practices and HIV infection (see Leclerc-Madlala 2008:18). The same applies for South Africa (see Jewkes et al. 2006).

\textsuperscript{27} As also portrayed in Leclerc-Madlala (2008), research from Swaziland showed that “young women's sexual behaviours resonate with the traditional bridewealth system, as girls from an early age in Swaziland are enculturated with the view that their bodies are assets for transactions” (ibid.:20).
6. What could stop the spread of HIV among youth?

This chapter sheds light on the groundBREAKERs thoughts of HIV prevention in relation to the future. I was curious to hear their suggestions of HIV prevention strategies and to learn more about their notions of what needs to be done to reduce the spread of HIV. Here, I asked them: What could reduce the spread of HIV among youth? And, what needs to be done? The gBs had several different suggestions, some of them wanted to promote more HIV awareness through extensive outreach work and information dissemination. Whilst others stressed the importance of easily accessible condoms as a means of getting youth to condomize more, but not only that, they also requested more fun condoms with colours and scents. Some of the gBs had an optimistic outlook on the future whilst others were very pessimistic and stressed that the only solution to stop HIV would be for scientist to come up with a cure.

6.1 Preach

Three of the gBs stressed the importance of continuing the fight against the HIV epidemic through verbal communication. One of them was Andisiwe, who rendered that she liked the way loveLife are working with HIV prevention. She also said that it is important to talk about HIV and to try to convince people to listen. She explained that: “Some say – I have heard all this before, what you are saying. So you ask for their attention to listen even though they know. Then you can ask them to tell you what they know. There will be some information where they are wrong, and that’s where you correct them”. Her suggestion on how to reduce the spread of HIV among youth was to: “Preach, do what we are doing at loveLife. If we talk to ten people not all ten will hear you, maybe three will and they will then convince their friends”. Andisiwe had a positive outlook on the future and said that she believes that there will be an HIV free generation within our lifetime.

Thulani followed a similar line. He stressed the importance of peer to peer education and to share fact based information. He stated explicitly that: “People need to be taught of this, of HIV, and people need more information. And information that is scientific, information that is factual, not just information. Information that is very very factual. And people, those who know about stuff like this, even though it’s a little information, but if it’s factual, share it with the person that sits next to you”. He then continued by giving an example:

If you see that this person, maybe your next door neighbour or your friend, is doing something that is out of line, and you know that it’s out of line, why don’t you share that information that you have? So yeah, share information, no matter how little information you have. But if you know that that information is the information you should be telling
people, then share it. Don’t wait for us as groundBREAKERs, or people that are coming from Health [clinics], or people who are professionals, to talk about it. [If a next door neighbour does something that is out of line], I think one should stand up and say – no, what you are doing is not right to yourself. I care more for you than you think, so what you are doing to yourself is damaging your body in a way. – Thulani

Nwabisa also stressed the importance of talking to people. However, her focus was more on visibility and about getting the word out there. From her point of view politicians have tended to give HIV and other societal ills too little attention. Her idea of how to work preventative against the spread of HIV included the following:

I think we need to do more of these talks, go to churches, go to rallies. Where, instead of Presidents only talking about their parties and how we should vote for them, also talking about the social issues we have here. Because really, the last thing on my mind is voting for who ever. Because the first thing on my mind is trying to make a change out there. So, I am not going to think about politics at the same time because that is not the issue I have right now. The issue is that people are dying from HIV, and the issue is that people are dying from drug abuse, and people are killing each other because of domestic abuse. So, if our Government official could talk about these things, and not about them giving 20 million towards the Department of Health, but actually discuss the issues. There are shows on TV where they debate about these political issues, why not have shows where political parties debate about social issues? Or the President debate about social issues and how they can be sorted? I think that there is a lot we need to do in regards to the HIV prevention. Because some people they do not believe in condoms, and we need to change those minds, which is hard.

Here, I asked Nwabisa to elaborate on what else she thought should be done when it comes to HIV prevention. She then problematized how we need to get rid of the stigmas and the myths that are surrounding HIV. She expressed that:

My personal thoughts are that the stigmas are overclouding our judgement. The cynicism is overclouding our judgement. I think that when people get scared or when they get intimidated, they quickly get defensive and they quickly want to blame witchcraft, or want to blame what ever. They don’t want to deal with the situation at hand. And, I think if people don’t change their mindset HIV is still going to grow. Because these are our parents saying these things, and what ever a parent says a child hears, and then they speak to their peers and it spreads across the whole country. So, if people could just be open minded and change their mindsets then maybe we could decrease HIV and have an HIV-free generation. And that is what we are trying to do, we are trying to get rid of all those stigmas and get rid of all those myths, in order for people to realize that it [HIV] is a reality.
6.2 Distribute condoms – make them fun

Several of the groundBREAKERs stressed the importance of youth to condomize, yet, that in order for them to do so they need to have easy access to condoms. But not only that, the gBs also pointed out the importance of re-making Choice for it to become more user friendly so that more youth would start using it. Nwabisa declared that:

I think more condoms need to be distributed. I know it would be a lot of waste of money for the country but I think young people want to use these different flavours from the ones that they buy. I think that the things people say out there is – I’m not going to use Choice. Why would I want to use Choice? It’s a Governmental condom, it’s free. Things like that need to be addressed. Because you usually buy condoms, but today you don’t have the money to buy condoms, and you are telling me that you are not going to use Choice because it doesn’t go with your status? Things like that also need to be addressed. I think that is a mistake people make, maybe that one moment when they say they are not going to use Choice, and they don’t have other condoms, is the day that they actually receive the virus.

“So you think more people would use condoms if they were more fun? Like with smells and colours?” I asked. “I think so. I personally would. I would make it a point that I would have a whole stash of strawberry and what ever” Nwabisa replied. Another gB who also stressed the importance of condoms was Lungile. He expressed that the best way to prevent HIV would be to try to convince youth to condomize at all times, and, to only have one partner [at a time]. Here, I asked him if he thought it would be more attractive for youth to use condoms if they had access to condoms with different colours and scents? He answered that: “Yeah I think it would be, because every time I go to schools they ask me – when are we going to get the flavoured instead of the Choice? because we don’t want the Choice. Because Choice, the smell, wooh”.

At the time of my field study, there was only one type of condom that youth could access free of charge and that was Choice. As already mentioned, it was a regular condom but it had a distinct smell and it was drenched in an oil based lubricant. However, due to the decline in condom usage Choice got re-branded as Max in 2016. Here, they expanded the selection and added three scented varieties: a red one with strawberry scent, a purple one with grape scent, and a yellow one with banana scent.28

From Vusi’s point of view nothing within the preventative work against HIV needed to be changed except for peoples attitude towards the virus. She said: “[t]he HIV prevention is awesome, everything is right. The nurse is waiting for you to come, there is no problem. For me, how I see it, there is no problem. The only problem is us who doesn’t want to accept that we have HIV, that

28 There is also a forth variety: Max regular. I am not sure if this is just Choice in a new package or if they have improved it in any way. I hope to find research in the future that explores if these new condoms have increased condom use among youth.
doesn’t want to be seen by other people. So we deny those things that we have HIV, we don’t go for prevention”. Here, I asked her why she thought that people do not go for prevention? Vusi answered that: “[t]hey are ashamed of people to know that they are sick”. “Why?” I asked. “I don’t know” she replied. “Because it’s stigmatised?” I wondered. “Maybe it can be that. I don’t know because there is no valid reason for why they don’t go, except that they don’t want it to be gossip, to become the topic of the place or whatever. They just think it’s for other people, not for themselves. They are the ones that are sick, I don’t understand that” she continued. Here, I asked: “If somebody is HIV positive do people think that that person has been sleeping around a lot or what are they gossiping about?”. Vusi explained that:

They are just gossiping about that you have this disease. Some other times they don’t even care how you got it, they [are] just laughing at that you have the disease, that is what matters. They don’t even get why people say – you get it by blood [also]. The only thing that they know is that you get HIV when you sleep [with someone] without using a condom, with someone who is HIV. But you didn’t even know that he or she has HIV and AIDS, you just slept without using a condom.

After this, Vusi came with a suggestion on how to make youth condomize more: “Distribute [condoms] more into the public places where they can see [them]. Even if they throw them away we out them, then they will see [them]. The others will just take them even though they will be ashamed to take them in front of their friends. But they will know that when they go back, they will find them. So, we should put them even in taverns”. Vusi is advocating for the visibility of condoms in public spaces so that they are easily accessible and so that people know where to find them when they need them. Other than that, she was seemingly content with the HIV preventative efforts in this setting. In contrast to this, two of the groundBREAKERs had a considerably more pessimistic view on HIV prevention and the future.

6.3 The scientists have to invent a cure

Zizipho did not share the view of Vusi and Andisiwe who thought that the existing HIV preventative efforts are enough the way they are, rather, quite the opposite. She expressed that: “There is no hope in this country for things to change. And it’s really hurtful. Because there is no way people will actually condomize nor only sleep with one partner”. She then concluded that: “The scientists have to event a cure. What is the use of telling people how to live their lives, giving them ideas how to try to reduce the virus, but people do the same things over and over again? The scientists have to come up with something that will at least reduce HIV/AIDS”.
Another groundBREAKER who did not look too bright on the future either was Xolela. Before asking him about his thoughts of what needs to be done to reduce the spread of HIV among youth I first asked him regarding how he saw HIV, if he thought of it as a problem or not? He answered that: “It is a big problem in a way, it is. It is invading the country in a way because almost every day a certain number are getting affected. And, it is not curable. There is no way in which you can decrease it, decrease the number. It is only going up, which is, it is invading the country. It will kill the country soon enough if we don’t find a cure”. When it comes to strategies for HIV reduction he came with a very creative suggestion. He said that if a law would be implemented that would force all youth under the age of 25 years, with an HIV-negative status, to move and to stay away from the rest of society for a long time, then things might change for the better. In his scenario, boys and girls would be separated from each other and they would receive education and information regarding HIV and other diseases, in their separate locations. Xolela then got quiet, he pondered for a while and then continued, “[i]t would never happen, but if we can be separated we cannot have any AIDS. Youth are the ones being affected by HIV because the ones who are old they are responsible over themselves. And those who already have it, they are treating it. So it’s only we who are not taking anything serious”. Xolela then added another thing, that if alcohol consumption would become prohibited then the incidence rate of HIV would probably also decrease. He said: “[t]he other thing is that if alcohol can be banished, because when we drink we get irresponsible, that’s why most people get infected. If alcohol can be banished out from the country, then maybe the numbers can go down slow”.

As can be seen, the groundBREAKERs had a variety of different suggestions on how to prevent HIV from spreading among youth. Let us now move on to the final discussion.
7. Concluding discussion

Few can question the influence of gender, poverty, violence and cultural norms on the spread of the disease. However, there is no single explanation for the HIV/AIDS epidemic in South Africa. A unique combination of factors influence the pattern and profile of the epidemic. The mix of poverty, violence, and rapid political change, migrancy and sexual networks has created an environment in which the disease is spreading at an unprecedented\(^{29}\) rate. (Walker et al. 2004:20)

The aim of this study was to describe and analyse perceptions of HIV and of HIV prevention among Xhosa youth in the township of Langa, Cape Town. I wanted to gain knowledge on what fuels the HIV epidemic in this context. To do so, I examined the thoughts and notions of the groundBREAKERs working at loveLife. I wanted to explore how they related to HIV/AIDS, sexuality and sexual behaviour, since, the incidence of HIV is declining slowly among youth, and I wanted to know why. To understand this better, I wanted to get a glimpse into young people’s life worlds, I wanted to listen to their stories since they are the only ones who can share their lived experiences.

Through my research, I found that the challenges are many in the preventative work. The groundBREAKERs had to navigate in a context where it is hard to talk about HIV and sex. One of my findings included that youth do not use condoms and do not want to use condoms. This derives from a number of components. Some of the factors important in the decision making of condom use include: sexual pleasure (“you can’t eat the sweet with the paper on”), the view of unprotected sex as something natural (“our forefathers did not use condoms”), the fear of being perceived as someone with HIV when suggesting condom use, lack of decision power (for girls), and the belief that HIV will not affect them, a mindset of “it will not happen to me”. According to Thulani, this thought might be derived from the complex of problems of parents not being open about their HIV-positive status towards their children. As he explained it, it is hard for youth to relate to HIV if it has not happened to anyone in their family or close surrounding. However, as showed in this thesis, it is not easy to be open with an HIV-positive status in this setting. The gBs described how others will mock you once they find out that you have an HIV-positive status. Xolela also explained how whole families are seen as “HIV victims” if one family member has acquired HIV. And by this, he meant “HIV victims” as in, they are all HIV-positive. The fear of social alienation and the stigma that has followed HIV since its beginning make silence the dominant response to HIV (as also found by Squire 2007:3, Ban ki-Moon in Washington Times 2008-08-06). Many aspects of living with HIV/AIDS remain unspeakable, which in turn has led to HIV attitudes.

\(^{29}\) Note that this was written in 2004. The spread of HIV is today declining, yet, in a slow pace.
where it is being considered an insult to ask someone “what is your HIV status?”. Thus, getting
information regarding a (sexual) partners HIV status is quite complicated as it seems. My empirical
findings have also suggested that knowledge of your own HIV-positive status might not lead to
HIV-preventative precautions but rather the opposite, since, people might want to share the burden
of having HIV with others, thereby spreading it on purpose. Leclerc-Madlala (1997) found that: “If
you think you’ve got it, spread it. This seems to be the predominant ideology shaping the sexual
activities of young people in the HIV/AIDS epidemic” (ibid.:371).

My material shows, as also stated by many researchers (e.g. Dilger 2010, van Woudenberg
1998:30), the importance of exploring HIV and AIDS in its specific setting and cultural context.
This, is to increase the understanding of how the virus and the disease could be interpreted and
analysed, both in relation to the past, the present and the future. The South African society has made
a great progress since apartheid, however, there are still major challenges in its aftermath. The
structural violence that was incorporated in the apartheid system still exists in many forms and my
findings need to be understood in the light of this.

The biomedical model in HIV prevention

As explained in section 2.1, the biomedical model has been used to a large extent within HIV
preventative efforts. The model assumes that information = knowledge = belief = behaviour. Thus,
the take off point is that information will lead to behavioural change (Dickinson & Deutsch 2009:5).
The way I see it, this is also the stance that loveLife sets off from. The tool in their HIV
preventative efforts is based on peer education where the groundBREAKERs are assigned to create
change within the target group (youth between the ages of 12-25 years). Their mission statement is:
“To promote social activism for healthy living, active lifestyles and HIV consciousness among
young people; through: –Advocacy –Information, education and awareness campaigns –Healthy
living and behavioural change interventions –Youth development programmes” (loveLife 2017a).
They claim that their innovative youth development programmes are addressing the societal ills,
although, one can problematise whether these programmes are really making a vital difference.
However, I will not go deeper into the subject here since my role is not to evaluate their
programmes. Rather, I will explore another topic that has been present in this thesis, namely the
question whether youth are HIV educated or lacking in knowledge.

According to the experiences of the groundBREAKERs many young people relate to HIV as
something that would never happen to them, they see it as something that could only happen to
other people. The gBs associated this with youth being “close minded”, “in their own little box” and
that they are “playing with fire”. The gBs expressed that HIV is spreading due to ignorance and lack
of knowledge. But at the same time many of them also pointed out that youth are well educated
regarding HIV, and, that there are sources of information easily accessible for them. When I asked Xolela if youth in Langa are well informed or not? he answered that: “Here they are informed, well informed. Because this is an urban area so there are many organisations that are preaching it, HIV books, magazines, also loveLife, and clinics. I can’t see any excuse of not having information, I can’t see it”. Clearly, there is an ambiguous message from the gBs side here where they are saying that youth are educated but at the same time they also claim that people are uneducated. However, I would like to point out here that these two expressions do not rule out each other, since, it seems evident that there is not necessarily any correlation between what people know and how they behave. Youth can be well educated in HIV but still keep up with high risk sexual behaviour. And here is where the biomedical model fails. Another important factor to point out here is also that knowledge do not protect one from being exposed to HIV by others. As Thomas points out: “[b]y focusing its prevention efforts on effecting change in behaviour at an individual level, the loveLife campaign elides the multiple socioeconimic factors that are determining factors in the spread of HIV” (Thomas 2004:30).

Multiple scholars have found that youth are well informed when it comes to HIV and HIV prevention (Stadler 2003:366, Campbell & MacPhail 2002, Skinner 2001). As Skinner (2001) shows, for example: “The youth know about AIDS, how it is transmitted, and how to protect themselves, but there are too many pressures in terms of the prevailing sexual norms for condoms to be widely used” (ibid.:17). However, in contrast to this, surveys and statistics as presented by UNAIDS and HSRC have indicated that youth are not that educated in HIV: “Knowledge about HIV prevention among young people aged 15-24 was 45,8% in 2016” (UNAIDS AIDSinfo). And, in the South African National HIV Prevalence, Incidence and Behaviour Survey from 2012, it is stated that: “Knowledge of other HIV risk-reduction measures, such as faithfulness, partner reduction and abstinence, are reported to also be relatively low. This suggests that promoting HIV-related knowledge and awareness should remain as a focus area” (HSRC 2012:4). Now again, the question that comes to my mind here is: would people really change their behaviour in relation to knowledge of partner reduction, faithfulness or abstinence, as HIV preventative strategies? The findings in this thesis indicates that it is not as easy as that. As stated by Deutsch and Dickinson, “[t]elling people what they should do to help themselves does not stop unhealthy eating, smoking, drinking, or reckless driving. Nor is it stopping AIDS” (Dickinson & Deutsch 2009:4). Even so, as Baxen and Breidlid points out: “the majority [of HIV preventative initiatives] are still driven by the need to know ‘what’ knowledge youth have with the view to providing them with ‘more’ knowledge even in the face of its ineffectiveness” (Baxen & Breidlid 2004:22), as this is the foundation of how the biomedical model functions.
To conclude, the biomedical model is excluding too many pieces of the puzzle to function properly within HIV preventative efforts. It does not include the context and cultural factors such as: How do youth perceive HIV? How do they live with HIV? How is it to live surrounded by HIV? How is it to live with the risk of acquiring HIV? How is it to live with the fear of getting HIV? We cannot analyse these questions from a stance based on our frameworks as outsiders. I believe that this is important to keep in mind at all times because otherwise there is a great risk that we will underestimate the problem. Which leads to a mindset of “can’t they just”, (insert: use condoms, not have multiple partners, stay faithful etc.). Admittedly, I had myself a biomedical starting-point when I initiated this research and I could not comprehend why youth were not using condoms in a setting with high prevalence of HIV. However, it now stands clear that we must meet HIV and its complex of problems from another angle. The assumption that knowledge will lead to behavioural change seems too simplistic. With this understanding, the question why is HIV spreading even though youth are (well)educated is irrelevant. HIV prevention must be something else than just knowledge. But what then? I believe that sociocultural factors need to be addressed further, and, as I have indicated in this thesis, a gender perspective is essential. However, public information, HIV campaigns, as well as HIV programmes in schools have tended to not address gender inequities historically (Squire 2007:16).

**A masculinity approach to the drivers of HIV among Xhosa youth**

Discrimination against women both in sexual relationships and in broader social relations is embedded within the social, cultural and religious assumptions and discourses of most societies struggling with the HIV epidemic. (Boesten & Poku 2009:13)

In this thesis I have shed light on that gender inequalities are one of the factors that fuels the spread of HIV among youth. Here, it is important to remember that the current masculinity and femininity ideals have been formed in a highly patriarchal society formed by apartheid. Today are young women considerably more affected by HIV than males in the same age span. This is partly explained by women being more susceptible to HIV because of physiological differences but also due to a range of sociocultural factors where men’s dominance over women play a key role. Scholars have found that women are submissive, not only in their relationships but also in the wider community (Nduna et al. 2001:9 in Walker et al. 2004:31-2). As demonstrated in section 1.3 A gendered epidemic, multiple researchers have found that it is very difficult for young women to protect themselves against unwanted sex. And, that coercive sex has become so common that it has been normalised to now be seen as a normal part of a ‘love’ relationship by many youth (Walker et al. 2004:56, Squire 2007:27, Vincent 2008:436, Wood & Jewkes 2001, Outwater et al. 2005). This
infer that it is also extremely difficult for young women to “stay HIV free”. The disempowerment of females in South Africa makes them more vulnerable of acquiring HIV than their male counterparts.

My empirical findings were analysed through Connell’s concept of gender construction. She advocates that being a man or a woman is not a pre-determined state but rather a becoming, a condition actively under construction. When it comes to manhood, one is not born masculine but has to transform into one through socialisation (Connell 2009:5). Furthermore, Connell emphasises that there are multiple forms of masculinities in each society at any particular time, which was also found and explored in this thesis. With her concept of hegemonic masculinity (Connell 1995:77) the established hegemonic masculinity found among Xhosa males is the indoda man (Mfecane 2016). What it means to be an indoda man was explored by looking at ‘manhood acts’ as defined by Schrock and Schwalbe (2009).

When it comes to gender inequalities and how these fuel the HIV epidemic, there are particularly two main themes that stand out, the way I see it: hegemonic masculinity (dominant male sexuality) and multiple (parallel) sexual partners. I find that these two themes capture the essence of much of the complex of problems brought up here. Again, drawing on Connell (2009), one is not born a man but rather has to transform into one. In Xhosa culture, this happens through the manhood rite ulwaluko. Here is where hegemonic masculinities are born and reproduced, since this is the only route to becoming a real man, an indoda (Vincent 2008, Mfecane 2016, Mavundla et al. 2010). Which, as explained in this thesis, is the hegemonic masculinity in Xhosa culture (Mfecane 2016). I understand ulwaluko intrinsically as a ‘manhood act’, as Schrock and Schwalbe (2009) define it. However, the manhood rite also includes teachings of how an indoda man should act and behave, these can also be read as ‘manhood acts’. During ulwaluko the initiates learns (or, is supposed to learn) the essential manhood virtues and how a real man should act. These ‘manhood acts’ include showing respect towards fellow human beings, selflessness and responsibility. However, it is evident that ulwaluko today contains contrasting messages. One of the most prominent features of successful masculinity today consists of acquiring multiple sexual partners. This ‘manhood act’ is also interpreted as an ulwaluko teaching. In section 5.8, Thulani sheds light on that the ulwaluko guardians say “bring us babies” which he means has been modified as a way to justify men having multiple sexual partners. Multiple partners as a ‘manhood act’ is strongly connected to the achievement of higher status. But also to power: power over uninitiated males, over other indoda men, and, over women. Having multiple sexual partners with or without consent, is today seen as a male right (Vincent 2008:443, Wood & Jewkes 2001:317-336). Connected to this is another ‘manhood’ act, namely the ability to control girlfriends. As stated by Vincent: “While traditional circumcision rites once played the role of socialising Xhosa youth into social expectations of responsible and restrained sexuality, in contemporary South Africa, … initiation has
come to be viewed as a permit for sex. Moreover, it is a permit for sex within a context of gender relations characterised by high levels of coercive sex and the widespread belief that girls do not have the right to refuse sex” (Vincent 2008:436-7). In section 5.8, Thulani explains that it is important for guys to be pleased in their sexual relations, otherwise, they will move on and find another girl. Wood and Jewkes calls these attempts to dictate the terms of sex with their partners as ‘controlling strategies’, which is a part of male dominance (Wood & Jewkes 2001:324). This is also substantiated by the female gBs, as expressed by Nwabisa: “the man takes over in the bedroom and that’s that”.

Young women do have multiple partners as well, however, it is not comparable to young men because it is not incorporated into femininity to have multiple partners. It does not make you “more of a woman” to have many sexual partners in this setting. As a woman, you will not increase your status nor gain benefits such as a higher position in the hierarchy by having multiple sexual partners\(^{30}\), as the correlation is for males. Seen from this, these unequal structures fuels the HIV epidemic. And, it is especially putting young women at risk.

These findings do not provide all the answers to why HIV continues to spread amongst youth, but taken together they could provide some useful insights into the realm of youth in this setting.

**Concluding remarks**

A well functioning HIV prevention strategy is a hard nut to crack. Condoms seem to not be widely used, ARVs do not cure HIV but do treat it. However, for them to function properly you need to take them on time and just as prescribed. If you do not, the virus might mutate, making the ARVs not function properly or even become useless, which means that if you stop taking them for a while, they might no longer work when you start taking them again. And, not only that, as Squire points out: “Economic hardships may increase: ARVs make you healthier, hungrier and remove your entitlement to disability grant. If you are unemployed, travel to clinics and buying enough food becomes even harder. As with other serious chronic illnesses, you may live in an uncertain state, by turns ‘healthy’ and ‘sick’” (Squire 2007:44). There is no quick fix here until a cure is found or a vaccine is developed and out on the market. There are no easy answers to how to best work with HIV prevention. However, my findings clearly underscore that the biomedical model always needs to be combined with deep understandings of the historical, social, political, economical and cultural conditions in any specific setting, and not least gender dimensions are crucial to understand in order for any prevention efforts to become successful. And in South Africa, the HIV epidemic today needs to be understood in relation to the legacy of apartheid.

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\(^{30}\) In line with how the case is for women in most societies globally.
Bibliography


**Electronic References**


Appendix

Questionnaire

Name:
Age:
Where do you come from?
Can you tell me about your background?
Where do you live now?
When did you first find out about loveLife?
Why did you choose to become a groundBREAKER?
What programme are you responsible for?
What did you learn in the 10 days training?
What information about HIV/AIDS have you received from loveLife?
Did you learn something new? (What?)
What information have you received from other sources?
What information from loveLife have you received about HIV prevention; how to decrease the spread of HIV amongst youth?
How do you work as a groundBREAKER?
What do you do in the schools?
What subjects do you bring up?
What are your thoughts about HIV/AIDS in this country?
What are your thoughts on HIV prevention? What needs to be done?
What are the reasons for the spread amongst youth?
How do you work to prevent HIV as a groundBREAKER?
[Is loveLife focusing more on structural issues or individual behaviour in their HIV prevention?]
[What are the pros and cons of being a gB?]
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