Gender, Sexuality and HIV/AIDS Entwined

A gender sensitive approach to HIV/AIDS stigma, discourse and behaviour in Ramaswikana, Limpopo, South Africa.

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Photographs Frontpage[1]

[1] These pictures were taken in the local clinic, they are posters that revolve around sexual and reproductive health issues, put there by the Limpopo government. The photo on "life skills" comes from the local primary school in Ramaswikana, it shows the school curriculum on information regarding sexuality and health.

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Renske Thalia Poelma & Rosan Stuijt

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List of abbreviations

AIDS = Acquired Immune Deficiency Syndrome
ART = Antiretroviral Treatment
ARV = Antiretroviral (Drug)
DIC = Drop-In Centre
HCBC = Home Community Based Care
HIV = Human Immunodeficiency Virus
PLWHA = People Living With HIV/AIDS
MRC = Mogalakwena Research Centre

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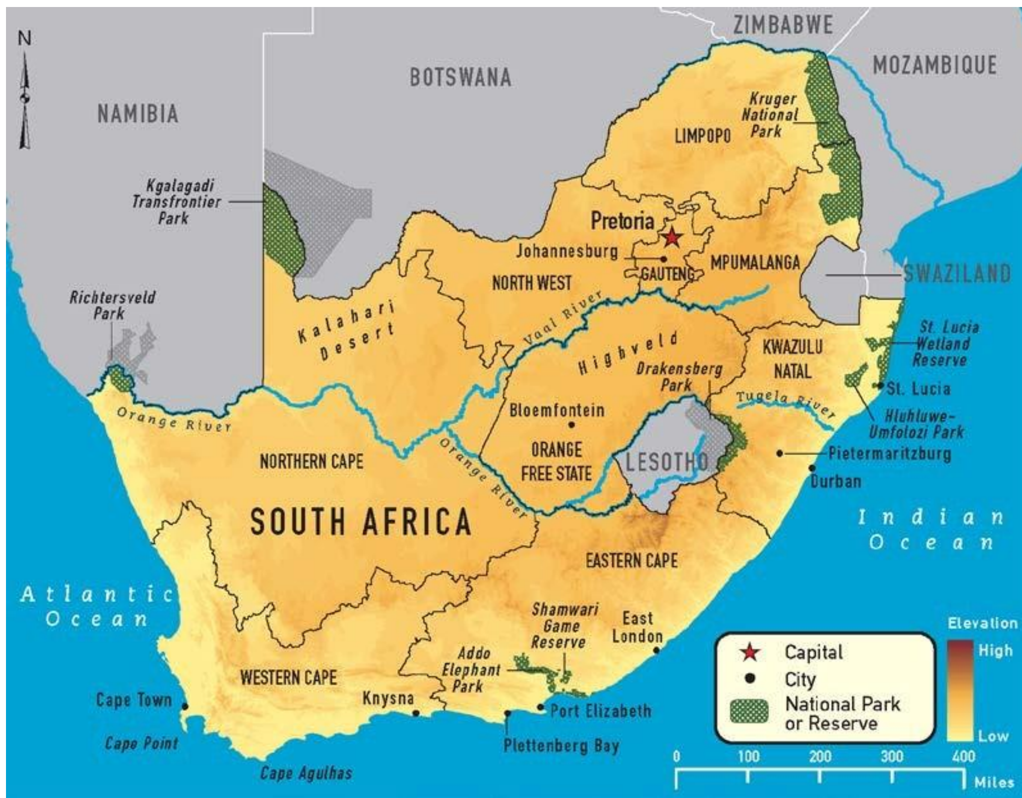
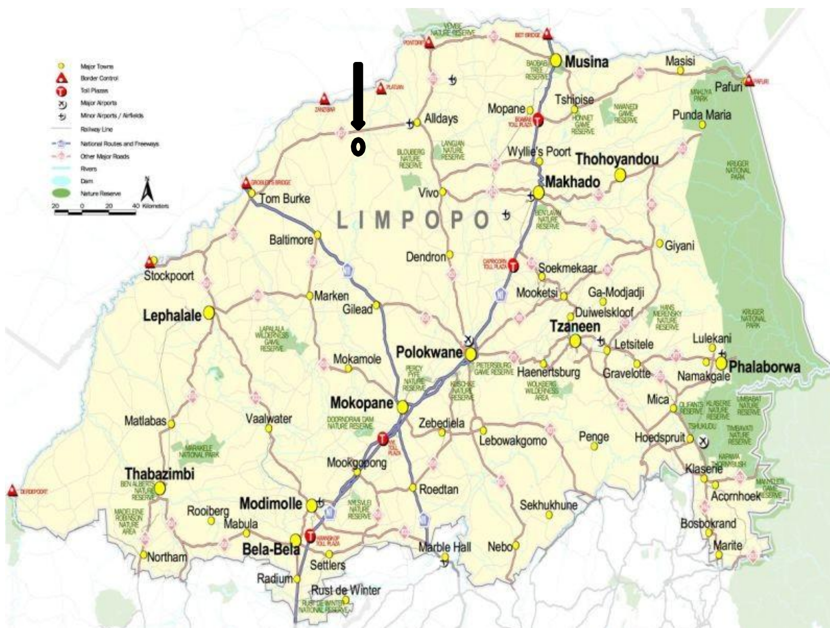
Maps of Location



1. Map of South Africa (12.000.scripts.mit.edu)



2. Limpopo Province (www.southafricaholiday.org.uk).
Arrow locates Ramaswikana.

Introduction

The astounding fact that over 39 million[2] people have lost their lives to the infectious disease HIV/AIDS since its outbreak in 1982, is in itself enough reason for the international community to panic (Brown et. al 2011: 256). Given the fact that to this day millions of people suffer from the disease and by the end of 2013, approximately 35 million people were HIV positive, 1.5 million people died of HIV/AIDS and in that same year 2.1 million people were newly infected (UNAIDS 2014), research on the topic remains relevant as ever. More specifically, with over 5.3 million HIV infected people (11% of the population), South Africa is unfortunately still leading country in the HIV/AIDS pandemic (UNAIDS 2013). Not surprisingly after over thirty years of HIV/AIDS epidemic, the body of literature on HIV/AIDS in South Africa (Mazzeo et al. 2011[3]) and beyond (Liamputtong 2013[4]) has taken on outstanding proportions[5].

Much has been written on HIV/AIDS from a variety of disciplines and fields (Rohleder et al. 2009). Within this body of literature, earlier research towards a solution to the epidemic focused on biomedical preventive and treatment methods. Whereas research from the biomedical field and a focus on direct solutions remains infinitely important, research from the social scientific field on HIV/AIDS stigma, behaviour, discourse and perspectives, must be taken into account in search for the 0% HIV infection goal (UNAIDS 2013). As Parker (2001) so aptly noted over a decade ago, finding a solution to the problem is not merely finding a cure and educating people, it has to do with understanding behaviours, discourse and perspectives regarding disease and sexuality (Parker 2001: 163). Cultural, social, political, economic and psychological factors shaping the HIV/AIDS stigma are not always considered in biomedical research, which makes social scientific contribution indispensable. UNAIDS (2013) argues that socio-culturally and political-economically bound issues such as stigma and discrimination, but also gender inequality and sexual behaviour need to be addressed within HIV/AIDS research (Rohleder et al. 2009). As Erickson (2011: 271) so righty states: if there were ever a topic in need of an anthropological perspective, it is sexual and reproductive health. Even though anthropology's engagement with HIV/AIDS research and especially gender and stigma sensitive research, started quite late into the epidemic (Mattes 2012; Parker 2001), much progress has been made since then.

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[2] See http://www.who.int/mediacentre/factsheets/fs360/en/ accessed 2015-05-27.

[3] See alsoDickinson 2013; Schatz et al. 2013; Jones 2011; Hitchcock and Babchuck 2011; Singer 2011; Sellen and Hadley 2011; Kalichman et al 2010; Rohleder et al 2009.

[4] See also Kaufman et al. 2014; McGrath et al. 2014; Mojola 2014; Dworkin et al. 2013; McGrath et. al 2012; Mattes 2012; Bain Brickley et al 2011; Brown et. al 2011; Copeland 2011; Erickson 2011; Irving 2011; O'Connor and Earnest 2011; Wyrod 2011; Sengupta 2010; Ippolytos 2010 McGrath et. al 2012; Mattes 2012; Bain Brickley et al 2011; Brown et. al 2011; Copeland 2011; Erickson 2011; Irving 2011; O'Connor and Earnest 2011; Wyrod 2011; Sengupta 2010; Ippolytos 2010.

[5] For a complete overview of the different types of social scientific research on HIV/AIDS done since 1990 until 2007 see Anush et al (2008). Furthermore Biehl 2007; Bourgois and Schonberg 2009; Butt and Eves; 2008, Fasin 2007; Feldman 2008; Padilla 2007; Singer 2009a; Susser 2009; Thornton 2008; Whelehan 2009; Whelehan and Bolin 2009 in Singer and Erickson 2011.

This thesis aims to make a humble contribution to the body of anthropological literature by taking up a gender and sexuality sensitive approach to the study of HIV/AIDS, aiming to strengthen the bridge between gender and medical anthropology. More specifically, this project aims to contribute to the body of literature assessing the HIV/AIDS stigma from a gender perspective; not necessarily to reduce stigma, but to create an overview of what contributes to this stigma in a rural village in South Africa on the border with Botswana. Thereby highlighting with Dworkin et al (2013: 703) that researchers have recently taken up the perspective that an emphasis on individual and small-scale HIV/AIDS intervention will have better results.

The theoretical objective of this thesis is to strengthen the bridge between the Medical Anthropological perspective on HIV/AIDS and the gender perspective on HIV/AIDS and to show the relevance of a holistic perspective in combination with a gender perspective to the understanding of the perspectives, discourse and behaviour surrounding HIV/AIDS. The practical objective is to provide information for HIV prevention, treatment and care programs. To be able to create efficient programs focussing on biomedical information is not enough. Studying the socio-cultural and politico-economic factors will create a better understanding in why this HIV/AIDS epidemic exists in the rural villages of Limpopo, South Africa and how the 0% infection goal can be achieved in this area.

This thesis is based on ethnographic and interview-based fieldwork conducted in the rural village of Ramaswikana, Limpopo, South Africa. In the period from 28 January until 1 April 2015, complementary research was done by the authors of this thesis. Miss Poelma focused on the discourses and behaviours, stigmatization and perspectives regarding HIV/AIDS and Miss Stuijt emphasized the gender approach of this thesis by looking at the perspectives and behaviours surrounding gender identity and sexuality, focusing on gender and sexuality related stigmatization and power relations. These foci combined have formulated qualitative data that provide an answer to the research question of this thesis: *In what ways do perspectives and behaviours surrounding gender identity and sexuality entwine with the discourses and behaviours surrounding HIV/AIDS in Ramaswikana, Limpopo, South Africa?*

The research question was accompanied by a number of sub questions focusing on the themes of gender identity – manhood and womanhood – sexual behaviour and desires, gender and sexuality stigma, sexual health, reproductive health, health risks, HIV/AIDS stigma, healing and contextual factors such as poverty and governmental institutions (the education and health systems). Within this thesis the concepts of perspective, behaviour and discourse are defined as follows. Perspectives are attitudes towards or ways of regarding something, in this case gender, sexuality and HIV/AIDS. Perspectives are directly linked to behaviour, as they can provide huge insight on why people behave the way they do. With regards to behaviour, this thesis holds the following definition:

behaviour is the way in which one acts or conducts oneself, especially towards other individuals. Finally, in defining discourse this thesis holds Michel Foucault's definition, which states that it is a formal way of thinking that can be expressed through language, a social boundary that defines what can be said about a specific topic (Foucault 1982).

Ramaswikana[6] is a small settlement in the North of South Africa. As the need of a better understanding of the perspectives and behaviour surrounding HIV/AIDS in Ramaswikana was emphasized by Mogalakwena Research Centre, this village provided a rich opportunity to carry out this research. The inhabitants mostly descend from the Pedi people, and speak Sepedi: one of the eleven official languages of South Africa[7]. The research population consisted predominantly of teachers, nurses, carers and students from Ramaswikana, as within these educational and health spheres the topics gender, sexuality and HIV/AIDS are regularly mentioned and discussed[8]. As the researchers are not equipped to speak Sepedi, the decision was made to focus on English speaking people. It should be noted here though that in some cases certain informants were interviewed who could not speak English, in those cases a translator was used to conduct interviews.

Reliability and validity in this research have been ensured through the use of anthropological qualitative research methods and techniques. Because the themes of this study – the meaning of gender identity, sexuality and HIV/AIDS – are sensitive topics and stigmatization surrounds them, participant observation has been a valuable method to investigate the topics. Participant observation created rapport and provided the researchers with insights in the tacit knowledge[9]. Moreover, as the investigation involved studying behaviour, this method was highly relevant. Participant observation was predominantly conducted at the Primary and Secondary Schools, the Home Community Based Care (unqualified nursing facility), the Drop-in Centre (after-school care), the crèche, and during various other social events such as a wedding and daily family life in said village. Furthermore conversations (group and individual) and interviews (informal, unstructured, semi-structured and life-history) with teachers, students, carers, nurses and patients were held, including two focus group talks with the students. Finally visual data such as education books, health related informative posters and books and clinical health data files were collected and studied. In addition, different

[6] The authors have chosen to refer to the research location under the name of Ramaswikana, which was the main village of the research. However the research did not merely take place in said village, it evolved into a multi-sited ethnography, meaning it was not conducted in one geographical site but was influenced by participants locations and the geographical locations of their networks, constructing a multi-sited network. As the ethnographic field has a larger methodological role in anthropology as context (Ferguson 2011), the physical methodological context is in this case replaced by sets of relations and practices that make up a network "distributed knowledge system" (Marcus 2011). Instead of just Ramaswikana it has been more about the network on and offline, the connections, relations, and boundaries where people are situated and situate themselves in. The data thus reflects the network of people in and around Ramaswikana and other names of villages such as Arrie, Sias and Taaibosch will thus be mentioned within this thesis.

[7] See Chapter 2 and 3 for more elaborate information on the research population.

[8] How and when these topics are mentioned and discussed will become clear in the following chapter.

[9] Knowledge that goes beyond consciousness

kinds of qualitative research techniques were used. Data was (audio) recorded and jot notes and field notes were made during fieldwork. Furthermore a logbook was kept up and photos were taken during research activities.

It should be noted that within any research but particularly anthropological research, it is key to be aware of one's own identity and how this may influence the research population and the information they provide. Especially as this research has been conducted in an area where the black-white division is still intensively present, being researchers who can be placed under the white race, while participants identify themselves as black. The researchers were often attached to a higher status[10] compared to the informants, which was constantly emphasized during fieldwork and thus influenced the gained information. By keeping a diary and holding a 'reflection-date' once a week, the researchers assured this research made intensive use of the technique self-reflection.

As Fleuhr-Lobban so aptly stated, "bad ethics makes bad research" (2000), especially as this research revolves around such sensitive and stigmatizing topics as HIV/AIDS, gender and sexuality. To assure ethically correct research – meaning the research did not affect the population negatively – the researchers have continually communicated with the participants about the purpose of particular activities, interviews and the research as a whole. Therefore the participants were able to decide at any moment if they were willing to participate or not. The filling out of informed consent letters by the informants, helped to ensure this goal. Because of the sensitivity, the researchers have been focussing on addressing sensitive topics only with rapport or otherwise on the initiative of the participant. By focussing on the agency of the participants, the researchers tried to do ethically correct research. Additionally, the research has made use of anonimisation of all informants. By using pseudonyms, the safety, dignity, and privacy of the research population, or anyone who might reasonably be thought to be affected by the research, was ensured.

The raw data of this research consists of jot notes, field notes, a diary, logbook, photos and audio and visual recordings. Data analysis – the sorting, categorizing, naming and connecting of data (Boeije 2010) – has been enacted by filling in the forms called 'research journal' and 'participation list', by writing field work reports after two, six and ten weeks and by putting all our data into the computer program Nvivo to be able to code and connect the raw data.

In the first chapter of this thesis the theoretical framework will be outlined. Starting with a description of the constructivist approach, the theoretical basis of this thesis will be drawn. Contemporary theory on gender anthropology, gender identity and sexuality, with a focus on power, will provide a framework for the gender and sexuality perspectives and behaviours studied. Current debates in medical anthropology regarding HIV/AIDS and HIV/AIDS stigmatization will provide

[10] As they are white, well-education, (compared to them) rich and above that guests, which have a particular status within the Pedi culture.

background for the HIV/AIDS discourse and behaviours researched. Chapter two takes a closer look at the theoretical themes discussed in chapter one by outlining what has been written in literature on gender, sexuality, HIVAIDS and stigma in South Africa, especially focusing on the Pedi people and as such frames the context of the research. In chapter three the ideal and real gender identities and sexual behaviour in Ramaswikana will be outlined, concluding with the stimgatization that accompanies it. Manhood, womanhood, hegemonic masculinity, motherhood and cleanliness will be important terms within this chapter. The fourth chapter focuses on the discourses, perspectives and behaviours surrounding HIV/AIDS in Ramaswikana and how they are constructed by contextual factors. The last chapter will conclude by outlining the construction of the HIV/AIDS stigma the entwinement of gender identity, sexuality and HIV/AIDS as they co-construct the HIV/AIDS stigma in Ramaswikana. Finally, the answer of the research question will be provided in the conclusion, following with the shortcomings and possible future research.

1. Theoretical Framework

As this research aims to strengthen the bridge between Medical Anthropology and Gender Anthropology, this theoretical framework will outline both perspectives to set a theoretical framework with a common focus on stigma. It will commence with the gender perspective by outlining the concept of gender, which will focus on the constructionist approach and its relation to power. Only continuing to outline gender identity and sexuality in the second paragraph, explaining hegemonic masculinity, motherhood, cleanliness and the co-construction of gender and sexuality. Paragraph three will focus on the medical anthropological perspective, in which an overview of the current research on the anthropology of disease and HIV/AIDS will be discussed and the global statistics and facts on HIV/AIDS will be provided. In the final paragraph the concept of stigma will be defined and applied to the concepts of HIV/AIDS, gender and sexuality. This last paragraph will emphasize the role of power, discrimination and fear in both gender research and medical anthropological research.

1.1. Gender

Written by Rosan Stuijt

Taking a gender perspective in research on HIV/AIDS is of vital importance. It can be argued that a gender perspective is useful in any research to understand the full meaning of a particular concept. Gender structures and constructs the material, immaterial and symbolic world and therefore the influence of gender provides insight on the construction and the meaning of a particular concept (Steenbeek 1992). Before applying this perspective, gender will be defined and a relevant overview of the existing literature will be provided.

Defining Gender

Before the 1980s feminists saw women as a universally oppressed, homogeneous category (Nencel 2007, Butler 1990). However, with the accumulating literature on this topic[11], the realization came that this homogeneity of the sexes does not exist along the lines of cultural, racial and class differences (Nencel 2007, Butler 1990). This led to a critical view of biological determinism[12] and the essentialist approach[13], and to the rise of the significance of the social and cultural context (Vance 1991). With this development, gender became an important notion within anthropology (Nencel 2007), as it defines the social and cultural meaning of masculinity and femininity (Steenbeek 1992).

Gender consists of the shared expectations and norms existing in a society about appropriate male and female behaviour, characteristics and roles. This social category imposed on the sexed body differentiates women from men and defines the way they interact with each other (Gupta 2000; Scott 1986). Gender has four different principles from which it can be analysed and which give a broad overview of the concept. The first consists of gender being (1) a structuring principle: an important category through which every person orders his or her material, immaterial and social world in masculine and feminine. The second principle defines gender as a (2) cultural construction, the third recognizes gender as (3) the object and subject of power and the fourth applies (4) an intersectional approach to gender: this recognizes its interrelatedness and co-construction with other phenomena in society (Steenbeek 1992).

[11] As Judith Butler (1990) and Joan Scott(1986).

[12] Biological determinism states that human behaviour and identity are determined by their genes.

[13] Within the essentialist approach people believe in a static essence within every entity that determines human behaviour, identity and behaviour (Nagel 2003)

Gender as a Socio-Cultural Construct

Gender constructs, but is simultaneously constructed, by contextual factors. This construction and constructedness of phenomena is grounded in constructivism. Bourdieu, an important thinker in this approach, describes it as follows:

> By constructivism, I mean that there is a twofold social genesis, on the one hand of the schemes of perception, thought, and action which are constitutive of what I call habitus, and on the other hand of social structures, and particularly of what I call fields and of groups, notably those we ordinarily call social classes.
>
> *(Bourdieu 1989: 14)*

Bourdieu explains that constructivism[14] focuses on the way in which people are influenced by their cultural background when interpreting phenomena. Their social 'reality', which determines their thoughts and behaviour and creates new constructions, is in fact subjective; it is a cultural construction that constructs (Bourdieu 1989). Bourdieu talks about a “twofold social genesis”, because this subjective point of view is created by social beings, which are influenced by their common-sense, and the social structures existing in society. Thus, by taking this approach as its theoretical basis, this research recognizes the social constructiveness of concepts and therefore the importance of the social and cultural context[15].

The existing culture-specific social 'reality', as mentioned by Bourdieu, influences the meaning people give to men and women[16]. Beauvoir explains: "one is not born as a woman, but, rather, becomes one", when culture gives meaning to the body (Beauvoir cited in Butler 1990: 8). As gender is a construction, the meaning given to masculinity and femininity is related to culture-specific common-sense and existing social structures in a society, and therefore strongly connected to time and place.

[14] Constructionism opposes structuralism, which believes in the existence of objective social facts (Bourdieu 1989).

[15] As this approach takes the co-constructedness and interrelatedness of concepts into account, it applies also the intersectional approach – the forth principle of gender (see paragraph 1.1).

[16] Actually even the categories ‘men’ and ‘women’ are cultural constructions: there is no universal, fixed and clear definition about what a woman or a man is and why these categories are there; culture has invented the bounded concepts of 'men' and 'women' (Butler 1990).

Gender and Power

Gender structures the world and most importantly gives value to these categories, which can portray power[17] from one category over another (Steenbeek 1992). As Scott explains, gender creates "distributions of power [meaning] differential control over or access to material and symbolic resources" (Scott 1986: 1969). Besides gender being the object of power, gender can also be the subject of power relations: power relations construct the meaning that is given to men and women (Nencel 2007, Scott 1986). As Foucault states, various forms of power – present in institutions[18] – create, define and reproduce the subject (Foucault 1982). The meaning of this subject – in this case a woman or a man – seems natural, but in fact they are produced in and by power relations (Butler 1990).

[17] Power is "a way in which certain actions modify others". It is not universal or static and only exists when it is put in action (Foucault 1989).

[18] This is strongly related to the before mentioned structures in society which are formations of power and create the categories of gender and their meaning.

1.2. Gender Identity and Sexuality

Written by Rosan Stuijt

People have multiple identities, of which gender and sexuality are significant ones. These identities influence one's thoughts and behaviour, yet they also influence each other. In applying a gender perspective to HIV/AIDS, the examination of gender identity and sexuality and their relation is relevant.

Defining Gender Identity

Identity consists of a label based on specific characteristics or affiliations belonging to an individual or a whole social group. One's identity emerges from categorizing oneself with others – and being categorized by others – based on particular characteristics (Hogg 1995; Litosseliti and Sunderland 2002)[19].

Gender identity – which consists generally of the binary man/women[20] – is an important part of one's identity. This identity can have different meanings varying over time and space; however, in every society there exist hegemonic[21] ideas about men's identity and women's identity, which are performed on a large scale (Nagel 2003). As Wekker (1998) explains, these identities consist of particular social and cultural expectations – gender roles and gender stereotypes – which influence the performances of people within this identity. Performance "refers to the ways in which we adorn and use our bodies to present ourselves in various roles", as Nagel explains (2003: 52). In performing culturally and socially expected gendered roles – in the way we act, how we speak, our appearance etcetera – people take part in the performativity of the hegemonic gender identities[22]. Performativity refers "to the way in which we affirm and reaffirm, construct and reconstruct hegemonic social roles and definitions" (Nagel 2003: 52). Because political recognition and social structures are an important factor within these performative processes (Nagel 2003), power takes a significant role therein. Foucault explains that the power-folded "regulatory discourses" coerce people in performing hegemonic identities to maintain the performativity (Butler 1990)[23].

[19] In taking a constructionist approach, this thesis defines identity as a construction. Therefore identity is a concept that is fluid, always in process and therefore "a matter of becoming" (Hall 1990:225). Identity is also relational in which the boundaries between 'the self' and 'the other' are continually negotiated and repositioned (Wekker 1988; Hall 1990). Therefore identity is positioned (Hall 1990).

[20] Note that this gender binary is also constructed (Butler 1990), as there are persons who do not identify with one of these categories. Still this thesis only mentions these two categories because these are the recognized and widely used gender identities within societies and these are useful for our research.

[21] Hegemony refers to the exercise of power through the performance of accepted ideas or values (Jewkes and Morell 2010).

[22] Nagel explains that because of this unnoticed construction and reconstruction of gender, performativity is a powerful mechanism of social construction and social control (Nagel 2003).

[23] However, people can also resist these expectations with performing aberrant gender behaviour (Nagel 2003).

Hegemonic Masculinity and Emphasized Femininity

Within the traditional hegemonic ideas men are generally linked to productive activities and women to reproductive and domestic activities. The unequal power distribution traditionally favours men above women (Gupta 2000). In 1987 Connell[24] created the notions of hegemonic masculinity – "the pattern of practice ... that allowed men's dominance over women to continue" (Connell 2005:832) – and emphasized femininity – the compliance of accommodating the desires of men (Connel 2005). Connell argues that these images are not universal, but they consist of the general normative view of being the most honoured and successful man and woman (Connell 2005). Although these notions were widely used in the 1980s, they became highly contested concepts in the years that followed (Connel 2005). The most influential criticism on these notions is the perceived essentialist character (Petersen, 1998, 2003; Collier, 1998; MacInnes, 1998, cited in Connel 2005), the ignorance of differences and constructivism (Martin, 1998; Wetherell and Edley, 1999; Whitehead, 1998, cited in Connel 2005) and the lack of the acknowledgement of women's agency (Holter, 1997, 2003; Collier 1998, cited in Connel 2005). Although this thesis recognizes these critics and does not belief in the universally truthfulness of this masculinity and femininity, it also recognizes the possible present performance and performativity of these gender identities within some social spheres, which makes them useful and interesting concepts.

Motherhood

Recently the focus within the study of motherhood has shifted from motherhood as instrument to the development of their children towards the examination of the experience of the mother itself (Cowdery and Knudson-Marti 2005). Motherhood is now recognized "as a set of social interactions that arise within a gendered set of relationships and social institutions at a particular time and place" (Arendell 2000; Baber & Allen 1992; Glenn 1994; Thompson & Walker 1989, cited in Cowdery and Knudson-Marti 2005).

Mothering appeared to be "the primary frame by which woman communicate and sustain their identity" (Faircloth 2009: 15). As this concept is a powerful force within the lives of women and can be a means of empowerment, motherhood is connected to power structures (Cowdery and Knudson-Martin 2005). Oyěwùmí (1997, 2005) and Nnaemeka (2005) even recognize motherhood as a rite de passage[25] that can provide women with a higher status and a positive self-esteem (Pfeiffer 2014).

[24] Connell mentioned the notions for the first time in his book 'Gender and Power', written in 1987.

[25] The term rite de passage originates from Arnold van Gennep, with which he means "rites that indicate and constitute transitions between states" (Victor Turner 1987).

Defining Sexuality

Like with gender, the scientific community changed their essentialist idea about sexuality a few decades ago: from something purely biological, to sexuality as cultural construct (Nagel 2003). Gupta defines sexuality as "the social construction of biological drive" and argues that one's sexual identity – hetero, gay, lesbian, bisexual[26] – "is defined by whom one has sex with, in what ways, why, under what circumstances, and with what outcomes" (Gupta 2000:2). Nagel defines sexuality as the "culturally defined appropriate sexual tastes, partners, and activities" (Nagel 2003: 8). Furthermore, she explains that there are hegemonic sexualities present in societies, which determine approved sexual behaviour and desires. Heteronormativity[27] refers to a society where heterosexuality – which means having sexual desires towards, and activities with, the opposite sex – is the commonly accepted hegemonic and normative sexuality. As with gender, this commonly culturally approved sexual identity influences people's sexual desires and behaviour, as sexuality is also performed and performative (Nagel 2003).

Sex Performing Gender

Gender and sexuality are two different analytical concepts, but they are strongly interrelated. As gender structures, it also structures sexual desires, partners and activities (Nencel 2007; Jackson 2006). Yet perceptions of sexuality and sexual desires structure gender categories and gender relations as well (Nencel 2007). Gender identity defines appropriate sexual behaviour, and thus sexuality has the ability to perform gender identity. Someone who performs sexual behaviour can take part in both the performativity of the hegemonic sexuality and the performativity of the hegemonic gender identity.

Dirtiness and Cleanliness

Mary Douglas (1966) discovered that human beings have the tendency to name unclassifiable things 'dirt' – which they imply as something 'bad' – as they are seen as a threat to the society. Within each society, dirtiness counters c*leanliness*, which is associated with order and something good (Douglas 1966). As these terms are also used in relation to the human body, cleanliness means to be healthy and dirtiness to be diseased (Yu 2013). In particular, sexual diseases are linked to the violation of moral and cultural taboos and therefore perceived as a negative factor within society (Das 2001;

[26] Note that there might be more sexual identities in particular societies. The ones mentioned here are the widely used ones.

[27] Heteronormativity not only concerns sexuality, but also gender relations: as Jackson writes, it orders "not only sexual life but also domestic and extra-domestic divisions of labour and resources" (Jackson 2006:107). Schilt and Westbrook (2009) argue that the institutionalization of heteronormativity not only maintain the assumption that sexual attraction between the opposite sexes is natural, but also the assumption of the gender binary and of gender reflecting biological sex. They see heterosexuality as a significant factor in "maintaining the gender hierarchy that subordinates women to men" (Cameron and Kulick 2003:45 cited in Schilt and Westbrook 2009:441).

Huang et al. 2004; Hyde 2007; Mason 2012; Zhang 2011, cited in Yu 2013). Stigmatization surrounds the people that are identified with dirtiness – by diseases, activities or occupations – as they are associated with the accompanied negative qualities (Selmi 2012, Yu 2013).

1.3. The Anthropology of HIV/AIDS

Written by Renske Thalia Poelma

As HIV/AIDS continues to be a growing threat to global health, the international community consisting of governments, politicians, researchers, scientists, and non-governmental organizations, remains under high pressure to tackle the task of overcoming the HIV/AIDS pandemic. This pressure is not only shown by the staggering 10 to 15 billion US dollars spent on HIV/AIDS each year (Mazzeo et al 2011:1), but also by the amount of researchers from a great variety of disciplines focussing on the issue. Anthropology and especially its sub discipline medical anthropology have contributed a great amount of research on the topic of HIV/AIDS since the 1980s (Singer and Erickson 2011; Mazzeo et al 2011)[28]. Anish et al. (2008) have tried to create an overview in the bulk of research from the medical anthropological sector and argue the literature is divided between (1) HIV/AIDS theory-based analysis, (2) a HIV/AIDS stigma assessment aiming to reduce stigma and (3) a legal/policy assessment. This thesis takes on an HIV/AIDS stigma assessment, however before elaborating on HIV/AIDS stigma first this paragraph will outline the analytical perspective of medical anthropology on disease by discussing HIV/AIDS facts, HIV preventive methods, HIV treatment and HIV infection to set the basis for HIV/AIDS stigma assessment. The next paragraph will focus on the theory on HIV/AIDS stigma and behaviour and perspectives on PLWHA.

The Anthropology of Disease

Anthropology largely failed to respond to the HIV/AIDS epidemic as a social scientific discipline in the eighties (Parker 2001: 163)[29]. Medical anthropology is the sub-discipline in anthropology that combines methods and perspectives from socio-cultural and biological anthropology to assess health issues through a holistic lens (Singer and Baer 2011; Brown et al 2011; Townsend 2011). A rather concise definition of the analytical perspective of medical anthropologists is provided by Brown (1998): "medical anthropologists look at disease by focusing on the socio-cultural aspects that construct and formulate discourse, perspectives and behaviours surrounding a disease". The importance of discourse, perspectives and behaviours for the assessment of disease is emphasized by many of the major authors in the field of medical anthropology (Brown et al 2011; Singer and Erickson 2011; Baer 1997; Inhorn 1995; Inhorn and Brown 1990).

[28] "The body of work that resulted is now quite extensive, including many recent book-length publications (Biehl 2007; Bourgois and Schonberg 2009; Butt and Eves; 2008, Fasin 2007; Feldman 2008; Padilla 2007; Singer 2009a; Susser 2009; Thornton 2008; Whelehan 2009; Whelehan and Bolin 2009)"(Singer and Erickson 2011: 516)

[29] Anthropological research on HIV/AIDS pre 1990s: Bolognone 1986; Conant 1988a,b; Feldman 1985; Feldman & Johnson 1986; Feldman et al 1987 Gorman 1986; M. Gorman 1986; Herdt 1987; Lang 1986; Nachmann & Dreyfuss 1986; Sindzingre & Jourdain 1987; Stall 1986; for further references to early anthropological work on HIV/AIDS, see Bolton et al 1991).

The definition of medical anthropology above underlines the main perspective carried out by the sub-discipline, namely the constructionist perspective. As in other aspects of social science such as gender, identity and sexuality, medical anthropology believes health and disease should be studied from a constructionist rather than a structuralist perspective[30].

HIV/AIDS

With a constructionist approach to disease medical anthropologists such as McGrath et al. (2014) and Mojola (2014) have recently examined HIV/AIDS. In their assessment of HIV/AIDS, they have been stressing the fundamental importance of "human culturally constructed and socially mediated attitudes, knowledge, perceptions, emotions, networks, imaginings, and behaviours in the pandemic". (Singer and Erickson 2011)[31]. The perspective of medical anthropologists can be applied to various stages of the disease. Starting with the general perspective on HIV/AIDS itself. The World Health Organization provides the following definition of HIV and AIDS:

> The *Human Immunodeficiency Virus (HIV)* targets the immune system and weakens people's surveillance and defence systems against infections and some types of cancer. … individuals gradually become immunodeficient.… Immunodeficiency results in increased susceptibility to a wide range of infections and diseases that people with healthy immune systems can fight off. The most advanced stage of HIV infection is *Acquired Immunodeficiency Syndrome (AIDS)*, which can take from 2 to 15 years to develop depending on the individual. AIDS is defined by the development of certain cancers, infections, or other severe clinical manifestations.
>
> *(WHO 2011, emphasis in original)*

While this definition is truthful and based on medical facts, according to sociologist Thomson's rule: a situation is not defined real if they are not real in their consequences, or in his words put positively: "if men define situations as real, they are real in their consequences" (Lacunas & Thomas 1928:572 in Merton 1995). The seriousness and destructiveness of HIV and AIDS is often not perceived as such by those people who are at risk. Cultural perceptions of people may force them to give a different meaning and behave differently than the meaning given by the WHO, this may be because in the first

[30] As was explained earlier in the first paragraph on gender, constructivism focuses on *"patterns of perception, thought and action (*Bourdieu 1990: 123 in Singer and Erickson 2011*)".* This is in stark contrast with the structuralist approach which looks at aspects of social life as 14*"objective structures which are independent of the consciousness and desires of agents and are capable of guiding or constraining their practices and their representations (*Bourdieu 1990: 123 in Singer and Erickson 2011*)".*

[31] In this discussion of HIV/AIDS it is necessary to keep in mind the focus lies on these constructions, perceptions, behaviours and general discourse, rather than medical factual discussions on the topic.

stages of HIV infection there are no perceived consequences. Anthropologist Inhorn (1995: 286) describes research has proven this to be true, when he says: "In fact, medical anthropologists have provided rather convincing evidence that *disease itself is a cultural construction*."

Any discipline that has done research on the topic of HIV/AIDS has proven that HIV is transferred through sexual and or bodily contact[32]. Consequently prevention of HIV transmission consists of (1) preventive methods[33], (2) adequate information on the use of these contraceptive methods and (3) access to both information and contraceptives (Dworkin et al. 2013). While prevention may seem like a feasible three-step concept, once again the meaning that is given to each of these aspects of prevention is culturally defined[34]. Treatment towards a curing is unfortunately impossible for AIDS. However antiretroviral therapy (ART) is provided to have a humane life with HIV. WHO gives the following definition: "[It] consists of the combination of at least three antiretroviral (ARV) drugs to maximally suppress the HIV virus and stop the progression of HIV disease (WHO 2011, emphasis in original)."

The socio-culturally defined discourse on HIV/AIDS constructs social behaviours and perspectives surrounding all aspects of it. Next to this socio-cultural discourse on HIV/AIDS, stigmatization based on gender, sexuality, economic status, ethnic and religious background and political and ecological environment plays a significant role in the HIV/AIDS pandemic. The next paragraph will outline this stigmatization surrounding HIV/AIDS, Gender and Sexuality by focusing on power and discrimination specifically.

[32] Sexual contact is the most important route of infection for HIV/AIDS, …[it] can result from infected fluid entering the body of an uninfected person through micro- abrasions caused by vaginal or anal intercourse. Transmission through oral sex or direct contact with sores or chancres on the genitals is also possible. (Brown et al 2011: 261)
[33] Such as condoms and abstention.
[34] Moreover research on the treatment of HIV has reached a point where mother-to-child transmission can be prevented and the life quality of people living with HIV/AIDS (PLWHA) can be significantly improved.

1.4. Stigmatization

Written by Renske Thalia Poelma

Even though there seems to be quite a distinct relation between gender roles, sexual behaviour and HIV/AIDS stigma, medical anthropologists to this day (McGrath et al. 2014), fail to approach HIV/AIDS from a gender perspective when doing a stigma assessment. Stigmatization based on gender and sexuality is one of the major influences on the HIV/AIDS pandemic. From within medical anthropology few have taken on this perspective: Inhorn and Brown (1997) and Singer et al. (2006) have initiated research on STIs including HIV through the lenses of gender inequalities and stigmatization (Brown et al. 2011: 261), furthermore Liguari and Lamas (2003) have literally addressed HIV/AIDS stigma from a gender perspective. Stigmatization based on contextual factors such as gender and sexuality especially but also economic status, ethnic and religious background and political and ecological environment play significant roles in the HIV/AIDS pandemic. To create an understanding of the co-construction of stigma, this paragraph will outline what stigma is from a social scientific perspective and will further elaborate on gender and sexuality stigma and HIV/AIDS stigma.

Stigma, Power and Discrimination

Anthropological research on stigma and power (Gregg 2011; Douglas 2008; Castro 2005; Skinner and Mfecane 2004; Das 2001; Ablon 1981) almost always refers to the definition of sociologist Erving Goffman on stigma:

> It is the *identification* that a social group *creates* of a person (or group of people) based on some physical, behavioral, or social trait perceived as being divergent from group norms. This *socially constructed identification* lays the groundwork for subsequent disqualification of membership from a group in which that person was originally included.
>
> *(Goffman (1963) in Castro 2005: 53, emphasis added)*

Goffman emphasized the importance of analysing stigma in terms of relationships rather than individualistic perceptions and attitudes. However psychological research has held a focus on the individual nature of stigma, which is shown by a general lack of attention paid to issues of power and inequality as they relate to stigma (Madru 2003).

Recently the role of power in creating stigma has been underlined by sociologists and anthropologists (Castro 2005). As Link and Phelan (2002:363) emphasize: “for stigmatization to occur, power must be exercised”. Ultimately stigma is entirely dependent on social, economic and political power dynamics, as power is required to be able to introduce stigmatization. Stigmatization is

formulated by people with power over others, whereas on the other hand, power is taken away from the stigmatized person; this dualistic role of power and stigma emphasizes their link (Gregg 2011; Skinner and Mfecane 2004).

Discrimination is one of the main consequences and drivers of stigma, and can be defined as follows: "[discrimination is] … when in the absence of objective justification, a distinction is made against a person that results in that person's being treated unfairly and unjustly on the basis of belonging or being perceived to belong, to a particular group" (Castro 2005). Stigma, power and discrimination are thus highly related. Which socio-culturally constructed notions formulate this stigma can best be examined by ethnographic fieldwork which can dig up underlying stigmatizing factors as in the case of HIV/AIDS are predominantly gender and sexuality.

HIV/AIDS Stigma

HIV and AIDS-related stigma has a unique relation to other stigma layers associated with race, gender, homosexuality, drug use, promiscuity etc.' (Lee, Kochman & Sikkema, 2002: 310 in Skinner and Mfecane). These layers are aptly exemplified through the main result and driver of stigma: discrimination: "Discrimination is perpetrated against communities which are perceived to be more affected by HIV, be these physical criteria, such as skin colour …; gender…; sexual orientation …; type of work, such as prostitution …; or geography, and even an entire continent, such as Africa." (Skinner and Mfecane 2004).

The HIV-related stigma does consequently not only occur at a psychological individual level but on a relational level as well. This relational level is measurable in behaviour, discourse and perspectives of a community. The human nature of wanting to belong to a group plus the fear of not belonging ergo being stigmatized makes for particular behaviour around HIV/AIDS. One of the main barriers to changing attitudes and behaviour regarding HIV and AIDS is the fact that those infected or believed to be infected are often harshly stigmatized by their communities and even sometimes by their families (Maduna-Butshe 1997, Kasigwa and Ngambi 2001 in Castle 2004). The fear of being HIV positive is thus a fear of being stigmatized, discriminated, a fear of non-belonging. Especially in remote areas in which family values and community feeling are often stronger than individualistic feelings this can cause major problems (Link and Phean 2002).

Gender and Sexuality Stigma

In relation to the previous paragraphs, stigma can be defined as the expression of power inequalities defined by socio-culturally constructed notions of gender, sexuality and ethnicity, religion and economic status, provoking discriminative behaviour. As was mentioned in paragraph one of this chapter, gender and power are intimately linked, as gender portrays power from one category over another (Steenbeek 1992). When looking at gender and sexuality related stigma, next to these power relations, it further derives from the tension that occurs when set norms and ideas about gender identities and sexuality are not performed accordingly. Gender and sexuality stigma like HIV/AIDS stigma occur at the individual level and the relational level. Behaviour, perspectives and discourse on gender and sexuality portray stigma and discrimination, moreover stigma further causes discriminative behaviour.

Conclusion

This theoretical framework has made a first attempt to outline two bodies of literature in order to set the basis for this research, namely the gender perspective, and the medical anthropological perspective. The first two paragraphs explained the constructionist view of gender, gender identity, sexuality and their relation. With this, it has provided an overview and the relevance of the gender perspective and more importantly outlined the social constructionist view and the relation between gender, sexuality and power. The second body of literature on the medical anthropological perspective was outlined in the third paragraph in which it was applied to HIV/AIDS. In the fourth paragraph stigmatization was defined focusing on the relation between HIV/AIDS, discrimination and power as well as highlighting the similarities with gender and sexuality stigma.

The authors note that this very basic outline requires more exploration and elaboration. More information is needed to bridge the gap between gender, sexuality, power, stigma and HIV/AIDS. However two general trends can be outlined in this conclusion. The first is the constructionist perspective held by both gender studies and medical anthropology. The second connection that can be made is the relation between gender, sexuality and HIV/AIDS in power and stigma. Power relations construct and are constructed by gender, sexuality and HIV/AIDS and within these relations create stigma. Stigmatized gender identities, sexualities and HIV-positive persons are the consequences.

The research of this thesis provides an example of how these bodies of literature can be combined. By highlighting when and where (stigmatizing) gender and sexuality perspectives and behaviour entwine with the (stigmatizing) discourses and behaviours on HIV/AIDS, this thesis contributes to the argument that a gender sensitive approach is needed to study the HIV/AIDS stigma. Hereby this thesis strengthen the bridge between the above outlined gender perspective and medical anthropological perspective.

2. Context and location

South Africa has been home base to the devastating HIV/AIDS pandemic for over three decades now (Jones 2011). With an estimated 11% HIV positive people out of a population of 53 million, the epidemic represents an ongoing threat to South Africa's national health[35]. Over the past three decades HIV/AIDS research has focused predominantly on the populations most harshly affected by the epidemic, like the urban areas in the province of Kwazulu-natal (Strebel et al. 2006). Rural and remote areas in the province of Limpopo have been largely under researched in recent scientific work, while they provide unique context to HIV/AIDS. Limpopo is home to 5.404.868 people, this is 10.4% of population in South Africa (Capeinfo 2011). One in five (21.9 %) of the population of Limpopo was infected with the HIV virus in 2010 (UNAIDS 2012). Although this percentage is average compared to extreme HIV percentages in Kwazulu-natal (39.5 %), it is still shockingly high. Located near the border of Botswana, next to the Mogalakwena River in the Blouberg Municipality, Limpopo Province, the village of Ramaswikana offers a rich and unique research context to do research on HIV/AIDs.

2.1. Demographics

Ramaswikana covers a total acreage of 1.73 km². The population is approximated to be around 3000 inhabitants[36]. The officially counted population of 2011 was 1297 people[37], this may be due to (mostly male) family members working in the bigger cities and only coming back for a monthly visit. In the official count of 1297 people, 57.05% were female, male inhabitants made up the other 42.95%. The ethnicity of the inhabitants of Ramaswikana can be classified as black[38], although more specifically they are part of the Pedi people, an ethnic group with their own culture, history and language which will be further elaborated on below.

As Ramaswikana is located on the outskirts of the Republic of South Africa, there are little to no facilities and a very basic infrastructure. In 2011 Ramaswikana was identified as a place with very poor living standards. That the population is so poor is mainly due to a high unemployment rate. This is shown by the large percentage of the population under 21 years old in the Blouberg Municipality, because most adults find jobs near the larger cities. Poverty levels in the Blouberg are high: a large number of the households have to survive with an annual income of R18 000 (€ 1343.03). As a lot of men have to work in bigger cities, such as Johannesburg or Polokwane, more than 50% of the households are headed by females[39][40].

[35] (http://www.worldometers.info/world-population/south-africa-population/accessed 5-12-2014).
[36] Semi- structured interview Nurse Sarah 25-02-2015
[37] Semi- structured interview Nurse Sarah 25-02-2015
[38] Measured by 'the Statistics South Africa'. From: http://census2011.adrianfrith.com/place/969003001
[39] http://www.blouberg.gov.za/?q=demographics, http://www.localgovernment.co.za/locals/view/118#demographic

2.2. Pedi People

People living in the village Ramaswikana belong to the *Pedi* culture[41]. The Pedi[42] is one of the Northern Sotho tribes, which has their own Northern Sotho language, named Sepedi[43]. Bantu speakers – offspring of the Sotho-Tswana – settled in the late 15th century in the Northern Transvaal[44] and created a kingdom known as Pedi[45]. Nowadays, Pedi people are still mostly situated in the northern province of South Africa.

Ramaswikana and the surrounding villages were created in 1954 – during the Apartheid regime – when chief Kibi agreed to move all people working for the white farms to live near the farms. There are four sub groups in Pedi culture: Ba Nanwa, Ba Hokwa, Ba Nenwa, and Ba Pedi, each with slightly different dress and different pronunciation of Sepedi[46].

Lebaka[47] (2008) defines that the Pedi culture is originally an oral culture in which singing and dancing are important factors: traditional values are handed over to the next generation by songs. By analysing these songs, Lebaka concludes that within the Pedi culture the community well-being is of significant importance, and that respect for the elders is highly valued. As European conquerors came to South Africa during the 17th century and implanted their own cultural values on the African people, Pedi values were influenced by the Europeans. Most importantly, they brought Christianity to the Pedi people. Today a large percentage of the Pedi people believe in and follow Christianity intensively. However, most of the Christian churches – of which the local Zion Christian Church is the most important – consist of a mix of Christianity and African traditional religion. This is visible in the incorporation of the power of ancestors in church[48].

[40] For more statistics see appendix 2.
[41] There are also people living in Ramaswikana who are originally from the Venda culture (a culture that lives next to the Pedi), but as these people are a minority and had to adapt to the Pedi culture, this culture is not relevant for this research.
[42] In the literature also known as the BaPedi (see for instance, Semenya et al. 2012).
[43] Northern Sotho is one of the eleven official languages in South Africa and has thirty different dialect, from which Sepedi is one.
[44] Now known as Limpopo Province.
[45] http://www.sahistory.org.za/people-south-africa/pedi
[46] Semi-structured interview Mr. Engel 23-03-2015, informal conversation Mrs. Atlantis 20-03-2015.
[47] Lebaka himself originates from the Pedi culture.
[48] Lebaka (2007) states that the way these two religions are mingled varies between different societies.
[49] www.globalsecurity.org/military/world/rsa/bapedi-kingdom.htm

2.3. Gender Identity, Sexuality and Stigma

As this thesis argues for a gender perspective, it is important to outline gender and sexuality in South Africa. The relevance of this becomes clear when looking at the statistics of HIV-positive people aged 15-24 in South Africa: the number of women – 13.9% – greatly outdoes the number of men – 3.6% (statistics from 2009, UNAIDS 2012). Much research has been done on the socio-cultural constructions of gender identity and sexuality in South Africa from which this paragraph will outline the hegemonic theories.

South Africa is a heteronormative society. Following Jewkes and Morel (2010) hegemonic masculinity in South Africa consists of physical strength, courage and control. This is mainly expressed by success in heterosexual activities; by winning and controlling desirable women (Jewkes and Morel 2010). Women are mainly expected to be desirable to men: hegemonic femininity in South Africa consists of being strong enough for having – and keeping – a masculine man and of respecting his control, as stated by Jewkes and Morel (2010)[50]. Furthermore fidelity – "proper and reproductive women" (Albertyn 2003: 600) – is an important part of women's identity (Albertyn 2003). Also in the domains of the bedroom is a woman expected to act according to the wishes of her husband (Jewkes and Morel 2010, Nkosi 2011). Furthermore, having multiple sexual partners – which is either accepted or tolerated[51] within South Africa (Delius and Glaser 2011)[52] – or paying for sexual activities is perceived as manly (Jewkes and Morel 2010). In South Africa sex in general - for both men and women, young and old - is considered as an important and normal factor in human life (Jewkes and Morel 2010, Delius and Glaser 2002). Sexual pleasure is of significant importance and the use of condoms is therefore not preferable (Jewkes and Morell 2010).

Lebaka (2008) found out that there exists a big gender division within the Pedi culture, in which men have generally a higher status compared to women. He provides us with the information that Pedi culture is patrilineair and shows us that it is women’s role to clean, cook, take care of people and to respect and be humble to her husband (Lebaka 2008). For men strength, courage and endurance are significant characteristics, as for women the ability to get a child is the most important quality (Lebaka 2008). Lebaka (2008) discovers that parenthood has a significant meaning for Pedi people: it provides girls with the full status of being a woman and men with someone who can inherit and pass on his family name.

[50] Hegemonic masculinity and emphasized femininity – as defined by Connell (2005) and explained in the theoretical framework – are thus relevant terms within South Africa.

[51] When extramarital relationships are tolerated within a society, it means that a society does not accept it but everybody just leaves it. When someone has multiple partners people will probably speak bad about him, but nothing shall be done against it.

[52] Christianity played a big role in how people deal with extramarital relationships. Polygamy existed much more before the coming of this religion, but after this is often less accepted and it forced the extra-marital relationships to go underground (Delius and Glaser 2011).

Delius and Glaser (2002) describe that sexuality is a topic that is easily spoken about within the Pedi culture. Furthermore, they explain that before the 19th century boys and girls learned about relationships and sex during initiation and that pre-marital sexual intercourse was strictly punished (Delius and Glaser 2002, Nkosi 2011). But after the coming of Christianity, Western education, migrant labour and therefore the taboo on initiation and less peer pressure, sex was much less controlled within the Pedi culture. “An inter-generational silence on sexual matters” (Delius and Glaser 2002:37) resulted in a lot of pre-marital pregnancies (Delius and Glaser 2002).

These hegemonic ideas about masculinity, femininity and sexuality in South Africa are strongly related to status. Acting along the lines of these images is beneficial for one's status (Jewkes and Morell 2010): if one does not do so, he/she will be stigmatized and marginalized. Status also influences gender and sexuality. Men, for example, who live in a lower strata of society are generally more dominant and use violence on a higher level (Jewkes and Morell 2010). Another example is the changing views of sexuality among women with a low status: for them sex can become a means to survive (Albertyn 2003).

2.4. HIV/AIDS discourse and stigma

In South Africa HIV/AIDS discourse is shaped by a dynamic history of social and political turmoil. After the era of Apartheid, which created an ethno-racial divide of monstrous proportions, a period of AIDS-denialism as response to the HIV/AIDS epidemic once again shocked the country. This denial came to the attention of the international community in 2000, when President Thabo Mbeki made international headlines with his claim that AIDS was not caused by HIV and refused to implement ART in South Africa (Brown et al 2011: 264). This period of AIDS-denialism in South Africa prevented HIV/AIDS from being treated as a chronic illness (Liamputthong 2013). For a long time HIV/AIDS discourse in South Africa had been counterproductive for attacking the virus and preventing further infection, up until 2003 when the first ARTs were implemented and proper education and health care programs were installed nationally (Brown et al 2011).

Next to these social, economic and politico-historical context factors, interpersonal (individual and relational) aspects have constructed an HIV/AIDS stigma in South Africa. The stigma that surrounds HIV/AIDS is predominantly shaped by socio-cultural and religious notions of sexuality, health and disease[53]. Jewkes (2006) explains how HIV/AIDS stigma in South Africa is visible in the ineffectiveness of HIV treatment, HIV prevention and HIV education and health care programs. The HIV/AIDS stigma is not only felt in these aspects of HIV management in South Africa but especially discrimination of PLWHA is highly prevalent in South African urban and rural communities. This is expressed in a survey which explained that “more than half of people sampled believed that PLWHA should not be allowed to work with children and more than half stated that PLWHA should expect to have their freedom restricted” (Kalichman et al. 2005). Not surprisingly, adverse experiences of PLWHA are prevalent in this context, with 40% of PLWHA having experienced discrimination resulting from having HIV infection and one in five having lost a place to stay or a job because of their HIV status. A survey of people living in an impoverished township outside Cape Town found that believing HIV/AIDS is caused by spirits and the supernatural was associated with prejudice, including a sense of repulsion, and endorsement of discriminatory practices, including support for social sanctions against PLWHA (Kalichman and Simbayi 2004).

[53] These terms are explained within the Theoretical Framework, paragraph 4.2.

3. Gender and Sexuality Perspectives and Behaviour

Written by Rosan Stuijt

Within this chapter I will outline my empirical data gained in Ramaswikana concerning the perspectives[54] and behaviour surrounding gender and sexuality and the stigmatization that accompanies it. The perspectives and behaviour in Ramaswikana will be analysed from a constructivist approach, by using a gender perspective. To be able to outline the entwinements of gender, sexuality and HIV/AIDS in Ramaswikana and to be able to argue for the use of a gender perspective while studying the HIV/AIDS stigma, gender and sexuality perspectives and behaviour shall be addressed firstly.

Gender consists of the shared expectations and norms existing in a society about appropriate male and female behaviour, characteristics and roles (Gupta 2000; Scott 1986), which are well defined in Ramaswikana. There exists a wide variety in the perspectives and behaviour of people living in Ramaswikana, but – as Nagel (2003) describes – there are hegemonic meanings of manhood and womanhood present in every society. The hegemonic meaning of masculinity, femininity, and masculine and feminine roles according to Pedi tradition, will be described and explained. As gender identities define sexuality, the appropriate sexual partners, tastes and activities within Ramaswikana will be outlined simultaneously. I have recognized a gap between traditional Pedi gender identities, which creates a perspective of the ideal man and the ideal woman, and the reality in which gender identities are performed[55]. Therefore I will follow my description of the 'ideal' man and woman with a description of the 'real' man and woman. In the latter, I will describe gender behaviour of people living in Ramaswikana and how this is constructed by the reality of the village. Finally I will conclude how these perspectives and behaviour around gender and sexuality create stigmatization in Ramaswikana.

[54] Here has to be mentioned that the following perspectives do mostly originates from the educational spheres within Ramaswikana. Teachers from the Primary School and women from the Drop-In Centre, but also learners from the secondary school told me about their perspectives on these topics and have tried to tell me something about the hegemonic perspectives and behaviour within Ramaswikana. Some do also originates from the Arts and Craft women, but most of the data about gender and sexuality originates from the educational sphere within Ramaswikana.

[55] Performance "refers to the ways in which we adorn and use our bodies to present ourselves in various roles", as Nagel explains (2003: 52).

3.1. Ideal Man and Woman

With the ideal man and woman I refer to the by society perceived as most appropriate masculine and feminine characteristics, roles and behaviours. These are normative within a society and influence people's behaviour. As gender identities and sexuality are constructed by a culture-specific common sense and the existing social structures in society (Bourdieu 1989, Foucault 1982, Nagel 2003), the perspectives on the ideal man and woman, are as well. The context – with its social structures – that has had and still has a huge influence on the existing ideal gender identities within Ramaswikana, shall be outlined first[56], before going on with the gender identities itself.

The perspectives on the ideal man and woman in Ramaswikana originate mostly from the Pedi tradition. "It's African tradition", is what all my informants explained to me. They note it is part of their common sense, taught by their culture. The so-called circumcision schools[57] played an important role in the construction and maintenance of these gender perspectives: they can be seen as a social structure by which the performances of those gender identities are recognized and taught. Here the ritual initiation of boys and girls into men and women, takes place: they get circumcised and they learn how to be a grown man or woman and other traditional rules such as respect. A few decades ago, the inhabitants of Ramaswikana had to attend those schools for six weeks to become a man or a woman[58].

Religion is also a social structure that creates, defines and reproduces a subject as gender. Religion can say something about those subjects that influence the perspectives of the followers. As most Pedi people in Ramaswikana are Christian[59], the Bible has a significant influence on their perspectives and behaviour.

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[56] In fact those contextual constructions are very complex. Therefore only the factors that have (had) the biggest influence – perceived by myself – within the construction of gender and sexuality in Ramaswikana will be outlined here.
[57] The circumcision schools are named 'mojakoma' for boys and 'dikgopa' for girls.
[58] Informal conversation Mr. Engel 26-02-2015, semi-structured interview Mr. Engel 23-02-2015, semi-structured interview Mr. Jordan 24-03-2015, unstructured interview Mr. Five 23-03-2015 (Miss Poelma).
[59] In Ramaswikana Christianity is mostly mixed with the traditional Pedi belief in ancestors.

Masculinity and Femininity and Their Connected Roles

> A man, from what I know, a 'real' man, in the family, doesn't allow things to take place ordinarily, so without reason. [He] doesn't allow children to do their things their own way. […] They have to follow the rules. It is discipline. […] when I go out my children sometimes want to disobey the rules of the family and the mother used to say: "when your father is coming back I am going to tell him you are doing this and that and he will punish you for that". [...] A man has been dignified for that[60].
>
> *Mr. Fifty, 50*

Here Mr. Fifty tells his perspective of the 'ideal' man during our interview. It illustrates the hegemonic perspective within Ramaswikana. Mr. Fifty – 50 years old – is a primary school teacher within Ramaswikana and follows the Uniting Reformed Church[61].

Within Ramaswikana masculinity means strength – physically and mentally –, courage and power[62]. This means that the ideal man has these characteristics and performs those. Therefore, particular roles – linked on these characteristics – are connected to the real man. To be the head of the family is such an important masculine role in Ramaswikana. This role consists of earning money, taking care of the safety of the family and taking decisions within the family: it is man's role to take the power within the family[63]. The man is meant – according to my informants – to earn money, as he is strong and thus able to do tough jobs like building houses, taking care of cattle and driving a donkey car[64]. Moreover, they note that money and power are connected: without one you cannot have the other.

Like masculinity, femininity also consists of particular characteristics that ideally belong to a woman in Ramaswikana: caring, soft, sympathetic and compassionate[65]. Because the ideal woman has these characteristics, according to the Pedi culture, she suits perfectly to perform domestic jobs like caring for children, cleaning and cooking[66]. All my informants agreed with this feminine role and this expectation that is projected on females. The cleaning role is illustrated by the lyrics of the

[60] Semi-structured interview Mr. Fifty 23-02-2015
[61] This is the same church as the Dutch Reformed Church and does not follow traditional Pedi beliefs.
[62] Unstructured interview Mr. Five 26-02-2015, semi-structured interview Mr. Jordan 24-03-2015, unstructured interview Mrs. Atlantis 22-03-2015.
[63] Semi-structured interview Mr. Engel 23-03-2015, semi-structured interview Mr. Fifty 23-02-2015, semi-structured interview Mr. Jordan 24-03-2015, Group-interview DIC 26-02-2015, unstructured interview Mrs. Atlantis 22-03-2015.
[64] Semi-structured interview Mr. Engel 23-03-2015, Group-interview DIC 26-02-2015, unstructured interview Mrs. Atlantis 22-03-2015, unstructured interview Mr. Five 29-02-2015.
[65] Unstructured interview Mrs. Atlantis 22-03-2015.
[66] Semi-structured interview Mr. Engel 23-03-2015, semi-structured interview Mr. Fifty 23-02-2015, semi-structured interview Mr. Jordan 24-03-2015, unstructured interview Mr. Five 29-02-2015, unstructured interview Mrs. Atlantis 22-03-2015.

wedding song which is presented here. This song is traditionally sung during weddings and directed to the bride[67]. It makes her role within a family explicitly clear[68].

Boys and girls learn to perform these roles within circumcision schools, but also the Bible mentions the man as the head of the household[69]. Another quote from Mr. Fifty provides insight in this influence: “Because we believe that if […] a woman must be in power, will be maybe disobeying even the bible’s laws, because it has never been challenged even in the bible that a man will rule, a man will be the leader of the family” (Mr. Fifty, 50)[70].

SEPEDI:
Fiela, fiela, fiela, ngwanyana
Fiela, ngwanyana
O se jele matlakaleng

ENGLISH:
Sweep, sweep, sweep girl
Sweep, girl
Don’t eat at a dirty home

Sweeping song.
Source: informal conversation Skat and Nilsa 18-02-2015

Hegemonic Masculinity and Emphasized Femininity

Gender can be the object – as well as the subject – of power: gender can divide power differently between the two sexes, which can provide differential control over or access to material and symbolic resources (Scott 1986, Nencel 2007). This is recognizable within Ramaswikana as the man has ideally more control over and access to particular resources – as money and power – compared to the woman. Furthermore, the ideal woman is expected to behave according to the desires of her husband. This became clear during a conversation I had with Yappie about cheating. Yappie – a 27-years-old woman – works voluntarily at the Drop-In Centre[71] and is a full-time house-mom. Her boyfriend works at Polokwane[72] and comes home once every three months. Yappie told me that she would never leave her boyfriend even though she knew he was cheating on her. When I asked her about women and cheating, she laughed and said: “if I cheated on him, he maybe kill me or […] divorce me” (Yappie, 27). I asked her why this difference existed, to which she answered: “because in our culture they said a man is head of the family. We have to listen to them… every time…”[73] (Yappie, 27). This conversation shows the present performance of the by Connell (2005) created notions of hegemonic masculinity – "the pattern of practice ... that allowed men’s dominance over women to continue" (Connell 2005:832) – and emphasized femininity – the compliance of accommodating the desires of men (Connell 2005) – in Ramaswikana.

[67] Informal conversation Nilsa 18-02-2015, Informal conversation Skat 13-02-2015.
[68] Fidelity and childbearing are also important in woman’s identity of which we will talk in paragraph ‘parenthood’.
[69] Unstructured interview Mr. Five 26-02-2015, Group-interview DIC 26-02-2015, Semi-structured interview Mr. Fifty 23-02-2015, Semi-structured interview Mr. Engel 23-03-2015.
[70] Semi-structured interview Mr. Fifty 23-02-2015
[71] Almost all children in Ramaswikana go to the Drop-In Centre every day after the Primary School at 14 o’clock. Here they get some bread, some drinks and the women – trained by ISIBINDI, a governmental organization – try to fill their time by helping them with homework or by playing with them.
[72] The nearest big city, which provide enough job opportunities for men. Therefore many men from the village work there.
[73] Group-interview DIC 26-02-2015

Sexuality

Beside gender defining roles within the house and at work, gender also defines sexuality. *Sexuality* consists of appropriate sexual partners, tastes and activities (Nagel 2003). Within the perspectives on ideal sexual behaviour present in Ramaswikana, there exists a division between the educational sphere and the traditional Pedi sphere. The school curriculum on sexual behaviour, originating from the government, provides the students with the ABC-model: 'Abstain, Be faithful and Condomize' to avoid STI[74][75]. All secondary school students are taught about this ideal sexual behaviour according to the government[76]. However, this conflicts with the ideal sexual behaviour originating from the Pedi culture.

Ramaswikana is a heteronormative society, which refers to the normative sexual desires towards, and activities with, the opposite sex (Nagel 2003, Jackson 2006, Schilt and Westbrook 2009). Sexuality is a crucial part of life according to the inhabitants of Ramaswikana – outside and inside a relationship, for young and old. Men and women are expected to experiment with sex while they are young, as it is perceived as 'cool' within Ramaswikana to have had sex once[77]. This gives sexual intercourse huge meaning among the youth. This is illustrated by the posters that were made during our first 'You(th) Talk'. Miss Poelma and I arranged two 'You(th) Talks' during our research, to talk with secondary school students about their perspectives on gender, sexuality, HIV/AIDS and life in Ramaswikana. The first time we were with approximately twenty students, who made four groups in total. The main assignment of this 'youth talk' was to make a poster about gender and sexuality related topics and to present this to the group. A few girls chose to make a poster about peer pressure[78], which is shown in Appendix 3. The provided box (right) portrays the text they wrote down on it and shows the peer pressure on sexual activity that exists among youth in Ramaswikana.

> "She regrets no sex. She is now pregnant". "They put pressure on her. They were saying: "oh, join us, why are you still a virgin? Everyone is doing it!"
>
> *Text on poster concerning peer pressure made by secondary school learners*

Sexual behaviour is especially essential within a relationship. It is the ideal man's job to perform well on a sexual level and to provide his wife with sexual pleasure[79]. Most informants focus on this responsibility of the man, but Mrs. Atlantis told me about the responsibility of the woman. Mrs. Atlantis – 56 years old – is a teacher within the Primary School, as well as a preacher within the Uniting Reformed Church. During an interview she explained her responsibility towards her husband:

[74] Sexual Transmitted Infections.
[75] Unstructured interview Mr. Jordan 24-03-2015.
[76] You(th) Talk 1 24-03-2015.
[77] You(th) Talk 1 24-03-2015.
[78] 'Peer pressure' was the only topic Miss Poelma and I did not invent ourselves. These girls asked us if they could talk about this, showing us the need of discussing the topic.
[79] Unstructured interview Mrs. Atlantis 22-03-2015, unstructured interview Mr. Five 23-03-2015 (Miss Poelma).

"my responsibility is the house ... and in the bedroom. This is very important!"[80] (Mrs. Atlantis, 56), she said explicitly. The ideal man and the ideal woman are able to provide their partner with enough sexual pleasure.

Besides this general significance, masculine identity is traditionally especially connected to having a significant amount of sex – preferably with many women. This is connected to the history of polygamy in Pedi culture, as it was normal to marry two or more wives a few generations ago[81][82]. Mr. Fifty told me his perspectives on the masculine nature, which provides insight in this masculine sexual behaviour:

> As men we have this thing of sharing our love to more than one wife. Sometimes we lose interest in one wife. I don't know where that... How can I call it maybe it is the force of nature… which we cannot know. You see. I don't know what pushes us to feel that I must have more than one wife. It is just maybe the feelings I don't know[83].
>
> *Mr. Fifty, 50*

Here the interconnectedness of gender and sexuality becomes clear: sexual behaviour in Ramaswikana performs the feminine, but especially the masculine, gender identity. This provides this particular sexual behaviour with more value.

There are two important concepts that are related to ideal sexual behaviour in Ramaswikana: (1) parenthood, and motherhood in particular and (2) cleanliness. In the next paragraph I will explain the meaning of these concepts in Ramaswikana and how these influence sexuality.

[80] Unstructured interview Mrs. Atlantis 22-03-2015.
[81] Informal conversation Loulou 06-02-2015, semi-structured interview Mr. Fifty 23-02-2015, semi-structured interview Mr. Jordan 24-03-2015, unstructured interview Mrs. Atlantis 22-03-2015, Group-interview DIC 26-02-2015.
[82] Why polygamy is not practiced anymore, will be explained in paragraph 3.2.
[83] Semi-structured interview Mr. Fifty 23-02-2015.

Parenthood

Parenthood is essential within the lives of people living in Ramaswikana. In their perspective it is a normal part of life and it follows on a relationship. I asked Mrs. Atlantis about her perspective on children and family, to which she said the following:

> It is very much important. […] Because I think if you don't have a family, who is going to take care for you? Maybe you get sick or whatever… and if I die being alone, the generation is gone. It is better to have a family […] To have children is natural. You cannot say I don't want to have children. […] even the bible doesn't allow that[84].
>
> *Mrs. Atlantis, 56*

It is common sense to have children within Ramaswikana, as everybody wants to pass their family name and nobody wants to be alone when they got older[85][86]. It is therefore a responsibility for both men and women to provide their partner with children: according to people living in Ramaswikana, the ideal man can provide his wife with 'strong sperm' and the ideal woman is fertile[87].

Moreover, for women in Ramaswikana, parenthood has even more value. Faircloth (2009) states that mothering is an important identity frame for women. I argue with Oyěwùmí (1997, 2005) and Nnaemeka (2005) that motherhood can be seen as a rite de passage that can provide women with a different status, namely that of 'a woman' instead of 'a girl'. According to the people living in Ramaswikana, a girl can never be a 'real' woman if she has never had a child[88]. That motherhood has a huge meaning for women, is shown by the fact that almost all women have children, also at a young age: the average age of getting children in Ramaswikana varies between 15 and 18 years old[89]. The only exceptions to this trend are nowadays to be found at the secondary school[90]. Also during our games 'cross the line' at the second 'You(th) Talk', this essential part of the ideal woman became clear. All but one secondary school student agreed on this essentiality of becoming a mother. Beyoncé[91] – a 20-years-old girl from Sias – argued: "only then she knows how it is to have

[84] Unstructured interview Mrs. Atlantis 22-03-2015.
[85] Unstructured interview Mrs. Atlantis 22-03-2015, semi-structured interview Mr. Jordan 24-03-2015.
[86] Especially in a society as Ramaswikana where there exists no care from the government for older people.
[87] Unstructured interview Mr. Five 23-03-2015 (Miss Poelma), Semi-structured interview Opium 26-03-2015.
[88] You(th) talk 2 17-03-2015.
[89] Semi-structured interview Mr. Engel 23-03-2015, Group-interview DIC 26-02-2015, informal conversation Sunshine 12-02-2015.
[90] An important note is that people in Ramaswikana nowadays get taught about teenage pregnancies, the consequences and how to avoid it. My informants all agree that teenage pregnancies are not a good thing, but still at the end of the day a lot of them got children when they were still a teenager. So their perspectives about teenage pregnancies are not positive, but their behaviour differs from that (in which the importance of motherhood plays a significant role).
[91] I discovered during the last day that Beyoncé had a child from 3 years old with her current boyfriend.

responsibilities”[92]. As motherhood is such an essential part of female gender identity, womanhood is most importantly defined in relation to procreation and children.

Here again the connection between gender and sexuality becomes clear, as sex is used to fulfil – especially – the feminine gender identity. Therefore sexual intercourse and getting a child has an enormous value: it makes becoming the ideal woman possible.

Cleanliness

As explained, sexual activities are of crucial importance for people in Ramaswikana, especially for men and in a relationship. He has the responsibility to provide his wife with sexual pleasure and ‘strong sperm’ in order to reproduce. According to Pedi people circumcision and cleanliness are crucial for the performance of this sexual behaviour[93]. Circumcision is perceived to be able to provide a man with a clean penis as the cover of the penis carries diseases and is thus associated with dirtiness. As dirt is associated with disorder and thus implies something bad for society, cleanliness, on the other hand, is associated with order and goodness (Douglas 1986). Sexual health and thus a clean penis are essential to be able to be a ‘real’ man within Ramaswikana[94].

This is not only because cleanliness itself, but also because this clean penis is perceived to be able to – firstly – produce high sexual pleasure for a woman, as shown by the quote of Mr. Five. – a 47 year old teacher within the primary school:

> And there is also this difference between boys and girls who have gone through circumcision, so those who haven’t yet gone, who go with a woman. It is a very big difference. Women they say he feels immature. So with circumcision, with that one, that is preparation for to make a long lasting relationship last in the family[95].
>
> *Mr. Five, 47*

He illustrates here again how important sexual pleasure is, as this is essential for a long lasting relationship. Secondly, a clean penis is also perceived to be able to produce ‘strong sperm’ in order to get children: “disease will disturb your […] they kill the tracks of the pathways, the transport […] sperms that must come out fresh to make babies”[96] (Mr. Five, 47). The high value on sexual health – a clean and thus circumcised penis – is thus interlinked with sexual pleasure and parenthood.

[92] You(th) talk 2 27-03-2015.
[93] Unstructured interview Mr. Five 23-03-2015 (Miss Poelma), You(th) Talk 2 27-02-2015.
[94] Semi-Structured Interview Hermanus 12-02-2015 (Miss Poelma), Semi-Structured Interview Mr. Engel 24-03-2015 (Miss Poelma).
[95] Unstructured interview Mr. Five 23-03-2015 (Miss Poelma).
[96] Unstructured interview Mr. Five 23-03-2015 (Miss Poelma).

3.2. Real man and woman

The ideal gender characteristics, roles and expectations influence one's behaviour, which leads to the performance of these gender identities. However, the amount of people who do not perform those perspectives continues to increase within Ramaswikana. There are several factors that have contributed to this difference between the 'ideal' and 'real' man and woman[97], of which the most significant ones will be explained here. They are predominantly a consequence of a mingling of the existing perspectives on gender and sexuality, and the struggles inhabitants of Ramaswikana experience as a consequence of the economic situation. Also the disappearance of the circumcision schools[98], the increase of televisions[99] within the houses in Ramaswikana and the increased importance of education[100] has constructed the 'real' man and woman. As the economic situation is the most influential, I will outline this contextual factor before going on with the 'real' man and woman in Ramaswikana.

> The first time walking in Ramaswikana. The sun was shining bright. Everybody was wearing long sleeves, long skirts or long trousers and struggling to stay on both feet and keep walking through the heat of the day. There was a small child with torn cloths walking by, not believing his eyes by the sight of a white person. Down the road I saw a small cabin entirely made from tin; it was the home of a woman. A bit further I saw a house where only children lived as their parents passed away. When arriving at the primary school, I was not able to speak to the headmaster, as his colleague just passed away. I went on to the Drop-In Centre. Directly, I was confronted with the question: "what are you going to do for US?!" (Yappie, 27), followed by a sum of the struggles they experienced: "too less jobs, too much illiterate, too much orphans, no clinic" (Chany, 27).
>
> *First days in Ramaswikana (04-02-2015), illustrating the poverty in the village.*

[97] This 'real' man and woman that will be described is observed by me and confirmed by my informants.

[98] For an estimated twenty years everybody gets circumcised at the nearest hospital without lessons about man- or womanhood. Because of the – in the governmental eyes – inhuman aspect of those schools and inability to miss six weeks from the secondary school, it is not accepted anymore. With the loss of this important social structure – as well as political recognition – the ideal gender identities are less strongly taught, with probably a slightly less performance of those identities among the younger generation as a consequence.

[99] Televisions shows people within Ramaswikana how life is within the bigger cities. Here they see that gender identities can be different than they used to know.

[100] In a 'Life Skills' book from grade 6 from the primary school in Ramaswikana a few pages are spend on gender with the title: 'no to gender stereotyping, sexism and abuse'. Here they explain what the 'sexist gender stereotypes' are – boys: tough, strong and assertive and girls: cute, sweet-natured, helpful and expected to stay and help at home – and that they influence behaviour – with abuse as example. They show the children that those identities are *stereotypes* and thus not something that just *is*. The book shows that this stereotyping can lead to bad behaviour and in the end they show an example of a man that cooks.

An estimated ten years ago, the Department of Social Development has recognized Ramaswikana as officially poor[101]. Since approximately 2005, help is provided by the government as teachers nowadays get guidance, an after-school care – the Drop-In Centre – is build up and food send to the village. Most people have too little money to take good care of themselves and their family. Additionally, there is a lack of opportunities in Ramaswikana to overcome poverty: there are almost no jobs and the ones that exist are badly paid. Furthermore it is too dry to cultivate food. People are dependent on the money and the food from the government. This has resulted in a large amount of especially men finding work and living in Polokwane or Johannesburg, where jobs can be found and money earned. They either take their family with them or send the money to their family and come back a few times a year. Both men and women from the younger generation are leaving the village. As there are also almost no leisure activities, a large amount of the – particularly young – population wandering around the street or spend their free time drinking alcohol in the taverns. In the weekends the two taverns in Ramaswikana are full of especially men, but also young girls – between 13 to 18 years – are curious to see what happens inside. As there is little control from parents[102], children can easily do what they want to do[103].

Working and Single Mothers

As the men are nowadays unable to provide enough money to buy food for their family, it is also the woman's role to help her husband with earning money[104]. But also due to the fact that many mothers in Ramaswikana are not married, almost all women in Ramaswikana work in order to take care of their family. Although within these jobs the ideal man and woman are still recognizable, as women mostly work as carers and men still earn most money with their physically tough jobs. Furthermore, the 'real' woman in Ramaswikana often has taken up the role of being the head of the family, as there is no father to perform this role[105]. A lot of women in Ramaswikana get pregnant without being married. Marriage is less valued and practiced within the reality of Ramaswikana and many women live with their children together with their parents, brothers and sisters instead of their husband.

[101] Informal conversation Becky 04-02-2015.

[102] There is less control within households, as parents sometimes pass away and men and women nowadays are often working during the day – which will be explained in the next paragraph.

[103] Informal conversation Nilsa 04-02-2015, Semi-structured interview Jesus 07-03-2015, informal conversation Mr. Atlantis 21-03-2015, Semi-structured interview Mr. Fifty 23-03-2015, semi-structured interview Rappa 26-03-2015, informal conversation Rappa 29-03-2015, additionally to my own observations.

[104] Unstructured interview Mr. Five 26-02-2015, informal conversation Mrs. Atlantis 26-02-2015, Group-interview DIC 26-02-2015.

[105] Although there are a lot of families now led by woman, most informants who I asked about this situation, told me that this is not as good as when a man is the head of the household. Women are not good in taking such a big responsibility as being a head of the household, they perceive.

Interesting about this behaviour is that it is predominantly constructed by the economic situation in Ramaswikana, but in the end influences the perspectives of the people living in Ramaswikana. As the hegemonic gender identities are not performed anymore, the performativity will stop and therefore the hegemonic gender identities will change (Nagel 2003). In Ramaswikana the perspectives on gender identity have not changed much, but nowadays it is accepted by everybody that women work for example; it has become normal. Also other perspectives – especially among the younger generation – are not similar to the traditional ideal ones. One day at the Arts and Craft Centre, I spoke to the women who were working there about their home-situation and their perspectives about that. Holina – a woman 34 year old woman, who gave birth to a child when she was fifteen from which the father passed away – told me that her new boyfriend had no job, because "you know, he is too lazy", she said laughing. I asked what she thought about that, to which she replied: "yeah, you know what: I know that he only likes me. He has no problem with it too"[106] (Holina, 34). So as Foucault explains that the power-folded regulatory discourses coerce people in performing hegemonic identities (Butler 1990), there are also structures in society that coerce people to not perform the hegemonic identities – which in the end can evolve the hegemonic gender identities.

That a large amount of women in Ramaswikana are single mothers has several reasons. As a lot of men are moving out of the village in search for a job, there are not enough men for all the women living in Ramaswikana, as perceived by my informants[107]. The other factors are that people living in Ramaswikana are sleeping around a lot and that there is a significant meaning attached to motherhood, which will be explained in the following paragraphs

Sexuality

The ideal sexual behaviour according to the government is hardly practiced within Ramaswikana. The inhabitants place more value on the perspectives coming from the Pedi culture, but – as explained – their behaviour is also constructed by the economic situation existing in Ramaswikana.

As outlined above, the 'real man and woman' place much value on sexual activity. The enactment of this value has changed during the years in which the economic reality of Ramaswikana has played an important role. A few generations ago polygamy was the norm in the village, but today as men are not able to take care of more than one family, the practicing – and the acceptance of – polygamy has decreased[108]. However as the perspectives on sexual behaviour have not changed on a larger scale, it still influences their behaviour, only in a different way: the result is having several

[106] Informal conversation Holina 18-02-2015.
[107] Semi-structured interview Mr. Fifty 23-03-2015, informal conversation Flower 12-02-2015.
[108] Informal conversation Loulou 06-02-2015, semi-structured interview Mr. Fifty 23-02-2015, semi-structured interview Mr. Jordan 24-03-2015, unstructured interview Mrs. Atlantis 22-03-2015, Group-interview DIC 26-02-2015.

dinyatsi, which means unofficial wives[109]. The 'real' man and woman in Ramaswikana rarely perform polygamy openly, however they do so secretly. As is confirmed by all my informants: everyone who is married within Ramaswikana is having extra-marital relationships[110]. Also the youth are 'sleeping around' a lot[111]. An important factor within this sexual behaviour is alcohol: people get drunk often, which make them much less conscious about the decisions they make concerning sex[112].

Another important factor is the lack of money in Ramaswikana. As a large number of the women living in Ramaswikana do not have enough money to get food, clothes or other basic needs, getting money one way or another is important for them. Starting a – or several – sexual relationship with a man can be a means for women to gain money or food as this consists of man's role towards her.

Abstaining and being faithful – the A and B from the governmental ABC-model – are therefore almost not enacted within Ramaswikana, but also condomizing – the C from the ABC-model – is something that is predominantly not done. All my informants agreed that the amount of the use of contraceptives is very low in Ramaswikana[113]. Condoms are not preferable as it is perceived to lower sexual pleasure, which is highly valued. Mentioning the use of one, can create discontent by their sexual partner, which can lead to negative consequences within a relationship or, for instance, makes the chance on getting money for women smaller[114]. Furthermore, condoms are associated with people who 'sleep around' or carry sexual diseases, with which one does not want to be associated[115]. The secondary school students also admitted that when they want to have sex but they do not have a condom, they probably still would do it[116].

This sleeping around without using a condoms thus provide women getting pregnant without being married, as described above. However, this resulted motherhood is not only a 'by-product' but also often the goal of women by performing sexual behaviour.

[109] Unstructured interview Mrs. Atlantis 22-03-2015, semi-structured interview Mr. Jordan 24-03-2015.
[110] Semi-structured interview Mr. Fifty 23-02-2015, semi-structured interview Mr. Jordan 24-03-2015, unstructured interview Mrs. Atlantis 22-03-2015, Group-interview DIC 26-02-2015.
[111] Unstructured interview Mr. Jordan 24-03-2015, Group-interview DIC 26-02-2015, unstructured interview Mr. Engel 23-03-2015, You(th) Talk 1 24-03-2015, semi-structured interview Rappa 26-03-2015 (Miss Poelma), You(th) Talk 2 27-03-3015, informal conversation Phinius 29-03-2015.
[112] Semi-structured interview Jesus 28-02-2015 (Miss Poelma), semi-structured interview Rappa 26-03-2015 (Miss Poelma). unstructured interview Mr. Engel 23-03-2015, informal conversation Phinius 29-03-2015.
[113] Unstructured interview Mr. Jordan 24-03-2015, unstructured interview Mrs. Atlantis 22-03-2015, unstructured interview Mr. Engel 23-03-2015 , semi-structured interview Mr. Jordan 24-03-2015.
[114] Semi-structured interview Mr. Fifty 10-03-2015.
[115] This correlated with the stigma that surrounds a condom, which will be explained in paragraph 3.3.
[116] You(th) Talk 2 27-03-3015

Motherhood to Survive

Motherhood has a huge meaning within the performance of the ideal woman in Ramaswikana; however in reality this meaning has even more value. The government of South Africa nowadays provides mothers with 320 Rand per month per child – from 3 months to eighteen years old[117]. Most of my informants agreed that this money from the government causes girls and women to 'sleep around' a lot in order to get children and consequently money.[118] The consequence of the economic structure – and the answer of the government to this – is that motherhood, besides a means to fulfil the expected gender role, has become a means to survive[119]. Also the fact that the man has to provide the woman with money, according to the Pedi tradition, helps creating this meaning attached to motherhood. In combination with the before mentioned fact that there are less men than women in Ramaswikana and that much inhabitants sleep around, motherhood has more value than marriage. Mrs. Atlantis told me about the behaviour of women in Ramaswikana exemplifying this perspective: "They just get the boyfriend and then the children and then she goes, get another one, get the children, go and get to another one. Just like that" (Mrs. Atlantis, 56)[120].

[117] Unstructured interview Mrs. Atlantis 22-03-2015, Semi-structured interview Mr. Engel 23-03-2015.

[118] Unstructured interview Mrs. Atlantis 22-03-2015, informal conversation Mr. Atlantis 21-03-2015, Semi-structured interview Mr. Engel 23-03-2015, Informal conversation Phinius 29-03-2015, semi-structured interview Mr. Jordan 24-03-2015, unstructured interview Mr. Five 23-03-2015 (Miss Poelma).

[119] Yappie attached even more value to motherhood: it ensures love and marriage. "If a man wants to marry me he can say I have to have a baby before marriage to ensure him that I love him. A lot of men [do that]. It's a part of marriage and shows your husband that you love him" (Yappie, 27).

[120] Unstructured interview Mrs. Atlantis 22-03-2015

3.3. In Conclusion: Gender and Sexuality Stigma

Stigma is "the identification that a social group creates of a person (or group of people) based on some physical, behavioral, or social trait perceived as being divergent from group norms" (Goffman (1963) in Castro 2005: 53). As gender and sexuality are identity frames that belong to a person, stigmatization can surround these topics. In this chapter I have outlined the existing gender identities – with their interconnected characteristics, roles and behaviour – in Ramaswikana, which are expected to be performed. The performance of gender and sexuality that is not in line with the hegemonic ones can be perceived as divergent behaviour and connected to stigma. A person who performs perceived divergent behaviour or characteristics can be stigmatized within society: he or she is deprived from power as others assume this power over him or her (Gregg 2011; Skinner and Mfecane 2004). Here again it becomes clear that gender can be the object of power: it distributes power differently between people based on the performance gender. The most apparent stigmas[121] that surround gender and sexuality and the resulted behaviour in Ramaswikana will be outlined within this paragraph.

Stigmatized Man and Woman

Men who are not physically and mentally strong are stigmatized within Ramaswikana. Behaviour that is not similar to the hegemonic gender identities can lead to "subsequent disqualification of membership from a group in which that person was originally included" (Goffman (1963) in Castro 2005: 53). Strength belongs to the identity of the 'ideal' and 'real' man and thus the non-performance of this quality makes him disqualified from the – socially constructed – masculine identity in which he originally belonged. Those perceived 'weak' men are stigmatized within Ramaswikana. Moreover, as the masculine gender identity also defines appropriate sexual behaviour, not performing well on sexual level and nog being circumcised is also stigmatized within Ramaswikana. During the game 'cross the line', which Miss Poelma and I did during our second 'You(th) Talk', we asked the secondary school students: "cross the line if a man is not a 'real' man[122] without circumcision". Only one student did not cross the line; the others agreed with the dismembering of the perceived unclean person[123]. This stigma is strengthen by the perspective that not being circumcised is associated with dirtiness and thus seen as a threat to the society (Douglas 1966).

[121] As stigmatization is a highly sensitive topic of which people do not talk easily, the described stigmas follow out of my analysis of especially the perspectives, but also the behaviour, of people living in Ramaswikana. Nobody did explicitly address these as stigmas and told me how they act towards this stigmatized person; the stigmas are implicitly present in their perspectives and behaviour.

[122] The here mentioned 'real' man, used in our game, includes the above described 'ideal' and 'real' man.

[123] You(th) Talk 2 27-03-2015.

"Congwa"[124] is the name given to women who are around 30 years old and who do not have a child yet[125]. Infertile women or women who are not a mother around that age are stigmatized within Ramaswikana. As mentioned before, in the eyes of the secondary school students a woman can never be a 'real' woman if she does not have children[126]. In this way she is dismembered from the group 'women' in which she was originally included and thus she is stigmatized.

When someone is stigmatized, people judge and discriminate this person; he or she is deprived from status and power. The influence of stigmatization on the life of men and women in Ramaswikana is predominantly connected to the ability to marry and start a family. Mr. Five illustrates this connection: "but who will ever love a man who is not as strong as he should be. And sexual activities will show the strength of the man; it is one of those things"[127] (Mr. Five, 47). The quality of having 'strong sperm' and being able to provide your partner with sexual pleasure and children are perceived as essential within a relationship. "At an age of 30, if I don't make him a baby [...] he is going next door. He will go see another woman"[128], Chany (27) explained to me.

Because of the stigmas on not performing well on sexual level and not being a parent existing in Ramaswikana, it is also stigmatized to use a condom. A condom is associated with a decrease in sexual pleasure and with the use of one reproduction is not possible. Additionally, they are linked to someone who sleeps around or is HIV-positive[129]. All these images are feared within Ramaswikana, which results in the small amount of the use of condoms.

Through the fear of getting stigmatized – and thus the fear of non-belonging and discrimination – these stigmas influence the behaviour of people living in Ramaswikana (Maduna-Butshe 1997, Kasigwa and Ngambi 2001 in Castle 2004). As humans want to belong to a social group, the non-belonging and the subsequent discrimination creates fear of stigmatization. This fear leads men and women in Ramaswikana behave according to the expectations that are projected on them. For instance, as men in Ramaswikana are afraid to be perceived as weak and dirty by their community – as this can lead to discrimination and inaccessibility to marriage and children – they will behave to proof that they are masculine and thus will perform the hegemonic gender identities. These stigmas make men and women in Ramaswikana behave in line with the in this chapter described gender identities.

[124] You(th) Talk 2 27-03-2015. Here I am not sure about the spelling and the meaning of this word. However, I do not that it is a word with a negative connotation.
[125] You(th) Talk 2 27-03-2015.
[126] As described within paragraph 3.1.
[127] Unstructured interview Mr. Five 23-03-2015 (Miss Poelma).
[128] Group-interview DIC 26-02-2015.
[129] You(th) Talk 2 27-03-2015, Unstructured interview Mr. Five 23-03-2015 (Miss Poelma).

4. HIV/AIDS in Ramaswikana

Written by Renske Thalia Poelma

In this chapter I present my empirical data on the discourses and behaviours of the people in Ramaswikana concerning HIV/AIDS. From a medical anthropological perspective I take on a holistic, constructionist approach on HIV/AIDS (Brown et al. 2011). I start by outlining the socio-cultural–Pedi and Christian–, and politico-economic –poverty and government– context that form the larger structuring discourses on health, disease and sexuality in Limpopo, South Africa. Thereafter I zoom into the local level and introduce the roles of the research population regarding HIV/AIDS by analysing people in social spheres.

I then provide an overview of the discourses and behaviours regarding HIV/AIDS from participants within the social spheres in Ramaswikana. I describe HIV/AIDS discourses and behaviours within three fields: (1) the history of HIV/AIDS in Ramaswikana, (2) HIV prevention and infection, and (3) PLWHA and HIV testing, treatment and care. Within each of these topics I present different discourses from the social spheres and use ethnographic examples that represent best how these interact with each other and structure individual behaviour and community discourse on the particular topic. Moreover I highlight how these local discourses are intensified by stigma and how they are constructed by the larger discourses of Pedi, Christian and politico-economic contexts.

Finally I argue that larger conflicting discourses from the socio-cultural and politico-economic context become visible at the local level, where friction of discourses exists between social spheres and within, at the individual level. I further argue that this friction between local HIV/AIDS discourses and behaviours is intensified by stigma surrounding HIV/AIDS.

4.1. Larger Discourses

As noted by Castro and Farmer (2005) and Dworkin et al. (2013) larger socio-cultural and politico-economic contexts have to be taken into account when studying local discourses, behaviours and perspectives on HIV/AIDS. The socio-cultural structures affecting the research population in Ramaswikana are mainly the Pedi culture and Christian religion, each producing a set of norms and values concerning health, disease and sexuality. These structures strongly affect the view on and use of for example clinical, religious and traditional healing and treatment, but also the view on sexual activity, which highly affects HIV infection (Brown et al. 2011). Politico-economic structures affecting the behaviour and discourse of the population in Ramaswikana are the governmental structures of the education system and the health system. Moreover the politico-economic factors of poverty and lack of jobs have major influences on local behaviour and discourse regarding health and sexuality.

From the socio-cultural context a discourse on health and sexuality can be formulated from Pedi and Christian values and perspectives. Unofficial health services, in the form of church healing and traditional healing, work from a traditional Pedi and Christian discourse on health and sexuality. In Pedi culture talking about health and especially sexual health is taboo, which creates a culture of silence or in this case, a 'discourse of silence' (Dixon-Mueller and Wasserheit 1991). Moreover even though abstaining and being faithful to one partner is in line with Christian values, in Pedi culture polygamy is not unheard of, and abstaining is quite uncommon, as reproduction has a major role in being a man or a woman, which was emphasized in the previous chapter on ideal and real gender identities.

The governmental HIV/AIDS discourse that derives from the politico-economic context of South Africa is mainly focused on the prevention of HIV infection through (1) preventive methods, (2) adequate information on the use of these contraceptive methods and (3) access to both information and contraceptives (Dworkin et al. (2013). In South Africa the discourse can also be defined as the ABC discourse on HIV/AIDS, meaning HIV infection can be prevented by Abstaining, Being Faithful to one partner, and Condomizing (Brown et al. 2011; Skinner and Mfecane 2004). Access to health care is provided by the official health services (the clinics and hospitals), and information is provided by the education department.

How people choose from larger discourses to construct their own discourse on HIV/AIDS, differs per social sphere, as each social sphere is influenced by different factors. Moreover within these social spheres discourse and behaviour can differ per person.

4.2. Social Spheres

I describe local discourses and behaviours on HIV history, HIV infection and prevention, PLWHA and HIV testing, treatment and care in Ramaswikana, from different social spheres. Social spheres can be envisioned as groups of people that hold a common role in the society, like students, nurses or teachers. These social spheres consist of Home Community Based Care (HCBC) carers, nurses, the traditional healer, the teachers from the local primary and secondary school, students, religious leaders from the local churches, HCBC patients, and families, children, and (young) women and men in general[130]. Each of these social spheres experiences and/or executes different aspects of education or provides information on health care, concerning HIV/AIDS. Combined they form one community, one social group with group norms, thereby directly influencing each other's discourse and behaviour on a social group level. As mentioned in the previous paragraph on larger discourses, each social sphere picks and chooses from aspects of the larger shaping discourses and formulates its own discourse and behaviour accordingly. Furthermore the various spheres influence each other, the most direct examples being teachers to students and parents to children.

Below I provide a short description of the social spheres and their roles and relation with HIV/AIDS, before moving onto their behaviours and discourse regarding the separate HIV/AIDS themes.

The Health Department officials and HCBC carers

The Limpopo Health Department directly funds the Home Community Based Care centres in remote villages. The HCBC[131] carers consist of a group of eleven young women (18-30 years old) with no official schooling apart from a course on health risks once a year. Their work consists of doing door-to-door walks, providing the patients with their medication and assisting or appointing them to the clinic if necessary. The Limpopo Health Department also provides direct health care through the yearly Health Campaign, in which they provide health advice, free condoms, HIV tests and TB checks.

The Kibi clinic and Ratshatsha Hospital Nurses

Twenty kilometres south of Ramaswikana lies the Kibi clinic, and another ten kilometres farther the Ratshatsha hospital which has about 30 active nurses and one doctor. Especially the Kibi clinic is responsible for the daily health care of the inhabitants of Ramaswikana and holds around 10-15 active nurses and one head nurse. The hospital also owns a mobile clinic (a small van driving around at set days through set villages), which provides minimal health service locally.

[130] The Churches and the Schools have been included in the social spheres as they are of major influence and are local representations of the larger discourses.

[131] From now on Home Community Based Care(rs) is referred to as HCBC.

The Traditional Healer or Ngaka Ya Setho

The traditional healers or *Ngaka Ya Setho* perform healing rituals and have knowledge on traditional medicine from Pedi tradition. The Ngaka Ya Setho is the only person to perform traditional rituals concerning the ancestors, marriage and blessing the family amongst other things, which are all very important aspects in Pedi culture. For these practices the Ngaka is still considered a valuable member of the community. Moreover the Ngaka is often combined with consulting the official health facilities: the clinic and the hospital.

The Churches

The two main churches in Ramaswikana: Zion Christian Church and Apostolic Church are often consulted to perform healing rituals or give medicinal advice, but also provide guidance in love matters[132]. Other churches like the Dutch Reformed Church do not preach they can heal and thus do not perform healing rituals or promote traditional healing or ancestral healing. They do provide advice and counselling on matters such as HIV/AIDS.

The Schools

The two schools in Ramaswikana are Modikwa Primary School for grade one until seven (ages 5-13) and Ngwakwena Secondary School for grade eight until twelve (ages 13-20). In the Modikwa primary school primary school as well as in the secondary school they provide over two weeks of education on sexuality, puberty, teenage pregnancy, and other sexuality related topics. Another two weeks are spent on health risks: such as TB and HIV, and another week especially on HIV/AIDS. Within the curricula provided there is a lot of good quality information on HIV infection, HIV prevention and HIV testing and treatment[133].

The Teachers

The teachers from the Modikwa Primary school consist of eight men and women between the ages of 40 and 60, only Mr. Engel and Mr. Fifty live in Sias and Mrs. Atlantis in nearby Arrie. The Secondary School teachers consist of a younger group of about ten men and women aged 30 to 60, none of whom live in or near Ramaswikana.

[132]Love matters refer to sexual activity, relationships, reproductive health issues and other issues in this area.

[133]Posters with information on HIV/AIDS and TB are also found in the schools, however they are all in English and are not hanging outside the office, thus seem to be more instructive to teachers.

The Students

This group officially consists of the 350 primary school children and the 300 Secondary school children, however informants derive solely from the Secondary School Students and consist of a group of 20-25 young boys and girls aged fifteen to 22 years old. Their knowledge on HIV/AIDS is formulated by the school curricula but is also constructed by the church, their family and Pedi tradition.

The HCBC patients

This group is represented by ten men and women aged 45-90 who all speak Afrikaans, Sepedi and once or twice very poor English. The patients receive weekly care via the door-to-door visits from the HCBC carers. Most of them have lived in Ramaswikana since its origin in 1954 and their HIV/AIDS discourse derives mostly if not solely from what they have learned from their family, their work place or the HCBC carers as HIV education was absent when they were in school.

The Families and Friends

This group – consisting of parents, other family members and peers –is represented by all previous groups but mainly by my guest families and friends: Jesus and his Family, Mrs. Atlantis and her family and the Ramini Family. Within these families the Pedi and Christian discourses regarding health, family, marriage, love and sex are well defined.

4.3. History and Experiences of HIV/AIDS

As mentioned in chapter two of this thesis, HIV/AIDS first arrived in South Africa as early as 1982 (Singer and Erickson 2011). However according to most informants, including the teachers and nurses, HIV/AIDS did not arrive in Ramaswikana until the millennium[134]. Much of this discourse seems to derive from the mere fact that during Apartheid (until 1994) there were no newspapers amongst the Pedi people in Ramaswikana and there was little to no access to health care or information[135]. One of my key informants and friend Jesus, a 27 year young man, went as far to say he was absolutely sure there was no HIV/AIDS before 1994 in Ramaswikana[136]. The HCBC patients, did not know at all about HIV/AIDS or its origins, which can be explained by the lack of HIV education while they were in school[137]. According to Jesus[138] the first time the community became aware of HIV/AIDS was when people started to become visibly ill and started to die of diseases in the early 2000s[139]. Many informants disclosed to me the disturbingly large amount of deaths in each of their families. Examples vary from loss of at least one or two siblings, cousins, nephews and nieces, to their own children in the past fifteen years[140]. This confirms the disease must have been there for a long time as death and major illnesses occur in the last and final stages of AIDS[141].

Mr. Fifty, a primary school teacher born in Ramaswikana, explained to me that during the time HIV/AIDS came under the attention of the community many people were afraid to talk about it:

> Today people are free to talk about the disease. But since it was discovered, during that few years of discovering if you could talk about it to the people, we were feeling shy, and if you could be examined or diagnosed it could disturb you mentally, you were not feeling comfortable. We were regarded as somebody who could be isolated from other family members, or friends were no more in need of being closer to you because we thought 'if I'm closer to such person I may be infected or affected[142].'
>
> *Mr. Fifty, 50*

[134]Semi-structured interview Mr. Fifty 10-03-2015, Group Interview Mrs. Atlantis 22-03-2015, Semi-structured Interview Mr. Engel 24-03-2015,Group Interview Jesus Family 27-03-2015.

[135]Group Interview Mr. Atlantis 22-03-2015

[136]Group Interview Jesus Family 27-03-2015

[137] , Semi-structured Interview Brand 24-02-2015, Semi-structured Interview Loekie 24-02-2015

[138]Jesus is a 27 year old young man from Sias and one of my key informants. He used to work in a pharmacy and helped me understand my data throughout my stay.

[139]Life-history Interview Jesus 28-02-2015

[140]More on HIV/AIDS death in the paragraph on PLWHA. Semi-structured Interview Mr. Engel 24-03-2015, Semi-structured Interview Brand 24-02-2015, Mrs. Savia Semi-structured Interview 25-02-2015.

[141] After HIV infection it may take between 6 months to ten years until HIV positive people reach the stage of AIDS. After they have acquired AIDS the immune system is so low they are likely to get deathly disease as cancer, TB and others which will lead to death within 1 to 10 years, all depending on health levels, age and the initial HIV virus itself (Nurse Sarah 25-02-2015).

[142] Semi-structured interview Mr. Fifty 10-03-2015

Mr. Fifty's explanation not only shows the influence of the politico-economic factors of apartheid and poverty, which was visible in the discourse on HIV/AIDS in the education and health systems until the early 2000s[143]. Mr. Fifty's explanation also shows the importance of health and sexuality deriving from the Pedi and Christian discourses in Ramaswikana. In the history of HIV/AIDS conflicting discourses were already intensified by the stigma that surrounded it, leading to the discrimination and isolation of people with HIV/AIDS. The next paragraph will show how this discourse and behaviour is today and how this is intensified by stigma.

[143] See Chapter 2, paragraph 2.2. on Mr. Mbeki.

4.4. HIV Infection and Prevention

In doing my research on the infection of HIV I often asked the straightforward question to my informants: “How does HIV infection work?” The answers would vary between the very accurate “HIV you can get through unprotected sex, blood contact, sharing needles, blood transfusion, and mother to child.”[144], from Annie, a 24-year-old HCBC carer, to “HIV you get through bleeding, like during playing sports and love”[145], from Jesus family who strongly believe in traditional healing and religious healing and hold a Pedi discourse of silence on disease and sex.

The contemporary discourses on HIV infection in Ramaswikana are in line with the WHO definition on infection (Brown et al. 2011). Unsafe sex is regarded as the prime cause of HIV infection, thereafter contamination through dirty blood either via needles, traditional razor cutting or even playing sports[146] and finally mother to child infection. However, how informants behave around this information differs greatly and is dependent on a number of socio-cultural and politico-economic factors.

HIV infection through unsafe sex

As mentioned earlier, within Pedi culture, the belief is that sex and pregnancy only occurs amongst young people. Therefore a common belief is that HIV infection through unsafe sex can only take place amongst young people. The belief that young people are most, if not solely vulnerable to HIV infection, is upheld by not only families, churches, and HCBC patients but also by those facilitating health care and information: teachers, HCBC carers and nurses[147]. When we were doing one of our door-to-door check-ups on patients, Lovable (one of the HCBC ladies) elucidated to me that they do not tell patients about HIV/AIDS. When I asked why she laughed with surprise and gave me the, in her eyes obvious, explanation: “because they are too old to have sex and it is a sexual disease so it does not apply to them[148].” The local discourse on prevention of HIV infection thus surrounds sexual behaviour of young people and excludes older generations, in line with Pedi values.

[144] Unstructered Interview Annie 04-02-2015
[145] Group Interview Jesus Family 27-03-2015
[146]Mr. Jordan explained to me that: “playing sports might cause infection because when you play football you may cut yourself and then if someone else cuts him or herself they might get infected.”Semi-structured Interview Mr. Jordan 25-02-2015[147]Semi-structured Interview Mr. Engel 24-03-2015, Semi-structured interview Mr. Fifty 10-03-2015, Semi-structured Interview Brand 24-02-2015, Semi-structured Interview Loekie 24-02-2015, Semi-structured Interview Lenie and Neel 24-02-2015, Semi-structured Interview Jew 24-02-2015,Mrs. Savia Semi-structured Interview 25-02-2015, Semi-structured Interview Mr. Jordan 25-02-2015.
[147]Semi-structured Interview Mr. Engel 24-03-2015, Semi-structured interview Mr. Fifty 10-03-2015, Semi-structured Interview Brand 24-02-2015, Semi-structured Interview Loekie 24-02-2015, Semi-structured Interview Lenie and Neel 24-02-2015, Semi-structured Interview Jew 24-02-2015,Mrs. Savia Semi-structured Interview 25-02-2015, Semi-structured Interview Mr. Jordan 25-02-2015.
[148] Informal conversation Lovable 11-02-2015

Infection through blood and mother to child infection

HIV infection through blood is the number two mode of HIV infection and unfortunately also still seems to happen in Ramaswikana. The clinics, nurses, HCBC carers, teachers and students are very aware of the dangers of blood to blood contact however traditional practices of cutting the skin to release high blood pressure still occur[149]. This happens mostly in the Zion Christian Church and The Apostolic church, but also by the traditional healer, who performs healing rituals that involve spitting water, smoke, and calling to the ancestors[150].

Mother to child infection unfortunately occurs a lot in Ramaswikana as there is a high pregnancy rate and women are very vulnerable to HIV infection[151]. The reason given by Annie, a 25-year-old HCBC carer, is that the HIV virus is spread easier from sperm to vagina than from vaginal liquids to the inside of the penis[152].

Risk Factors Influencing HIV Infection

As Parker (2001) emphasized, before preventive methods can be put in place, the risk factors surrounding HIV infection should be addressed. One of the first factors that students and teachers define as most influential on HIV infection through unsafe sex, are poverty and lack of jobs[153]. Poverty and lack of jobs influence HIV infection through a number of ways. As was mentioned in the previous chapter on gender and sexuality, a lack of local jobs force parents to work far away from home, often leaving children alone in their houses. This provides dangerous freedom for young people and children (aged twelve-22) leading towards risky behaviour such as hanging out on the streets and experimenting with sex. Often they go to the local tavern, looking for boyfriends or girlfriends, getting drunk and ending up having a higher risk of unsafe sex. Also when parents are home they may have a, what Mr. Engel calls Laissez-faire policy[154], meaning they will allow their children to go to the tavern and roam the streets anyway.

> It may be caused by parents, we find that learners are living alone without parents and some parents, you see they don't even care why their children are not sleeping at home, and they come in the morning and they don't even ask.. Laissez-faire some of the parents they use laissez-faire[155].
>
> *Mr. Engel, 55*

[149]Semi-structured Interview Mr. Jordan 25-02-2015
[150]Semi-structured Interview George and Juliana 11-02-2015, Semi-Structured Interview Mrs. Snuf.
[151]Semi-structured Interview Annie 24-02-2015
[152]Unstructured Interview Annie 04-02-2015
[153]Semi-structured Interview Rappa 26-03-2015
[154]Semi-structured Interview Mr. Engel 24-03-2015
[155]Semi-structured Interview Mr. Engel 24-03-2015

Moreover, some parents will be jobless and encourage their children to earn some extra money, which stimulates a drop out of school and thus less education on the topic of sex and health. A lack of jobs and money influences young boys to choose to drop out of school to find work and earn money for their families.

These economic reasons entwine with ideas about gender roles, as girls may choose to try get pregnant because of the money that the man who impregnates them has to provide them according to Pedi values. Pedi discourse on gender roles further influence this type of risky behaviour, in such a way that: "the parents encourage sexual relations amongst girls, because a girl can only become a real woman if she becomes pregnant"[156]. This discourse secondary school teacher Mrs. Secunda describes is intimately linked with Pedi discourse on womanhood. Moreover unsafe sex to get pregnant is stimulated by the social grant of 320 ZAR from the government, which is provided to mothers per child under the age of eighteen. Both Pedi values on masculinity and femininity and governmental structures thus indirectly stimulate unsafe sex. Mr. Fifty summarizes the factors that influence unsafe sex and thus increase the risk of HIV infection perfectly when he states:

> Here in Ramaswikana you find you are lacking of money, of food, your parents are not working, it ends up leading a lady to come in contact with some man who is working. So as you are looking for *something*, something from that gentleman, you feel feared to talk to him by saying let's use condom when we sleep together. Because you see if he can just go away, 'I will not get money', so you are trying to please the man, whereas you do not know whether the man is infected or not that's where the problem starts[157].
>
> *Mr. Fifty, 50*

Next to parents and poverty, another factor that influences HIV infection is the school. While the curricula may be well structured around Health Education, most if not all students are not equipped with the English language, which makes learning from English books and fully understanding the subjects, difficult. Unfortunately this is a crucial time for girls to understand this information on HIV infection, pregnancy and other SRHR accurately. When girls reach the age of 14-15 it is highly likely for them to start sexual relations and get pregnant which means that without the proper sex education and precautions they will likely get involved in unsafe sexual behaviour leading to HIV infection.

[156] Mrs. Secunda informal conversation 21-03-2015
[157] Semi-structured Interview Mr. Engel 24-03-2015

Prevention of HIV Infection

Most participants hold on to the governmental discourse that HIV should be prevented through the ABC method. From a governmental perspective, HIV prevention consists of encouraging abstention, one partner and promoting safe sex through the use of a condom. This becomes a problem when Pedi values, described in chapter three of this thesis and the previous paragraph on risk factors, encourage pregnancy and thus unsafe sex and multiple partners for men. Most informants pointed at pros and cons of each of the ABC methods, some refer to traditional medicine to prevent HIV infection[158].

ABC Discourse

Abstaining and being faithful are used most often as an answer on how to prevent HIV infection, especially from the church discourse and that of the families. This view is supported mostly by the older generation, like grandma Atlantis who upholds strong Pedi values that say sex is only to have children and Jesus parents who emphasize that being faithful to one love and sex partner is in line with Christian values[159].

Using a condom is the most effective method of prevention according to the carers, nurses, students and most of the teachers. However pregnancy, which stands for reproduction and a family, is so important for both men and women, that the use of a condom is often frowned upon. As Mr. Fifty explains: “Two partners, let’s say we are two partners, and we fail to condomize when coming to the love situation, and maybe I promise to marry you so I say if you don’t accept that I sleep with you without a condom, I can’t be in love with you[160].” This shows the importance of sex with the purpose of getting pregnant in Pedi culture. Fear of rejection is thus a major factor in condom use and thus HIV prevention. Moreover this shows how the Pedi and Christian discourses come to conflict with governmental discourses on condom use, and thus indirectly on HIV infection.

Next to the ABC method, religious and poor families may consult traditional medicine to help prevent girls from getting *magoma*[161]. The Nyaka ya Setho[162] can provide women and girls with a particular *muti*[163] that may prevent women who want children from getting HIV when they have

[158]Semi-structured Interview Mr. Engel 24-03-2015, Semi-structured interview Mr. Fifty 10-03-2015, Semi-structured Interview Brand 24-02-2015, Semi-structured Interview Loekie 24-02-2015, Semi-structured Interview Lenie and Neel 24-02-2015, Semi-structured Interview Jew 24-02-2015,Mrs. Savia Semi-structured Interview 25-02-2015, Semi-structured Interview Mr. Jordan 25-02-2015.
[159]Semi-structured Interview George and Juliana 11-02-2015
[160]Semi-structured Interview Mr. Fifty 10-03-2015
[161]Magoma is the Sepedi word for any abdominal or sexual disease, sexual matter or love matter.
[162]Traditional healer
[163]Muti is the Sepedi word for medication for anything. It is made of plants, roots and other natural products and comes in the form of powder, mud, and drinkable liquids (Opia 26-03-2015 Semi-Structured Interview)

unsafe sex[164]. The anecdote below describes a consult with the local Ngaka Ya Setho, Mrs. Atlantis son, Miss Stuijt and myself.

> A 60 year old Pedi woman is sitting in front of Rosan, Goldy and me. We are sitting inside a small traditional round hut and are surrounded by old plastic bottles and tin cans filled with herbs, sticks, leaves and powder. On her chin two small moustache like grey hairs give her a mysterious look. Goldy translates for us as Rosan takes a picture. "She says she can give the *muti* to someone to prevent [her] from getting HIV, because it's [HIV] coming in this way. Because mostly it's from men, because they go outside and then they get extra relationship and then they take it and then they come back home and then they give it to the woman, so it's to protect the woman from getting HIV.
>
> *Opia 26-03-2015 Semi-Structured Interview*

[164]Opia 26-03-2015 Semi-Structured Interview

4.5. PLWHA, Testing and Treatment

According to the Kibi clinic there are a total of 168 HIV positive people out of which eighteen are children under eighteen in Ramaswikana, as of March 2015[165]. However, this number is quite misleading as it reflects only those people who have gone to the Kibi clinic and got tested. Moreover out of these 168 people, 110 people are HIV positive and on treatment, 58 are HIV positive and not on treatment yet because they are not eligible – meaning their CD4 count is higher than 500[166]. Next to these 168 people there are those who have been tested HIV positive but have failed to take up or continue their ARV treatment, those people are referred to by the Kibi clinic as *defaulters*. There are a number of politico-economic reasons[167] why defaulters default. Next to these economic reasons, the discourse and behaviour around HIV testing and HIV treatment structured by Pedi and Christian discourses on health and sexuality influence the defaulter rate.

In Ramaswikana, HIV testing and treatment of HIV positive people is surrounded by a stigma surrounding HIV/AIDS. The fear of becoming, being or being perceived as an HIV positive person (PLWHA) is thus constructed by socio-cultural and politico-economic discourses and is visible in the discriminative behaviour and fear surrounding PLWHA, testing and treatment. How these HIV/AIDS and gender stigmas intensify the friction between Pedi discourse and the government (clinical) discourse on HIV/AIDS, are expressed in testing and treatment.

Fear of Becoming a "Positive"

HIV/AIDS stigma applies to people living with HIV/AIDS or "the positives" as Mr. Engel refers to them[168]. The discourse on stigma or the fear of being HIV positive and therefore not belonging to the "negatives"[169], consists of different layers of fear. Firstly there is a layer of fear surrounding health that derives from the Pedi discourse. When people get a label that directly says something about their health this is considered embarrassing[170]. Secondly there is a fear of uncleanliness or dirtiness regarding sexuality and reproduction, this idea also derives from the larger Pedi discourse which

[165] Total population in Ramaswikana according to the Kibi clinc is estimated around 3000 people.

[166] CD4 is the cell in your immune system that protects you from viral infections, without it you are sure to die of infections or diseases very quickly. ARVs are only provided for free by the government if your CD4 count is lower than 500, if it is higher you have to pay yourself for the medication. Semi-structured interview Nurse Sarah 25-02-2015

[167] Before April 2014 ARVs consisted of three separate containers, which had to be taken at exact moments during the day. They would also cause humps and swollen bellies[167].Only since January 2015 the clinic provides a three-month provision of medication instead of having to go to the clinic for a monthly provision of ARVs. This greatly helps working-class people (Ramaswikana is often referred to as a workers town), who work on farms far away for months in a row during the week and weekends and cannot get a day off. Secondly, defaulters can be people who used to have a low CD4 count and have now gotten better due to medication, they may feel healthy again and decide to quit the medication. Another financial reason is that the government provides a disability grant for HIV positive people with a CD4 count of 500 or lower. So some people may choose to quit medication to get to a worse health condition for money. Semi-structured interview Nurse Sarah 25-02-2015.

[168] Semi-structured Interview Mr. Engel 06-03-2015

[169] Semi-structured Interview Mr. Engel 06-03-2015

[170] Semi-structured Interview Mr. Jordan 25-02-2015

considers health and especially reproductive health as a central part of being a real man and woman as was emphasized in the previous chapter. This stigmatizing idea about the sexuality and health of PLWHA has implications for both men and women as it holds the perspective they can no longer have a family, have sex, or are fit as wives or husbands. HIV/AIDS is a direct threat to both the eligibility and health identity of men and women.

The HIV stigma differs per gender as there are different discriminations for men and women surrounding HIV/AIDS. For women it is the general perspective that women with HIV are sexually overactive and whores and therefore unreliable, unhealthy and unclean, whereas men with HIV are as unmanly, considered weak and unhealthy. In Ramaswikana the stigma around PLWHA is not as intensely behaved upon or perceived as in the early 2000s[171], however the stigma is still present and behaved upon. As Mr. Five one of the primary school teachers, explains this:

> They may not be seen as weak, it is only we who are among the guys who say this and this and this. It is always in the back of our minds, it is that 'men' mentality. That perception is always in our head, because we know he is .. you know.. But for someone who doesn't know he is HIV positive, he can see him strong. I know this guy, he is HIV positive he is taking medication for quite a long time he is… He has maintained his strength and as I'm saying, he is married, he's got a wife, he already told me he doesn't sleep, he and his wife, they make use of condoms when they sleep"
>
> *Mr. Five, 47*

Mrs. Powder, teacher in the primary school however, shows the stigma from an older traditional woman's perspective. To her HIV, AIDS and TB are topics she does not want to talk about. Mrs. Powder takes it even further when talking about HIV/AIDS: "In fact I don't know. I just heard that people get HIV/AIDS and what happens I don't know. Even myself I don't know whether I'm HIV positive or negative…because I never go to test….I trust myself." [172] Mrs. Powder and Mr. Five are examples of how discourses within one social sphere can differ, even though they are constructed from the same Pedi discourse, one individual experiences HIV/AIDS stigma more intensively than the other.

[171] See paragraph in this chapter: History and experiences of HIV/AIDS.
[172] Semi-structured interview Mrs. Powder 26-03-2015

HIV Testing and Treatment

Testing for HIV is very important for the health of those infected, in order for them to get the appropriate treatment and care. The Kibi clinic and the Health Department provide testing services, however HIV testing as is described by Mrs. Powder is still quite often related to not being strong, trustworthy or healthy. The behaviour of patients regarding medication reflects the importance of being perceived as healthy and strong: "Patients say: "I'm ok, I don't take treatment anymore!", then they become defaulters, so a lot of people find the medication is working and decide to quit as soon as this happens[173]." The HIV/AIDS stigma perceived by men creates a certain behaviour regarding testing and treatment, as is explained by nurse Sarah:

> Men will often default from going to the clinic to test or get medication once they have tested HIV positive. Women will often come to collect their medication but at home their husbands will ask for the medication as well because they are HIV positive too but they will not come to test for fear of exposure, so the woman ends up taking half her doses[174].
>
> *Nurse Sarah, 42*

The HIV/AIDS stigma surrounding women explained by the Ratshatsha hospital nurses shows the Pedi idea of HIV women as unclean and unreliable. "When you as a woman go to the clinic to test people will say: 'Why did you go to the clinic? Did you sleep with someone? Did you cheat? You are sleeping around[175]!'" The fear of being excluded from the community is further explained by Jesus family: "once they know they are positive they will get bad moods and they might not have the will to live anymore[176]." HIV/AIDS stigma surrounding PLWHA thus has a major influence on the HIV testing and treatment.

In conclusion, the fluidity and constructive nature of discourses and behaviours in Ramaswikana makes for a difficult social framework because stigma occurs when the perspective, behaviour and/or physical status of an individual or group diverges from the group norms concerning HIV/AIDS (Goffman (1963) in Castro and Farmer 2005: 53). Stigma co-constructed by Pedi and Christian larger discourses is visible in the local discourse and behaviours surrounding HIV/AIDS in Ramaswikana. This stigma intensifies the meaning that is given to HIV infection, prevention, testing and treatment.

[173] Semi- structured interview Nurse Sarah 25-02-2015
[174] Semi- structured interview Nurse Sarah 25-02-2015
[175] Group Interview Ratshtsha Hospital Nurses 23-03-2015
[176] Group Interview Jesus Family 27-03-2015

5. Conclusion and discussion

This thesis has illustrated the perspectives, behaviours and discourses that surround gender, sexuality and HIV/AIDS in Ramaswikana, with a focus on stigma. As was already shown in chapter four, perspectives and behaviours around gender and sexuality flow through the discourse, behaviours and stigmatization surrounding HIV/AIDS in Ramaswikana. These entwinements of gender, sexuality and HIV/AIDS in Ramaswikana, represent the findings of this thesis, which will be explicitly outlined in this chapter. With this the research question of this thesis will be answered: *In what ways do perspectives and behaviours surrounding gender identity and sexuality entwine with the discourses and behaviours surrounding HIV/AIDS in Ramaswikana, Limpopo, South Africa?* By showing this strong interconnectedness of gender, sexuality and HIV/AIDS in Ramaswikana, the use of a gender perspective towards the study of HIV/AIDS will be argued for.

Aligning the empirical chapters and theoretical framework, provides insight in the entwinements of gender, sexuality, HIV/AIDS and stigma. Before outlining the entwinements of gender, sexuality and HIV/AIDS, this concluding chapter will start by summarizing the findings of the research. First the findings on the ‘ideal’ and ‘real’ man and woman and the gender and sexuality stigma present in Ramaswikana will be discussed. Then a summary of the discourses and behaviour surrounding infection, prevention, PLWHA, testing and treatment and the HIV/AIDS stigma within the village will be provided. By outlining these ethnographic findings of the thesis in the entwinements of gender, sexuality and HIV/AIDS in Ramaswikana, the research question is answered. Furthermore the practical and theoretical relevance of this thesis is summarized, showing this research and its methods provide an example of applying a gender perspective to medical anthropology, strengthening the bridge between medical and gender anthropology. Finally, this chapter and thereby this thesis will end with a short reflection on the research, providing the reader with the shortcomings and recommendations for future research.

Gender and Sexuality

There exists a difference between the ideal gender identities – which are constructed by the Pedi culture and Christianity – and the 'real' gender identities – which are particularly created by a mingling of the Pedi culture and the struggles created by the economic situation – in Ramaswikana. The ideal man is mentally and physically strong and therefore it is his role to be the head of the family and provide them with money. The ideal woman is caring, takes responsibility for the domestic sphere and listens to the instructions of her husband. Both ideal men and women are heterosexual and provide their partner with enough sexual pleasure and children. The ideal man has 'strong sperm' and is clean – which means, is circumcised – and the ideal woman is fertile and wants to be a mother. But also outside a relationship, sexual performance is of significant importance within Ramaswikana.

Entwined with these ideal gender identities, are the man and the woman who exists in the 'reality' of Ramaswikana. The 'real' woman is often a single mother, who works and is the head of the family. Both man and woman have in reality several unofficial sexual partners and the use of contraception is not preferable. Furthermore, sleeping around and getting pregnant is used as means to get money by women in Ramaswikana.

These perspectives and behaviour create stigmatization within Ramaswikana, as men and women who do not perform the described gender identities have a big chance on getting dismembered from being a man or a woman. Although some characteristics and roles are more important than others: men are mostly stigmatized if they are not physically and mentally strong, not clean and not able to perform at a sexual level – and thus able to provide his partner with sexual pleasure and children – whereas women are mostly stigmatized if they are no mother around their thirties. Furthermore for both it is stigmatized to use condoms Being stigmatized will lead to discrimination and will impede the ability to marry and start a family. The fear of stigmatization, - non-belonging, discrimination, will lead to the behaviour of men and women in Ramaswikana which is in line with the expectations that is projected on them.

HIV/AIDS

Larger Pedi, Christian and governmental discourses construct behaviours and local discourses around HIV/AIDS, which are conflicting at the local level. The friction between these discourses and behaviours are intensified by the fear, discrimination and stigma that surround HIV/AIDS. The larger Pedi discourse on health and sexuality consists mainly of a culture of silence around these topics and is held by the traditional healer and older generations in Ramaswikana. Within the family sphere HIV/AIDS related topics are discussed with the *Ngaka Ya Setho*, the ancestors or with family members. The larger Christian discourse on health and sexuality is predominantly upheld by the local

churches, which can provide advice and sometimes healing aid around HIV/AIDS related topics. The government discourse on health and sexuality consists mainly of the ABC discourse and the medication and care provided by the clinics and the hospitals. These three discourses come into conflict at the local level where social spheres define their meaning and behaviour around PLWHA, HIV infection and prevention, testing and treatment.

Regarding infection and prevention, the group at the highest risk are the students and young people; they feel the friction between these larger discourses when they have to make decisions regarding sexual activities. Their Pedi values tell them it is important to have sex with the purpose of getting pregnant at an early age. For girls this is because pregnancy is important for their identity as reproductive women and for becoming a real woman. For the boys it is encouraged to have a lot of sex because it gives them the identity of a strong and sexually healthy man. This is in conflict with the Christian discourse on health and sexuality, which tells students to abstain from sex until marriage and stay faithful to one partner afterwards. Then the third discourse from the government tells students the ABC discourse and provides them with a lot of information on HIV/AIDS prevention and infection. Students thus know the risks of unsafe sex but have to make decisions on listening to family from the Pedi discourse, churches from the Christian discourse and school, which creates a difficult social framework for them. Moreover with the politico-economic factors of poverty and a lack of jobs young people often engage in unsafe sex and thus have a high risk of HIV infection.

People living with HIV/AIDS are highly stigmatized and discriminated in Ramaswikana, therefore people fear going for HIV testing and HIV treatment as they fear being rejected from the community as a viable member. The meaning given to being a viable member of the community is partially constructed by Pedi values regarding health and sexuality. The Pedi discourse tells people it is wrong to disclose health related statuses like HIV/AIDS, which comes in conflict with the government discourse on testing and treatment, driven by the 0% HIV infection goal that aims to find all HIV positive people, get them on medication and teach them how to prevent transmission. This leads to a problem as people now stand to choose between being a viable member of the community and not knowing their status on the one hand and getting tested and possibly going for treatment and definitely being discriminated and feared by community members, on the other.

Entwinements

The entwinement of perspectives, behaviours, discourse and stigmatization surrounding gender, sexuality and HIV/AIDS in Ramaswikana, happens in two different ways. On the one hand gender and sexuality stigmas, perspectives and behaviour entwine with the discourse and behaviour surrounding HIV infection and prevention. On the other hand gender and sexuality perspectives and behaviour entwine with the stigmatizing discourse and behaviour surrounding PLWHA which is apparent in HIV testing and treatment.

HIV Infection and Prevention

In chapter four it is explained that unsafe sex is the prime cause of HIV infection in Ramaswikana, in which entwinements of perspectives and behaviour around gender and sexuality with HIV infection become apparent. The sexual behaviour of having unprotected sex is the consequence of poverty and lack of jobs, mixed with perspectives on sexuality and gender in Ramaswikana. These perspectives and behaviour and their influence on HIV infection and prevention will be concluded here.

Firstly, within Ramaswikana parenthood is of significant importance in the life of the inhabitants, for both ideal men and ideal women it is part of life and it creates the responsibility of providing their partner with children. It is even stigmatized to not perform this ideal gender behaviour. Especially for women motherhood is highly valued: it provides them with the status of being a woman. Furthermore, it provides women – 'real' women – with money from both the government and the man who impregnated her (according to the Pedi culture). Because reproduction is important gender behaviour in Ramaswikana, unsafe sex is essential which increases the chance of getting infected with HIV.

Secondly, in Ramaswikana sexual performance and pleasure is crucial within a relationship but also outside there is a lot of meaning attached to it. Performing well on sexual behaviour is an important part of the ideal masculine gender identity, but it also makes a man a good husband/boyfriend. It is therefore stigmatized for men to not perform well on sexual level. For the ideal woman in Ramaswikana sexual activity is high valued as well, as it is perceived as 'cool' among the youth and especially in order to be an ideal wife/girlfriend. For 'real' women sexual intercourse can even be a means to get money from (maybe several) men, as it is man's job to provide her with food and money. This fact creates women sleeping around to be able to get financial support. This importance of sexual pleasure would not have been a significant factor within the HIV infection in Ramaswikana, without the perspective that condoms decreases sexual pleasure for both men and women. Thus the stigmatization of men and women, who do not perform well enough on sexual level, creates less use of condoms and thus a bigger chance of getting infected. However not only the

perspective on sexual behaviour, also the perspective on masculinity – men have to provide women with food and money and have the power – and femininity – women follow the desires of men – creates that women sleep around for money without the use of a condom, and thus makes them highly vulnerable to HIV-infection. This shows the entwinement of hegemonic masculinity and emphasized femininity with HIV infection.

As mentioned, the economic situation within Ramaswikana, as well, has constructed and still constructs sexual behaviour and creates a higher chance on HIV infection. The lack of jobs in Ramaswikana causes 'real' men/boys and women/girls to get drunk and experiment with sex, whereas poverty strengthens the value for women/girls to sleep around to provide themselves with money and food. While being drunk and/or young the chance on using a condom gets smaller and as women/girls fear for rejection by mentioning condoms, this sexual behaviour in Ramaswikana has a big influence on HIV infection.

Finally, because of these significant perspectives originating from men and women in Ramaswikana that lies behind having unsafe sex, HIV prevention from the governmental discourse – the ABC discourse – is impeded. As shown, abstaining, being faithful and condomizing are because of the meaning attached to parenthood, sexual behaviour and sexual pleasure for both men and women in Ramaswikana not preferable. The perspectives and behaviour on gender and sexuality in Ramaswikana conflict with the HIV prevention programs, which decreases the success of these programs.

PLWHA and HIV testing and treatment

As was noted by Skinner and Mfecane, "HIV and AIDS-related stigma has a unique relation to other stigma layers associated with race, gender, homosexuality, drug use, promiscuity etc." (Lee, Kochman & Sikkema, 2002: 310 in Skinner and Mfecane). As was highlighted in chapter four, perspectives and behaviour on gender and sexuality further entwine with the stigmatizing discourse and behaviour surrounding HIV/AIDS visible in PLWHA, testing and treatment.

Gender and sexuality perspectives about the notions of cleanliness and dirtiness by Douglas (1986), as outlined in chapter three, play a significant role in the discourse around HIV/AIDS. Perspectives about sexuality and reproduction are entwined with HIV/AIDS behaviour as PLWHA are considered to be either overly sexually active or unable to have sex and reproduce. Moreover HIV/AIDS stigma characterised by a fear of uncleanliness or dirtiness regarding sexuality and reproduction, has implications for both men and women as it holds the perspective they can no longer have a family, have sex, or are fit as wives or husbands.

The behaviour of men shows this entwinement as they will not go to the clinic for testing or treatment out of fear of being considered weak or unclean. Women are considered unclean and

unreliable as they are seen as whores when going to the clinic. Again the importance of masculinity and femininity is in conflict with the testing and treatment programs of the South African government. Gender and sexuality stigma thus entwine with HIV/AIDS and gender and sexuality entwine with HIV/AIDS stigma surrounding HIV/AIDS related aspects – PLWHA, treatment and testing– in Ramaswikana.

Theoretical and practical objective

This thesis has attempted to strengthen the bridge between medical anthropology (Inhorn and Brown 1997; Brown et al. 2011) and gender anthropology (Jewkes et al 2003; Albertyn 2003), regarding the research on HIV/AIDS. The empirical data of this research has proven the strong entwinement of gender, sexuality and HIV/AIDS, which becomes visible in HIV infection, prevention, testing and treatment and the stigma surrounding PLWHA.

This thesis has argued for the use of a gender perspective in order to create a useful understanding of HIV/AIDS in a rural village in South Africa on the border with Botswana. Thereby this research aligns with previous research done on the relation between gender, sexuality and HIV/AIDS in South Africa (Dickinson 2013; Schatz et al. 2013; Jones 2011; Hitchcock and Babchuck 2011; Singer 2011; Sellen and Hadley 2011; Mazzeo et al. 2011; Kalichman et al 2010; Rohleder et al 2009). By taking on a gender perspective as well as a holistic medical anthropological approach to HIV/AIDS, a fully holistic overview of the HIV/AIDS situation in Ramaswikana could be provided, making this research a clear example of the importance of this bridge between gender and medical anthropology. Both perspectives are necessary to research HIV/AIDS, as gender and sexuality are part of the socio-cultural factors that define perspective, behaviour and discourse around HIV/AIDS.

The practical objective has been to provide information for HIV prevention, treatment and care programs, to be able to create efficient programs that take into account the socio-cultural and politico-economic factors. The researches has attempt to provide a better understanding of HIV/AIDS in Ramaswikana and with that tried to be valuable for the prevention programs existing there. Unfortunately – and here an ethical dilemma comes in play – the researchers were not able to directly contribute this research to HIV prevention, treatment and care program nor can they themselves provide efficient program outlines as this is an initial ethnographic study.

Shortcoming and future research

By outlining the entwinements of gender, sexuality and HIV/AIDS within a rural village in the north of South Africa, this thesis has attempted to cover a huge and complex topic. As gender, sexuality and HIV/AIDS are broad and complex concepts on their own; the entwinements are even more complex. These topics – and the entwinements – are strongly connected with the socio-cultural and politico-economic context. Nine weeks of research is simply not enough to cover the influence of every large discourse on gender, sexuality and HIV/AIDS and with that provide a satisfying image of perspectives and behaviour surrounding gender, sexuality and HIV/AIDS,.

More research needs to be done to provide an overview of the perspectives and behaviour surrounding gender and sexuality and the discourse and behaviour surrounding HIV/AIDS according to all social spheres existing in Ramaswikana. As explained, the researchers were mostly focussed on the educational and health sphere and thus more data is needed originating from other social spheres.

Furthermore, as the research topics are highly sensitive and stigmatization surrounds them, more time and further research is needed to create a truthful outline of gender, sexuality and HIV/AIDS and its entwinements in Ramaswikana. Time is needed to create trust among the research population and observe their true behaviour. Moreover the influence of the researcher as disturbing factor will become less through time. Other factors in this that have to be taken into account in future research are the politico-economic context – the poverty and history of Apartheid – in which the research population lives.

Finally as the gender, sexuality and HIV/AIDS are constructions, they are constantly subject to change. The concepts and the interaction between them evolve over time and therefore future research is needed to capture a correct understanding of the entwinements of gender, sexuality and HIV/AIDS in Ramaswikana.

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Appendix

1. Research Summary

Gender, Sexuality & HIV/AIDS Entwined

A gender sensitive approach to HIV/AIDS stigma, discourse and behaviour in Ramaswikana, Limpopo, South Africa.

Renske Thalia Poelma & Rosan Stuijt

As South Africa is unfortunately still leading country within the HIV/AIDS pandemic with over 5.3 million HIV infected people, research on HIV/AIDS in this beautiful country is still highly relevant. In the period from 28 January until 1 April 2015 research was done by miss Poelma and miss Stuijt, in a remote village called Ramaswikana, located in the South African province of Limpopo. The people in Ramaswikana are vulnerable to HIV/AIDS due to their perspectives, behaviour and discourse around HIV/AIDS, which are constructed by socio-cultural factors and politico-economic factors. Politico-economic factors include a history of apartheid, high poverty and a lack of jobs that influence their behaviour and perspective. Socio-cultural factors are more complex but are formulated from the Pedi culture and Christian religion. By taking a gender and sexuality approach in combination with a medical anthropological approach this complex social framework for HIV/AIDS was researched.

A particular focus on the ways in which gender, sexuality and HIV/AIDS entwine were studied by doing ethnographic fieldwork. A focus on gender and sexuality perspectives, behaviour and stigma by miss Stuijt on the one hand, and a focus on HIV/AIDS discourse, behaviour and stigma by miss Poelma, on the other have provided rich findings on the entwinements of gender, sexuality and HIV/AIDS.

The perspectives and behaviour of the informants showed that gender, sexuality and HIV/AIDS are strongly entwined in Ramaswikana. This entwinement can be divided in two different ways: on the one hand gender and sexuality perspectives and behaviour entwine with the discourse and behaviour surrounding HIV infection and prevention. On the other hand gender and sexuality perspectives and behaviour entwine with the stigmatizing discourse and behaviour surrounding PLWHA which is apparent in HIV testing and treatment

Unsafe sex appeared to be the prime cause of HIV infection in Ramaswikana. This sexual behaviour is the consequence of poverty and lack of jobs, mixed with perspectives on sexuality and gender in Ramaswikana. Firstly, in Ramaswikana parenthood is of significant importance in the life of the inhabitants: for both men and women it is a normal part of life and it creates the responsibility of

providing their partner with children. It is even stigmatized to not perform being a parent in Ramaswikana. Especially for women, as motherhood provides her with the status of being a woman. Furthermore, it provides women with money from both the government and the man who impregnated her (according to the Pedi culture). Because reproduction is important gender behaviour in Ramaswikana, unsafe sex is essential which increases the chance of getting infected with HIV.

Secondly, in Ramaswikana sexual performance and pleasure is crucial within a relationship but also outside there is a lot of meaning attached to it. Performing well on sexual behaviour makes a man a 'real' man and a good husband/boyfriend. For women in Ramaswikana sexual activity is high valued as well, as it is perceived as 'cool' among the youth and especially in order to be an ideal wife/girlfriend. Within the reality of Ramaswikana, sexual intercourse can even be a means to get money from (maybe several) men for women, as it is man's job to provide her with money. This importance of sexual pleasure would not have been a significant factor within the HIV infection in Ramaswikana, without the perspective that condoms decreases sexual pleasure for both men and women. Thus the stigmatization of men and women, who do not perform well enough on sexual level, creates less use of condoms and thus a bigger chance of getting infected. However not only the perspective on sexual behaviour, also the perspective on masculinity – men have to provide women with food and money and have the power – and femininity – women follow the desires of men – creates that women sleep around for money without the use of a condom, and thus makes them highly vulnerable to HIV-infection.

As mentioned, the economic situation within Ramaswikana, as well, has constructed and still constructs sexual behaviour and creates a higher chance on HIV infection. The lack of jobs in Ramaswikana causes men/boys and women/girls to get drunk and experiment with sex, whereas poverty strengthens the value for women/girls to sleep around to provide themselves with money and food. While being drunk and/or young the chance on using a condom gets smaller and as women/girls fear for rejection by mentioning condoms, this sexual behaviour in Ramaswikana has a big influence on HIV infection.

Finally, because of these significant perspectives originating from men and women in Ramaswikana that lies behind having unsafe sex, HIV prevention from the governmental discourse – the ABC discourse – is impeded. As shown, abstaining, being faithful and condomizing are because of the meaning attached to parenthood, sexual behaviour and sexual pleasure for both men and women in Ramaswikana not preferable. The perspectives and behaviour on gender and sexuality in Ramaswikana conflict with the HIV prevention programs, which decreases the success of these programs.

Perspectives and behaviour on gender and sexuality further entwine with the stigmatizing discourse and behaviour surrounding HIV/AIDS visible in PLWHA, testing and treatment. Perspectives about sexuality and reproduction are entwined with HIV/AIDS behaviour as PLWHA are considered be either overly sexually active, or unable to have sex and reproduce. Moreover HIV/AIDS stigma characterised by a fear of uncleanliness or dirtiness regarding sexuality and reproduction, has implications for both men and women as it holds the perspective they can no longer have a family, have sex, or are fit as wives or husbands.

The behaviour of men shows this entwinement as they will not go to the clinic for testing or treatment out of fear of being considered weak or unclean. Women are considered unclean and unreliable as they are seen as whores when going to the clinic. Again the importance of masculinity and femininity is in conflict with the testing and treatment programs of the South African government. Gender and sexuality stigma thus entwine with HIV/AIDS and gender and sexuality entwine with HIV/AIDS stigma surrounding HIV/AIDS related aspects – PLWHA, treatment and testing– in Ramaswikana.

By showing these entwinements a better understanding is provided in why a large amount of inhabitants of Ramaswikana is HIV-infected and thus how the 0% HIV infection goal can be achieved.

2. Statistics about Blouberg Municipality

Population	162 629
Age Structure	
Population under 15	39.00%
Population 15 to 64	53.70%
Population over 65	7.30%
Dependency Ratio	
Per 100 (15-64)	86.20
Sex Ratio	
Males per 100 females	83.80
Population Growth	
Per annum	-0.54%
Labour Market	
Unemployment rate (official)	39.20%
Youth unemployment rate (official) 15-34	47.20%
Education (aged 20 +)	
No schooling	28.30%
Higher education	5.20%
Matric	15.30%
Household Dynamics	
Households	41 192
Average household size	3.90
Female headed households	56.30%
Formal dwellings	92.80%
Housing owned	58.80%
Household Services	
Flush toilet connected to sewerage	6.10%
Weekly refuse removal	20.70%
Piped water inside dwelling	7.70%
Electricity for lighting	88.00%

Source: Census 2011 Municipal Fact Sheet, published by Statistics South Africa.

Source: http://www.localgovernment.co.za/locals/view/118#demographic.

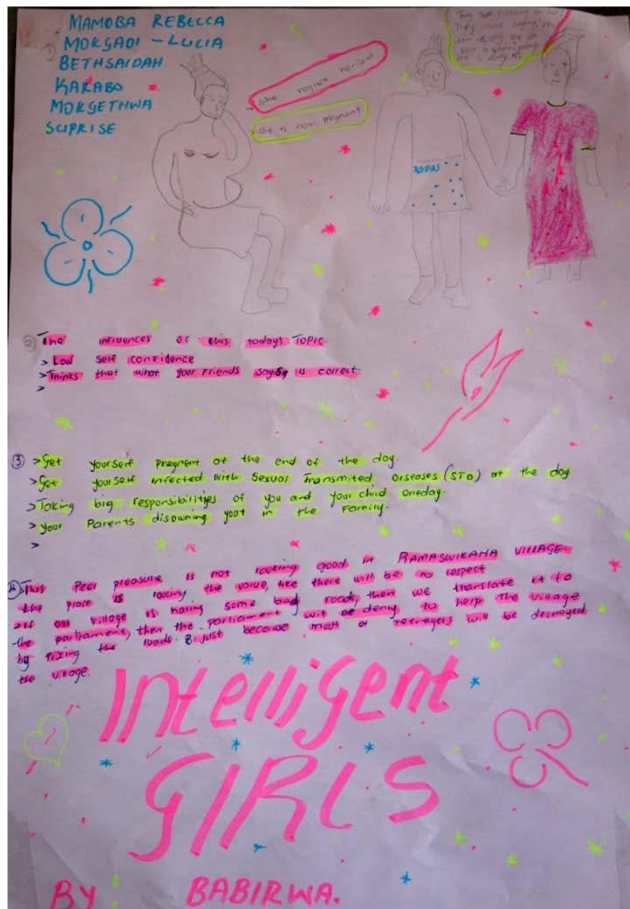
Group	Percentage
Married	16,7%
Living together like married partners	3,6%
Never married	75,4%
Widower/Widow	3,7%
Separated	0,3%
Divorced	0,3%

Group	Percentage
No Schooling	3,2%
Some Primary	47,4%
Completed Primary	6,7%
Some Secondary	35,7%
Completed Secondary	6,1%
Higher Education	0,5%
Not Applicable	0,5%

Income	Percentage
None income	15,8%
R1 - R4,800	6,6%
R4,801 - R9,600	13,6%
R9,601 - R19,600	27%
R19,601 - R38,200	22,7%
R38,201 - R76,4000	6,8%
R76,401 - R153,800	3,7%
R153,801 - R307,600	2,6%
R307,601 - R614,400	0,8%
R614,001 - R1,228,800	0,1%
R1,228,801 - R2,457,600	0,1%
R2,457,601+	0,1%

Source: http://www.statssa.gov.za/?page_id=993&id=blouberg-municipality.

3. Poster about Peer Pressure



Poster about Peer Pressure. Made by Secondary School students during the second 'You(th) Talk'[177]. Photograph taken by Rosan Stuijt.

[177] You(th) talk 2 17-03-2015.