Women's vulnerability, sexual power and prevention of stigma: What do prevention campaigns tell us?

By

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Dissertation presented for the degree of Master of Political Science (International Studies) in the Faculty of Arts and Social Sciences at Stellenbosch University

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April 2014

Declaration

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own original work, that I am the authorship owner thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Date: 01/11-2013

Abstract

The HIV-epidemic that is evident in South Africa today is infecting more women than men. This is mostly due to the vulnerability that women are facing in sexual relationships, where they are not able to negotiate the terms and conditions of their sexual engagement. Patriarchy, the culture of masculinity and a general male dominance influence women's dependency on their man and agency inside and outside of the home, and contribute to the oppression of women both generally in society and sexually. Women have by this not the control over their own bodies and are for this reason in a high-risk position of contracting HIV. The vulnerability is further linked to the stigmatisation that women experience if they do try to negotiate preventative measures to reduce the risk of transmission. The fear of being stigmatised as 'loose' or HIV-positive by both men and women if suggesting condom use, inhibits women to propose the necessary actions for protection. Stigmatising behaviours also impact on a person's fear of becoming HIV-positive and reduces the likelihood of getting tested, disclose one's status to sexual partners and receive treatment.

This thesis examines cultural and socio-economic issues that contribute to gender inequality in South Africa, and can generate stigma towards women on the basis of HIV and AIDS. This is done by using radical feminism as the theoretical framework for contextualising how women are situated in the South African society, in terms of general and sexual agency. Through the method of content analysis and the findings from the theoretical framework, the thesis further analyses how the three HIV-prevention campaigns loveLife, Brothers for Life and TAC manage to address the issues related to stigma based on HIV/AIDS, which are directed towards women.

Race, class and gender are all factors that influence the likelihood of becoming HIV-infected and of becoming stigmatised. Women's low social status situates women in a position where they are more probable to be the object of stigmatisation since they already are considered lower in rank. If the women also are of colour, poor and low educated the chances of becoming stigmatised on the basis of HIV and AIDS are even more likely, the same is the chances of becoming HIV-infected. This indicates that poor, uneducated black women are the group that is most vulnerable towards stigmatisation as well as towards HIV-transmission.

Socio-economic and cultural factors have a strong influence on the gender inequality in sexual relationships found in South Africa, which cause HIV to spread and can generate stigmatising behaviours. Stigmatisation on the basis of HIV/AIDS is therefore important to address in order to reduce the number of new HIV-infections. The three campaigns analysed for this thesis did neither

directly address stigma on a general level nor directed towards women. The campaigns are therefore considered to be missing an important feature of HIV-prevention in South Africa.

Opsomming

Die huidige Suid-Afrikaanse Vigsepidemie infekteer meer vroue as mans. Dit is die geval weens die kwesbaarheid wat vroue ervaar in seksuele verhoudings, waar vroue nie die mag het om die omstandighede van hul seksuele interaksies te onderhandel nie. Patriargie, die kultuur van manlikheid en ‘n algemene manlike dominansie beïnvloed vroue se mag en dra by tot die onderdrukking van vroue, beide in die samelewing in die algemeen en in seksuele verhoudings. Om hierdie rede het vroue nie beheer oor hul eie liggame nie en daarom ervaar hulle ‘n hoë risiko om MIV op te doen.

Hierdie kwesbaarheid word ook verbind aan die stigmatisering wat vroue ervaar wanneer hulle probeer om voorkomende aksie te neem ten einde die risiko van Vigsoordrag te verminder. Die vrees om deur mans en ander vroue gestigmatiseer te word as iemand met ‘losse sedes’, of as iemand wat MIV-positief is wanneer hulle kondoomgebruik voorstel, weerhou vroue daarvan om die nodige voorkomende aksie vir selfbeskerming te neem. Stigmatiserende gedrag het ook ‘n impak op ‘n mens se vrees om MIV-positief te word en verminder die waarskynlikheid dat jy jouself vir die virus sal laat toets, dat iemand hul status aan seksuele maats sal verklaar, of behandeling sal ontvang. Diegene wat reeds MIV onder lede het is bang om hul status te verklaar weens die gepaardgaande stigma.

Hierdie tesis ondersoek kulturele en sosio-ekonomiese kwessies wat bydra tot geslagsongelykheid in Suid-Afrika, en wat stigma kan veroorsaak teenoor vroue met betrekking tot MIV and Vigs. Die studie analiseer dan of Vigsveldtogte hierdie stigma kan aanspreek. Dit word gedoen deur radikale feminisme toe te pas as ‘n teoretiese raamwerk om vroue se plek in die Suid-Afrikaanse samelewing te kontekstualiseer, beide in terme van algemene en seksuele mag. Die metode van inhoudsanalise word toegepas om drie Vigsvoorkomingsveldtogte (loveLife, Brothers for Life en TAC) te analiseer en vas te stel of en hoe hulle kwessies wat betrekking het op stigma teenoor vroue aanspreek.

Sosio-ekonomiese en kulturele faktore het ‘n sterk invloed op die geslagsongelykeid in seksuele verhoudings in Suid-Afrika; dit lei daartoe dat MIV versprei word en kan stigmatiserende gedrag vererger. Om hierdie rede is dit belangrik dat MIV/Vigsvoorkomingsveldtogte stigmatisering aanspreek ten einde gedrag te wysig en om die getal nuwe Vigsbesmettings te laat daal. Die drie veldtogte wat in hierdie tesis geanaliseer is het beide nagelaat om stigma direk aan te spreek op ‘n algemene vlak, en was ook nie direk gerig op vroue nie. Die veldtogte kan daarom beskou word as ontoereikend deurdat hulle belangrike komponente van MIV-voorkomig in Suid-Afrika misgekyk het.

Acknowledgements

First and foremost, I would like to thank my supervisor, Prof Amanda Gouws. I am grateful for all her help, patience and efforts, in order for me to complete this thesis. It would not have been possible without her instructions, guidance and constructive criticism that have been much appreciated. I would secondly like to thank my co-supervisor, Prof Pieter Fourie, for his helpful comments and assistance that I consider to have improved the quality of my work. Thirdly, I am thankful to my editor, Pieta Seppänen, for helping me with the finishing touches.

Last, but not least, I would like to thank my family and friends, from near and far, for their love and support. This has made the last weeks of writing a lot easier and has motivated me to keep working.

List of Acronyms and Abbreviations

ABC	Abstinence, Be Faithful, Condomize'-campaign
AIDS	Acquired Immune Deficiency Syndrome
ARV	AIDS-Associated Retrovirus
COSATU	Congress of South African Trade Unions
HIV	Human Immunodeficiency Virus
NGO	Non-Governmental Organisation
STI	Sexually Transmitted Infection
TAC	Treatment Action Campaign
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
WHO	World Health Organisation

Chapter 1: Introduction

1.1 Background

HIV is a silent epidemic. It can be claimed to be so since it only manifests itself as AIDS at the end of the infection process, and is thus difficult to detect. In this sense, anyone can be carrying the virus and still appear as a healthy person, and it can, due to this, through sexual intercourse and other sexual practices, be passed on without any of the partners being aware of it (Nattrass, 2004: 23; Stadler, 2003: 132). The epidemic can also be claimed to be silent since it is often sexually transmitted. Many people are ashamed or unwilling to talk openly about sex, with family members or with a sexual partner. Hence, knowledge about the epidemic, as well as one's HIV status, is limited. However, the silence surrounding the epidemic is about to be broken, as the many infections and deaths, and the suffering they cause for many families and communities, cannot not stay hidden much longer if there ought to be a reduction in the number of new infections (Frohlich, 2005: 352).

Without a cure for the epidemic, or rather the pandemic, at present time, the fear of becoming infected is strong. Stigmatisation of people living with HIV and AIDS on the basis of fear is common, of which the result is that in many cases people are too afraid to disclose their HIV status, and many tend to hide their positive HIV status, or are in denial of their condition. Such a tendency of denial and silence is dangerous, since it puts both oneself and a potential sexual partner at great risk of contamination with the virus. This can also contribute to HIV-positive people continuing to engage in high-risk sexual behaviour (Petros *et al*., 2006: 68). Infection related to high-risk sexual behaviour is among the main concerns of HIV/AIDS analysis as regards the spread of HIV (Nattrass, 2004: 26). However, by disclosing one's positive HIV status there is a possibility of stigmatisation and/or rejection both by the immediate family and the whole community. It can even lead to murder. This is what happened to Gugu Dlamini, a HIV-positive woman who disclosed her status and was soon after stoned and stabbed to death because of her condition. The explanation for the murder was that she had given her community a bad reputation and had brought disgrace upon it (Albertyn and Hassim, 2003: 138). In many places, HIV and AIDS are such stigmatised diseases that they cannot even be referred to by name (Stein, 2003: 95). This has made HIV and AIDS not only a medical or biological issue, but also a social phenomenon that has implications for the socio-economic, cultural and political sections of societies at risk (Smith *et al*., 2008: 1266). In Africa, ethnicity, poverty, patriarchy, working in the informal economy, gender, sexual behaviour and social relationships are all factors that have an impact on a person's vulnerability towards HIV infection (Alvarez-Castillo *et al*., 2009: 130).

South Africa has the highest number of HIV-infected people in the world, with approximately 6.1 million people living with HIV and AIDS, according to estimates from 2012 (UNAIDS, 2012). The

incidence of HIV has not increased, and the number of infected people has been stable in the last decade, rather than decreasing. The antiretroviral treatment rollout has contributed to keeping the number of infected people stable in South Africa.

Africans in South Africa have a considerably higher HIV prevalence than other population groups, and the highest prevalence can be found in the Northern and Eastern provinces of the country, with KwaZulu-Natal and Mpumalanga as the provinces with the most infected (Marais, 2011: 269). The apartheid era can therefore take some of the blame for the rapid spread of the disease among the African population due to the widespread social dislocation, employment-related male migration and long-term disruption in family and social organisation (Gilbert and Selikow, 2011: 328). The apartheid government used the excuse of the epidemic being a 'gay disease' for not acting expeditiously and hence was caught unprepared when the first cases of HIV were reported among the heterosexual population (Abdool Karim *et al*, 2009: 922; Nattrass, 2004: 41). The government was inhibited by its members' own sexual morality, cultural taboos and xenophobia, which limited the government's attempts to promote condom use (Nattrass, 2004: 41). Condoms, in turn, were proclaimed by some as racist and politically motivated in terms of reducing or controlling the black population. Such claims were the result of inadequate knowledge about the disease intertwined with the political environment in South Africa in the early 1990s (Nattrass, 2004: 41). In the 1990s, the number of heterosexually transmitted HIV infections skyrocketed, and by 1998, South Africa had one of the world's fastest growing epidemics, with most of the infected among the heterosexuals being from the poor black population that had already been politically, socially and economically neglected by the apartheid-run government (Marks, 2002: 16-17).

Despite the huge number of HIV-infected people, the politics of HIV and AIDS did, however, not drastically change for many years. When Thabo Mbeki became South Africa's president in 1999, he soon began to seek non-mainstream advice on the AIDS-epidemic that had swept over his country. Until Mbeki's departure in 2008, the issue of the cause of AIDS was dealt with inadequately, since many on Mbeki's expert panel believed that there was no causal link between HIV and AIDS, but that AIDS was rather a consequence of poverty and hence a forced unhealthy lifestyle (van Rijn, 2006: 522, 531; Marais, 2011: 280-281). Thus, Mbeki denied that there was a connection between HIV/AIDS and sex (Posel, 2005: 142). When a government refuses to take proper action against something that threatens to negatively affect many sectors of the society and economy of its country, it can contribute to making the HIV pandemic shameful in the eyes of the population. With silence, shame and stigma going hand in hand with HIV and AIDS, actions to promote openness and support should be put forward by governments. Although Mbeki eventually agreed upon certain policies, such as giving anti-retroviral (ARV) treatment to rape victims and pregnant women, his denial and late

reaction has cost many people their lives, and South Africa is now suffering from its repercussions (van Rijn, 2006: 522).

There is a link between HIV/AIDS and inequality and/or poverty status in South Africa (Marais, 2011: 269). Especially young women in poor households have engaged in sex with older men in exchange for money, food or material assets, as a way of survival, called transactional sex (Stadler, 2003: 128). Such a pattern can be illustrated through the age difference between infected girls/women and men. Especially among the younger population in South Africa, young women of the age of 15-29 have a much higher infection rate than men of the same age. With young women having little power to negotiate safe sex in situations with older men, the women are at great risk of becoming infected. Using sex as a commodity can at the same time be a root to stigmatisation since this can be considered as highly inappropriate behaviour in addition to the high risk of contracting an HIV infection. However, for some women, dying of AIDS is better than dying of hunger, and they are, therefore, using sex for survival although it comes with a great vulnerability towards infection (Nattrass, 2004: 27).

The sexual practices that can be found in Southern Africa and South Africa have contributed to the spread of the pandemic and create barriers to the prospects of behaviour change (Nattrass, 2004: 147). This type of culture and behaviour can be characterised by, for instance, socio-cultural norms of gender inequality, multiple sexual partners, sexual violence and pressures to prove one's fertility, which all contributes to a high-risk environment for HIV-transmission (Nattrass, 2004: 26-27, 146). Instances of violence against women are numerous in South Africa, and are often projected through sexual violence and assault set in a condition where both men and women are accepting of "(...) sexual violence as 'normal' masculine behaviour along with the 'right' of men to control sexual encounters" (LeClerc-Madlala, 2001: 41) and where also "men who have limited resources and lack the opportunity for social advancement often resort to exerting power and control over women" (HIV & AIDS and STI National Strategic Plan 2007-2011: 30). Since much of sexual violence happens domestically and having multiple sexual partners is common even when married, it makes marriage in itself a risk factor for contracting HIV (Patterson, 2006: 9). Negotiating condom use with someone whom you are married can be difficult due to the fear of being perceived as admitting to adultery, or accusing one's partner of such. However, this kind of situation does increase the risk of contraction (Alvarez-Castillo *et al.,* 2009: 131).

In South Africa, the system of patriarchy is evident and the cultural notions of masculinity are strong which has the consequence of the male usually determining the sexual relationship. This implies that women have little power to negotiate the terms of the sexual encounter and possible prevention measures against HIV transmission (Jewkes and Morrell, 2010: 5; Mash *et al*., 2010: 3). A

heterosexual transmission of the epidemic is most common and women have a higher infection rate. However, it can be argued that HIV/AIDS-related stigma is expressed more strongly against women than men (Achmat 2001, in Petros *et al*., 2006: 68; Stadler 2003: 128; LeClerc-Madlala: 2008: 17). One of the reasons for this is the above-mentioned disproportion in the numbers of infected women in contrast to that of men, resulting from women's vulnerability towards infection (Stadler, 2003: 128). As a result of this, local discourses often blame women for the spread of AIDS, while men are represented as merely passive recipients of HIV infection (Stadler, 2003: 128). This is, however, contradictory, since men have the power in most sexual relationships, yet are claimed to be victims when it comes to the transmission of HIV and AIDS. This indicates a gendered structure, where women are perceived as an ideal target for blame in sexual relations, while at the same time, they do not have the right to own the control over their own bodies.

Women's physiology in itself places them at higher risk of acquiring HIV through sex, in comparison to men. In addition, the gendered power imbalances in sexual relationships, as regards to negotiating the use of protection, when to have sex, and so on, has contributed to women being more vulnerable towards the risk of infection and also stigmatisation (Abdool Karim, 2005: 246; Marais, 2011: 265). The sexual power imbalances are often an extension of other types of gender imbalances within and outside a household, where gender gaps in favour of men are evidenced in employment patterns, literacy levels, land ownership, access to credits and school enrolments. Women are also usually the primary caregivers and have less control over productive resources outside the household (Abdool Karim, 2005: 246). Vulnerability to HIV is then not only determined through the biology that causes women to more easily become infected, but it is also rooted in women's lack of economic and educational power. This lack of power influences the choices that women make in life in relation to marriage, formal or informal employment, and male relationships (Patterson, 2006: 9).

Women's lack of political power in many African governments and at the civil-society level makes it more difficult for women to engage with the negative impacts that the epidemic has on them. Less political power means that governments are less likely to pass and implement laws that can improve women's condition towards HIV vulnerability (Patterson, 2006: 10). This is a great concern, since it means that in many places, women are not a natural part of important political decision-making processes. It also shifts the responsibility concerning the impact of gendered HIV vulnerability away from the government and instead places it in the hands of non-governmental organisations (NGOs) and the media for them to promote women's empowerment in relation to HIV and AIDS. Even though the media and NGOs may have power to influence the civil society, laws and policies are also important, since they give legitimacy to certain behaviour, and simultaneously, can limit negative behaviour.

Media and prevention campaigns have a great deal of responsibility as regards to how HIV and AIDS are perceived among people. The stereotyping of HIV and AIDS in South Africa as either a 'black disease' or a disease of white gay men has, to a great extent, been a product of the media. The type of people who have come forward with their positive status has also contributed to giving a certain image of the epidemic (Soul City HIV Booklet, n.d). This gives the media and prevention campaigns very important roles in discussions around stigma, as they can produce as well as help reduce HIV- and AIDS-related stigma. By reducing stigma, the numbers of infected people can also decrease. Prevention campaigns do play a key role both in the promotion of knowledge about HIV and AIDS and the reduction of stigma related to the infections, and hence, can function as an indicator of how South Africa is handling such stigma, and where the focus lies.

The preferred preventative method towards HIV/AIDS for campaigns is evident in their approach. The discussion concerning the most efficient way to prevent HIV infection has been substantiated mainly by two different strategies, or approaches, namely the biomedical-model and the behavioural-model. The behavioural-model aims at HIV prevention through behaviour change, by promoting a general change in the social norms towards safe sex and condom use as well as a reduction in the number of sexual partners. The biomedical-model, on the other hand, focuses on HIV prevention through medical treatment of persons in high risk of becoming infected. This approach is most widespread among donors at the present time, and has shifted the perception of HIV prevention from a focus on changes in sexual conducts and meanings towards a medicalization of sex and HIV (Giami and Perrey, 2012: 353-355). This will have implications for the future treatment and prevention of the epidemic, and may further have a yet undetermined effect on stigmatising behaviours.

Studies show that there is not necessarily a correlation between the levels of HIV and AIDS related knowledge and stigma. Knowing actual facts about the health conditions of HIV- and AIDS-infected people does not necessarily lead to widespread stigma reduction, because people's responses are usually a construct of different cultural, political or socio-economic factors (Campbell *et al.,* 2007: 404). Knowledge about HIV and AIDS is however for many prevention campaigns an important tool to reduce the infection rates. According to Stein (2003: 99), stigmatising behaviour does sometimes actually protect us from infection, because both valid and misguided fear relating to HIV and AIDS can produce stigma that makes people take less personal risks.

However, reducing HIV/AIDS-related stigma is important and it can be argued that the more vulnerable a person is towards HIV and AIDS, the higher the risk of being stigmatised. In 2000, the World Health Organization (WHO) and the United Nations (UN) declared stigma as the greatest obstacle that the world has in order to combat the HIV/AIDS epidemic (Petros *et al*., 2006: 68) The proposed context of South Africa makes stigma still a relevant issue of research.

1.2 Research Problem

1.2.1 Relevance of Research

Stigma related to HIV/AIDS, and specifically the stigma that is directed towards women is an under-researched area in the prevention of HIV and AIDS. Stigma is important to explore since women are especially vulnerable towards HIV transmission in South Africa. By exploring HIV prevention campaigns the research, examines if enough is being done to reduce stigma, and also to understand which approaches are adopted and who they are aimed at. The behavioural-model approach directs itself towards HIV-prevention through sexual behaviour change. This prevention strategy is decreasing in popularity among donors, who are rather placing their support in biomedical prevention measures. Still, since there are a large number of infected people in South Africa, there seems to be a need for less expensive measures to be taken towards prevention of HIV. Behaviour change can imply a change in both sexual practices and in general behaviour and can contribute to a change in stigmatising behaviours related to HIV/AIDS, especially directed towards women. How stigma is handled can be important both for the South African government and the organisations behind the prevention campaigns, for future interpretation of HIV-reduction and stigma-reduction.

1.2.2 Research Question

Based on the research problem, the study will analyse the socio-economic and cultural context t in the South African society, and consider how this has an influence on HIV/AIDS related stigma towards women, and what HIV prevention campaigns do to address these issues. The system of patriarchy, as well as the cultural notions of masculinity, that enforces women's vulnerability, is significant to address. However, class, race and gender are all factors that can contribute to vulnerability and a high risk of HIV infection in South Africa. These factors can therefore be situated into the context of HIV/AIDS and stigma. Hence stigma, sexual vulnerability and gender inequality are all important features of the spread of the HIV epidemic, and in combination, they are a great obstacle to HIV reduction. It can further be argued that black, poor and low-educated HIV-positive women belong to one of the most stigmatised groups in the South African society. This is a claim that has been discussed in the introduction above and that will be further explored in this study. Young, black, low-educated and poor women are also in a high-risk group of contracting the virus. Therefore, women's empowerment and tackling gender inequality are important factors in battling HIV/AIDS and stigma. Knowledge about HIV and AIDS alone does not generate a profound reduction in stigma. It is therefore significant to examine the cultural, socio-economic and political conditions that considers gender-based HIV/AIDS-related stigma in order to understand how a reduction in the rate of new

infections can be possible. This implies presenting issues of male dominance, masculinity and behaviour change, as well as addressing women's sexuality and (sexual) empowerment.

Reflecting on this: some important considerations to examine for women's empowerment are sexual behaviour and expanding women's ability, and agency, to control sexual relationships, as well as their own bodies, and negotiate condom use in sexual encounters (Gibbs, 2010: 1620-1621). Moreover, there is then a need to implement the effect that social, economic and cultural factors have on women's agency, and how patriarchy, dominance and masculine behaviour often limits women's sexuality. The power relations between men and women are important to explore within the context of stigma. Nevertheless, to be able to contextualise risk and vulnerability towards HIV and AIDS in South Africa, the power relations between the poor and the rich, and its intersectionality with race also need to be addressed, which implies looking at gender-, economic- and social inequality. The research question of this study formulated in consideration of this is:

Certain cultural and socio economic factors contribute to gender inequality that drives stigma around HIV/AIDS. How do prevention campaigns address issues of gender-based stigma?

1.2.3 Aim of the study

The aim of the study is to comprehend how HIV/AIDS prevention campaigns are addressing issues of gender-based stigma. This will be done by using radical feminism as the theoretical framework for analysing cultural and socio-economic factors that contribute to women being target of stigma. The study will further use the method of qualitative content analysis to analyse the prevention campaigns in order to answer the research question.

The theoretical framework for this thesis will be radical feminism. Radical feminism will be used to explain how patriarchy and male dominance within sexual relationship can contribute to the transmission of HIV/AIDS and HIV/AIDS-related stigma, when it is imposed through gender inequality. This involves exploring the cultural and socio-economic factors that generate male oppression and female submission at a general and a sexual level. It further implies including the issues of masculinity, women's (sexual) empowerment, the (lack of) control of women's bodies and women and men's sexuality, in order to comprehend the situation of women in South Africa.

1.3 Methodology

To reach the aim of the study, this study will take shape as a qualitative research project based on secondary analysis. This implies that the data will be collected through a focus on basic, descriptive research where the primary purpose is to give a detailed picture of how HIV- and AIDS-related stigma is influenced and encouraged by gender inequality that is based in cultural and socio-economic issues.

The study is further a single case-study of South Africa. It is a single case-study since it aims to comprehend how HIV prevention campaigns address gender-based stigma. The unit of analysis are the different prevention campaigns (Neuman, 2011: 42, 68-69). Qualitative content analysis will be used as the methodology for the purpose of analysing the intended message of HIV-reduction behind the campaigns. The organisations chosen for this study are Treatment Action Campaign (TAC), loveLife and Brothers for Life. loveLife was chosen because it is one of the largest HIV awareness campaigns in South Africa, and is focusing on youths, sexual behaviour and behaviour change, as well as gender related issues in its campaign. Brothers for Life is an organisation that attempts to promote masculinity in an alternative, more gender-equal way, and was thus chosen in order to pursue the gendered approach that the study has adopted. Even though it is an organisation for men, its campaign is focusing on HIV/AIDS and gender issues. TAC was chosen because it is more than a campaign, it is a successful civil-society movement that has contributed to raising awareness of the health-care situation of HIV-positive people in South Africa and has taken actions towards creating a better life for South Africans infected by HIV and AIDS.

The content analysis of the prevention campaigns will identify consistencies and meanings in the three prevention campaigns and analyse these. The focus will be on how they address stigma, and specifically, stigma that is directed towards women. How the three campaigns approach HIV prevention is significant to this matter. The three campaigns are all focusing on HIV prevention from a perspective of behaviour change. The analysis will therefore emphasise how the campaigns are encompassing sexual behaviour and behaviour change, knowledge and awareness of HIV and AIDS, unequal distribution of power in sexual relationships and vulnerability towards infection into their approach. This will be done by using the organisations' official websites as well as secondary literature as the basis for retrieving information.

1.4 Limitations to the study

I did not conduct any interviews with the different organisations due to difficulties in getting a positive response from the three organisations for possible interviews. Due to this, the study is not using any primary data that can verify the impact of the three campaigns. Limitations to the gathering of information about the campaigns' communication strategy and their overall impact on HIV-prevention are therefore relevant obstacles in this study since it is conducting a secondary analysis. The information the study retrieves can only give an indication of the situation of HIV and AIDS in South Africa and how successful the three campaigns are, since it will rely on existing statistics and research findings and their accuracy.

1.5 Structure of the thesis

Chapter 2 of this thesis will present the literature review, providing relevant literature on the HIV/AIDS epidemic in South Africa, stigmatisation and prevention campaigns to elucidate the research question. Chapter 3 consists of the theoretical framework of radical feminism and the methodology of content analysis. It will provide the theoretical foundation for further analysis. Chapter 4 will be an analysis of the campaigns of loveLife, Brothers for Live and TAC. In chapter 5 the findings will be summed up and conclusions will be presented.

Chapter 2: Literature review

2.1 Introduction

Even though the HIV epidemic has a global impact, the burden of it has not been equally distributed. Geographic location, gender, social or cultural categories and material inequalities within countries, are all factors that have contributed to the existing state of the epidemic (Gilbert and Selikow, 2011: 325). This chapter will explore the causes and consequences of South Africa's present HIV epidemic, which for now, has the highest number of HIV infected people in the world. The focus of the chapter is on the intertwined web of cultural forces, gender relations, patriarchy, socioeconomic factors, inequality and stigma related to HIV and AIDS that play their part in shaping and sustaining the epidemic in South Africa. It will also make reference to HIV/AIDS prevention campaigns that run in South Africa, in order to establish if prevention campaigns can influence HIV- and AIDS-related stigma caused by socio-economic and cultural factors. Social class, gender, race and geographical location are all dimensions of the HIV epidemic and health care inequalities that cannot be studied in isolation from one another if one wants to give a broader perspective on HIV and AIDS (Walker and Gilbert, 2002: 76). On the basis of this, this chapter will offer an insight into the context of HIV/AIDS in South Africa to inform the later analysis of HIV/AIDS and gender inequality.

HIV and AIDS are gendered infections in South Africa, which means that they are driven by the gender inequalities in the country, and since women most often have less power than men in sexual relationships, they are also more vulnerable towards the infection. Masculinity and patriarchy are cultural forces that contribute to this inequality and vulnerability, and are therefore also presented in this chapter. Poverty and the socio-economic status of women also contribute to women's vulnerability towards HIV and AIDS. Their socio-economic position, gives women fewer options when it comes to choosing a partner, and they often have fewer resources to provide for themselves and their families, and must sometimes take drastic decisions for the sake of survival that can heighten their risk of infection, in order to survive.

HIV- and AIDS-related stigma tends to focus on the social cognitive impacts of the issue (Campbell *et al.*, 2007: 404). This study will, however, focus on the understandings and consequences of stigma. Recognising that stigma is a cultural and social phenomenon, it also becomes clear that it is driven by the political and socio-economic conditions of a given society. Accordingly, the theory and arguments of this study will be drawn from perspectives addressing the structural conditions that shape the issues of gender inequality. This includes addressing the factors of culture, power (social, economic and political) and difference, in relations to HIV and AIDS stigma. The study will also be focusing on stigma towards sexual behaviour among heterosexuals, and thus, exclude others that can be

stigmatised due to the epidemic, including homosexuals, drug users and the ones affected by mother-to-child transmission.

The study will also explore the role of prevention campaigns, what they are and what they do. Establishing an effective campaign is a complex process, since gender-, culture- and age differences create obstacles for reaching 'everyone' with the same campaign. Campaigns are, however, one of the most efficient ways to reach out to a large number of people with information about HIV/AIDS and sexual matters.

2.2 HIV and AIDS in South Africa

How HIV spreads, differs in pace and extent, and depends on a complex set of societal factors, which themselves change over time and from place to place. The high levels of infection in South Africa are due to a combination of particular factors: it is primarily found among heterosexuals and is dependent on patterns of sexual behaviour entwined with the social relations and inequalities in the country that shape these patterns (Marais, 2011: 265). Links are made between social and economic conditions and health; when explaining the epidemic, the emphasis is often placed on behaviour of, and risk, for individuals rather than the underlying social relations and structural conditions (Marais, 2011: 267). Nevertheless, structure and behaviour are greatly intertwined, and this section and section 2.5 will focus on high-risk situations that have contributed to the high HIV infection rate in South Africa, while the sections 2.3 and 2.4, will have an emphasis on issues related to high-risk behaviour.

From Marks' (2002: 17) perspective, HIV spread so quickly in South Africa, because it was an epidemic just waiting to happen. She refers to Zwi and Cabral (in Marks, 2002: 17) that in the beginning of the 1990s suggested that certain situations are high-risk situations that would place certain groups of people at particularly high risk of HIV infection. These situations were impoverishment, disenfranchisement, rapid urbanisation, the anonymity of urban life, widespread population movements and displacement, labour migration, social disruption and counter-insurgency wars. Most of these were, according to Zwi and Cabral, situations where the daily survival was precarious, and where alcoholism, drug use and high levels of sexually transmitted diseases were prominent.

In South Africa in the 1980s, the black population faced all of these high-risk conditions. By forcing men to migrate due to labour needs, and consequently, forcing the men to be away from their wives and families for many months at the time, the migrant labour policy encouraged men to acquire sexual relationships in and around their workplaces. Many scientists and doctors could thus predict that a rapid spread of HIV would be just a matter of time (Kenyon *et al*., 2010: 36; Marks, 2002: 17). Lurie

(in Marais, 2011: 272) also acknowledges many of the same factors as Zwi and Cabral when it comes to the spread of HIV, as he points out:

> If one were to design a social experiment in an attempt to create the conditions conducive to the spread of HIV and other sexually transmitted diseases, you would remove several hundred thousand rural men from their families, house them in single-sex hostels, provide them with cheap alcohol and easy access to commercial sex workers and allow them to return home periodically (Lurie in Marais, 2011: 272).

In relations to this, but with a focus on women, Hunter (2007: 693) has examined the changes in the political economy of sex in South Africa from the 1970s until present time, and has found three changes that have taken place. One is "the rising unemployment and the marginalization of women". The economic crisis that shook the country in the 1970s hit African men the hardest, and many lost their jobs or were unable to get a job. The economic decline contributed to the unemployment rate increasing, which has further widened the great gap between the poor and the rich and contributed to the unequal distribution of income found in South Africa today. Women working in urban areas, for instance at clothing factories, also lost their jobs, which forced them back to the rural areas where they were to acquire highly unstable and poorly remunerated informal work. During this period their income fell sharply, which resulted in the marginalisation of the women, who thus became more dependent on their men (Hunter, 2007: 693-694). The second dimension is the "rapidly declining marital rates". Hunter sees that a significant trait of the present generation of young South African is that they are experiencing a simultaneous collapse of wage and agrarian livelihoods, which has significant consequences for household formation, marriage and sexuality. Statistics indicate that there have been drastic declines in registered marriages over the last four decades, and that the marriage rate among Africans are at present very low, which has led to an increase in one-person households.

There are several reasons for this decline in marriage rates. Many (urban) women have become more economically independent, and do not need men to provide for themselves, while men, due to increased unemployment, do not always have economic stability and many are not able to secure brideprice for marriage. In this sense, Hunter (2007: 693-695) points out; marriage has become 'a middle-class institution'. This also generates a basis for both sexes to have multiple sexual partners.

The third dimension is "the growth in women's movement, often in circular migration patterns that pivot around a rural 'home". Although labour migration has been a dominant institution for South African men since the 1930s, a greater expectation has now developed for women to also migrate into urban or informal settings. This is most likely due to a reorganisation of rural households into more geographically flexible institutions, where it is acceptable for women to migrate, and where they contribute to their household, by sending money (Hunter, 2007: 693, 695-697). Drawing from this,

Hunter's claim is that male migration and apartheid are factors that have had an undeniable influence on the transmission of HIV and AIDS, but that in South Africa, the contemporary social and economic issues must be considered, in order to understand the sexual behaviour of South Africans that has contributed to the spread of the HIV-epidemic. The migration of men and the increase in migration among women have led many people to temporarily settle in the informal settlements, which can explain why the rates of HIV in informal settlements are twice the national average (Hunter, 2007: 689).

Historical changes, can then play a role in the spread of the epidemic in South Africa, but also the response from the government, as well as communities, have to be considered as factors responsible for the high rates of infected South Africans.

In South Africa, the government has to take a lot of blame for the country's high infection rates, and scholars, such as Nattrass (2004: 29) and Reid and Walker (2003: 86), have been critical of the way the issue was handled by the political leaders of South Africa. The disbelief in the 'AIDS orthodoxy'[1] was what hindered progress in the political management of HIV and AIDS in South Africa in the first years of Thabo Mbeki's presidency. Mbeki's argument was that not everything could be blamed on a single virus, and that poverty was a main factor of the many deaths in South Africa. Making such a link between poverty, inequality and AIDS was not new; instead, the debate was caused by the questioning of the causal link between sex and HIV and AIDS (Mbali, 2004: 105-106). These kinds of assumptions can, however, be argued to have been a response to South Africa's history of racist understandings of African sexuality and the obsession with colonial and late apartheid discussions about race, sexuality and disease (Mbali, 2004: 104).

Mbeki's rhetoric, when it came to AIDS, contributed to associating the disease with a stigmatising racial imagery, since he constantly defended his view on HIV and AIDS by overtly accusing others of stereotyping it as African or black behaviour (Patterson, 2006: 40). He did have a point, as there have been several racist and sexist explanations for the spread of HIV and AIDS, in which notions that AIDS was spread by African prostitutes or through 'weird' African sexual behaviour, appeared in public health literature. These were, nevertheless, challenged soon after they appeared (Mbali, 2004: 113). However, Mbeki distanced himself from people affected by HIV and AIDS by saying, in 2003, that he did not know anyone with HIV or AIDS (Patterson, 2006: 40). The government, to a degree, hence ignored the suffering and death that were predominantly affecting the black majority that they were trying to defend (Patterson, 2006: 41). The denialism and ignorance did not contribute to spreading more knowledge about HIV and AIDS to the population either, and has also distracted policy-makers, activists and citizens from discussing important AIDS issues such as sex, gender

[1] This study does agree with the 'AIDS orthodoxy', which means the generally accepted scientific view that HIV

(in)equality and responsibility for sexual behaviour (Patterson, 2006: 41). Mbeki's suspicion of the West, and drug companies, has also strained the relations between the South African government and donors, which affects the civil society's rights to anti-retroviral drugs (Patterson, 2006: 41).

At the forefront of the opposition to Mbeki's AIDS policy decisions were the Treatment Action Campaign (TAC), together with the Congress of South African Trade Unions (COSATU), church organisations and other kinds of AIDS activists. Their goal was to challenge the health-service providers, the government and the pharmaceutical companies in order to help poor people attain better access to treatment. Their campaigning included protests, petitions and community activities, and they also had lobby groups that challenged the government in court accusing the government of failing to uphold the health rights enshrined in the Constitution. The Constitutional Court ruled against the government, and in 2001 the drug nevirapine was instructed to be given to all HIV-positive pregnant women, and in 2003, the Cabinet approved that free anti-retroviral drugs should be provided in the public-health system (Marais, 2011: 279-280). The government was however not convinced about the HIV/AIDS treatment, as can be seen in how the Ministry of Health continued to promote traditional remedies and vitamin supplements, as well as a mixture of garlic, beetroot and lemons as alternatives to the medical treatment of AIDS. This was highly criticised and ridiculed by many AIDS specialists, but Manto Tshabalala-Msimang, the Health Minister at the time, remained in her post for many years (Marais, 2011: 280).

By the end of the 2000s, approximately 43% of the deaths in South Africa were due to AIDS. Free anti-retroviral therapy via the public-health system was introduced in 2004, but for many people it was already too late. The government's refusal to timely introduce anti-retroviral drugs in the early 2000s, has caused people, such as the Harvard professor Pride Chigwedere and his colleagues, to blame Mbeki and his government for the loss of approximately 330 000 South African lives. The Mbeki government has even been accused of genocide for the same reason (Boseley, 2008; Cronje, 2009; Marais, 2011: 281).

The failure to establish anti-retroviral drug policies is, however, only the surface of the AIDS problem in South Africa. Marais (2011: 284) argues that in order to understand the damage of AIDS it is important to understand the ways that unequal distribution of privilege, risk and responsibility in societies both channels and shapes the epidemic's impact and how this impact may reinforce those patterns of inequality. When South Africans become infected, the health-care system is an expression of such inequalities in South Africa (Marais, 2011: 288). This is an argument that Mbali (2004: 109) also supports. She argues that poorer HIV patients have less access to the anti-retroviral drugs or health facilities, while richer patients have access to private hospitals and thus greater health care facilities.

Poorer people also often have a lower level of nutrition that can contribute to compromising the immune system, and increase the chances of contracting HIV. It also affects the disease's progression in the sense that poorer patients do not have access to the needed facilities in order to control the disease, whereas wealthier patients have this access, and can therefore live longer with the disease (Mbali, 2004: 109). One striking issue is that most South Africans with HIV are unaware that they have been infected. For hospitals, this has the consequence that many people only seek treatment when they are very ill, thus utilising a lot of resources from the public hospitals that already suffer from a lack of resources (Marais, 2011: 289). However, this is an even greater concern for the public, since people who are unaware of their status can transmit HIV to others. In this sense, prevention campaigns, as introduced in the last section of this chapter, have a major task and responsibility in order to generate awareness of the importance of HIV testing. One of the main challenges for prevention campaigns is that high levels of knowledge and awareness of HIV does not seem to change the attitudes around sexual behaviour among young people (LeClerc-Madlala, 2002a: 22). A change in attitude towards sex, sexual behaviour and condom use is therefore necessary in order to control and reduce the transmission of the epidemic.

There are, however, also traditional beliefs that interfere with HIV knowledge and sexual behaviour, which can reinforce stigma in the communities and discourage people from seeking treatment. Knowledge, secrecy and silence go hand in hand. Stadler (2003: 129-130), in his research on a village in South Africa, identified a public secrecy related to AIDS, as people often knew the symptoms of HIV and AIDS, but chose to be publicly silent about it. Such a reaction, or rather lack of reaction, was common because an accusation of someone having AIDS would create a bad reputation within the community and for the family of the infected, and because there was a general fear of shame and stigma in the community. However, there was also a sense of denial of the symptoms being AIDS if the person was 'respectable' in the community. In this sense, people's knowledge about HIV and AIDS is sometimes overshadowed by traditional thinking (Stadler, 2003: 131-132).

The HIV and AIDS epidemic is no doubt one of South Africa's biggest challenges. Since it tends to affect the young generation of South Africans, who are also the future of the country's social, cultural, political and economic development. Moreover, it has been the source of massive loss of lives; the loss of parents, grandparents, children, grandchildren, siblings, spouses and lovers, it has fuelled stigma and provoked anger and violence, but it has also been denied or kept silent, both by the government and local communities. In addition, the epidemic has had a greater burden on women than men in South Africa. Gender inequalities fuel the HIV and AIDS epidemic, while the inequalities are at the same time fuelled by it (Albertyn and Hassim, 2003: 153). This is one of the reasons why it is important to take gender into consideration when researching HIV and AIDS in South Africa.

2.3 HIV/AIDS and gender

In 2002, Kofi Annan, the then Secretary General of the United Nations, stated that: "In Africa, AIDS has a woman's face" and this was still the case in 2010, according to the UNAIDS Global Report (in Gilbert and Selikow, 2011: 331). This strengthens the assertion that the epidemic in sub-Saharan Africa is gendered. In sub-Saharan Africa, approximately twice as many women than men have been infected with HIV and AIDS (Gilbert and Selikow, 2011: 326). In South Africa, young women at the ages of 15-24 have approximately four times higher HIV prevalence than that of young men of the same age (LeClerc-Madlala, 2008: 17). Biology, in the sense of women having larger body surfaces that can be exposed to and contract HIV infection, is a factor explaining why the numbers are so much higher among young women than men, but there are also societal factors that provoke and contribute to HIV vulnerability (LeClerc-Madlala, 2008: 17).

Mane and Aggleton (2001: 24-25) refer to two factors that contribute to the likelihood of HIV infection: individual risk and societal vulnerability. Individual risk relates to the knowledge that people have, in the sense of what they know, understand and feel about HIV and AIDS, and what they do. This further correlates with individual behaviour and safety practices that correspond with their knowledge. Societal vulnerability towards HIV and AIDS is determined by economic, sociocultural, legal and political factors which limits the individuals' options and agency to reduce their risk of transmission. Such factors can be policies and norms or other social arrangements that the individuals have little control over, but have great influence on their daily lives.

According to Mane and Aggleton (2001: 25-26), gender is also one of the most crucial social factors that contribute to vulnerability towards HIV and AIDS, and its impact. Since women lack power to determine where, when and whether sex takes place, their vulnerability is greater than that of men's. This applies especially when women are in a situation where they are socialised to please men and submit to male authority. This becomes evident when women cannot negotiate (safe) sex, if they are economically and socially reliant on men, when they have a lower status within the family and when they inhabit the traditional roles as nurturers and caregivers. The power imbalance between men and women has made it clear that men's behaviour often places women at a heightened risk of transmission. This is further reinforced by societal and cultural norms and expectations that contribute to creating an environment where sexual risk is acceptable and often encouraged for 'real' men (Mane and Aggleton, 2001: 27). Fertility in many African communities is important, hence women have to prove their fertility before marriage, and this contributes to their vulnerability in the absence of safe sex (LeClerc-Madlala: 2002a: 26).

Within the group of African males, the acceptance of having concurrent sexual relationships was higher than among coloured and white South Africans. This was further related to cultural differences, where in African societies, the norm of males having multiple sexual partners was considered highly acceptable and even expected (Kenyon *et al*., 2010: 41). The main concern for Kenyon *et al*. (2010: 42) was that the awareness of HIV risk and transmission was reduced among the Africans who had more concurrent sexual partners compared to other racial groups who perceived themselves at increased risk of HIV transmission by having multiple partners.

Multiple partners, employment-related migration, drug and alcohol abuse and paying little attention to sexual health and safety, all of which have been proven to be behaviour more typical of men, create a causal chain of risk transferred by men's high-risk behaviour to women, with the result of making women very vulnerable to HIV infection if they rely on one partner. Dominant masculinity can thus be argued to put both men and women at greater risk of HIV infection, especially since men are under pressure to follow ideologies that stress sexual prowess, authority over women and multiple partners (Mane and Aggleton, 2001: 27, 32). Mane and Aggleton (2001: 33) also allude that men and women, fathers and mothers, have contributed to the influence of the existing gender relations by teaching and reinforcing traditional ideas about manhood.

On the basis of this, Mane and Aggleton (2001: 28) make the point that in most discussions about women and HIV/AIDS, men have had to take the blame for the spread of the epidemic due to their sexual behaviour. Evidence, however, shows that people often blame women for the spread of the disease, even naming it the 'women's disease' (Albertyn and Hassim, 2003: 155). In some societies in South Africa, as LeClerc-Madlala (2002a: 33-34) has noted, men can be perceived as victims of the HIV epidemic. One reason, she mentions, is because it is perceived that men cannot control their sexual urges, and are not expected to either, because the urges are seen as natural. Another reason is that men are victims of a cultural construct in which they are expected to be able to regularly satisfy women sexually because it is important for women's sexual health. Accordingly, from this cultural perception, women need the 'protein' that is provided in semen, but women are also supposed to need sex in order to maintain dignity and womanliness. A woman therefore needs a man in her life to become more, subdued and behave properly (LeClerc-Madlala, 2002a: 33-34). In another one of her studies of women and AIDS in KwaZulu-Natal, LeClerc-Madlala (2001: 42) has found that the main assertion of AIDS symbolism is that women are perceived as the source of HIV infection, due to traditional views of women as contaminated through their sexual fluids. They are also being perceived as the disseminators of AIDS-illness and death. She further links this to the patriarchal notion of male control within the sectors of health, law, order and decency in society. Women who challenge men in these sectors are seemingly 'out of control' and are slipping out of patriarchal control, which can have disastrous consequences, such as the spread of HIV (LeClerc-Madlala, 2001: 42). In these contexts,

women are, therefore, considered to need sex, but it should only happen within controlled circumstances, and if this does not happen, the society can blame immoral or 'promiscuous' women for the transmission of HIV (Albertyn and Hassim, 2003: 155).

It is not only men that blame women for such behaviour and try to control women's sexuality within the context of HIV/AIDS. Older women are often the ones who have to take care of those infected by HIV and AIDS and children orphaned by the epidemic. They too stigmatise and blame younger women for being 'promiscuous', and want to reinforce traditional gender roles in order to reduce the transmission rates. These perceptions can explain why virginity testing has had its resurgence among Zulu communities in KwaZulu-Natal, as an attempt to reinforce conservative sexual norms. However, such practices draw the attention away from the role of men when it comes to spreading the disease (Albertyn and Hassim, 2003: 155). The myth that virgins can cure AIDS has contributed to a madonna/whore dualism for girls and women, where virgins are perceived as the salvation, while sexually active women can become 'out of control' and sexually promiscuous. This has, however, led to increased incidences of rape of virgin girls, which puts these girls in a high-risk position of contracting HIV (Albertyn, 2003: 602).

The issue of lobola, or brideprice, in certain cultures in South Africa has also contributed to women's vulnerability and risk of HIV contraction because husbands claim they have paid for their wives, thus own them and their bodies, and are therefore entitled to have sex with them whenever they want to. Some women are, as a consequence of brideprice, perceived rather as servants than equal partners when it comes to marriage. Many women do not feel that they have the power to negotiate sex under such circumstances, but rather do as they are told (Albertyn, 2003: 600; Campbell *et al.*, 2007: 410; Yun *et al.,* 2001: 76).

Transactional sex, i.e. sex in exchange for transport, fashion, education and the like, is one of the key drivers of HIV and AIDS in South Africa (Gilbert and Selikow, 2011: 329). Transactional sex is prominent in relationships between young women and older men. It is known that such sexual relationships place young women in a vulnerable position of HIV transmission due to their lack of ability to negotiate the terms of the sexual encounters since they receive something in return for their sexual favours (Stadler, 2003: 128). In a context like South Africa, where many women have little access to resources, sex, is often the only resource that women have and can use for their own material growth, and the arrangement of such a division in sexual relations places women in a weak opposition to men.

However, there are many differences between transactional sex and sex work. One difference is that the women engaging in transactional sex often consider themselves as girlfriends, and the relationships are based on emotional involvement and intimacy. Nevertheless, the emotional involvement makes it

more difficult for women to succeed in negotiating condom use, if that is even what they want (Gilbert and Selikow, 2011: 329). Marais (2011: 274-275) places transactional sex in a broader perspective of sexual networking that has its base in traditionally polygamous and patriarchal systems, where the context of material disparities, the pursuit of consumption and the notions of manhood and sexual conquest together contribute to its presence. However, most women do not picture themselves as victims in such relationships, because sexuality, status and consumption usually go hand in hand (Marais, 2011: 275).

Even though the women do not consider themselves as victims, there is a certain stigma related to their actions. Stadler (2003: 128) notes that young women who engage in transactional sex were said to 'buy their own coffins', which implies that they exchanged a risk of HIV infection and death for either survival or wealth, status and entertainment. This is a paradox between poverty and consumerism that transactional sex invokes, but both situations, however, place women in a vulnerable position of becoming HIV-infected.

In South Africa, there is little doubt that women are more vulnerable to HIV infection than men, because men are usually the dominant partners in the relationship. Since male behaviour is one of the main determinants for HIV transmission to women, men must be seen not only as the problem, but as part of the solution when it comes to HIV and AIDS (Langen, 2005: 197; Mane and Aggleton, 2001: 34-35). For this to happen in South Africa, patriarchy and the culture of masculinity need to be re-evaluated.

2.4 Patriarchy and masculinity in South Africa

Marais (2011: 271) sees patriarchy[2] as a social order of domination that has continuously established itself in South Africa over the centuries, and was further shaped by colonialism and apartheid into its current form. According to Bentley (2004: 247), patriarchy is still evident among all races and cultures in South Africa. This is something Morrell (2002: 310) also recognises, and argues that new laws and policies have not been able to overthrow patriarchy or to stop men from dominating in the fields of politics, public life and earnings.

According to Walby (1990 in Connell, 2000: 24) there are six structures that characterise modern patriarchy: the patriarchal mode of production, patriarchal relations in the state, in sexuality, in paid work, in cultural institutions and male violence. As Connell (2000: 24) argues, many of these structures are so closely related that there are few distinctions. Connell recognises two main structures where patriarchy is evident; one is the overall subordination over women and the dominance by men,

[2] According to Stanistreet *et al*. (2005: 873) patriarchy can be defined simplistically as ''the systematic domination of women by men and domination of men by other men''.

which is the structure that women's liberation movements have named 'patriarchy'. The other is within the production relations, or the gendered division of labour, and Connell calls it the patriarchy dividend. In this type of patriarchy, it is the benefits that men gain from unequal sharing of the social products of labour in terms of wage rates, control of major corporations and other factors of a gendered character of capital (Connell, 2000: 24-25).

Burnett (in Bentley, 2004: 257) argues that patriarchy in South Africa is a hybrid of settler and indigenous culture, that has been influenced and intensified by other forms of inequality, especially imbalances in political, economic and social power hierarchies of race and class. This has further produced unique forms of gender subjugation of women, divided along racial lines, which has prioritised national freedom rather than freedom for women, and in this sense has led to the exploitation and vulnerability of (especially rural) women and the maintenance of the patriarchal system.

Patriarchy is hence in many ways linked to the notions of masculinity and domination over women. Much of the literature on masculinity was written as a reflection on the growing numbers of studies and discussions of feminism that appeared in the 1970s and 1980s. Although the dominance of men and male sex roles had been subject to public records, little was actually known about masculinity. The purpose was to retrieve greater knowledge about men, in the sense of placing emphasis on the social factors that reinforce masculinity (Morrell, 1998: 605-606).

Masculinity, according to Connell, is not just one pattern, but differs among different cultures and periods in history, and therefore constructs the notion of gender differently (Connell, 2000: 10). This means that masculinity is socially constructed and fluid, as there is no universal form of masculinity, but rather several masculinities within a society. Class and race are factors that are constitutive in shaping masculinity, which means that there are both subordinate and dominant forms of masculinity (Morrell, 1998: 607). However, for Connell, the idea of a hegemonic masculinity reveals the dominant form of masculinity within a society. Hegemonic masculinity builds itself around cultural domination, and both oppress women as well as silence or subordinate other masculinities to the extent that they have no currency or legitimacy. The hegemonic masculinity has its own culturally produced, ideal version of masculinity, including ideas of what 'real men' are and how they should behave (in Morrell, 1998: 607-608).

Jewkes and Morrell (2010: 2-3, 6), drawing on Connell, see hegemonic masculinity in South Africa as an integral part of patriarchy which allocates, secures and distributes the power of men over women. They argue that this kind of hegemony is characterised by a set of practices that expresses men's power within the social system and serves to reinforce this power. It is built on an ideal of masculinity

that legitimises and mobilises subordination and control of women by men, and although it is not ideal, violence may be used to bolster the masculine ideal and demonstrate control. This also has an effect on HIV vulnerability, as South African men who have been physically violent to their partners are more likely to be infected with HIV (Jewkes and Morrell 2010: 2-3, 6).

There is, however, no feminine counterpart to hegemonic masculinity. Instead, masculine hegemony has become a 'cultural norm', and women who adapt or engage in acts of resistance risk becoming marginalised, stigmatised or victims of violence. This further reinforces the feminine and masculine differences and power relations. The quest of being desirable to men makes women accept the dominant social order and the control by men (Jewkes and Morrell, 2010: 3, 6).

On the other hand, Jewkes and Morrell (2010: 3-5) highlight that gender identities often change over time, and that there is evidence that this is happening in South Africa with greater public diversity and fluidity. One example of this is the urban 'modern girl' femininity that is associated with independence, the use of specific fashion commodities, 'explicit eroticism', and other kinds of female agency, whether it is for sexual or economic independence or political emancipation. It is this change in gender identities, they argue, that is needed in order to achieve a better HIV prevention and optimisation of care in South Africa (Jewkes and Morrell, 2010: 1).

According to Jewkes and Morrell (2010: 5) South African masculinities have certain aspects in common, in that they all value the martial attributes of courage, physical strength, toughness and hierarchical authorities, and they demand men's exercise of control, both over women and other men. The African 'manhood' is about heterosexual success, which is demonstrated by the ability to 'win' desirable women, prevent them from being seduced by other men, and by being a man in control in the relationship (Jewkes and Morrell, 2010: 5). The prodigious sexual expression of such manhood, and thus their masculinity, is something that women desire, and similarly womanhood is proven by being desirable to men (Jewkes and Morrell, 2010: 1, 6).

This is, however, risky business when it comes to sexually transmitted diseases, such as HIV, because being desirable sexually means that both women and men will often have multiple sexual partners and will oppose condom use both for sexual pleasure and in order to get and keep a partner (Jewkes and Morrell, 2010: 1, 6). LeClerc-Madlala (2002b: 92) recognises that patriarchal fears of female power are highly symbolised by the vagina, as it is an organ of reproduction, and an organ related to sexual pleasure, but at the same time it is dark, wet and contains 'dirt' that can be traced to different sexually transmitted infections (STIs) and HIV/AIDS. She argues that this is related to male fear and insecurity, when it comes to a woman's inherent power, a power that deviates from her social inequality and general lack of power in society (LeClerc-Madlala, 2002b: 92). The complexity of masculinity and

femininity is further demonstrated by how successful women often desire dominant men, because they are 'real men' (Jewkes and Morrell, 2010: 7).

The notion of masculinity can be especially complex for young men and boys. Makahye (2005: 316) argues that socio-cultural norms of masculinity, especially the assumption that 'men know everything', victimise men. This is because the norms make it difficult for boys and young men to seek advice or to use proper information sources when it comes to sexual knowledge and HIV/AIDS, while they at the same time pressure boys to become sexually active. The norms of masculinity also prevent men from engaging in reproductive responsibilities, such as child health services and antenatal services. Makahye does, however, see a change in the pattern of awareness of unacceptable behaviour among young boys, when it comes to abuse of women and children and the phenomenon of 'sugar daddies'. She, therefore, stresses the importance of focusing on boys and young men in order to change gendered behaviour in sexual relationships and HIV/AIDS prevention (Makahye, 2005: 317-318).

Patriarchy is evident as a political, cultural and socio-economic factor in the South African society. This has further consequences for the gender perspective and the gender inequality recognised in the country, where many women live in poverty and are socio-economically marginalised.

2.5 Poverty and the socio-economic inequality of women in South Africa

The link between poverty and HIV/AIDS is not always clear. Marais (201: 268) argues that at a national level, the link is rather weak. His claim is based on the notion that in sub-Saharan Africa, the poorest countries are not the countries with the highest HIV-prevalence. Instead, most of these countries have a rate of about 1-2%. The worst prevalence is, in fact, found in two of the richest countries in Africa, namely Botswana and South Africa. Within South Africa, the intertwined web of population groups, gender, income groups and regions, has contributed to the uneven distribution of HIV infections. The infections seem to mirror the social order enforced by apartheid, in which the black population is the group that is the most affected by the epidemic, but also, the most affected by the socio-economic inequality gap in South Africa. However, as Marks (2002: 22) points out, it is not only the marginal and the poor that are infected with HIV in South Africa, but also many professionals, nurses, teachers and high-profile politicians with significant education and affluence are HIV-positive. The spread of HIV is, according to Marks, due to both high-risk situations and high-risk behaviour. Poverty and socio-economic inequality are high-risk situations, but as this section will show, such situations can lead to high-risk behaviour.

Poverty is more than the amount of income and expenditure that people have (Marais, 2011: 211). According to Kehler (2001: 42-43), poverty can be contextualised and measured by the determinants of well-being. This primarily includes factors such as welfare, health and human rights, but also the determinants of the availability of access to health care, shelter, education facilities and income, as well as access to basic services such as water, sanitation and electricity. Marais (2011: 218) also includes the ability to eat regularly and healthily as an indicator of well-being. In South Africa these factors of poverty and well-being are closely related to race, class and gender (Kehler, 2001: 43). Poverty tends to be more severe among women than men in South Africa, and is also often experienced differently by women than men (Bentley, 2004: 247).

For instance, women-headed households are disproportionately more likely to be poor than the one's headed by men (Marais, 2011: 203). Available data indicates that this is because women have less access to economic activity and employment opportunities, and if they are in the formal economy, they usually have a lower per capita income than men, which is often less than half of what men earn. Still, women work longer hours than men, although often within the informal economy, and they also need to take care of the household when they get home from work. In this sense, one can say that poor women do more work, for less pay, and they are still primarily situated in the informal economy as well as the domestic sphere (Bentley, 2004: 255-256). However, more than half of rural black women are unemployed (Kehler, 2001: 47). Rural women are more exposed to such inequalities than urban and semi-urban women. This is because rural women lack access to basic services and resources, while also having unequal rights within the family structures, which implies that they have less access to family resources such as livestock and land (Kehler, in Bentley, 2004: 258). Almost half of the women in South Africa are living in rural areas, but the percentage of rural women differs greatly between the population groups. In other words, in 1999, 57% of black women lived in rural areas, compared to only 8% of white women and 17% of coloured women. Combined with the often limited access to education and skills training for rural women, this indicates that the majority of black women live under very poor conditions in rural areas, and will continue to do so as long as their opportunities are limited (Kehler, 2001: 46-47).

Offering a different perspective, Marais (2011: 268-269) argues that it is not poverty in itself that directly makes the risk of HIV transmission higher. In that case, the rural areas would have been more affected than the urban areas, but this is not the case in South Africa, or most other places in Africa for that matter. Hunter (2007: 690) argues that, although little discussed, it is in the informal settlements where the HIV rates are the highest; they are approximately twice as high as in the urban and rural areas. This is because a large part of the population consists of migrants, poor and typically young, unmarried and without secure work.

However, according to Marais, poverty can drive people into behaviour that has a high risk of HIV infection, such as commercial or transactional sex, hindering them from seeking treatment, and not getting enough information about the epidemic and it can force especially women to depend on partners, who may have several sex partners. Poverty also tends to diminish the concerns about health and diminishes the access to health care (Marais, 2011: 268-269; Marks, 2002: 17). In this sense, Marais' argument corresponds to Marks' (2002: 22) argument presented in the introduction that one cannot simply look at high-risk situations, such as poverty and marginalisation, to understand the spread of HIV, but one has to also look at high-risk behaviour, such as risky sexual practices and beliefs.

Patriarchy also has a negative influence on women's participation in the political sphere, human rights of women and the acknowledgement of equal rights to resources, since patriarchy does not recognise such a sharing of power (Bentley, 2004: 248). On the basis of this assertion, Bentley (2004: 248) argues that the retention of patriarchal power is a key factor in the economic marginalisation of women. Even though the South African Constitution of 1994, and the Bill of Rights in particular, give women greater protection of basic rights, opportunity and freedom. In practice, however, the traditional patriarchal culture does not recognise these rights and still believes, according to Kehler (in Bentley, 2004: 258), that women are less 'valuable' members of society and that their contribution to the household is of less value than that of men's. According to Bentley (2004: 259), economic inequality and the occurrence of violence against women are both symptoms of a deeper inequality that exists in South Africa, and consequently, human beings are not equal in worth and dignity, but women's lives and well-being are considered of less value than men's.

Sharp *et al.* (2003:282) argue that many women in the third world do not have the time to promote ways to enhance their power by gaining economic equality, as they have too much to do at home to chase 'status-enhancing' activities. In this sense there are socio-economic factors that women need to deal with before the political, economic and cultural empowerment of such women can proceed. For the majority of South African women the socio-economic rights guaranteed in the constitution are, in practice, not accessible, which contributes to the perpetuation and increase, as well as feminisation, of poverty (Kehler, 2001: 51). The feminisation of poverty is further enhanced by the high number of women who are part of the care-economy. Approximately 90% of care-givers in South Africa are women and girls, and many of them are taking care of AIDS patients. This is a kind of labour that, although time-consuming, is largely invisible and taken-for-granted, which means that it is not highly valued or paid, even though it is important and greatly needed (Marais, 2011: 286).

Tallis (2000: 58) argues that awareness of the link between gender inequality and vulnerability to HIV and AIDS has increased. Mannell (2010: 1613) is of the same opinion and argues that socio-economic

inequalities between men and women give rise to inequality in issues related to AIDS, and that traditional gender roles and power relations have a negative impact on women's vulnerability to HIV/AIDS. Men are also affected by the power differences, and in combination with masculine sexual behaviour, men are also vulnerable towards HIV infection in the sense that they are under pressure to perform sexually with several partners (Tallis, 2000: 59).

Examining the link between gender inequality and HIV/AIDS vulnerability helps to further explore the link between HIV/AIDS, poverty and inequality. HIV and AIDS exacerbate poverty and inequality, but poverty and inequality also facilitate the transmission of HIV (Parker and Wilson, 2000: 92). Women are often poorer than men, which heighten women's vulnerability towards HIV infection (Tallis, 2000: 60). This highlights Marais' earlier point, that the vulnerability is evident because the HIV infection pattern follows the biases of poverty, and as a consequence, poor women offer sex in exchange for food, shelter or other basic necessities for survival, or they engage in short- or long- term sexual relationships (Albertyn, 2003: 598). According to Farmer *et al.* (1993: 388), social and socio-economic factors increase the risk for women, whether it is due to poverty or women's inability to protect themselves in sexual relationships. According to Nattrass (2004: 29), there is evidence which indicates that poorer women, compared to their better-off counterparts, know less about the transmission of HIV, and have reduced access to condoms and ability to use them.

All in all, the HIV infection pattern seems to follow the path of the least resistance, and to find its place where there is economic and social inequality, which means that gender, race, age, marital status, poverty and work-related issues all influence the vulnerability towards HIV and AIDS – all categories within which, women often lose socially and economically (Albertyn, 2003: 597). Stigma and stigmatisation also have a considerable effect on the course of the epidemic. The impact of stigma is highly negative in the sense that it discourages people from coming forward with their status and even getting tested, in the fear of social repercussions and sanctions.

2.6 Stigma and HIV/AIDS

"If you test HIV-positive you are dead. They will take you as a living corpse" – a villager in north-eastern South Africa (Marais, 2011: 300). This statement indicates how stigma can be crucial for the decision of whether or not to disclose one's HIV status, because it can have serious consequences for the lives of the infected.

The contribution of Erving Goffman has been much addressed in discourses about stigma and HIV/AIDS. Goffman defines stigma as 'an attribute that is significantly discrediting' and that is 'an undesirable difference' which further reduces the person who possesses such an attribute, in the eyes

of the society (Goffman 1963 in Parker and Aggleton, 2003: 14). Stigmatisation can, hence, be seen as a dynamic process that occurs when it is perceived that a violation of a set of shared beliefs, attitudes and values has happened, and the group or person who is perceived to have violated these is labelled as different or deviant (Brown *et al.*, 2003: 50). This definition has been used to define stigma as regards various of illnesses, such as leprosy, cancer and mental illnesses, and has thus been used for HIV/AIDS (Parker and Aggleton, 2003: 15). Link and Phelan (2001: 377) define stigma in relation to interrelated components. Stigma then "exists when elements of labelling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them" (Link and Phelan, 2001: 377). However, such situations are not set and the experiences of stigma are shaped by the relative power relations between the stigmatised and the stigmatiser (Link and Phelan, 2001: 378).

Brown *et al.* (2003: 50) argue for distinguishing between felt or perceived stigma and enacted stigma. Whereas felt stigma consists of real or imagined fear of attitudes and potential discrimination from the society as a consequence of having an undesirable attribute, such as the HIV infection, enacted stigma refers to the real experience of discrimination in relation to how, for instance, an HIV-positive status can lead to a loss of a job or social ostracism. Parker and Aggleton (2003: 15) present similar ideas when suggesting that stigma can either be analysed as something in the person or what others attach to the individual.

Parker and Aggleton (2003: 17-19) further link HIV- and AIDS-related stigma to a debate on structure and agency. Stigma is not an individual process, but is facilitated by structures of power that some groups inhabit over others. They claim that stigma and stigmatisation operate at the intersection of culture, power and difference and that these different categories together are central to the constitution of the social order. This is because the construction of stigma and stigmatisation involves the marking of specific differences between categories of people, that further place the people in systems or structures of power. In terms of a structural understanding of the concept of stigma in relations to HIV and AIDS, Parker and Aggleton (2003: 16) argues that stigma plays a key role in the production and reproduction of power and control in the sense that some groups are devalued while others feel superior in some way. Because of this, stigma can be linked to social and gender inequality, which contributes to socially exclude some groups or individuals. Link and Phelan (2001: 375) go even further suggesting that stigma is entirely dependent on political, economic and social power, as it takes power to stigmatise.

Parker and Aggleton (2003: 18-19) further argue that stigma is constructed by concrete and identifiable actors who seek to legitimise their own dominant status within the existing structures of social inequality. Stigmatisation is part of a constant social struggle that roots itself in social inequality. Parker and Aggleton thus link stigmatisation as a process with a competition for power and

a legitimisation of multiple social hierarchies and inequalities that are produced and reproduced. Castro and Farmer (2005: 53) take a similar stance, arguing that stigma is often just the tip of the iceberg and a part of complex systems of illness and disease that are rooted in social inequalities, and it is more powerful in poorer than in wealthy nations.

Stigma and discrimination in relation to HIV and AIDS in developing countries are social and cultural phenomena that are linked to the actions of whole groups of people rather than individual action, as bonds and allegiances to family, neighbourhoods, villages and communities are strong and important (Parker and Aggleton, 2003: 17). Stigma is, however, also political, according to Parker and Aggleton. Drawing on ideas of hegemony: political, social and cultural forces that organise dominant meanings and values within the social field can have the ability to legitimise the structures of social inequality, and obtain consent even from those who are the objects of domination (Parker and Aggleton, 2003: 17-18). Accordingly, HIV- and AIDS-infected people often accept the stigmatisation brought upon them by others, as they, for instance, may feel ashamed themselves. The shame and silence that HIV/AIDS-related stigma can produce is so severe in many places that HIV and AIDS cannot even be referred to by name (Stein, 2003: 95).

There is a general stigmatising perception that most people living with HIV and AIDS are prostitutes, homosexuals, deviants or promiscuous individuals (Patterson, 2006: 62). This perception highlights the feeling of 'otherness', where people becoming infected are not like themselves, but others who behave in a different kind of way. If the general public cannot, or dare not, relate to or identify themselves with the infection, it is not only problematic for the containment of the epidemic, but also the politics based around the epidemic. It can result in low public pressure on the government to address the disease (Patterson, 2006: 62).

Stigma also has a strong influence on HIV transmission and the actual health of the infected people. Gupta *et al.* (2008: 765) argue that structural factors, such as fear of stigma and discrimination in relations to HIV and AIDS discourage people from adopting HIV-preventative behaviours, such as getting tested, seeking counselling or disclosing their HIV status to their sexual partners. This makes stigma an obstacle in treatment, care and reduction of HIV and AIDS (Mbonu *et al.*, 2009: 201). This also has further implications. According to Patterson (2006: 105), stigma makes it less likely that people belonging to marginalised groups will disclose their HIV status and join HIV and AIDS organisations, although they are the ones most in need of representation from such organisations.

Castro and Farmer (2005: 54-55) propose structural violence as a conceptual framework for understanding HIV- and AIDS-related stigma. According to them stigma results from the social forces in a society that together shape the structural violence. Such social forces include racism, sexism, poverty, political violence and other kinds of social inequalities which are rooted in historical and

economic processes that further shape the distribution and outcome of HIV and AIDS. Moreover, social forces shape who is most at risk of infection and the rate of disease progression, but also determine who has access to treatment, and to a great extent, who actually suffers from HIV- and AIDS-related stigma and discrimination. This means that in a society, such as South Africa, where there is profound racism, it is expected that people of colour with HIV or AIDS will be more stigmatised than in societies where racism is less common. The same can be illustrated with gender inequality and how this determines the extent to which sexism contributes to vulnerability towards HIV. In highly sexist societies, having a positive HIV status is more likely to provoke stigma and a threat of domestic violence towards women, than in places where women are more equal. This can be argued to be the case in South Africa, where gender inequality and domestic violence are prevalent.

Castro and Farmer (2005: 55) also argue that class often trumps racism and sexism, when it comes to stigma, and that poor people with HIV suffer more from HIV- and AIDS-related stigma, experiencing violations of social and economic rights. All three categories do, however, reinforce one another, and together create a greater risk of both HIV infection and HIV- and AIDS-related stigma.

Stein (2003: 97), on the other hand, sees that HIV- and AIDS-related stigma differs from other kinds of prejudice, such as racism and sexism. This is, because being an infectious disease, the lines between who is in-group and who is part of the out-group are porous, and everyone is constantly under threat. In this context, people who were in the in-group or their own group can, once infected, become stigmatised by the ones previously considered their own group.

Religion also plays a part in the stigmatisation of HIV-positive people. In both traditional South African belief systems and other religions, there is sometimes a belief that illness is caused by ancestors or God being angry at the people who are ill, because they have done something to anger the spirits of ancestors, or God. In this sense, the people who are HIV-infected have brought the condition upon themselves and their community. This brings forward stigmatisation both through a sense of repulsion and the justice of social sanctions (Kalichman and Simbayi, 2004: 578).

Stigma and stigmatisation have serious consequences of HIV and AIDS, and they are obstacles in creating a decrease in the rates of HIV-infected people and a change in behaviour and attitudes in South Africa. These are significant characteristics of the epidemic that are essential for the prevention campaigns to grasp, when aiming to raise awareness of HIV and AIDS. HIV/AIDS prevention campaigns are important bricks in stabilising and reducing the transmission of the epidemic.

2.7 HIV/AIDS Prevention Campaigns

Campaigns, such as prevention campaigns, aim to reach a large number of individuals through a coordinated set of communication activities, often within a specific time period, in order to generate a specific effect. These campaigns can either be local, regional, national or international, and are often part of multi-component programmes, but can also be a stand-alone effort (Noar *et al.*, 2009: 16). As the concept implies, most HIV/AIDS prevention campaigns focus their messages on prevention of HIV and AIDS, and not the treatment, although the biomedical approach based on treatment is becoming more recognised by donors to prevention campaigns at present time. Prevention of HIV and AIDS is one of the most important factors in reducing HIV rates and future transmission.

Campaigns have been an integral part of HIV prevention efforts since the beginning of the epidemic, and a focus on issues related to stigma and discrimination is now a top priority among prevention efforts taken by the international community (Johnny and Mitchell, 2006: 755-756). If managed correctly, prevention campaigns can have a great influence on the spread of knowledge about the different aspects of HIV and AIDS. They can do this by providing general information and education about HIV and AIDS. It can encourage disclosure of HIV status and stigma reduction; raising awareness of transmission and high-risk sexual behaviour; challenging attitudes and government policies and providing guidance for those who are infected and affected. It can also help those infected to realise that a positive HIV-status does not necessarily mean that it is a 'death sentence'. However, HIV and AIDS prevention campaigns seem to be the most effective when they are related to the cultural environment where they are promoted. This means that the campaigns should be tailored to the traditions, norms and the specific needs of a society (Johnny and Mitchell, 2006: 758). McKee *et al*. (2004: 27) promote a combination of mass media and interpersonal channels together with community and social mobilisation as the key for strategic communication about HIV and AIDS.

The majority of HIV and AIDS related prevention campaigns currently focus on information-based awareness programmes that aim to reduce ignorance about people living with HIV and AIDS (Campbell *et al*, 2007: 404). Many campaigns can seem to be successful in redefining images of HIV and AIDS, but if analysed more deeply, they can be interpreted differently (Johnny and Mitchell, 2006: 755). Both Johnny and Mitchell (2006) and Stein (2003) argue that prevention campaigns can actually reinforce or produce more rather than less stigma, despite an increase in risk-related knowledge (Stein, 2003: 100). According to McKee *et al.* (2004: 27), experience shows that interventions and campaigns directed at specific groups who are more vulnerable towards HIV, such as truck drivers and sex workers, can produce more stigmatisation of those groups as well as make the general population deny their own risk of becoming infected. The ABC (Abstain, Be Faithful and Condomize)-campaign is a good example of a campaign that has harvested both a lot of critique as

well as praise. The campaign has received much recognition for the positive development of declining HIV rates in Uganda, while in South Africa, it has contributed to discussions about the complexity of cultural and gender differences that are difficult for prevention campaigns to capture in the search for a perfect slogan.

Stein (2003: 100) argues that sexual morality, such as can be found in the ABC-campaign, can undermine its goal of prevention and rather increase stigmatisation among those who become infected, and hence, put the blame on the infected. Johnny and Mitchell (2006) argue that campaigns can also contribute to guilt and shame among individuals who cannot live up to the expectations outlined in the HIV/AIDS health campaigns, especially in countries where the individual is of less relevance. This can be due to cultural differences or misunderstandings, especially when campaigns are not directly related to a certain cultural group, but try to be universal within cultural, gender, age and socio-economic contexts, as both the ABC-campaign and UNAIDS 'Live and Let Live' campaign have attempted to be (Johnny and Mitchell, 2006: 756-758). In this sense it can often be difficult for prevention campaigns to 'make it right' and reach out to everyone at the same time, because people's situations, attitudes and behaviours differ.

Even though considered quite successful in many places, according to Mitchell and Smith (2001: 57) the ABC-campaign is naïve in promoting 'A' - 'Abstinence', and in this sense also 'innocence'. This is because it fails to account for the many young women who are powerless in the face of unwanted sexual advances, situations where the young women often do not have a choice of whether to abstain or not. The 'B' that stands for "Be Faithful' is, according to them, also problematic because it suggests that young women and girls have a say in, or control over, the sexual life of their partners. As highlighted earlier in this chapter and also pointed out by Mitchell and Smith, interviews and surveys indicate that having multiple partners is common and that the male partner in a relationship is more likely to have several partners than the female partner. Being faithful, for young women, can then be highly risky if their male partner does not act in the same way, or if their partner is violent. It further restricts women's freedom to choose their sexual partner(s) (Mitchell and Smith, 2001: 58). The 'C' – 'Condomize' also places young women in a position of weakness. One example, according to Mitchell and Smith (2001: 58), is that if young women insist that their male partner uses a condom it can be interpreted as if 'he is not trustworthy', and if women carry the condoms themselves, they can be perceived as sluts. Mitchell and Smith, therefore, want to challenge what the A, B and C stand for and represent now, and instead, would like to come up with new concepts that are better suited for adolescent girls in South Africa. Their suggestion is that 'A' should stand for 'Aggressive Masculinity', 'B' for – 'Biological Vulnerability' and 'C' for – 'Coercive Sex' (Mitchell and Smith, 2001: 58). Even though their suggestion has much truth in it and they claim that it spells hope for young people, this is, however, controversial and can be claimed not to promote any positive values.

This is one of the core issues related to prevention campaigns, and one of the key questions is how the campaigns should approach their audience in order to become more efficient.

Data indicate that many young South Africans are tired of hearing about AIDS, and have the so-called 'AIDS fatigue syndrome', while at the same time, the attitude of many young people towards HIV and AIDS is that they are 'going to get it anyway' or that it is about 'blacks' or 'township youths' or 'gays' or just 'somebody else' (Mitchell and Smith, 2001: 60). Mitchell and Smith (2001: 60) argue that such attitudes can be a reaction to information overload, which is something that the organisations running prevention campaigns need to consider in their process of creating new awareness campaigns in order to make them more efficient.

Prevention campaigns have a great responsibility in giving information and giving the right information in understandable ways, and for this reason, they need to be critically approached in order to reveal their flaws. Their importance lies in their ability to change behaviour and attitudes, be they about sexual behaviour or stigmatisation, and they are one of the most crucial ways to reach out to people with knowledge about HIV/AIDS.

Many people tend to associate condoms and promotion of condom use with sexual activities outside of marriage, and religious groups have in many places condemned or discouraged the use of condoms (McKee *et al*., 2004: 90). Condom use is a complex issue for HIV/AIDS prevention campaigns, as can be demonstrated by the ABC-campaign, for instance. Although being faithful is the key to reducing the number of transmissions, condoms also have to be promoted, because the reality is that most people will have several sexual partners in their lifetime and condoms are at present time the only efficient protection against HIV in sexual encounters. Even though people are against the immoral connotations surrounding condoms, they are still an important part of the prevention of HIV and therefore needs to be promoted by HIV/AIDS prevention campaigns. Moreover, as McKee *et al*. (2004: 90) argue, most campaigns gain from being balanced. This would mean, for instance, not focusing on only one of the ABC's for reducing the HIV incidence and prevalence, but maintaining a balance that corresponds to the specific cultural environment. For, as Yun *et al.* (2001) acknowledge, there are different factors that the different cultures and races in South Africa emphasise as the most important ways to retrieve information and knowledge about HIV and AIDS. Some of the biggest HIV/AIDS prevention organisations and campaigns in South Africa have different approaches, as well as different audiences that they want to reach.

Many studies on media indicate that the focus is on women's behaviour at an individual-level, which misses the social and economic constraints that contribute to shaping women's actions, and women are represented merely as vectors of HIV (Gibbs, 2010: 1621). Walker and Gilbert (2002: 82-83) argue that interventions should be targeted especially towards young black women, but should also include

young men. This would imply that the campaigns target both the sub-groups that are driving the epidemic and the sub-groups that are most likely to be affected by it.

Prevention campaigns are useful tools in raising awareness of HIV and AIDS and reaching many people simultaneously with the information. However, it is difficult to find an approach that can appeal to, or include, everyone within the risk group that they are trying to reach out to. Universal HIV/AIDS campaigns have shown not to be successful, and the campaigns, therefore, need to be tailored for the culturally different societies. In South Africa, prevention is the key to reducing the rate of infections. This involves focusing on the young population, especially young women; giving them information about (risky) sexual behaviour, the seriousness and consequences of stigmatisation and stress vulnerability towards transmission; and empowering women to be able to negotiate sex and condom-use. It is difficult to include all these many factors within one campaign, which demonstrates the intricate issue that organisations face in order to be effective and successful.

2.8 Conclusion

This chapter has provided an insight into the complexity of the HIV/AIDS situation in South Africa. The country has the highest prevalence of HIV in the world, and the question following this is: why South Africa? The HIV transmission in the country has resulted from a combination of high-risk behaviour and high-risk situations that, influenced by historical conditions, have affected the black population more severely than the other population groups. It has been shown that the migration patterns, imposed during apartheid, have had a strong impact on the transmission pattern, since this contributed to a disruption of family arrangements and the development of new sexual arrangements with multiple partners. The government, led by President Thabo Mbeki and Health Minister Manto Tshabalala-Msimang, has been responsible for the slow progress of AIDS policies, and the denial of the seriousness of the epidemic.

This denial has cost many lives, but lives are also lost because of risky sexual behaviour. Since many South Africans do not know their HIV status, sex is a risky business, but even more disturbing is it that people who are HIV-positive choose not to change their practices of sexual behaviour. In South Africa, having concurrent multiple partners is common, and among young men, more or less expected. The patriarchal system that puts pressure on young men to prove their masculinity is one of the key drivers of men's sexual behaviour. This behaviour also involves being the dominant part of a sexual relationship and controlling women's sexuality as well as controlling them in the cultural, political and socio-economic spheres. This control places many women in a vulnerable position of retracting HIV, as the terms of sexual relationships lie with the man, and opportunities to negotiate the sexual encounters are often non-existing. Women who challenge this control are often seen as 'promiscuous'

or ‘bad women’, which has created a sense of acceptance of the ‘hegemonic man’ to the point that many women desire such a ‘real man’. Among young women, transactional sex and the ‘sugar daddy’ phenomenon have also made them more vulnerable towards HIV transmission. However, for some women, transactional sex is a way of survival. A poor woman in a rural settlement has many odds against her, since her situation alone places her in a vulnerable position, where she is economically reliant on her man, and the man then owns her sexually. She is also vulnerable in the sense that health treatment is often far away, should she become ill, and information about HIV/AIDS is often difficult to trace. Knowledge about HIV/AIDS and treatment is thus reduced, as are the chances of condom use.

Stigma further reinforces the vulnerability, because it, above all, categorises the infected as different and not part of the in-group. The emotions and reactions resulting from such a categorisation often have serious consequences for the person involved. Rejection, condemnation, labelling and stereotyping are some of the responses that a HIV-positive person can experience. HIV and AIDS are often stereotyped to refer to sex workers, homosexuals, promiscuous people and blacks. This stereotyping generates a sense of ‘otherness’ that can contribute to people regarding persons having HIV and AIDS as different from themselves, and lead to people choosing not to get tested. People may also refuse to get tested or to disclose their status in fear of stigmatisation. Stigma is often imposed on the people who are already marginalised in society. Due to the power structures that stigma revolves around, poor black women can be claimed to be especially vulnerable towards stigmatisation since they are subordinate within the strongest structures of the South African society, namely, class, race and gender. HIV/AIDS prevention campaigns, therefore, have a responsibility in reaching out to these women, as they are the most vulnerable both to HIV transmission and stigmatisation. Whether prevention campaigns are achieving this will be analysed in Chapter 4. The theoretical approach underlining and substantiating this analysis will be presented in the next chapter.

Chapter 3: Theoretical framework and Method of Analysis

3.1 Introduction

This chapter will present the theory of radical feminism and the methodology of content analysis, which will be used for the further analysis of the thesis. The main aims for this chapter, is to provide an insight into the world of radical feminism and its interpretations that support the research question of the study, and to introduce a method for understanding how prevention campaigns can be analysed. The most important aspects that will be extracted from the theoretical approach, and contextualised for the analysis of the research problem, are how radical feminism considers women's control of their own bodies, the influence of patriarchy and the issues concerning gender roles and sexuality. These issues inform the South African context regarding HIV and AIDS. Even though radical feminist theory is, by name and action, radical and provocative, it brings to light many relevant thoughts for women`s liberation and empowerment. These are important comprehensions in the fight against stigmatisation of women, be it through HIV/AIDS, poverty or violence against women, or all of them combined. This chapter will also support the position that poor black women are the group that is most vulnerable towards HIV/AIDS stigmatisation if they are infected. For prevention campaigns, the main focus is on the presentation of information-strategies and how these can be analysed with regards to gender-based HIV- and AIDS-related stigma. The first part of this chapter will elucidate radical feminism.

3.2 Radical Feminism

Radical feminism evolved as a reaction to the on-going subordination of women by men, which to their understanding has interfered with every aspect of women's lives. These feminists were women, frustrated and angry with the current situation of women, who could no longer wait for a women`s revolution by modern women against patriarchy, and decided to take action. The liberation of women from the prison of patriarchy was bound to begin and the way to do it was by radically change women's own perceptions of love, sexuality, gender roles, mothering, men, oppression, politics and other parts of women's daily experiences. Their criticism was therefore not directed towards a specific theory, but rather a line of thinking that could be found everywhere from politics to sexual relations. Radical feminism has for this reason involved themselves more with actions and reactions towards and against the total system of patriarchy and male power than they have theorised their radical opinions.

Radical feminism is inspired by democratic liberalism and Marxist socialism, but is generally not too tied to them: their worldviews are different because of radical feminism's women-centred focus (Rowland and Klein, 1996: 14). It is a theory of, by and for women and claims to 'go to the root', hence the concept of 'radical', of sexism and women's oppression, considering women's own

experiences and perceptions. Radical feminists perceive women's oppression to be the ultimate universal and fundamental form of domination and human oppression. The system of patriarchy is the root to male domination and has imposed the oppression of women. Hence, it is male power and its interference in the structures of society that has forced women into their submissive gender roles and sexual behaviour (Bryson, 2003: 163; Rowland and Klein, 1996: 11; Tong, 1989, 71, 95). Radical feminists aim is to understand and eliminate this oppression. Emancipation and equality on male terms are not enough, there has to be a total revolution of the social structures. Women's interests are opposed to those of men, and hence, women are encouraged to stand together as a group to attain their liberation. They believe that the personal is political - male domination is not only acted on in politics and paid employment, but also within the private sphere, where patriarchal domination can be found in the arrangement of families and in sexual relationships (Bryson, 2003: 163; Rowland and Klein, 1996: 12).

The expression that 'the personal is political' soon became the slogan of radical feminism. The 'personal is political' has two meanings for radical feminists. First of all, it has to do with sexual politics and male's domination of and power over this, secondly, it is about women's experiences in personal life and how these experiences can provide inspiration for the establishment of new politics, where the hope is that all institutionalised relations of domination will disappear. The personal and the political are not distinctions, since sexual politics exists, according to radical feminists, in every area of life. Institutions, such as love, marriage, childrearing, housework and all kinds of sexual practices are considered natural and ideologically concealed to cover up the systematic oppression of women. Although with some variety, this institutionalised oppression can be found in every society in the world, and has persisted through all times. This expression, hence, makes radical feminist thinking a subject of political analysis (Jaggar, 1983: 101, 255).

3.3 Relevance of radical feminism to the research question

Albertyn (2003: 597, 600) argues that HIV and AIDS are prevalent in South Africa because it mimics the social and economic inequalities within a national context. Women's vulnerability towards HIV and AIDS is further due to the lack of power they have over their sexual lives and their own bodies. The vulnerability is reinforced through the gendered cultural norms in sexual relationships and the economic and social inequality that women are facing in the country. Radical feminism aims at exposing the social reality of male domination. However, this power is not absolute; women are not powerless. Some women have more agency than others, for instance if they are involving themselves in feminist resistance (Thompson, 2001: 8). Therefore, by analysing factors that contribute to this male

domination, it is possible to comprehend the issues related to this, and also provide information that can influence women`s empowerment.

Radical feminism has provided several arguments that relate cultural and socio-economic factors to gender inequality. The next two sections will place these issues in a context of radical feminism, HIV/AIDS and stigma. The first section will provide a view of what radical feminism argues is men's and women's culture. The two cultures build the foundation of what is perceived as men's and women's sexuality, gender roles and reproductive roles and how these factors affect the control women have over their own bodies. It will also position these interpretations into the context of HIV/AIDS and stigma. The second section will provide an insight into the socio-economic role of women, considered from a radical feminist standpoint, and relate this role to perceptions of gender, class, and race, HIV/AIDS and stigma. First, however, the radical feminist arguments of why men are considered dominant and women are considered subordinate will be provided. For radical feminists, patriarchy is the main reason for gender inequality and is an obstacle for women's empowerment.

The system of patriarchy enforces a structure of gendered inequality that intersects with every area of both women and men's lives, according to radical feminists. Kate Millett wrote about patriarchy as a total form of domination. Her claim was that in all societies, relationships between the sexes are based on power that has presented male dominance over women as universal, and therefore, the personal is political. This dominance has become so 'natural' and complete that it is no longer visible. Accordingly, it can be interpreted as the most pervasive ideology of our culture and a fundamental concept of power. Since it can be found in all societies, it overrides both class and 'race' divisions (Bryson, 2003: 166). Through racism, imperialism and class society, men seek to dominate each other, but most of all do men seek to dominate women. Men legitimate this domination of male culture by inventing ideologies that define subordinate groups, and among them women, as inferior. This male dominance in every aspect of society makes patriarchy a total system of domination (Jaggar, 1983: 255). The 'cultural norm' of male domination, places women in vulnerable positions regarding HIV/AIDS prevention and risk, by having less power in sexual relationships and it can generate a stigmatisation of HIV and AIDS infected people, and especially women. One example that demonstrates women's inferiority based on such an ideology, is how HIV has been named the 'women's disease', while men are considered victims of the epidemic. Men are considered victims, because they are naturally sexually dominant, to the extent that they cannot control their sexual needs and behaviour. Women, on the other hand, need sexual relationships with men in order to maintain their womanliness, but are at the same time perceived as contaminators of sexual fluids that transmit the infection. Especially if women are thought to be sexually 'out of control', they are considered to be the ones to blame for HIV transmission (Albertyn and Hassim, 2003: 155; Jewkes and Morrell, 2010: 3, 6; LeClerc-Madlala, 2001: 42; LeClerc-Madlala, 2002a: 33-34). If women, are challenging the

terms of patriarchy, there are often repercussions, and women risk becoming stigmatised for their, in the eyes of men, perceived deviant sexual behaviour, to the degree that they are considered to be the transmitters of HIV and AIDS. This illustrates the radical feminist argument that it is only by eliminating patriarchy and male control that women can become (sexually) liberated. This is also an important notion for interventions concerning HIV and AIDS (Tong, 1989: 96). The paradox in such a setting, however, is that women need to become liberated from the control that men have over their bodies, in order to become less vulnerable towards HIV infection. However, the more power women have over their own bodies, their sexuality and their life in general, the more likely they are to become stigmatised on the basis of HIV and AIDS for being 'loose' women. Male cultural perceptions of women and the lack of control that men then have over women's sexuality are often the motives behind these attitudes (Hunter, 2005: 398). This demonstrates the centrality of women`s sexuality in the study of HIV prevention, in order to both empower women, and fight against stigmatising attitudes towards women. Radical feminism recognises this.

3.3.1 The control and politics of women's bodies

A goal for radical feminist movements is for women to be able to claim control over their own bodies. This is a key aspect to why radical feminism was chosen for the theoretical framework of this thesis, instead of other kinds of feminist thinking. Since the research problem revolves around the notions of gender inequality, female empowerment and HIV and AIDS, claiming control over one's body is crucial for preventing transmission of the virus. For women, this implies being able to decide whether or not to be involved in sexual relations, and how the sexual relations are conducted. Accordingly, it means that women are able to control their own sexuality and prevention methods. However, such a control is also influencing women's culturally-, socio-economic- and politically freedom.

For radical feminists, gender roles, reproductive roles and sexual roles are all socially constructed and have, under patriarchy, restricted women's behaviour and identity. They have also restricted women's possibility to develop and identify their sexual needs and desires. Sexuality is, for this reason, a major issue for radical feminists, and is closely linked to gender and the ability for women to claim control of their own bodies. Male sexuality, men`s aggressiveness and their need to dominate, have been accepted as normal in the society, and are prominently featured in many South African cultures (Jewkes and Morrell, 2010: 5; Tong, 1989: 110). This has further contributed to the normalisation of women's sexuality as passive and submissive. The acceptance of these two sexual roles has also influenced other areas and contexts: male violence against women is a common phenomenon and the idea that women will never be politically, economically or socially equal to men within heterosexual relationships is recognised in many societies. Radical feminism, therefore, claims that as long as

men's sexuality is the factor that interprets women's sexuality, the two sexes cannot have an equal relationship (Tong, 1989: 110).

Since male supremacy has been interpreted as the most basic form of domination for radical feminists, women's oppression has been considered not only the oldest, or the most universal form of domination, but also the primary form (Bryson, 2003: 165; Willis, 1984: 96). Male culture has been portrayed to be the only culture in society, and although female culture exists, it has been based on cooking, cleaning and child raising chores (Jaggar, 1983: 250). The male culture further defines women as sexual objects for male pleasure, and women are evaluated in terms of their sexuality and 'sex appeal' (Jaggar, 1983: 260). Male hegemony has positioned men as representers of the world and it is their own world view that has become the truth. When a man looks at a woman as a sex object, he knows that he is a man, and the objectification of women becomes a constructed legitimation of this notion and of his male power. At the same time it 'makes' women and verifies who women are (MacKinnon, 1982: 537-539). Hence, the oppression of women is rooted in control of women's sexuality, and fertility, where men are in control of women's bodies (Jaggar, 1983: 266).

In alignment with the belief that 'the personal is political', sexuality is political, for radical feminists, and it is especially the interrelationship between heterosexuality and power that is of significance. MacKinnon argues that heterosexuality is the male power's primary social sphere, and that this power is the foundation of gender inequality (Rowland and Klein, 1996: 27). To know the politics of women's condition is to know their personal lives, and their personal lives are built on powerlessness in relation to men, expressed daily as sexuality, but made visible through the social construction of gender division, where sexual objectification is synonymous with the lives women live as the female gender (MacKinnon, 1982: 535).

As a reaction to the patriarchal institution of the nuclear family, and the oppression of women within this institution, some radical feminists have turned to lesbianism (Rowland and Klein, 1996: 27). The turn to lesbianism was also a reaction to the inequality of power, within the institution of heterosexuality, where men are a first priority or rather the only priority, and was conducted through non-participation in heterosexuality. The patriarchal control of women would not make women free as long as women were involved sexually with men (Tong, 1989: 123, 125).

Hence, male domination and female submission are prominent features in sexual practices, and are rooted in heterosexuality. Sexuality is greatly bound up with personal identity, and traits of the female gender are sexually charged, but women's sexuality is for men and for their pleasure. On the other hand, men's sexuality is not for women, men also control their own sexuality. This is apparent considering who has the power in heterosexual relationships, who prostitution is for, for whom pornography exists, who rapes whom and who batters whom. In most of these cases it is the man that

has the control (Tong, 1989: 110-111). Since men control sexual relationships, women are merely sexual slaves under patriarchy, and men control women's sexuality for their own purposes. This means that women do not have the ability to negotiate sex (Bryson, 2003: 168; Jaggar, 1983: 260-261).

The arguments provided above demonstrate how the male culture is based on masculinity, sexual aggressiveness, domination and control. These are all factors that contribute to gender inequality, where women are the submissive part and by this become vulnerable to HIV transmission. For radical feminists it is important to acknowledge that women do have assets that are exceeding many of the qualities highly valued within the male culture.

The celebration of womanhood established itself as one of the main characteristics of radical feminism, and was an essential element that all the women, despite their different backgrounds, could agree upon. They honoured women's achievements and the womanculture. By emphasising the differences in female bodies and female beauty, they challenged the male conceptions of what is attractive, and respected the processes and the parts of the female body that men considered unclean. They claimed that there is a certain power inherent in the female biology. This is not a distinct power, but there is a special connection and closeness between women and the non-human nature that give women knowledge and a perception of the world, which men cannot obtain because of their patriarchal mind-set. They considered women to be part of nature, not separated from it (Jaggar, 1983: 95-97). The characteristics of emotionality and nurturance that form and identify the power and strength of women, are used by radical feminists, to encourage women to realise the importance of these factors, and that they are more valuable than the characteristics identified with men, although the patriarchal society has portrayed them not to be.

This provides examples of how to turn a position of submissiveness into a motivation for empowerment by the oppressed group. It can also be significant in consideration of stigma and being part of a stigmatised group. Whittaker (1992: 385-389) argues that stigmatising metaphors has contributed to the construction of AIDS, and that HIV-positive people's experiences and rhetoric have to be included in the attempts to control the conditions of the AIDS discourse. Accordingly, HIV-positive people have the ability to empower themselves as a group, if they manage to extract the negative connotations that people have about the infection, and reject the stereotyping and stigmatising behaviours and attitudes related to HIV and AIDS that contributes to positive people being considered a group that can be oppressed.

Oppression is simpler to conduct if the conditions are right. Women that are poor, of colour and infected by HIV/AIDS are hence in a situation where they are part of various groups that are all oppressed. This places these women in a vulnerable position of becoming victims of stigmatisation. In South Africa, patriarchal values, and social and cultural norms, keep women in positions of

subordination and inequality, which means that they have little power in sexual relationships (Albertyn, 2003: 596, 599). The customary law, still evident in South Africa today, is an example of this, since it is deeply patriarchal and it restrains women`s possibility of equality, by for instance constraining women`s control of land and earnings, and by enforcing brideprice and polygamy (Bronstein, 1998: 390). Virginity testing is another example of the patriarchal tradition that reinforces the damaging cultural practices of gendered inequality. LeClerc-Madlala (2003: 17, 19) argues that virginity testing is a way of controlling girls' sexuality and making them more attractive to the male sex. She further argues that the practice is sexist, and can be placed within the category of sexual abuse, and the modern legal definitions of sexual harassment. Even though practitioners of the customary law argues that such practices can stall girls and young women from having sex, and in this sense, keep them from contracting HIV, it, nevertheless, prevents the same girls and young women from developing a sense of ownership over their own bodies and sexuality (LeClerc-Madlala, 2003: 20-21).

Hunter (2005: 390) argues that in South Africa there is also a tradition for men to have multiple partners, which is both a result of, and a practice that shapes, male power. He claims that isoka - the Zulu word used at present time to describe a Zulu man with multiple partners, and a man that is popular among girls - has changed its meaning and the practices surrounding it, during the last century. In the nineteenth century KwaZulu-Natal, having multiple partners was not a prerogative only for men, but unmarried women could also have more than one boyfriend. This changed when, paradoxically, migrant labour increased while at the same time it became expected of men to marry, establish an independent household and become the homestead head. To be able to control the women from far away, unmarried women with multiple partners then faced public censor. It was seen that the right of isoka were to be a male-only privilege. The high rate of unemployment in the recent decades has challenged the institution of marriage due to the difficulties men have in securing an affordable housing and being able to pay bride price.

Unemployed, or poor, women are on the bottom of the social hierarchy in South Africa and are often forced to engage in transactional sex with multiple men. Urban women in South Africa that have gotten better work opportunities, however, have disrupted men's position as sole providers, and marriage is for some women considered undesirable. Within this cultural and socio-economic context, having multiple partners seem to have bolstered men's self-esteem, and it has become the expression of manliness to celebrate having numerous sexual partners. However, this kind of masculinity is built on male weaknesses and vulnerabilities of not being able to become sole providers of a household. According to Mash et al. (2010: 6), studies from South Africa also indicate that men are often opposing contraceptives. South African women are afraid to use contraceptives due to the impression it gives of not being faithful, or having multiple partners. The fear of losing their partner or experience

violence due to this, hence, forces women to either not use contraceptives or not dare to tell their partner that they actually do so. For women, the consequential risk of gender based violence and HIV/AIDS that follows these attempts by men to retrieve power and proving their masculinity, is evident, and places African women in South Africa in a vulnerable position in sexual relationships (Hunter, 2005: 389, 391,395, 396, 401).

For radical feminists, these are examples of patriarchal cultural practices and mind-sets that oppress girls and women at the utmost. However, it is not only the cultural factors that influence women's position in society, socio-economic obstacles are also evident in women's oppression under patriarchy.

3.3.2 The sexual economics of women

The personal is economic for radical feminists, everything from motherhood to beauty has an economic character, and it affects women of all classes and cultures (Leghorn and Parker, 1981: 93, 102, 105). A woman of colour is likely to get the least paid within the formal economy, while a white male usually is on the top of the economic hierarchy. The white dominant (male) cultural system contributes to a double economic burden for women, if they are facing both racism and sexism, and many women of colour, in order not to have to confront the degrading racism, end up in jobs with low income or no income (Leghorn and Parker, 1981: 16, 109-110). Leghorn and Parker argues that women's role outside the home has an effect on how women's reproductive role is viewed. If women have a possibility to have paid labour outside of the home, they bring in extra income that, in the eyes of men, mean that they are not considered a burden with an only purpose of producing children (Leghorn and Parker, 1981: 23). Hence, the more women earn and the higher status women have, the less likely it is for them to be subjects of violence or repressive sexual customs, and the more likely it is for women to experience tolerance from the society (Leghorn and Parker, 1981: 23, 25). The more children a woman has, the more likely it is that her access to education and work is, or has been, limited, which further makes her general status in the society low (Leghorn and Parker, 1981: 96).

The heterosexual standard for women, and having to be desirable, contributes to maintaining the ideology of how women should look. The standard of desirability is also influenced by ethnic, racial and class factors together with sexual factors; to not have the right look or colour, or not being attractive enough, have the economic effect that women often cannot get well-paid jobs. The women that do have the well-paid jobs, nevertheless, risk a loss of influence when they get older (Leghorn and Parker, 1981: 105-106). The colonial period and the apartheid regime have changed the African family institutions and household, due to the impact that the migration labour system brought with it. However, in rural households, the connection to the patriarchal system of authority and the customary law has continued to subordinate women. Even though women became the household's representative,

the male control of women and gender relations, was ensured locally while the heads of the household were away (Harrison *et al.*, 2006: 710-711). While this contributed to the development of a new African masculinity, where multiple partners and a tolerance for sexual coercion appeared, women's lives as well as their sexuality, were restrained. In many rural places, girls and young women still do not have the same opportunities to education as boys and young men, but are rather burdened with domestic responsibility. In more urban areas, unemployed or poorly paid women are at the bottom of the social hierarchy, especially if they have to engage in transactional sex with men, in order to survive (Harrison *et al*., 2006: 711, Hunter, 2005: 396, 398). These arguments support the claim that poor black women are more likely to become stigmatised due to discrimination and their low status, and if infected by HIV or AIDS, it is even more likely that they will be victims of stigma.

Women may be sole providers of their family, or take up male dominated professions or chores, but the society is still run by fathers and their power. Women do only have access to so much privilege and influence as the patriarchy is willing to allow them, and to the extent that women are to pay the price for male approval (Bryson, 2003: 170). If men are not satisfied with their 'merchandise' they can send her back to her family, reclaim brideprice, rape or beat her. This sort of relationship enforces the master/slave comparison, especially if the woman does not have her own income (Leghorn and Parker, 1981: 122-123). Economic exploitation of, or by, men, be it for sex or other services, is a factor within the oppression of women that limits the economic opportunities for women (Rowland and Klein, 1996:25).

Radical feminists have acknowledged a feminisation of poverty, especially within the institution of marriage. Marriage has been considered as a statement of love between two people, while marriage contracts, traditionally, have been of an economic character. Women's unpaid labour within the household, especially if she has children, has gone unacknowledged or perceived as a 'labour of love', but it does establish an economic dependence of the woman on the man, who usually is the main provider of income. It is the patriarchal ideology that has maintained these structures, together with an ideology of heterosexuality. Women have difficulties of getting paid labour in a society that has idealised money as the currency of power, and hence has contributed to women's submission and dependence on a man. If a woman has been limited to work in the home, it becomes almost impossible to leave her husband, even if he is abusive and violent (Rowland and Klein, 1996: 15-16). Accordingly, if a woman were to leave her husband, she is facing the possibility of stigmatisation from the society, and if she is also poor, there is a risk of ending up having to beg for money or food, or sell or offer her body to men (Leghorn and Parker, 1981: 157). If everything fails in life, then women can always offer their bodies to men in order to attain attention and money (Tong, 1989: 91). Nevertheless, when a woman sells her body, she becomes isolated from the rest of the womankind, and she can end

up being despised by other women. This generates a position, among women, of a difference between 'bad' and 'good' women that men can use to their advantage (Leghorn and Parker, 1981: 118).

The infection pattern of HIV does seem to favour the people that are in vulnerable positions politically, socially and economically, which places all women in great risk of becoming infected. An important step in the right direction is, then, for women to become economically independent, since this opens the path for other privileges. In South Africa, the vulnerability towards contracting HIV is linked to both poverty and gendered income inequalities, and it is therefore more likely for African women to contract HIV than for white women, since African women are predominantly poorer. African women will probably have less income, less education, are more likely to be unemployed and have less access to health services and facilities (Albertyn, 2003: 598). Radical feminists do encourage women to exercise their own right for economic power, although it might be easier said than done (Albertyn, 2003: 597; Rowland and Klein, 1996: 15-16). However, economic independence is important for women in order to be able to claim control of their own body, since it offers a freedom for women to choose their own sexual relationships that can further provide women with the power to negotiate the terms of their sexual relationships.

3.4 The applicability of radical feminism

Radical feminism has managed to place all women in the sphere of politics, by promoting that the personal is also political, and hence that all of women's experiences, outside and in the home, are of political value. Sexuality and gender roles are central to the topics of HIV transmission and prevention, since they represent the core of the relationship between men and women, and transfer into the realms of gendered politics and economy. Hence, it is crucial for a development in the relations of gender roles, sexuality and women`s empowerment that women believe that they can claim control of their own bodies. Radical feminism has raised gendered awareness and made women realise their oppressive position in a patriarchal society. It has also contributed to a broader, but at the same time more cohesive, reflection on the current condition of male domination. Since male domination can be found everywhere means that even a small progress in women's personal freedom can represent a political advancement, be it inside or outside of the home. Radical feminists' analysis of the society may seem pessimistic of the situation of the female gender, but there is hope of a future gendered transformation through their determination of changing the society.

In chapter 2, this study argued that gender inequality could be related to stigma, due to the production and reproduction of power that devalues certain groups, in this case women, while making others (men) feel superior to this group, and can further lead to social exclusion of the devalued (Parker and Aggleton, 2003: 16). Accordingly, stigma is constructed by people who seek to legitimise their own

status of dominance, by exploiting the existing structures of social inequality in a society (Parker and Aggleton, 2003: 18). Since stigma is fuelled by power: social, political and economic power is essential to stigmatisation, according to Link and Phelan (2001: 375). These power structures are all central elements in radical feminist thinking, and present the foundation of male domination over women that further influence sexuality and gender roles. The structure of social, political and economic inequality that from a radical feminist perspective, is performed by men over women in the context of patriarchy, provides a good basis for examining gender-based stigma. Relating this to HIV and AIDS, sexual relationships reinforces the inequality between men and women, with the consequence that women often do not have the power to negotiate sex, but are rather in their man's possession. This increases the vulnerability towards transmission of HIV drastically, especially in cultures where multiple sexual partners are common, and the expression of manhood, in order to prove one's masculinity, is important. These are factors that are evident in South Africa today (Jewkes and Morrell, 2010: 2-3, 5-6).

The arguments above have contributed to the decision of using radical feminism for the theoretical framework of this study, instead of other strands of feminism. The next section will provide some of the criticism towards radical feminism, as well as criticism that can be found within feminist thinking, where the debate around the new strand of post-modern feminism is the main focus.

3.4.1 The critique of radical feminism

The most prominent critique of radical feminism has been that it supports essentialism or biological determinism, which is the biologically based conception of the division between male and female, where sexuality is perceived to be universal and unchanging. It is the radical feminists claim that female subordination is universal and a primary form of oppression, their arguments on the sex role paradigm and sexual division of labour, and their claim that there has not been a time where the sexes have been equal, that has triggered this criticism (Jaggar, 1983: 88, 92; Rowland and Klein, 1996: 33; Richardson, 1996: 146). Radical feminists response to this criticism of essentialism and biological determinism, have been that they do recognise biological differences between men and women, but that these differences have not single-handedly created the relations of oppression and submission between the sexes. Hence, biology is not the only cause for the oppression. Men do need women for several reasons, such as sexual relationships, reproduction or for domestic labour, so in order to maintain their power position, they have developed an ideology that can justify the maintenance of their position. There is possible to change the biological base, but it requires change in both consciousness and actions of both sexes (Rowland and Klein, 1996: 33-34). The enemy for radical feminists is not the biological male itself, it is the power inhabit in the manifestation of the male. This

power is socially constructed and contestable rather than embodied in every biological male (Bryson, 2003: 173). Lienert (1996: 156) argues that radical feminists have renounced biological explanations of the sex roles. If it was accepted that men were naturally violent and women naturally passive, then there would be no point for a feminist movement, because there would no hope for change. However, there are women who have resisted the oppression of men, and also men who have worked to distinguish themselves from patriarchy.

Radical feminism is not as prominent today as it was in the 1960s and 70s, it is rather being considered out-dated and old-fashioned by new feminist groups. Nevertheless, radical feminists have found their opponent in post-modernists, which they claim have revitalised the essentialist perception of them (Richardson, 1996: 144-145). The radical feminists criticism of post-modern feminism focuses much on the aspects of gender, race and class - since marginalised groups finally are starting to be heard and have gained political momentum - and it is especially the deconstruction of the 'subject' that is of concern (Waters, 1996: 285).

Post-modernism and post-structuralism has challenged radical feminism by its way of deconstructing the political meaning of 'woman', 'man' and 'feminism'. To radical feminists, the linguistic tools that are used by these two theoretical approaches does not provide a way for acknowledging the socio-economic hierarchies that establish the very meaning of gender differences, they rather dismiss any collective notion of the concepts of 'woman' and 'women' by focusing on the differences among women. They derive their meaning from the individual's own implicit and explicit interpretation and deconstruction of the discourse. This further implies that important aspects and meanings of a coherent subject gets lost, to the point that 'women' does not even exist. In this sense, post-modern theories are good to conceal the domination of men over women, according to radical feminists (Lienert, 1996: 156; Hoff, 1996: 401).

Post-modern feminists were intrigued by the idea of positioning themselves and women as marginalised, dislocated and excluded. For them, women's liberation was constructed on the concepts of women's otherness, plurality and difference (Tong, 2007: 33). Feminists of colour have criticised post-modern theory for being repressive to black women's literature, where they seem to disappear, and are not listened to in the theory, when 'deconstructing the subject' (Waters, 1996: 286). And so, they consider post-modernism to be apolitical, ahistorical, self-contradictory and irresponsible (Hoff, 1996: 393-412). The critique of post-modern feminism has even gone so far that Denise Thompson, a well-known radical feminist, refused to write about post-modern feminism in her book about feminism, because she claimed it was not even worth the time to criticise since it would reinforce post-modern feminism's role of pre-eminence (Thompson, 2001: 2).

Postcolonial feminists has criticised Western feminism, which includes radical feminism, of only considering Western women in their approaches, while women other places are being ignored. They perceived it as hegemony of Western feminism, where there in the 1980s was a tendency to presume that all women were under the same kind of oppression, and that the political vision was the same. Accordingly, Western feminists were dominating the discourses around gender relations and sexual politics, but they did not fit the description of all women, according to postcolonial feminists. It was especially the concept of men being the primary source of the oppression that postcolonial feminists discarded. For them, oppression did not have only one source, but was inextricably linked to race and class. For women outside of the Western world, the feminism produced was insufficient for the historical and cultural meanings of their experiences (McEwan, 2001: 96-98). Postcolonial feminists, then, tries to rather downplay the power of the Western feminists' assumptions, to integrate different kinds of oppression, such as nation, race, class and sexuality, and demands that other feminists' (eg. not Western) points of views are being taken seriously (McEwan, 2001: 105).

Even though radical feminism has received much criticism for their arguments, it is still a suitable theoretical framework for this study. The next section will argue for the choice of radical feminism.

3.4.2 Why radical feminism?

The choice of selecting radical feminism to be the theoretical framework for the topics of this study of HIV/AIDS and stigma was, to a great extent, due to radical feminism's emphasis on sexuality, male domination and patriarchy, and their undeniable correlation. Radical feminism differs from the other strands of feminism on these areas. Marxist feminism bases its arguments in class, wealth, production and economic empowerment. They claim that if women ought to be liberated, the class system cannot prevail, and the capitalist system must be replaced by a socialist system in order for women to be economically free from men and by this become equal to them (Tong, 1989: 2). However, many Marxist feminists claim that class trumps gender in the issue of women`s oppression, and is by this the most fundamental factor for the oppression (Tong, 2007: 29). The problem of Marxist feminism for this study is their explicit focus on the economic empowerment. For this reason it lacks the social and cultural aspects that are crucial in order to correlate feminism with HIV, AIDS and stigma, and by this becomes insufficient for the study's research problem. Liberal feminism, on the other hand, does provide political, economic and cultural analyses of women's situation. They argue that women have the same capacities as men, but not the same opportunities, and for this reason do women not live up to their true potential. Women's oppression is, for liberal feminists, rooted in legal and customary constraints that further hamper women's actions in the public world. However, if women did get the same opportunities as men, there would be gender justice, which is what liberal feminists aim to

achieve (Tong, 1989: 2). Liberal feminism provides an analysis that is based on equal rights, within a political context, that could be useful in an analysis of the rights of HIV/AIDS infected women, and how to legally provide policies that handles stigma. However, it lacks the in-depth analysis of women's sexuality and the control men have over both their bodies and the sexual relationships. In accordance with this study, this is an important aspect that cannot be ignored when it comes to the transmission of HIV/AIDS and women's vulnerability towards transmission, which in its turn can produce stigma.

HIV and AIDS prevention campaigns' focus on stigma is one of the key elements of this study. However, the study also focuses on the HIV/AIDS-related stigma that is gender-based, which means that women's vulnerability towards such stigma is emphasised. Until now, this chapter has focused on how women are oppressed in their relationships with men, be it in or outside of the home, which provokes the transmission of stigma and women's vulnerability in society in general, as well as in sexual relationships. The next part of this chapter will look at prevention campaigns, and how these can be analysed, through their approach and their strategy. There are certain themes abstracted from the previous chapter and radical feminism that will be important for the analysis of the prevention campaigns in Chapter 4. These will be introduced here to give the framework of the prevention campaigns a more fruitful basis, and it will be sensitive to the intersectionalities of gender and race.

3.5 Method of analysis: Content analysis of prevention campaigns

Content analysis has been chosen as the method of analysis of the HIV and AIDS prevention campaigns. Since this is a qualitative study, the content analysis also has a qualitative approach. Qualitative content analysis has several different approaches, but its main qualification is that it allows for the researcher to understand the social reality in its study subjectively, and at the same time scientifically (Zhang and Wildemuth, 2009: 308). The definition of qualitative content analysis chosen for this study is; "any qualitative data reduction and sense-making effort that takes a volume of qualitative material and attempts to identify core consistencies and meanings" (Patton, 2002: 453). This is a broad definition but it captures the essence of this study's analysis of prevention campaigns. The objective is to analyse in what sense HIV/AIDS prevention campaigns address issues of gender-based stigma on the basis of HIV/AIDS in their texts. The purpose is to examine the intended message of the creator, and to situate them within a larger social and cultural context (Neuman, 2003: 362).

Many of the HIV/AIDS campaigns are based on the cognitive behavioural model that recognises the individual's (1) recognition of risk, (2) commitment to change, and (3) acquisition of risk that can lead to risk-reducing behaviour change (Harrison *et* al., 2000: 286). However, the challenge for campaigns have been to successfully affect behaviour change among women and men, since information and

knowledge about HIV and AIDS in itself may impact men and women differently, and has not been enough to effectively reduce high-risk sexual behaviour and promote condom use. In South Africa, where the numbers of adolescents either infected or in risk of infection is high, behaviour change is crucial, in order to reduce the numbers of infected (Francis and Rimensberger, 2005: 87). However, there are many factors that has to be evaluated and implemented in order for a prevention campaign to be successful.

Stigma is often a result of misinformation about HIV and AIDS, and limits the effectiveness of prevention. It is therefore crucial that knowledge and awareness about HIV/AIDS is being promoted (McKee *et al*. 2004: 102). The creator's intention is to create a strategic approach that can communicate knowledge and awareness of HIV and AIDS and increase the impact on behaviour and social change. A starting point for such an approach is often to create optimism, by focusing on how to avoid HIV, how to live positively and how to show compassion to those infected, and motivate people towards certain behaviour. Strategic communication includes many forms of communicating the message, from face-to-face interaction, to community events, to the mass media (McKee *et al*., 2004: 30). However, for this study the communication is based on prevention campaigns, and will be implicit when using the phrase of strategic communication.

The lack of a medical cure for HIV and AIDS has made prevention of infection and behaviour change important steps for eradicating the epidemic, and prevention campaigns plays a central role in this setting. Communication, through information, is an essential segment to prevent high-risk sexual behaviour and reduce social stigma, through awareness. However, not all prevention campaigns are successful and fail to generate behaviour change (Melkote *et al.*, 2000: 17-18). In order to analyse prevention campaigns there is a need to explore the factors and the societal context that contribute to high-risk behaviour and behaviour change. Race, class and gender are all factors that influence a person's health status, and together they will affect people's perception of health and illness, their knowledge of HIV/AIDS and the possibility of high-risk sexual behaviour (Melkote *et al*., 2000: 22-23). Melkote *et al*. argues that it is not efficient enough to advocate knowledge of HIV/AIDS and attitude changes for a reduction in risk behaviour, but that in order to attain effective intervention strategies one has to identify perceptions of risk, examine factors that predict risk, and investigate the social context that influence the individuals' behaviour within social, cultural and economic settings (Melkote *et al*., 2000: 24-25). To not only predict individuals' chance of behaviour change from HIV/AIDS awareness campaigns, but also to understand the social context of those in a position of high-risk behaviour is important, in order for prevention campaigns to be successful in the long term, according to Melkote *et al*. (2000: 25). Several researchers agree with them.

McKee et al. argue that the intention of self –efficacy and self-agency, placed by the creator on the target audience in the communication of HIV/AIDS, indicate that the individual can control the actions of sexual relationships. This is however not always the case, and gender stratification, gender role stereotypes and sexual mores do influence the practice of safe sex (McKee *et al*., 2004: 43). HIV and AIDS communicators do also imply that individuals act rationally and consider the information they have obtained carefully, but under certain circumstances such as social pressure, alcohol or drug influence, or in the heat of the moment, people tend to undermine good intentions and proceed with high-risk behaviour (McKee *et al*., 2004: 43). This provides great challenges for HIV/AIDS communicators.

Airhihenbuwa and Obregon (2000: 5) emphasise the importance of evaluating regional differences and cultural contexts when introducing communication strategies for HIV/AIDS prevention and education. There ought to be different strategies for HIV prevention and care in Africa and the Western world, where differences in cultural behaviour and thinking should be recognised in planning, evaluation and implementation of health communication, in order to become successful. Most models, frameworks and theories of communication strategies and health behaviour change focus on rational individuals, who are claimed to follow a process based on a linear path from awareness, to attitude, to action. However, cultural norms often influence individuals' decisions around the prevention of HIV (Airhihenbuwa and Obregon, 2000: 6, 9, 12).

In Africa, family, but specifically, men as heads of families, and communities are set above the individual's own interests and are essential to the well-being and health of individuals. From such a point of view it is difficult to capture an individual's feelings about herself or himself. Instruments used for measuring health behaviour can then be irrelevant for the individual in certain cultures. For this reason, capturing the complexity of the different cultures is crucial in order to establish a good communication strategy for health behaviour. The cultural politics of HIV/AIDS, then, will be more efficient if the focus is both on the individual and the context that nurtures the individual and the family or community, so that it is established as a diverse mode of producing and acquiring knowledge and information (Airhihenbuwa and Obregon, 2000: 9-10, 12). However, as acknowledged in earlier chapters, knowledge in itself does not necessarily produce behaviour change. Campaigners, then, needs to better understand their target audience, especially if the audience is from a different culture or social background than themselves, and be careful at imposing foreign values on the people they are campaigning for. The strategy should therefore be to place culture within the framework of the HIV/AIDS communication, and not to solely focus on individual behaviour and beliefs in order to communicate HIV/AIDS prevention and care messages (Airhihenbuwa and Obregon, 2000: 13).

McKee et al. acknowledges important approaches for the distribution of the intended message of prevention campaigns. It is essential for campaigns to target social norms as well as individual behaviour. This implies creating a holistic view of individual behaviour, as a result of multiple, overlapping environmental and social influences, where information about HIV/AIDS should be timely and accurate, and motivation for behaviour change should be evident through the communication placed forward by prevention campaigns. The aim is to change individuals' behaviour, as well as the social context the individuals operate in, and establish communication aimed at different levels of the society (McKee *et al*., 2004: 44-46). The mass media has had success in breaking the silence around HIV and AIDS and has a powerful reach, but by integrating community-based initiatives, the communication can have a far greater impact, because it can expand to a larger portion of vulnerable groups and at the same time adapt their information to target certain groups (McKee *et al*., 2004: 53).

A challenge for both communicators of HIV/AIDS prevention campaigns and their primary audience is that people, and especially youths, are being bombarded with messages from the mass media about sex and sexuality that does not correspond to the information they retrieve about HIV and AIDS, for instance by the ABC-campaign (Francis and Rimensberger, 2005: 87). In this sense, it is necessary to analyse how the campaigns are composed, what their message is, and whom their target audience is, in order to establish whether or not their strategies are effective. In this study, the relevance of the campaigns is connected to the research question and what cultural and socio-economic factors contribute to gender-based HIV- and AIDS-related stigma.

In order to analyse the prevention campaigns, this study has recognised, through this and the previous chapters, a number of themes that are relevant for such an analysis:

- HIV/AIDS related stigma – how prevention campaigns address stigma, both in general and specifically related to women?

- Sexual behaviour and behaviour change – how is the sexual behaviour of the target audience addresses, especially when it comes to multiple partners and condom use, and how does prevention campaigns seek to change the sexual behaviour of both women and men?

- Knowledge and awareness of HIV and AIDS – who does the campaigns try to reach out to with their information, is their target audience disaggregated to include women, men, youth or the general public?

- Vulnerability towards infection and dominant sexual relationships – how are men and women situated in their relationships?

- Social and socio-economic status – how are women and men's class status portrayed?

- Cultural context – how is culture being infused into the campaigns, how do they address the power men have in the South African society and women's lack of power, men's superiority on many levels in the everyday life and women's submissiveness?

- Women`s (sexual) empowerment – how does the campaigns address the need of women's empowerment both in general and in sexual relationships?

- Control or lack of control of women over their own bodies?

These are the themes that will be further analysed in the next chapter and will help to understand the intended messages of the prevention campaigns.

3.6 Conclusion

This chapter has integrated the theoretical framework of radical feminism into the research question, and has introduced the method of content analysis for the continued analysis of prevention campaigns for this study. It has argued that radical feminism is a suitable angle for the analysis of the research question, due to its view women's position in society, as oppressed by patriarchy, where the cultural and socio-economic factors, radical feminists argue, contribute to this situation. In South Africa, patriarchy is evident in all areas of life, and is especially evident within the customary law. This oppression of women further influence women's sexuality, their sexual roles and the ownership of their own bodies, which are crucial components of radical feminism. The oppressive situations of women has implications for women's vulnerability towards HIV and AIDS, since women lack power in sexual relationships and for this reason is often not able to negotiate the terms of sexual encounters, especially if they are married and working inside the house, or are just economically underprivileged. Radical feminists believe that the personal is political and because of this every aspects of women's oppressed position is important. Since women themselves are situated low in the social, political, economic and cultural hierarchies, they are also more exposed to stigmatisation from the society, and a woman would then be especially exposed to stigma if she were HIV-positive.

Radical feminism encourages women to empower themselves in the private sphere by taking control of their own bodies and sexuality. This contributes to women being able to negotiate the terms of sexual encounters and the use of condoms, which are critical actions to be taken to reduce the risk of HIV and AIDS. Prevention campaigns have a huge task in communicating the values of women's empowerment for the sake of reducing the vulnerability of HIV transmission, especially among women. Behaviour change is one of the most crucial factors to communicate in order to reduce the

vulnerability, however components such as knowledge, awareness and cultural contexts are important aspects for a change in behaviour. How prevention campaigns manage to communicate their messages is therefore important to analyse.

The next chapter will introduce the campaigns of loveLife, Brothers for Life and the TAC, and will analyse these campaigns based on the themes introduced above by using content analysis. This will give an indication of how the different campaigns address gender-based HIV and AIDS related stigma.

Chapter 4: Analysis of Prevention Campaigns

4.1 Introduction

HIV in Africa has become significantly researched and documented to the extent that the sexual lives of African people have become a public domain and the private element of intimacy can be questioned, according to Jungar and Oinas (2010: 179). For them, prevention efforts invest in breaking the silence when it comes to sexuality and the construction of it, and has at the same time made the private public. When researching HIV prevention campaigns through a radical feminist perspective, the personal has also become political, sex and sexuality has become a political issue through governmental policies related to the rights of HIV-positive persons, but also by how sex, sexuality and HIV are presented and represented in different campaigns. Different approaches towards HIV-prevention by various campaigns clearly send out diverse political messages on the issues of sex and sexuality, and are through this entering into the personal and private sphere of people. Even though this means that sexual relationships are no longer as private as they used to be, talking about sex is important in order to change negative sexual behaviour that places people at risk of contracting HIV and becoming stigmatised.

The purpose of this chapter is to answer the research question of how HIV and AIDS prevention campaigns address issues of gender-based stigma. However, the socio-economic and cultural indicators that influence such behaviour are also relevant to analyse in order to provide an answer. This chapter will analyse the prevention campaigns of loveLife, Brothers for Life and the Treatment Action Campaign by using content analysis linked with the themes presented in chapter 3. The themes will give an indication of how the campaigns are operating in accordance with the research question. The themes are extracted from both the theoretical framework of radical feminism and from the socio-economic and cultural factors that influence gender-based stigma related to HIV and AIDS.

This chapter will first introduce the biomedical debate around HIV/AIDS-prevention and the medicalization of sex, and how HIV campaigns are divided about two different models of HIV-prevention – behavioural and biomedical. It will further contextualise the issue of (male) condom use in South Africa. The lack of condom use is not only one of the main causes of HIV transmission, it also indicates the distribution of power within sexual relationships and often contributes to a stigmatisation of women who seek to negotiate the use of condoms. A condom often symbolises a lack of trust, adultery or having multiple partners, while the lack of it indicates that the man is in control of the relationship. At the same time, condoms are the only efficient prevention intervention against HIV and AIDS and the issue of condoms is therefore a crucial matter when it comes to women's vulnerability towards transmission.

Secondly the chapter will contextualise prevention campaigns in South Africa and introduce the method of content analysis, to provide the basis for the analysis of the prevention campaigns through the findings, where the themes of the analysis again will be introduced. Thirdly it will analyse and discuss the three campaigns'/organisations' communication strategies and how they address gender-based HIV/AIDS-related stigma.

4.2 The biomedical debate

In chapter 1, this study argued that HIV/AIDS was not just a medical or biological issue, it was also a social phenomenon with integrated socio-economic, cultural and political issues. Moreover, in chapter 3, the study introduced the behavioural model as this study's approach for prevention campaigns and HIV-prevention. Discussions around how to approach the prevention of the HIV/AIDS epidemic have been relevant since the 1980s, with two different models as prominently featured, namely the behaviour model and the biomedical model (Giami and Perrey, 2012: 353). The biomedical model has accepted that exposure to HIV risk is in itself a medical condition that can be drastically prevented through medical treatment, such as anti-retroviral treatment and medical male circumcision (Giami and Perrey, 2012: 354, 356). The behavioural model is based on changing sexual behaviour through establishing social norms of condom use, safe sex and reduction in the number of sexual partners as prevention of HIV. For some programs, often religiously influenced, HIV prevention through behaviour change implied no premarital sex and marital fidelity, which nevertheless can be considered a morally problematic perspective (Giami and Perrey, 2012: 355; Vanwesenbeeck, 2011: 293).

At the present time the debate has headed towards a return to interpreting the epidemic as a medical problem that is best solved by using technical, biomedical solutions. The emphasis is turning towards a focus on the treatment instead of behavioural prevention, especially among donors, and 'treatment as prevention' has signalled a shift in paradigm in the fight against HIV and AIDS (Nguyen *et al*., 2011: 291). This can be seen in how more money now is donated to the non-sexual prevention programmes (eg. mother-to-child transmissions) than to programmes focusing on prevention of sexual transmission (Vanwesenbeeck, 2012: 291). This shift has been criticised by supporters of the behavioural change model. A medicalization of HIV prevention does imply a reduced focus on gender issues and condom use, where HIVAIDS is not seen specifically as a social or sexual disease (Vanwesenbeeck, 2011: 291-292). The promotion of male circumcision can have the unfortunate effect of causing greater vulnerability towards women, since it does not reduce the risk of HIV transmission for women, only for men. The likelihood that men who have become circumcised choose not to use a condom is evident, even though condoms are a much safer choice for both parts (Giami and Perrey, 2012: 357-358). Critics also claim that treatment should be given to people that are HIV-positive, and not at the

risk of becoming infected, since treatment in itself will not remove the vulnerability towards infection that places individuals at risk in the first place, such as socio-economic and cultural factors (Nguyen *et al*., 2011: 292). It is also an expensive approach, much more expensive than the behavioural change approach. Even at present, only about a third of the people in need of treatment receive it. This indicates that a budget for such HIV-treatment and prevention will have to be much higher than it is and will have to rely on political and economic avenues for access to funding, that are certainly not yet there (Giami and Perrey, 2012: 358; Vanwesenbeeck, 2011: 292).

This study sides with the behavioural model's approach since it focuses more comprehensively on gender issues, but without claiming that a biomedical-model approach cannot be successful for certain campaigns. Nevertheless, the three prevention campaigns have different strategies of HIV-prevention. These strategies will be further analysed later in this chapter.

4.3 Sexual relations in South Africa

South Africa is a male dominated society, especially when it comes to sexual relationships. Sexual relationships are often based on an unequal distribution of power where the male's definition of sexuality is usually determines the relationship, and where women are placed in a disadvantaged position in terms of negotiating safe sex or refusing unwanted sex. This further implies men's control of women's sexuality and child bearing capacity and determining how women should behave within a sexual relationship. Men may fear that they will lose their role as the head of the family as well as that their female partner will become promiscuous or adulterous if they do not have control over their partner's sexuality. For women, this entails that they have very little power over their own bodies as well as in the negotiation of condom use (Harrison *et al*., 2006: 710; Mash *et al.*, 2010: 3). Issues of trust and intimacy are especially evident when it comes to condom use. Condoms are often associated with casual sex and adultery and a general lack of trust in a partner. Being in a trusting and romantic relationship, then, means that there is no need for a condom. For women in South Africa, being single is related to low social status, and the ability to have and keep a man is a proof of their social worth and often benefits women economically as well. Women's social status is further related to having a monogamous relationship, and for this reason, asking a male partner to use a condom could be devastating for her self-esteem as well as for her social status, if he refuses. On the other hand, if a male partner accepts the use of condoms on the request of the woman, it can boost her self-confidence. However, both men and women will often consider women who suggest the use of condoms to be 'loose' or promiscuous. The risk of being stigmatised for indicating a lack of sexual innocence or giving the impression of being HIV-positive is for many women an obstacle in the possible negotiation of condom use. Hence, having unsafe sex is a sign of being in a 'safe' relationship. Not

wanting to face undesired confrontation about possible adultery, sexual history and the risk of HIV, that can destabilise the relationship, women usually keep quiet about condom use (Jewkes *et al*., 2003: 126; Mash *et al*., 2010: 4-5).

Moreover, multiple partners are common, especially among men, in South Africa. It is perceived as a male 'right' to have many women (Jewkes *et al.*, 2003: 127). 'Sexual networking' has become an integral part of (young) South African male's sexual behaviour where concurrent rather than serial sexual partners are common. This is driving the HIV epidemic at present since it leads to a more rapid spread of sexual diseases and infections. This kind of behaviour is embedded in the underlying socio-economic and cultural structures that consider multiple sexual partners as an integrated part of South African masculinity and male sexuality (Hunter, 2005: 390-391). Having multiple partners have become an expression of manliness and competition among young men to have the most sexual partners is common, even though it increases the risk of HIV transmission (Hunter, 2005: 397). Women's lack of power in sexual relationships compromises their sexual health, and there is a clear link between a lack of sexual power and HIV risk and infection (Pettifor *et al.*, 2004: 1996, 2003). Hence, gendered power inequality plays a key role in the transmission of HIV. Addressing this issue can contribute to a further exploration on the issues of stigmatisation that women face on the basis of HIV and AIDS.

Behaviour change contributes to a decrease in the number of HIV transmission and stigma related to HIV and AIDS. The arguments above indicate that the decision for women to use a condom is a complex issue that would imply great cultural changes within the South African society in order for women to dare to negotiate the terms of the sexual relationship. The fear for women of being stigmatised as loose or promiscuous or even HIV-positive if they suggest the use of condoms is a great obstacle in the fight against HIV and AIDS and contributes to the continuation of women's lower social status in South Africa. The arguments towards a change in condom use are more reliant on rational rather than medical influences (Mash *et al.*, 2010: 7). Since prevention campaigns often have a 'behaviour change'-approach towards HIV/AIDS, they should aim at empowering women within sexual relationships and abolish the stigmatisation they face within such relationships, in order to decrease HIV transmission.

4.4 Contextualising HIV/AIDS prevention campaigns

The previous chapters have provided an insight into the South African context of HIV and AIDS and what socio-economic and cultural factors that provoke the transmission of HIV. These factors also provoke stigma related to HIV/AIDS, especially towards women in vulnerable positions. This study has already argued that poor, uneducated black women are most likely to become stigmatised on the basis of HIV and AIDS due to their low social and economic status as well as due to how their life situation can lead to atypical sexual behaviour, such as exchanging sex for money or material goods. In 2004, Thomas (2004: 32) argued that 'economically impoverished black women' have yet to find their place within mainstream representation of HIV prevention campaigns. This chapter will seek to answer if this is still the case.

HIV/AIDS prevention campaigns in South Africa have taken on a major responsibility whether their aims are to generate knowledge and awareness of HIV and AIDS, eradicate transmission of HIV/AIDS, changing behaviour and attitudes within sexual relationships or fighting for the rights of HIV-positive people. In order to be successful, they have to understand the environment they are operating in, which incorporates the socio-economic and cultural factors that drive the transmission. There are many ways to analyse prevention campaigns, therefore the themes and topics for this specific research are chosen because they have a gendered focus towards the analysis that contributes to making women visible. Since women are most vulnerable towards contracting the virus, they are important to acknowledge and target in prevention campaigns. If this is not done, behaviour change is almost impossible, sexual empowerment of women is difficult and stigmatisation related to HIV and AIDS towards women will continue.

4.5 The content analysis of HIV/AIDS prevention campaigns

For the analysis of this study, three prominent campaigns/organisations in South Africa that address the prevention of HIV and AIDS have been chosen. The three campaigns/organisations are loveLife, Brothers for Life and the TAC. These have all different foci and approaches in their prevention strategies, as well as different primary audience. Together the three different prevention campaigning strategies are targeting South African people in the ages between 15 and 49. In addition to the main topic of gender-based HIV/AIDS-related stigma, the topics encompass sexual behaviour and behaviour change of the target audience, the target audience's perceived knowledge and awareness of HIV and AIDS, the target audience's vulnerability towards infection and how dominant sexual relationships affects such vulnerability, social and socio-economic status of the primary audience, the cultural context into which the campaigns are being infused and how the campaigns address women`s (sexual) empowerment as well as women's control or lack of control over their own bodies.

The analysis of this study aims at identifying core consistencies and meanings (Patton, 2002: 453) within the different campaign strategies that further provide answers to the research question. Cultural conditions, race, class and gender are all components that influence HIV-risk, vulnerability and their general health status which further affect their perception of health and illness, their knowledge of HIV/AIDS and the possibility of high-risk sexual behaviour (Melkote *et al.*, 2000: 22-23). For this reason, the prevention campaigns should not only involve themselves with sexual behaviour change, but they also need to address the social context of those in a position of high-risk behaviour (Melkote *et al*., 2005: 25). Since this study is not providing any self-produced texts, the deductive analysis towards the research question aims at using arguments from the theoretical framework of radical feminism and the themes presented as a guideline for the analysis of the different campaigns. This implies that there are no specific codes that will be identified in order to extract core consistencies and meanings, but rather that the analysis of the themes in themselves will be able to identify the consistencies and meanings that seeks to address how the different campaigns, as empirical evidence, relate to socio-economic and cultural factors of gender-based HIV and AIDS related stigma, and the issues related to this (Neuman, 2011: 69).

The analysis' body of material is the different campaigns' own webpages as well as secondary literature written about the different campaigns. Some of the campaigns are more featured in academic literature than others. The qualitative content analysis is used as an analysing tool for the prevention campaigns' content, relevance and significance within the study's theoretical framework of radical feminism as well as an observational tool for identifying the communication strategy of the campaigns (Zhang and Wildemuth, 2009: 310-311, 314).

The next sections will introduce the three different campaigns/organisations and provide a description of their campaign strategies as well as their contents. The last sections uses the presented socio-economic and cultural specific themes and topics to discuss the three campaigns/organisations prevention campaigns in order to acknowledge similarities as well as differences between the various strategies and content in order to conclude how they address issues of gender-based stigma related to HIV and AIDS.

4.6 The prevention campaigns

4.6.1 loveLife

loveLife has been chosen for this study because it is one of the most prominent HIV and AIDS awareness and prevention campaigns in South Africa. Established in 1999, it is one of the longest running HIV-prevention campaigns in South Africa, but due to this it is also one of the most researched, analysed and criticised campaigns. loveLife is one of the most far-reaching and visible HIV/AIDS campaigns in South Africa. It focuses more on the youth in the ages between 12-19 years and their individual behaviour, raising awareness and disseminating information about condom use, gender norms and multiple partners and other issues that are relevant in terms of HIV risk (LeClerc-Madlala, 2002a: 27; Pettifor *et al*. 2007: 70). It aims to "reduce HIV, other STI's and unwanted pregnancies among South African youth", with a goal to "trigger and sustain changes in sexual behaviour and related social norms to halve the rate of new HIV infections among young people" (Pettifor *et al*., 2007: 71). loveLife uses change agents, who are community-based peer educators and opinion leaders, including well-known South Africans, and who act as communicators of the campaign's ideas and messages (Pettifor *et al.*, 2007: 70-71). The campaign bases itself in reaching young people who are not yet been infected, although also giving information to people who are infected. At the same time, the campaign have received critique concerning their approach as it has sometimes been seen as confusing and not easy to interpret, and can therefore give wrong impressions to the youth who need clear and straightforward information about HIV/AIDS, risk and sexual behaviour (LeClerc-Madlala, 2002a: 27).

Its approach is related to the behavioural model directed towards behaviour change, and to address the underlying factors that fuel the spread of HIV, teenage pregnancy and sexually transmitted diseases, including society's reluctance to address youth sexuality, the impact of peer pressure and sexual coercion and the obstacles that keep young people away from South Africa's health clinics. The campaign is using radio, TV, billboards and magazines as well as its own website to promote its messages (lovelife.org/za, Know the facts, n.d.).

4.6.2 Brothers for Life

Brothers for Life (BfL) has been chosen for this analysis because it gives a different gendered perspective. BfL is an organisation that, with a focus on men, emphasises changing gender perspectives and the attitudes towards women, as well as raising awareness about HIV prevention and gender-based violence. It "encourages male awareness, self-help groups and male solidarity to get men to better negotiate the crisis before them and tackle their inner demons on route to finding their 'new man' inside" (Hamber, 2010: 82). The approach primarily targets men and their behaviour and

attitudes towards women. HIV-prevention is an important part in the process of changing attitudes and behaviour as HIV demonstrates a consequence of the 'masculine' sexual behaviour that the BfL wants to eradicate. The campaign is reaching out to men that seek greater gender equality within sexual relationships. BfL is an organisation of which the primary audience is men in the ages of 30 and above. The campaign is promoting HIV testing as well as general health seeking behaviours and is focusing on the risks associated with having concurrent and multiple partners, sex and alcohol use, together with gender based violence, and it is promoting male circumcision for health benefits (brothersforlife.org, About Brothers for Life, n.d). From such a perspective, it has a strategy that is combining the behavioural and the biomedical approach.

Its communication strategy is to influence a variety of audiences through interpersonal communication and mass media advocacy in print, television and radio as well as advocacy initiatives that are targeting all levels of government, civil society, traditional leaders and faith based and opinion leaders within the communities that are focusing on social constructions of men and male responsibilities. Its communication strategy bases itself around the concept of brotherhood in order to promote the importance of the decisions men make and how these impact upon their future and that of their dependents (brothersforlife.org, n.d, brothersforlife.org, About Brothers for Life, n.d.).

4.6.3 Treatment Action Campaign

TAC has been chosen for this study's analysis because it is one of the most comprehensive HIV/AIDS campaigns in South Africa, and has even been named 'the world's most effective AIDS group' by the *New York Times* in 2006. TAC was founded in 1998 in Cape Town in response to the increasing HIV/AIDS epidemic. A large number of its members are unemployed black working-class women. TAC advocates women's and men's, hetero-, homo-and transsexual people's rights to adequate health care (Jungar and Oinas, 2010: 178, 180; Scheepers, 2013: 87; tac.org.za, n.d.). TAC campaigns for South Africans to have greater access to HIV and AIDS treatment by raising public awareness and understanding of the health-care process, access, treatment and affordability. Its aim is to be a grass-roots organisation engaging in racially representative HIV and AIDS activism, and its goal is to "ensure access to affordable and quality treatment for people with HIV/AIDS" in order to "prevent and eliminate new HIV infections" and to "improve the affordability and quality of health-care access for all" (Friedman and Mottiar, 2005: 513). TAC tries to create a picture in which being HIV-positive is not only negative. It tries to create awareness of how to live as an HIV-positive person. It has through this adopted a behavioural-model approach, however, by its focus on health rather than sexual concerns, it has the approach that is most closely linked to biomedical prevention of HIV and AIDS, among the three campaigns.

4.7 Findings in the prevention campaigns

This section will analyse the three campaigns on the basis of the presented themes and topics. It will do this by introducing the findings of the campaigns, based on the different themes and the biomedical debate, and further discuss the three campaigns in relation to these findings.

Sexual behaviour and behaviour change: It is essential for prevention campaigns to know what the sexual behaviour of their target audience is, especially when it comes to multiple partners and condom use, since this establishes the basis for the communication of sex and sexual relations of the campaigns with their target audience. The prevention campaigns are expected to develop campaigns that will communicate issues related to sex. If they seek to change the sexual behaviour of both women and men, or just one of the genders, is expected to have an influence on how they approach sex, and the same can be anticipated in relation to age differences in the target audience.

Addressing sexual behaviour and behaviour change implies that the campaigns need to know their audience, and all three campaigns do have a target audience that they communicate with. However, it seems that the more general the audience is, the more general the campaign for sexual behaviour change is as well.

loveLife's target audience is both men and women, however its main focus is South African youths in general. It says that: "To tackle HIV in South Africa, loveLife believes that a broad, holistic approach is needed; one that goes beyond safe sex messaging" (lovelife.org/za, loveLife strategy, n.d.). From such a point of view, the organisation tries to do more than simply provide information to the primary audience, but to get the audience to internalise and personalise the risks that are evident in sexual relationships. It recognises that behaviour change is not only provided through rational decision making, but also by a change in values. Its strategy is then to convey their message by working within the structure of the youth culture and marketing themselves as a lifestyle brand for youths that is based on shared responsibility, positive sexuality and informed choice. loveLife has its own TV shows, where sexual behaviour change among youths is addressed. It also invites young people in the ages between 18-25 to become "groundbreakers", which implies community-based peer educators to educate on HIV risk, sexual behaviour and behaviour change (Jansen and Janssen, 2010: 130; Thomas, 2004: 29, Pettifor *et al.*, 2007: 70; lovelife.org.za, loveLife strategy, n.d.; lovelife.org.za, groundBreakers and mpintshis, n.d.).

Brothers for Life has adult men as their target audience. The campaign is strongly focused on sexual behaviour and behaviour change, mostly within settled relationships. It is using its own produced manifesto to proclaim "there is a new man in South Africa. A man who takes responsibility for his

actions. A man who chooses a single partner over multiple chances with HIV. A man whose self worth is not determined by the number of women he can have" (brothersforlife.org, Our Manifesto, n.d.). The manifesto is further promoting that a man should have respect for his woman and to have protected sex. It also provides information about how to change attitudes towards gender based violence and is addressing the risk of HIV by promoting male circumcision, and concerning itself with issues regarding multiple partners and sexual networking (brothersforlife.org, About Brothers for Life, n.d.; brothersforlife.org, Our Manifesto, n.d.; brothersforlife.org, HIV prevention, n.d.).

TAC's campaign on the other hand does not target a specific gender or age group, rather its primary audience is the general South African public, and more specifically any individual that is HIV-positive. This means that promoting sexual behaviour on the basis of preventing HIV and AIDS is not in its main interest, but "campaigning for and support the prevention and elimination of all new HIV infections" is part of the organisation's objectives and is by this aiming towards sexual behaviour change by mobilising communities and provide training to people in order to communicate prevention within these communities (tac.org.za, About the Treatment Action Campaign, n.d.; tac.org.za, About TAC's Community Health Advocacy Programme, n.d.).

There is a clear difference in the approaches towards sexual behaviour and behaviour change, which is likely to be due to their different strategies of HIV-prevention. Brothers for Life has the most specified campaign on this topic, while TAC's campaign is very general, and loveLife's campaign is very broad. It is no surprise that the TAC campaign is very general since their approach does not place much focus on this topic. BfL's approach is good for their target audience, however, it is at the same time ambiguous by its promotion of both male circumcision and condom use (together), which implies that it does consider condom use to be the safest protection against HIV. loveLife's campaigns seems to want to incorporate every issue related to sexual behaviour change. Providing much information is good, however, whether people actually act on such information is difficult for campaigns to control.

Knowledge and awareness of HIV/AIDS: The lack of general knowledge about HIV and AIDS, especially among young people in South Africa is an issue of concern for many prevention campaigns. A lack of knowledge contributes not only to transmission of HIV, but it can also make people adopt stigmatising behaviours related to HIV and AIDS. In this sense, who the campaigns try to reach out to with their information, if their target audience is disaggregated to include women, men, youth or the general public, is expected to have much to say how the campaigns generate knowledge and awareness.

This is a topic that all the three campaigns have a main focus on, even though their focus might differ from one another depending on the aim of their campaign.

loveLife has for a long time used cryptic messages on its billboards, such as 'Get attitude' and 'Born free', with the aim that youths will start conversations about them and in this sense start talking about sex (Jansen and Janssen, 2010: 133). From such a perspective it does try to generate awareness about sexual relations as well as HIV. However, research carried out by Zisser and Francis in 2006 (in Jansen and Janssen, 2010: 133-134) indicated that the percentage of youths discussing the loveLife billboards was relatively low even though most of the people understood their messages. From such a perspective, loveLife has not been as successful in generating awareness to the degree it has tried to attain. Thomas (2004: 29) is among the critics of loveLife's cryptic campaigns. She acknowledges that loveLife rarely mention HIV and AIDS in their campaigns, but that they rather feature abstract and seemingly nonsensical text and images. In a country like South Africa where misinformation and denial about HIV and AIDS have been common it is then no surprise that prevention campaigns such as loveLife that does not mention HIV/AIDS, will (rightfully) attract criticism. Targeting youths, loveLife has on its website many different ways that youths can retrieve information, either by phone, chat, text messaging or email, or through 'Love facts', where youths can then get answers to some of the most asked question about for instance condom use and contraceptives (lovelife.org.za, Love facts, n.d.). In this way it does provide information that can lead to knowledge and awareness on its website even though its billboards might not do the same.

Brothers for Life provides knowledge and awareness about HIV and AIDS through its focus on HIV risk and HIV testing. Focusing on targeting men with its campaigns, its communication strategy does focus on getting the attention of men by formulating its information from a male perspective and by using famous men within areas of men's interest, like sports, in order to reach out with information: "Be a man who is not afraid to know his status" – Teko Modise, soccer player, "Be a man who takes no chances and always uses a condom" – Graeme Smith, cricket player and "Be a man who chooses to be responsible with sex, even when he drinks" – John Smit, rugby player (brothersforlife.org, Resources, n.d.). However, even though men are the target audience, it is reaching out with basic information regarding knowledge and awareness about HIV and AIDS, risk of having multiple partners, benefits of condom use and what to do if you become HIV-infected, which can benefit both genders (brothersforlife.org, n.d.; Brothers are beating HIV, n.d.).

TAC is positioning itself towards individuals that are already HIV-positive. Its focus is on the political aspect of HIV and AIDS rather than the personal. However one of its objectives is to "educate, promote and develop an understanding and commitment within all communities of developments in HIV/AIDS treatment" and its Community Health Advocacy Programme is focusing on "greater access to comprehensive HIV and AIDS prevention, treatment, care and support services, including social referral services, at grass-roots community level" (tac.org.za, About the Treatment Action Campaign, n.d.; tac.org.za, About TAC's Community Health Advocacy Programme, n.d.). In this sense, TAC

aims to generate knowledge and awareness about access to prevention treatment as well as the opportunities that HIV-positive individuals have in order to live a healthy life, which include their access to health care services and ARV-treatment, through mobilisation at community and national level (tac.org.za, About the Treatment Action Campaign, n.d.). Hence, it does provide knowledge and awareness about HIV and AIDS, but through a different approach and with different information than the others.

Even though the three campaigns focus on knowledge and awareness of HIV and AIDS, loveLife and Brothers for Life are placing this topic within a sexual context while TAC focuses it towards a context related to health and knowing your rights to treatment as an HIV-positive person. This demonstrates the differences in perspective towards risk and prevention of HIV, which the two different approaches of HIV-prevention are representing.

Vulnerability towards infection and dominant sexual relationships: How men and women are situated in their relationships indicates the vulnerability towards HIV transmission. Male dominant sexual relationships are common in South Africa and contribute to a male advantage in sexual relationships where a lack of condom use is normal practice and where multiple partnerships are common and sometimes even expected of (young) men but not of women who are rather expected to be faithful to their one man. This does not only contribute to maintaining a culture of masculine sexuality but is also a key driver of HIV transmission for (young) women.

Vulnerability is not as prominently depicted in all three campaigns, and neither are dominant sexual relationships. It is possible to recognise that these are topics that are of greater priority for some campaigns than others.

loveLife recognises that "infection rates remain high among young women (…)" (lovelife.org.za, Our Strategy, n.d.) and women are through this particularly vulnerable towards becoming infected with HIV, especially if they are involving themselves in dominant sexual relationships with older men, so called sugar daddies. loveLife further argues that for any HIV prevention programmes for young people in South Africa to be successful they need to directly address new infections among young women. Statistical numbers presented on its website indicates that among young women in South Africa, the numbers of HIV incidences have decreased from 2005-2008 and that this can almost entirely be attributed to an increase in condom use. However, loveLife notes: "where new HIV infections is most tenacious (…) condom use is hardest to negotiate because of the power differences that exists between sexual partners". It further acknowledges that: "An intervention that works today would need to tip the scales to even out the power differences created by gender roles, socioeconomic factors, and the exigencies of your phase of life. In other words, an intervention that works needs to

deal with structural drivers of risk head-on" (lovelife.org.za, Get involved – The opportunity, n.d.), and needs to be multidimensional.

Young, black women are often featured in loveLife's campaigns. They are projected as strong, independent-minded young women that depict a female sexual autonomy, and portray a world where young women can behave in such a way and choose the premises of their sexual encounters, with whom and when they want to engage in sexual relations. Unfortunately, for many South African young women this is not the case, these are rather the individuals that are most vulnerable towards HIV infection (lovelife.org.za, n.d.; Thomas, 2004: 32-33). However, this is information loveLife has acknowledged, and portraying young, black women as independent, both in general and sexually, can rather be assumed to be intended as inspirational, that any young woman in theory could be the woman portrayed.

Brothers for Life is, especially through its focus on gender-based violence, stressing the importance of gender equality within relationships, both in general and within sexual relations. It acknowledges that: "It is increasingly understood that men's use of violence is generally a learned behaviour, rooted in the way boys and men are socialized" (brothersforlife.org, Gender-based violence, n.d.), and further refers to research that recognises some of the causes being attitudes about gender, relationship power imbalances, relationships with older men and influence of drugs and alcohol. All these causes can relate to vulnerability for women. By also promoting the benefits of condom use it situates women in better positions within sexual relationships that further benefit both sexes since they become less vulnerable towards HIV transmission (brothersforlife.org, Gender-based violence, n.d., brothersforlife.org, About Brothers for Life, n.d.).

For TAC, vulnerability is mostly related to the unequal access to health services and prevention treatment that people face in South Africa. However, it does also focus on women's rights and promoting actions against gender-based violence and how women can take actions after being a victim of gender-based violence and rape (tac.org.za, About the Treatment Action Campaign, n.d.; tac.org.za, How to respond to rape and other gender-based violence, n.d.).

loveLife's campaign addresses both of the topics, while Brothers for Life addresses mostly dominant sexual relationships. That TAC not directly approaches the topics indicates that this is not one of their main priorities. This is understandable since they focus mostly on health, but by this they are not addressing some of the main causes of HIV and AIDS properly that is further significant in relation to HIV-prevention and healthier sexual relationships for both HIV-positive and negative persons.

Social and socio-economic status: The class status of men and women influences both the access to information about HIV and AIDS and access to health clinics as well as vulnerability towards HIV

infection. Due to this, people with a low working class status are most likely to contract HIV in South Africa and are therefore often the target audience of prevention campaigns. However, how women and men's class status is portrayed in the different campaigns gives an indication on who they aim their campaigns towards and what their focus is for a decrease in the HIV prevalence.

Social and socio-economic status is not mentioned specifically in any of the campaigns, however, there is possible to make some assumptions about what kind of status their audience have through who their audience is.

Since loveLife has youths as their target audience class status is not portrayed as significant. However, social and economic vulnerability is. It understands that youths are vulnerable towards social and economic pressure and that this has the consequence of creating peer pressure when it comes to sex and unequal distribution of power in sexual relationships. loveLife recognises that "in South Africa, 40% of teenage girls get HIV before they turn 20, and most of these girls get it from having sexual intercourse with sugar daddies" (lovelife.org.za, Sex for money, n.d.). For the large number of young poor women that are using sex as a way to gain material goods and money, it does provide information on its website at 'Sex for money' about the high HIV risk that follows such behaviour and letting them know that such relationships will not benefit them in the long run:"(…) give lots more than the latest gear – they can give you HIV and other STI's" (lovelife.org.za, Sex for money, n.d.).

Brothers for Life seems to be relating to educated men with a stable economy by its way of communicating to the modern man and promoting male circumcision as a choice for male adults (with the money for its cost) (brothersforlife.org, About Brothers for Life, n.d.). This does nevertheless not imply that poor and less educated men can and will not agree and identify themselves with the ideals and values of Brothers for Life. The campaign has organised rallies, for instance a national men's rally with the theme 'Not in my name', against gender violence, where 'everyone' is encouraged to join and it is in this sense incorporating both men and women and every layer of the South African society to raise awareness about unequal (sexual) power relations and "to build a safer and healthier South Africa" (brothersforlife.org, News, n.d.).

TAC acknowledges that the majority of its members are people that are poor and working class. To TAC, HIV-positive people in South Africa are examples of the unequal distribution of health care due to their social and socio-economic disadvantage. Zackie Achmat, founder of the TAC, challenged this position in a John Foster Lecture in 2004 saying that:" Our bodies are the evidence of global inequality and injustice. They are not mere metaphors for the relationship between inequality and disease. But our bodies are also the sites of resistance. (…) We challenge global inequality. (…) In the Treatment Action Campaign, the voices of our comrades, friends and children echo around the world to resist injustice. (…)" (in Jungar and Oinas, 2010: 177-178). Through, for instance, its grassroots

treatment literacy campaign, the TAC is empowering South African HIV-positive people that are poor and physically and emotionally debilitated to make demands and be activists for their own treatment and care (Scheepers, 2013: 90). By aiming its campaign towards the people that are vulnerable and are having a low social and socio-economic status in the South African society and further letting them take part in their own fight for health benefits, TAC is contributing to equality among the different layers of people within the society as well as knowledge and awareness about living with HIV and AIDS that would possibly not have reached these individuals without such actions.

The three campaigns are reaching out to audiences with different social and socio-economic statuses. loveLife and TAC seems to have a clearer sense of their audiences background and a clearer strategy towards reaching them, than Brothers for Life. However, BfL has not been operating as a campaign for as long as the others have, and may need to know their audience a little better before they find their complete communication strategy.

Cultural context: The cultural context of South Africa is necessary for the campaigns to understand in order to be successful. For this reason it is vital for the analysis to recognise how culture is being infused into the campaigns, how they address the power men have in the South African society and thus women's lack of power, men's superiority on the many levels in the everyday life and women's submissiveness in the same areas.

Cultural context is a complex issue and involves many factors. The three campaigns seem to be aware of the factors that are most essential to their approach, which is also expected.

loveLife has to address the youth culture in order to comprehend the cultural context it is operating in. This implies understanding how young people think, what they are interested in and how they behave. The campaign has recognised that in order to relate to the interests of youths with their information they have to maintain a young profile. It has certainly done so, maybe to a greater extent than it needed to, with its 'cool' attitude, billboards and TV shows, and its youthful language. It does manage to relate to the reality of youths in South Africa by addressing their vulnerability, sexual pressure and lifestyle that further contributes to a high risk of contracting HIV (lovelife.org.za, n.d).

Brothers for Life has understood that the cultural context surrounding masculinity and dominance needs to be addressed and challenged in South Africa in order for progress to happen in the area of HIV and AIDS. HIV/AIDS infections are not going to decrease or become eradicated unless sexual behaviour and the attitude towards women change and Brothers for Life communicates this by focusing on gender equality, equal distribution of power in sexual relationships and HIV prevention through condom use and committing to one sexual partner at the time (brothersforlife.org, About Brothers for Life, n.d.).

Poor black women are especially engaged in TAC's actions and with a focus on gender and women's rights in their campaign it seems to be aware issues that are of importance for its members, and hence, of the cultural context it is operating in. However, it is political issues rather than cultural issues that are of highest importance for TAC (Jungar and Oinas, 2010: 178, 182; tac.org.za, About the Treatment Action Campaign, n.d). This implies that its communication strategy is aimed at gaining political influence on health issues that can benefit all HIV-positive people in South Africa and not necessarily on sexual behaviour change of the South African people.

It is obvious that the different campaigns cannot take into consideration all the social and cultural issues that are pressing on the HIV epidemic. Due to this, the campaigns seem to have provided a fair comprehension of the specific context that they are operating in. However, a broader interpretation of the cultural context could help the campaigns identify other factors that are of importance for HIV prevention, such as women's lower status in society and the customary law's position in the society that enforces oppressive cultural practices upon (young) women, such as virginity testing.

Women's (sexual) empowerment: In order for the HIV prevalence among women, and especially young women, in South Africa to decrease women needs to become (sexually) empowered. Addressing women's empowerment both generally and in sexual relationships in prevention campaigns can contribute to a woman's awareness of an empowered role within sexual relationships that helps them understand the need for negotiation of condom use and the general terms of the sexual engagement in order to make them less vulnerable towards infection as well as creating an awareness of their own powerful sexuality.

The general empowerment of women is more of a focus for the three campaigns than the sexual empowerment of women.

The loveLife campaign focuses on a general empowerment of young women and youths in general in terms of "(…) giving them a greater sense of aspiration for the future" (lovelife.org.za, loveLife Strategy, n.d.). It does this by addressing HIV-prevention through 1) the individual factors (such as low self-esteem); 2) the societal factors (the disempowerment of girls and young women through societal attitudes); 3) the structural factors (for instance unemployment, poverty and school dropout (lovelife.org.za, loveLife Strategy, n.d.). A goal is therefore for young women to adopt a higher self-esteem when it comes to sexual relationships. This incorporates raising awareness about HIV risk, peer pressure both towards sex, alcohol and drugs, the benefits of using a condom and how to say no to unwanted sexual engagements. Such knowledge can contribute to young women taking on an empowered role within their sexual relationships and this is what the campaign aims for (lovelife.org.za, Know the facts, n.d.).

Brothers for Life is not directly targeting women's (sexual) empowerment. However, it is focusing on modern men's empowerment within sexual relationships that aims at an equal distribution of power for men and women. This implies a focus on for instance condom use and restraining from using violence against their partner (brothersforlife.org, Our manifesto, n.d.). In this sense, women in South Africa become empowered by their men retreating from the traditional male sexuality and masculinity.

TAC is mainly addressing women's empowerment on a general level through its emphasis on women's rights and gender equality. However, by addressing these issues it is also addressing a sexual empowerment of women through its focus on HIV and AIDS, and the eradication of new HIV infections. Women are the majority of the members of TAC and they are also the ones that are in the forefront of the campaign. By identifying themselves as members of the campaign they are empowering themselves as well as being role models for other women in the same situation. TAC has recently started to intensify their work towards women's rights by mobilising communities to advocate women's rights and through campaigns focusing on ending violence against women (tac.org.za, About the Treatment Action Campaign, n.d.). TAC has been criticised for its male dominated leadership, but many consider TAC as fighting both men and women's cause: "Indeed, the TAC's readiness and capacity to mobilize its membership in the struggle for gender justice gives us all hope that patriarchal notions of sex and women's subordination can be ended and that gender relations between women and men can be truly transformed" (Peacock, Budaza and Greig, 2009: 100 in Jungar and Oinas, 2010: 181). One of its objectives, written in the Constitution of the Treatment Action Campaign (2008: 6), is: "To build and sustain campaigns to eradicate gender inequality, violence against women and to achieve full equality for women through the development of women leaders and social justice activism".

The focus on women's empowerment through women's rights, gender equality and awareness of an empowered role within relationships is valuable information for women. Nevertheless, even though general and sexual empowerment of women are connected in HIV-prevention campaigns, the lack of a direct focus on sexual empowerment implies that something is missing from the campaigns since this is a significant issue when it comes to HIV risk and prevention. Cultural factors related to the (sexual) empowerment of women in South Africa ought to become more visible in the campaigns, since cultural context does influence women's vulnerability towards HIV-transmission. Culture is contributing to constructing the notions of masculinity and femininity, where it celebrates men's sexual liberty to have multiple partners, but at the same time constraints women's agency and sexuality. In South Africa, where the customary law is still highly evident, cultural practices such as brideprice, restrains women's independency and control's their sexual lives. Hence, cultural factors have an effect on sexual behaviour, which HIV-prevention campaigns should address.

Control or lack of control of women's bodies: In addition to women's (sexual) empowerment and in line with the theoretical framework of radical feminism, how the prevention campaigns address the control of women's bodies, if women have a control of their own bodies or if they can claim control of their bodies, will contribute to an understanding of how the prevention campaigns address women's sexuality.

This is not an issue that is directly raised by the three prevention campaigns. There is however possible to imply certain related understandings of and encouragements for women to take control of their own bodies:

Young women are vulnerable towards sexual pressure, especially if the man is older, and through this they do not have control over their own bodies. loveLife encourage young women to adapt a sense of control of their bodies from a young age for instance through their website pages 'Know the facts' where it provides awareness about contraception, that no means no, the risks of having sex for money and how to build up youths self-esteem (lovelife.org.za, Know the facts, n.d.). This can affect their behaviour when they become sexually active or it can boost their confidence if they are sexually active so that they are able to negotiate the terms of their sexual relationships and by this empower themselves from a young age.

With Brothers for Life focusing on men, it is expected that the campaign does not directly relate to women's sexuality and the control of their bodies. Its focus is rather on men's sexuality and control of their bodies (brothersforlife.org, n.d.). However, the encouragement towards men to change their sexual behaviour opens up to the possibility of women being able to claim control of their own bodies in such relationships and the campaign is through this concerning itself with women's sexuality.

TAC does not focus on women's sexuality and bodies. However, its activism bases itself on the individuals' right to control their own bodies by also controlling the infection and their health through access to HIV/AIDS prevention treatment (tac.org.za, About the Treatment Action Campaign, n.d.). With access to such treatment, HIV positive people can live a close to normal life and have a close to normal sex life. TAC is promoting openness and a healthy life for HIV positive people that can be an inspiration for people to get tested. Knowing one's status can contribute to a healthier sexual life, where openness is included and a greater control of one's body is a consequence.

The three campaigns' approaches provides different ways of perceiving control of one's body, either it is through control of medicine to ensure a healthy body, being able to restrain from sexual peer-pressure or promised economic advantages through sexual relations, or by aiming at gender equality. Still, cultural factors that inhibit women's (sexual) empowerment also restrains (young) women's control of their own bodies. The campaigns are therefore missing the element of directly reaching out

to (young) women with encouraging prospects that can empower them enough to know how and why they should claim control of their bodies.

HIV and AIDS related stigma: Lastly, how the prevention campaigns address stigma, both in general and specifically related to women will give the last indication of how the campaigns are addressing the research question.

None of the three campaigns address HIV and AIDS related stigma in any direct form on their webpages, neither in general or specifically towards women. This is interesting since stigma is one of the most relevant issues when it comes to the unwanted stabilisation of the HIV infection rate in South Africa. People do not dare to test themselves in fear of becoming stigmatised and many do not disclose their status due to the same reason. So what does the three campaigns actually address that is related to such stigma:

loveLife has programmes for youth that are teaching them about issues related to HIV/AIDS related stigma, such as the 'Born Free Dialogues' that encourages parents and youths to "communicate[ing] openly about the values shaping attitudes and sexual behaviours of different generations" (lovelife.org.za, Born Free Dialougues, n.d.). Since it is also highly engaged in sexual behaviour and behaviour change it does raise some issues, especially intended for young women, which can help youngsters not becoming stigmatised, either through HIV prevention, building up self-esteem or emphasising how to live in a healthy relationship where they are not sexually vulnerable.

Brothers for Life's campaign does encourage an equal distribution of power within sexual relationships and is at least not generating any stigmatising behaviours, hopefully rather the opposite, when it calls for an equal worth of women and men, that women should be treated with respect and that living with HIV is not something to be ashamed of. In this sense it is not targeting stigma, but is indirectly challenging stigmatising behaviours by promoting healthy behaviour towards women and people living with HIV and AIDS (brothersforlife.org, n.d.; brothersforlife.org, Our manifesto, n.d.).

Since the TAC is mostly directed at individuals that are already infected with HIV, stigma and discrimination against HIV positive people should be of its main concerns. In its vision it states "The Treatment Action Campaign supports the constitutional vision that every person is born with the inalienable rights to life, dignity, health, freedom and equality" (Constitution of the Treatment Action Campaign, 2008: 5). The TAC activists have publicly displayed their positive status in order to show others that anyone can be HIV-positive, for instance by wearing "HIV +" t-shirts. They are through this acknowledging an acceptance of being HIV-positive and in this sense encouraging others to dare disclose their own status. Its strategy is to fight shame and silence together as a political movement,

which is one of the main reasons why stigmatising behaviours develop (Jungar and Oinas, 2010: 183; tac.org.za, n.d.).

The problem is that since none of the campaigns are directly targeting stigma it is difficult to know how they are actually addressing the issue, their focus on stigma and what their main concerns are related to this. Women are especially vulnerable towards stigmatisation and this is important to acknowledge in order to decrease the number of infections, which is something the three campaigns all aim to do. In this sense, all of the campaigns have failed to relate their prevention strategy towards one of the most crucial issues of HIV and AIDS in South Africa. This will be further discussed in the next section.

4.8 Analysis and discussion of the prevention campaigns

The personal has become political in prevention campaigns. HIV and AIDS make it impossible for sex to be private in countries like South Africa, where the infection rate is high. Sex is not just a social conduct, political, cultural and socio-economic aspects also influence the conditions and terms of a sexual encounter. Moreover, sex is now also interpreted as a medical issue. Nevertheless, every HIV/AIDS-prevention campaign has a different strategy towards reaching out with information and has a different focus on sex. This is a matter that this chapter has explored. The three campaigns have different prevention approaches towards HIV and AIDS, whereas loveLife has a clear 'behaviour change'-model approach, TAC is including the biomedical aspect of HIV prevention in its behavioural model, and the same seems to be the case for Brothers for Life. The focus on behaviour change also implies a greater focus on culture than the biomedical approach. Cultural norms and practices in South Africa have an influence on the sexual norms and practices and by this shapes notions of male and female sexuality. This can be seen for instance by the acceptance of multiple concurrent partners within the male culture, while women are expected to be faithful to their one partner and the customary law that enforces virginity testing of young girls. Practitioner of this testing argue it contributes to the prevention of HIV by stalling girls and young women from engaging in sexual relationships, however, it restrains these women's sexual behaviour and prevents them from having control of their own bodies. That men have the power to control the terms of a sexual encounter is also an example of how male and female sexuality is perceived. These are issues that behaviour change-models often are concerned with. Due to this, the meanings of for instance sexual behaviour change and control of one's own body differs amid the two approaches. Placing this within the context of radical feminism, it is clear that the straightforward behavioural model has a greater emphasis on women's sexuality and empowerment. However, women, and especially the group of women that are most vulnerable towards HIV-infection, namely poor, low-educated black women, are highly engaged

in the TAC movement. Since they do not address women's sexual issues and vulnerability considerably in-depth, this popularity seems likely to be due to its focus on the equality among its members.

With the same aim of reducing the number of HIV and AIDS infected people in South Africa, and the same socio-economic and cultural issues to overcome, they do have certain similarities. Extracted from the findings above there is possible to recognise core consistencies and meanings by their behavioural approach, which aims at HIV prevention and reducing the number of new infections. However, their approaches differ, and in this sense their priorities are different. They all provide knowledge and awareness of HIV and AIDS, and are spreading this information by engaging the South African people, either it is through specific programmes or rallies. They all focus on the subject of gender and vulnerability within the context of HIV and AIDS, risk and prevention, but also here from different perspectives. Nevertheless, it is issues of gender-based stigma related to HIV and AIDS that are of most concern for this study, and at this point the three campaigns coincide by not addressing this directly. This implies that there is a need to look at other constituents to analyse, in order to grasp how they are rather indirectly addressing issues of stigma.

Since stigma has not directly been addressed by the three campaigns, stigma is driven by many, often interconnected, factors that the prevention campaigns should address in order to reduce stigmatising behaviours. One factor is that people do often not have the proper knowledge about HIV and AIDS and by this either misinterpret the condition, or fear people that are HIV-positive. The cultural circumstances surrounding women's low position in society contributes to women often being blamed for the infection. Nevertheless, many men refuse to protect themselves in sexual encounters and by this are conducting high-risk sexual behaviour, while many women do not dare to negotiate condom use, even though it drastically decreases the risk of infection.

All the three campaigns have a strong focus on providing knowledge and awareness of HIV, either it is for HIV-positive or HIV-negative people. Both loveLife and TAC has community programmes where information about the epidemic is put forward. These programmes can contribute to generating knowledge that can reduce stigmatising behaviours. However, such knowledge needs to reach the whole of the South African people in order to stop stigmatising behaviours all together. loveLife's cryptic billboards are in this sense not the right strategy to generate knowledge to the South African people. TAC, on the other hand, has voluntary HIV-positive individuals to promote their cause. Giving the infection a face and a story can contribute both to reduce the shame and silence that is often related to HIV and AIDS, and at the same time reduce the fear of HIV-positive people by presenting them as normal people and like everyone else.

The essential issue regarding stigma, for this study, is that women are more likely to become stigmatised than men. The conditions of class, race, gender and culture have a determining effect on this issue, which has contributed to the outcome of poor, low-educated black women being the group that is most likely to become stigmatised on the basis of HIV and AIDS in South Africa. TAC seems to be the campaign among the three that addresses poor black women most notably, however these women are already HIV-positive, and in this sense are not the target group for most prevention campaigns. Nevertheless, these women are fully recognised within TAC and are key drivers of the campaign. In this sense, they give other poor black HIV-positive women someone to identify themselves with. However, this could be further explored by the campaign in order to reduce stigma. loveLife recognises that poor black young women are especially vulnerable towards HIV infection, and black young women are heavily featured both on its billboards and on its webpage. It is an advantage that it acknowledges that poor young women in South Africa use sex to gain money and material goods that they need, and through its website, gives these young women a place where they can retrieve information about their situation and talk or chat to someone if needed. However, if the information had contained issues related to stigma, it could challenge stigmatising behaviours towards stigmatised groups among people from an early age. Brothers for Life is the campaign among the three that recognises poor black women the least, but these are not its target audience. On the other hand, since it promotes gender equality within sexual relationships, it does bring up issues that are also concerning women and by this also poor black women. In this sense, some campaigns have been better at recognising poor, low-educated black women in their HIV-prevention strategy than others.

However, to see if prevention campaigns address the issues of why women are being more stigmatised than men, is the most crucial matter to analyse for this study. This matter is more complex than the previous ones, involving the socio-economic and cultural factors of gender-based inequality, sexual behaviour, patriarchy, masculinity, female empowerment, vulnerability, dominance and condom use. Chapter 3 provided arguments of why women are more vulnerable towards stigmatisation than men. The stigmatisation is based on cultural conditions, gender, class and ‘race’, where women are generally portrayed as having a lower status than men, and women of colour are ranked with the lowest social and economic status. Furthermore, this general oppression of women by patriarchy places women in a situation where they are often dependent on their man economically, which deprives them for power both inside and outside of the home. Women’s sexuality is therefore in the man’s possession, and the same is true of her body. Refusal of women to incorporate themselves into this position often generates stigmatising behaviours towards women. However, since this situation causes vulnerability and high-risk for women, these are issues that prevention campaigns have to address in order to reach their goal of decreasing the number of new HIV infections in South Africa.

Women's empowerment is an issue that TAC addresses by promoting women's general rights. The majority of its members are women, which implies that the situation of women in South Africa is important to the campaign. Since it bases itself on equality among its members there seems to be no room for the system of patriarchy, masculinity or male dominance within the movement. Most of the members of TAC are HIV-positive and with an aim to decrease the number of new infections, sexual behaviour, is an issue that TAC's members have first-hand experience of. TAC, then, has one of the best HIV-prevention components; it has HIV-positive individuals that can communicate their experiences to others and by this can generate knowledge that can contribute to a reduction in stigmatising behaviours. However, due to its focus on health and not sexuality, it does not concern itself with the in-depth issues of masculinity, dominance, the sexual empowerment of women, the control of women's own bodies, vulnerability and condom use. TAC is successful in its health-focused approach and for this reason seems to understand the general South African context it is operating in. Even though this is good for the HIV-positive people in South Africa, TAC is missing crucial elements in its campaign of contextualising socio-economic and cultural issues of HIV-prevention in South Africa that would contribute to a more comprehensive and far-reaching campaign that could benefit the whole of the South African people.

loveLife reaches out to young people in South Africa. South Africa is a tough place to grow up both socially and economically, and patriarchy is influencing the culture of sexuality and sexual behaviour from an early age. The campaign addresses these issues by focusing strongly on changing negative sexual behaviour among youths, which implements dominance by an older and economically powerful (male) partner and a great vulnerability of the younger (female) partner, and towards a positive sexual behaviour that bases itself on healthy decisions like condom use and dare to say no to sexual pressure. From such a perspective, loveLife engages with the issue of gender inequality by advocating for positive sexual behaviour among youths based on preventative measures to reduce the risk of HIV/AIDS and equal respect between the partners in the relationship, without a prominent masculinity or dominance, but rather an empowerment of young women to stand up for themselves. By targeting people at an early age, the chances of reducing stigma towards HIV and AIDS, through knowledge and awareness, are more likely to be successful. However, with such a comprehensive campaign built on knowledge and awareness, if the campaign would have had a direct focus on stigma and stigmatising behaviour, it is likely that it could make an actual difference in HIV/AIDS-related stigma, and not just by chance.

Brothers for Life engages comprehensively in gender-based inequality, masculinity, dominance, sexual behaviour and condom use by challenging the traditional (sexual) male power in South Africa and aspiring towards 'a new man'. By this the campaign means a modern man that respects his woman by not using violence against her, getting himself circumcised, only having one sexual partner and

protect himself and his partner from getting infected, by for instance using a condom. Through this it is also challenging the existing patriarchal notions in South Africa by promoting gender equality from a male perspective and is fighting vulnerability both towards HIV and sexually dominant relationships. However, its focus on male circumcision for health benefits and HIV-prevention may place women in a vulnerable position, since it often implies a lack of condom use. At the same time the campaign does encourage condom use. This kind of ambiguous messages may, however, be a setback in women's sexual empowerment. The campaign is for this reason more concerned with men's vulnerability than women's vulnerability. Even though its focus on changing the South African man is a good approach for challenging the male dominance, it captures gender equality from a male perspective, and thus cannot place itself in women's position. Due to this, it will also have difficulties in addressing stigma directed towards women.

Even though the three campaigns are addressing relevant issues, South Africa still has a long way to go before the distribution of power in sexual relationships is equal. HIV/AIDS prevention campaigns are important because they distribute knowledge, awareness and positive values when it comes to sexual behaviour, vulnerability towards HIV/AIDS and condom use. On the other hand, HIV and AIDS are complex epidemics existing in a context that is infused with socio-economic and cultural issues and perceptions based on gender that seem too much to grasp by campaigns alone. The masculine culture based on patriarchy must retract in order for women to confidently engage themselves in their sexuality and dare to take control of their own bodies without a fear of being stigmatised.

The question is then, has the campaigns done enough to change stigmatising behaviours in general and especially towards women? Unfortunately no, since stigma is a complex issue the campaigns need to implement a more comprehensive, direct and aggressive line towards stigma in order to address it properly. The three campaigns provide much information about HIV and AIDS, and this is good. The campaigns that are concerning themselves with sexual issues are also more concerned with the cultural factors that drive stigmatisation of women. Nevertheless, if they had been addressing stigma directly – for instance in terms of why women should not be perceived as promiscuous, adulterous or HIV-positive if they try to negotiate condoms, or what can be done to change women's low status, especially if she is HIV-positive - this information could have become even more useful since it would contextualise the issues related to why people, and especially women, do not dare to act on this information in order to keep themselves HIV free. The obstacles that stigma provides to HIV-prevention are significant and obvious when people do not dare to get themselves tested, disclose their status or communicate prevention measures within sexual relationships in fear of becoming stigmatised for their behaviour or status. In a very general sense, reducing the negative thinking related to HIV-positive people should be possible, through greater knowledge about HIV/AIDS and

stigmatising behaviours, and an encouragement of gender equality in sexual relationships. Prevention campaigns can contribute to a rise of awareness about HIV and AIDS related stigma that will further benefit the South African people, and especially those that are most vulnerable towards stigmatisation, which is women. Hence, in relation to the research question, even though the context is provided for understanding and fighting stigmatisation, the three campaigns do not directly address stigma and are by this not doing enough to address HIV and AIDS related stigma, neither on a general or gender-based level.

4.9 Conclusion

This chapter has contextualised three prevention campaigns in South Africa, namely loveLife, Brothers for Life and the Treatment Action Campaign. These are all campaigns that have a national outreach that are reaching many people. The three campaigns are all popular, in the sense that they are able to attract the attention of many people, and in this sense they do seem successful. There are certain consistencies among the three campaigns: they all focus on knowledge and awareness of HIV and AIDS, reducing the number of new HIV infection and issues related of gender and vulnerability within the context of HIV and AIDS, risk and prevention. They are also approaching HIV prevention from a behaviour-model perspective. However, they have different target audiences and approaches towards HIV-prevention that place them in different categories of prevention campaigns. While TAC is mostly concerned with health issues, loveLife and Brothers for Life are focusing mostly on sexual behaviour. This means that they are addressing the underlying causes of HIV/AIDS-related stigma towards women differently.

loveLife and Brothers for Life are concerning themselves more with the issues of sexual behaviour, masculinity, dominance, gender inequality, vulnerability and condom use, than TAC. loveLife's target audience is youths. These are important to target since they are supposed to live long, healthy and HIV-free lives, and also because they are vulnerable towards HIV infection due to low self-esteem, sexual peer pressure and since they are curious about sex and girls are having relationship with older men. Changing young people's attitudes towards sexual encounters and providing them knowledge of HIV and AIDS can contribute to a decrease in stigmatising behaviour and the overall HIV rate, and is therefore an essential element to focus on for HIV prevention in South Africa. Brothers for Life aims at changing adult males' behaviour towards South African masculinity and sexual relationships in order to decrease the HIV prevalence in the country. Its perspective aspires to more gender equal and healthier sexual relations based on a single partner relationship, no violence or abuse of alcohol, and promoting both male circumcision and condom use. This approach challenges the general patriarchal notions in South Africa but is projected to be an inspiration for the modern South African man that

takes greater care of himself, his partner and his family. TAC speaks openly for the HIV-positive people in South Africa and provides other HIV-positive individuals with a story, a person and a face to identify themselves with. It further advocates for better access to health care services and treatment for these individuals, as well as promoting women's rights and education on HIV and AIDS. This has given the campaign many members, especially among poor black women.

South Africa is a country where patriarchy and the culture of masculinity are dominant features of sexual relationships that are preventing HIV campaigns to be successful in significantly decreasing the number of HIV infections at present time. However, the campaigns are not addressing cultural factors as comprehensively as they ought to. For instance, the customary law enforces oppressive practices upon women, such as enforcing brideprice and virginity testing. The pressure on young women to engage in sexual relationships, either with friends or an older partner, increases the risk of becoming infected. The perception of masculinity and dominance that enables sexual relations with several partners and a male control of the relationship, are obstacles for HIV prevention, since it provides women with little room for negotiating the terms of the sexual relationship and condom use. It further gives women little control of their own bodies. Accordingly, cultural factors allow stigma related to HIV/AIDS and sexual behaviour to establish itself, especially towards women that seek to take charge of their own body, sexuality and HIV risk. Campaigns therefore have to better address prevention measures that encourage women to take control over their own sexual independence and empowerment.

The three campaigns introduced for this study has all provided a context where information about HIV risk and prevention is uttered, nevertheless, none of the campaigns directly address stigma related to HIV and AIDS, in general or directed towards women. They do recognise issues that are related to why women are stigmatised, and by this recognises a need for promotion of women's rights, gender equality and condom use. Nevertheless, since stigma is a great obstacle for a decrease in new HIV infections, which is something all three campaigns are aiming for, this should have been a significant issue for the campaigns to address. That they do not address this implies that they are missing an important feature of HIV prevention and that there is still work to do for the campaigns. Issues related to stigma should become essential parts of the knowledge and awareness of HIV and AIDS in order to reach the goal of reducing the number of new HIV infections in South Africa.

Chapter 5: Conclusion

5.1 Introduction

The purpose of this study has been to analyse HIV/AIDS prevention campaigns to determine how they address the issue of HIV/AIDS-related stigma. The focus is on the stigmatisation of women and that can be related to their disempowerment in sexual relations. By using a radical feminist framework, the study revealed socio-economic and cultural factors that subordinate women and place them in a position where they are vulnerable towards HIV transmission, which is an element that should be addressed by prevention campaigns. Content analysis was used as the methodology for analysing the prevention campaigns' content. The study has argued that women are more likely to become stigmatised on the basis of HIV and AIDS, due to the socio-economic and cultural factors in South Africa that oppress women and contribute to their general low status in society. It has further argued that it is the women who are positioned lowest on the social hierarchy who is the group most vulnerable towards stigmatisation. These are the poor, lowly educated black women. The purpose was to determine how the three prevention campaigns loveLife, Brothers for Life and the Treatment Action Campaign address the issues of gender-based stigma related to HIV and AIDS. The conclusion is that the three campaigns did not directly address this issue and were overlooking one of the main reasons for the stabilisation of the infection-rate in South Africa. The campaigns were, however, to a certain level addressing issues that are related to the gender-based stigmatisation. Nevertheless, they were ignoring several cultural factors that contribute to stigmatisation of women, such as their low status in society. For this reason, the campaigns were considered to have relevant information that could, and should, be used for the purpose of addressing stigmatisation in general, and especially towards women. Nevertheless, the campaigns will need to focus more strongly on the cultural issues that generate stigmatisation for this to be addressed successfully.

5.2 Stigma

Stigma has been projected in this study through Goffman's interpretation of it as 'an attribute that is significantly discrediting' to a person and that is 'an undesirable difference', which the society uses to reduce the person who possess such attributes (Goffman 1963 in Parker and Aggleton, 2003: 14). It has also included Link and Phelan's (2001: 377-378) understanding of stigma that is set in a context of power relations between the stigmatiser and the stigmatised, which allows for stereotyping, discrimination and status loss. HIV/AIDS-related stigma can be considered to fit into these

interpretations. Accordingly, stigma is usually conducted by whole groups of people such as a neighbourhood, community or the family, and not through individual actions. It can further lead to shame and silence and even make HIV-positive people accept the stigmatisation towards them, due to the shame the epidemic generates. Moreover, stigma has a significant effect on HIV transmission, since the fear of becoming stigmatised or discriminated against, influence people's preventative behaviours. These behaviours include disclosing one's status to sexual partners, seeking counselling and treatment, getting oneself tested and using condoms (Gupta *et al.*, 2008: 765; Jewkes *et al*., 2003: 126). Stigma is further related to social, cultural and economic factors, as well as gender relations, that influence power relations, and produces inequality (Link and Phelan, 2001: 375; Parker and Aggleton, 2003: 16).

5.3 HIV/AIDS and inequality

For instance, has this thesis argued that there is a clear link between HIV/AIDS and/or social inequality, which has contributed to the spread of the epidemic and it has also made women more vulnerable towards infection. In South Africa, the social inequalities among the races have contributed to the spread of the epidemic among the heterosexual population. It is Africans who have the highest number of infected, and these are often also among the poorest in the country. This study has identified two types of vulnerability towards HIV transmission – high-risk situations and high-risk behaviour. High-risk situations are related to the prevailing socio-cultural, economic and political conditions in a society and these conditions have impacted on the individual's risk of transmission, such as having to engage oneself in transactional sex in order to survive. High-risk behaviour, on the other hand, is related to knowledge, feelings and understandings of HIV, which influence the willingness to engage in safe sexual relations (Mane and Aggleton, 2001: 24-25). In South Africa, women are the most vulnerable towards becoming infected, and this is why women have a higher number of infections than men.

5.4 HIV/AIDS and women in South Africa

There are several reasons for the high number of infected women in the country. First of all, is the physiology of women more receptive of HIV than the male physiology. Secondly, socio-economic, cultural and political factors influence women's vulnerability. Chapter 2 and 3 of this thesis provided a detailed depiction of the circumstances related to women's vulnerability in sexual relationships. The thesis has argued that the system of patriarchy is one of the most influential factors for women's

vulnerability in South Africa. This is because it incorporates men's dominance and women's subordination on both a general and a sexual level. South Africa is a male dominated society that has steeped a culture of masculine identities and male power. This is bolstered, for instance, by the customary law, which is strongly infused by patriarchy and that expects men to be the head of the household with the power this entails. The customary law further restrains women's possibilities to own land, control their earnings, and it is enforcing brideprice. Rural women are still less likely than men to receive education or have a job, which situates women in a position of having a lower status in society than men, and forces women into the private sphere, where they are forced to become economically dependent on men. Relationships of power imply that women are, and have to be, sexually available for their partner whenever they desire this.

From the radical feminist perspective chosen for this thesis, this vulnerability and submission that women face within sexual relationships with men, have restrained women's ability to take control over, and own, their own bodies. This causes vulnerability towards HIV infections. A consequence of the unequal distribution of power within sexual relationships in South Africa, is that women are often not able to negotiate the terms of the sexual encounter. This implies that they are not able to negotiate preventative measures that could reduce the risk of HIV transmission, such as by for instance using condoms. Especially in cases where women are engaged in sexual relationships with older men, or are involved in transactional sex, is this an issue. The culture of masculinity in South Africa further celebrates manhood, and having several female sexual partners at the same time, is perceived as part of the concept of being a man. Women, on the other hand, are expected to be faithful with one male partner, and because of this, are not expected to have the need to negotiate the use of condoms. Conversations with their male partner(s) about condom use are, therefore, usually avoided, since it can be perceived as a confession of adultery, or it can generate stigmatisation towards the woman for being promiscuous, 'loose' or HIV-positive.

This thesis has argued for the suitability of radical feminism as the framework for this study, due to its focus on women's sexuality and its emphasis on the need for women to obtain the control of their own bodies. From the radical feminist perspective, there is still hope for women to be able to take control over their own bodies. The personal is political for radical feminists, and hence to address sex and sexuality as political issues make it possible to change male-dominated relationships of power. For radical feminists, this would imply that women generate solidarity, through movements, in order to for them to collectively reject the terms of patriarchy, male dominance and women's submission, and promote women's (sexual) empowerment and the right to control their own sexuality. Relating this to HIV and AIDS: women's (sexual) empowerment is crucial in order for women to become less

vulnerable towards HIV infection. This is why there is a general need in the society for HIV prevention campaigns that are focusing on sexual behaviour change.

5.5 Prevention campaigns

This study has introduced three campaigns focusing on the prevention of HIV, namely loveLife, Brothers for Life and TAC. Through the method of content analysis it was possible to identify certain consistencies and meanings among the three campaigns. All the campaigns aim at reducing the number of new HIV infections, and they all provide knowledge and awareness of HIV and AIDS. The campaigns are all approaching the topic of HIV prevention from a behavioural-model perspective, addressing prevention as a need for change in behaviour. The thesis has considered the behavioural-model to be more appropriate for the context of HIV related to this research, and has by this this, not implemented campaigns that have a biomedical approach towards HIV prevention, even though there is an extensive focus on the biomedical approach among donors at the present time. Nevertheless, the three campaigns have different areas of priorities, whereas loveLife and Brothers for Life concern themselves mostly with issues regarding sex and sexual behaviour, the TAC is concerning itself mostly with issues related to health-care, treatment and changing the government and the pharmaceutical industry's behaviour towards the rights of HIV-positive people. This means that their perspectives on gender issues differ, for instance by how they address women's (sexual) empowerment, taking control of one's own body and changes in sexual behaviour.

Moreover, the study has argued that neither one of the prevention campaigns have directly addressed issues of stigmatisation based on HIV and AIDS, neither in general nor specifically towards women. They have neither focused enough on issues related to culture and gender equality, that drive such stigma, in order for them to be able to address this kind of stigma successfully. However, there is potential. TAC's membership mostly consists of HIV-positive people and this can be a huge asset when it comes to addressing stigma. By using 'real' HIV-positive people to promote its campaign, it can contribute to perceiving HIV-positive people not as deviant, but rather as normal people that are like anyone else. For this reason, TAC has to address the cultural issues related to masculinity, gender inequality and unequal distribution of power within sexual relationships in South Africa, in order to begin comprehensive campaigning towards a reduction in stigmatising behaviours.

Brothers for Life is promoting male behaviour change and greater equality among the genders within sexual relationships from a male perspective. This implies that it is challenging the patriarchal notions and the view on masculinity that are present in South Africa today. Even though this is all good, it

fails at implementing the women's perspective and how they are affected by the present situation of general oppression and sexual submission. To be able to address stigma towards women, the campaign will have to address cultural issues that are related to women, and promote equal status of men and women in society at large, in order to begin to raise the issue of stigma and stigmatising behaviour related to HIV and AIDS.

loveLife has a wide-ranging campaign directed towards youths, with the purpose of promoting a healthy and positive sexual behaviour. Since the campaign is comprehensive and directed towards youths, it has the potential of having a great effect on stigma, if it were to address this directly. It would need to have a more thorough message of the promotion of (young) men and women's equal status, and address the cultural issues that enforce sexual power, masculinity and women's lack of power in general. However, targeting youths are crucial for a forthcoming change in behaviour in South Africa, and stigmatising behaviours can be reduced if these youngsters are targeted for this specific issue. For this reason, HIV- and AIDS-related stigma, especially directed towards women, should become a natural part of their campaign. This would be benefiting the South African society and its people, HIV-positive or negative, in the encounter with stigmatising behaviours.

5.6 Concluding Remarks

As a final concluding remark for this thesis: South Africa has a long way to go in order to drastically reduce the number of new HIV infections in the country. It is inhibited by the culture of patriarchy and masculinity, which is entrenched in the socio-economic, cultural and political levels of the South African society. The perception of women, and their low social status in the society, needs to be changed, and male power has to be challenged, in order for prevention measures against HIV and AIDS to be successful. This means that the government, civil society and local communities, as well as prevention campaigns, has to explore how to address women's vulnerability towards HIV, as well as their general and sexual empowerment. The shift in the HIV prevention strategy, towards the biomedical approach and a medicalization of sex, can have serious implications for the further course of sexual behaviour change and prevention of HIV. Especially among youths, a focus on behaviour rather than prevention treatment is still needed. Young women are in the high-risk group of becoming infected, and therefore, young people have to be able to attain information about high-risk sexual practices if it ought to be a reduction in new infections among this group. Vulnerability towards HIV transmission will not severely decrease unless social and cultural factor are being included in the prevention of HIV. This means that there has to be a focus on women's sexuality and empowerment for cultural attitudes, such as male dominance and women's oppression, to diminish. Hence, actions

towards a reduction in stigma and women's (sexual) empowerment have to be promoted by prevention campaigns, but it is in the end up to the South African people to change their behaviour for the benefit of their own good.

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