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Student name: Nqobile Thobile Ndzinisa

Student number: 216073982

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Appendix 1

Abstract

An estimated 78 million people worldwide have become infected with HIV since the epidemic was first diagnosed in 1986. About 19 million people are living with HIV in East and Southern Africa in 2015 and approximately 7 million people are infected with the virus in South Africa alone. KwaZulu – Natal, in particular, has the highest prevalence rate of HIV infection in the country. Numerous interventions and campaigns have been implemented internationally, regionally and nationally to curb the impact of HIV, however, the virus continues to spread. Despite high knowledge of HIV and access to testing services on campus, university students remain susceptible to HIV infection. Statistics reveal that young women aged 15 -24 years are disproportionally infected by HIV compared to their male counterparts due to various factors, including culture. Using the Culture Centred Approach (CCA), this study seeks to understand the influence of Zulu culture in educated perceptions of HIV and AIDS as well as their treatment seeking options. Central to the CCA is the understanding that communicating about health comprises the negotiation of common meanings among cultural members. Focus group discussions were used as a primary source of data collection in this qualitative study and emerging themes were analysed through thematic analysis. Findings reveal that while students may have high knowledge of HIV and AIDS transmission, it does not translate to high knowledge about AIDS treatment and care. Further, findings imply that culture does influence treatment-seeking options among students at Howard College, UKZN. Therefore, this makes it imperative for health communication to be culturally sensitive if it is to be accepted by cultural members.

Key words: Gendered epidemic, Culture Centred Approach

Introduction

The Human Immuno Deficiency Syndrome (HIV) and Acquired Immuno Deficiency Syndrome (AIDS) is a universal public health problem (Karim et al., 2014; Kharsany et al., 2014; Dellar et al., 2015). Globally, 78 million people have become infected with HIV since the epidemic was first diagnosed and 19 million people were reported to be living with HIV in East and Southern Africa in 2015 (UNAIDS, 2016). Worth noting is the disproportionate rates of HIV infection that young women experience compared to their male peers. It is reported that young women (between the ages of 15 to 25) are more likely to be infected with HIV than males (Simbayi et al., 2014). Factors contributing to the high prevalence rate are early sexual debut, having an older sexual partner, poor or no condom use and having multiple sexual partners (Zuma et al., 2016). Scholars (Leclerc-Madlala, 1994; Airhihenbuwa and Webster, 2004; Govender et al., 2013) contend that beliefs and attitudes also play a significant role in the way people receive information about HIV. Beliefs and attitudes are often informed by culture and as Collin Airhihenbuwa and Webster (2004) argue, "culture plays a vital role in determining the level of health of the individual, the family as well as the community and values of extended family and community significantly influence the behaviour of the individual" (Airhihenbuwa and Webster, 2004: 4). This means, therefore, that culture can be considered a contributing factor to the high HIV prevalence rate among young women.

Research into the Zulu cultural context has often uncovered contentious beliefs and practices that seem to be contrary to behaviour change recommendations for HIV prevention (Burgess et al., 1990; Leclerc-Madlala, 2001; Leclerc-Madlala, 2002; Selikow et al., 2002; Tomaselli and Chasi, 2011) . Zulu culture is characterized by its masculine societal structure (Selikow et al., 2002), the genderification of HIV/AIDS (Leclerc-Madlala, 2001), a reliance on traditional healers as a cultural practice (Tomaselli and Chasi, 2011) and a dual interpretation of disease (Crawford and Lipsedge, 2004). In the Zulu cultural context, women are perceived to be 'naturally' unclean (Leclerc-Madlala, 2001). The Zulu term *umnyama* is commonly used to describe a woman's 'dirtiness' (Leclerc-Madlala, 2001). *Umnyama* denotes "contagious pollution or a mystical force most often associated with women" (Ngubane, 1977: 76). Similarly, Leclerc-Madlala (2001) posits that "the foundational assertion of AIDS symbolism is that women are both the source of HIV infection and the disseminators of AIDS illness" (Leclerc-Madlala, 2001: 42). The perception of women being dirty leads to the belief that they are carriers of disease in society and this further

problematizes the already complex HIV and AIDS epidemic as it perpetuates stigma and discrimination for women in the Zulu culture (Simbayi et al., 2007).

When it comes to treatment seeking options within the Zulu culture, community members can access either medical doctors or traditional healers. An estimated 80-85% of Black South African people access traditional healers for treatment in both rural and urban areas largely because healers are "more easily accessible geographically and provide a culturally accepted treatment" (Petzer and Mngqundaniso, 2008: 370). Numerous studies devoted to examining the significance of culture in HIV and AIDS awareness interventions have been conducted over preceding decades (Leclerc- Madlala 1994; Tomaselli 2011; Airhihenbuwa and Webster 2004; Zuma et al. 2016), however, there is a dearth of research into educated perceptions of cultural beliefs, values and practices and how these impact HIV and AIDS communication and treatment seeking behavior. While cultural backgrounds mould perceptions, values and beliefs, education allows for their critical examination. An educated person may receive an HIV and AIDS message differently to someone without an academic background. This study will explore the educated views of Zulu students studying at Howard College at the University of KwaZulu –Natal on their cultural background and if this aids or inhibits effective HIV and AIDS communication and treatment seeking behaviours. It seeks to gather the views of individuals who are in the privileged position of being in an academic institution where they are constantly exposed to correct HIV and AIDS messages, but still maintain close ties to their Zulu culture.

Background

Globally, 36.7 million people were living with HIV in 2015 and alarmingly, 19 million of these people are in eastern and southern Africa. An estimated 7 million people are infected with HIV in South Africa alone and 4 million of those are women aged 15 and over (UNAIDS, 2016). Out of all the nine provinces of South Africa, KwaZulu –Natal recorded the highest provincial prevalence in 2001 (Zuma et al., 2016). The same survey revealed that prevalence was higher among African women in the age group 15 – 25 years.

These statistics prove that in almost 3 decades since the first diagnosis, HIV and AIDS continue to spread relentlessly and researchers (Tomaselli and Chasi, 2011; Govender et al., 2013) observe that "it has become clear that HIV and AIDS communication interventions have not been very successful" (Tomaselli and Chasi, 2011: 51). This is despite numerous awareness campaigns and

various interventions put in place by governments and non- governmental organisations globally. It has further been argued that the most essential "problem of HIV is not simply one of health nor is it one only of development, but rather of the failure to recognise the context of participation with regard to HIV and AIDS" (Tomaselli and Chasi, 2011: 52). This implies that the environment is a critical factor to consider when designing HIV interventions.

This study will examine how educated perceptions of cultural beliefs, values and practices impact effectiveness of HIV and AIDS communication as well as treatment options and this will be sought by using the lens of the Culture- Centred Approach. The Culture – Centred Approach seeks to encourage "a space where voices of cultural members may be brought to the forefront in order to articulate the questions that are important to them" (Dutta, 2008: 46). The Culture-Centred Approach "emphasises attempts at changing societal structures surrounding health through dialogues with cultural members that create spaces for marginalized cultural voices" (Dutta, 2007: 305). This approach will allow the researcher to investigate how the Zulu culture influences the perception of HIV and AIDS among Zulu university students. Do Zulu university students perceive it purely logically? Does Zulu culture influence the choices they make despite being constantly exposed to 'correct' messages on HIV and AIDS on campus? The study will also explore how Zulu culture influences Zulu university students' treatment seeking options as well as whether they regard the adoption of the biomedical approach as a denunciation of their culture.

Purpose of the study

This study aims to evaluate and document whether Zulu students' cultural background influences their perception of HIV and AIDS as well as their treatment seeking behaviours.

Objectives of the study

The study seeks to understand the influence of culture in contemporary Zulu students' perceptions and conception of HIV and AIDS and related communication. This will establish whether there are any gaps in health communication that may need to be addressed to ensure that messages and initiatives are culturally sensitive and suit the context.

Research Questions

1. Do Zulu cultural beliefs assist or impede effective HIV and AIDS communication and treatment seeking options for young women?

2. What are the cultural beliefs that inform young women's treatment seeking options? Is there still a need to clarify outlandish myths about the disease in 2016?

3. Do UKZN students consider being partial to a biomedical approach a denunciation of their Zulu identity?

Significance of the study

The study will stimulate discussions about any myths and stereotypes and data sourced from respondents can be used to improve existing gaps in HIV and AIDS communication by addressing myths such as *umnyama*, virgin cleansing as well gendered expectations that drive the HIV and AIDS epidemic. Consequently, if young people are receptive to the improved messages and initiatives they are likely to adopt the recommended behaviour, which could result in a lower prevalence of HIV infections among young women aged 15- 25.

Literature review

Introduction

It has been over 30 years since HIV was discovered and "the HIV and AIDS catastrophe has been one of the defining features of the past quarter of a century" (Fauci, 2008: 289). This chapter explores (1) the HIV and AIDS landscape globally, locally and within KwaZulu Natal, (2) culture as the driving force behind the "gendered pandemic" (3) Zulu culture systems as well as (4) university students and their perceptions of HIV and AIDS.

HIV landscape

In the first 20 years of the advent of the epidemic, academics and policy makers debated whether or not HIV and AIDS would have socio-economic impacts and what these might be (Barnett et al., 2002). The world was caught unaware and early efforts to contain the virus were disjointed, piecemeal and enormously under-resourced (Hankins et al., 2006). This was because when HIV was first diagnosed in 1981, it was associated with homosexuality (Parker and Aggleton, 2003; Koblin et al., 2006; Simbayi et al., 2007; Tomaselli and Chasi, 2011). This is no longer the case, however, as "of the five ways HIV is usually contracted, ordinary heterosexual sexual intercourse is the most common" (Hunter, 2003: 24). In 2015, about 1.1 million AIDS related deaths were reported globally (UNAIDS, 2016) and sub-Saharan Africa remains the hardest hit region in the world (Hankins et al., 2006). An estimated 470 000 people died of AIDS related causes in East and Southern Africa in 2015 and out of this number, approximately 180 000 people died of AIDS related illnesses in South Africa in the same year (UNAIDS, 2016). This illustrates the impact of HIV, despite the numerous global, regional and national interventions that have been implemented since its discovery.

There are about 7 million people living with HIV in South Africa. Among adults aged 15 years and above, the rate of new infections is higher in females than in males (Zuma et al., 2016). Of 6.7 million adults aged 15 and over who are infected, women aged 15 and over account for 4 million of those living with HIV in South Africa (UNAIDS, 2016). The province of KwaZulu Natal has been reported to have the highest rate of HIV prevalence in South Africa with 14.1% of young people and 16.5% of the general population being estimated to be HIV positive (Shisana and Simbayi, 2002).

Risky behaviours that put young people, including university students, at risk for HIV infection such as experimentation with unprotected sex and sex with multiple partners (Gayle et al., 1990) ,

are still common. This is despite the wide availability of awareness campaigns and HIV prevention interventions. Further, the early onset of sexual activity is associated with increased sexually transmitted disease infection, pregnancy, induced abortion, multiplicity of partners, and reduced condom and oral contraceptive use" (Ma et al., 2009: 6). University students are more likely to be particularly at risk due to their newly found sense of independence as well as alcohol and drug use, which can result in impaired decision making about sexual choices (Gayle et al., 1990). Although the existence of HIV on university campuses is well documented (Nguyen-Dinh et al., 1987; Galye et al., 1990; Hightow et al., 2005; Heeren et al., 2007; Ma et al., 2009), there is a dearth of statistics of HIV infection on campuses.

Culture as a driving force of the "gendered" epidemic

Statistics show that women are disproportionately affected by HIV when compared to their male counterparts and a number of factors have been attributed to this. Biological, socio-economic as well as cultural and contextual factors contribute to the vulnerability of women when it comes to HIV infection (Casale et al., 2011). Zulu culture is characterised by gender inequity, transactional sex, the socio-cultural *isoka* ideal of multiple sexual partnerships (Varga, 1997) , lack of discussion on matters of sexuality in the home and between sexual partners, the conditioning of both men and women to accept sexual violence as 'normal' masculine behaviour along with the 'right' of men to control sexual encounters (Krige, 1936) and the existence of increasingly acrimonious and debated gender scripts (Leclerc-Madlala, 1994).

"Socio-cultural beliefs about appropriate sexual conduct have encouraged young women to be sexually available to partners and allow male partners to have sexual decision making authority" (Casale et al., 2011: 56) in South Africa. Moreover, most HIV prevention methods do not allow for autonomous decision making (Harrison et al., 2001) and this puts women at a distinct disadvantage. Women still need to negotiate condom use with their partners who may or may not agree to use a condom. "This unequal power dynamic is rooted in prevailing patterns of gender socialisation, and also in low overall levels of female empowerment" (Harrison et al., 2001: 69). Therefore, gendered expectation of behaviour in Zulu culture plays a role in the vulnerability of women (Harrison, 2008). Although other researchers (Larkin et al., 2006; Bhana and Pattman, 2009) argue that females are not always submissive and passive participants in sexual relationships that may appear unequal, a woman's lower status can leave her more exposed to infection (Türmen, 2003).

Zulu culture demands that young women display good behaviour or '*ukuziphata'*. In referencing *'ukuziphata'* reference is made "to a young woman's 'inappropriate' behaviour, which could include having sexual relations with more than one partner or simply not remaining a virgin" (Harrison, 2008: 181), although young men do not face the burden of this expectation. Women are often placed at a disadvantage because even when they are virgins, they often have to prove their virginity to their male sexual partners (Leclerc-Madlala, 2001; Selikow et al., 2002).

Further, the current neo-traditionalist discourse within South Africa contributes to the uncurbed HIV prevalence (Harrison et al., 2001) . This refers to the application of 'cultural' approaches to modern contexts to manage young people's sexuality, particularly in Zulu culture (Harrison, 2008). However, emphasis on efforts such as abstinence or virginity testing as HIV prevention methods have tended to restrict sexuality and reinforce gender inequality, rather than educate and prepare young people for sexual life (Harrison, 2008). The high prevalence rate among young people and in particular women in South Africa bears testament to the fact that fewer young people are abstaining from sexual intercourse and as such, empowering young women with the correct information about sexuality should be prioritised.

Zulu culture systems

This discussion leads to the observation that HIV and AIDS is not only a biomedical entity, but also a cultural construction. It is imperative, therefore, to consider how HIV and AIDS is perceived in the Zulu cultural systems as well as the metaphors, myths and ideologies that cultural members use to understand and respond to the epidemic.

In Zulu culture, "disease, especially a contagious disease of epidemic proportions, is a phenomenon heavily laden with meanings that shift, expand and change as the epidemic grows" (Leclerc-Madlala, 1994: 38). Therefore, although the term "AIDS" may be a relatively general clinical term encompassing a number of illnesses, it has enormous traditional connotations (Leclerc-Madlala, 1994). Culturally, a woman is perceived as being naturally unclean or 'dirty' and the Zulu call this 'dirtiness' '*umnyama',* which denotes an infectious pollution or a "mystical force most often associated with women" (Ngubane, 1977: 76). This 'dirtiness' is perceived as the cause of the trouble that befalls the community, therefore the symbol of HIV and AIDS in Zulu culture is the concept of a naturally 'dirty' woman that is expressed by and associated with the theme of tainted and contaminating sexual fluids (Leclerc-Madlala, 2001). Krige (1936) suggests

that in Zulu culture, disease is signified by its visible symptoms and the assumption is that when there are no symptoms, there is no disease. Menstruation is therefore seen as the visible sign of the cleansing of the 'dirt' that women carry (Leclerc-Madlala, 2002). This validates the perception that women can 'contaminate' men with the dirt they carry inside of them.

The vagina is the primary site of male pleasure as well as being the site or passage of birth (Douglas, 2003). Beyond the connotations associated with pleasure there are meanings that increase psychological value to dry and 'clean' vaginas (Leclerc-Madlala, 2002). "A dry vagina negates the fears conjured up by associations of female wetness with 'dirt' related to illnesses of all kinds that may have descended from other parts of the body" (Leclerc-Madlala, 2002: 92). Further, women have adopted the use of dangerous items such as Jik (bleach), Dettol or Savlon (topical antiseptics) to make a douche that is believed to cause the vagina to tighten to make sexual intercourse more pleasurable for men (Leclerc-Madlala, 2001; Selikow et al., 2002; Karim, 2005). These perceptions have led to practices such as virgin cleansing, which Leclerc-Madlala (2002) defines as "sexual intercourse with a virgin, said to be a way in which a man thought he could obtain a measure of 'strength' against HIV infection" (Leclerc-Madlala, 2002: 92). Such perceptions perpetuate young women's vulnerable to HIV infection because men who are infected with HIV believe that unprotected sexual intercourse with a virgin 'cures' HIV (Leclerc-Madlala, 2002), possibly leading to rape.

University students and their perceptions of HIV and AIDS

In a study of black young people in KwaZulu –Natal, there is a high knowledge of HIV and AIDS and the methods of its transmission and prevention among young men and women aged 15 -26 years (Varga, 1997). Young people listed unprotected sexual intercourse, multiple partners and shared razors as ways in which one can be infected with HIV while condoms, abstinence and thigh sex (*ukusoma*) were listed as effective ways of HIV prevention (Varga, 1997; Simbayi et al., 2014). Despite high knowledge of HIV and access to testing services on campus, university students remain susceptible to HIV infection (Pletzer, 2000).

Disconcertingly, scholars suggest that regardless of their high knowledge of HIV/ AIDS, many university students underestimate their susceptibility to contract the virus (Eaton et al., 2003). Negotiating sex "and decision-making were influenced, and in many cases overridden, by a complex set of social and cultural factors which outweighed the potential threat of HIV" (Varga,

1997: 92) among university students in South Africa. In traditional Zulu culture, sex play was permitted between unmarried couples, but highly regulated through thigh sex (*ukusoma)* and boys and girls were taught about sexual matters separately by elders in their group (Varga, 1997). Culturally, gender roles were emphasised with women being taught to be submissive while men learned to be outspoken and self-assured (Krige, 1936). This is often the reason that young women fail to introduce condoms or negotiate condom use in relationships as proof of fidelity and expression of love (Eaton et al., 2003).

Peer pressure has also been cited as a factor informing university students' perceptions of HIV and AIDS. In male students, peer pressure has to do with proving manliness and having multiple sexual partners "wins a young man status and admiration" (Eaton et al., 2003: 159). This practice can also be culturally justified with the Zulu tradition of *isoka*, in which a young man proves his manliness and virility by having many girlfriends (Krige, 1936). This perception exposes not only the man to HIV infection, but also the numerous girls he is likely having unprotected sex with. Women are vulnerable to peer pressure as well, with girls reported to exclude friends from conversations and activities if they have not had sex (Bhana and Pattman, 2009).

Gender based violence and coercion as well as socio – economic reasons are among the factors influence students' perception of HIV despite the high knowledge of HIV/AIDS transmission and prevention methods (Varga, 1997). Literature (Leclerc-Madlala, 1997; MacPhail, 2001; Karim, 2005) reveals that regardless of receiving correct information about risky sexual behaviour and their susceptibility to HIV infection on campus, students often default to behaviour influenced by social and cultural factors.

Conclusion

The low status of women in society places them at a distinct disadvantage in terms of negotiating safe sexual practices. This literature review has highlighted that there are social, economic and cultural factors that contribute to the high risk of young women's susceptibility to HIV infection.

The literature review further highlighted that although university students have a high knowledge of HIV as well as its methods of transmission and prevention, these social, economic and cultural factors often result in a failure to adopt HIV prevention behaviours. This is particularly true for young women who, due to gender inequity and cultural stereotypes are not empowered to negotiate

safe sexual practices with their partners. The next chapter explores the theoretical framework of the study.

Theoretical framework

Introduction

Theoretically, the study is located within the Culture Centred Approach (CCA) proposed by Mohan J. Dutta (2008). Culture plays a vital part in shaping the level of health of the individual, the family and the community (Airhihenbuwa and Webster, 2004). This study will examine how educated perceptions of cultural beliefs, values and practices impact effectiveness of HIV/AIDS communication and treatment seeking options among young Zulu women at the Howard College campus of the University of KwaZulu – Natal (UKZN).

The Culture Centred Approach is the ideal theoretical framework to employ in the study because it permits the researcher to understand how and why culture influences students' understanding of HIV and AIDS, as well as their treatment seeking methods. This, therefore, will allow the researcher to understand or make sense of the educated perceptions of HIV and AIDS among UKZN students and how their cultural beliefs, values and practices assist or hinder educated HIV communication and treatment seeking options.

What is Health Communication?

Health communication is defined as:

> "the study and use of communication plans and strategies to inform and influence individual and community decisions in ways that improve health" (Rensburg and Krige, 2011: 17).

Health communication should consider the culture of the community or society in which communication takes place, if it is to have any significant impact (Airhihenbuwa and Webster, 2004). Culture is "learned, shared, transferred inter-generationally, and mirrored in a group's values, beliefs, norms, behaviours, communication, family and social roles" (Kreuter and Haughton, 2006: 795). These definitions provide the premise from which this study will be making reference to health communications.

Dutta (2008) proposes two "distinct strands in health communication scholarship and health communication applications" (Dutta, 2008: 40); the culture sensitive approach, which perceives culture as an unchanging set of principles, beliefs and practices and the Culture Centred Approach where culture is seen as dynamic and transformative, established through the voices of the members of that culture (Dutta, 2008). This study will draw upon the Culture Centred Approach

to examine whether Zulu cultural beliefs assist or impede effective HIV and AIDS communication and treatment seeking options among Zulu young women.

The Dominant Paradigm

The dominant approach to heath communication scholarship is premised on the "expert position of the communication scholars and the object positions of the participants they study" (Foucault, 1988: 12). There is a contention that communication in the health setting is habitually theorized as a top-down approach (Lupton, 1994).

Health campaigns that are located in the dominant paradigm often fail because the dominant approach has individual level focus, perceptive bias and assumes a rational thinker, therefore it does not consider an environment where behaviour is influenced by the cultural context (Dutta, 2008). This is what sets the Culture Centred Approach (CCA) apart from the dominant paradigm. The CCA is relevant for this study because it moves away from the view of culture as a barrier to particular behaviour and instead, acknowledges that narratives of health become meaningful when understood in terms of culture. Using the lens of the CCA, the researcher aims to understand the narratives that exist in Zulu culture. The study further seeks to understand how these narratives inform perceptions of women as carriers of disease and how these perceptions ultimately contribute to the disproportionately high HIV infection rates among young women.

The Culture Centred Approach

The culture centred approach (CCA) builds on the criticism offered by Airhihenbuwa (1995) and Dutta- Bergman (2004) to the dominant models of health communication (Dutta, 2008). The CCA is concerned with the ways in which the health experiences of the cultural members are marginalised, constructed as deviant or abnormal, and are accompanied by a minimal access to healthcare resources (Dutta, 2008).

Central to the CCA is the understanding that communicating about health comprises the negotiation of common meanings rooted in "socially constructed identities, relationships, social norms and structures" (Dutta, 2008: 55). These connections, identities, structures and social norms are interrelated (Dutta, 2008). Therefore, the CCA provides an alternative angle of theorizing health communication by suggesting that communication about health occurs in the relationship between structure and the agency of the participant.

Culture is seen as a critical aspect that must be central to health communication because the recognition of culture in this aspect results in success of health communication interventions (Airhihenbuwa and Webster, 2004) . Culture plays an active role in influencing the level of health and well-being of the individual, the family and the community (Airhihenbuwa and Webster, 2004). This is particularly significant in the context of Africa, where the values of extended family and community considerably affect the behaviour of the individual (Airhihenbuwa and Webster, 2004). Cultural factors that influence individual behaviour are well documented and vary from beliefs and values about sexuality (including when to become sexually active and the number of sexual partners), condom use, and the cultural definition of sexual orientation to the cultural practice that encourages vagina dryness for enhanced friction for the penis (Kun, 1998; Leclerc-Madlala, 2002; Shisana & Simbayi, 2002; Niang, Tapsoba, et al., 2003). Therefore the CCA underscores the need to develop programmes in ways that are consistent with a community's cultural framework (Airhihenbuwa, 1995).The current study assumes that Zulu students' behaviour is influenced by their culture and seeks to understand whether this influence is positive or negative in relation to their perception of HIV/ AIDS and treatment seeking behaviour.

One of the main principles of the CCA is the interaction between structure, agency and culture in the creation of meanings by cultural members, in this instance Zulu university students.

Structure

Structure denotes those organisations, institutions and systems in society which "determine how that society is organised as well as the rules on how people engage with each other and the structures around them" (Dutta, 2008: 62). Structures may refer to clinics or hospitals, road infrastructure, and any basic health facility. It is important to note that structures can encourage or limit certain health behaviour in individuals and in the CCA, the emphasis is placed on acquiring a sense of understanding of those structural processes which limit the possibilities of health for community participants (Dutta, 2008). In the context of this study, structure refers to health facilities such as clinics and hospitals. The study aims to understand how the cultural beliefs of young Zulu people influence their interaction with these structures in light of their perception of HIV and AIDS and their treatment seeking options.

Agency

The CCA seeks to alter the status quo (dominant paradigm) by interrogating its practices. Dutta (2008) posits that agency is one of the key elements of this approach. Agency denotes "the active participation of cultural members in the co –construction of meanings and meanings based on these actions" (Dutta, 2008: 87). This infers that not only does agency influence culturally available meanings, it further aims to use the actions of individuals and groups to change these meanings (Dutta, 2008). The CCA employs dialogue with community members to co –create meanings of health and their perceptions of health problems (Dutta, 2008). This dialogical process emphasises the understanding that community members are agents of change who encounter the structural processes in their daily lives (Dutta, 2008). Therefore agency, in turn, creates, alters and transforms structural circumstances (Dutta, 2008). This study seeks to understand the social construction of HIV and AIDS in the Zulu cultural system as well as the metaphors, myths and ideologies that cultural members use to understand and respond to the epidemic. The researcher will conduct focus groups with young Zulu men and women to understand whether their culture influences their behaviour as well as observe whether this influence is positive or negative in relation to their perception of HIV and AIDS and treatment seeking behaviour. In this way, the researcher conforms to the CCA's principle of agency because dialogue will be the means through which meanings of any existing HIV and AIDS myths will be co –created and their perceptions of treatment seeking options.

Culture

Culture is defined as "a system of interrelated values active enough to influence and condition perception, judgment, communication, and behavior in a given society" (Abdullahi, 2011: 8). Therefore the interrogation of culture provides a different set of criteria for the assessment of the inferred norms engaged by the dominant paradigm of health communication scholarship (Dutta, 2008). This study aims to interrogate Zulu cultural beliefs that are held by young people belonging in this cultural group. It aims to understand how these cultural beliefs influence their perceptions of HIV and AIDS as well their treatment seeking options.

The CCA is a wide theoretical framework that has the following characteristics; voice and dialogue, structure, context and space, values as well as criticism (Dutta, 2008). This study will focus on the first three of these:

Voice and dialogue

The Culture Centered Approach (CCA) stresses the construction of a communicative space for dialogue with formally marginalized participants into the ways in which issues of health are understood, interpreted and communicated. However, it is imperative to note that this emphasis is not on "being a spokesperson for the subaltern, rather the culture centered approach is built upon a dialogical engagement between the researcher and the community" (Dutta, 2008: 61). Therefore, the CCA encourages the researcher to understand subaltern perspectives rather than imposing solutions to interventions (Dutta, 2008). Understanding the subaltern voice is rooted in the emphasis on human agency, which is promoted by the CCA. Agency denotes the "capacity of human beings to interact with structures in order to create meanings; such meanings provide scripts for interacting with structures, sustaining these structures and for transforming them" (Dutta, 2008: 61). In this study, subaltern voice refers to young Zulu students who are beneficiaries of HIV and AIDS interventions on campus. Such interventions include the provision of condoms and HIV and AIDS awareness campaigns. However, the CCA posits that such interventions prove ineffective if their provision is not informed by subaltern voices.

Structure

Structure denotes those organisations, practices and systems in society that define how a society is ordered, how it works and how individuals get access to healthcare (Dutta, 2008). Structure can limit or encourage access to healthcare. The CCA is concerned about how structures in a community can limit agency among community members (Dutta, 2008). Structures "constrain human action by setting up communicative barriers" (Dutta, 2008: 62). Structure exists in a dialectical relationship with agency. In the context of this study, structures refers to clinics that students access on campus. The researcher is interested in understanding how these structures encourage or limit certain health behaviour among students as well as how Zulu cultural beliefs influence access to these.

Context and space

Context refers to the local and immediate environments within which cultural members make choices (Dutta, 2008). Contexts are where individuals' health meanings, health values, health beliefs and health practices are formed and shaped. Dutta (2008) posits that contexts connect the individual members to the cultures within which they live and simultaneously offer opportunities for enacting cultural change through the practices individuals adopt in response. Contextual

experience of health, the negotiation of health meanings and the interfaces with structures also may be located spatially (Dutta, 2008). In this study, the context refers to the modern environment that students negotiate together with their traditional backgrounds, which has formed their beliefs and values regarding health. The study is interested to find out how the negotiation of health meanings and their interaction with structures are located in the academic space.

Conclusion

Culture is critical in influencing the level of health and well-being of the individual, the family and the community. Therefore, if health interventions are to be effective in changing behaviour, they need to be culture sensitive. The CCA is concerned with the ways in which the health experiences of the cultural members are marginalised, demonised as deviant and accompanied by lack of access to health facilities. Thus health interventions that take into consideration the cultural context have a better chance of impacting behaviour among cultural members.

Methodology

The methodology section explains to the reader how the researcher intends to find answers to the research questions (Struwig and Stead, 2013). Therefore, this section explains the research methodology and method that will be employed in this research. Research method refers to the processes used to execute the research project while research methodology denotes the discipline that make use of these processes (Struwig and Stead, 2013). The chapter will focus on the research paradigms, the research design, sampling frame, data collection and data analysis procedures that will be employed in the research.

Research paradigm and design

This study aims to understand how culture influences the educated perceptions of Zulu students studying at Howard College of the University of KwaZulu –Natal in relation to HIV/AIDS communication and their treatment seeking options, therefore this qualitative study takes on an interpretive paradigm. A paradigm embodies a worldview that describes, for its holder, the nature of the "world" and the individual's place in it (Guba and Lincoln, 1994). Interpretivism looks for "culturally derived and historically situated interpretations of the social life world" (Crotty, 1998: 68). Therefore interpretivists take a "subjective perspective and tend to have a nominalist ontology" (Clarke, 2010: 3). Qualitative research is defined as:

> "any research that produces findings not arrived at through any statistical procedures or other means of quantification" (Strauss and Corbin, 1990: 11).

The term "qualitative research" does not describe a single research method as there are numerous research methods related to this type of research (Struwig and Stead, 2013). Therefore qualitative research can refer to research about a person's life, emotions or lived experiences (Strauss and Corbin, 1990). Thus qualitative researchers seek to understand the context or setting of participants by visiting this context and gathering information personally. Researchers further interpret what they find. "Personalised analysis of data can provide important understandings about individual subjects as well as suggestions for the advancement of knowledge" (Neuman and McCormick, 1995: 4). Qualitative research works where there is a requirement to cultivate an initial understanding of something. A primary objective of qualitative research is to generate hypotheses that may be tested through formal research (Struwig and Stead, 2013). The process of qualitative research is largely inductive as the researcher generates meaning from the data collected in the

field (Creswell, 2013). This study will consider the perceptions of the cultural beliefs, practices and values that contribute to the continued high infection rates among young women in the University of KwaZulu Natal's Howard College.

Sampling Technique

The most accurate way to obtain information is from a sample than from an entire universe or population (Struwig and Stead, 2013). There are two main types of sampling techniques namely: non –probability sampling and probability sampling. This study employs the non –probability sampling technique, also called convenience sampling where "the probability of any particular member of the population being chosen is unknown and the selection of sampling units is arbitrary as researchers rely heavily on personal judgment" (Struwig and Stead, 2013: 116). Snowball sampling was also employed to ensure that the researcher secured at least 8 participants for the focus group. Snowball sampling is defined as a method where initial participants are requested to suggest other people who may have information on the topic under discussion (Struwig and Stead, 2013). The population refers to the "combined total of all the elements the researcher is focusing on" (Struwig and Stead, 2013: 114). The population in this study refers to the Zulu students in Howard College at UKZN. The sampling unit "consists of the things or people that are the focus of the study" (Struwig and Stead, 2013: 114). In this study, the sampling unit refers to students of KwaZulu-Natal. Participants were selected based on availability, accessibility and cooperation. This technique is ideal for this study because participants should be conveniently selected only if they have something in common. The main requirement of participants in this study is that they should be postgraduate Zulu students of Howard College in the University of KwaZulu- Natal because the researcher aims to understand the Zulu culture's influence on HIV/AIDS communication as well as it influence on the student's treatment seeking options.

Methods of Data Collection

Data collection in this study relied on one focus group discussion. Focus groups are set up by researchers to conduct group interviews for the purposes of collecting data on a particular research topic (Hopkins, 2007). They are a type of group interview, which exploits communication between research participants for the purpose of generating data (Kitzinger, 1995). Focus groups rely on the methodological questioning of several people all together in a formal or relaxed setting (Fontana and Frey, 2000). A distinct advantage of using focus groups as a data collection method is that they can "help in facilitating access to tacit, uncodified and experiential knowledge as well

as opinions and meanings of the participants" (Hopkins, 2007: 529). Therefore, focus groups can provide the researcher with more in-depth information on the subject under investigation, in this case the educated perceptions of Zulu students on HIV and AIDS and their treatment seeking options. A disadvantage of using focus groups can arise when they are convened to discuss a topic that participants consider to be sensitive as some respondents may be unwilling to talk openly about their thoughts, which could result in incomplete data (Struwig and Stead, 2013). Respondents in a focus group may also be affected by 'group think'. 'Group think' refers to "deterioration of mental efficiency, reality testing and moral judgment that results from in-group pressures" (Janis, 1982: 9). Although researchers (Fern, 1992; Morgan, 1996; Hopkins 2007) have not agreed on the ideal number of respondents, it is imperative to note that for purposes of proper management of a group, a focus group should consist of 10 members or less. Therefore, the focus group in this study comprised of 10 students, seven of which were female and three were male.

Data Analysis

Data analysis in this study will be conducted through the use of thematic analysis. Thematic analysis is a technique for classifying, examining "and reporting patterns or themes in data" (Braun and Clarke, 2006: 79). Thematic analysis is ideal for this study because it is a method that works both to replicate reality and to "unpick the surface of reality" (Braun and Clarke, 2006: 81). This means that thematic analysis allows the researcher to not only understand the representations as presented by the data, but to interrogate this reality.

Ethical considerations

When conducting research, it is important for the researcher to take into consideration some research ethics. These ethics serve as procedures on how to conduct research in a principled and suitable way (Struwig and Stead, 2013).

To meet ethical requirements for this study, ethical clearance was obtained from the UKZN Humanities and Social Science Research Ethics Committee. Further, each participant in the focus was required to sign a consent form if they agreed to participate in the study and if they were comfortable with having the discussion recorded. The nature of the study as well as the contents of the consent form were explained prior to the beginning of the discussion. Participants were assured that they could leave at any time if they felt uncomfortable with answering any questions. Participants' names were kept confidential even when the data was transcribed. Instead of using their names, participants were tagged as respondent 1, respondent 2 etc.

Limitations

Initially, two focus group were planned to gather views on the Zulu culture's influence on students' perceptions of HIV and AIDS and their treatment seeking options at UKZN, Howard College. However, due to protest actions which resulted in constant suspension of academic activity on campus, only one focus group was convened. This was a major limitation of the study because it resulted in a reduced sample size.

Research findings and analysis

Data analysis refers to the process of methodically probing and arranging the interview transcripts, field notes, and other materials to come up with findings (Bogdan and Biklen, 1997). Interpretation, on the other hand, encompasses "explaining and framing ideas in relation to theory, other scholarship, and action, as well as showing why the findings are important and making them understandable" (Bogdan and Biklen, 1997: 147). Therefore, this section of the study aims to present and analyse the findings on the Zulu culture's influence on educated perceptions of HIV and AIDS and treatment seeking options among students at Howard College, University of KwaZulu Natal (UKZN). The findings are presented using thematic analysis and this process minimally consolidates data and describes it in rich detail (Braun and Clarke, 2006).

This section presents findings from a focus group that was conducted to understand how Zulu culture influences educated perceptions of HIV and AIDS among students as well as whether their cultural beliefs influence the way they seek treatment. Three major themes came out of the focus group discussion. The themes were defined as follows: firstly, UKZN students' views on HIV and AIDS; secondly culture and its influence on the students' perceptions of HIV and AIDS, and finally, the choice between the traditional and biomedical approach to treatment.

Discussion and analysis of data

Students' views on HIV

Prior to exploring the subject of Zulu culture and its influence on UKZN students' perceptions of HIV and AIDS, the researcher was interested in finding out their understanding of the virus and the disease it causes. This was necessary to assist the researcher to understand how students perceive the virus itself and if these perceptions are purely logical or informed by their culture. The researcher was also interested to know if cultural beliefs assist or impede students' perception of HIV and AIDS communication, in the event that findings show that culture is a factor in influencing their perception. Culture, as defined in the theoretical framework of this study, is "learned, shared, transferred inter-generationally, and mirrored in a group's values, beliefs, norms, behaviours, communication, family and social roles" (Kreuter and Haughton, 2006: 795).

Because culture is shared among community members and transferred inter-generationally, it tends to influence the way of life and decision making on health issues among cultural members (Airhihenbuwa and Webster, 2004). Culture also allows cultural members to form and share

meanings in their environment. Therefore, exploring the UKZN students' perceptions of HIV allows the researcher to understand how HIV is understood in the context of Zulu culture. Literature (Varga, 1997; Zuma et al., 2016) suggests that students have high knowledge of HIV and methods of its transmission. In previous research (Varga, 1997; Simbayi et al., 2014), students listed unprotected sexual intercourse, multiple partners and shared razors as ways in which people can contract HIV.

However, findings in this study suggest that while students may have high knowledge of HIV and AIDS transmission, it does not translate to high knowledge about AIDS treatment and care. Respondents believe that HIV is curable and that a cure is being withheld by drug manufacturing companies mainly for profit.

> *It's a manufactured virus…. I don't believe that it's not curable cos trust me, the rich, they do everything possible to survive. A virus can be cured whereas a disease it's debateable.* (Respondent 2: 14 October 2016)

> *Well, I didn't wanna go to where he went, but he kind of has a point though. There's a cure somewhere but there's a market for AIDS now with all this AIDS awareness thing, cure AIDS how...was it five pills has now become one pill, if you miss that pill you have to go back to five pills, I mean it's a system, I mean, I just disagree that you can't cure it. It is curable and someone is just holding it until the right time. A virus is curable.* (Respondent 3: 14 October 2016)

The literature reviewed in this study (Varga, 1997; Simbayi et al., 2014; Pletzer, 2000; Bhana and Pattman, 2009) does not make reference to students' knowledge of whether HIV and AIDS is curable or not, which is a possible gap in research. This finding further implies that cultural beliefs do not influence the understanding of HIV among participants in this study. Educated beliefs about the virus are that a cure is available, but is being withheld for profit by drug manufacturing companies. Thus, employing the CCA is critical in this study because this approach emphasizes the construction of a communicative space for dialogue with subaltern participants. Therefore, the importance of voice and dialogue cannot be overemphasized in this context because if health communication and interventions targeting university students do not take into account their voice as an expression of their views and beliefs, then such misinformation goes uncorrected.

Influence of culture on perceptions of HIV and AIDS

Statistics show that women are disproportionately affected by HIV when compared to men (Simbayi et al., 2014; UNAIDS, 2016) and culture has been cited as one of the factors that account for this (Casale et al., 2011). Culture is plays a vital role in influencing the health of an individual, family and the community, especially in the African context where values held by the extended family and the community largely contribute to influence the individual (Airhihenbuwa and Webster, 2004). Culture informs traditional practices which, in turn, inform how people live. This study applies the Culture Centred Approach (CCA), which essentially emphasizes the understanding that communicating about health comprises the negotiation of common meanings which are embedded in socially fabricated identities, relationships, social norms and structures (Dutta, 2008). This observation by (Dutta, 2008) implies that context and space influence the meanings derived by cultural members. Therefore, this study seeks to understand cultural beliefs that result in mythical meanings that drive the uncurbed rates of HIV infection among young women.

Literature suggests that gendered expectation of behaviour in Zulu culture plays a role in women being disproportionately affected by HIV when compared to their male counterparts (Krige, 1936; Ngubane, 1977; Leclerc-Madlala, 1997; Leclerc-Madlala, 2001; Leclerc-Madlala, 2002; Douglas, 2003; Karim, 2005). This is because women are socialised to be submissive to men and men retain decision making power in relationships (Harrison, 2008). In keeping with literature, some students agreed that social norms and gendered beliefs did put young women at a disadvantage when it came to negotiating condom use with their sexual partners (Harrison, 2008).

> *Well ya, mina, from where I stand, I believe that culture has a big influence on the spread of HIV, but at the same time it depends on you individually and beliefs that you have and your values. For example, from where I come from a majority of men, this whole thing of using a condom, testing and circumcision it's not something they do. This whole thing of having many girlfriends, they do that. You find that you are dating that Zulu man and then you starting to negotiate about sex and everything you find that the guy wouldn't wanna use a condom so because of tradition as they are saying it was something that was not done*

*before, they will tell you that NO. Even the circumcision part, you find that they will tell you that our fathers never did that. (*Respondent 10: 14 October 2016)

Also because other men are so cultured to such an extent that they wouldn't use a condom, they would tell you that why do you want to use a condom, don't you trust me; so those things you find that females don't even negotiate to use a condom or they don't even have a say to suggest the use of a condom and for a guy to agree. So they end up agreeing to not using a condom (Respondent 6: 14 October 2016)

However, some respondents argued that culture in itself does not influence the high prevalence of HIV infection among women, but suggested that it was the loss or selective application of certain traditional elements of the Zulu culture that perpetuates HIV infection among women. This is in keeping with literature, as observation has been made that the neo-traditional approach within South Africa contributes to the uncurbed HIV prevalence because this approach seeks to manage young people's sexuality, rather than educate and prepare them for sexual life (Harrison et al., 2001).

But also the loss of that particular traditional element can lead to it because umkhosi womhlanga, umhlonyana and ummemulo, all those things are done as measures to keep you in line, it's not just kinda like to cage you in, it's been done throughout the years so as a way of avoiding certain things, because back in the day they weren't worried about AIDS, but they were worried about pregnancy and all that stuff. If you are not married, you couldn't have a baby in our culture. So now with the loss of that, teenagers whether boys or girls, they can just do whatever. (Respondent 7: 14 October 2016)

Respondents further likened culture and traditional practices to religion because they provide guidelines for expected behaviour. In this context, respondents explained that cultural practices were in place to guide behaviour, just as in any other religion. Students observed that HIV is a moral issue and not a cultural issue. Scholars (Gifford, 1994; Garner, 2000; Takyi, 2003) have observed that in modern-day Africa, church participation is significant for the investigation of general reproductive health "not so much as a direct measure of religious piety, but also as an indicator of social exposure and interaction" (Takyi, 2003: 1222). Therefore, there is a need to further investigate the influence of religion as an indicator of social exposure and interaction among university students.

*You see things like that (*reference to umhlonyana[1], umemulo[2] and virginity testing at the annual reed dance*), we have such events and traditions to bring up our children to be disciplined. These things help us to be very disciplined in society. It's like church, the Catholic Church, the Anglican Church there's certain things you do and certain things you don't do to keep discipline to keep our kids in line. So like the reed dance, females look forward to it. Those stay virgins until because it's a huge thing there's status around it (*Respondent 2: 14 0ctober 2016)

It's just wrong on all levels, in terms of a moral stand point as well as for you as a woman because once you have a child at an early age its easier for another man to have a child with you at the end of the day, the whole point like lobola was to thank parents for raising a daughter well not to buy [a wife] so now you have 4 kids, which man would actually bring the same amount of cows or whatever to thank the parents? Obviously, a good job was not done. (Respondent 7: 14 October 2016)

The thing is that people will say the Zulu tradition has resulted in higher HIV rates, but that's not true. All religions have the same moral values about virginity etc. And it's all linked... But the reason of increasing rates of HIV is a lack of morals. (Respondent 3: 14 October 2016)

These findings illustrate that participants in this study do not believe that culture plays a significant role in the high rates of HIV among women. This could be the result of their interaction with structure on campus and in their day to day living as residents in an urban area. It emerged that the participants in this focus group were not culturally oriented, despite a significant number of them claiming to have one parent, often the father or grandfathers, who was very culturally oriented. While the virgin cleansing myth was briefly mentioned, participants were quick to clarify that this was common in the early days of HIV discovery and had led to increased reports of rape.

[1] Umhlonyana was defined by respondents as a ceremony held for girls at their 16th birthday.

[2] Umemulo was defined by respondents as a ceremony to celebrate the 21st birthday for girls. Hosted by parents to "thank" their daughters for good behaviour.

*There were beliefs that if you engage in sexual activity with a virgin you will be cured. (*Respondent 2: 14 October 2016)

*Like during the early ages of HIV when it first started. (*Respondent 7: 14 October 2016)

The rate of rape actually increased then. (Respondent 9: 14 October 2016)

Students tagged themselves "Zulu-lite", a term that explains their detachment to the core values of the Zulu culture. Moreover, due to this detachment from their culture, respondents were unaware of any myths that may still exist which contribute to the continued rise of high HIV prevalence rates among women. Participants stated that in the event of illness, they go to clinics for treatment which implies that in this case, structure assist access to health care.

Traditional vs. Biomedical approach to treatment

Literature suggests that when it comes to treatment seeking options within the Zulu culture, community members can access either medical doctors or traditional healers (Petzer and Mngqundaniso, 2008). Statistics reveal that an estimated 85% of Black South African people consult traditional healers in both rural and urban areas largely because healers are "more easily accessible geographically and provide a culturally accepted treatment" (Petzer and Mngqundaniso, 2008: 370). In keeping with literature, respondents concurred with this finding although a few students mentioned that they would go to a clinic rather than to a traditional because of the way they were raised. Although respondents did not admit to going to traditional healers themselves, they did state that they considered traditional healers and doctors as being fundamentally similar.

> *You see, for me I believe biomedical practitioners and inyanga are the same thing. It's just that one uses herbs and leaves and one uses pills. The end results are the same thing*. (Respondent 2: 14 October 2016)
>
> *Let's say you believe in culture and at the same time you go to western doctors. It depends on what you personally think your sickness needs which intervention. If your parents say go to a clinic you be strong with your feelings and state that you don't think a doctor or nurse will help you* (Respondent 10: 14 October 2016)
>
> *Cos we shouldn't look at traditional healers as people who are backward because they do the same thing that doctors do, but in their own environment* (Respondent 1: 14 October 2016)

> *See the media is a very powerful tool guys, it has managed to paint our beliefs, as Africans as a whole as backward, of which it is not, cos they wanna perpetuate their beliefs and their way of living and indoctrinate us. I always ask myself why HIV and AIDS higher is on the youth than our parents and our fore fathers and yet they say it's been there…why is that? It because when it comes to tradition, some things require traditional assistance whether we like it or not as Africans. For some things we need to consult with tradition* (Respondent 2: 14 October 2016)

These findings imply that culture does influence treatment seeking options among students at Howard College, UKZN. This makes it imperative for health communication to be culturally sensitive if it is to be accepted by cultural members. Participants spoke strongly against communication that labels cultural practices as deviant and argued that culture is an identifying marker for them. This makes it clear that such communication would be rejected by cultural members who share this view, which emphasises the importance of voice and dialogue as proposed by the Culture Centred Approach.

Conclusions

This study explores the influence of Zulu culture on educated perceptions of HIV and AIDS among Zulu students at Howard College, UKZN. The study further examines their treatment seeking options in relation to Zulu cultural beliefs. The researcher sought to understand whether Zulu cultural beliefs assist or impede effective HIV and AIDS communication and treatment seeking options for young women at Howard College, UKZN. The study employed the Culture Centred Approach (CCA) proposed by Dutta (2008) because it underscores the need to develop programmes in ways that are consistent with a community's cultural context (Airhihenbuwa, 1995).

The literature outlined the HIV landscape globally, regionally and nationally and further discussed culture as a driving force of the "gendered" epidemic. Moreover, the literature highlighted Zulu cultural systems and university students' perceptions of HIV and AIDS. The study is framed by the three characteristics of the CCA; namely voice and dialogue, structure as well as context and space. The CCA emphasises that if health communication is to be successful, it must take into account the subaltern voice which is facilitated through dialogue. This is important because it leads to the understanding of how formally marginalized participants understand, interpret and communicate health meanings (Dutta, 2008). Further, effective health communication must consider structure because it determines how individuals access health care, therefore structure can either inhibit or promote access to health care (Dutta, 2008). Context and space are a critical aspect to consider because they define the environment where health meanings, beliefs and practices are formed and shaped (Dutta, 2008).

A focus group discussion with male and female postgraduate students of Howard College, UKZN was employed as a data collection method for this study. The focus group served to highlight the students' educated perceptions of HIV and AIDS and their treatment seeking options. This section presents the conclusions from this research. The sample size was too small to generalize findings from this study, however, limited recommendations for further research will be suggested.

Firstly, it emerged that respondents' perceptions of HIV are viewed from a logical perspective. Respondents contended that HIV is a curable disease and argued that the cure is being withheld by drug companies for profit. Secondly, it was discovered that cultural beliefs significantly influence the disproportionate HIV infection rates among young women. It emerged that young women felt

that gendered expectation of behaviour placed them at a disadvantage when it came to negotiating condom use with their sexual partners. Cultural practices such as *isoka* were also mentioned as perpetuating the high rates of HIV. However, some participants argued that culture on its own does not promote high HIV infection rates. It emerged that respondents believe that the loss of and selective application of certain cultural practices resulted in the continued high HIV infection rates. Data showed that educated perceptions of HIV infection are that it is a moral issue and not a cultural issue. Participants likened culture to religion in that in keeping culture, one must adhere to certain expected behaviour. Participants taking part in this discussion argued that failure to observe certain cultural practices such as abstinence, which is enforced through virginity testing, showed poor moral judgment. Therefore, there is a need to further investigate the influence of religion as an indicator of social exposure and interaction among university students. While the researcher was interested in understanding cultural myths that exist in Zulu culture, which perpetuate HIV infection among women, it emerged that the students participating in this study did not believe that such myths still exist. This leads to the conclusion to the conclusion that educated perceptions of HIV and AIDS are not founded on cultural myths among the participants taking part in this study.

Finally, findings reveal that culture does not influence treatment seeking behaviour. While a number of respondents said they would consult a medical practitioner over a traditional healer, all of them agreed that a traditional healer and a medical doctor are essentially the same thing. This finding leads to the conclusion that adopting a biomedical approach to treatment does not mean a denunciation of Zulu identity among participants in this focus group. Participants suggested that some illnesses can only be healed by traditional healers.

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