

**Engaging the Fertile Silence: Towards a Culturally sensitive
Model for dealing with the HIV and AIDS Silence.**

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DECLARATION

I declare that this thesis, unless specifically indicated in the text, is my own original work which has not been submitted in any other University.

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2009

ABSTRACT

This thesis critically examines one of the major hindrances to dealing adequately with the HIV and AIDS problem facing Africa – the issue of silence. The study has examined the hypothesis that there are cultural factors underlying the silence that surrounds the disease, which when investigated and identified, will provide cues for breaking the silence and a way forward for dealing with the HIV and AIDS epidemic. The study utilises the concept of ‘cultural context’ proposed by Hall and ‘dimensions of culture’ postulated by Hofstede, to investigate the cultural reasons behind the HIV and AIDS silence among the Zulu people in and around Pietermaritzburg in the Kwazulu Natal province of South Africa.

Testing these theories in the field with participants in a community-based HIV and AIDS Project called the Community Care Project (CCP) the study found that cultural contexts strongly influence silence around HIV and AIDS. In terms of dimensions of culture, the area was found to exhibit high power distance, low uncertainty avoidance, high collectivism and is feminine in nature in terms of assertiveness, but having high gender inequality (high masculinity in terms of gender egalitarianism). The analysis of the results of the field research revealed that each of the dimensions of culture contributes in various ways to the silence around HIV and AIDS

The study argues that there are two kinds of silence, namely *barren silence* and *fertile silence*, existing on a continuum. In a low context culture, barren silence is the silence that exists as absence, because when people do not talk about the issue, then there is no communication at all about the issue. In a high context culture, fertile silence is the silence that exists as presence, because when people do not talk about the issue at hand, they may still be communicating about it – either through non-verbal signs, or through coded language.

The concepts of barren and fertile silence provide new insights into the issues of stigma and discrimination. Reasons for the silence included stigma, rejection, gossip, witchcraft,

shame, blame, discrimination, secrecy, judgement, suspicion and taboo. It was found that each of the themes had something to do with stigma and discrimination, and lead to infected persons keeping silent about their HIV and AIDS status.

In the final chapter, the research shows that when an intervention such as CCP takes the question of fertile silence seriously, then it is much easier to break the silence around HIV and AIDS and to deal with stigma and discrimination. The research therefore concludes that the concept of 'Fertile Silence' and 'Barren Silence' has provided us with clues as to how to 'break the silence' around HIV and AIDS in a high context culture such as that of Africa.

DEDICATION

This thesis is dedicated to my father, Benjamin Yaw Okyere, my late mother Abena Nyantakyiwah and my late grandmother, Elizabeth Akua Tonoah, who through hard work and dedication showed me the road to higher heights in education,

AND

to my family:

Beatrice, Ebenezer, Gifty, and Emmanuel,
for their love, encouragement, care, support and prayer,

AND

to the staff of

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the Community Care Project (CCP), all the members
of the HIV Support Group for their dedication to this research,

May the Almighty God richly bless you all.

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy or ARV Treatment
ARV	Anti-Retroviral (drug)
CBO	Community-Based Organization
CBOs	Community Based Organisations
CCC	Christian Community Church
CCP	Community Care Project
CHART	Collaborative for HIV and AIDS, Religion and Theology
ECAP	ESSA Christian AIDS Programme
FBO	Faith-Based Organization
FGD	Focus Group Discussion
Gogo(s)	Grandmother(s)
GoLD	Generation of Leaders Discovered
H-BC	Home-Based Care
HIV	Human Immunodeficiency Virus
HIV/AIDS	HIV and AIDS
NAT	Newfrontier Aid Trust
NGO	Non-Governmental Organisation
NPO	Non- Profit Organisation
OVC	Orphans and Vulnerable Children
PCF	Pietermaritzburg Christian Fellowship
PEPFAR	President's Emergency Plan for AIDS Relief
PG	Project Gateway
PLWHA	Person Living with HIV and AIDS
RSBCS	Rob Smetherham Bereavement Counselling Service for Children.
SABC	South African Broadcasting Corporation
SHAPE	Sachibondu HIV & AIDS Prevention and Education
SIM	Serving in Mission
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TAC	Treatment Action Campaign
TB	Tuberculosis

UN	United Nations
UNAIDS	Joint United Nation's Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
VCT	Voluntary Counselling and Testing
WCC	World Council of Churches
WHO	World Health Organisation

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CHAPTER ONE: GENERAL INTRODUCTION TO THE STUDY

1.0 Introduction

In 2002, UNAIDS made a statement about HIV and AIDS in which they called for all possible efforts to be put in place to stop the spread of the disease, so that the task of dealing with the effects of the disease could begin. The world body dealing with HIV and AIDS said “HIV/AIDS marks a severe development crisis in sub-Saharan Africa, the worst-affected region in the world. *Even if exceptionally effective prevention, treatment and care programmes take hold immediately, the scale of the epidemic means that the human and socioeconomic toll will remain massive for many generations*” (Fact Sheet 2002: 1). The task of halting the pandemic is crucial and urgent. The task of dealing with the effects of the disease, when it is over, is equally an arduous one. An African proverb says, “The best time to have planted a tree was 20 years ago, the second-best time is now” (Dream Supporters 2006).

It is for this reason that every method of prevention must be employed to deal effectively with the HIV situation at hand (Ammann 2005: 40). One of the major hindrances to dealing effectively with the pandemic in Africa is that of the silence around the disease. It was with the purpose of drawing attention to this huge problem that the first ever World AIDS Conference to be held in Africa, in July 2000, was devoted to finding ways of breaking the silence around the disease. The conference was effective in getting governments and policy makers to see the need and begin to put in place measures to break the silence of HIV and AIDS. However, analysts have pointed out that the benefits of the conference have been observed predominantly at the levels of governments and international agencies. Silence around the disease continues to create massive walls between policy makers and the people, and among the people themselves, even in their own homes (Balch and Hollenberg 2002). Out of this situation arises stigma and discrimination around the disease, which causes further barriers to the prevention of infections, provision of the necessary care for the infected and support to families and individuals affected by the disease.

This research explores whether there are cultural factors underlying the silence that surrounds the disease which have been overlooked in the various attempts to break this silence. The hypothesis is that when such cultural factors are investigated and identified,

they will provide cues for breaking the silence at grassroots level and a way forward for dealing with the HIV and AIDS epidemic. This will also help members of the church who show willingness to be involved in HIV and AIDS work, and the activists who are involved in various HIV and AIDS community interventions, as well as affected families are dealing with the disease, to offer their services in a more appropriate and better-informed manner.

This first chapter is an introduction to the study as a whole. It provides the background, outlines the main aim of the study and identifies the problem statement to be dealt with in this research. Within this chapter I propose an hypothesis to be tested and also outline the areas of investigation in this study.

1.1 Background to the study

The problem of HIV in the world cannot be overlooked, especially in Africa, which carries 70% of the burden of the pandemic. The problem of HIV and AIDS is worse than a Tsunami because it is wrapped in silence, especially in Africa. People do not give it the attention it deserves, or which the Tsunami was given. According to the *Mail and Guardian Online*, a year after the Indian Ocean Tsunami, conservative government figures put the number of people who had died at about 216,000 from 11 countries (2005). The Tsunami was in the open, and very graphic, as people saw dead bodies on the sea shores. HIV and AIDS on the other hand is a concealed disease that is not yet a notifiable disease and so most medical personnel cannot inform relatives that the cause of death was AIDS. In this case the silence around the disease also means that people die in silence.

In the year of the Tsunami, according to the UNAIDS report, the AIDS death toll averaged 3.1 million (3,100,000) and could go as high as 3.5 million (3,500,000) (UNAIDS/WHO 2006). What this means is that in terms of AIDS deaths, there was a Tsunami every 3½ weeks. However, it is silent and we do not publicise it, and so HIV is not given the attention it deserves.

1.1.1 The South African Situation

HIV and AIDS undoubtedly presents a crisis to South Africa. The country's AIDS epidemic is one of the worst in the world, affecting all segments of society (PEPFAR

2008). Beginning with the first few patients with AIDS-related illnesses admitted to the Pretoria Academic Hospital in 1983, HIV and AIDS has today become the most rapidly spreading infective disease syndrome in South Africa (Buchel 2006: 5). South Africa records an overall HIV-prevalence rate of about 11%, according to Statistics SA. However, UNAIDS puts the figure at between 18% and 19% (18.8% in 2005 and 18.3% in 2006); this is significantly higher than the rate in sub-Saharan Africa (5.9%) and the world (1%) (Mediaclub South Africa 2007:1). Estimates of HIV prevalence among antenatal clinic attendees show even higher rates of up to 30.2% in 2005 (*see*: table 1.1.1 below).

Province	2001 prevalence %	2002 prevalence %	2003 prevalence %	2004 prevalence %	2005 prevalence %	2006 prevalence %
KwaZulu-Natal	33.5	36.5	37.5	40.7	39.1	39.1
Mpumalanga	29.2	28.6	32.6	30.8	34.8	32.1
Free State	30.1	28.8	30.1	29.5	30.3	31.1
Gauteng	29.8	31.6	29.6	33.1	32.4	30.8
North West	25.2	26.2	29.9	26.7	31.8	29.0
Eastern Cape	21.7	23.6	27.1	28.0	29.5	29.0
Limpopo	14.5	15.6	17.5	19.3	21.5	20.7
Northern Cape	15.9	15.1	16.7	17.6	18.5	15.6
Western Cape	8.6	12.4	13.1	15.4	15.7	15.2
National	24.8	26.5	27.9	29.5	30.2	29.1

Table 1.1.1: Estimated HIV prevalence among antenatal clinic attendees, by province from 2001 to 2006 (Adapted from AVERT 2008a)

The international AIDS charity, AVERT, in outlining the South African AIDS crisis acknowledges that it is difficult to exaggerate the suffering that HIV has caused in South Africa. For each person living with the disease, not only does it impact on their own lives, but also those of their families, friends and wider communities (AVERT 2008b). Generally, a person is either infected with the disease or affected by it or, both. Though there is antiretroviral treatment that can help people maintain their health and lead relatively normal lives, the organisation says there are very few people who have access to this treatment. As a result AIDS deaths are alarmingly common throughout the country, amounting to almost half of all deaths in South Africa. According to AVERT a startling 71% of deaths among those aged between 15 and 49 are caused by the disease. AIDS deaths are so high that, in some parts of the country, graveyards are running out of

space for the dead and people spend more time at funerals than in having their hair cut, shopping or having barbecues (AVERT 2008b).

South Africa's HIV and AIDS epidemic has had a considerable impact on the nation's overall social and economic progress:

- Average life expectancy in South Africa is now 54 years – without AIDS, it is estimated that it would be 64. Over half of 15-year-olds are not expected to reach the age of 60.
- Between 1990 and 2003 – a period during which HIV prevalence in South Africa increased dramatically – the country fell by 35 places in the Human Development Index, a global directory that ranks countries by how developed they are.
- Hospitals are struggling to cope with the number of HIV-related patients for which they have to care. In 2006 a leading researcher estimated that HIV-positive patients would soon account for 60-70% of medical expenditure in South African hospitals.
- Schools have fewer teachers because of the AIDS epidemic. In 2006 it was estimated that 21% of teachers in South Africa were living with HIV (AVERT 2008b).

HIV and AIDS are affecting mainly those who are young and sexually active, which implies that the demographics of the country are slowly changing. According to UNICEF, AIDS deaths in families results in families having to stretch their finances and this also increases the vulnerability of children: “Even after death, funeral expenses can reduce the financial resources available to households. A study in four provinces in South Africa found that households with an AIDS-related death in the past year spent an average of one third of their annual income on a funeral” (2006:10). UNICEF further says that studies in three of the provinces of South Africa confirmed that material needs were the highest priority for households with orphans, and the availability of funds to pay for essential needs was the greatest constraint (2006: 13).

Considering the historical background of South Africa, AVERT traces the most rapid increase in South Africa's HIV prevalence to the period between 1993 and 2000, when

the country's attention was diverted by major political changes during the transition from Apartheid. Although the results of these political changes were desirable, "the spread of the virus was not given the attention that it deserved, and the impact of the epidemic was not acknowledged" (AVERT 2008). Even after the World AIDS Conference of 2000, which drew world attention to the severity of the pandemic in South Africa, a number of occurrences have made analysts conclude that the government's response to the crisis has not been sufficient:

- In 2000, President Mbeki publicly denied that HIV is causing AIDS and controversially suggested the main cause of AIDS to be poverty (BBC News 2000)
- In 2001 the South African government had to go to great lengths to appoint a panel of scientists, including those who questioned the mainstream view on HIV (dissidents) to report on the issue. It was based on their report that the government had eventually presented a policy on the premise that the cause of AIDS is indeed HIV (BBC News 2001).
- At the 2006 International AIDS Conference in Toronto, the Minister of Health surprised the conference by displaying garlic, lemon, beetroot and African potato, alongside two bottles of anti-retrovirals, thereby exhibiting her cure for AIDS (Blandy 2006).
- This led to many leading HIV and AIDS experts and political figures calling for her removal from her post (Bridgland 2006).
- President Mbeki dismissed the Deputy Health Minister, Nozizwe Madlala-Routledge in early August, 2007: "It should have been no shock last summer when President Mbeki, a man who has not recently tolerated dissenting views, sacked Nozizwe Madlala-Routledge, the Assistant Health Minister who very publicly tried to advocate for stronger action on South Africa's AIDS epidemic. Madlala-Routledge had taken the helm of the Health Ministry from Dr. Manto Tshabalala-Msimang, who was absent on medical leave. But after a short stint at the post, Madlala-Routledge was fired for 'insubordination', when Mbeki disapproved of her decision to attend an AIDS meeting in Europe" (Acronym Required 2007).

AVERT, on its part, points out how Jacob Zuma, the Former South African Deputy-President and now the president of ANC, and who became South Africa's third president in 2009, went on trial for allegedly raping an HIV-positive woman. He argued that the woman had consented to sex, and was eventually found not guilty. However he contributed to the HIV and AIDS crisis in the nation by saying that he had showered after sex, believing that he was so cleansed and thereby reducing his chances of becoming HIV infected (AVERT 2008).

Criticism of the government's response to the pandemic was at its peak when UN Special Envoy Stephen Lewis attacked the government as 'obtuse and negligent' at the International AIDS Conference in Toronto. The announcement by the government to put in place a draft framework to tackle HIV and AIDS and to improve access to antiretroviral drugs in 2006, however, has been hailed by civil society groups as marking a turning point in the government's response to the pandemic. (AVERT 2008).

1.1.2 The Kwazulu Natal and Pietermaritzburg Situation

The Table 1.1 above clearly shows that the Kwazulu Natal Province of South Africa has the highest HIV infection rate, averaging 40% currently. With a population of about 9,069,771, Cele says "the province is the third smallest in South Africa and home to 21% of the country's population. It occupies 92,100 square kilometres, equivalent to almost 8% of the total land area of the country (Cele 2005:4).

The HIV information received from Mr. Thulani Mandiriza, Economist - Policy and Planning at the KZN Department of Economic Development, revealed that of the 5,934,183 persons living with HIV at the end of 2007 in South Africa, 1,664,839 of them (28%) lived in the Kwazulu Natal Province. The data revealed as well that of the 397,967 recorded deaths due to AIDS in South Africa in 2007, 127,706 (32.1%) occurred in the Kwazulu Natal. Nicolay summarises the Kwazulu Natal HIV and AIDS situation at the end of 2008 in Table 1.1.2 below:

Table 1.1.2: Kwazulu-Natal HIV and AIDS statistics

	Kwazulu-Natal
Whole population	16%
Antenatal clinic estimate	40%
Adults (ages 20 - 64)	28%
People living with HIV	1,561,000
New HIV infections(over the year)	134,000
AIDS deaths(over the year)	115,000
Total people in need of ART (mid year)	297,000
Total people accessing ART (mid year)	127,000
Accumulated AIDS deaths	849,000
New infections per day	366
New deaths per day	316

Nicolay (2008: 4)

Even though the 2008 data shows a decline in the number of people living with HIV, Nicolay indicates:

- Kwazulu-Natal is experiencing the most severe HIV epidemic in the country.
- A total of 1.6 million people (16% of the population) and nearly a third of all adults are estimated to be HIV positive in 2008.
- The epidemic has reached a mature phase with AIDS deaths and new infections levelling off.
- An estimated 300 000 people are in need of antiretroviral treatment in 2008 with less than 50% having taken up treatment. (2008: 4)

The Pietermaritzburg Area,¹ where this research is conducted, falls within the Umgungundlovu District municipality in the Kwazulu Natal Province. The Umgungundlovu District municipality with a population of 948,069 is second only to the eThekweni Metropolitan Municipality of a population of 2,964,277 (Cele 2005:12). The HIV and AIDS data from Mandiriza follow the population trend with eThekweni Metropolitan Municipality having 32.1% of the people living with HIV in the province and the Umgungundlovu District municipality having 10.7%.

¹ The Pietermaritzburg Area is the geographical area where the research is conducted and is fully described below.

The Pietermaritzburg Area is composed of the local municipality known as the Msunduzi Municipality. The municipality is located in the province of KwaZulu-Natal, approximately 80 kilometres inland from Durban. The majority of the population is black and Zulu speaking (BESG: 2003). According to the South African Cities Network (SACN) website:

The Msunduzi Municipality in Kwazulu-Natal serves a population of over half a million people in Pietermaritzburg and surrounding areas. The legacy of apartheid is still felt in the uneven development between the suburbs and city centre, and the poorly developed townships and surrounding rural settlements. While the City serves as the provincial capital, its limited industrial and commercial development does not provide the economic opportunities needed to ensure employment and adequate livelihoods for all. There is an estimated 35% unemployment in the Municipal area. The Municipal budget of approximately R1,750 per capita per annum is severely strained to maintain existing services and promote development and servicing in poorly-served areas. (SACN, u/d).

The municipality of Msunduzi was organized around the Pietermaritzburg city centre after the 2000 South African elections, when five previously independent areas were amalgamated to create a large urban area under the jurisdiction of a single council. This incorporation includes the city of Pietermaritzburg as well as the suburbs of Msunduzi, Ashburton, rural Vulindlela, Claridge and Bishopstowe. Sutton argues that the re-demarcation process occurred in order to make South Africa's cities more efficient post-apartheid (2008: 54-55).

The data from KZN Department of Economic Development indicates that 61.4% of the total number of people identified to be living with HIV in the Umgungundlovu District municipality at the end of 2007, live in the Pietermaritzburg Area. This is a steady increase from 58.1% in 1995. A similar trend in the number of people dying from AIDS has been observed, showing a steady increase from 56.1% in 1995 to 60.6% in 2007. (Mandiriza 2009). This high and increasing incidence of HIV and AIDS has made the area the epicentre of the disease.

The effects and challenges of the pandemic have not escaped the Msunduzi municipal authorities. Chatiza has pointed out that:

The Msunduzi Municipality (Pietermaritzburg) in KwaZulu Natal Province is one local government which has demonstrated the political will and leadership to develop and manage a comprehensive HIV/AIDS strategy. Its work is based on partnership and shared responsibilities that go beyond 'City Hall'. The strategy came from within the Municipality in part prompted by demand from concerned local groups. The Municipality started with a citywide consultation process to develop a wide partnership base for developing and managing the strategy. The City Health Department and partners conducted a situation analysis, impact scan and survey of existing services and with the support of the University of Pretoria a workshop to share information and develop a strategy was convened in 2001 (i.e. strategy in place since then) (Chatiza u/d).

Dr Nomsa Nkosi, in a presentation at a workshop organised by the South African Cities Network, in the City of Tshwane, April 22, 2002, on behalf of the Msunduzi Municipality, pointed out that in the Pietermaritzburg Area, 60% of deaths related to HIV/AIDS are in the economically active age group 20 – 39 and that impacts on the economy. He noted that 36% of sexually active people are HIV positive and that would impact on the council in high rate of absenteeism therefore resulting in the loss of productivity, which in turn would affect the local economy. Dr. Nkosi acknowledged that the municipality was already feeling that impact of the HIV and AIDS pandemic on service delivery (SACN 2002).

Yet in the midst of all the interventions and responses to the HIV and AIDS situation in the Pietermaritzburg Area, the CINDI Network, that has been an activist voice in the area of HIV, sees the deep disturbance of the profound, silent disorder of the AIDS epidemic (Simon-Meyer 2000: 28).

HIV silence creates a vicious circle in which silence generates stigma and discrimination and stigma and discrimination creates silence, which is why such a pressing problem as HIV and AIDS is not regarded as a priority in the community. For this reason in

his *Supporting Local Government Responses to HIV/AIDS*, Kelly intimates:

HIV/AIDS stigmatisation means that AIDS-related illness is generally suffered in silence and it is often not perceived by communities as a priority issue, even in areas where AIDS prevalence is particularly high; people who are most affected often do not have the opportunity, skills or resources to enter the public domain as activists, especially if they are coping with illness in their homes; HIV does not show its consequences for many years; organisations representing such people frequently do not have active and strong local chapters and their membership is often depleted by ill-health and death; health services are usually highly under-resourced and understaffed and where provision of basic health services is not established HIV/AIDS is regarded as being on a par with other serious medical conditions; and perceptions that too much attention is paid to AIDS at the expense of other medical and developmental problems (2003: 26).

The need to deal with silence around HIV and AIDS is urgent in this situation if we are to make a headway in dealing with the disease in the Pietermaritzburg Area and beyond.

1.1.3 The Church in the midst of the HIV and AIDS Crisis

In the midst of the HIV and AIDS crisis, the church, as a caring community, is involved in caring for people. Marika Fahlen, the Director of Social Mobilization and Information for UNAIDS, in a statement to the Symposium of Catholic Bishops Conference Africa and Madagascar (SECAM) in Dakar on the 6th and 7th of October 2003 confirmed that “Faith-based communities with their core values of togetherness, across geographical boundaries and social differences, are important pillars of a society successfully dealing with this deadly virus” (2003a:3). The 2003 SECAM was reminded of their earlier Conference in 2001 in South Africa, which stipulated that religious leaders be proactive in demanding access to care, treatment and a life of dignity for people living with the disease. To do this the conference reiterated their 2001 priorities of:

- Deepening theological reflections around HIV/AIDS and the expanded role of the religious ethos of compassion and solidarity, keeping human rights and dignity at the centre;

- Rejecting the stigma and discrimination of people living with HIV/AIDS; and addressing the growing impact of the epidemic on women and children, so often fuelled by gender inequality and lack of social justice (SECAM 2003: 2).

It is clear that the HIV and AIDS crisis in South Africa raises a number of issues for the church: questions of suffering, questions of care, questions of God's absence, questions of justice, and gender issues. But in the midst of all this there is the question of the *silence* around the disease, which is preventing any meaningful education and ample discussions on these issues and thereby compounding the problem. The major problem therefore is how best to break the HIV and AIDS silence, and this is the area on which this thesis focuses.

Breaking the silence is the main issue that Marika Fahlen concentrated on in her address to the church. Of the priorities set out by the church, she used the opportunity to draw attention to an aspect that UNAIDS finds to be deepening the HIV and AIDS crisis in Africa: stigma and discrimination, which is fuelled by the silence around the disease. She told the African church leaders:

We must reject and combat all tendencies of stigma and discrimination which have already robbed so many of their friends, excluded them from their workplace, disintegrated their families and ruined their livelihoods and led to banishment and violence. Much of these prejudices are rooted in the fear that grows out of ignorance. Breaking the silence about HIV/AIDS, providing a stronger voice to people living with HIV/AIDS in affairs that concern them, listening to perspectives of young people and combating gender inequalities are all essentials in forging a tolerant society capable of dealing with this epidemic and its impact. We should all be staunch advocates to combat stigma and discrimination wherever it occurs. As we move ahead in scaling up access to treatment, stigma and discrimination would hopefully fade away along the route (UNAIDS 2003a: 7)

Even though the 2000 World AIDS conference has come and gone, the effort to break the HIV and AIDS silence is a major problem that contributes hugely to the crisis. Sarah

Boseley, health editor of *The Guardian*, quotes an editorial in the *Lancet Medical Journal* to apportion the majority of blame upon the government: "Social stigma associated with HIV/AIDS, tacitly perpetuated by the Government's reluctance to bring the crisis into the open and face it head on, prevents many from speaking out about the causes of illness and deaths of love.... The South African Government needs to stop being defensive and show backbone and courage to acknowledge and seriously tackle the HIV/AIDS crisis of its people" (Boseley 2005). Breaking the silence is a major issue for the government in leading the fight against the disease, and both the leadership and ordinary people need to be helped to participate. Former South African President Nelson Mandela has shown leadership in this regard. When his son died of AIDS in 2005, he publicised the cause of his death in an attempt to challenge the stigma that surrounds HIV infection and thereby to break the silence: "Let us give publicity to HIV/AIDS and not hide it, because [that is] the only way to make it appear like a normal illness" (AVERT 2008).

The South African AIDS Memorial Quilt has pointed out that there is a culture of silence and fear around HIV and AIDS in the country. As a result, they say, "In South Africa individuals refrain from disclosing their HIV status because of fear of rejection and isolation in their communities" (Dalrymple 2000). The silence around the disease is something that the South African bishops of the Catholic Church sought to fight. Archbishop Buti Tlhagale expressed his grief that in his archdiocese of Bloemfontein, in the Orange Free State, he spends so much time going to funerals that weekly attract up to 2,000 people for burials. He said that his major concern was the silence around the disease: "Everyone knows what the person died of, but no one speaks of it, not even the priest. The spectre of AIDS is stalking Southern Africa, decimating its population across generations, across cultural and economic classes. Alongside the corpses that it claims is left a surging population of orphans, many of them infected or at risk from the killer disease." (Lefevere 2000).

There is an indication that issues of sex and death, which normally come into HIV and AIDS discussions, make it more difficult to discuss the situation openly, whether in the church or in the community. Alongside the fear of rejection and isolation indicated above, there is also fear in the African community of discussing sex and death. In actual fact it is a taboo to discuss issues of death, when death has not occurred. Even when

death occurs it is the family heads or elders who are supposed to discuss the situation. It is also a taboo to discuss sex outside the confines of marriage. If discussed, it is only between husband and wife. The only public discussion is when the elders, in the worst scenario such as the possibility sexual issues leading to divorce, get involved to put things right (Parker and Birdsall 2005: 12). As will be shown in Chapter 4, issues of taboos do create silence around the AIDS situation.

Another major contribution to the silence created around HIV and AIDS is the suspicion of ‘witchcraft’. In many places in Africa, any insurmountable problem is linked to witchcraft or may be linked with improper treatment of the ancestors. AIDS in particular is linked with witchcraft. Magesa says, “Still, by and large, the African people interpret the disease in terms of their cultural world as a breach of a taboo and witchcraft,.....” (2000: 78). Once a disease is linked with witchcraft then you dare not discuss it, as this is in the hands of medicine men and ancestors.

The silence around the HIV and AIDS situation is a major hindrance in all attempts to bring the disease under control. It hinders good education because people are not ready to be involved in discussions around the subject. The silence generated as a result of stigmatisation of HIV and AIDS undermines processes of healing for affected family members, and also undermines constructive community response to the pandemic - prevention or care. As we shall see, however, silence and attitudes towards silence are deeply rooted in culture. This research argues that there are cultural underpinnings of silence that need to be investigated if any meaningful attempt is to be made to break the silence surrounding HIV and AIDS.

A situational analysis conducted among Evangelical churches in Pietermaritzburg area by the staff of ECAP² (1999-2000) and CCP³ (2001-2003), at the time when these organisations were being initiated, revealed that silence around the disease is a major

2 ECAP stands for Evangelical Seminary of Southern Africa (ESSA) Christian AIDS Programme, an initiative to help evangelical churches to respond to the HIV/AIDS pandemic in Pietermaritzburg.

3 CCP stands for Community Care Project, an initiative of the Pietermaritzburg Christian Fellowship (PCF) and now called Grace Generation Church, and it is one of the eight projects of Project Gateway. It was established in 1999 with the help of the researcher to help communities respond in a holistic way to the HIV pandemic and break the silence around the disease. Section 1.4.4.1 below deals the birth and history of CCP and Chapter Six looks at the operations of CCP and how it contributed to the study.

problem in the churches. In their normal operation, the church leadership visit and pray for people infected with the disease. But this is done in just the same way that any other people with any other diseases are helped. No one dares to say anything, whether pastors, church members, family members or the sick person. A number of churches considered the disease as a curse or punishment from God for immoral behaviour. Some pastors reiterated, “If God is punishing sinful behaviour, who are you to intervene”.

It was clear throughout the analysis undertaken by ECAP and CCP that people in the churches were willing to help the sick but did not have sufficient knowledge about the disease. The biggest challenge in the community, as well as in the church, is that the silence around the disease is evident but that people do not know how to break it. People, especially in the churches, were not ready to discuss issues pertaining to culture and HIV but rather concentrated on issues of sin and punishment. People in the community in general did not make links between the silence and culture. These are the issues that motivated this study.

1.2 The Aim of the Study

The aim of this study is not to answer the many theological questions raised above; questions of suffering, questions of care, questions of God’s absence, questions of justice, or questions of gender⁴. Even though these issues are in the background, the aim of the thesis is about how to break the silence around the disease, taking into consideration the cultural factors that underlie this silence.

The research study has a two-fold aim: firstly, the research aims to identify and understand the cultural factors underpinning the HIV and AIDS silence. The second aim is to determine whether interventions offered to People Living With HIV and AIDS (PLWHAs) through CCP, (based on pointers from the cultural factors) will help break the HIV and AIDS silence.

⁴ The most up-to-date research on this is being undertaken by the Collaborative for HIV and AIDS, Religion and Theology (CHART) and the Cartography workshop (12th October 2008 to 17th October 2008) presented draft research papers on all these issues.

1.2.1 Outline of the Topic

The title of this study is *Engaging the Fertile Silence⁵: Towards a Culturally sensitive Model for dealing with the HIV and AIDS Silence*. The study examines the cultural factors that prevent people, both within and without the churches, from breaking their silence on a disease that they know is devastating the lives of people in Pietermaritzburg, a key city of the Kwazulu-Natal region, a region that has the highest HIV rate of infection, in a country known to be the highest infected in the world (UNAIDS 2000: 9).

1.3 Problem Statement and Key Research Questions

This study uses mainly a qualitative approach. Creswell (1994:70) intimates that, unlike quantitative research which is based on hypotheses, qualitative research emerges from research questions or problems. It is the research questions that drive the research by making reference to the specific query to be addressed, by setting the boundaries of the project, and by suggesting the methods to be used for data-gathering and analysis (Strauss and Corbin, 1998:35).

In this thesis the problem statement is:

Can the cultural reasons underpinning the HIV and AIDS silence be identified to provide clues for engaging with and breaking the silence and providing a way forward for dealing with the HIV and AIDS epidemic?

Three research questions were formulated for the study, which included:

1. Does the culture of the people contribute to the way silence 'works'?
2. To what extent do cultural dimensions contribute to the silence around HIV and AIDS?
3. Can the interventions provided by the Community Care Project suggest constructive ways of engaging with or breaking the silence around HIV and AIDS in the Pietermaritzburg area?

⁵ This thesis considers the expression of silence in two ways: i) Barren silence, meaning that when there is silence it is assumed that nothing is being communicated. It denotes absence because the vocalisation, expression or visualisation that are needed to communicate with people is not there; ii) Fertile silence, meaning that when there is silence it is assumed that something is being communicated, though not spoken. In this way silence can connote presence of information that is expressed in symbolism such as facial expressions and hand movements, which makes the person who is present with you reveal things that are not said or seen. Chapter two deals with this in more detail.

1.4 Research Design and Methodology

The thesis makes use of a mixed mode of methods. While it mainly entails qualitative methodology, there is also a quantitative component used in investigating the cultural factors underlying the silence that surrounds the HIV and AIDS.

The research begins with the reviewing of the literature as a way of gaining direction for the topic. The literature helps us to understand silence from a cultural perspective, and provides insights into how culture may influence the silence around HIV and AIDS. With the cultural insights gained through library research, the researcher through ethnographic means immersed himself into the cultural setting of the community struggling with HIV and AIDS. De Vos and Fouché (1998:80) and Fouché (2002:274) consider ethnography as a research design that is characterized by observation, in which the researcher is a participant observer. This leads to the description of the behaviour of a small number of cases which aims at understanding and interpreting the meaning that the participants give to their everyday lives as the researcher enters their life world.

In the field therefore, the CCP was engaged through its interventions and activities to set up a Support Group for People Living with HIV and AIDS (PLWHA) as a case study for field research, allowing the researcher to engage with the group and its social networks, as well as CCP's stakeholders (including individuals, families and groups linked with CCP) for three years. This allowed the researcher to exercise a role in the community as a leader, whom the community knew had provided HIV activism in early stages of interventions into the disease in the Pietermaritzburg area. Further the researcher was provided with the necessary credibility and trust to enable him to conduct interviews.

The Support Group became the centre for mixed quantitative and qualitative field research to investigate the cultural dimensions of HIV and AIDS silence in the churches and communities. The researcher managed the CCP, through an organisation called Newfrontier Aid Trust (NAT), which he set up as a tool to facilitate community-based organisations, churches and schools that are involved in HIV and other community initiatives. The CCP and its staff, and the Support Group, gained access to individuals, families, pastors and churches, as well as community members, to gather data.

The CCP interventions were injected with insights from the literature review and with current ‘best practice’⁶ models, such as memory work, play skills, wellness and HIV and AIDS celebrations and prayers, to aid openness in engaging with or breaking of the silence around HIV and AIDS.

1.4.1 Research Design

A research design is defined by De Vos and Fouché as “a blueprint or detailed plan for how a research study is to be conducted” (1998:77). This means a research design refers to all decisions made about how the research study is to be conducted, including when and from whom data will be acquired. The research design also points to how the research is arranged, what happens to the subjects and what methods of data collection are employed” (McMillan and Schumacher, 2001:31).

1.4.2 The choice of Research Methodology.

Going to the field, it was understood that the issue we were looking into was the silence in and around a stigmatised disease, HIV and AIDS. As confirmed by the literature reviewed, people - whether infected or affected by the disease - are not engaging with the issue of HIV and AIDS at the level that makes others aware of the various facets of the disease. In this case, in the field the researcher was not only interested in asking questions about the HIV and AIDS silence to get whatever answers that were given to him, but he was interested in the people’s own interpretations and explanations of why this silence prevails. It is understood in the research that it is this engagement through various relational means with those infected and affected by HIV and AIDS who are themselves silent about the disease, that helps in dealing with the silence at their level. This will then lead to further levels of engagement, with others who may consider themselves unaffected by the disease, with the view to breaking more silences. This will therefore be the main reason for any chosen methodology. It must be a methodology that has the ability to build relationships that lead to the unearthing of cultural underpinnings of this

⁶The UNAIDS has documented a host of best practices. Single copies of Best Practice materials are available free from UNAIDS Information Centres. To find the closest one, visit the UNAIDS website (<http://www.unaids.org>), contact UNAIDS by email (unaids@unaids.org). CCP staff has received memory work training from the Sinomlando Centre for Oral History and Memory Work in Africa at the School of Religion and Theology, University of KwaZulu-Natal.

silence and for further engagement with the silence. It is clearly activist research that seeks, in the very process of research, to make a practical difference.

1.4.3 The Researcher and Respondents.

In this research, due to the kind of information and data that is sought, which can mainly be obtained through relationships with participants and informants, the researcher needed to be ready to incorporate himself into the social situation of the respondents as a participant observer. This gave rise to over three years of gathering experiential, dialogic, ethnographic and significant qualitative data.

1.4.3.1 The Researcher as a Participant Observer.

Considering the nature of the issue being researched, i.e. the cultural dimensions underpinning the HIV and AIDS silence, participant observation is chosen as an important means of data collection. Pratt and Loizos advise that for such sensitive topics as political loyalty, debts and sexual practices, participant observation is needed (1992: 59). This method offers an opportunity for the researcher to build relationships and trust with the respondents. Pratt and Loizos (1992:64) further indicate that participant observation is particularly useful when collecting information on groups with whom contact is difficult to achieve when one enters a community for a short time, especially low-status groups such as those infected and affected HIV.. By this a situation is avoided where people employed to gather information are not trusted with the needed information “either because they are strangers to the respondents or because they are members of the same community, and might be thought tempted to gossip, or use the information for personal advantage” (Pratt and Loizos, 1992:59). By participant observation, the researcher is not an outsider who just come to gather information and leave, but is deeply engaged in the lives of participants in a way that builds trust for the easy transmission of information.

As suggested by McMillan and Schumacher (2001:268), the purpose of the research was clearly explained to the respondents so that they could make an informed decision as to whether they wanted to participate. This was to reduce bias, and was enabled by the researcher’s interactive role with respondents. Both questionnaires and interview questions were carefully put together, in English and Zulu, so as to be clearly understood

by participants. The researcher followed up the initial interviews and questionnaires with group discussions and a continuing evaluation of the study.

1.4.3.2 The Researcher's Team.

Pratt and Loizos point out a concern that has been raised amongst the research community in the field of development: that traditional research procedures are seen within local communities as intrusive, aggressive and above all distanced from the people (1992:8). To heed this concern, the researcher embraced an idea of participatory research, which sought to promote the collaboration of the researcher, local people and organisations in identifying issues that require further research and action. This research study came about as a result of the researcher, in December 2000, offering to assist the CCP with their strategic plan process. A situational analysis conducted in 2001 made the CCP team realise the severity and the huge impact which the lack of openness about the HIV and AIDS situation was having on the community. It was worrying that as a result of the silence around the disease people were being discriminated against and stigmatised, while many were dying.

CCP at this time felt helpless about the situation as it sought to help churches and congregations to see the need to be involved in HIV and AIDS work. More and more problems erupted, signalling the need to break the HIV and AIDS silence, both in the church and in the community. This led the researcher to write his PhD research proposal at the University of KwaZulu-Natal in 2001, with the view of working, through CCP, to investigate reasons behind the HIV and AIDS silence and a way to deal with this and apparent perception of HIV and AIDS as being taboo.

In line with Pratt and Loizos' suggestion that "it is important to establish at an early stage the nature of the research participation expected and desired" (1992:100), the researcher agreed to oversee the CCP from 2002, when he would have the organisation's strategic plan ready to deal with the silence on HIV and to assess a methodology for the study.

It was understood that the staff of the project would have opportunity to be part of the research, which in the end would significantly enhance their self-esteem and skills and empower them (Pratt and Loizos 1992:10). The staff of CCP therefore became the

researcher's team or research assistants⁷, who through staff meetings and workshops received training in the data collection process for the research. The researcher, not a fluent Zulu speaker, also had the advantage of having Zulu-speaking CCP staff helping in the translation during interviews and discussions with non-English speaking respondents. The roles of the researcher's team, in which they acted as researchers and participants, were defined and planned for, from the onset⁸.

A series of situational analyses conducted by the researcher together with CCP staff and the staff of a sister organisation by the name of ESSA Christian AIDS Programme (ECAP) between 1999 and 2003 provided the basis and insight for the study.

1.4.4 The Parents of CCP: Pietermaritzburg Christian Fellowship (PCF)⁹ and Project Gateway (PG)

The Community Care Project (CCP) was established in 1999 by the Pietermaritzburg Christian Fellowship (PCF), under the umbrella of Project Gateway (PG). The history of the project is closely tied to that of PCF and PG.

In the late 1980s, a church, known then as Maritzburg Fellowship, which was led by an English local dentist, Brian Andrews, dreamt of seeing the churches in the city come together to work amongst the poor and the disadvantaged, based on the words contained in Matthew 25. "It was a passion born out of a desire to see God's kingdom come, on earth as it is in heaven" (Larsen and Lanham 2002:3). This same vision was also in the hearts of two other church leaders in the city. One was Piet Dreyer, an Afrikaner with a passion for the poor and an indomitable spirit that refused to accept defeat; the other a Zulu man, Ernest Zikhali, who for years has been yearning to work closely with people of other colours to respond to the plight of the poor through the Church.

⁷ The CCP staff consists of Pastors, Development Workers (Filed Workers), Social Workers, Nurses, Youth Workers, Volunteers and Office Managers.

⁸ In this study, the roles of the research assistants from CCP can be described as 'non-concealed, minimal participant' or as 'observer-as-participant' who identify themselves as a researcher and interacts casually with the respondents during the interviewing process and as they themselves come from the community, they are participants (Refer Rubin and Babbie, 1997:379 and Yegidis and Weinbach, 1996:151-152.)

⁹ The name PCF has since the April 2009 been changed to Grace Generation Church (Grace Gen)

In 1989, these three men committed their respective churches to the vision God had given them, forming one congregation, the Pietmaritzburg Christian Fellowship. As these three men continued to pray for direction, Piet Dreyer and his wife visited a friend who led a church in Kokstad. As they were praying together one Sunday afternoon Piet Dreyer, a lawyer and agricultural Scientist, who made a decision to become a pastor, says “all of a sudden a clear vision burst into my mind.” (Larsen and Lanham 2002:15). He saw a place where people entered shattered and without hope, but having being in this place, were transformed into joyful people who left the place with skills to deal with their desperate situations and offer their gained skills to those around. “And he saw that wherever these people went they turned barren places into productive fields” (Larsen and Lanham 2002:15).

The trio then undertook a mission to get the Church of the city see the vision and the new thing God was doing in the city and beyond. Larsen and Lanham (2002:3) say “Churches throughout the city were called to commit themselves to this unified vision. And they did, with great excitement and a sense of real purpose. Twenty one churches in the city bought into the vision, and the place Piet Dreyer saw in his vision became a reality as Project Gateway was launched on March 16, 1991. Pastor Dreyer became its first director, with PCF becoming the leading church carrying the vision forward.

The launch of PG was necessitated by the increasing demand on PCF to respond to the desperate situation faced by the poor areas of Pietermaritzburg, including the Edendale valley, Imbali, Caluza, Sweetwaters Foxhill, Copesville and other townships. Political tensions¹⁰ that had been building in the area over the years, culminated in the “Seven Days War” between the followers of the African National Congress (ANC) and the Inkatha Freedom Party (IFP) in the Edendale Valley and the surrounding Townships. The effects of the war were the major cause of the displacement of whole communities in the area:

Then in late March 1990 the tension that had been building over several years erupted into full scale war. On the morning of Tuesday March 27, a

¹⁰ The details of the political tensions in the area and the resulting seven day war is beyond the scope of this study. See Levine, Lou (Editor). 1999. Faith in Turmoil: The Seven Days War. Pietermaritzburg: PACSA

3000 strong impi from Mpumzuza in Vulindlela, descended on Caluza township, driving the residents out before them. They burnt and plundered houses and killed people, including women and the elderly. The first salvo's of the war had been fired two or three days beforehand when Inkatha members travelling to a rally in Durban were stoned in Edendale. In the revenge attack on Caluza, numbers were killed and 130 gunshot wounds were treated in Edendale hospital. From there the war escalated and eyewitness accounts tell of terrible atrocities, and police complicity with Inkatha forces (Larsen and Lanham 2002: 10).

According to the findings of the Truth and Reconciliation Commission in 1998, over 100 people were killed, a lot of houses were damaged by fire and close to 20,000 refugees had to flee from the ensuing violence (Levine 1999: 12). Many of these refugees, who had lost everything, fled the war zone to safe areas where the South African Defence Force had set up tented camps. One of these areas was on a farm several kilometres outside Pietermaritzburg, others were in Foxhill (Larsen and Lanham 2002: 10).

Pastors in these areas attribute the eruption of the HIV and Aids pandemic in the Pietermaritzburg area to the setting up of the tents with a large contingent of police from all over South Africa coming to the place. As Pastor Ernest Zikhali himself pointed out in an interview, "The sexual indulgence at the time was unprecedented as families were dispersed and women selling their bodies to survive" (Personal interview, 20-09-2004). No wonder Larsen and Lanham indicate that over a decade later the Edendale Valley still feels the effects of war. As one drives along the main road through the Valley, whole areas still remain uninhabited and the burnt out shells of houses are evident above the weeds. Most schools were interrupted for a year and a number of children never went back when they re-opened (2002: 10). The birth of PG was really at the right time to serve people in this situation through the provision of food, clothes, education and caring for the sick and wounded, even though the pioneers of the project were wary of creating dependence. Its aim was to empower communities to be productive:

The empowerment that Project Gateway aspired to, however, was more than supplying the means to material prosperity. As a church based organisation Gateway believed an essential key to sustainable development was a

relationship with the Triune God who imparts his creative energy and vitality into people such that they not only seek to provide for their own needs but are also able and willing to look to the needs of others (Larsen and Lanham 2002: 16).

Based on the convictions that Pastor Brian Andrews had that the vacant Old Prison in Pietermaritzburg would be given to the Church for the community development work, PG then approached the National government for the use of the Old Prison. A long process of appeals and negotiations up to the Cabinet level ensued. “The churches had no money to pay for the buildings and initially a figure of several million Rands was being asked. Over a year later, however, the Old Pietermaritzburg Prison was given at no cost to Project Gateway by the Department of Public Works and Land Affairs in August 1992 just as God had promised Brian” (Larsen and Lanham 2002: 21).

With the premises in hand, PG began various projects, at different times, to meet the needs of the community and empower the people who previously were disadvantaged by the political dispensation prior to 1994. Just when the centre was acquired, some women from the communities who benefited from the feeding scheme were invited to attend sewing lessons in the evenings, and various Self-help Community gardens were started in most areas where the feeding scheme was operating. In 1993 PG started Adult Basic Education in a garage in Scottsville; street children were housed at the Project Gateway centre and taught various life skills. In addition, Computer training, TagTec Electrical Training and Riverside Christian Pre-School were opened. A Sunset Overnight Shelter operated in the night. Between 1994 and 1997, Prison Ministry, Khangisa sewing development, Metal work training, Pregnancy Crisis Centre, Hopewell farm, Woodwork training, Fabric Painting training, Block making and Block laying training were added.

1.4.4.1 The Community Care Project (CCP)

As the various projects were initiated at PG, PCF held on to the ministry of providing care and relief to the sick who knocked at the door of the church. This was given the name “Mercy Ministry” and done on behalf of PG. In 1996 a lady by the name of Anne

Ntombela¹¹ from Kenya who was living with HIV and at the time very sick, and whose husband had died of the disease, joined the Church. She was under the care of the Mercy Ministry. Anne gave a testimony in PCF about her status and thanked the church for having taken care of her. This public disclosure of her status, began to send a positive message to others who were living with the disease. Slowly sick people started trickling into the church for help. At this time people were not talking about the disease at all.

In 1998, Pastor Craig Botha took the reigns of leading PCF as Brian Andrews left for the UK and Piet Dreyer left for Zimbabwe to help set up projects in agriculture. He was to give direction to PG as well. At this time the city of Pietermaritzburg had woken up to the AIDS pandemic devastating the city. The Children in Distress (CINDI) Network was formed, with the aim of mobilising organisations and people to advocate on behalf of children infected and affected by HIV and Aids. Project Gateway was a founding member of CINDI. During this time the researcher who was lecturing at the ESSA, led the Seminary through strategic planning to initiate ECAP. This was because reports from students revealed that the HIV and AIDS pandemic was rapidly creeping into the townships but there was no one to help. ECAP was established to train the Seminary students, pastors in the field and members of churches to respond to the pandemic.

Pastor Craig approached the researcher to help establish an HIV and AIDS outreach ministry into the community as more and more people were coming to the church for help. Later in 1998, the ECAP team was invited to PCF to perform a interactive drama with the view of educating and mobilizing the entire church and raising volunteers for the HIV work. In 1999, a team was organized around those involved with the Mercy Ministry for an HIV and AIDS outreach into the community. Through the outreach, many people who were rejected by their families for being HIV positive were identified and cared for through provision of basic food stuff, blankets and medicines. Those who were left to die were help by the Mercy Ministry outreach team to die with dignity.

By mid 1999, the Charismatic and Pentecostal fraternity of the churches in the city, Church In Action (CIA), woke up to a new vision emerging among its members. “The

¹¹ Anne Ntombela was the first Person Living with HIV that I ever met who openly disclosed her status. Anne today has established an HIV Support Group known as Springs of Hope.

churches were no longer merely committed to meeting the needs at hand, rather there was a passion to transform the life of the entire city, and Gateway was seen as a key in this process. This began to play out most specifically in response to the AIDS pandemic that was sweeping the city” (Larsen and Lanham 2002: 34). Church in Action, in their vision for city transformation, identified six key areas for citywide intervention and AIDS was one of them. PCF and Project Gateway, under Pastor Craig Botha, was charged with leading this initiative. Once again Craig approached the researcher for a formal establishment of a project under the umbrella of PG, overseen by PCF. The researcher, in consultation with the Mercy Ministry team, designed the project utilising the data gathered over the previous years. It was clear that there were many orphans in the community as a result of AIDS related deaths, who needed care. In this case the project to be established in response to the pandemic, should be a holistic one intervening in the HIV situation. The concept of helping people die with dignity was to be done away with, and replaced with helping people to live and care for their own families. The founding documents were finalised and a proposal for funding from donors was put in place.

Finally, having met the basic needs in the area of HIV and AIDS informally through the church context of Pietermaritzburg Christian Fellowship for a number of years, the Community Care Project was formally established and moved into its base at Bethany House¹² in May 2000. The house, besides being used for offices, was used for the training of church volunteers and community members in HIV and AIDS issues, as well as providing counselling rooms. Trainees were community members, in and around Pietermaritzburg and Impendle, who were trained to be able to support, care for and equip their own families and neighbours.

In 2001, recognising the needs of the CCP’s target communities, it became evident that a strategic plan was necessary to address these needs (particularly those resulting from poverty and HIV and AIDS and focusing on children and care-givers). To this end a situational analysis was conducted, feeding into the strategy aimed at mobilising the community, through the Church, to be trained and assisted to manage and break the silence that hinders interventions into the pandemic. By this the CCP exists to see to the

¹² Bethany House is located at No. 3 Burger Street and was given to Project Gateway for its HIV and AIDS work by the Msunduzi Municipality.

establishment of a holistic and practical base for the fight against the spread of HIV and AIDS and a vehicle for breaking the silence and reducing the effects of the disease by:

- Providing hands-on practical wellness training for Home-Based Care (H-BC) and Childcare training and support to selected members of churches in and around Pietermaritzburg.
- Providing HIV and AIDS Education and Leadership Development in HIV and AIDS issues in selected Schools in the Pietermaritzburg Area.
- Providing a *Future Hope* for Orphans and Vulnerable Children filtered through the Churches and Schools programmes.
- Facilitating Churches to initiate Community Based Organisation (CBOs) or Projects to work with affected families (those identified families whose PLWHAs and OVCs CCP works with) to manage the disease.
- Establishing Sustainability Programmes with Stakeholders to help them start some businesses or gardens, to receive spiritual supervision, and to help those families who qualify, to access government grants to sustain these families.

The implementation of this strategic plan is through the CCP model for dealing with HIV and AIDS and breaking the silence around the disease, which makes use of 2 principles, put forward by NAT: 1) the Filtration Principle and 2) the 2x2x2 Principle. The former uses the Church and the School as captive audiences for HIV and AIDS Prevention education and mobilisation to enter the community; the latter helps in the dissemination of the HIV and AIDS information in a rapid way

For the above strategy, when the research opportunity came for the researcher to look into the cultural underpinnings influencing the HIV and AIDS silence in the Pietermaritzburg Area in 2001, CCP was the immediate choice. Through CCP, a research project was instituted to investigate the cultural reasons underpinning the HIV and AIDS silence and ways to deal with it.

The CCP strategy, now in its eighth year of implementation, has over the years attracted funders including: SIM, HopeHIV, Geneva Global, KNH, DCI, Dorcas Aid International, the UK Trust, NAMPAK, National Lottery, Ithemba Aids Foundation, NABTA, ABI, AAC Trust, Irish AID, PEPFAR and individuals and Churches.

1.4.5 Selection of Respondents (Sampling)

One of the main purposes of qualitative research is to understand social phenomena from the respondents' perceptions. For this to occur, the researcher, to some extent, participates in the respondent's life during the research (McMillan and Schumacher, 2001:15-16). Participants are asked questions in relation to their beliefs, opinions, characteristics, and past or present behaviour" (Neuman, 1997:228). In this study, our interest is in both the description of personal experiences and the understanding of the phenomenon of silence around HIV and AIDS. In line with our study, Kelly specifically says "The reality of HIV infection, for example, is not only constructed by, and through, people who have direct personal experience and knowledge of HIV infection" (2006: 293).

The selection of the study population was based on sampling methods including: opportunistic sampling; snowball or network sampling, stratified sampling and purposive or judgemental sampling. In these approaches, respondents included PLWHAs. The PLWHAs were four members of the Support Group who agreed to be interviewed in advance (*see*: Appendices 5C1 to 5C4) , as well all 29 members who attended the Support Group meeting for the answering of questionnaires as the group were reminded weekly about the event several weeks before it took place (*see*: Appendices 5G and 5G1 for questionnaires and detailed results respectively). 10 female and 8 male Support Group members were selected to be part of Focus Group Discussions (*see*: Appendix 5J1 detailed results). Those who answered the questionnaires were then given copies to be taken to other PLWHAs they knew within their communities who were not members of the Support Group. 21 people received and answered the questionnaires (*see*: Appendices 5H and 5H1 for questionnaires and detailed results respectively). Two PLWHAs, who are not members of the Support Group were also referred to by their Support Group friends for interviews (*see*: Appendices 5C5 and 5C6).

An interview was conducted with one family member of a founding Support Group member who has worked with CCP in the area of HIV and AIDS for a considerable period of time (*see*: Appendix 5C10). Among the respondents were also pastors who work closely with CCP, who have had the opportunity to work with people infected and affected by HIV and AIDS and therefore understand issues pertaining to the disease. One

pastor was interviewed (*see*: Appendix 5C7) and 10 pastors answered questionnaires (*see*: Appendices 5D and 5D1 for questionnaires and detailed results respectively). The CCP member of staff who has been in charge of the Support Group since its inception was interviewed (*see*: Appendix 5C9).

Among the respondents were 12 Caregivers who answered questionnaires (*see*: Appendices 5E and 5F1 for questionnaires and detailed results respectively), and one who was interviewed (*see*: Appendix 5C8). Thirty church members who expressed interest in working with individuals and families infected and affected by HIV and AIDS who were undergoing training by CCP were also given the opportunity to respond through questionnaires (*see*: Appendices 5E and 5E1 for questionnaires and detailed results respectively). Forty one members of the CCP Youth from the communities where CCP works, were among the respondents. These are mainly students from the families that CCP works with and are deeply affected by HIV and receiving various interventions from the organisation. One member was interviewed (*see*: Appendix 5C11) and all the 41 answered questionnaires (*see*: Appendices 5I and 5I1 for questionnaires and detailed results respectively).

1.4.6 Ethical Considerations

In any research, respondents have the right to refuse to participate in any method chosen to gather information, and the right to confidentiality, privacy and anonymity. McMillan and Schumacher on their part remind researchers of the need to be sensitive to ethical principles “because of their research topic, face-to-face interactive data collection, an emergent design and reciprocity with participants” (2001:420). The ethical problems to be considered, among others, include: informed consent from respondents, deception on the part of the researcher, harm to participants, and privacy (McMillan and Schumacher, 2001: 420-422).

In this research, only those respondents who were willing to participate were interviewed, given questionnaires or involved in any activities, including group discussions. Respondents were briefed on the topic of the research and were given consent forms to sign (*See*: Appendix 5A). As part of the research process, an agreement was made with CCP to utilise its confidentiality policy, in which respondents and participants were

assured of confidentiality. The policy of CCP also allows interventions into the lives of OVCs that help them to cope with life. Permission was sought from CCP to undertake research on the effectiveness of these interventions to OVCs, youth (both in schools and communities), PLWHAs and their families, in contributing to the engaging and breaking of the HIV and AIDS silence. Completed questionnaires and data were kept locked up and no personal detail was revealed to anyone. Due to issues of confidentiality, a decision was made to conceal or change the names of the respondents.

In the research process, steps were taken to avoid harm to participants, either physically or emotionally. More often than not, participants, especially Support Group members, were given money for transport, snacks or lunch, and counselling when needed. The final thesis will be published without disclosing the identification of participants. Only interviewees who wished to be quoted will have their names mentioned.

1.4.7 Data Gathering Techniques and Methods

Most qualitative researchers use multi-method strategies. In this research, a Case Study of PLWHAs was the central method of research, with other methods arising from that in order to collect and corroborate data. The research used a multi-method strategy of looking for convergent evidence from different sources such as interviews, participant observation, questionnaire administration, etc., in what Kelly (2006:287) calls methodological triangulation. As suggested by Greeff, all the data-gathering techniques used in this research were piloted with a small number of respondents, to help the researcher come to grips with some of the practical aspects of the data-capturing process, and to eliminate all ambiguity and confusion that might arise (2002:300).

Using a multi-method approach, this study followed Neuman's technique for field research:

Most field researchers conduct case studies on a small group of people for some length of time. *Field research* begins with a loosely formulated idea or topic. Next, researchers select a social group or site for study. Once they gain access to the group or site, they adopt a social role in the setting and begin observing. The researchers observe and interact in the field setting for a period from a few months to several years. They get to know personally

the people being studied and may conduct informal interviews. They take detailed notes on a daily basis. During the observation, they consider what they observe and refine or focus ideas about its significance (1997:32).

This field study began by gaining insights on the situation of HIV and AIDS silence from a situational analysis of the research area conducted between 2001 and 2003 by the researcher through two organisations: CCP and ECAP. The researcher then used multi-method data collection techniques for the study, including: case studies, in-depth interviews, questionnaires, Focus Group discussions and personal observations and reflections.

1.4.8 Data Analysis

Data collected in this research, as a result of employing multi-method data collection techniques, was subjected to both qualitative and quantitative analyses. Most of the data collected is qualitatively analysed. Neuman notes that in qualitative study, “Data analysis involves examining, sorting, categorising, evaluating, comparing, synthesising, and contemplating the coded data as well as reviewing the raw and recorded data” (1997:427). Even though through the inductive process the raw data is analysed to bring to the surface narrative and visual representation, a deductive mode of thinking at suitable times is employed to ensure more abstract levels of synthesis.” (McMillan and Schumacher, 2001:462).

Analysing data in this research used both inductive and deductive processes, which means that, in the data analysis process, the researcher kept revisiting, double-checking and refining the various phases of the process. On occasion the researcher went back to the field to obtain additional information to ensure the proper validation of emerging patterns. The field data was critically analysed to ensure that accurate deductions were made about whether the dimensions of culture¹³ contribute to the HIV and AIDS silence or not, and to what extent the interventions of CCP were able to suggest constructive ways of engaging the fertile silence surrounding the barren HIV and AIDS silence for the barren silence to be exposed and broken.

¹³ ‘Dimensions of culture’ is a terminology, which is a dimensional framework for characterising culture, and was advanced by Geert Hofstede¹³ to analyse culture into various dimensions on a continuum. It will be considered in details in Chapter 3.

1.4.9 Validity/Credibility

Van der Riet and Durrheim (2006:90) consider validity or credibility of a study as the extent to which the research conclusions are sound. In other words it means “the degree to which the explanations of phenomena match the realities of the world” (McMillan and Schumacher 2001:407). Credible research results in findings that are convincing and believable. In qualitative research, McMillan and Schumacher (2001:407) maintain that validity rests on the data collection and analysis techniques used and enhanced by the use of a combination of existing strategies including: prolonged field work, multi-method strategies, participant verbatim language, low-inference descriptors, multiple researchers, mechanically recorded data, participant researcher, member checking, participant review, and negative cases. This research combined most of these strategies, as mentioned before, in the data-collection process and allowed triangulation as well as assessing the reliability of the data through correlation with literature reviewed.

1.5 The Field Data Collection Process and Results.

The field research data for this study was gathered using multi-method data collection, ranging from a pre-research situational analysis (1999-2003) to case studies (2004-2007). Due to the volume of data obtained from the various methods used in the study, the detailed information on how the Situational Analyses, Case Studies, In-depth Interviews, Focus Groups Discussions and Questionnaires were conducted, and the subsequent results obtained, can be found in Appendix 5 Series. However, outlined below is a summary of events and periods within which these various data collections took place:

- ***Situational Analyses:***

Prior to this study, between 1999 and 2003, the researcher had helped in the establishment of ECAP and CCP, two sister church organisations that work in the field of HIV and AIDS in the communities in and around Pietermaritzburg where this study was conducted. During this period the researcher led the staff of these organisations to conduct situational analyses, through the churches in the area of operation.

The situational analysis of ECAP (1999-2000) and CCP (2001-2003) showed denial, discrimination and stigma as the main ingredients that feed into the silence

surrounding the disease. It was this which drove the research question for this thesis. (see: Appendix 5A1 for a detailed results of Situational Analyses).

- **Case Studies:**

Three different case studies falling within the 2004 to 2007 period of the research were done. During this period the researcher, with his team, had an opportunity to interact with the Support Group as a whole from 2004-2007 (Case Study 1), the youngest of the Support Group and her family from 2004-2006 (Case Study 2) and the member of the Support Group living longest with HIV infection and family, from 2004-2005 (Case Study 3).

- **Case Study 1** is centred around the support group known as the CCP Support Group. It was formed in May 2004 with 4 active members who were clients of CCP suffering from different HIV-related illnesses. The motivation behind the formation of this group was that findings of the situational analysis conducted between 1999 and 2003, concerning people living with HIV and AIDS, revealed that infected people were not ready to disclose their status and a number of them were dying without proper social and emotional support. However, the literature reviewed indicated that people in a high context culture such as the research area, exhibit less barren silence on HIV and AIDS whilst maintaining more fertile silence around the issue. Further, it was noted that it is only through culturally sensitive education, relationships building and trust that the fertile silence around the disease is engaged with. It is through engagement with the fertile silence that infected people and their families, if they know, will disclose their HIV situation and status to others. The CCP Support Group was therefore formed to determine whether interventions from CCP with the members, their families and relations, would have the desired aim of building relationships and trust leading to engagement with the HIV and AIDS silence. The following activities were implemented with the Support Group members: social and emotional support, home visits, an education through wellness course, weekly devotions and monthly prayer meetings.

The CCP interventions above helped the members to be open with one another and the CCP team. The members began to invite others in their communities known to be HIV positive to join the group. The openness about their HIV status helped the CCP team to intervene with the families of members, to help some of the Support Group members disclose their status to family members, an action that most saw as the most difficult thing to do and yet was seen as a major breakthrough to their recovery. Members were helped to get onto ARVs and their family members were equipped to manage the HIV situation in their family. The group members became a source of support for each other. Interactions and discussions with the group revealed that good relationships and trust were built between the researcher, CCP staff and the Support Group members (and most of their families) which led to real engagement with silences surrounding HIV and AIDS. The group continued to grow and at the end of this research in 2007 the registered number of people was 150 with an average weekly attendance of 40 HIV-positive members (*See: Appendix 5B1 for detailed account of Case Study 1*).

- ***Case Study 2*** covers the history of the youngest member of the Support Group and explores how, through the group, she dealt with her own silence around HIV and AIDS within culture. Thuli¹⁴ was the youngest among the four enthusiastic women living with HIV who started the Support Group at CCP in May 2004. She had been involved with the CCP since 11th of February 2003. She was referred to them at the age of 17 when she was critically ill, could not even walk and was living in an unhygienic environment with her mother. The CCP team helped by cleaning the house and offering regular food parcels, vitamins, infection control, clothing, and lots of love and prayer. She improved a great deal within three weeks and was again able to walk unaided. She returned to school and started a normal life just like any other teenager. Thuli, in her testimony during the first Support Group meeting, revealed that she was able to go back to school six weeks after her referral to CCP, when everyone around her, including her own family, had given up hope of her surviving. Even though, clinically, Thuli had many opportunistic HIV infections, she did not know her status during all of this time;

14 Thuli is not the real name of this respondent. It is name coined for her to protect her identity as the youngest member of the group.

she only tested HIV-positive in 2004 after much encouragement from CCP. She later joined the CCP Youth Group and was very instrumental in the running of the youth programme in CCP.

The CCP prayer meeting on the 6th of May 2005 was the day that Thuli took steps to engage with the HIV and AIDS silence in her own life. After hearing the preaching on the topic: "What do you want me to do for you", from Luke 18:35-43, Thuli became the first PWLHA to respond openly to the call to be prayed for publicly. Her response inspired two other Support Group members to come forward to deal with their HIV silence before a gathering of about 120 people from the communities in and around Pietermaritzburg. Since then the nature of the prayer meeting changed from praying generally for the sick to praying specifically for people who are HIV-positive and by touching and hugging them. The interesting part of Thuli's boldness was that though she was brave enough to declare her status to about 120 strangers in the church, it took her two years after knowing her HIV status, to disclose it to her mother and sisters. This happened on the 14th of June 2006.

When Thuli became strong and healthy enough, she started sleeping around and defaulting in her medication. She visited a *Sangoma*¹⁵ and was given "Muti"¹⁶ which she took whilst taking other medication from the hospital. On the 4th of September 2006, her illness became critical and she was rushed to the hospital, where she died a few hours later. The funeral and burial for Thuli took place on the 9th September 2006. The staff of CCP and the various other groups contributed towards a well-organised and attended funeral. As was personally requested by Thuli, the researcher conducted the funeral and preached a message on HIV, pointing out the need for people to help others who are infected. The family are still linked to CCP (*See: Appendix 5B2 for detailed account of Case Study 2*).

15 Sangoma is the traditional doctor or traditional healer. They are also known as witchdoctors, even though they prefer to be called traditional doctors or healers. In this research these names are used interchangeably.

16 This is the potion one gets from the traditional doctor.

- **Case Study 3** looks at whether or not the various interventions of CCP with Mama Zulu¹⁷ and her family helped her to deal with her silence around HIV and AIDS in the midst of the dimensions of culture. The case study follows various areas of Mama Zulu's life, not necessarily in chronological order. She was 48 years old when the Support Group started in May 2004 and had by then been living with HIV for 10 years. She was one of the very few clients of CCP who disclosed her status to some of the CCP staff before the establishment of the Support Group. Mama Zulu had been on CCP's programme with her 10 children for a little more than a year before the establishment of the Support Group. The last five children in particular, whose ages ranged from nine to eighteen at the time, received interventions from the CCP programme. In terms of Mama Zulu's care and diagnosis she also had multiple other health issues, both physical and psychosomatic. She always looked sick in the sense of being very wasted and having a constant cough.

Besides the Support Group and CCP, Mama Zulu had good support from her church. Though Mama Zulu was involved in the Support Group, she had not told any of the children about her HIV status. As the researcher and the team interacted with all the children, it was clear that the older children were suspicious about their mother's health and because of their own sexual experience saw the CCP team as a threat rather than a help to the family.

By October 2004, one could see that Mama Zulu's health was deteriorating and that ARVs would help her. She pointed out how the discussions in the Support Group around disclosure had made her aware that her family, especially the younger, ones needed to know the truth. Her biggest problem was that as her four girls were members of the CCP Youth Group and learning about HIV and AIDS, it would be in the family's best interest for them to know that it was HIV that was making her sick, rather than them discovering it themselves and confronting her. After all, the four girls knew very well that CCP is an HIV project, yet the disease was not discussed in their family.

¹⁷ Mama Zulu is not the real name of this respondent. It is name coined for her to protect her identity as the member of the group living longest with HIV.

Mama Zulu requested the researcher and the social worker to help her disclose her status to the five younger children. This took place on 15 November 2004, and was an emotional moment. A week later, the researcher, the social worker and the CCP youth worker went to the family to give them some encouragement. In an unexpected way, the 19 year old daughter apologised to her mother for having carried the HIV burden alone and promised her their support. The rest of the children contributed and assured Mama Zulu of what each one of them would do to make life easier for her. The team also assured all of them of CCP's continual help and support all times. Soon after the disclosure Mama Zulu's health started to deteriorate rapidly and she was admitted to the hospital. The youth from CCP went there regularly to sing and pray with her. On the March 10th 2005 at 3.00 p.m., with the help of CCP, Mama Zulu's children performed a dance, amidst the youth group and the government hospital's staff, for their mother, who was very weak and tender.

As the days went by, she became very weak and passed away on the 27th March 2005. There is still a strong relationship between this family and CCP (*see*: Appendix 5B3 for a detailed account of Case 3).

In a number of ways the case studies show how interventions from CCP helped members of the Support Group deal with their HIV and AIDS silence. Most of the Support Group members at the time they joined the group found it very difficult to disclose their status to their family members. However, they were able to disclose their status to their own family members. Through the prayer meetings members were able to come forward publicly to disclose their HIV positive status and request for prayers.

- ***In-depth Interviews:***

Through a snowballing sampling process in-depth interviews were conducted with 11 respondents, within the Support Group network. Stratified purposive sampling was used to identify the individuals to be interviewed. The respondents were to be either

members of the Support Group or those who were closely related to them. The researcher selected four respondents from the Support Group – the oldest member, 57 years (since she had agreed from the very beginning to be interviewed), the youngest Support Group member at the time of interviews (21 years) and two other Support Group members (a male and a female) with an average age between the youngest and the oldest (i.e. $57+21 \div 2 = 39$). The others were randomly selected from different groups that closely relate to the Support Group members. They included two PLWHAs who are non-Support Group members referred by members of the group (a male and a female), a pastor, a caregiver, a family member of one Support Group member, a Youth Group member and a CCP staff member. These were open-ended interviews aimed at exploring the research problem statement: *Can the cultural reasons underpinning the HIV and AIDS silence be identified to provide clues for engaging with and breaking the silence and providing a way forward for dealing with the HIV and AIDS epidemic?*

Owing to the sensitive and personal nature of the research topic, the researcher and his team took extra precautions to ensure confidentiality. To this end the presentation of the data is kept anonymous, and if a name is mentioned at all, it is not the real name of that person. Most of the respondents did not want audio recordings of the interviews, and the researcher decided to take notes of the proceedings. All interviews took place at a venue chosen by the respondents for their own security and freedom. Where respondents understood English, it was used as the medium of communication. Where the respondent preferred, the Zulu language was used with an interpreter. Personal observations and reflections of the researcher were noted.

In an attempt to answer the main research question, various questions were asked, relating to how the various dimensions of culture impinge on the HIV and AIDS silence and how various people have dealt with HIV and AIDS disclosure. However, interviews with the family member of a PLWHA and the Youth Group member, followed a different set of questions and concentrated on the third question of the main research question, i.e. *Can the interventions provided by the Community Care Project suggest constructive ways of engaging with or breaking the silence*

around HIV and Aids in the Pietermaritzburg area?. For full and detailed account of the other interviews *see*: Appendices 5C1 to 2C9.

After the analysis of the data that was gathered, the researcher went back to the pastor, the male Support Group member, the female Support Group member and the CCP Staff member for more in-depth interviews to seek clarifications and more insights on issues of stigma and discrimination and silence revealed by the analysis. Other informal discussions with colleagues in the field as well as the support Group on the issues also took place.

- ***Administration of Questionnaires:***

The questionnaires were an important part of the research method as they provided for triangulation through access to another form of data. They broadened the pool of respondents and confirmed the findings obtained from the face-to-face interviews. Furthermore, they gave an opportunity to respondents who were available for interviews to answer questions and feel that they were contributing to the research findings. The actual empirical questionnaires were preceded by a pilot testing.

Questionnaires designed mainly for the Support Group members were piloted between 2nd and 5th April 2007, with two randomly selected people from each of the four groups to whom the questionnaires would be administered: namely a Support Group member, a pastor, a Church trainee and a caregiver. The respondents had no problems in answering the questions, although some of the questions were not applicable to non-Support Group members. However, explanations had to be given to respondents on the terminologies used for the various dimensions of culture in questions under the heading “Communities – Dimensions of Culture”. The questionnaires for youth and non-Support Group PLWHAs were also piloted during the same period with two randomly selected people each of the two groups. The questions which were set to establish out how the respondents experience HIV disclosure were answered without problems.

The questionnaires for the formal empirical study were administered to six main groups, namely; Members of CCP Support Group, non-Support Group PLWHAs in the community, Pastors, Caregivers, Church Trainees and the CCP Youth Group. Questionnaires were composed of similar questions used in the interview, and were intended to corroborate the findings of the interviews and to focus group discussions so as to answer the research questions:

- a) Does the culture of the people contribute to the way silence ‘works’?
- b) To what extent do cultural dimensions contribute to the silence around HIV and AIDS?
- c) Can the interventions provided by the Community Care Project suggest constructive ways of engaging with the silence around HIV and AIDS in the Pietermaritzburg area?

- ***Questionnaire for Pastors:*** The researcher administered questionnaires on Monday 16th of April 2007 (*see: Appendix 5D*) to ten pastors who work closely with CCP, and managed to collect all of them by Wednesday 18th April 2007, giving a 100% participation. The pastors’ questions follow the pattern of the Support Group, with relevant changes amounting to 27 questions in total, and were written in English. The questions were grouped under two headings, namely: Your Status, and Communities and Dimensions of Culture (*See: Appendix 5D1 for detailed results*).

- ***Questionnaire for Church Trainees:*** Thirty Trainees from 11 churches participated in a group-administered questionnaire (*see: Appendix 5E*) on Friday 11th May 2007 at Bethany House. All 30 Church Trainees were willing to answer the questionnaire, which was written in English. The questionnaire consisted of 31 questions grouped under three main headings, namely: Status, The Church, and Community Dimensions of Culture (*See: Appendix 5E1 for detailed results*).

- ***Questionnaire for Caregivers:*** The Caregivers were invited to Bethany House on Friday 25th May 2007 and participated in a group-administered questionnaire (*see: Appendix 5E*). The questionnaire was the same as that given to the Church Trainees, as the Caregivers are all from churches and were also once Church Trainees. All of the 12 Caregivers attending the training were willing to answer

- the questionnaire, which was written in English. The questionnaire consisted of 31 questions grouped under three main headings, namely: Status, The Church, and Community - Dimensions of Culture (*See: Appendix 5F1 for detailed results*).
- ***Questionnaire for Support Group:*** The Support Group meeting of Tuesday, 29th May 2007 was devoted to the filling in of group-administered questionnaires for members who were willing to participate. All 29 members who attended the meeting were willing to answer the questionnaire. Questionnaires were written in both English and Zulu (*see: Appendix 5G*). In all there were 37 questions grouped under five headings, namely: Your Status, The Church, HIV Prayer Meeting, Support Group and Communities - Dimensions of Culture (*see: Appendix 5G1 for detailed results*).
 - ***Questionnaire for PLWHAs in the community (non-Support Group members):*** The Support Group members who participated in the group-administered questionnaires on the 29th May 2007 were asked to take questionnaires to community members they know to be living with HIV but who are not members of their group, and to and bring completed questionnaires to the meeting on 5th of June 2007. The questionnaires, (*See: Appendix 5H*) composed of 8 questions, aimed at assessing how best to disclose one's HIV status in the community and were both in English and Zulu. Of the 29 questionnaires that were distributed, 21 were returned, giving a 72.4% recovery. (*see: Appendix 5H1 for detailed results*)
 - ***Questionnaire for the Youth Group:*** The meeting of Youth Group on Friday, 22nd June 2007 was devoted to a group-administered questionnaire (*see: Appendix 5I*) for the youth who were willing to participate. All 41 members who attended the meeting were willing to answer the questionnaires. The youth were given 10 questions to answer, which were written in English. Detailed results are provided in Appendix 5I1
 - ***Focus Group Discussions:***
The focus group discussions were conducted with the HIV Support Group. The main purpose of including the focus group was to discuss issues pertaining to HIV disclosure, so as to find out to what extent CCP interventions with the Support Group

have helped members to understand their role in engaging with the HIV silence. It was also to assess the effectiveness of the CCP intervention in helping the Support Group members to engage with the HIV and AIDS silence. Three separate focus group discussions were carried out. The first comprised 10 randomly selected, all female, Support Group members (FGD1). The second comprised 8 randomly selected, all male, Support Group members (FGD2). The third comprised 10 randomly selected Support Group members (FGD3), half female and half male, chosen from those who participated in the all-male and all-female groups.

Members of the first group were selected by writing the names of all the females who indicated their willingness to be part of the discussion, on pieces of paper and folding each of them and putting them into a hat. There were 13 names of those who were willing to participate out of 17 present in the meeting of the 29th May 2007 when they answered the questionnaires. The register of the Support Group had 105 females listed at that time. The same was done for the males who indicated willingness to be part of the discussions. There were 10 names out of 12 present, and 15 males registered in the support group at that time. The researcher then asked one of the CCP Team members to pick the number of people needed for each group from each hat. Those selected were asked to confirm their participation and when they had done so, invited to participate in the discussions on set dates (*see*: Appendix 5J1 for detailed results of the Focus Group Discussions).

- ***Focus Group discussion 1 (FGD1)***: The group consisted of 10 women and the discussion took place at 13.00 on 5th June 2007, in the CCP training room. The researcher himself conducted the focus groups, with the help of two Zulu-speaking CCP staff members who acted as interpreters. The researcher and the two CCP staff all took notes of the discussions and these were then collated. Three questions were discussed, focusing on the difficulty in disclosing HIV status to one's partner, and the respondents' roles in dealing with HIV and the silence that surrounds it (*see*: Appendix 5J1 Sub 1.0 for detailed results).
- ***Focus Group discussion 1 (FGD2)***: The group consisted of 8 men. The discussions took place at 14.30 on the 5th of June 2007 in the CCP training room. The researcher conducted the focus groups himself with the help of two Zulu-

speaking CCP staff members who acted as interpreters during the discussions. The researcher and the two CCP staff all took notes of the discussions. Three questions were discussed, focusing on the difficulty in disclosing HIV status to one's partner, as well as the respondents' roles in dealing with the silence that surrounds it (*see*: Appendix 5J1 Sub 2.0 for detailed results).

- ***Focus Group discussion 1 (FGD3)***: This group consisted of five women and five men. The discussion took place at 14.30 on the 12th of June 2007, outside the CCP building while participants warmed themselves in the sun. The researcher himself conducted the focus group with the help of two Zulu-speaking CCP staff members who interpreted the proceedings. Notes were also taken by the researcher and the two CCP staff members. The respondents had three questions to discuss: looking at culture, how culture affects HIV disclosure, and how the Support Group has benefited this group in engaging with the HIV silence (*see*: Appendix 5J1 Sub 3.0 for detailed results).

- ***Field and Participant Observation:***

The researcher's involvement in the establishment of ECAP and CCP, through the situational analyses, provided initial field observation for this study. Attendance at Support Group meetings from the start provided a lot of observation through various activities during meetings, personal interactions with members and other important persons in their lives (their significant others) during visitations to their homes and communities. The field observations by the researcher accounted all the 3 case studies.

During all the 11 in-depth interviews and the 3 different focus group discussions, the researcher noted his personal observations and reflections. These observations and reflections led to further discussions and informal interviews with participants.

1.6 Limitations of the Study

The main limitation of this study is the fact that the researcher is not a fluent Zulu speaker and mostly had to depend on others to interpret discussions and interviews where respondents did not speak English fluently. In order to minimize errors in this case, the researcher had to go back to some of the respondents to clarify some of the issues

raised, with a different interpreter to ensure they heard right, understood what they were being asked and that their response were correct. Linked to the question of language was the translation into Zulu of new concepts in the area of dimensions of culture, with further explanation of terminology to respondents with low education level, to help them understand the concepts. Care was taken to ensure that explanation of concepts did not influence their responses to the questions. The other limitation to the study was the fact that as a result of the nature of the study, a snowball methodology was used for sampling and so the sample size was out of the control of the researcher.

1.7 Outline of the Study

The Study is divided into seven chapters. Following the general introduction, Chapter 2 is devoted to understanding the phenomenon of silence. Looking at silence through an anthropological lens, the first part of the chapter considers the complex nature of silence. This is followed by considering how Edward Hall categorised cultures¹⁸ into two main groups: low-context and high-context communication cultures and how this impacts on the silence phenomenon. According to Hall, communication in high context cultures is implicit and indirect. The social importance and knowledge of the transmitter of the message and the environment surrounding the message add extra meaning to the information. An interpretation of the context of the communication is consequently necessary in order to develop a good understanding of the message. Low context cultures, on the other hand, depend more on spoken words or presented actions for meaning, without having to read between the lines. In this case communication is expected to be clear and direct. The chapter then helps us answer the first research question: Does the culture of the people contribute to the way silence ‘works’?

Chapter 3 looks at *dimensions of culture* and how they work in cultures to promote silence. The chapter considers five cultural dimensions. One is proposed by Hall, High-Low Contexts, as a main dimension of culture. This embodies five others proposed by Hofstede: Time orientation; Power distance (PDI); Individualism/collectivism (IDV); Masculinity/femininity (MAS) and Uncertainty avoidance (UAI). In this thesis, time

¹⁸ It must be noted from the very onset that this study in using culture, recognises its dynamism. As such, it serves to recognise cultural differences without essentialising them. In a continuum, cultural differences are noted in its blending characteristics. This disclaimer is re-echoed in Chapter 3 as the dimensions of culture are introduced as a framework for the study.

orientation is considered simultaneously with uncertainty avoidance and Hofstede's categories are seen as four. Consideration is given to the way in which these dimensions contribute to silence. This chapter helps us to begin to answer the second research question: To what extent do cultural dimensions contribute to the silence around HIV and AIDS?

In Chapter 4, the insights from Chapter 3 on the dimensions of culture are considered in relation to the HIV and AIDS silence. Personal experiences of various people living with HIV and AIDS and the experiences of others relating to them in various ways are analyzed to provide evidence of fertile and barren HIV and AIDS silence, emanating from the various dimensions of culture. The chapter helps us now to answer fully the second research question: to what extent do cultural dimensions contribute to the silence around HIV and AIDS?

Chapter 5 engages various current research on HIV and AIDS, looking at the various ways stigma and discrimination exhibit themselves in the field by promoting the barren and fertile HIV silence. The understanding of barren and fertile silence in this way provides clues for dealing with the HIV and AIDS silence and helps to understand the current debate on HIV and Aids silence, stigma and disclosure. The chapter helps us to prepare to look into the third research question: Can the interventions provided by the Community Care Project suggest constructive ways of engaging with and breaking the silence around HIV and AIDS in the Pietermaritzburg area?

Chapter 6, *Engaging the Fertile Silence*, looks at how the CCP Model provides some ways to help us to deal with the HIV silence. Without considering the *CCP model* as the *only* model, it is considered as being a research experience through interactions with people who are in touch with CCP in the field. The experiences bring to light how the fertile silence is engaged with in order for the barren silence to be exposed and engaged with, resulting in HIV status disclosures. The chapter helps us to answer fully the third research question: Can the interventions provided by the Community Care Project suggest constructive ways of engaging with and breaking the silence around HIV and AIDS in the Pietermaritzburg area?

Finally, Chapter 7 concludes the study. This chapter summarises the main findings of the study. Recommendations are made for more effective strategies for breaking the silence around HIV and AIDS, thereby answering the problem statement pointed out in Chapter 1: *Can the cultural reasons underpinning the HIV and AIDS silence be identified to provide clues for engaging with and breaking the silence and providing a way forward for dealing with the HIV and AIDS epidemic?*

1.8 Research Finding

HIV and AIDS continue to be a crisis in South Africa. One of the major contributing factors to the scenario is the silence in and around the disease. Research indicates that silence is a complex phenomenon that is culturally specific; this makes the silence around the disease one that is culturally rooted.

In a continuum, silence in low context cultures denotes *absence* because the vocalisation, expression and visualisation that are needed to communicate with people is not there. We have called this *barren silence*, meaning that when there is silence it is assumed that nothing is being communicated. However, in a continuum, in high context cultures, silence connotes *presence* of information that is expressed in symbolism such as facial expressions and hand movements, which reveal things that are not said or seen. We have called this *fertile silence*, meaning that when there is silence it is assumed that something is being communicated, though not spoken. In a continuum therefore, a low context culture has more barren silence and less fertile silence. In a continuum, a high context culture exhibits more fertile silence and less barren silence

It is our understanding that when people say that we need to ‘break the AIDS silence’, they are assuming that the silence is a barren silence that must be broken so that there can be verbal communication about HIV and AIDS. However, in a high context culture such as our research area, the study shows that one has to first engage with fertile silence, and discover what is in fact being communicated (usually non-verbally and obliquely). Only then will one be able to deal with the barren silence, to start talking about HIV and AIDS. This is because this research has discovered that in a high context culture, the fertile silence wraps completely the barren silence that we seek to break, and needs engagement to expose the barren silence then to be broken (see diagram in Figure 2.4.1) This suggests breaking the HIV and AIDS silence in this culture is not a straight-forward tackling of

that which is absent, by starting to talk about HIV status. One must begin by dealing with the smiles and cries that the face presents. As one deals with what is present, that which is absent begins to unfold.

Aspects of the culture such as taboos on sexual matters, witchcraft, death and its relationship to sickness, the centrality of the family and the need to save its 'face', (among other cultural practices,) contribute to the HIV and AIDS silence. The dimensions of culture also contribute in various ways to the HIV and AIDS silence, as they make infected and affected people and families unwilling to expose their situation for fear stigmatisation and discrimination, leading to Rejection, Gossip, Witchcraft, Shame, Blame, Secrecy, Judgement, Suspicion and Taboos. To deal with this situation, the study, through the work of the CCP, found that building relationships with people is a key factor in engaging the fertile silence that leads to the exposing and breaking the barren HIV silence. It is this finding that has led us to the topic of the research: *Engaging the Fertile Silence: Towards a Culturally sensitive Model for dealing with the HIV and AIDS Silence.*

1.9 Summary

The introduction to the thesis provides an overview of the rationale behind the study. HIV and AIDS poses a major crisis to South Africa, and all efforts need to be made to deal with this crisis. The silence around the disease is hampering all efforts to deal with it effectively, hence the need to examine the silence in and around HIV and AIDS is crucial. This is a major issue that the World AIDS Conference in South Africa in Durban in 2000 recognised. The assumption of this research is, therefore, that cultural factors underline the silence around the disease, and that these factors should be studied in order to establish an effective way of dealing with the problem.

Located in Pietermaritzburg, the epicentre of the HIV and AIDS pandemic, this research hopes to unearth the cultural underpinnings of the HIV and AIDS silence through field research.

CHAPTER TWO – THE SILENCE PHENOMENON

2.0 Introduction

One of the major difficulties in dealing with the HIV and AIDS problem in Africa has been that of dealing appropriately with the silence that surrounds the disease. It is for this reason that many calls have been made for “breaking the silence” (Piot 1999: 1). For South Africa in particular, Morrell recounts “For nearly ten years, the slogan ‘Break the Silence’ has been a feature of AIDS prevention work in South Africa” (2003: 41). It is for this reason that the world conference on AIDS at the threshold of the new millennium in South Africa (9-14 July 2000), focused on the need to break the silence. Robin Lustig, reporting from the Durban AIDS conference for BBC Radio 4 and World Service, pointed out that the conference focused world attention on AIDS, and in particular on AIDS in Africa with the theme “Break the Silence” – “because for millions of Africans, the stigma of living with HIV and AIDS is still too great, and they suffer alone and in silence” (Lustig, 2000). He added that, slowly, governments in Africa and elsewhere are waking up to the scale of the disaster, but many more millions will die before this 21st century catastrophe has been beaten. It is against this background that the former president of the host nation, Nelson Mandela, made the statement to the world that “The challenge is to move from rhetoric to action, and action at an unprecedented intensity and scale.” (Garcia 2000: 2).

In South Africa this call to ‘move from rhetoric to action’ is exemplified by the Treatment Action Campaign (TAC)¹⁹ to which, “Break the silence” is a very audible slogan. “The slogan is a response to the reluctance of individuals who are HIV positive either to test or to disclose their status” (Morrell 2003: 41). A quick and rapid response to breaking the silence on HIV and AIDS is necessary from all walks of life. This task, however, demands a thorough understanding of the silence we are dealing with, in order for it to be properly ‘broken’.²⁰ To do this demands a considered response to the cultural

19 TAC is a group of HIV/AIDS activists who have themselves tested positive to the HI virus.

20 For now the term “breaking the silence” is used as the way to deal with the silence that surround HIV and AIDS but as the studies progress and the nature of the silence surrounding HIV and AIDS, with respect to the culture of the people has been identified, then we will know whether there are ways of dealing with the silence other than breaking it, and if it can eventually be re-channelled or eliminated.

and social dimensions of the subject. In breaking the HIV and AIDS silence in Africa in particular, Airhihenbuwa's call for the necessity of any group or community-based interventions addressing health behaviours to begin with culture is very crucial. This will help to determine whether a community's health and illness behaviours are "rooted in (its) cultural values and beliefs" (1995: 11).

As noted in Chapter 1, the ultimate aim of this thesis is to investigate the silence that surrounds HIV and AIDS from a cultural perspective, and to suggest a better way for "breaking" the silence through using the interventions by a church-initiated project, the Community Care Project. However, in order to know and understand the silence that surrounds HIV and AIDS it is important to understand the phenomenon of silence itself. This chapter therefore looks at what the silence phenomenon is, by investigating the forms in which it manifests itself. An attempt is made to consider silence beyond the normal dictionary definition or the 'normal' understanding of the term. In this way we will be able to identify the different forms of silence, and thus gain a deeper understanding of the silence around HIV and AIDS.

Looking at silence in this way will avoid misconceiving it as being uniform, and failing to recognise its multifaceted and multifunctional nature (Höritzauer-Wilhelm 1986:21). In this way the chapter reveals the complex nature of silence that leads us to investigate the cultural context of South Africa within which it is manifested.

2.1 Silence as Absence?

Silence is that part of human life which, when mentioned, is immediately considered to imply an *absence*, either by consent or by complicity. Any dictionary, in defining 'silence', has a line referring to an absence of sound.²¹ Phil Thompson points this out as a common attitude of the "West": "Silence is a kind of nothingness or absence, an absence to be feared, detested or even challenged" (2003). He even wonders why the very first definition of silence given in The Canadian Oxford Dictionary, for example, is

²¹ I have made a conscious effort to look at the definitions of silence in any dictionary I lay hands upon and not a single one has failed to mention the absence of sound.

“the absence of sound or noise.” For Thompson the understanding of silence as absence is mingled in the tradition of the ‘moment of silence,’ which honours the absence of valued bodies and lives, and is a departure from the usual sociality of sound-making. He quotes Schafer:

“Man (sic) likes to make sounds to remind himself that he is not alone. From this point of view (or “point of hearing,” one should perhaps say) total silence is the rejection of the human personality. Man fears the absence of sound as he fears the absence of life. As the ultimate silence is death, it achieves its highest dignity in the memorial service.” (1980: 256).

However, I do not consider that the attitude of equating silence to absence of sound or speech is a problem in the “West” alone. It is a human understanding that must be appreciated. Silence, in this understanding of absence of sound, is consciously observed when, for example, someone is offering a speech – the others must refrain from producing any form of sound so as to help people make sense of what is being said. In human life, Schmitz says “Being silent can be expected of us in one situation and unexpected in another, but it can also be incidental” (1994). It is a tool for communication and brings meaning to some situations.

Silence can be considered as a pointer that needs to be followed to a specific meaning. As Clayton rightly points out, “The presence of silence is universal; however, its meaning and use vary considerably from culture to culture” (2003:119). Silence always has something to point to which can only be determined within the correct cultural interpretations. However, cultures themselves have been defined according to several perspectives, ranging from the most simple (e.g. Hofstede, 1997)²² to the most complex and the most comprehensive (e.g. Kluckhohn, 1962).²³ To be able to break silence, its specific understanding within a given cultural perspective is crucial.

Silence used non-verbally is not only used by an individual but also by a group. For example, our church leadership arranged for the congregation to watch the movie, *The*

²² Hofstede defines culture as “the collective programming of the mind which distinguishes the members of one group or category of people from another” (1997: 5).

²³ To Kluckhohn, “Culture consists of patterns, explicit and implicit, of and for behaviour acquired and transmitted by symbols, constituting the distinctive achievement of human groups, including their embodiments in artifacts” (1962: 73).

Passion of the Christ by Mel Gibson. As we went into the cinema everyone was chatting, eating popcorn and being in the normal “entertainment” mood. As the movie began there was a degree of noise and eating of popcorn., but from the time Jesus was arrested in the Garden of Gethsemane to the end of the movie, silence broke into the entire auditorium. No movements, no eating of popcorn, no giggles nor whispering were observed inside the room. After the movie people walked quietly out of the hall and very few spoke immediately. Most people I questioned later told me they were surprised at the suffering that Jesus went through, as they had never seen any treatment of the kind to a human being. The shock and bewilderment produced an immediate silence, exhibited by lack or absence of sound. In this example, an entire group of people expressed their shock in silence.

2.2 Silence as a Complex Phenomenon.

As we seek to break the silence around HIV and AIDS, looking beyond our normal understanding of the subject will go a long way to help us recognise silence exhibited in other forms. Until recently, even within linguistics, silence was traditionally ignored except “for its boundary-marking function, delimiting the beginning and the end of utterances” (Saville-Troike 1985:3). However, many theorists on silence, including Bernard Dauenhauer (1980) acknowledge silence as a complex phenomenon that is not simply the absence of something else.

Research has revealed that the many forms and types of silence expose its complex. Warburton (2001), when considering the traditional notions of sound and silence, indicates "We become aware that each moment is completely filled with sensations and thoughts. Silence is (for me anyway) far more packed with experience, far more complex than anything we can produce with sound". In this way, just considering silence on the surface and from the normal day-to-day understanding of it, makes it a simple concept; but when it is subjected to scholarly analysis it becomes complex.²⁴ Yet this

²⁴ I am aware of the wealth of research that has gone into silence ranging from its simplistic meaning of “absence of something”, through a variety of its different aspects in the fields of media studies, discourse studies, gender studies, aesthetics, literature, linguistics, politics and music, to its polysemic and polyvalent character in socio-cultural and computerization the human life, which makes it such a complex subject to tackle.

scholarly interpretation is important in helping us come to a helpful analysis of such a complex disease as HIV and AIDS, especially if we need to break any silence surrounding it. The study therefore looks at the anthropological and symbolic roots of the word 'silence' to provide a lens for analysing its complexity.

2.2.1 Anthropological Concepts of Silence.

Before attempting to delve into the various aspects of silence and later explore how it manifests itself in the HIV and AIDS scenario, it is important to backtrack into an anthropological exploration of its general function and to examine how it reveals itself in everyday human endeavours. Höritzauer-Wilhelm's (1986) study, undertaken to explore the philological development of the word "silence" and its meaning, its symbolic representations, as well as literary, philosophical and religious notions concerning human life, are key to helping us understand silence from an anthropological point of view. This anthropological enquiry has revealed a wide-ranging and antithetical experiential demonstration of silence that forms a suitable basis for a deeper and a more extensive understanding of it (Höritzauer-Wilhelm 1986: 21).

2.2.1.1 The Philological and Etymological Development and Meaning of 'Silence'.

Höritzauer-Wilhelm undertook an etymological investigation into the derivative and original significance of 'silence', with a view to establishing whether the original meaning has been enriched or has deteriorated over the years. This was motivated by the suspicion that "the original signification might have encompassed valuable implications, currently forgotten, and warranting reintegration into the study and comprehension of silence in human experience" (1986:21-22). The study revealed the following logical grouping arising out of the major language²⁵ roots that gives meaning to the word in English:

- (i) Originally the early derivatives of the indogermanic "si" could encompass in a very general sense both ebb and flow.
- (ii) The Latin derivative "silentium" could refer to general absence of motion or expected activity.

²⁵ The major languages derivatives giving meaning to "Silence" in English, in Höritzauer-Wilhelm's research include Latin, French and German. (1986: 22).

- (iii) It could refer specifically to the absence of auditory activity or noise or,
- (iv) even more specifically, to the absence of verbalisations, and
- (v) most specifically, to the withholding of certain verbalisations only (secretiveness) (1986: 23)

Hörizauer-Wilhelm points out that a perusal of modern English reveals that besides the antithetical usage described in (i) above, the usage in the other forms has not undergone any major changes. Ordinary English no longer uses the word in the sense of (i). By this Hörizauer-Wilhelm indicates that modern colloquial offshoots such as ‘silent butler’ as well as ‘silent’ used to refer to the flatness of distilled spirits, are used in the general sense as pointed in (i) (1986: 23). The study therefore concludes that, “modern usage no longer includes antithetical connotations and the meaning of silence is often restricted to specific withholding of speech or absence of mention and secretiveness” (1986: 24).

Hörizauer-Wilhelm is concerned that where the original antithetical understanding is completely disregarded, a one-sided conception of silence results. “Silence is by no means the distinct opposite of speech, in that neither one nor the other is to be regarded as invariably active or passive” (Hörizauer-Wilhelm 1986: 24). It is therefore important that our concept of silence, as regards the life of a human being, goes beyond the norm of linking it with absence in order to fully understand the true situation of a person. Absence of something else is a necessary but not sufficient condition to define what silence means. The antithetical use of the word brings to light some other aspects that are not ordinarily considered. As will be seen later in the study, I wish to propose that the antithetical aspect of silence is a component of some form of ‘presence’ that needs to be considered to provide a full and adequate picture of the silence phenomenon. The ‘presence’ aspect of silence in many ways makes the phenomenon complex.

2.2.1.2 The Symbolic and Mythological Aspects of Silence.

The symbolic and mythological presentation of silence, according to Hörizauer-Wilhelm, contributes to providing the antithetical manifestation of silence (1986: 25). In the dictionary of slang and conventional English, “to silence”, means to kill, which denotes death or inactivity. This trend follows from Freud for whom “silence symbolised

Thanatos, the death instinct, to Rank, conversely, the womb, and to Jung the archetypes mother, earth and the origin of things” (1986:25). By drawing on the works of Reik 1968; Jobes 1962; Cirlot 1962 and Waddington 1970, Hörizauer-Wilhelm shows how, anthropologically, ancient Greeks personified silence as Harpocrates, Hermes and Hercules,²⁶ a sign of vitality. She therefore concludes that:

Silence is potentially both a destructive or creative phenomenon; it represents, symbolically, the coalition of birth and death, depicting the ancient wisdom that in all matters death and birth are equivalent in as much as new life springs forth from decomposition in an overflowing process of transformation. (1986: 28)

As we look at silence, Hörizauer-Wilhelm’s study hints that there is a divergent side to the meaning of the word, which must be considered. Both the roots of the word and the primal symbolism attached to it not only show such divergent aspects but also its ambivalent nature.

Hörizauer-Wilhelm’s work suggests that silence is not restricted to only one end of the pole, but balances at both ends. There is the need therefore to consider the antithetical connotations of the word; where there is death linked to the word at one end, there might be life, vitality and birth linked with it at the other end; and where there is absence connected with silence at one end, there might be presence connected with it at the other end. Through symbols, silence connotes presence of many meanings that speech fails to present. Linking silence with presence will unfold the complex nature of the word.

Such modern studies as media studies, discourse studies, gender studies, aesthetics, literature, linguistics, politics and music, to mention only a few, help to depict the ‘presence’ notion of silence and therefore help in making sense of the complex nature of the phenomenon.²⁷ Schmitz in his article “Eloquent Silence” quotes Bindeman (1978:191) that “Silence is neither nothing nor another language”. He concludes that “it is both the

26 Hermes and Hercules are symbols of full vitality, and Harpocrates, whose image was simultaneously used as a talisman for fecundity by the ancient Greeks, was the image of youthful dynamism and not of withdrawal, inactivity or death (Hörizauer-Wilhelm 1986: 25).

27 See, e.g., Fitz, Earl E. (1987), Schmitz, Ulrich (1994), Jaworski, Adam. (1993) and Dauenhauer, BP. (1980)

presence and the absence of language, and the boundary between the two is complex: it does not stand still, and it is intertwined in itself". (1994).

2.3 Silence as Presence.

When it comes to the notion of silence as the 'presence' of something, Dauenhauer (1980) applauds poets who have known this concept throughout recorded history. It is in line with this that Jaworski points out that poets value silence as a means of communication that is universal and perhaps more efficient than words: "When words fail poets, when artists find language inadequate to express themselves, they find refuge in silence" (1993: 161). I support Jaworski's thesis that silence is not just an absence but a presence that needs to be brought into a situation when the "more upheld" speech²⁸ fails its duty. He expresses the view of Sontag (1966) that the solution for the artist trying to get free from the limitations of language is to move on to silence as the most adequate and 'chaste' form of artistic expression.

Adrienne Rich, a renowned poet herself, had earlier pointed to silence as 'presence'. In her work "Cartographies of Silence", the third stanza goes:

The technology of silence

The rituals, etiquette

The blurring of terms

Silence not absence

of words or music or even

raw sounds

Silence can be a plan

rigorously executed

²⁸ Jaworski (1993: 12-13) contrasts speech with silence and points out such theorists as Bruneau (1973) who posit silence as merely providing a background to speech. He offers the analogy of the printed page, "Silence is to speech, as the white of this paper is to the print" (1973: 18). A similar understanding of silence is projected as "the contrastive material against which auditory images are cast" (Bowers, Metts, and Duncanson 1985: 523).

the blueprint to a life

It is a presence

it has a history a form

Do not confuse it

with a kind of absence (1984: 233)

Rich sees silence as presence, "The silence that strips bare that falls at the end/ of a night through which two people/ have talked till dawn" (1984: 234). Silence stays through the night lying side by side with speech inseparably tied to language itself. Damiano sees silence in the same line, "It is not just the absence of talk. Silence has substance. It is the presence of something" (2003)

Through music, composer John Cage in 1952 demonstrated that there is no such thing as absolute silence. Thomson argues that the composer's conclusion is as a result of his visit to an anechoic chamber, which is a room designed to be as silent as technically possible:

While in this "silent room" he heard the sound of his nervous system and his blood in circulation, which suggested to him that the perception of silence was impossible, since the mechanisms of sound perception were themselves producers of sound. Thus "silence," for Cage, came to have a kind of psychological meaning: "Silence is not the absence of sound, but the fact of having changed one's mind about the sounds that there are, to hear them" (2003: 5).

According to Cox and Warner, Cage said, "Until I die there will be sounds. And they will continue following my death. One need not fear about the future of music." (2004:4). It is this understanding that led to the composition of his masterpiece "4'33". The piece was composed to last four minutes and thirty-three seconds during which the performer played nothing at all, creating silence. However, within the so-called silence, noise and sound created by the environment - the wind, audience etc, became the music. "Although commonly perceived as 'four minutes thirty-three seconds of silence' the piece actually

consists of the sounds of the environment that the listeners hear while it is performed (Weller 2008: 3).

In his work, Cage exemplifies the point that silence is the absence of one kind of sound but the presence of another kind. For this Solomon reflects:

To Cage, silence had to be redefined if the concept was to remain viable. He recognized that there was no objective dichotomy between sound and silence, but only between the intent of hearing and that of diverting one's attention to sounds. "The essential meaning of silence is the giving up of intention," he said. This idea marks the most important turning point in his compositional philosophy. He redefined silence as simply the absence of *intended* sounds, or the turning off of our awareness. "Silence is not acoustic," he said, "It is a change of mind. A turning around." (1998)

It is important to note that whenever there is silence, if there is an absence of something to denote silence, there must equally be something present to connote the silence. This discovery implies that any attempt to break silence is not a task of causing something that is absent to come to light, but also causing something that is present that people fail to recognise to come to light as well, either to be cherished or caused to disappear by dealing with it. This is further developed by an understanding of the linguistic concept of connotative and denotative silence, to which we now turn.

2.3.1 Connotative and Denotative Silence

In the field of linguistics Yan Zuo argues for 'silence as presence' vis-à-vis the familiar understanding of 'silence as absence'. He derives the concept by using the notion of 'connotative and denotative' in relationship to the silence phenomenon (2002). In a research article exploring the silence phenomenon as it occurs in dyadic English conversations, published on the *Linguist* Homepage, Zuo presents the fundamental position that "silence is far more than a mere absence of speech: rather it is a linguistically significant category constituting an integral part of the communicative framework of conversation" (2002). He accordingly argues that three dimensions might be identified for silence, namely structure, meaning and function. Zuo then treats the

meanings of silence by dividing them “into the two broad aspects of connotative and denotative” (2002).

In the same line of thinking, Yarbrough (2004) also considers silence to be denotative or connotative. He points out denotative silence as referring to “the primary, explicit meanings that have come to define the thing itself, in which case, silence denotes absence” (2004:11). This is, as we have alluded to before, an absence of sound, or lack of verbal communication. In this denotative sense he points out the following definition:

1. The fact of abstaining or forbearing from speech or utterance, (sometimes with reference to a particular matter); the state or condition resulting from this; muteness, reticence; taciturnity...
 2. The state or condition when nothing is audible; absence of all sound or noise; complete quietness or stillness; noiselessness. Sometimes personified...
 3. Omission of mention, remark, or notice in narration. ("Silence").
- (2004:12)

In an earlier work in sound-drama, Schutterhoef (1994) uses ideas from the semiology of French philosopher Roland Barthes (1915-1980) to point out that in issues of sound, denotative means “the existence of tangible data, also known as the visible factors”.

In terms of *connotative* silence, Yarbrough sees this as having presence. “It contains associations that it has acquired socially, culturally, or from personal experience” (2004:12). In this case, when used connotatively, the complex nature of silence emerges in that silence displays a series of meanings which vary from person to person, or from situation to situation when interpreted. “It connotes presence; every pause, hesitation, understatement, omission, and gesture is meaningful. It operates here at the micro-level, as a more private, internalized form of behaviour” (Yarbrough 2004: 12). In this way the symbolic nature of silence is seen. The silence that is connoted here is therefore left to be interpreted or deciphered.

When it is obvious that a person is silent and there is an absence of ‘something’, one must note that there is another ‘something’ that becomes present – a presence is connoted. The English expression, “he was conspicuous by his absence” explains this point, in that when

the physical presence of someone is not immediately available, there is an intentional non-physical presence of that person and hence he or she is conspicuous. Sánchez-Colberg (u/d) in looking at silence from a point of view of drama, notes that even though silence is commonly understood as a rejection of speech, it is noted as a component and complement of the dramatic speech act. In that case “silence acquires the status of a paralinguistic, non-verbal communication cue revealing the character's psychological complexity, propelling the dramatic action (which could be through a paradoxical negation of action) and by contributing to the narrative structures (rhythm, pace, organisation of temporality, causality, etc) disclosing the world of the play” (Sánchez-Colberg (u/d)). Silence then becomes a presence, part and parcel of the whole dramatic performance.

Looking at team communication, Wilcox et al point out the difference between the denotative and connotative meaning of words that provide further insight into the silence phenomenon. They point out that the denotative meaning of the word is the dictionary definition, which does not reflect any meaning provided by the people speaking or hearing the words (2002: 2-6). In this case a person's silence in the denotative sense is seen as the mere recognition of the absence of utterance or activity. But to Wilcox et al, the connotative meaning of a word reflects the emotions, culture and experience of the speaker and “for others to understand this meaning, they must understand something about the speaker” (2002:2-6). This understanding is an important consideration if we are to break any form of silence in a person's life. It is not simply the addressing of something absent in the person's life, but also involves addressing a host of other things in the person's life and environment, especially within his or her culture. It is important therefore to note that when it comes to dealing with silence, there is much to bring meaning to the phenomenon.

The writers further say that the task of understanding connotative meaning can be very complex, as people also hear with their own emotions, culture and experiences. One's understanding of silence, coupled with one's cultural background, plays a crucial role in breaking the silence. This makes any effort to break silence a complex exercise, since connotative silence is silence in action, presenting “various forms of connotative, indirect expression which include disjunctive indirect speech, colloquial dialogue, negation,

repetition and echoing, pauses, over/under statement, silent scenes, mute characters, silence as a metaphor for isolation, evanescence, silence/absence of the playwright, and unanswered questions” (Kane 1984).

With Kane’s comment, denotative silence (absence) and connotative silence (presence) can be illustrated in the popular TV comedy, *Mr. Bean*, a TV series performed by Rowan Atkinson. Siobhan Synnot, a commentator, comparing the *Mr. Bean* series to the artist’s other comic sketch TV series *Not The Nine O’Clock News* and the literary satire of *Blackadder*, refers to the *Mr. Bean* series as “Silent Bean”, because the show has a marked absence of speech (denotative silence). On his part Mr. Ian Jane, who has done a review on all the Bean Series comments on its popularity:

What makes Atkinson’s performances even more incredible is the fact that he does them all more or less silent. Mr. Bean doesn’t talk much at all, and on the rare occasion that he does, what he says is usually made up of grumbles and strange noises and expressions, rather than actual dialogue. It’s because of this that the sketches and episodes rely more on Atkinson’s abilities as a physical comic and his amazing facial expressions than witty dialogue or banter, making Mr. Bean an accessible form of comedy that almost extends international boundaries” (Jane 2003).

The reality is that this near speechless performance has a connotative presence that acquires a paralinguistic nature which people from all manner of cultures and language are able to decipher. Synnot points out that “Mr Bean, that over-extended Buster Keaton homage, can still be seen in more than 94 countries and on planes from over 50 airlines” (2004). The key to Mr Bean’s popularity globally is that the individual viewer is left to bring interpretation and meaning to whatever they watch. Mr. Bean’s silent act connotes a presence to be understood from the viewer’s own lens. The use of silence in this way makes the phenomenon complex as it displays a series of meanings which vary from person to person, even culture to culture or from one situation to another.

The use of silence so as to enable people to achieve their own meaning and interpretation is not restricted to performance in the public arena such as theatre or television (as with Mr. Bean), but also in the individual’s day to day communication. It is cultural, and on

this basis Yarbrough considers the distinction between connotative and denotative nature of silence to be parallel to Hall's (1976) differences between what he defines as low-context and high-context communication as a result of cultural differences (2004: 12).

It is also important to note at this point of the study that, while silence is generally thought of as being absent of meaning (what we will call *barren silence*), it is crucial to be attentive to the silence in which meaning is present, (what we will call *fertile silence*.) Silence can have both absence and presence and this is an indication that silence need not only be *broken* in its 'absence' form so that we can 'speak' about HIV and Aids, but it also needs to be *engaged with* in its 'presence form' to find out what is already being 'spoken' about HIV and Aids. This forms the basis on which we will be able to understand silence in relationship to HIV and AIDS, and therefore to move beyond a simple desire to 'break the silence'.

2.3.2 Silence in Low-Context and High-Context Communication.

Anthropologist Edward Hall in his book, *Beyond Culture* (1977), has broadly categorised cultures into (i) a high-context culture - one which is characterised by information being available in the physical environment or internalised in people who often have to use non-verbal communication; and (ii) a low-context culture - one in which communication relies more on detailed verbal interactions or on the explicit code (1977: 91). This work builds upon his earlier works, *The Silent Language* (1959), and *The Hidden Dimension: Man's use of Space in Public and Private* (1966).

To explain cultural differences, Hall has developed a concept in which different cultures can be looked at on a continuum of high- and low-context. Hall is clear that the model is not to be applied unproblematically to whole cultures and situations. It is important to view cultural differences as patterns and tendencies, rather than as absolutes. Cultural patterns exhibited in high- and low-contexts should be considered as a continuum extending from a low to high degree of intense socialisation within cultural groups and in different interpersonal situational contexts, depending on the messages or interactions being carried out (Hall 1977: 91-94). The characteristic of culture that this theory is based on is communication, noting, "The cultures of the world can be placed on a continuum, based on the amount of communication contained in the nonverbal context compared with the amount in the verbal message" (Hall 1998: 19).

Even though this high/low-context dichotomy is not an option or scenario, but best considered to be a continuum in which no culture exists exclusively at one end of the scale, it is easy to see the contrast in the basic philosophy of interpersonal communication between Japan and America, for example where most of Hall's research focuses (1977: 109-114). In high-context cultures great importance is attached to implied meaning from the unspoken, which makes the communication style indirect, relying heavily on the listener's intuition and co-operation:

People raised in high-context systems expect more of others than do the participants in low-context systems. When talking about something that they have on their minds, a high-context individual will expect his interlocutor to know what's bothering him, so that he doesn't have to be specific. The result is that he will talk around and around the point, in effect putting all the pieces in place except the crucial one. Placing it properly - the keystone - is the role of his interlocutor. To do this for him is an insult and a violation of his individuality (1977: 113).

When communicating, people from high-context cultures tend to seek meaning from situations, implications, and what is not being said. In this case the high-context culture individuals believe that words alone are not enough. One would watch out for non-verbal cues that will provide meaning to situations. People from high-context cultures, when expressing their thoughts, tend to be indirect and to use proverbs. Generally, people understand the information without verbally expressing it. On the other hand, individuals of low-context cultures tend to be direct in their speech and believe that most of the message is in the words. They seek meaning from the exact words that have been expressed and, to a certain extent, if something is not said or expressed explicitly, it is seen as not having been communicated. People from low-context cultures may therefore seek information by asking many questions, whereas their high-context counterparts seek information by listening silently (2001: 7).

In terms of silence in relation to Hall's work, Hasegawa and Gudykunst point out that "the use of and attitudes towards silence in the United States and Japan can be explained by cultural differences in a low- and high- context communication" (1998: 669). In low-

context communication, meanings are implanted mainly in the message conveyed. This means that using low-context communication involves making direct and precise statements. In the continuum of the high/low-context communication, Hasegawa and Gudykunst consider silence as an extreme form of high-context communication that barely uses understatements and indirect statements. “In cultures such as America, communication is verbal and a speaker has to make himself or herself understood” (1998: 670). In this way silence, according to the writers, can be very disruptive when communicating in low-context culture. This is because verbalisation has ceased. But “in high-context communication that does not place emphasis on verbalization by the speaker, but rather intuition by the hearer, silence is seen more positively” (Clayton 2003: 119). It is important to note in this case that silence is more pronounced in high-context cultures. Clayton further says “In cultures that are comfortable with it, silence has a variety of functions” (2003: 119).

Yarbrough builds further on the phenomena of silence as seen in the high/low-contexts, linking it to the concept of denotative and connotative silence. To him: “Low- context communication is denotative; its meaning depends upon the use of direct, exact, and precise statements into the messages being transmitted. Connotative silence is high-context communication. Its meaning is embedded in the context in which it is used or in the persons using it” (2004: 12). In low-context situations where the emphasis is on personal and explicit verbal messages where the speaker assumes responsibility for its clarity, Labour et al say “Words serve as a form of social control, while silence tends to be used as a form of tacit consent or a sign of failure (e.g. guilt, incompetence)”(2002). Often in low-context cultures detailed and sometimes repetitive explanations are essential to ensure exact information transfer.

In considering silence in the context of Hall’s high-context culture, Labour et al imply that the onus is on the listener to decode meaning from the socio-linguistic context, not for the speaker to utter an explicit message that can be understood by everyone. “This ability to read between the lines includes the understanding of the various registers of silence. In this way silence is used as a means of social control.” (2002). In other words, connotative silence is symbolic. Symbols are learned and the context in which a symbol is presented is crucial to its interpretation (Yarbrough 2004: 12). The insights from

Labour et al reveal that in a low-context culture power lies in the ability to speak, whereas in a high-context culture, power lies in silence, as it requires ability to interpret. This understanding is relevant, as breaking silence in high-context communication requires interpretation of any cues made available by the silent person.

2.4 Barren Silence and Fertile Silence

Our study so far has brought to light that silence is both the absence of ‘something’ and the presence of ‘something’ else. ‘Something’ indicates that silence is ‘issue-specific’. One keeps silent about an issue - verbally - whilst still communicating in other ways. This understanding is crucial if we are to understand what it might mean to ‘break the silence’ or engage with the silence around ‘HIV and AIDS’ (our ‘something’ or ‘issue’). Hall’s study in identifying communication characteristics in different cultures is beneficial in understanding the context in which silence is used or interpreted. The model holds together all the components of silence we have considered in a holistic way. We can therefore posit two forms of silence on the ends of a continuum, namely, *barren silence* and *fertile silence*.

Barren silence is associated with low-context cultures. Here silence denotes *absence* because vocalisation, expression and visualisation are needed to communicate. This means that if words, which are the main medium in conveying messages, are not there silence means absence. To put it bluntly: if people are not talking about the issue, then there is no communication about the issue.

Fertile silence is associated with high-context cultures. Here silence connotes *presence*. Silence presents a message expressed in symbolism and is to be non-verbally interpreted by the listener. Silence has something to offer that is being presented – a presence that cannot be denied but has to be acknowledged. To put it bluntly: if people are not talking about the issue, they may still be communicating about it – either through non-verbal signs, or through coded language.

It is vital, also to note that in any culture both forms of silence will exist to varying degrees. As we will illustrate below in diagram form (Figure 2.4.1), in low-context cultures there is always a thin layer of fertile silence surrounding a thick layer of barren silence. In a high-context culture, there is a thick layer of fertile silence, surrounding the

barren silence. If we are to start talking about an issue – which clearly we need to do about HIV and AIDS - we need to move through the fertile silence in culturally appropriate ways so that we can ultimately deal with the barren silence – the silence that carries little or no meaning.

If a culture is low-context, and we are dealing mainly with barren silence, then in order to start communicating we need to break the silence. On the other hand, in a high-context culture, where we are dealing with a strong element of fertile silence, then communication is present in such form as facial expressions, hand movements, symbols etc. In actual fact, the whole person who is present with you may reveal things that are not said or seen.

This is what makes the task of breaking the silence of a high-context culture more complex, as one is not just dealing with silence only in the form of absence, but mainly with it as presence – one is not just dealing with barren silence i.e. silence as absence of verbalisation (even though one may have all the necessary tools to help people to talk), but dealing mainly with a fertile silence - silence present in diverse ways. In a low-context culture silence is easily recognised by ‘absence of that which is obvious’ and so various means can be employed to break it open, to get people to verbalise and to talk.

However, in a high-context culture, fertile silence has a presence, in various but less obvious ways and therefore needs recognition and engagement in order to expose the hidden barren silence that needs to be broken. As Clayton has it: “around the world, the meaning of silence is different: Some may use it as agreement; some, as privacy; some, as respect; some, as control (Clayton, 2003: 120).

Given this, *the task of breaking silence around an issue in a culture therefore begins first with an “engagement with” fertile silence. Once this has been done the barren silence can then be “exposed” for it to be “broken”.* As illustrated in Figure 2.4.1 below, the extent of engagement with silence as presence depends on the layer of silence as presence.

The diagrams below help us to sum up silence within a context:

In this thesis therefore, breaking or engaging with silence in the midst of HIV and AIDS (our issue at hand), is a task of considering the cultural context - low or high-context - of the people and analysing the characteristics of this culture that exacerbate silence - both barren and fertile silence - to provide a framework in dealing with it. Like silence itself, the idea of 'breaking the silence' is a culturally specific idea, and does not have the same meaning in a high-context culture as it evidently has in a low-context culture. In a high-context culture, the barren silence around an issue (in this thesis HIV and AIDS) can only be broken if it is exposed through engaging with the thick layer of fertile silence around it. In the case of a low-context culture, the layer around the barren silence is so thin that there is almost direct breaking into the barren silence. In this case, the concept of breaking the silence is directly appropriate in a low-context culture but in a high-context one, there is the need to engage with the silence, before attempting to break it.

Within a high context culture, people are conditioned to be silent on issues for various required cultural reasons. Normally all that people know is that someone is silent on certain issues. Nevertheless, a person who is culturally sensitive recognises that silence on an issue in a high context culture is barren and has fertility around it. The concept of barren and fertile silence is therefore more of an analytical category rather than a real category. It is this fertile silence that gives cues to anyone wishing to have the silence around an issue broken. In this way it is the culturally sensitive person who understands that to break the barren silence, one has to go through the cues that the fertile silence provides.

2.5 Cultural Context types in South Africa.

Silence, as we have seen in the discussion so far, is a cultural phenomenon that differs from place to place. Haram affirms that "while culture is something shared and thus collective, it is also diversified, varying from one society to another as well as within one society" (2001:52). People should not be put into cultural 'boxes', which could be seen to be polarising one from the other or as cultural stereotyping. At the same time we should not overlook the differences which, if not taken into cognisance, lead to misunderstandings between nations, business corporations and individuals from different backgrounds. Hall correctly points out that it is irrational to argue that each culture is not unique (1977: 2).

In our quest to analyse and seek ways to break the silence that surrounds the HIV and AIDS pandemic, it is crucial that we know the cultural context of the research area. Broadly put, African cultures are seen to be predominantly high-context cultures in their communication style. For example, Shabazz when discussing the use of multimedia technology in business which engages users in a vivid and animated process of communication, raises concerns about “the traditional forms of African high-context communication which rely on a variety of subtle gestures and expressions” (2000:37). This is an important understanding that one needs to gain to be able to communicate well with people in Africa generally.

To illustrate further, we can look at a meeting of Episcopalians and Anglicans from Africa, the Americas and elsewhere on June 2-5, 2004 at Kanuga, North Carolina, to gain a new understanding around communication. In a conference that was “deliberately planned to ‘listen’ to and called for a more intentional approach to local, national and global church communications,” the need to pay attention to communication styles was emphasised (Davies and Seiferth 2004). This conference examined how communications ministries are being practiced in different parts of the world and heard some of the challenges that the Anglican/Episcopal family faces. A workshop led by Katerina Katsarka Whitley entitled ‘Communicating across the Cultural Divide’ focused on learning how to listen with intelligence and understanding to people of other cultures. From their report, Davies and Seiferth noted that Whitley pointed out differences in values, beliefs and attitudes of different cultures and concluded that Africa is a high-context society:

Whitley described how we all have a ‘perceptual set’ of values, beliefs and attitudes and how this changes from culture to culture. This, she explained, is why there is more respect for a bishop in African society than there is in the US, adding that America is a "low-context" society, whereas Asia and Africa are "high-context" societies (2004).

Building on Hall’s (1959, 1966, 1977) concept of high-context and low-context cultures Storti (1999) has researched and placed a number of cultures, including African ones, on a continuum in terms of the role of context. In the table 2.5.1 below, Storti shows how 13 cultures are placed in the continuum of high and low-context (bearing in mind that these

As it is said in an African proverb, cultural and family issues are like a forest. When you are far away from a forest, it looks one unit but when you get closer to it, then you realize that it is made up of individual trees and that each stands on its own. My interaction with a number of people from Europe and America, who have never visited Africa, has suggested to me that they perceive Africa to be one country with the same culture. This experience is echoed by many others. Yet as Hall rightly points out “on the horizon are the multiple cultures of Africa and the emerging nations of Latin America demanding to be recognized in their own right. The future depends on man’s transcending the limits of individual cultures. To do so, however, he must first recognize and accept the multiple hidden dimensions of the nonverbal side of life” (1977:2). Africa is composed of various cultural groupings within different countries. South Africa has its own cultural groupings:

The South African society consists of various cultures and sub-cultures, bound by ethnic, religious or language similarities. In addition to these various cultures, there is also a polarisation between ‘white’ and ‘black’ cultures. These two so-called cultures cannot be defined as such, but broadly point to African and Western frames of reference. Within the “white” culture there is a further division, namely between Afrikaans and English speakers, who traditionally represented two different cultural groupings (Bezuidenhout, 1998).

In this case, having concluded that Africa is generally a high-context culture, we need to know the specific context of a particular country or culture we are dealing with in Africa. It is therefore important to have an idea about the communicating style of South Africa. Specifically we will proceed further to establish communicating style of the area of the research and eventually be able to consider the nonverbal side of it.

The work by H. J. Groenewald et al (in Marais, 1988), which was co-authored by 8 others including E. Hall, is crucial when it comes to analysing communication in South Africa, especially considering its high/low cultural nature. As alluded to earlier on, if we are to ‘break’ any form of silence exhibited by people, the cultural and communication styles of the people must be considered. In a multicultural society like South Africa, until each group takes an interest in the other, and makes every effort to understand their cultures, it will be difficult to deal with issues that perpetuate silence and affect everyone. As

Groenewald et al point out: “In South Africa there is a growing realisation that people can no longer live in isolation and that events that radically affect one population group must also influence other groups. These groups may differ culturally and socio-economically but broadly speaking they share the same social reality”²⁹ (1988: 233).

Further, in dealing with conflicts and misunderstanding as a result of cultural communication differences that occur in multicultural societies such as South Africa, Groenewald et al draw attention to the need to recognise the low/high-context of South Africa:

In addition to the many personal, group and culturally diverse factors, South Africa also harbours the factor of high and low-context cultures. The concept of high and low-context cultures has been dealt with by Hall (1976)³⁰. The concept is broadly associated with “types of cultures” which may either advance or complicate communication between members of the different cultures in a multi-cultural society (1988: 234).

Unlike many African nations that are mainly mono-racial in composition, South Africa is a multi-racial, multi-cultural and multi-lingual society. Even in other countries in Africa, as a result of globalisation, things are changing, as McMurray has noted, “countries no longer have a monocultural context and, with globalization, cultures and workplaces are becoming multicultural.” (2003: 479). It is therefore impossible to point to South Africa as a whole as having a particular cultural context. Knowing that culture is not static and that change and acculturation are a continuous and active process, Groenewald et al assert that “In South Africa, the culture of whites, coloureds and Asians may be labelled as predominantly low-context and that of blacks as predominantly high-context” (in Marais 1988:234). Singh and Kotze say of the composition of the South African culture: “The South African population can be described as a fragmented set comprising subsets of

29 Speech by the then Minister of Home Affairs, Dr Mangosuthu Buthelezi, during the Commemoration of the arrival of Indian Settlers in South Africa in 1860 at Richards Bay on the 9th November 2002 re-echoed these sentiments and called on all South Africans to build a society which is fair, just and equitable for all (See [http://www.search.gov.za/info/previewDocument.jsp?dk=%2Fdata%2Fstatic%2Finfo%2Fspeeches%2F2002%2F02111116111001.htm%40SpeechesandStatements&q=\(+buthelezi+\)%3CIN%3E+title\)&t=Buthelezi%3A+Commemoration+of+arrival+of+Indian+settlers+in+1860](http://www.search.gov.za/info/previewDocument.jsp?dk=%2Fdata%2Fstatic%2Finfo%2Fspeeches%2F2002%2F02111116111001.htm%40SpeechesandStatements&q=(+buthelezi+)%3CIN%3E+title)&t=Buthelezi%3A+Commemoration+of+arrival+of+Indian+settlers+in+1860))

30 The authors are referring to the same book, *Beyond Culture*, which was originally published by Anchor Press/Doubleday & Company, Inc. in 1976. The 1977 edition used in this study, published by Anchor Books, makes reference to this.

various wholes. Each race group (Indigenous Africans [IA], South Africans of mixed decent [SAM], Afro-Asians [AA] and Afro-Europeans [AE]) is uniquely different” (2003:900).

“According to the 2001 Census, KwaZulu-Natal is a predominantly black province, with black people making up some 85% of its total population of 9.4 million.” (Cele 2005:4). Indians comprise 8.5% of the total population, whites account for 5.1%, and coloureds only 1.5% (Office of the Premier 2004). This being the case, Groenewald et al’s assertion is key in making us aware that KwaZulu-Natal and for that matter the Pietermaritzburg Area³¹, where this research is conducted, falls predominantly into a high-context communication category. Further, most of the Blacks are Zulus and Kwenda *et al* (1997:128) confirm that a number of Black cultures, including the Zulu and Xhosa cultures, are examples of high-context cultures, where meaning is derived from the social environment and traditions.

This is crucial because silence is more pronounced in a high-context culture. In such a high-context culture as this, Groenewald et al asserts that communication codes are centred in the social and cultural knowledge of the context, which implies that which is not said is often more significant than that which is said (1988:234). Since our task in this thesis is to explore how best to break the silence over HIV and AIDS in such a high-context culture, I suggest that our framework should be to outline the characteristics of this culture, which perpetuates silence (in such a context).

2.6 Framework: Characteristics of a High-Context Culture contributing to Silence.

By analysing a number of studies³² that have been conducted on the meaning of silence in different cultures, Krieger concludes that the only major generalisation that can be drawn concerns the divergent attitudes in high-context and low-context cultures (2001:234).

31 See the description of the area in Chapter One.

32 See, e.g., Basso, (Western Apaches); Howard Giles et al., 'Talk is Cheap ...' but 'My Word is My Bond': Beliefs About Talk, in *Sociolinguistics Today: International Perspectives* 218 (Kingsley Bolton & Helen Kwok eds., 1992) (comparison of beliefs about talk and speech of Caucasian American, Chinese American, and foreign Chinese students); Hasegawa & Gudykunst, *supra* note 11 (comparison of silence in Japan and America); Lehtonen & Sajavaara, *supra* note 11 (Finland); Nwoye, *supra* note 11 (Igbo in Nigeria); Samarin, *supra* note 11 (Gebya in the Central African Republic); Saunders, *supra* note 146 (Italian village); Sifianou, *supra* note 85 (comparison of attitudes toward silence in Greek and English society); Tannen, *supra* note 12 (comparison of speech and silence patterns of Eastern European New Yorkers at a Thanksgiving dinner).

This conclusion is vital to our studies in that it draws our attention to the reality that the incidence of silence in a community has reference to the cultural context of that community. Edward T. Hall (1959, 1966, 1977) has pioneered a way of differentiating cultures on the basis of communication, and elaborates the nature and description of cultures in terms of high- and low-contexts. This, as Albertsson and Klingenstierna highlight, makes him one of the first researchers to examine the notion of cultural dimensions³³ as a way of understanding different cultures (2002:61).

Krieger's analysis of key research into silence and culture reveals that people's silent attitudes are related to cultural contexts, (2001:233), an assertion that supports Hall's original thesis (1959, 1966, 1977). Judging from the fact that Hall's work has led to further research into dimensions of culture (Albertsson and Klingenstierna 2002: 61-65), I theorise in this research that an analysis of the major dimensions of culture will provide a framework for fully understanding the factors that contribute to silence in a high-context culture. This hypothesis is supported by the fact that an understanding of these dimensions has been advanced by theorists to help organisations and businesses in the world deal adequately with problems arising in a multicultural setting³⁴. In addition, this concept is widely considered as a reference in cross-cultural management and dominates current international management studies.³⁵ Tackling these cultural dimensions will enable us to engage with silence in its 'presence' form and further breaking any silence in its 'absence' form,.

2.7 Summary

We now understand that the South African Zulu culture we are dealing with, in the Pietermaritzburg area, is high-context in nature. This culture therefore has the ability to generate a silence that is complex - a silence that connotes presence and is expressed in symbolism, and that has to be interpreted non-verbally by the listener. In this high-context culture we will expect more fertile than barren silence. In this context fertile silence therefore overshadows barren silence, the form that we are familiar with and

33 Cultural theorists such as Inkeles and Levinson (1959), Bernstein, B. (1975), Hofstede, G 1991, Moran, R. T. (1991) are among those researched into dimensions of culture building on what Hall began, as we will see below.

34 See Hall (1977), Munter (1993), Marcus and Gould (2000)

35 See Sekaran (1983), Nasif et al. (1991), Mead (1998), Robbins and Coulter (1999), Child (2000), Lim & Firkola (2000), Black, (2001).

desire to break. Therefore an analysis of silence is needed within a particular cultural situation in order to help us engage with silence as both presence and absence. But for our area of research, the analysis show that the culture of the people in itself contribute to silence within the people. This chapter has therefore helped us to answer the first research question: Does the culture of the people contribute to the way silence ‘works’, in the affirmative.

In line with the overall aim of this research, if we are to understand the silence around HIV and AIDS, and respecting the fact that HIV and AIDS is a complex disease that requires a multisectoral approach,³⁶ involving all stakeholders of different cultural backgrounds,³⁷ then an understanding of the various characteristics of culture that shape and determine silence is needed. It is through such an analysis that we will be able to understand what kind of silence we are dealing with and to know how we need to engage with it and/or break it. Considering the success that the understanding of these cultural dimensions has given businesses around the world in terms of relationship building and effectiveness, especially recently through the GLOBE³⁸ (Global Leadership and Organizational Behavior Effectiveness) study, I believe such an understanding will provide a framework to explain why people or families act in silence and what kind of silence is exhibited. This then will point to ways in which we can engage with and/or

36 The Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO) in 2001 saw the need to develop multisectoral strategies to address the impact of the HIV/AIDS epidemic at the individual, family, community and national levels by 2003. Refer to AIDS epidemic update December 2001 on the Internet: <http://www.unAIDS.org>. Refer to Mani for a profile of 24 countries that USAID had helped to put in place multisectoral HIV/AIDS programmes.

37 I would like to point out that breaking the HIV/AIDS silence in South Africa and for that matter in the Pietermaritzburg Area, is a task for the entire nation and from my personal observation, since I have been involved in the HIV/AIDS activism, most leaders of organisations involved in the fights against HIV/AIDS are Whites whose cultural backgrounds are different from the Blacks they serve.

38 GLOBE is an innovative, large-scale project on international management research receiving participation and contributions from nearly 17,300 middle managers from 950 organizations in 62 countries. This is possibly the largest project of its kind ever undertaken. GLOBE takes its definition and content of culture and leadership dimensions from the collective wisdom gleaned from the first GLOBE research conference in 1994, with the participation of 54 researchers from 38 countries. It has since become both a research program and a social entity. The GLOBE social entity is a network of 170 social scientists and management scholars from different cultures throughout the world, working in a coordinated long-term effort to examine the interrelationships between societal culture, organizational culture and practices, and organizational leadership. So far two volumes of its work has been published, namely; VOLUME 1 – House RJ, Hanges PW, Javidan M, Dorfman P, Gupta V, eds. 2004. *Culture, Leadership, and Organizations: The GLOBE Study of 62 Societies*. Thousand Oaks, CA: Sage and VOLUME 2 – Chhokar, S. Jagdeep, Brodbek, C. Felix and House, J. Robert. (Editors). *Culture and Leadership, across the World: The GLOBE Book of In-Depth Studies of 25 Societies*. Mahwah, N.J.: Lawrence Erlbaum Associates, Inc.

break the HIV and AIDS silence. This then will help us to begin to answer the second research question: To what extent do cultural dimensions contribute to the silence around HIV and AIDS?

I would therefore like to point out these cultural dimensions and highlight those which I think explain silence in the high-context culture we are studying. This knowledge, I believe, will provide a framework to help us to identify the areas to tackle when dealing with silence in this high-context culture, and thereby to deal with it. Further, I believe that knowledge and understanding of these cultural dimensions will help us deal with the HIV and AIDS silence in our multicultural approach. To this we now turn.

CHAPTER THREE: THE DIMENSIONS OF CULTURE AND SILENCE

3.0 Introduction

It is noted in the previous chapter that the area where this research is carried out, the city of Pietermaritzburg in the province of KwaZulu-Natal, is composed mainly of South African Black culture and is high-context in nature. This means it is a culture that is generally comfortable with silence in certain settings and this silence is one that connotes presence. It is a fertile silence that makes people, on matters of HIV and AIDS, communicate indirectly around the disease. However, if the fertile silence is engaged with, it could lead to the exposure and breaking of the barren silence that surrounds HIV and AIDS, in which there is no communication at all. The silence we are dealing with is not the low-context type, that is mainly a barren silence, and therefore a simplistic slogan such as ‘break the silence’ may not be appropriate. A high-context fertile silence has a presence that is available to us, but in a coded form, and must be engaged with. In the era of HIV and AIDS, engaging with and breaking the silence will help us deal with the disease appropriately to the culture.

With this understanding, this chapter investigates further dimensions of culture that combine with high-context culture in contributing to silence. Insights into how these dimensions of culture contribute to silence will then provide cues for engaging with fertile silence that will then expose the barren silence that we desire to break in the era of HIV and AIDS. This chapter therefore considers the various cultural dimensions, explains what the main ones are, and points out how they contribute to silence. This will be a new area of investigation of dimensions of culture and silence that we will be able to link to the HIV and AIDS silence.

3.1 The Dimensions of Culture as a Framework for Analysing Silence

Following the pioneering work of Hall (1959, 1966, 1977), which analyses culture into various dimensions on a continuum, cultural theorists have conducted studies into what has become known as ‘dimensions of culture’. This terminology, which is a dimensional

framework for characterising culture, was advanced by Geert Hofstede³⁹. An overview of the most known Cultural Dimensions by theorists⁴⁰ reveals 29 different aspects namely:

1. Communication context, (Hall 1959, 1966, 1976, 1987, 1989, 1998b)
2. Time Orientation, (Hall 1959, 1966, 1976, 1983, 1989)
3. Perception of space, (Hall, 1959, 1966,)
4. Nature of people, (Kluckhohn & Strodtbeck, 1961)
5. Person's relationship to nature, (Kluckhohn & Strodtbeck, 1961)
6. Person's relationship to other people, (Kluckhohn & Strodtbeck, 1961)
7. Primary mode of activity, (Kluckhohn & Strodtbeck, 1961)
8. Conception of space, (Kluckhohn & Strodtbeck, 1961)
9. Person's temporal orientation, (Kluckhohn & Strodtbeck, 1961)
10. Power distance, (Hofstede 1980, 1997)
11. Masculinity/femininity, (Hofstede, 1980, 1997)
12. Uncertainty avoidance, (Hofstede, 1980, 1997),
13. Individualism/collectivism, (Hofstede, 1980, 1997; Trompenaars 1993)
14. Long-term Orientation (Hofstede & Bond, 1989, 1997)
15. Confucian Work Dynamism, (Chinese Culture Connection 1987; Hofstede and Bond, 1988)
16. Universalism/Particularism, (Trompenaars, 1993; Trompenaars & Hampden-Turner. 1998)
17. Individualism/communitarianism, (Trompenaars, 1993; Trompenaars & Hampden-Turner 1998)
18. Neutral/Emotional, (Trompenaars 1993; Trompenaars & Hampden-Turner, 1998)
19. Specific/Diffuse, (Trompenaars 1993; Trompenaars & Hampden-Turner, 1998)
20. Achievement/Ascription, (Trompenaars 1993; Trompenaars & Hampden-Turner, 1998)
21. Attitudes to time, (Trompenaars, 1993; Trompenaars & Hampden-Turner, 1998)

39 See Geert H. Hofstede, *Culture's Consequences: International Differences in Work-Related Values* (1980, abridged ed. 1984); Geert H. Hofstede, *Cultures and Organizations: Software of the Mind* (1991); Geert Hofstede, *Culture's Consequences: Comparing Values, Behaviors, Institutions, and Organizations Across Nations* (2d ed. 2001).

40 This is not a comprehensive list of all theorists who have done work in this area. Others have contributed to the works listed in different ways. I am indebted to Zakour, Amel Ben. *Cultural Differences and Information Technology Acceptance*. University of Georgia, Terry College of Business. ameluniv@yahoo.fr sais.aisnet.org/2004/.%5CZakour.pdf -, whose list encouraged me to compile this list below

22. Attitudes to environment, (Trompenaars, 1993; Trompenaars & Hampden-Turner, 1998)
23. Conservatism, (Schwartz, 1994)
24. Intellectual autonomy, (Schwartz, 1994)
25. Affective autonomy, (Schwartz, 1994)
26. Hierarchy, (Schwartz, 1994)
27. Egalitarianism, (Schwartz, 1994)
28. Mastery, (Schwartz, 1994)
29. Harmony, (Schwartz 1994)

In this study I would like to propose that of the dimensions listed above, we concentrate on Hall's and Hofstede's cultural dimensions to provide insight into silence in a high-context culture. These dimensions are used as a *framework*, in the midst of cultural differences, to help identify common threads and patterns that underpin silence. It is the ways these dimensions contribute to silence that will provide us with cues to engage with fertile silence in order to expose the barren silence that complicates HIV and AIDS.

The choice of Hall is simply because the concept of high- and low-contexts were proposed by him and his views on time dimension will provide some clues as to how silence is exhibited in a high-context culture. The reasons for choosing Hofstede's dimension over others are:

- i) That of all the theorists, Hofstede's dimensions overlap and cover well the areas of common basic problems in cultures worldwide, identified by Inkeles and Levinson in 1954 (Ashkanasy et al, 2004)⁴¹. This is the epoch when Hall's research was done.
- ii) Unlike others who lack empirical data, Hofstede's work is the result of analyses twice conducted on data collected from 116,000 individual questionnaires of the HERMES international attitude survey programme in 1968 and 1972 from 40 countries (Hofstede 1980: 39-64). Later during 1980-1984, Hofstede conducted

41 The writers point out that "Inkeles and Levinson (1969) took the task of specifying universal problems of society but they did so out of a composite literature from psychology and sociology as much if not from anthropology. Hofstede worked out of Inkeles and Levinson's categories in analysing national cultures. However no one has yet systematically drawn from either of these categories or any others that are more strictly anthropological to construct value dimensions for analysing organisational culture" (2004: 10)

- detailed interviews with hundreds of IBM employees in 50 countries and 3 regions who participated in his study (Hofstede 1983: 335-355).
- iii) Hofstede's work has been acknowledged by several authors as one of the few studies in cross-cultural management with both a large sample and longitudinal data and is unquestionably the most widely accepted evaluative technique for national culture (Nasif et al. 1991:86; Yates & Culter, 1996:78).
 - iv) Hofstede's work is widely recognised in the field of measuring differences between both national cultures and ethnic groups. (Thomas and Bendixen 2000: 510).
 - v) All the other dimensions of culture can be seen to evolve around Hall and Hofstede's work in a continuum of a range of possible stances between two polar extremes.
 - vi) Hofstede's "value belief theory of culture (Cultural dimensions)" (Hofstede, 1980) is integrated with "leadership theory" (Lord & Maher, 1991), "implicit motivation theory" (McClelland, 1985), and "structural contingency theory of organizational form and effectiveness" (Donaldson, 1993; Hickson, Hinings, McMillan, & Schwitter, 1974) to provide an expanded model of cultural measures. It contributes to the theoretical base that guides the GLOBE (Global Leadership and Organizational Behavior Effectiveness), research program, which is currently used worldwide in business leadership (Chhokar et al 2007). This work considers the cultural dimensions of South Africa holistically in light of the new political dispensation in the country (Booyesen and Van Wyk 2007)

The areas to be considered therefore, in terms of the fundamental dimensions of culture with characteristics that contribute to silence in a high-context culture such as the predominantly black areas of Pietermaritzburg where our study is located, would be: Hall's monochronic and polychronic time as well as Hofstede's dimensions of power distance, uncertainty avoidance, individualism/collectivism and masculinity/femininity. Habke and Sept confirm the decision to use these two theorists when they write:

Hall (1976) was the first to draw distinctions between cultures on the basis of abstract, generalized characteristics. He introduced the widely used and now well-researched continuum of "high-context" and "low-context"

cultures. To this basic framework, Hofstede (1980) added dimensions of power distance, masculinity/femininity, uncertainty avoidance, and individualism/collectivism. In combination, the research of Hall and Hofstede provides a multi-dimensional array of cultural differences that have direct implications for intercultural communication (1993).

In the use of these dimensions, I would like to point out two important considerations:

- i) That Hall's dimension of time orientation and silence will be explored thoroughly in this chapter. It will also be acknowledged within Hofstede's dimension of uncertainty avoidance as a basis for silence. Thus when it comes to exploring how time orientation affects the silence around HIV and AIDS, in the next chapter, the influence of time orientation will be considered under Hofstede's dimension of uncertainty avoidance, and not as a stand-alone sub heading as done in this chapter.
- ii) That in discussing the four dimensions of culture proposed by Hofstede, and mentioned above, the masculinity/femininity dimension will be considered in the light of recent studies that further divide it into two sub dimensions, namely assertiveness and gender egalitarianism.

3.1.1 Critique of Dimensions of Culture – Essentialism.

In using the concept of cultural dimensions the writer has noted the potential problem of essentialism that it raises. Essentialism, is defined “as a belief in true essence – that which is most irreducible, unchanging, and therefore constitutive of a given person or thing” (Fuss 1989:2). Tomaselli points out that using this theory simplistically can lead to polarisation of individuals and groups, even though the theory was not intended “to be applied unproblematically to whole 'nations', 'cultures', 'groups' or 'races'” (1996). Guest points out how critics such as Said 1978; Spack 1997; Zamel 1997; Pennycook 1998; Susser 1998 and Kubota 1999 see such differentiations as perpetuation of a ‘colonial discourse’ that serves to essentialize a culture by reducing it to a few fixed essences. In this way, some critics say that in a classroom situation, for example, such essentialism ‘otherizes’ the foreign teacher from the students. They argue that “such essentialist constructs may effect how teachers view their students, that learners may be reduced to or bound by fixed cultural stereotypes” (2006: 4).

In considering the dimensions of culture and other areas of culture in this study, I wish to point out again that I am not trying to regard cultures as fixed, concrete entities within polarised domains – people of one culture being essentially one, and those of the other culture essentially another, merely because of their race. Culture is considered in this study as an evolving process that differs not only from place to place and from class to class, but from one individual to another and from one year to the next. Culture is dynamic and embraces a process of constant change, sometimes rapid, sometimes slow, with some dimensions of life changing at different times than others (Haines. 1999). Culture in this sense, is seen not to have sharp boundaries between one group and the other, or one nation and the other. Hence, in this study the concept of a continuum is important in considering the dimensions of culture. The dynamic nature of culture, as well as the learning abilities of humans, can over time, cause people to navigate themselves in terms of what they have, and what they aspire to.

The use of dimensions of culture as a frame work to investigate the underlying causes of silence in different cultures is to provide a guide for dealing with silence in the era of HIV and AIDS, just as the concept, despite its potential problems, has successfully helped in the field of business, leadership etc., as depicted in the GLOBE⁴². This is to help us come to terms with the observation that different cultures deal with silence differently. However, Guest sees that dimensions of culture may lead to stereotyping, exoticizing, or essentializing. He calls for remedial measures, for; “researchers to resist the urge to reduce cultures to binary opposites which produce false dichotomies, distort realities and easily lead to the stereotyping, exoticizing, or essentializing of a culture. Researchers should be agents of discovery not transmitters of previously held dogmas and prejudices. If we hope accurately to portray the culture under study and truly help teachers and learners to absorb this understanding in ways beneficial to the classroom, it is the least one should do” (2006: 13-14). Cues from Guest’s work are taken to avoid essentializing by taking note of what Hofstede’s is about:

It should be noted though that Hofstede's categories are not static. He correctly recognizes fluctuations and variations within a culture (particularly

⁴² See House, R. J. et al (2004) and Chhokar, S. et al (2007)

in the dichotomy of individualism vs. collectivism) and sees these features as existing on a continuum, not as fixed polemic opposites, although, as we shall see, this was not always appreciated or understood by those citing him. (Guest 2006:3)

3.2 Ways in which the Dimensions of Culture contribute to Silence in a High-Context Culture.

Our study has pointed out that silence, in the cultural sense, is more pronounced in a high-context culture than in a low-context culture. At this juncture, we need to investigate characteristics of these selected dimensions of culture which could contribute to silence in the high-context culture we are studying. In order to be able to deal effectively with the silence that is identified in this culture, or to suggest what best to do with the silence that is discovered, I suggest that these characteristics of dimensions of culture, if investigated, will provide the necessary clues which can be used to develop a framework to expose the silence. In this chapter, therefore, each of the five identified dimensions above will be explained and located in its general sense, in Africa and in the South African situation. Each of these dimensions of culture is then considered in terms of how it contributes to silence. This will be a new a new area of investigation taking the dimensions of culture further into areas of silence, a contribution that will help us understand the HIV and AIDS barren and fertile silence.

3.2.1 Time Orientation and Silence.

After the ground-breaking work in high/low-context cultures, the second dimension of culture that Hall tackles in his work is time orientation, which he describes in the two contrasting ways it is handled; namely monochronic (M-time) and polychronic (P-time) (1977:17-24). "Time is one of the fundamental bases on which all cultures rest and around which all activities revolve. Understanding the difference between monochronic time and polychronic time is essential to success..." (Hall 1990: 179).

Monochronic time is linear and consists of one thing at a time. People from M-time cultures therefore generally prefer to undertake one activity at a time and emphasise priority setting, schedules, segmentation, and promptness (Hall 1977:7). In this culture Hall says that time could be viewed as tangible, and spoken of as being saved, spent,

wasted, lost, made up, ‘crawling’, ‘killed’ and ‘running out’ (1983: 48). Polychronic time, on the other hand, consists of multiple events happening at once, and is a culture that stresses involvement with people rather than adherence to preset schedules.

Hall points out that time orientation is linked to the context dimension of culture. High-context cultures tend to be polychronic, which means that people of the culture can be involved in many different activities with different people at the same time. It is this high involvement of people that produces a greater degree of context. Hall says that “to the low-context, monochronic, one-thing-at-a-time person, polychronic behaviour can be almost disorganizing in its effect, which is identical in its consequences to over crowding” (1977: 150).

Hall’s assertion that high-context cultures are generally polychronic is very important to our study, since we are interested in how silence could best be engaged with, exposed and broken in a high-context area such as ours. Furthermore, Singh and Kotze quote Hall to affirm that “Some cultures such as Arab, Latino, or black African cultures are polychronic (Hall, 1989, Hall, 1990)” (2003: 900). Regarding South Africa specifically, Singh and Kotze use the works of Prime (1999) and Morrison et al.(1999) to point out that the country’s sizable Afro-European population is recognised as monochronic and the majority indigenous Africans recognised as polychronic. They conclude that research conducted by Walton et al. (2002), confirms that Indigenous Africans are generally polychronic.(2003:901). Hall and Hall (1987), in a comparative chart which is reproduced in Table 3.2.1.1 below, outlines ten specific differences between extreme monochronic and extreme polychronic people.

Monochronic people	Polychronic people
Do one thing at a time	Do many things at once
Concentrate on the job	Are highly distractable and subject to interruptions
Take time commitments (deadlines, schedules) seriously	Consider an objective to be achieved, if possible
Are low-context and need information	Are high-context and already have information
Are committed to the job	Are committed to people and human relationships

Monochronic people	Polychronic people
Adhere strictly to plans	Change plans often and easily
Are concerned about not disturbing others; follow rules of privacy and consideration	Are more concerned with those who are closely related (family, friends, close business associates) than with privacy
Show great respect for private property; seldom borrow or lend	Borrow and lend things often and easily
Emphasise promptness	Base promptness on the relationship
Are accustomed to short-term relationships	Have strong tendency to build lifetime relationships

Table 3.2.1.1: Contrasts between Monochronic and Polychronic people (Source: Hall and Hall 1990:18-19).

3.2.1.1 Time Orientation in Africa

In commenting on Hall and Hall’s comparison, Kaufman-Scarborough reveals that among polychronic people punctuality is less important, while flexibility and changes of activity are common and expected; “polychronicity is based on change and flexibility, with attention being diverted among various possible activities” (2003:89). This understanding is very crucial in dealing with an African on such issues as engaging with or breaking the silence on HIV and AIDS. John Mbiti, the African philosopher and theologian, throws light on the African’s time concept, explaining the flexibility and changes in activities. He points out that the African concept of time is related to events, so when one sees an African sitting down, he is not wasting time: rather he is “either waiting for time or in the process of ‘producing’ time” (1990: 19).

Unlike the Western time that is monochronic and linear in nature with an indefinite past, exact present and infinite future, the African concept of time is a two-dimensional phenomenon, with a long past, a present, and virtually no future. Mbiti uses two Swahili words, “Sasa” (Micro-time) and “Zamani” (Macro-time) to illustrate the traditional African’s understanding of time. “Sasa has the sense of immediacy, nearness and ‘now-ness’; and is the period of immediate concern for the people, since that is ‘where’ or ‘when’ they exist (Mbiti 1990:21). Sasa therefore could stretch back to those who are remembered, even up to five generations, but in the future can only stretch for a few months towards an incoming event (Corder 2001: 47). In summary Sasa is in itself a complete or full time dimension which has a short (not more than two years) future, a

dynamic present, and an experienced retrievable past both for the individual and the community.

Zamani has also past, present and future components. Zamani is the bigger component of time which overlaps with Sasa. The two are not separable, with Sasa feeding or disappearing into Zamani. In recalling the past, Zamani is the period beyond which nothing can go (Mbiti 1990: 22).

From Mbiti's concept of time the dimension of relationship comes out. "Sasa generally binds individuals and their immediate environment together. It is a period of conscious living. On the other hand, Zamani is the period of the myth, giving a sense of foundation or 'security' to the Sasa period; and binding together all created things, so that all things are embraced within the Macro-time" (Mbiti 1990: 22). Ruch also links mystery with relationship and says "Because of this respect for the mystery of existence, the African feels more at home with people and more intimately participating in the mystery of their personality, than Western man, who prefers to take refuge in things that can be thoroughly analyzed and dissected without talking back" (1975: 13).

3.2.1.2 Time Orientation in South Africa

In South Africa, the concept of time orientation among Blacks is not different from the rest of the continent. Looking at time representations within companies in South Africa, Prime (1999) suggests that, generally, the various racial groups live in different temporal patterns. He introduces the concept of quantitative and qualitative time representation:

The cases describe the Whites and Indians as sharing a dominant quantitative representation of time where 'time is money', monochronic behaviours, time precision and digital organization are preferred. The dominant temporal horizon is future where consciousness first projects into. This future orientation amongst the Whites and Asians was also observed by Collier and Bornman (1999) as opposed to Blacks expressing the need to acknowledge the legacy of apartheid before attempting to create a future for the 'new South Africa'. Therefore, the Blacks tend to share a different time culture dominated by a more qualitative representation of time where 'time is events' (little time consciousness

without something happening), where polychronic behaviours are preferred and past and present orientation are not psychologically eliminated at the exclusive benefit of future (Prime 1999).

This time orientation is not restricted to the working or co-operate environment within which the Black African in South finds himself. It is part of his or her day-to-day life.

As regards time orientation in a high-context culture, we can conclude that time exists for humans to deepen their relationship with one another and with all created things. Therefore it does not have to be rigid but is flexible and can be changed to accommodate events as they happen naturally. Hamminga, reflecting on how natural the African concept of time is, says “Does the rain come always at the same time? Of course not. Does it come at the same time for all tribes? Certainly not. Why be more precise than the rain? African time is connected to nature, just as Western time, but the natural processes and events chosen to relate to are the ones emotionally relevant to African life” (2000). Using examples of America and Korea, Lundy says:

“One of the major differences between Western and Two-Thirds World cultures is concerning the view of time. Studies reveal that Americans tend to be at the extreme end of a continuum in being chronos shaped, whereby time is viewed sequentially, with Koreans being at the other end in being kairos shaped, whereby time is event-oriented. Reward in the latter frame of reference is association with the people in the event, or just that the event took place. Reward for the former is measured in terms of punctuality, achievement of goals in the event, etc.” (1999: 150-151).

3.2.1.3 Effects of Time Orientation on Silence

It is important to note that the traditional understanding of time in Africa is still functional in rural Africa to a larger degree, and for that matter in newly-urbanised areas, such as where this research is conducted. However, because of education and access to modern technology, many black Africans do not fully adhere to this way of life. However, this concept of time has been handed over from one generation to the other and is inherent in the African’s life as a “person experiences time partly in his own individual life, and partly through the society which goes back many generations before his own

birth” (Mbiti 1990:17). This scenario may be likened to the traditional practice of eating with fingers. Most educated Africans still eat with fingers, especially with certain types of meals. In eating foods such fufu⁴³ in Ghana, nshima⁴⁴ in Zambia or putu⁴⁵ in South Africa, most black Africans are so in contact with their own fingers for these types of food that if one ate with a cutlery set, the food would not taste the same. In a similar way, people who are born in typical traditional African society still adhere to this concept of time because the concept is in both their traditional lineage and their daily experience. Mere exposure to available education does not change this. Njoroge and Bannaars explain that education to the African is not necessarily for change:

There is more continuity than change in African thought about education broadly conceived ... Notwithstanding its diversity across ethnic boundaries, indigenous African thought on education was highly value-orientated and transmitted a well-defined social ethic. Intense social bonds reinforced these values, namely lineage, family, and age group and they were internalized by the ‘initiation pedagogy’ (1986:64).

City Africans may have daily experience with modern and western concepts of time, but still have the traditional view inherent in our behaviour through our lineage.

The problem, normally, is to know the length of time it will take to have a particular silence broken. In a polychronic culture, as Buckingham et al quote Storti (1999) to suggest, “time is not quantifiable and limitless” (2000:84). Time goes on until one is confident enough to release information in the engagement process and thereby expose the silence which is to be broken. De Vito’s assertion provides an explanation as to why time is required for silence on delicate issues to be broken:

Silence may be used to prevent communication of certain messages. In conflict situations silence is sometimes used to prevent certain topics from surfacing and to prevent one or both parties from saying things they may later regret. In such situations silence often allows us time to cool off before expressing hatred, severe criticism, or personal attacks— which, as we know, are irreversible (2002:149).

43 This is pounded yam, cocoyam, plantain, cassava or sometimes a mixture of these food items .

44 Cooked Millie mill among Bembas

45 Cooked Millie mill among Zulus.

The only way to fast-track the release of information and subsequent engagement with silence, or the breaking of silence, is through building relationships with those who have the information. This too has to happen naturally and is dependent on time: it is a time of being there for the other person to develop a natural relationship that is not based on the mechanical time of the chronos. In describing a paradigm for cross-cultural counselling used at the School for International Training (SIT), Buckingham et al point out from their experience that, in dealing with newcomers to the school community, hospitality is key. Hospitality has multiple manifestations, depending upon the cultural perspective of each student. “For some, hospitality means unhurried time to meet new student colleagues and to begin to develop relationships that provide a framework for the graduate school experience” (2000: 80).

Albertsson and Klingenstierna use Hollensen’s (2001) “General Comparative Characteristics of Culture” table that identifies the major differences of high- and low-context cultures, and point out that in high-context cultures, time is elastic, relative, spent on enjoyment and time builds relationships (2002: 65). In this case, when the counsellor views time from a perspective of being equal to money and therefore limited, it becomes difficult to get people to open up within a given time-frame offered to the counsellee. In psycho-social interventions, issues such as counselling require enough time for people to ‘open up’. In the SIT counselling experience, Buckingham et al say, “because time concepts vary across cultures, flexible scheduling is important. It allows the counsellor to accommodate walk-in students who may be reluctant to arrange appointments in advance. Flexibility also permits adjusting session length if necessary. Sometimes a fifteen-minute consultation is all that is needed; at other times two hours or more could be required. The standard fifty-minute hour in therapy may simply be too rigid a mould for working in a cross-cultural setting” (2000: 81-82).

Time-orientation is therefore an important consideration in any attempt to engage with silence in a polychronic environment. Within this time, various opportunities are granted for relationship building that allows for engagement with fertile silence, in a high context culture. Barren silence is then exposed and can be ‘broken’.

The time-orientation dimension links and merges well with Hofstede's dimension of uncertainty avoidance which is considered below. In this case, in the next chapter, as we consider dimensions of culture and the HIV and AIDS silence we will explore time considerations within the framework of uncertainty avoidance and not as a 'stand-alone' factor, as we have done in this chapter.

3.2.2 Power Distance and Silence.

As we now move from time considerations to 'power distance', we are moving from Hall's categories to those of Hofstede. The latter's first cultural dimension concerns social inequality, including relations with authority, taking into account the degree to which members of a group accept authority, hierarchy and status. This dimension is termed *power distance*. He says:

The basic issue involved, to which different societies have found different solutions, is human inequality. Inequality can occur in areas such as prestige, wealth, and power; different societies put different weights on status consistency among these areas. Inside organizations, inequality in power is inevitable and functional. This inequality is usually formalized in hierarchical boss-subordinate relationships. (1980:65).

Power distance indicates that there is inequality in any society. Some people have more power than others, which normally makes them more able to determine the behaviour of others than the less powerful would (Hofstede 1991: 23). In his research amongst IBM employees, to measure the degree of inequality in society, Hofstede assigned to each country in which the research was conducted a score known as Power Distance Index (PDI)⁴⁶ which indicates the level of power distance. PDI is a measure of the degree to which a culture values power and authority. Contrary to the usual trend of power distribution explained from the behaviour of the more powerful members, Hofstede defines power distance as "the extent to which the less powerful members of institutions and organizations within a country expect and accept that power is distributed unequally. 'Institutions' are the basic elements of society like the family, school, and the community; 'organizations' are the places where people work" (1991:28). Power distance

⁴⁶ See the Power distance column of Appendix 3A or Appendix 3A1.

is therefore explained from the value systems and the understanding of the less powerful members of society.

High power distance (high-PDI) indicates that an unequal distribution of power in society is viewed as legitimate and relationships are expected to be more distant, hierarchically ordered, and reserved. A high power distance society therefore tends to support inequality within the society. On the other hand, low power distance (low-PDI) indicates a general desire for equality and the relationships between people in positions of authority and their subordinates are theoretically close and less formal in nature. In this case a low power distance society tends to be considerably more open to challenging the status quo or challenging those in leadership.

Table 3.2.2.1 below shows the differences between small and large power distance societies as generally exhibited in families, schools and workplace as summarized by Hofstede 1991: 37.

Small power distance	Large power distance
<p>General norm:</p> <ol style="list-style-type: none"> 1. Inequalities among people should be minimized 2. There should be, and there is to some extent, interdependence between less and more powerful people 	<ol style="list-style-type: none"> 1. Inequalities among people are both expected and desired 2. Less powerful people should be dependent on the more powerful; in practice, less powerful people are polarised between dependence and counterdependence
<p>In the family:</p> <ol style="list-style-type: none"> 1. Parents treat children as equals 2. Children treat parents as equals 	<ol style="list-style-type: none"> 1. Parents teach children obedience 2. Children treat parents with respect
<p>At school:</p> <ol style="list-style-type: none"> 1. Teachers expect initiatives from students in class 2. Teachers are experts who transfer impersonal truths 3. Students treat teachers as equals 4. More educated persons hold less authoritarian values than less educated persons 	<ol style="list-style-type: none"> 1. Teachers are expected to take all initiatives in class 2. Teachers are gurus who transfer initiatives in class 3. Students treat teachers with respect 4. Both more- and less-educated persons show almost equally authoritarian values

Small power distance	Large power distance
<p>In the work-place:</p> <ol style="list-style-type: none"> 1. Hierarchy in organisations means an inequality of roles, established for convenience 2. Decentralisation is popular 3. Narrow salary range between top and bottom of organisation 4. Subordinates expect to be consulted 5. The ideal boss is a resourceful democrat 6. Privileges and status symbols are frowned upon 	<ol style="list-style-type: none"> 1. Hierarchy in organisations reflects the existential inequality between higher-ups and lower-downs 2. Centralisation is popular 3. Wide salary range between top and bottom of organisation 4. Subordinates expect to be told what to do 5. The ideal boss is a benevolent autocrat or good father 6. Privileges and status symbols for managers are both expected and popular

Table 3.2.2.1: Differences between small and large power distance

It is evident from the above that respect for authority and status are typically more dominant in high power distance cultures than in low power distance cultures, and in this case decisions are usually made at the top and sent down without people questioning them. For low power distance cultures on the other hand, such decisions would be questioned and reasonably and factually debated. In extremely high power distance cultures, the respect for authority figures, such as teachers at school, priests at church, bosses at work and parents at home, is generally so high that their decisions are not questioned and have to be obeyed, regardless of whether or not these decisions make any sense to the recipient (Dahl 2000: 5).

One interesting finding of Hofstede's work was that there were patterns of the origins of power distance. This discovery helps to explain why it is difficult to generalise when it comes to power distances, as to whether low-context cultures will have a high PDI or low PDI. Hofstede suggested climatic, population size and economic reasons for these PDI differences. The origins of these power distance differences can be summarised into:

- a. Climate (geographical latitude). Cultures in high-latitude climates (i.e. moderate to cold climates) generally have low PDI and those in tropical climates generally have a high PDI. The reasons for this include the higher latitudes having less abundance of nature and for human survival,

- independent thinking, modernisation, questioning of authority, technology, low PDI results; where as the contrary holds for a high PDI.
- b. Population Size – A large population size fosters dependency on authority and enhances a more centralised concentration of political power: hence a high PDI. On the other hand, a less populous culture leads to low PDI in which people learn to be dependent and able to express their points of view.
 - c. Distribution of Wealth. The more unequally the wealth is distributed within a culture, the greater the culture's power distance. For example more ex-colonies or cultures will show larger power distances than ex-colonising nations, and having been either a colony or a coloniser at some point in the past two centuries contributes strongly to nation's present wealth (1991: 42-46).

This research showed that of the 40 countries that were analysed, the PDI scores could be fairly precisely predicted from the above 3 factors. As Hofstede points out in part, "...latitude, population size, plus national wealth (per capita gross national product in 1970, the middle year of the survey period), predict 58 percent. If one knew nothing else about these countries other than those three hard to fairly hard data one would be able to make a list of predicted PDIs which resembles Table 2.1⁴⁷ pretty closely" (1991:44). This suggests that if two countries of the same cultural context, falling into the same climate and having the same PDI some fifty years ago were now to have different population sizes and different national wealth, over this period of time, the PDIs of these countries would now differ. The factors above will therefore be able to help us understand the kind of power distance that exists generally in Africa and in South Africa in particular and throw light as well on how South Africa's power distance differs from the rest of Africa.

Hofstede also points out a general correlation that exists between power distance and another cultural dimension, namely individualism/collectivism⁴⁸ (1984:62). Knowing

⁴⁷ This Table is listed as Appendix 3B

⁴⁸ This will be considered in detailed below to show that Hofstede's dimension of individualism and collectivism is seen to be consistent with Hall's high and low-contexts.

how cultural context correlates with individualism/collectivism, it should be easy to have a general link between power distance and cultural context. However, the three factors mentioned above, especially the wealth factor, modifies what might have been easily seen as a general trend of linking the kind of power distance to the cultural context. It is against this background that Frank and Toland throw more light:

Hofstede's work indicated a strong relationship between a country's national wealth and the degree of individualism in its culture. Richer countries tend to have an individualistic style, whereas poorer countries are more collectivist. As a poor country grows richer it tends to move away from a collective pattern to an individualistic one. Additionally, people from a rural background tend to be more collectivist than those from an urban background. ... A country that is collectivist is also likely to be a high power distance country, where the views of senior people tend not to be questioned (2002: 42).

This would mean, generally, that high-context cultures are expected to have high power distances and low-context cultures expected to have low power distances. However, we know that culture is dynamic, and when the factors of climate, population size and extent of national wealth are considered, there would be cause for deviation from this expected norm.

3.2.2.1 Power Distance in Africa

Looking at *Appendix 3A* again it is clear that African countries, which we have identified before to be of high-context, have medium to high power distances. Considering *Appendix 3B*, Raghu and Kunal (1988: 273) maintain Africa as being generally a high power distance continent. Mbiti uses the motif of a ladder to explain how in human relationships in Africa there is emphasis on the concept of hierarchy - based partly on age and partly on status – a concept that throws more light on the power distance in the African culture. He explains that:

In practice this amounts to a ladder ranging from God to the youngest child. God is the creator and hence the parent of mankind, and holds the highest position so that He is the final point of reference and appeal. Beneath Him are the divinities and spirits, which are more powerful than

man and some of which were founders and forbearers of different societies. Next come the living-dead, the more important ones being those who were full human beings by virtue of going through the initiation rites, getting married and raising children. Among human beings the hierarchy includes kings, rulers, rainmakers, priests, diviners, medicine-men, elders in each household, parents, older brothers and sisters, and finally the youngest members of the community. Authority is recognized as increasing from the youngest child to the highest Being. As for the individual, the highest authority is the community of which he is a corporate member. This authority also has degrees, so that some of it is in the hands of the household-family, some is invested in the elders of a given area, part is in the hands of the clan, and part is in the whole nation which may or may not be invested in central rulers (1990:200-201).

This scenario described by Mbiti provides a deeper explanation of the hierarchy that Hofstede pointed out in the *Table 3.2* above. With hierarchy goes respect and degrees of authority as one ascends the ladder. Another traditional African theorist, Mbigi, on his part goes further to show hierarchy in the realm of the spirits from the point of view of the African. He lists the nine spirits in their English translation in order of significance as God, Rainmaker Spirit, Hunter's Spirit, Innovative Spirit, Divination Spirit, Clan Spirit, War Spirit, Avenging Spirit, and the Witch Spirit (2000:x).

In the African's world-view however, power distance is linked to the totality of communal life. The individual is expected to feed back into, and to respect, the authority vested in the leaders above him. According to Mulemfo even though there is the understanding that God is the source of everything, the success of the community depends on its respect for the interaction between God, the ancestors (the living dead), the living community and the environment (1996:132). In this case, when something disturbs the smooth interaction between these different forces, it affects not only the persons concerned, but also the community as a whole. This then calls for what he terms a 'palaver',⁴⁹ or a big gathering, convened specifically to find ways and means to remedy

⁴⁹ Wilhelm notes that the concept of Palaver has different names according to the language, people and context: lekgotla (Sotho/Tswana), imbizo or indaba (Zulu, Xhosa, siSwati, Ndebele, etc.). It is a common

the situation. To the African, a ‘palaver’ is understood as “a traditional meeting or gathering of the kinship group or the whole community” (Mulemfo 1996:133). The governing of people is therefore based on constant consultations with the people, which means that leaders are not to be distanced from the people. It is for this reason that Khoza points out, “After all in African villages the chiefs are highly dignified personalities but yet very approachable” (1994: 122).

3.2.2.2 Power Distance in South Africa

Though, generally speaking, the African culture is seen as a high power distance one, scholars see the South African situation as being complex. The complex nature of the South African situation stems from its composition – being multicultural – as well as its latitude, wealth and its history. The fact that Hofstede’s data from South Africa was obtained from Whites only (1997:130), that he puts the country on a PDI of 49, suggests that if Blacks were considered to be part of the research, the score would have been different. Commenting on the power distance in South Africa in a recent study, Hugo identified the following:

It must be noted that South Africa is characterised by a very complex power struggle in a large variety of sectors, including political, social and organisational. In spite of this the power distance is relatively low compared to the rest of Africa - there is a new tendency to view subordinates and supervisors as closer together and more interchangeable, with flatter hierarchies in organisations and less difference in salaries and status. Parents and children, and teachers and students, may view themselves more as equals (but not necessarily as identical.). Equality is expected and generally desired, especially in the post-apartheid era. However, in many organisations with a legacy of white management, clashes between different cultures sometimes occur (Hugo 2000).

This study is consistent with another study by Thomas and Bendixen (2000) who studied 586 middle managers in South Africa from different ethnic groups using Hofstede’s

dynamic in the African story. But has however, been misunderstood through distorted connotations (‘jaw talk’, flattery, cajoling) because the word is not from Africa but a Portuguese word (palavra) applied to the African context, in order to explain what is African (2003: 157).

(1994) VSM94 instrument⁵⁰. Surprisingly their findings showed very low PDI values for all the ethnic groups studied and South Africa as a whole (*see*: Table 3.2.2.2 and Table 3.2.2.3 below).

Country	PDI
SA—present study	1
SA—original study	49
France	68
India	77
Malaysia	104
Netherlands	38
United Kingdom	35
USA	40

TABLE 3.2.2.2: Comparison of Thomas and Bendixen SA study PDI values with countries with past influence on South Africa.

Group	PDI
White—English	5.4
White—	5.6
Asian	-1.0
Coloured	-5.4
Black—Xhosa	-1.6
Black—Zulu	-1.6
Black—Sotho	-4.5
Male	4.5
Female	-5.8

TABLE 3.2.2.3: PDI score for some South African Ethnic groups

Recognising the fact that this study was done in the working environment and with managers, Thomas and Bendixen provide possible reasons for these unexpected values:

The extreme values measured for South Africa on these dimensions in the present study are worthy of comment. The low PDI score is in keeping with the present political and economic climate of the country where participation, consultation and democracy are promoted as ideal forms of governance rather the historical hierarchical bureaucracies that characterised the previous regime. This manifests itself in current legislation e.g. The Labour Relations Act No. 66 of 1995 (Republic of South Africa, 1995) and the Employment Equity Act No. 55 of 1998 (Republic of South Africa, 1998). The legacy of the past is another possible explanation of the intolerance of hierarchy. The previously disenfranchised groups (black Africans, Coloureds and Asians) understandably have rebelled against historical authoritarianism (2000: 513).

In the South African working and political arena, many unexpected changes are taking place when it comes to issues of power.⁵¹ The intentional enactment of legislation such

⁵⁰ The VSM94 instrument comprises of a self-completion questionnaire which is analysed to provide score of in Hofstede's 5 dimensions of culture. The fifth in his 1994 version is Long-Term Orientation (LTO).

the Affirmative Action programme has helped South African companies make efforts to include, in management structures, people from the multiplicity of ethnic groups in the country who were previously denied such access (Thomas and Bendixen 2000:508). In the New South Africa where every culture contributes to the mix, the power distance at the national level and in the urban areas is made complex by each cultural entity exercising its natural tendency in the power struggles in all sectors.

The power distance situation in South Africa as a whole is made further complex by the fact that the urban areas and the business and working environments have controls to check any unwanted and extreme exercise of power. Thomas and Bendixen paint a picture of the previous history of the nation in which some groups exercised a 'will to power' which excluded others from managing the affairs of the nation. With this in mind, after the end of Apartheid in April 1994, the South African business and working environment has found itself in a period of significant transformation whereby previously excluded racial and ethnic groups are being both empowered and incorporated into management structures (2000:508).

However, the situation outside of the business and working environment is different. The day-to-day normal life of the ordinary man and woman in the street and in the rural and traditional homestead is different. There, my educated assumption is that the level of power distance will be like that in any other black African country. Here Hofstede's postulation of differences in economic activities and unequal worth distribution leading to higher power distances come to play (1997:45-46). From their perspective looking at power distance in South Africa, Easton et al suggest that an obvious contribution and undeniable factor in the country having a relatively high power distance is the high disparities between the poor and the rich (2003: 2). Obviously the tribal, patriarchal, colonial and racist historical background will have immediate power implications for our situation. However, until new formal research is conducted to find the power distance score of the new South Africa at grassroots level, focussing on the Black community, Rose et al state categorically that:

51 See Booysen and Van Wyk (2007: 434-443) on the Historical Overview of South Africa, which indicates the democratic struggle the country has been through until independence, that brought ANC into power. More importantly, they point out COSATU's pressure for democracy, transparency and accountability in the country.

While no Hofstede data exist for the current RSA, his work in the 1970s does lend some insight into what differences might be seen. Specifically, members of the euro-centric South Africa of the 1970s were found to have a moderate power distance index value (49). In contrast, areas of sub-Saharan Africa outside of RSA had scores of 64 (in East Africa) and 77 (in West Africa). These differences may be relevant to a study in RSA because much of the black population still lives in the rural former homelands. These areas are still homogenous and lifestyles in these areas are considered to be traditionally (black) African (2003:19)

Given the other cultural elements that are shared, it is likely that the power distance situation in the typical Black communities in South Africa will be closer to that of the higher values obtained by other African nations. Booysen's research into power distance among Black and White managers showed a similar score among the two groups (2000: 7-8). She points out that this is contrary to claims by Mbigi (1995a, 1997) and Khoza (1994) that power stratification is lower among blacks than among whites in South Africa. The research revealed that although, on the whole, white managers measured higher than black managers in terms of power distance cultural dimension; there was no significant difference between the scores of the Black and the White groups. More significantly that both Blacks and Whites scored above-the-scale average on power distance. (2000: 8). Given the history of South Africa and the disparities between the rich and the poor, one would expect Whites to score higher than Blacks at that level and generally in the urban areas (Easton et al 2003:2).

The above finding is helpful for us to know that generally, the Black culture has a higher power distance. More so, the Zulu culture which is the predominant culture of the people that this research targets, exhibits acceptance of authority, hierarchy and status that is not different from Mbiti's assertion above. According to Ndwandwe, hierarchy and power are seen even, through having respect for one another. "Respect among Zulus was and still is general; everyone must be respected irrespective of age or sex. But respect was also hierarchical in accord with their social structure. The highest one to be accorded respect being uNkulunkulu/uMvelinqangi and the next in line, in a retrogressive order

being the living dead, especially those who had occupied highest positions such as kings and leaders of families ” (2000:199-200).

Another area of the Zulu culture where power distance is shown is in the area of seniority, in which age commands respect. Ndwandwe quotes Ngobese (1981:6) to show that age in the Zulu culture means experience in many areas of life. From this he infers that respect does not originate from empty space, but is rather born out of a situation of life. The elders are people who are experienced in life. Therefore among the Zulus seniority came with age (Ndwandwe 2000: 200). This means that the aged are respected and placed higher in the hierarchy.

The third area that Ndwandwe shows command for respect in the Zulu tradition is status, in that “if you belonged to the right hand side of the family line (Iqadi), you always had more respect than those on the left hand side of the line (Ikhohlo)” (2000: 200). To the Zulus, the importance of social hierarchy is expressed in the understanding that all men have their determined place in society, and that must be respected. Using Ngobese, again, Ndwandwe brings to light the strictness of this hierarchy:

This hierarchical order was respected and observed very strictly especially during celebrations or the performance of any ritual affecting or involving the living dead. The same order of seniority was observed even among the women. This is so true among the Zulus that in the hut they would arrange themselves according to the hierarchical order on their side of the hut and so likewise the men on their side of the hut (Ngobese 1981:5). Seniority meant a lot in the Zulu culture. For instance a young man would not feel able to approach a senior man. Instead he would ask the man next to him to approach a senior man on his behalf. Being a young man he has no reason to approach a senior man directly, let alone call him by his first name (Ndwandwe 2000: 201).

From the above it is clear that the culture of the area in which this research is being conducted is of a higher power distance, where power is recognised and respected. It is for this reason that even in the new South Africa the Zulu social hierarchy is active, in the sense that KwaZulu-Natal - being the only province in the country with a tribal political

party – Inkatha Freedom Party (IFP), with a leader commanding unquestioned respect, and with no democratic discussion allowed about replacing him.

However, it must be noted that in practice, this power distance dimension works with other dimensions of culture and life, making the African live a holistic life. In this case the higher power distance, in term of government and ruling, is not divorced from the day-to-day communal life of the people. The ruling of the nations comes to the level of everyone through imbizos or indabas⁵². Traditionally, everyone gives power and authority to the leadership, knowing that the leader is there for the people and not for his or her personal gain. Power distance, in the true sense of how the African culture was meant to be, is exercised within the lifestyle of ubuntu.⁵³. Manci writes:

In ubuntu schemes, people are encouraged to encounter each other as persons interested only in sharing life in its fullness. It discourages the bossy types of relations where power is centralised in its leaders. In its ‘izimbizo’ and ‘izinkundla’ (national and tribal assemblies) types of relations ubuntu encourages consultations. Issues are thrashed out till there is there is a type of unanimity and only after consensus has been reached the people talk of a majority rule (Manci 2005: 409).

This situation may seem idealistic today, especially in the city. In the consumerist capitalistic economy of today, with its temptation to out-do others, there are increasing levels of corruption and arrogance that were not previously seen. However this does seek to capture what ‘the best intentions’ of the culture are, which can still be seen in many parts of rural Africa. This then helps us understand the kind of community in which this research is conducted. It is important therefore to know how high power distance affects or contributes to silence.

3.2.2.3 Effect of Power Distance on Silence.

In a high power distance culture, as has been noted above, respect for authority and the aged as well as regard for status is a norm. One would not dare share openly what is on

⁵² See foot note 26 above.

⁵³ As will be discussed below under individualism/collectivism, ubuntu is a concept of being humane or humanness.

one's mind until clear permission has been granted through such forums as imbizos. Since there is no easy way of communicating one's feelings, people keep silent and act as if they have accepted what is proposed, when in reality it may be rejected. Unfortunately, more often than not, such silence would be taken to mean consent (Deloitte & Touche. 2003: 90).

The general acceptance of hierarchy and status in power distance societies as part of the culture also perpetuates silence. Commenting on the situation in Japanese culture, Suvanto (2002:28) says "Silence may be used to save the Japanese from being embarrassed; it allows them to be socially discreet. Silence may also be related to a hierarchical situation, such as the presence of a senior person who has the superiority to initiate speech". In this case one has to be careful with the choice of words since what may be said could cause problems later.

In a high power distance culture, learning is determined by the older person who is the teacher, either formally (in most cases in an institution) or informally (in the home). This infuses silence from the children or the learner. Aguinis and Roth, looking at the relationship between power distance and instructional challenges with particular reference to China, make an observation that a 'teacher' in Chinese means one who is born early. This assertion therefore implies that teachers - because they were born earlier - deserve respect and deference (2003:11). This view is not different from African cultures where differences in age call for respect.

Further Aguinis and Roth quote Ho (1996) and Li (2003), to bring to light the effects of this high power distance situation, "In exchange, instructors are expected to demonstrate wisdom and to form the oral character of their students. Thus, filial piety teaches Chinese students to fear authority figures, to adopt silence, negativism, and passive resistance when dealing with authority demands" (2003: 12). In the Zulu setting, Denis points out that children (especially orphans) who grow up in families where customary respect for and avoidance of elders, *ukuhlonipha*, is practiced, become silent participants in family matters (2003: 7). He cites one of the Sinomlando⁵⁴ memory facilitators explaining at a

⁵⁴ Sinomlando is a Memory Box Project at the University of Kwazulu Natal, Pietermaritzburg where the writer is a director. The Project employs a concept of using a box containing colourful and meaningful activities with the sole aim of helping bereaved children to deal with their feelings of grief and at the same

university seminar dealing with bereavement issues, “It is in our blood that children do not ask questions” (2003: 7).

It is therefore clear that cultures of high power distance are more comfortable with silence. Information is not easily divulged, especially if the kind of information could affect others and clear permission had not been granted for its release. In this case within a high context culture such as ours, there will be a barren silence on an issue, yet to the culturally attuned person a fertile silence will exist which allows for gradual discussions and relationship building. In other words, one would not easily talk freely about an issue affecting one, until conditions are made conducive, through engagement. Only then will the barren silence be exposed for to enable to talk.

3.2.3 Uncertainty Avoidance and Silence.

The second dimension of national culture that Hofstede identifies, and the third that we consider, is labelled ‘uncertainty avoidance’. This dimension concerns cultural preferences for dealing with uncertainty. As he points out, “Uncertainty about the future is a basic fact of human life with which we try to cope through the domains of technology, law and religion” (1980:110). He then adds that extreme uncertainty creates intolerable anxiety and societies differ in their tolerance of the unpredictable (1991:110). Using the domains of technology, law and religion every human society has developed ways to alleviate this anxiety:

Technology, from the most primitive to the most advanced, helps to avoid uncertainties caused by nature. Laws and rules try to prevent uncertainties in the behaviour of other people. Religion is a way of relating to the transcendental forces that are assumed to control man's personal future. Religion helps in the acceptance of the uncertainties one cannot defend oneself against, and some religions offer the ultimate certainty of a life after death or of victory over one's opponents (Hofstede 1991:110)

time providing a keepsake which will be an invaluable memory of their parents in years to come. The basic assumption of this methodology is that children who remember their parents in a positive way are in a better position to cope with the hardships of their condition.

Though feelings of uncertainty stem from an individual, they are not only personal but may also be partly shared with other members of one's society. Hofstede declares that feelings of uncertainty are acquired and learned: "Those feelings and the ways of coping with them belong to the cultural heritage of societies and are transferred and reinforced through basic institutions like the family, school, and state. They are reflected in the collectively held values of the members of a particular society. Their roots are non-rational. They lead to collective patterns of behaviour in one society which may seem aberrant and incomprehensible to members of other societies" (Hofstede 1991:111). Uncertainty avoidance can therefore be defined as:

The extent to which the members of a culture feel threatened by uncertain or unknown situations. This feeling is, among other things, expressed through nervous stress and in a need for predictability: a need for written and unwritten rules (Hofstede 1991:113)

Hofstede has compiled uncertainty avoidance Index (UAI) values⁵⁵ for 50 countries and three regions, using the IBM research conducted among IBM employees in a way similar to the computation of the PDI above. He interprets the scores as:

High scores occur for Latin American, Latin European, and Mediterranean countries (from 112 for Greece to 67 for Ecuador). Also high are the scores of Japan and South Korea (92 and 85). Medium high are the scores of the German-speaking countries Austria, Germany (Federal Republic), and Switzerland (70, 65, and 58, respectively). Medium to low are the scores of all Asian countries other than Japan and Korea (from 69 for Taiwan to 8 for Singapore), for the African countries, and for the Anglo and Nordic countries plus the Netherlands (from 59 for Finland to 23 for Denmark). West Germany scores 65 (rank 29) and Great Britain 35 (rank 47/48). This confirms a culture gap between these otherwise similar countries with regard to the avoidance of uncertainty... (1991:114)

Cultures with high UAI scores generally feel more threatened by uncertain and ambiguous situations. They try every means to avoid these situations by providing greater career stability, establishing more formal rules, not tolerating deviant ideas and

⁵⁵ See the Uncertainty Avoidance column of Appendix 3A or Appendix 3A2.

behaviours, and by believing in absolute truths and the attainment of expertise (Samovar and Porter 2001:69). Therefore they expect structure in organisations, institutions, and relationships to help make events clearly interpretable and predictable. They tend to be generally expressive: talking with their hands, raising their voices, and showing emotions. Pattanayak points out that uncertainty avoidance cultures have preference for conservative practices and prefer familiar and predictive situations. “People in a high uncertainty avoidance region, like Asia, resist change and act to maintain the status quo” (2005:332).

By contrast, cultures with a low UAI score generally feel less threatened by uncertain and ambiguous situations, and tend to be less expressive and less openly anxious; people behave quietly without showing aggression or strong emotions. (Hofstede 1991:114-116). For strong uncertainty avoidance cultures “competence is a strong value resulting in belief in experts, as opposed to weak uncertainty avoidance cultures with belief in the generalist. In weak uncertainty avoidance cultures people tend to be more innovative and entrepreneurial” (De Mooij 2002:3). As strong uncertainty avoidance cultures depend on experts who know what they are doing, weak uncertainty avoidance cultures are not afraid to risk new innovations.

In social life in general, Hofstede notes that cultures with high uncertainty avoidance tend to have high rates of suicide, alcoholism, accidental deaths, and high numbers of prisoners per capita. Teachers are expected to be experts who know the answers and may speak in enigmatic language that excludes beginners. Businesses and work places may have more formal rules, requiring longer career commitments, and focus on daily planned operations as opposed to strategy. Generally, what is different may be viewed as a threat, and what is unconventional is usually regarded as dangerous. On the other hand, in low uncertainty avoidance cultures more people die from coronary heart disease due to lack of expressiveness within these cultures. People are not expected to show aggression and emotions. In this way stress cannot be released in activity and has to be internalised, causing cardio-vascular damage. There is larger number of chronic psychosis patients from a lack of mental stimuli. People resort to high intake of stimulating drugs and caffeine carriers such as coffee and tea. In schools teachers are accepted when they ‘don’t know’. Businesses may be more informal and focus more on distant strategic matters than

on day-to-day operations, since the formal are unstructured, demanding a greater tolerance for ambiguity than the latter. People seem relaxed and what is different may be viewed as something worth examining (Hostede, 1991: 114-125).

Strong uncertainty avoidance countries are therefore characterised by people seen to be busy, restless, emotional, hostile or active whereas in weak uncertainty avoidance countries people come across as being quiet, laid-back, indolent, controlled or lazy.

Weak uncertainty avoidance	Strong uncertainty avoidance
General norm: 1. Uncertainty is a normal feature of life and each day is accepted as it comes	1. Uncertainty inherent in life is felt as a continuous threat which must be fought
In the family: 1. Uncertainty is a normal feature of life and each day is accepted as it comes 2. Low stress; subjective feeling of well-being 3. Aggression and emotions should not be shown 4. Comfortable in ambiguous situations and with unfamiliar risks	1. Uncertainty inherent in life is felt as a continuous threat which must be fought 2. High stress; subjective feeling of anxiety 3. Aggression and emotions may at proper times and places be ventilated 4. Acceptance of familiar risks; fear of ambiguous situations and of unfamiliar risks
At school: 1. Lenient rules for children on what is dirty and taboo 2. What is different, is curious 3. Students comfortable with open-ended learning situations and concerned with good discussions 4. Teachers may say 'I don't know'	1. Tight rules for children on what is dirty and taboo 2. What is different, is dangerous 3. Students comfortable in structured learning situations and concerned with the right answers 4. Teachers supposed to have all the answers
At the work place: 1. There should not be more rules than are strictly necessary 2. Time is a framework for orientation 3. Comfortable feeling when lazy; hard-working only when needed 4. Precision and punctuality have to be learned 5. Tolerance of deviant and innovative ideas and behaviour 6. Motivation by achievement and esteem or belongingness	1. Emotional need for rules, even if these will never work 2. Time is money 3. Emotional need to be busy; inner urge to work hard 4. Precision and punctuality come naturally 5. Suppression of deviant ideas and behaviour; resistance to innovation 6. Motivation by security and esteem or belongingness

Table 3.2.3.1: Differences between weak and strong uncertainty avoidance societies

“These impressions are in the eye of the beholder: they depend on the level of emotionality to which the observer has been accustomed in his or her own culture” (Hofstede 1991:115).

Table 3.2.3.1 above shows the key differences between weak and strong uncertainty avoidance societies in the general norm, family, school, and workplace as summarised by Hofstede (1997:125).

3.2.3.1 Uncertainty Avoidance in Africa and South Africa.

The UAI table shows that Africa falls within the middle of the table, with slightly lower values and therefore is expected to exhibit more of the general characteristics of the weak uncertainty avoidance culture but less of the high uncertainty avoidance culture. As Hofstede himself has put it, the African continent as a whole, scoring between 54 and 49 UAI, is classified medium to low (1991:113). For this particular dimension, in the continuum, Africa exhibits characteristics that are seen more in the lower end, and still has the tendency to show some high uncertainty avoidance characteristics.

A more recent work by Booysen and Van Wyk places South Africa in the middle of the uncertainty avoidance continuum, though the country scores only a little above average on this dimension (2007:468). This is in agreement with Easton et al (2003:2) who highlight the work of Lebogang Mashile, a Sociologist at the University of South Africa, in identifying South Africa as having moderate uncertainty avoidance. However, Booysen and Van Wyk agree that though both Blacks and Whites will display uncertainty avoidance behaviour, Blacks have a significantly weaker uncertainty avoidance than Whites, which they illustrated by the following quotes from qualitative data:

“Whites are more regimented and non-flexible”, “Whites are more business-like, formal and restrictive” and “Blacks are rebellious, want flexibility, want freedom” (Booyesen and Van Wyk, 2007: 469).

Thus the authors declare that their work confirms that of Meeding (1994), Boon (1996) and Lessem (1994, 1996), which states that because of numerous differences that exist between the African culture and that of the Western world views, in the areas of

causation, time, self and probability, as well as the African ontology of not having control over the future, Blacks have greater tolerance for uncertainty than Whites.

Before looking at the current transformational activities in South Africa that foster low uncertainty avoidance among Blacks, we will take a look at the characteristics of the African culture in general that places it in the medium to low uncertainty avoidance bracket (Hofstede 1991:113). Our discussion is done in the areas of time, relationships, risk taking and taboos within Africa and South Africa.

A) Characteristics of African Culture influencing Uncertainty Avoidance.

I) Time

Lower scores for Africa in this dimension confirm the findings discussed above with regard to the African's view on the future aspects of time, which is the main thrust of the uncertainty avoidance dimension. Hamminga, looking at the African's concept of the future, compares time in the Western understanding to that of the African. To Westerners, time is a set of stripes drawn on the tarmac which is on the road on which one drives at an exactly constant speed, so that one knows exactly when one will cross these stripes (2000). In other words time is seen to traverse into the future at the same speed along these stripes - with one big stripe every hour, a small one every minute, a very small one every second, and so on. In this case, according to Hamminga, Westerners consider the road to be straight, regular, and going on forever. To them, unlike the African, their journey only ends when they die. However, dying soon is not a real possibility to most of them (2000). "Their agreements with each other about future deliveries and payments are very precisely drawn on this tarmac. If they fail to pay or deliver at the moment their machine of time has reached the agreed tarmac stripe they are in big trouble and probably lose their customer and all his friends. So, agreements made often cause Westerners to be very nervous" (Hamminga, 2000).

I see this attempt on the part of such cultures to make things fall into place as the future unfolds along this tarmac as one that leads to high uncertainty avoidance. Though this view of the linearity of time is typical of the West, we need to note that the degree to which cultures hasten to control the future and make their projections fall into place is not the same for all Western cultures, hence there are differences in uncertainty avoidance.

But for the African, time is tied to events and relationships with people and nature. The future is therefore not indefinite and predictable because, as we saw above, according to Mbiti, for many traditional Africans there is not a concept of future but all time is reduced to a present, to the now or “Sasa”, where the living and the dead, whose names are still remembered, dwell, and a past or “Zamani”, in which the spirits of the dead whose names have been forgotten exist.. (1990: 21-23). To this end:

Africans have no such unshakeable belief in the future. Constant speed over regular tarmac might be possible, but the car might as well break down, floods could take the road, and a relative might be met. Africans do not like to waste much time speculating about the future. The chance of it being what we expect is considered low. Why lose energy to such hypothetical considerations! Instead of hours and numerical dates, Africans traditionally rely on emotional marks of time, like when you were born, when you married, when you had your first child, when there was a war. But as far as the future is concerned these marks are still to be made, and the African typically considers his or her influence on that as small (Hamminga 2000).

The focal point of uncertainty avoidance is based on incidents of the future, which is time bound, and along the same lines covered by Hall’s time orientation. In this case, the implications of time on silence, as considered above under Hall’s dimension of time orientation, can well be considered in Hofstede’s dimension of uncertainty avoidance. It will therefore make sense to merge time orientation into the discussions of uncertainty avoidance in the next chapter as we discuss the implications of uncertainty avoidance on the HIV and AIDS silence.

II) Relationships

Sufficient time must be spent on building relationships with each other and with nature so that there will be a smooth and peaceful running of events. I will give an example to explain this. If there is to be a wedding, the traditional African will be pleased to know that it is taking place on the second Saturday of the third month rather than the precise time of 11.00 a.m. of that day. This is because, to the African, the wedding will happen at that precise time if there is a good relationship with nature, the spirit world and families

involved in the event. If, normally, weddings take place at the exact time known to Westerners as 11.00 am, the wedding will take place at that particular time if the weather – rain, sunshine, wind, sky etc., nature – rivers/flood, animals, farms, people etc., the living dead as well as the families are in good relationships with each other. If, on the day, for some reason the skies open and it rains in the morning, the wedding will not happen at that particular time but later that day. If an important dignitary delays in coming because on his way he found the river had overflowed its banks and had to wait until it receded, or if the donkey he was to travel with got sick and he had to travel by foot, the wedding will not happen at that time but later. In some instances, because of other events that naturally come ahead of the wedding, the wedding may have to be postponed to a later day or even be cancelled. All these are not in the control of the African. The African has to rely on those endowed with insight to deal with these situations, such as the ancestors through the diviners.

In events such as the above example, the African will not be too concerned about what happens on that day. This will depend on relationships that exist between the living (including the rainmakers and diviners) and the living dead (and all the others of the spirit world who will do their best to make sure the events happen by dealing with any obstacles⁵⁶). Ndwandwe (2000:199), looking at the role of the ancestors (also known as the 'living dead'), remarks that they are people who have changed their physical mode of being into a spiritual mode and live in a spiritual domain where they are in close proximity to uMvelinqangi. The fact that the 'living dead' are near to God qualifies them to be mediators between God and the living. He refers to Van der Watt (1999:144) to intimate that “even though ancestors are in another world, they continue to be part of the family (the living-living) and are still intimately involved in the lives of their children, both in matters of joy and sorrow, health or disease, prosperity or adversity” (2000:199). Ndandwe further contends that in this situation diviners ('izangoma' in Zulu) stand between the spirit world and the living so as to receive and convey messages from the land of the departed to the living. They are the ones who among other duties predict future events (2000:216).

56 Refer to Mbiti (1991) African Religions and Philosophy, chapter 16 on Mystical Power, Magic, Witchcraft and Sorcery to understand possible obstacles to important event that need the attention of the diviners.

With such understanding of an external source in charge and control of the future, the African is generally not anxious about what the future holds. He rather relaxes and builds relationships with other community members and those who hold power. It is interesting that people of low UAI cultures are seen to be relationship builders, a point confirmed by Gudykunst and Kim (1997:229) who comment “that people in high uncertainty avoidance cultures experience less joy from relationships than do people in low uncertainty avoidance cultures”

III) Risk taking

Another general characteristic of uncertainty avoidance has a bearing on our research: that of risk-taking. Normally, in a bid to avoid uncertainty, one would not take risks, which is the reason why high uncertainty avoidance cultures shun ambiguous situations by looking for a “structure in their organizations, institutions, and relationships which makes events clearly interpretable and predictable. (Hofstede 1991:116). On the other hand, when one is not particular about uncertainty that comes one’s way, one is not afraid to take a risk. It is along these lines that Choi et al say that “people in low uncertainty-avoidance cultures deal well with vagueness and can be characterized as risk-takers” (2005:2). People of low uncertainty avoidance cultures, because they are not too anxious about the future, tend to be reckless. Hofstede confirms this by saying it is a societal norm for cultures with low uncertainty avoidance to have “more willingness to take risks in life” (1980:140).

This does not mean that high uncertainty avoidance cultures do not embrace risk at all. Rather, in high uncertainty avoidance cultures, risk-taking is limited to known risks, i.e. risks of which the probability is known, as opposed to low uncertainty avoidance cultures that can take any form of risk, including unknown risks (one where the probability is known or not known). It is this therefore that contributes to high uncertainty avoidance cultures being extremely conservative, and in which people generally resist change (Stremersch and Tellis, 2004: 426).

IV) Taboos

We have seen that Africa is mostly a low uncertainty avoidance culture which nevertheless has the tendency to show some traces of high uncertainty avoidance

characteristics. Having said this, on the issue of taboos Africa is not lenient on rules. In his table showing the comparison of the characteristics between high and low uncertainty avoidance cultures which is cited above as Table 3.3, Hofstede points out that cultures with low uncertainty avoidance are lenient about rules for children on what is dirty and taboo, whereas tight rules are given for children on what is dirty and taboo in high uncertainty avoidance cultures. This is not true of Africa as a low uncertainty avoidance culture. From my own personal experience in Africa and the data available, in terms of issues of taboo, African cultures rather exhibit the characteristics that Hofstede has assigned to high uncertainty avoidance cultures.

The reason for this is that, as Hofstede rightly points out, “Taboos are supposed to be a characteristic of traditional, primitive societies, but modern societies too are full of taboos. The family is the place where these taboos are transmitted from generation to generation” (1991:118). Even though Africa has the world’s highest urbanisation rate with a growth of 19% (53 million) in 1960 to 27% (129 million) in 1980 and reaching 38% (297 million) in 2000 (Mosha 2001:28), most of Africa is still rural and traditional (Practical Action 2005:3). It is still an extended family-based culture, which makes it all the more capable of transmitting taboos.

Taboos are a major part of the African culture. They shape the day-to-day life of the African and must therefore be strictly observed. To the African, taboos mean everything prohibited. Junod defines taboo as “any object, any act, any person that implies a danger to the individual or to the community and that must consequently be avoided, this object, act or person being under a kind of ban” (1962:37). Issues of life and death are associated with taboos and as such the African is made to be familiar with them right from childhood. Senosi contends that in Africa taboos permeate every aspect of life from birth to death, to such a degree that health and significance could be explained along life events and ill-luck that befalls careless individuals (2004:39).

It suffices to say that in Africa taboos are active and alive even though, with passage of time and exposure to Western culture and modern forms of education, city dwellers in particular tend to overlook certain taboos (although new ones may emerge). This trend is not new but follows that of the Western cultures which years ago had many forms of

taboos but today have done away with a number of them, or transmuted them into the form of legislation. In this way taboos in the West today are not to do with menstruations, forbidden animals etc, but on political correctness, child pornography etc. Jackson, in his lexicography, mentions that the normal dictionary would label a taboo as a prohibition or restriction placed on a particular thing or person by a social or religious custom or as imposition of a prohibition or restriction on certain behaviour, word usage, etc. (2002:112). Considering the current situation in the Western culture that he is writing from, Jackson comments:

A taboo word, therefore, is one that you would not use in ordinary conversation, unless you wanted to shock your listener. Such taboo words would include those connected with sexual and excretory functions, blasphemies and other ‘swear’ words. However, there is little left in our society that is taboo, and so modern dictionaries no longer use the label (2002:112)

Taboos were, of course, instituted for various reasons that cultures found would be beneficial to the society at the time. Larbi suggests that the observance of certain prescribed taboos, as well as observance of purificatory and protective rites, helps to maintain and preserve societal equilibrium. “This means for Africans, violations of these demands may cause serious consequences to the individual, his or her family or an entire community.” (2002:93). In this way taboos are rules that guide the behaviour of people through informal sanctions. Senosi indicates that through taboos, African parents teach their children the African code of living (2004:39). With changes in the world brought about by science and technology, and even as a result of the dynamic nature of culture itself, changes in taboos are bound to happen, especially when they have outlived their usefulness. When this happens, taboos become a hindrance to human development. In this way a critical analysis of which taboos are considered to be unhelpful must be undertaken to propose ways of removing them.

According to Baba Ernest Zikhali, a pastor at Caluza Township, taboos were instituted for genuine purposes, but their real purposes were always kept from people. They were rather made to connect to fearful and powerful objects and creatures so that fear of

violation would be instilled into people (Personal interview 20-09-2004). This remark is in line with comments by Sem:

The traditional people worshipped God through the reverence of ancestors and lesser deities like stones, trees, rivers, and other inanimate objects. Some of the lesser gods and especially the ancestors were regarded as the guardians of God's moral laws. For instance, it is believed that they can punish man by striking lightening, causing bareness etc., and can also bless the faithful ones with bumper harvests, riches, and prosperity. And because of the fear of punishment the people adhered steadfastly to the moral codes of the society (2004:23).

For many years this kind of fear was instilled in people, and so it would be naïve on the part of modern society to think that we can just do away with all forms of taboo. In the first place a number of these taboos are internalised in individuals and in whole communities, so that simply doing away with them would not be possible. Secondly, a number of taboos are still useful for harmony in society and healthy living. Therefore a taboo would need to be carefully analysed to determine its efficacy before an attempt is made to do away with it.

There are varieties and forms of taboo in Africa to guide the moral and ethical life, as well as the health of the African. Niehaus points out variety of taboos upheld by Tsonga-speakers that I believe are common to other cultures in Africa, and include:

1) cosmic taboos such as making a fire from parasitic plants; 2) taboos of foresight, such as building a hut before one marries; 3) social taboos connected with hierarchy, exogamy, and respect; 4) religious taboos such as neglecting one's ancestors; 5) using obscene language; and 6) physiological taboos pertaining to persons defiled by sexual intercourse, menstruation, death, and the birth of twins (2002:193).

Of the above-mentioned taboos, the one on sex has effect on our research. In an interview, Baba Zikhali pointed out that there are many social reasons for sexual taboos, especially that of incest. It is one of the taboos that brings confusion into a family (Personal interview, 20-09-2004). "Sexual intercourse between father and daughter;

brother and sister are discouraged as disgraceful. It disorganizes the transmission and preservation of life. Incest angers the ancestors who have to be remembered through naming.” (Ngobese 2003:65). As Zikhali intimates, if for example a brother has sex with a sister and a baby is born of this union, an abomination that incurs the wrath of the ancestors transpires. The simple reason is the identity of the child, which is confusing to the entire community as to the identity of this child. If the baby is a boy, would he be a son to the man or a nephew? On the other hand, if a girl, would she be a daughter or a niece? If a father has a child with his daughter, would the baby be called a son/daughter or grandson/granddaughter? Could the baby refer to the mother as sister as well, since they have the same father? This was never allowed to happen and the child born would not be allowed to live and the culprits punished. (Personal interview, 20-09-2004)

B) Current Transformational Activities influencing Uncertainty Avoidance in South Africa.

South Africa as whole used to have a high level of uncertainty avoidance during the Apartheid days, with its many rules and regulations. “Control boards” for various items from maize to fruit controlled market fluctuations. These many boards, which blatantly interfered with the free market economy it professed to practice, were a clear examples of uncertainty avoidance (Booyesen and Van Wyk 2007:463). Since independence the situation has changed, giving lower levels of uncertainty avoidance to more Black people. Booyesen and Van Wyk say, “South Africa is currently going through a transformational period, one that is busy changing the existing intergroup dynamics due to societal power shifts among the different cultural groups that took place in South Africa since 1994” (2007:469). Apart from the inherent cultural diversities, Booyesen and Van Wyk (2007:469) point out three reasons why Blacks in the new South Africa continue to have decreasing uncertainty avoidance levels. The first reason is that even though the new constitution of the country guarantees equal rights to all people, there is an apparent shift of power to more Black people. The result is that Whites no longer have exclusive power and that brings a feeling of powerlessness, which causes increased levels of uncertainty to them. Blacks on the other hand have power they did not previously possess and that lowers their uncertainty levels. The second reason is the affirmative action in the constitution of the country, which can be construed as empowering Blacks, which lowers their own uncertainty levels and raises that of the Whites (2007:469). Thirdly, due to the

stringent White norms, rules and regulations of Apartheid, the Blacks who were in subordinate positions learned to deal better than Whites with change, uncertainty and ambiguity.

Our discussion in the areas of time, relationships, risk-taking and taboos within Africa and South Africa, are all sub-themes of uncertainty avoidance. Now we need to connect this with the issue of silence.

3.2.3.2 Effect of Uncertainty Avoidance on Silence

“The factor of uncertainty avoidance in a culture deals with the question about the extent to which that society is open for one to speak one’s mind on issues and welcome changes.” (Schubert 2007:72). In the business world and in particular in accounting values, Gray argues that secrecy can be linked most closely with high uncertainty avoidance cultures (1988:11). This preference for secrecy arises because of the need to preserve security by restricting the flow of information to a competitor to use. However, in day to day life, Stremersch and Tellis (2004: 426) say “uncertainty avoidance may not only affect intrinsic innovativeness of a culture, but it may also affect the extent to which it is important for members of a culture to learn from one another”. In high uncertainty avoidance cultures, there is a faster flow of information to reduce uncertainty and ambiguity. In this case, if there is a new product in the market, for example, Stremersch and Tellis say there is a faster diffusion and faster growth of the new product in an uncertainty avoidant country.

However, there is less flow of information in the low uncertainty avoidance culture, implying that more people keep information to themselves as they are not in a rush. In weak uncertainty avoidance cultures, members are comfortable with uncertain and ambiguous situations and for this Schubert says “Direct emotional confrontation is avoided” (2007:72). It is for this reason Lau and Ma say “Weak uncertainty avoidance societies maintain a more relaxed atmosphere in which practice counts more than principles and deviance is more easily tolerated” (1997:69).

Thus for example, when people are not in a rush to see things happen they often will remain silent about an issue until it gets to a point where it is unbearable or when silence

can no longer be kept. In most cases the weak uncertainty avoidant people will take all the necessary time needed to build relationships with others before divulging any information. This is in conformity with the effect of time-orientation on the silence pointed out above, and making it more reason why the effect of time orientation on silence should be considered and merged into the effect of uncertainty avoidance on silence.

Hsu (2003:279) says that cultures with low uncertainty avoidance tend to be less expressive and show less openly anxiety. In this case people behave quietly without showing aggression or strong emotions. Basabe et al confirm that “in weak uncertainty cultures anxiety is relatively low - subjects do not need to worry about predicted behaviour or to avoid ambiguities. Aggression and emotions in general are not supposed to be expressed. Emotions are internalized” (2000:57). In most African cultures, men in particular are taught not to express their emotions (Augustine 2002:74). But generally there are certain issues such as sex and sexual abuse about which one cannot express one’s feelings openly, whether men or women. Internalisation of emotions creates silence in people, but we need to understand that internalising emotions and keeping silent over issues and not expressing them can result in problems for the culture. Vihakara (2006:65) uses the work of Trompenaars and Hampden-Turner (1998: 69-79) to point out that weak uncertainty avoidance cultures resemble neutral cultures. Yet, she says, people from neutral cultures do not express their feelings openly, but if tensions accumulate they may occasionally explode. This scenario may contribute to the reasons for violence and unrest in parts of the Africa.⁵⁷

In terms of risk-taking, people of low uncertainty avoidance cultures may keep silent about issues even if it puts them at risk. Unlike high uncertainty avoidance cultures who “tend to avoid uncertain or ambiguous situations by believing in absolute truths and expertise, by seeking stability, and by rejecting unusual ideas and behaviours.” (Choi et al

⁵⁷ Violence and unrest in Africa cannot be blamed on cultural factors alone, but cultural factors contribute. See Nathan, Laurie who has identified four structural conditions as the cause for Intra-state crises in Africa and says these are “authoritarian rule; the exclusion of minorities from governance; socio-economic deprivation combined with inequity; and weak states that lack the institutional capacity to manage normal political and social conflict. These conditions pose a fundamental threat to human security and the stability of the state. They also constitute the primary causes of large-scale violence” (2004: 1).

2005:2), low uncertainty avoidance risk takers believe in vagueness and are more likely to undertake practices that put them at risk, silently, and bear the consequences silently. In traditional Africa communities, for example, just a handshake would seal a business deal. As Winslow has noted, “Not too long ago deals were done on a handshake and your word was your bond. If you failed to perform, cheated someone or lied, that was the end of things” (2007). One is not expected to say much for an understanding to take place. Even when things go wrong one maintains silence.

One of the main reasons likely to perpetuate silence in low uncertainty avoidance cultures is the fact that most of the risk-takers are the young ones. As people grow older the tendency to take risks decrease and the elders try to admonish the young about undertaking risks. When younger ones do not obey and get caught up, they keep whatever happened silent from others in order not to lose trust that has taken some time to build.

When it comes to taboos, for fear of being labelled a taboo-breaker and be asked to bear the cultural consequences mentioned above, people will keep quiet about issues that affect them when they know they are linked with a taboo. Taboos relating to sexuality are a major cause of such silence.

In a high context culture therefore, people will observe barren silence on issues. However, a culturally sensitive person will recognise the fertile silence that can be engaged with. They take cues from time availability and by relationship building they slowly work through the risks and taboos that confront people. This engagement will then expose the barren silence that can be ‘broken’.

3.2.4 Individualism/Collectivism and Silence.

Going by his *Culture's Consequences* (1980), Hofstede labels his third dimension of national culture as ‘individualism’, or what is known in many circles as individualism/collectivism. This is the fourth element that we will consider and this dimension of culture “describes the relationship between the individual and the collectivity which prevails in a given society” (Hofstede 1980:148). Generally, societies could be broadly viewed as structures in which the interests of the individual prevail over

the interests of the group to which he belongs, or vice versa. Hofstede refers to the former as individualist and the latter as collectivist:

Individualism pertains to societies in which the ties between individuals are loose: everyone is expected to look after himself or herself and his or her immediate family. Collectivism as its opposite pertains to societies in which people from birth onwards are integrated into strong, cohesive in-groups, which throughout people's lifetime continue to protect them in exchange for unquestioning loyalty (1997:51).

Hofstede's research revealed that people in individualist cultures are more prone to make their own choices while people in collectivist cultures conform more readily to the norms of the group. This results from the fact that children from individualist societies, as they grow up, soon learn to consider themselves as 'I' ('I' identity) while children from collectivist societies grow up learning that they form part of a 'we' group ('we' identity). In this way individualists emphasise self-realisation and individual goals, whilst collectivists emphasise in-group's aspirations; fitting into the group is important (Hofstede 1997: 50).

This dimension runs closely parallel to Hall's low- and high-context (1977) discussed above. Hofstede measures cultural dimension on a bipolar continuum, with individualism on one end and collectivism on the other. Gudykunst and Ting-Toomey suggest: "We believe that the dimensions of low-/high-context communication and individualism-collectivism are isomorphic. All cultures Hall (1976, 1983) labels as low-context are individualistic, given Hofstede's scores, and all of the cultures Hall labels as high-context are collectivistic in Hofstede's (1980, 1983) schema. It therefore, appears that low- and high-context communication are the predominant forms of communication in individualistic and collectivistic cultures, respectively" (1988: 44).

Hofstede has compiled an Individualism Index (IDV)⁵⁸ table, in which he ranks values obtained for 50 countries and 3 regions in terms of their individualistic natures. Countries with scores close to 100 are the most individualist and those close to 0 are the most

⁵⁸ See the Individualism column of Appendix 3A or Appendix 3A3.

collectivist. The table of Appendix 3A3 reveals that Western countries such as the USA ranked number 1 with an IDV score of 91, Great Britain ranking 3rd with an IDV of 89 and Belgium which ranks number 8 with an IDV of 75 are individualist countries. Countries such as Guatemala, ranking the last of the 53 countries with IDV score of 6, and Venezuela ranking number 50 and scoring 12 are collectivist in culture. Hofstede makes mention that what can immediately be recognised by inspecting the IDV table is that nearly all wealthy countries score high on IDV while nearly all poor countries score low, and that there is a strong relationship between a country's national wealth and the degree of individualism in its culture (1997:53).

When a culture is noted to be collectivist, it reflects close and committed member groups within the family, normally an extended family and even other extended relationships. This relationship is the major source of one's identity, and the only secure protection one has when it comes to issues of the hardships of life. In this case loyalty within a collectivist culture is vital. As Hofstede indicates, "Therefore one owes lifelong loyalty to one's ingroup, and breaking this loyalty is one of the worst things a person can do. Between the person and the ingroup a mutual dependence relationship develops which is both practical and psychological." (2005:75). Generally, in a situation of regular and constant social interaction within the group, the maintenance of harmony with one's social environment becomes an important virtue which extends to other engagements beyond the family or group. In this way, a direct confrontation with another person within most collectivist cultures is deemed rude and undesirable (Hofstede 1997:58). "The word 'no' is seldom used, because saying no is a confrontation; 'you may be right' or 'we will think about it' are examples of polite ways of turning down a request. In the same vein, the word 'yes' should not necessarily be seen as an approval, but as maintenance of the communication line" (Hofstede 1997:58).

On the other hand, when considering an individualist culture, that particular culture fosters societies in which the ties between individuals are loose and everyone is expected to look after him or herself and his or her nuclear family. Choe (2001:6) indicates that people from individualist cultures are much more likely to use a confrontational, direct-address, and a one-to-one negotiating style to resolve differences. This is done with the view that speaking one's mind honestly is a virtue. "Telling the truth about how one feels

is the characteristic of a sincere and honest person. Confrontation can be salutary; a clash of opinions is believed to lead to a higher truth. The effect of communications on other people should be taken into account, but it does not, as a rule, justify changing the facts. Adult individuals should have learned to take direct feedback constructively. In the family, children are told one should always tell the truth, even if it hurts. Coping with conflict is a normal part of living together as a family” (Hofstede 1997:58).

Table 3.2.4.1 below shows the key differences between collectivist and individualist societies in the family, school, and workplace as summarised by Hofstede 1997:67.

Collectivist	Individualist
<p>In the family:</p> <ol style="list-style-type: none"> 1. People are born into extended families or other in-groups which continue to protect them in exchange for loyalty 2. Identity is based in the social network to which one belongs 3. Children learn to think in terms of ‘we’ 4. Harmony should always be maintained and direct confrontations avoided 5. High-context communication 6. Trespassing leads to shame and loss of face for self and group 	<ol style="list-style-type: none"> 1. Everyone grows up to look after him/herself and his/her immediate (nuclear) family only 2. Identity is based in the individual 3. Children learn to think in terms of ‘I’ 4. Speaking one’s mind is a characteristic of an honest person 5. Low-context communication 6. Trespassing leads to guilt and loss of self-respect
<p>At school:</p> <ol style="list-style-type: none"> 1. Purpose of education is learning how to do 2. Diplomas provide entry to higher status groups 	<ol style="list-style-type: none"> 1. Purpose of education is learning how to learn 2. Diplomas increase economic worth and/or self-respect
<p>At the work-place:</p> <ol style="list-style-type: none"> 1. Employer-employee relationship is perceived in moral terms, like a family link 2. Hiring and promotion decisions take employees’ ingroup into account 3. Management is management of groups 4. Relationship prevails over task 	<ol style="list-style-type: none"> 1. Relationship employer-employee is a contract supposed to be based on mutual advantage 2. Hiring and promotion decisions are supposed to be based on skills and rules only 3. Management is management of individuals 4. Task prevails over relationship

Table 3.2.4.1: Differences between collectivist and individualist

3.2.4.1 Collectivism in Africa

All the African countries, with the exception of South Africa, fall below the middle IDV score of 50, with East Africa ranking between 33 and 35 of the 53 countries whilst West Africa ranks between 39 and 41. This is a clear indication that these countries are collectivist. One would easily see the difference between South Africa's high Individualism Index Value of 65, making her rank 16th and that of the rest of Africa, but here we need to be reminded that Hofstede's data from South Africa was obtained from Whites only (1997:130) and as such does not reflect the situation in Black culture. This means that input from Whites only would most likely give an output that very much represents that of a Western culture which, we have pointed out to be more individualist.

At the same time, the economic factor used to explain the difference in PDI emerges as a key factor. Hofstede intimates that in view of the correlation between power distance and collectivism one could consider them as two manifestations of one single dimension of cultural differences. However, he points out that one of the reasons for the correlation is that both are associated with a third factor, that of economic development. If economic development is held constant in that rich countries are compared to rich ones only and poor countries to poor ones only, the relationship disappears (1997:56). This means that even though South Africa is in the same region as the rest of Africa, as a result of better economic standing, the nation as a whole is likely to differ in IDV because:

Another link in the relationship is that, as will be shown, individualist countries tend to be rich and collectivist countries poor. In rich countries, training, physical conditions, and the use of skills may be taken for granted, which makes them relatively unimportant as work goals. In poor countries, these things cannot be taken for granted: they are essential in distinguishing a good job from a bad one, which makes them quite important among one's work goals (Hofstede, 1997:52).

Even within a single country, levels of collectivism would differ from place to place, with poorer communities being more collectivist. With this in mind, Africa as a developing country and less rich, is less individualistic but more collectivist. In his analysis of Hofstede's work, De Mooji concludes that "North Americans and Northern Europeans are individualists; in the south of Europe people are moderately collectivist. Asians, Latin

Americans and Africans are collectivists” (2003:200). It is characteristic and natural for Africans to have preference for co-operation, group work or "work as one", i.e. team work. This is in contrast to the West where individualism often translates into a sudden competitiveness and the individual's interest rules supreme and where society or others are regarded as nothing but a means to individual ends (Louw 2001:24).

A) Collectivism/Ubuntu

In Hofstede's terms, Africa is Collectivist, but I see the African culture to be more than collective in that it incorporates both the collective and the individual. In the African setup, one may see the individual through the collective. This is what the proverb which originates in Ghana, about the forest cited above means: “The African family is like a forest, when you are far away from a forest, it looks one unit but when you get closer to it, then you realise that it is made up of individual trees and that each stands on its own”. What is generally known to the outside world as collectivism is generally called “ubuntu”⁵⁹ in Africa. The word ubuntu is an Nguni⁶⁰ word which is a kind of ‘shorthand’ for an ancient African philosophy that ties one's personal identity as an individual to a much larger social context (Bell 2002:89). Ubuntu is not about competitiveness but about the common good of humanity:

Ubuntu as an orientation to life is opposed to individualism and insensitive competitiveness. Neither is it comfortable with collectivism where collectivism stresses the importance of the social unit to the point of depersonalising the individual. At the same time it places great importance on working for the common good, as captured by the expression: “Umuntu Ngumuntu Ngabantu” (literally translated as: A person is a person through other human beings); - *I am because you are, you are because we are* (Khoza 1994:122–123).

The expression “a person is a person through other persons” or “A person is a person through other human beings” is a central maxim in most African major languages, meaning that a human being needs another human being. The Ghanaian version says

⁵⁹ See Van Binsbergen's (2001) explanation and meanings of the word from its root ‘-ntu’ and linking it to morphological combinations among Bantu speaking family of entire group of languages, spoken from the South African Cape to the Sudanic belt.

⁶⁰ Nguni is a language family comprising of Zulu, Xhosa, Swati, and Ndebele (Van Binsbergen 2001: 53).

“Onipa nua ne Onipa” literally translated as “The best companion to a human being is another human being”. Ubuntu therefore is about interdependency. Mbiti explains the cardinal aspects of interdependency between the individual and his community in Africa when he says: “In traditional life, the individual does not and cannot exist alone except corporately. He owes his existence to other people, including those of past generations and his contemporaries. He is simply part of a whole. The community must therefore make, create or produce the individual; for the individual depends on the corporate group.... Only in terms of other people does the individual become conscious of his own duties, his privileges and responsibilities towards himself and towards other people ... The individual can only say: ‘I am because we are, and since we are, therefore I am’....” (1990:108-109).

A practical outworking of ubuntu is revealed by Diala when he mentions that Archbishop Desmond Tutu, Chairman of the South African Truth and Reconciliation Commission, “attributes the possibility of reconciliation, goodwill, and social progress in South Africa to the remarkable capacity of Africans to forgive; and to their recognition of interdependence and complementarity as the basic laws of life; simply to ubuntu.” (2002). Diala quotes Tutu to have said:

Africans have a thing called ‘ubuntu’; it is about the essence of being human, it is part of the gift that Africa is going to give to the world. It embraces hospitality, caring about others, being willing to go that extra mile for the sake of another. We believe that a person is a person through other persons; that my humanity is caught up, bound up, inextricably in yours. When I dehumanize you, I inexorably dehumanize myself. The solitary human being is a contradiction in terms, and therefore you seek to work for the common good because your humanity comes into its own in community, in belonging (Diala 2002).

Like Tutu, Louw points out that the central meaning of the concept of ubuntu is “humanity”, “humanness”, or even “humaneness” (Louw 2001:15). In times of difficulty and danger, one stands with and by the others. Considering the historical past of South Africa, especially in the minds of Blacks, the ‘stand by me’ and the ‘loyalty’ components of ubuntu are well understood.

3.2.4.2 Collectivism/Ubuntu in South Africa.

In a recent South African cultural dimensions study, Thomas and Bendixen (2000) obtained a surprisingly high IDV score for 586 middle managers from different ethnic groups using Hofstede's (1994) self-completion questionnaire called the "VSM94" instrument. The high IDV score for Black Africans contradicted the widely held views of philosophers and theorists⁶¹ who expound on the collectivism of Africans (2000:514). In providing possible reasons for this unexpected change in values, the writers distinguished between the vertical and horizontal components of individualism and collectivism stemming from a new scale developed by Singelis, Triandis, Bhawuk & Gelfand (1995). Their assertion was that horizontal individualism describes an autonomous individual who exists within an egalitarian society, whereas vertical individualism accounts for individualism within a society where hierarchy is accepted (2005:14). From our understanding of power distance within the Black people in South Africa, the latter category holds.

Further, Thomas and Bendixen point out that Senghor (1965) in his *On Africa Socialism* contrasts Black African collectivism with European collectivism. They reveal that while European collectivism is the basis of socialism and communism which is seen as the aggregation of individuals in society, Black African collectivism is the notion of people conspiring together as a group united at the core. Interestingly, the writers say that Senghor "coins the term 'communalism' to describe the Black African variety of collectivism. As such, communalism is seen to paradoxically co-exist with individualism rather than to represent an opposite pole (2000:514). As pointed out above, this is what ubuntu is all about. It is more than collectivism which strongly embraces individualism. For this, it is important to note that the writers in this study concede the shortcomings of applying the VSM94 instrument (Hofstede, 1994) in the African situation and say:

The findings of the present study indicate the necessity for the VSM94 instrument (Hofstede, 1994) to be extended to include the concept of communalism as distinct from both collectivism and individualism, at least when being applied to black African cultures. This may be illustrated by the phrasing of the first question in the VSM94 instrument: "has

⁶¹ These include Senghor (1965), Menkiti (1979), Lessem (1990), Adonisi (1993), Shutte (1993), Christie, Lessem and Mbigi (1994), Mbigi and Maree (1995), Christie (1996)

sufficient time for your personal or family life” (Hofstede, 1994, appendix). Assigning importance to this statement is indicative of individualism. However, the Black African connotation to the word ‘family’ is of significance in this context.” Shutte (1996:31) states: “Perhaps the best model for human community (communalism) as understood in (Black) African thought is the family.” This writer continues: “(Black) African society is famous for its notion of the ‘extended family’. The extended family is capable of extension to include anyone, not only those related by blood, kinship or marriage. In the last resort humanity itself is conceived of as a family, a family which one joins at birth but does not leave by dying (Thomas and Bendixen 2000:514-515).

Once again, what Senghor (1965) and Shutte (1996) call communalism or the ‘human community’ is what Thomas and Bendixen are using here to justify South Africans’ deviation from Hofstede’s VSM94 instrument values. It is this same notion that South African manager Reuel Khoza (1994) describes as ubuntu. Khoza sees it as a basis of a social contract that stems from, but surpasses, the narrow confines of the nuclear family to the extended kinship network which is the community. He says “ubuntu is a concept which brings to the fore images of supportiveness, cooperation, and solidarity; i.e. communalism.” (1994:122).

In Black South African social life, ubuntu is expressed very well in solidarity, loyalty supportiveness, co-operation and being there for one another. This situation stems from the indignity of Apartheid that undermined the dignity of the people (Mbigi and Maree 1995:16). It is for this reason that Mbigi and Maree call ubuntu ‘the solidarity principle’ where the individual’s conformity and loyalty to the group is demanded and expected (1995b:58). “Ubuntu is an expression of our collective personhood, and invokes images of group support, acceptance, co-operation, care, sharing and solidarity” (Mbigi 1995b: 57).

In the New South Africa, ubuntu is not just a virtue for Black Africans but a concept that the South African Government White Paper on Welfare (1996) makes reference to and upholds as:

the principle of caring for each other's well-being and a spirit of mutual support ... each individual's humanity is ideally expressed through his or her relationship with others and theirs in turn through a recognition of the individual's humanity. Ubuntu means that people are people through other people. It also acknowledges both the rights and the responsibilities of every citizen in promoting individual and societal well-being ... (Government Gazette no 16943, 1996:18).

Ndwandwe (2000) points out that in Zulu society there is no rigid separation, as too often found in Western religion, between the sacred and secular. Instead, like all other African traditional beliefs, all life is sacred and involved with the life of the community (2000: 237). In this case Ndwandwe intimates that the sense of community is enhanced by the stress on ubuntu, "being human, and realising one's true nature as a human being in relation to others. Ubuntu also implies a fundamental respect for human nature as a whole" (2000: 237-238). Ubuntu is therefore life in which there is a better relationship among individuals. To this Ndwandwe says "Umuntu Ngumuntu Ngabantu emphasises the fact that the wholeness of the individual can only be guaranteed within the network of family and community relationships" (2000:237). Ndwandwe makes us aware that this strong sense of communality operates in three key areas, namely the family, then the clan (extended family) and then the total community, and does not leave space for individualism (2000:218). Within the framework of ubuntu in the Zulu culture, one's identity and self-worth depend on being in tune with one's family and community.

3.2.4.3 Effect of Collectivity/Ubuntu on Silence.

As we have discussed above, in the nature of the African collective culture of ubuntu, loyalty is cardinal. Commitment to ubuntu principles is expected from each individual. The family is central and within it individuals are socialised and discover the meaning of true humanity. In this way, according to Ndwandwe;

The family therefore acts as the legitimating institution in the life of each individual. Individuals have to be obedient and in their lives exhibit all the

good values that the family stands for. Any action, which is contrary to ubuntu, i.e. socially validated norms and values, threatens the well-being of the family/community. Such an action could have serious consequences for the family/community as well as the offending individual. If it is not quickly attended to and remedied, it could spark the wrath of the ancestors, whose role is seen as that of being custodians and protectors of the family as well as the go-between God and the living (2000:218-219).

The points above raised by Ndwandwe are the basis for the unquestioning loyalty that Hofstede argues exists in collectivist cultures, loyalty that continues throughout the lifetime of the individual belonging to this culture (1997:51). This loyalty and commitment to family values as well as cultural norms and taboos, in a way, creates silence over a number of issues. For instance if one has something on one's mind and feels that verbalising it will create problems in the family or the community, one would rather keep quiet about that issue even if it would kill one. It is along these lines that Tylee says "Collectivist cultures value harmony more than truth, silence more than speaking, and there is a striving for the maintenance of 'face'. In society the emphasis is placed on collective socio-economic interests over the interests of the individual" (2006:4-5).

The individual would prefer to die instead of the family being in turmoil. It is for such reasons as this that Hofstede says in a collectivist family children learn to take their bearings from others when it comes to opinions. The 'we' identity prevails when it comes to opinions, and personal opinions on serious issues do not exist – they are predetermined by the group: "If a new issue comes up on which there is no established group opinion, some kind of family conference is necessary before an opinion can be given. A child who repeatedly voices opinions deviating from what is collectively felt is considered to have a bad character" (1997:59).

Commitment to one's family or community requires that one does everything possible to save the 'face' of the group to which one belongs. Trespassing on, or violating, the group's values leads to shame and loss of face for one's self and the group. This in itself leads to silence and secrecy since shame is social in nature and is felt when the

infringement has become known by others. Naturally, to avoid shame, one will keep the infringement to one's self.

In a high context culture therefore, as a result of loyalty and commitment to family values, cultural norms and taboos, and the desire to maintain 'face', a barren silence is created on issues that arise. However, the culturally sensitive person will be aware that there is a fertile silence that needs engagement to reveal the the barren silence on the issue so that it can be 'broken'.

3.2.5 Masculinity/Femininity and Silence.

The fifth and final dimension of culture to be considered is provokingly termed masculinity/femininity⁶². This is Hofstede's (1980) fourth dimensional framework for characterizing national cultures, and concerns the social implications of gender-linked behaviour. Hofstede focuses attention on the degree to which cultures reinforce, or do not reinforce, the traditional male values of achievement, heroism, assertiveness, challenge, ambition and power, or reinforce the traditional female values of family, good working relationships, co-operation, modesty, caring for the weak, and interpersonal harmony (1997:79-108). In their comment, Arrindell and Veenhoven see masculinity/femininity as representing one of the major dimensions that describe the basic problems of humanity with which every society has to cope (2002:804).

In Hofstede's understanding, masculine and feminine societies differ in the gender roles that are associated with the biological fact of the existence of two sexes, and in particular in the gender roles that are attributed to males. In the life of humankind, the only difference between women and men which is absolute is that women bear children and men beget them. Hofstede points out an important fact of life that is missed or overlooked by many cultures, especially those of Africa that I am very familiar with:

The biological differences between the sexes not immediately related to their roles in procreation are statistical rather than absolute: men are on the average taller and stronger (but many women are taller and/or stronger

⁶² Hofstede himself points out that the choice of these terms have received criticisms from some reviewers (see Hofstede 1997: 107 note 1) he argues that it reflects an empirical reality of gender differences that is independent of its normative undesirability.

than many men), women have on the average greater finger dexterity and for example, faster metabolism which makes them recover faster from fatigue. These absolute and statistical biological differences are the same for all human societies; but these differences leave a wide margin for the actual division of roles in most activities between women and men. In a strict sense, only behaviours directly connected with procreation (childbearing and child-begetting) are "feminine" or "masculine". Yet every society recognizes much other behaviour as more suitable to females or more suitable to males; however, these represent relatively arbitrary choices, mediated by cultural norms and traditions (1980:177).

In looking at the levels or extent to which cultures reinforce social gender roles, Hofstede says "masculinity pertains to societies in which social gender roles are clearly distinct (i.e., men are supposed to be assertive, tough, and focused on material success whereas women are supposed to be more modest, tender, and concerned with the quality of life); femininity pertains to societies in which social gender roles overlap (i.e., both men and women are supposed to be modest, tender, and concerned with the quality of life)." (1997: 82-83).

Masculine cultures therefore score higher values on Hofstede's Masculinity Index (MAS)⁶³, in which he ranks values obtained for 50 countries and 3 regions in terms of their masculinity tendencies; and the more "feminine" cultures earn lower MAS. A high MAS indicates that the country experiences a high degree of gender differentiation, in which case males dominate a significant portion of the society and power structure. On the other hand, a low MAS indicates that the country has a low level of differentiation and discrimination between genders and females are treated equally to males.

Interestingly, Hofstede did not only compute MAS values country by country but also separately for men and women within each country. Figure 3.2.5.1 below shows in a simplified form the relationship between masculinity by gender and masculinity by country. In this graph Hofstede points out that from the most 'feminine' (tender)

⁶³ See the Masculinity Index column of Appendix 3A or Appendix 3A4

countries to the most ‘masculine’ (tough) ones, the values of both men and women become tougher but that the difference is larger for men than for women. In the most feminine countries, (e.g., Sweden – MAS 5, and Norway – MAS 8), there was no difference between the scores of men and women, and both expressed equally tender, nurturing values. In the most masculine countries, (e.g., Japan – MAS 95, Austria – MAS 79, and Venezuela – MAS 73) the men scored very tough but also the women scored fairly tough. All the same the gap between men's values and women's values was largest for these countries. “From the most feminine to the most masculine country the range of MAS scores for men is about 50 percent larger than the range for women. Women's values differ less between countries than men's values do”. (1997: 83).

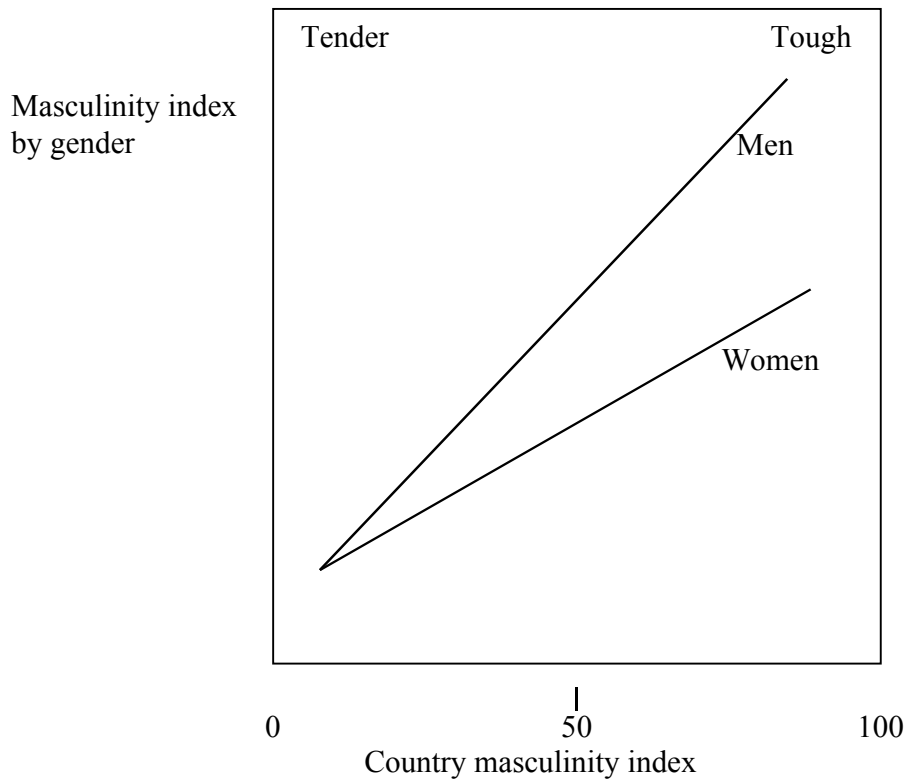


FIGURE 3.2.5.1: The relationship between masculinity index score and gender (Source: Hofstede 1997: 83).

Hofstede’s work has revealed how entrenched we are in our cultures on issues of social gender roles. No wonder he says:

If the duality of life and death is nature's number one law, the duality of female and male, which governs procreation in all higher vegetable and

animal species, is the number two law and follows very closely. In human societies of all ages and levels of complexity, this nature-given fact has been one of the very first issues with which each society has had to cope in its own specific way, and has profoundly affected a multitude of societal institutions (Hofstede 2001: 279-280).

Hofstede infers from Figure 3.1 that “a particular part of our mental programs depends (in most countries) on whether we were born as a girl or as a boy” (1997:85). Boy babies and girl babies get treated differently from the moment their umbilical cord is cut. Unlike being born a girl or a boy, we learn to be a boy or a girl in the eyes of the expectations of society. Therefore gender behaviour is more a result of society’s expectations than of sex at birth. From societal expectations one learns their significance so early that one is programmed and knows no other possibilities (1997:85). On issues of gender roles, Dube argues that they are a social construct of men and women, and quotes Geeta Rao Gupta to describe it as a culture-specific construct in which there are significant differences in what women and men can or cannot do in one culture as compared to another. But she reminds us that what is fairly consistent across cultures is that there is always a distinct difference between women’s and men’s areas of functioning.” (2003:88). It is therefore clear that in all our cultures we are taught how to be boys/men and girls/women.

Hofstede’s interpretation of Figure 3.2.5.1 is that, on average, men are programmed with tougher values and women with more tender values but that the gap between the sexes varies from one country to the other. Very few countries such as Sweden and Norway are feminine where both men and women are expected to be modest, tender, and concerned with the quality of life. Even then, Hofstede says “men's values and women's values need not be identical in all respects, only they do not differ along a tough-tender dimension. Any country is likely to show cultural differences according to gender. These are again statistical rather than absolute: there is an overlap between the values of men and those of women so that any given value may be found both among men and among women, only with different frequency.” (Hofstede 1997 85).

Another aspect of masculinity/femininity that Hofstede's work reveals is the fact that each country or culture as a whole exhibits feminine or masculine characteristics in a

continuum, although the nature of masculinity/femininity of one culture differs from the other.

The masculinity/femininity dimension of culture is one that is influenced, at the national and cultural levels, by power distance and individualism/collectivism dimensions. Generally speaking, masculinity/femininity begins in the family, from the nuclear to the extended, then to school and then to the work-place. Hofstede's analysis shows that within the family the prevailing gender role allocation between husband and the wife reflects the culture's expectations regarding masculinity/femininity. (1997:87). This pattern is emulated by children and normally they become accustomed to it and grow to practice these 'norms'.. The pattern recurs until deliberate and alternate education is sought to remedy the situation in the children's lives. However, depending on the individualism/collectivism nature of the culture, the situation may change. According to Hofstede:

Also, what is the 'family' context depends strongly on the country's position on the dimension of collectivism-individualism. In a collectivist society, the 'family' is the extended family, and the centre of dominant authority could very well be the grandfather as long as he is still alive, with the father as a model of obedience. Ultra-individualist societies contain many one-parent families in which role models are incomplete, or in which outsiders provide the missing roles. The typology serves to stress the importance of a society's role distributions in the family with regard to the values that are transferred from one generation to the next (1997: 88).

This means that gender influence will begin in one's immediate home but is reinforced by the society as a whole.

Hofstede also shows that the power distance score of a culture goes a long way in determining the way in which children are conditioned into gender roles. Power distance versus masculinity in Figure 3.2.5.2 below is used to show how people falling into the various quadrants are generally conditioned into gender roles.

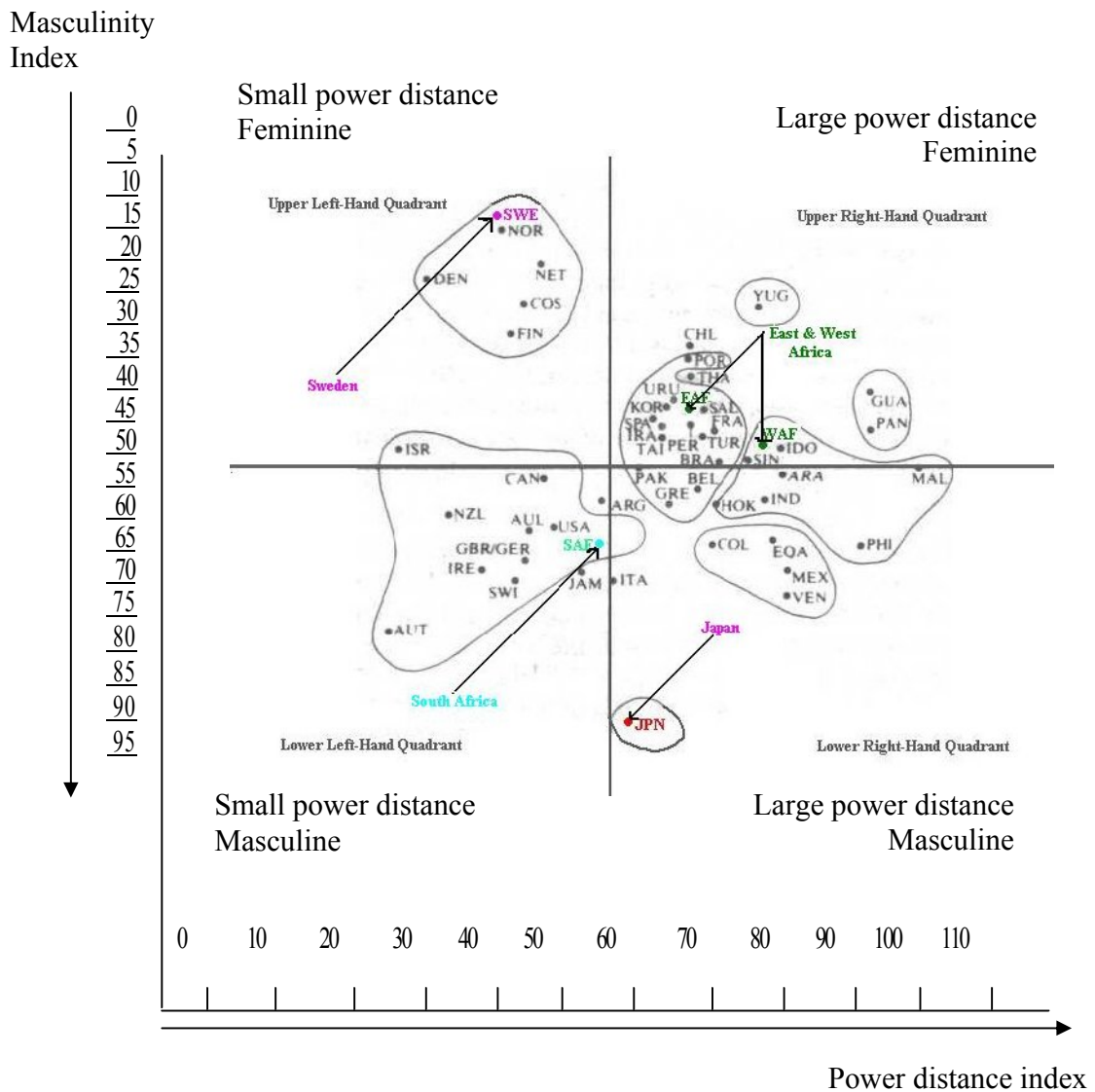


Figure. 3.2.5.2: Power distance versus masculinity index scores for countries studied by Hofstede. Adapted from Hofstede (1997:87).

For complete country name abbreviations see Appendix 3C.

In the right-hand section of Fig. 3.2.5.2 where countries and cultures have higher PDI scores (from Appendix 3A or Appendix 3A1), there is inequality between parents and children. Society expects children to be controlled by obedience, whereas children in countries and cultures in the left-hand section, with lower PDI scores, are expected to be guided by the patterns set by parents. In the lower half of the diagram, countries and

cultures have high MAS scores (*see*: Appendix 3A or Appendix 3A4.) and there is inequality between fathers' and mothers' roles (father tough and mother tender). In this half, "Men are supposed to deal with facts, women with feelings" (Hofstede 1997:87). In the upper half it is approved for both men and women to deal with the facts and with the soft things in life.

Looking at the quadrants of Figure 3.2.5.2 above, the lower right-hand quadrant represents countries or cultures such as Japan, with large power distance (unequal) and masculine (tough) dimensions of culture. For these cultures it is the norm in a family to have an authoritarian and tough father and a compliant mother who, although also fairly tough, is empathetic. The upper right-hand quadrant represents countries and cultures such as East and West Africa, with large power distance (unequal) and feminine (tender) dimensions. In these cultures it is normal to have primarily learning from two strong parents, sharing the same aspirations for a better life and for relationships with both parents offering authority and tenderness. The lower left-hand quadrant represents low power distance (equal) and masculine (tough) cultures, such as South Africa. In these cultures, children look to non-dominant parents, with a harsh father who deals with facts and a mother who is somewhat less harsh and deals with feelings. Boys in these families are expected to assert themselves and girls expected to satisfy and be satisfied. It is the norm for boys not to cry and they should retaliate when attacked. Girls are allowed to cry but not to fight. Lastly, the upper left-hand quadrant shows low power distance (equal) and feminine (tender) cultures, such as in Sweden. In these cultures the societal norm is that mothers and fathers are not merely to control: both are expected to be concerned with relationships, quality of life, facts and feelings, as well as setting an example of gender equality in the family context. (Hofstede 1997:87-88).

Table 3.2.5.1 below shows the key differences between feminine and masculine societies as a general norm in the family, school, and workplace as summarised by Hofstede 1997: 96.

Feminine	Masculine
<p>General norm:</p> <ol style="list-style-type: none"> 1. Dominant values in society are caring for others and preservation 2. People and warm relationships are important 3. Everybody is supposed to be modest 4. Both men and women are allowed to be tender and to be concerned with relationships 	<ol style="list-style-type: none"> 1. Dominant values in society are material success and progress 2. Money and possessions are important 3. Men are supposed to be assertive, ambitious, and tough 4. Women are supposed to be tender and to take care of relationships
<p>In the family:</p> <ol style="list-style-type: none"> 1. In the family, both fathers and mothers deal with facts and feelings 2. Both boys and girls are allowed to cry but neither should fight 3. Sympathy for the weak 	<ol style="list-style-type: none"> 1. In the family, fathers deal with facts and mothers with feelings 2. Girls cry, boys don't; boys should fight back when attacked, girls shouldn't fight 3. Sympathy for the strong
<p>At school:</p> <ol style="list-style-type: none"> 1. Average student is the norm 2. Failing in school is a minor accident 3. Friendliness in teachers appreciated 4. Boys and girls study same subjects 	<ol style="list-style-type: none"> 1. Best student is the norm 2. Failing in school is a disaster 3. Brilliance in teachers appreciated 4. Boys and girls study different subjects
<p>At the work-place:</p> <ol style="list-style-type: none"> 1. Work in order to live 2. Managers use intuition and strive for consensus 3. Stress on equality, solidarity, and quality of work life 4. Resolution of conflicts by compromise and negotiation 	<ol style="list-style-type: none"> 1. Live in order to work 2. Managers expected to be decisive and assertive 3. Stress on equity, competition among colleagues, and performance 4. Resolution of conflicts by fighting them out

Table 3.2.5.1: Differences between feminine and masculine societies

As a result of the social conditioning pursued in all cultures in terms of who a boy/man is and who a girl/woman is and the consequential role each should perform, there is a large gap between the sexes, which creates inequality. Hofstede notes how in human thinking the issue of equality or inequality between men and women has been contentious in religion, ethics, and philosophy since time immemorial (1997:101). This inequality has

always been to women's disadvantage but has not been seen as a serious issue. A number of feminists⁶⁴ who have been champions in advocating for equality between men and women acknowledge the work of Gayle Rubin (1975), a feminist anthropologist who used the signifying construct "sex/gender system" in her milestone paper entitled "The Traffic in Women: Notes on the Political Economy of Sex". This distinction between sex and gender has helped raised awareness of the need to bridge the gender gap:

It was useful, in conceptualizing this de/constructive work on gender, sexual identities, and pedagogy, to return to one of the original sites for the production of a distinction between sex and gender – a distinction of both historical and political import that circulated, for a time, within feminist writings and conversations as a source of optimism with its refusal of biological determinism and, hence, its affirmation of the plausibility of agency by means of direct cultural intervention within sites of cultural re/production (Bryson and De Castell 1993: 295)

Writing for the World Economic Forum (WEF) in their a recent study on measuring the gender gap in different countries, Lopez-Claros and Zahidi conceded that only within the past three decades has the world witnessed a steadily increasing awareness of the need to empower women through various measures to increase social, economic and political equity. They also point out other areas where women are behind and need equity include: broader access to fundamental human rights, access to improvements in nutrition and access to basic health and education (2005:1). Through this research, the international body realised that even in light of heightened international awareness of gender issues, it is a disturbing reality that no country has yet managed to eliminate the gender gap. Confirming Hofstede's findings, the WEF adds: "Those that have succeeded best in narrowing the gap are the Nordic countries, with Sweden standing out as the most advanced in the world" (Lopez-Claros, and Zahidi 2005:1).

3.2.5.1 Masculinity/Femininity (Gender) in Africa.

The values computed by Hofstede in Appendix 3A and Appendix 3A4 for MAS reveal that both East Africa, with an MAS score of 41, and West Africa, with an MAS score of

⁶⁴ See Haraway, D. J. (1987) and Cornwall, A. & N. Lindisfarne 1995.

46, fall among feminine cultures. South Africa, however, with an MAS score of 63 is moderately masculine, meaning that it is not in the extreme side of masculinity but closer to femininity. We can therefore generally say that Africa has a feminine culture, as pointed by De Klerk (2000:200) and Raghu and Kunal (1988:273).

However, to discuss Africa as a feminine culture is a loaded term and needs further clarification. The MAS score by Africa places it in the medium of the masculine/feminine continuum. With the lowest MAS of 8 by Norway and the highest MAS score of 95 by Japan (*see*: Appendix 3A and 3A4), all low MAS cultures fall between the scores of 8–37: all medium MAS cultures fall between the scores of 38–66 and High MAS cultures fall between the scores of 67–95. With this analysis, Africa falls in the middle range of masculinity/femininity, with East and West Africa showing more tendencies towards femininity and South Africa showing more tendencies towards masculinity. As Hofstede himself affirms, the masculinity scores represent *relative*, and not absolute, positions of culture (1997:84).

Hofstede's study on this dimension raises two implications as we consider the masculinity/femininity aspect of culture in Africa. Booysen and Van Wyk (2005: 28) point out that an analysis of the masculinity/femininity presented by Hofstede brings out two further separate dimensions:

The definition of the masculinity-femininity dimension incorporates two distinguishable dimensions, namely *degree of sex role division*, and rewarded *behavioral and personality attributes* (which were originally labelled as masculine versus feminine attributes by Hofstede, because he found a difference in preference for these among gender). Obviously these two dimensions are independent in principle. A society which is characterized by little or no sex role differentiation could still prefer either masculine or feminine behaviors and personal attributes; emphasis could be put on either assertiveness/strength or caring. On the other hand a society which does not clearly emphasise either assertiveness/strength or caring still might have developed clear roles for each of the gender groups which just are not separated by the above content categories

(assertiveness/strength versus caring) but by a different category (Booyesen and Van Wyk 2005:28).

Therefore in discussing the masculinity/femininity of Africa, it will be done firstly on the basis of what Booyesen and Van Wyk consider behavioural and personality attributes, where there is assertiveness/strength or caring, and secondly on the basis of gender inequality or sex role division. In terms of assertiveness/strength or caring, the issue is how members of the culture generally show these characteristics towards others within or outside the culture, regardless of whether one is dealing with a male or female. By this understanding, if a culture is masculine the general expectation for its members is achievement, heroism, assertiveness, and material success whereas feminine cultures expect relationships, modesty, caring for the weak, and quality of life (Booyesen and Van Wyk 2005:28). This is the consideration of how humane the culture is. In terms of gender inequality or sex role division, this is the role the culture expects a male or a female to play in the home or at work. For this, Booyesen and Van Wyk (2005: 28) say:

Masculinity pertains to societies in which social gender roles are clearly distinct, for example men are clearly supposed to be assertive, tough, focused on material success, whereas women are supposed to be more modest, tender and concerned with the quality of life. Roles requiring physical and psychological strength, boldness, courage, determination, higher level mental calculation and analysis, internal locus of control, supervision and management are reserved for men in highly masculine societies and shared by men and women in feminine societies. Roles reflecting concern with home making, care for children and others, and subservient roles are reserved for women only, in highly masculine societies and are shared by men and women in feminine societies. Femininity thus pertains to societies in which there is a high amount of social gender role overlap.

In the GLOBE study⁶⁵ to which Booyesen and Van Wyk's work (2005) contributed, Jesuino (2007:594) points out changes to Hofstede's masculinity/femininity dimension in the form of a replacement by gender egalitarianism and the introduction of assertiveness:

The GLOBE study has developed a scale for the evaluation of societal cultural norms. The scale builds on Hofstede's (1984) four cultural dimensions and includes Power Distance, Uncertainty Avoidance, Gender Egalitarianism, which replaces Masculinity/Femininity ... It introduces Assertiveness, which was previously part of Hofstede's Masculinity/Femininity dimensions.

In terms of assertiveness, a low value will mean femininity and high value will mean masculinity. In terms of gender egalitarianism, low value will mean masculinity and high value will mean femininity. When Africa is considered along these two differentiations, the score of masculinity/femininity will differ in each case.

In the case of behavioural and personality attributes, which were Hofstede's original label for masculinity/femininity dimensions, Africa is considered feminine i.e. it has the behaviour pattern of care for each other, building relationships, sympathy for the weak etc. as pointed in Table 3.7 above, in which both males and females are expected to practice in an overlapping manner. Africans are generally hospitable, whether females or males, and exhibit all manner of humane characteristics in their practice of ubuntu and in the desire to build relationships. Although in the economy and political development of the society we live in, it is difficult to maintain and practice these cultural norms, generally it is these feminine characteristics that make the collectiveness of the culture possible. This feminine side of Africa is seen through the practical application of what is referred to as the "concept of collective ethics" by various African Traditional Religious and Philosophers⁶⁶. Mkabela uses the collective ethic to explain how Africans express their feminine nature. She says "The collective ethic recognises that survival derives from group harmony and all actions are within a collective context, which seeks to maintain the harmony and balance of an interrelated and essentially egalitarian system. It always

65 See Chhokar et al (2007)

66 See Mbiti 1969; Magesa 1997 and Sundermeier 1998

stresses humanness (*ubuntu*) which is characterised by generosity, love, maturity, hospitality, politeness, understanding, and humility” (2005:185)

The behavioural and personality attributes or the assertiveness of the African culture is therefore linked to the collective ethics. Krawitz (2007:133) says that because of group precedence, ethics of the people are bound to the wellbeing of the entire group. It is emphasis on the group wellbeing that influences and shapes the codes of behaviour/ethics of members (2007:133).

For Sundermeier, African ethics mean (amongst other things) reverence for one’s neighbour and humankind (1998:174-190). It is because of this that the elders in the community ensure that their subjects try by all means to be of a well-disposed company to everyone, being loyal, helpful, with the ability to share what one has with others. Sundermeier prefers to sum up this feminine characteristic of the African people as ‘seeking peace’ with all:

However, this should not be confused with the Western understanding of peace. This latter first focuses on the individual (‘Leave me in peace’), and only then only on others. In the context of Africa, peace is essentially linked with community. Peace is not possible on your own. Neither is peace simply the opposite of war, or the absence of strife, but means ‘to live in harmony’. It includes the family, the neighbours, the cattle and nature. Strife separates, peace joins - peace and alliance are sometimes used interchangeably. Peace is thus not a gift, but an assignment, a social duty, a religious exercise (1998: 178-179).

One is expected, as one grows up, to be kind and hospitable. Here there are no rules for men and rules for women; this is just being African. For this reason it is not by chance that on the tourists’ radial, Africa is represented as by nature a friendly continent (Sunghe Kim, 2003). Examining the concepts of evil, ethics and justice, Mbiti confirms this feminine African nature and says: “A visitor to the village will immediately be struck by African readiness to externalize the spontaneous feelings of joy, love, friendship and generosity” (1990:204). However, Mbiti does not only look at the positive feminine side but points out the need to also look at the other human side of Africans. He says that,

being human beings, there are numerous occasions when the African's feelings of hatred, strain, fear, envy and suspicion also become readily evident. The African then becomes just as brutal cruel, destructive and unkind as any other human beings in the world:

They can be as kind as the Germans, but they can be as murderous as the Germans; Africans can be as generous as the Americans, but they can be as greedy as the Americans; they can be as friendly as the Russians, but they can be as cruel as the Russians; they can be as honest as the English, but they can also be as equally hypocritical. In their human nature Africans are Germans, Swiss, Chinese, Indians or English – they are men (Mbiti 1990:205).

This implies that being feminine and having a softer heart towards fellow human beings, does not mean that the African community is free from strife and ethnic tensions. The African, just like the rest of humanity, lives in the tension of the reality and of what is expected. This is an important consideration in the recently published research on *Culture and Leadership, across the World: The GLOBE Book of In-Depth Studies of 25 Societies*. Their researchers incorporate the concept of “As Is” (the present cultural practices of the people) and the “Should Be” (the inherent cultural values of the people):

Culture is often manifested in two distinct ways. The first is as values, beliefs, schemas, and implicit theories commonly held among members of a collectivity (society or organization), and these are variously called the attributes of culture. Culture is also commonly observed and reported as practices of entities such as families, schools, work organizations, economic and legal systems, political institutions and the like. The former are expressed as the response to questionnaire items in the form of judgments of what should be and the later as assessment of what is, with regard to common behaviors, institutional practices, prescriptions and proscriptions (Chhokar et al 2007a:4).

The values of the culture are always transferred to people within the families, for members to know what ‘Should Be’, but the historical context of the culture and the major influences the culture has been through over the years (Chhokar et al 2007a:10), determine the societal culture ‘As Is’. In the African situation, the people know the

collective ethic shaping their feminine expectation, but the history, economic situation and development etc. all culminate in a description of the culture in its current state, whether there are feelings of hatred or love, strain or relief.

When it comes to the second aspect which has emerged from the Globe study, namely, gender egalitarianism or gender inequality, the African culture now shows up not as feminine but as masculine. This examines the way in which the society allocates social (as opposed to biological) roles to males and females, which leads to inequality among them. As pointed out by Booysen and Van Wyk (2005: 28) social gender roles are distinct; the society knows clearly what a man is supposed to do and what a woman is supposed to do. It is not a situation where anyone can do anything as long as the job is done. Though Hussein points out that Africa before colonialism was an egalitarian society, a view she believes a number of feminists hold as well (2004:109), the present reality is that there is a huge gender disparity. Drawing from the works of Appiah and Gates (1999) and Steady (1987), Hussein reveals that:

Historical, anthropological and feminist records alike show that gender inequality was hardened after the fall of the egalitarian social institutions in pre-colonial African societies. The problems have been largely attributed to the sweeping colonial conquests, religious expansions, emergence of statehood and economic crisis. Prior to these internal and external pressures, African women had relatively prestigious positions (2004:109)

This state of affairs made men and women work together and share their humanity in all areas of life. A cue for this assertion regarding African egalitarianism before the advent of colonial incursion can be taken from the unadulterated cultural lifestyle of the Khomani San community in South Africa and Botswana. (Chennels 2004:217).

In using revisionist historical and anthropological evidence, and by the analysing of African proverbs and sayings by writers and feminists to critique the notion of Africa as an egalitarian society before colonialism, Van den Berg acknowledges that this notion is embraced by many African philosophers, both post-colonial and contemporary. He says, “This view is shared by post-colonial African intellectuals such as Nkrumah, Senghor,

and Nyerere, who advocated African socialism as a viable solution for the problem of uniting people(s) into nation-states and tribal units (real or constituted by colonial government) which traditionally had different and often conflicting socio-economic and political systems. Contemporary African philosophers and scholars on African cultures such as Gyekye, Gbadegesin, Okolo, Okafor, Khapoya and Okoye are advancing the same kind of argument” (1996).

There are obviously a number of factors that have led to the move away from being egalitarian and non-hierarchical to the present situation of gender roles.⁶⁷

As a result of gender inequality, in most places in the African continent, women are treated and made to feel like second-hand or second-class citizens who are at the receiving end of the pressure mounted by all the intrusions and changes that have descended upon the continent. The situation of gender inequality and exploitation, especially with regards to women, has not escaped the eyes of governments, yet not much has been done to rectify the situation. The then Organisation of African Unity (OAU) realised the situation and showed the desire to do something about it. Mufune draws attention to the establishment of the African Court on Human and People’s Rights which was adopted by the OAU on June 10, 1998. This took a further six years to come into effect on January 15, 2004. (2005:1).

According to Mufune, the main purpose of the African Human Rights Court is to complement and reinforce the functions of the Commission on Human Rights. However, Mufune’s concern is how Governments themselves stop being partial towards women: “While this all sounds really impressive, as a non-legal person, I am concerned as to how exactly the Court will be able to assist the thousands of African women who, on a daily basis, are treated as second class citizens by their own governments. These same women suffer discrimination and abuse in their own homes.” (2005:2). As Primo too has pointed out, gender justice has not been central to the many efforts to establish and institutionalise free and pluralistic media in African societies today. “For most African women, the exercise of the fundamental freedoms of expression and information is doubly

⁶⁷ Such writers as Swantz, 1985; Steady, 1987; Ferraro, 1995; Harris, 1995, Appiah & Gates,1999; and Hussein, 2004 help trace gender inequality to the history of the continent.

constrained by patriarchal laws and practice, and by economic and political conflicts whose impact is also gendered. The failure to understand these rights from a gendered perspective compounds the situation, and also poses gender-based difficulties for female media practitioners.” (2003:21- 22).

It suffices to say that the above analysis places issues of gender inequality in a negative category of the cultural empowerment domain. Africa exhibits this negative characteristic that needs to be removed for the continent to make progress.

3.2.5.2 Masculinity/Femininity in South Africa

Generally speaking, with an MAS score of 63, South Africa is a moderately masculine culture. As pointed out earlier, Hofstede’s research focussed on mainly Whites. However, De Klerk, looking specifically at the cultural dimensions of Black South Africans, with Coloureds or Indians excluded, sees the culture as feminine. Calling the Blacks as Africans, De Klerk refers to Hunt (1996:56) to point out that in line with Hofstede’s dimensions “the African culture may be characterized as a ‘feminine’ culture (Hofstede’s term) which is largely collectivist and has a high power/distance index and a low uncertainty avoidance score. In contrast, White (English) culture is more masculine, more individualistic, and has a low power distance index and a high uncertainty avoidance score.” (De Klerk 2000:200-201).

Booyesen and Van Wyk (2007:433ff) in their recent work on culture and leadership, focussing on South Africa, based it on two parallel studies: the GLOBE study and Media analysis. The Globe study which considered Societal Cultural Dimensions, was a Whites-only sample and the Media analysis which catered for organisational culture, included Blacks (2007:459). This means that, at the societal level, there are no current data for Blacks. However, the organisational level in terms of Booyesen and Van Wyk (2007:467) indicates that:

White managers measured higher than black managers on assertiveness ($p < 0.01$) and gender egalitarianism ($p < 0.05$). Whites scored above average on assertiveness and ranked it in fifth place, whereas Blacks scored below average and ranked assertiveness in sixth place. Though both groups scored far below average on Gender Egalitarian, and ranked it in last

place, there is nevertheless a significant difference between the groups, with Blacks showing more gender differentiation than Whites.

As pointed out above, assertiveness and gender egalitarianism are sub-cultural dimensions of Hofstede's dimension of masculinity/femininity. The data here reveals that at the organisational level, White South Africans are high in assertiveness, making them masculine and Black South Africans are low in assertiveness, making them feminine. In the case of Gender Egalitarian, both Whites and Blacks are masculine, with Blacks being more masculine than Whites. This research finding confirms that Black South Africans fall into the same masculinity/femininity cultural dimensions as the other African cultures considered. With the consideration that assertiveness represents Hofstede's masculinity/femininity, we will be able to agree with both De Klerk (2000) and Hunt (1996) that Black South Africans are feminine.

Being feminine like most African countries and tribes, the South African Black culture is expected to exhibit the general norms and family characteristics of masculinity/femininity pointed out above by Hofstede. This is where, in general, the caring, hospitality and humane side of the people are seen. This is the practice of ubuntu, which we discussed above. The sub-divisions in masculinity/femininity help to explain the contradiction between a Zulu with a heart of ubuntu and the strength of a warrior. In normal life, a person is expected to be human and kind to others. However, society expects a man to be able to fight and defend the people when the need arises. The problem arises when people show their bravery and might indiscriminately. In this case, in the Zulu culture, because boys are expected to grow up to become warriors, they are not expected to cry but to learn fighting skills. However, in terms of assertiveness, where one has to show compassion, a boy could cry.

In terms of the gender egalitarianism dimension of masculinity/femininity in South Africa, there seems to be a greater awareness in this country than in other countries on the African continent. Government commitment to gender equality is lauded and visible in its commitment to gender mainstreaming.⁶⁸ This comes against the background that

⁶⁸ Gender mainstreaming is a globally accepted strategy for promoting gender equality which was clearly established through the Platform for Action at the United Nations Fourth World Conference on Women in

Governments of the world, by 2001, had only managed to double the number of women ministers in the past ten years (Hemmati and Gardiner 2001:2). According to the Inter-Parliamentary Union and the United Nations Division for the Advancement of Women, by the 1st of January 2005 the South African government had appointed women to head 12 of its' 29 (i.e. 41.4%) Ministries ,and 131 of the 400 Lower or single House parliament (32.8%) positions as well as 18 of the 54 Upper House or Senate (33.3 %) positions were occupied by women. In the course of that year, a woman was appointed Vice President of the nation.

Though there is more room for improvement, the atmosphere for debate and dialogue on gender issues has been created through national leadership. However, in the midst of all positive efforts to redress gender inequality, the situation is worsening and requires serious intervention. As a result of the history of Apartheid in South Africa, gender inequalities, especially in most Black communities, have escalated beyond the social discrimination of men against women into “gender violence”. Lemke, in quoting Bank (1994), refers to this threatening situation as the ‘crisis of African masculinity’ (2003:65). For her, the underlying reasons for violence among Black South African men were revealed in a television documentary televised on SABC 3 on 23 November, 1998. The documentary argued that since colonial times and in circumstances reinforced during Apartheid, Black South African men have been constantly subjected to suppression and humiliation, which has left them with a loss of self-respect. According to Lemke:

They were cheap labourers in the mines and on farms, denying them family life and rights. They had to live on their own in deprived conditions in single-sex hostels, uprooted from their families, culture and traditions. In this documentary it is further argued that previously, young black South Africans grew up with the tradition of ubuntu, which implies having respect for others, and some felt they could prove their manhood in rites such as the ritual of circumcision. In the cities, these traditions were

Beijing in 1995. It therefore involves ensuring that gender perspectives and attention to the goal of gender equality are central to all activities - policy development, research, advocacy/dialogue, legislation, resource allocation, and planning, implementation and monitoring of programmes and projects. (See United Nations 1995). For this in February 1997, the SADC Council of Ministers passed a Declaration on Gender and Development that established a policy framework for mainstreaming gender in all SADC activities and strengthening the efforts of member countries to achieve gender equality. The Declaration stipulates that “gender equality is a fundamental human right” and resolves to “ensure the eradication of all gender inequalities in the region.” (See SADC 1999, Gender Unit note 16, para. B.i.).

sometimes replaced by gang activities where young men had to prove themselves, sometimes even by killing a person. All of these conditions added to the loss of self-respect and self-esteem of men and can result in violence as a means of reaffirming masculinity (Bank, 1994). This at the same time keeps women in their subservient roles and does not provide the possibilities for changes (2003:65).

One of the legacies which Apartheid has left behind is the migrant labour system whereby many South African men travel to cities in search of work (Zulu, 1998:148). This has left many homes in the black townships and locations to be headed by women who are living in poverty. Ndingaye laments that although poverty affects both women and men, it affects women more, as a result of gender divisions in labour, and of women's responsibility for household welfare. The writer reveals further that: "Women are experiencing more poverty than men when comparing the two groups. Blackburn (1991) mentioned that black women face the dual oppression of sexism and racism in the labour market. They experience a different position in the labour market to both White women and to men of all races. Black women tend to be in jobs with the lowest pay and the poorest conditions" (2005:12). The situation of black women in South Africa was acknowledged by South African President, T. Mbeki, when describing the inequality in the country as a 'two-nation' society: "One of these nations is White, relatively prosperous, regardless of gender or geographic dispersal. ... The second and larger nation ... is Black and poor, with the worst affected being women in the rural areas, the Black rural population in general, and the disabled" (Seekings, 2007:11).

However, as women make every effort to improve the economic status of their families, they are left out of economic decision-making and the preparation of financial and pecuniary policies. Women in South Africa are discriminated against in the economic arena.

In South Africa, women make up 52% of the adult population. Of this, only 41% are regarded as being part of the active working population and only 14.7% find themselves in executive managerial positions (KPMG,

2006)⁶⁹. Furthermore, a study commissioned by the South African Department of Trade and Industry (DTI) (2005:2)⁷⁰ highlights that “women in South Africa make up half of the business force and their contribution has not been adequately nurtured.” The study further indicated that the majority of South African women entrepreneurs operate within the crafts, hawking, personal services and retail sectors (Maas and Herrington ,2006:38-39).

This sub-section has brought to light that the masculinity/femininity dimension, as postulated by Hofstede, has two key aspects, namely assertiveness and gender differentiation. It is noted that African culture is feminine in terms of assertiveness and masculine in terms of gender egalitarianism. Both sub-dimensions of masculinity/femininity that Black South African culture falls into have implications for the question of silence.

3.2.5.3 Masculinity/Femininity and Silence.

In terms of being feminine in the assertiveness dimension, Africans will do anything within their ranks to seek peace and be tender to others for the sake of harmony. In this process, Africans would remain silent over certain issues in order to nurture this harmony. Even in situations when one has something on one’s mind, as Noelle-Neumann’s (1974) spiral of silence theory argues, one will be deterred from expressing one’s true opinion if one feels that it runs counter to the majority opinion. (Schmierbach et al, 2005:329).

The humane nature of the African, which exhibits itself in the practice of ubuntu to a greater extent, leads to silence. Hanks lists the African ubuntu 14 virtues which constitute qualities of humanness to be: hospitality, compassion, empathy, tolerance, respect, interdependence, collective solidarity, patience, kindness, reconciliation, co-operation, warmth, forgiveness and supportiveness (2008:131-132). Being humane to the African

69 See KPMG. 2006. www.kpmg.co.za.

70 See The Department of Trade and Industry (DTI) SAWEN - South African Women Entrepreneurs: A burgeoning force in our economy – A special Report 2005. <http://www.dti.gov.za/sawen/SAWENreport2.pdf>

means upholding these virtues and keeping silence about one's own situations, for the benefit of the community: "Ubuntu is the desire to live in harmony with others and to submit one's own needs for the benefit of the social framework in which one lives." (Van Vlaenderen, 2001:150).

For this study, the present state of high masculinity in terms of gender egalitarianism can be considered responsible for perpetuating silence in the continent. The prevailing gender roles and power relationships that exist as a result of the high power distance nature of the African culture mentioned above, coupled with the total change that has affected all spheres of the African life (Mbiti, 1990:213) are responsible for silence within families and communities. For this reason, when it comes to the African culture being masculine in terms of the gender egalitarian sub-dimension of femininity/masculinity, silence is much more pronounced than assertiveness. Because of gender inequality within the culture, there is no openness on the subject of sexual relationships. Women are mostly silent about what they could contribute in relationships, knowing very well that there is gender inequality and what one says could spark abuse. Morna et al bring to mind that in many religious and cultural traditions, female sexuality is depicted as a source of evil and a temptation to men, thus requiring control by society (2002:47). Here, if any sexual act should take place, even when a woman has been raped, the woman would keep silent about the situation to avoid being accused of being the tempter. The control of male sexuality is not treated in the same manner, and men who transgress religious and cultural norms may in fact blame women for leading them into temptation (Morna et al, 2002: 47).

In the African culture, the fear of being accused of wrong-doing causes women to be silent in abusive relationships with men. Even in situations of domestic violence, Schirch says "A woman may disgrace her family if she reports domestic violence. Acknowledging that there are problems within a family is sometimes seen as bringing shame to the family. In order to protect the reputation of the woman's larger family network, she may choose to keep silent about domestic violence" (2004:83).

Morrell is conscious of the fact that in South Africa, history and religious traditions have contributed to the silence:

In South Africa, stern Calvinist traditions compounded by the authoritarianism of Apartheid produced a silenced society for the majority of black and white people. Racial and gender inequalities underpinned the silence. Black people were silent before whites; women were silent and obedient to men. During the period of heightened political resistance to Apartheid (in the 1970s and 1980s), silence was a defence mechanism that could save one from incarceration at the hands of the security police (2003:45).

When women are afraid to be identified as victims in violent situations and so keep silent, men, on the other hand, also keep silent over the situation for fear of being referred to as perpetrators. In the concluding statements at their conference on Men and Masculinities, the Gender Education & Training Network (GETNET) identified the problem in South Africa that gets in the way when replacing the culture of silence around Gender Based Violence with dialogue. The problem, as the conference pointed out, is that men and women cannot embrace their identities as victims and perpetrators of violence and so they both cannot speak about Gender Based Violence (Maeger, 2003:24).

Various situations, as a result of being 'feminine' with regards assertiveness, make Africans keep barren silence on issues. Such situations include peace seeking, keeping of harmony and placing the interest of the community above one's own interest. The masculinity in terms of gender egalitarianism, causes women in particular, to keep barren silence for fear of being accused of wrong-doing. Trust and relationship building as well as reading in-between-the-lines when communicating with people will be required to engage with the fertile silence available, in order to expose the barren silence so that it can be broken.

3.2.6 Summary

It is clear from the above considerations that silence, in any aspect of the life of the community we are dealing with in Kwazulu Natal stems from a high-context culture that is characterised by various dimensions. In the Pietermaritzburg area and amongst Zulu people, in which this research is conducted, the culture is characterised by polychronic time orientation, high power distance, low uncertainty avoidance and collectivism

(ubuntu). In the masculinity/femininity dimension, the culture exhibits femininity in terms of assertiveness and masculinity in terms of gender egalitarianism.

In considering these dimensions of culture, we tend to consider cultures as fixed and solid units of people of one culture being essentially one, and those of the other culture essentially another. Rather culture should be considered as an evolving and dynamic process of constant change. The features of the dimensions of culture therefore exist on a continuum, not as fixed polemic opposites. The dynamism of culture, coupled with the abilities of humans learn skills, leads individuals to find their ways in life.

To different degrees, these dimensions of culture impact on silence within the culture, creating a thick layer of what we have called fertile silence around a barren silence that is unhelpful. The barren silence exist around an issue for which there is no talk or communication. However, the thick fertile silence communicates cues that if engaged with through trust and relationship-building, may espose the barren silence so that it can be 'broken'

The impact of polychronic time orientation is seen through the way people in the culture harbour silence, allowing a passage of time to build the relationship until strong enough to open up. When it comes to power distance, there is fear among the people that they might violate the hierarchical powers within the culture, through releasing of information, and so the subordinates keep silence. The low uncertainty avoidance nature of the culture impacts silence through time, relationship building, risk taking and taboos. The time and relationship building factors are the same as outlined above for time orientation.

Considering the general view on the future that Africans have, people are not in a rush to open up on issues as they first need time to build relationships. This leads to people taking risks by keeping silence about issues that are very important to them. In people will also keep silent about issues if they know those issues are linked with taboos.

Collectivism makes individuals be loyal to their families and so keep silent about in order to save the face of their families when they know those issues can bring disgrace. Finally, through femininity in terms of assertiveness, family members keep silent about issues in order to seek peace and harmony in the community. As a result of masculinity in terms of

gender egalitarianism, women keep silent in abusive relationships for fear of being accused by men of wrong-doing. Men also keep silent about situations in which they feel guilty, because they usually blame women for these situations.

This chapter has helped us in beginning to answer the second research question, as to what extent the cultural dimensions contribute to the silence around HIV and AIDS, pointing out that all the various dimensions of culture contribute to silence in general. But to answer that question fully and be able to deal significantly with the silence that surrounds the HIV and AIDS pandemic, we need to investigate from the field how these dimensions of culture contribute to the barren and fertile HIV and AIDS silence. This we will begin to do in the next chapter

CHAPTER FOUR: CULTURAL DIMENSIONS AND THE FERTILE/BARREN HIV AND AIDS SILENCE

4.0 Introduction

Chapter three pointed out how the various dimensions of culture contribute to the creation of fertile/barren silence in general. In a high context culture such as the study focus, the various dimensions of culture contribute to the creation of a silence for which there seems no talk or verbal communication – what we call barren silence. However, surrounding the barren silence is a thick fertile silence. This communicates cues that, if engaged with through trust and relationship building, expose the barren silence. This can then be ‘broken’.

With the insights gained from the literature about barren/fertile silence and the dimensions of culture, this chapter draws on the fieldwork and examines the HIV and AIDS silence in the light of these insights. The background to the field work and the research approach have been extensively covered in chapter one (see 1.4 – 1.6).

The HIV and AIDS silence that we desire to break is wrapped up in a thick fertile silence. People don’t speak about HIV and AIDS but present other things around the disease that if engaged with, could lead to the exposure and breaking of the silence that surrounds it. The fertile silence connotes implicit forms of communication using symbols, proverbs, hesitations, withdrawals, facial expressions, understatements, omissions, different gestures and other non-vocal means.

In looking at how the dimension of culture contributes to the HIV and AIDS silence, I utilise the cultural issues raised by Mr. Urban Jonsson, the UNICEF regional director for Eastern and Southern Africa, at the conference of the European Parliamentarians for Africa (AWEPA) in November 2001⁷¹, as a launching pad for analysis. Through personal analysis of the data obtained from the field, I show how the various dimensions of culture

⁷¹ See Balch, Jeff and Hollenberg, Geertje (Editors) AWEPA (European Parliamentarians for Africa) 2002. *Parliament and the AIDS Budget: Resources for Community Empowerment*. Report containing the Contributions, Conclusions and Recommendations of the Fourth International Parliamentary Conference on HIV/AIDS. Amsterdam: AWEPA. Internet www.awepa.org

contribute to the barren silence on HIV and AIDS and the various ways through which the fertile silence is exhibited. I draw on personal experiences of various people living with HIV and AIDS, the experiences of those close to PLWHAs or who work with them and the experiences of the Support Group to provide evidence to support his notion of fertile and barren silence. The ethnographical dimension of the field study provides an essential tool in understanding the way in which HIV and AIDS is both experienced and understood by those who are most affected by the disease. The analysis provides insights into how activists with the genuine desire to help break the barren HIV and AIDS silence, ignore the various fertile silences provided by those they seek to help, let alone engaging with these silences.

This chapter therefore begins by looking at the HIV and AIDS silence in general, locating it in different settings of societies, including individuals and families infected and affected by the disease. It then analyses the field data in the light of the contributions of the various dimensions of culture to the fertile/barren HIV and AIDS silence.

4.1 Locating the HIV and AIDS Silence

While recognising and commending UNAIDS and the scientific community for the persistent efforts to provide a cure for the disease, the truth of the matter is that HIV and AIDS is an epidemic that has challenged the ability of human beings to eradicate infectious diseases. Certainly, the production of anti-retroviral treatment (ART), in its many forms⁷² including the Nucleoside/Nucleotide Reverse Transcriptase Inhibitors (NRTIs) available in 1987, to the present forms of combinations⁷³, have saved many lives. Indeed the United Nations points out that since 1996 Anti-Retroviral Treatment (ART) has significantly reduced AIDS-related death rates in high-income countries (United Nations, 2003). However, in spite of highly successful combination ART which is able to suppress viral levels to almost undetectable levels, Ammann indicates that recent studies cast doubt on the ability to eradicate the virus (2005: 37). This is despite an acceleration in the advancement of technology and medicine.

72 See HIV and AIDS Treatment. www.avert.org/introtrt for different forms and combinations of ARTs

73 The combinations include what is commonly called T-20 which has been licensed both in the US and in Europe since 2003, but only for use by people who have already tried other treatments.

Ammann provides reasons for the difficulty in dealing with HIV and AIDS despite the present sophisticated technology. With HIV, it is difficult to draw from the successes in dealing with past epidemics to predict the impact of the disease on the future of the world's population. We know of the strategies used to deal with life threatening epidemics of the past such as measles, syphilis, the Black Plague, and smallpox. "But the spread of these epidemics was "contained" by limitations in travel, the smaller global population (500 million in the 1600s to 7 billion in this decade), and ultimate self containment of the epidemics by the development of an immune population. Most of the new regions of the HIV epidemic can be linked to travel and to the identified means of transmission – unprotected sex, intravenous drug use, unscreened blood products, and multiple sexual partners. Once established in an area, heterosexual and perinatal HIV transmission follows." (Ammann 2005:39). This situation described by Ammann, shows that the cure for HIV and AIDS is not immediately in sight. The best thing that the world is able to do immediately, to save itself from any further calamity, is to reduce or prevent HIV infections, beyond all previous efforts in this direction. Ammann's insight is a step in the right direction:

The unique biology of HIV, the immaturity of the epidemic, the high mutation rate of the virus, the rapid emergence and transmission of multi-drug resistant virus, the difficulty in effecting behaviour changes to reduce transmission, and the lack of an effective vaccine for prevention, strongly suggest that we are only at the earliest stages of this epidemic. It is for this reason that every method of prevention must be employed to effectively reduce the "pool" of HIV infected individuals (2005:40).

This thesis, and this chapter specifically, responds to this call to employ every prevention method, by turning to the question of the silence that engulfs HIV and AIDS in a cultural context, a silence that interferes with an effective prevention strategy.

One of the major obstacles to winning the battle against HIV and AIDS is the silence that surrounds the disease, especially when it comes to effective prevention (UNESCO 2001:30). In many places in the world, the immediate association of silence surrounding HIV or AIDS is seen through the lack of discussion and the reluctance of people to talk about the disease. This situation has hampered, and is still hampering, progress in

combating the disease. Through their HIV and AIDS online educational programme, “*What’s in the news*”, the Penn State Public Broadcasting (PSPB) points out that, “The dangers of not talking about AIDS were recognised early in the United States. By fearing discrimination, some people prefer to keep their secret” (2004:14).

As to the reason why Africa has only about 12 % of the world's population living in it and yet has 83% of all AIDS-related deaths, PSPB attributes this to the lack of education about the disease (2004:13-14). Even though in large cities in many African countries, the picture is changing, as a result of government-sponsored programmes to educate people about the dangers of risky behaviours which help in the spread of the HIV virus and lead to AIDS, PSPB says that in rural areas, it is silence that hampers HIV education:

In the villages and countryside, however, people are reluctant to talk about AIDS. Because it is most commonly acquired through sex or the use of illegal drugs, AIDS is a subject that makes people uncomfortable. Often those with the disease are shunned or treated unfairly by others. As a result, many people with AIDS are ashamed or afraid to admit that they have the disease. So they go untreated and AIDS continues its deadly spread (2004:14).

As we are arguing in this thesis, the reluctance to talk about HIV and AIDS in rural areas stems from cultural practices of the people and has been exacerbated by the way the disease has been introduced. Russell says “in Africa, studies suggest that the explosive rise of HIV rates may be related to cultural practices” (2004, paragraph 19). This is one of the reasons why a cultural understanding is key to tackling the HIV silence.

Davidson traces the HIV and AIDS silence to the demonising of the disease in the 1980s. Summarising a symposium held jointly by the Wits Institute for Social and Economic Research (WISER) and the ‘Ecole des Hautes Etudes en Sciences Sociales’ at the University of Paris on October 14-16, 2004, on the topic: “Life and Death in a Time of AIDS” Davidson wrote:

The emergence of HIV/AIDS in the early 1980s brought with it negative connotations including themes of immorality and sexual perversion. By demonising HIV/AIDS patients, the stigmatisation of HIV has been a

silent and disgraceful death within itself. Deboral Posel, director of WISER, argued that the theoretical significance of HIV/AIDS stigma cannot be ignored in the broader discussion of living and dying with HIV/AIDS. The symbolism of stigma has emotional and practical consequences for the patients, families and caretakers. Limiting stigma around AIDS should be an essential part of efforts to fight HIV/AIDS (2004:10)

In Africa in particular, the custom of associating HIV and AIDS with sexual perversion and immorality not only raised its awful head in the Church, leading to suspicion and stigmatisation, but it also raises cultural and moral issues in the communities, leading to stigmatisation, discrimination and ostracising. It is for this reason that Parker and Birdsall indicate that there have been changing processes of importance related to how HIV and AIDS has been located within society, how it has been dealt with, and how individuals have been directly, indirectly and unreasonably affected. The particular connecting pathways of the disease have contributed to negative opinions about people living with HIV and with AIDS, associating the mode of HIV transmission mainly with sexual immorality and promiscuity (2005:5-6).

In a multi-country study Parker and Birdsall found that, although knowledge of ways by which HIV could be transmitted was generally high, “there was a lack of understanding about how HIV could *not* be transmitted. This was found to be exacerbated by fear-based public messages and sensationalism. Perceptions of immorality were linked to promiscuity, moral transgression, choosing to engage in ‘bad’ behaviour, and punishment from God. This is contrasted with social values to do with what is considered normative, appropriate or ‘good’ behaviour” (2005:6). Faith Based Organisations (FBOs), the writers point out, delay to respond and their failure to acknowledge the extent and repercussions of the rising HIV infection rates, due to the moralistic, judgmental and socially conservative attitudes towards which have added to silence and secrecy (Parker and Birdsall 2005:12).

Parker and Birdsall mention that the church’s linking of HIV infection with immoral behaviour, and its failure openly to discuss the root causes underpinning HIV

transmission, mentioning in particular differentials of power, have contributed to stigmatisation and discrimination of people within the church living with the disease. (2005:12). They quote Cochrane (2005:2) to indicate how religion feeds into the setback of stigma through the “taboos, sanctions, and silences [about sexuality], much of it authorized by religious legitimations.”

Clearly then, to be able to limit or effectively deal with stigma and other factors that contribute to silence around HIV and AIDS, an understanding of the silence in its various forms is very important.

4.2 What is the HIV and AIDS silence?

In Africa, one cannot escape from the conclusion that the silence that surrounds HIV and AIDS has got something to do with the origins and history of the disease (De Cock et al 2002:68-69). As pointed out above, how the disease was made known to the people, and how it was understood, was a main contributor to the silence around it. (Davidson 2004:10). De Cock et al, looking specifically at the history of HIV and how it has contributed to silence and a lack of urgency towards it, say:

Although human rights instruments and legal interdictions can protect HIV-infected people against discrimination, such as in relation to housing, education, or employment, they cannot protect against stigma, which is social rather than structural. Stigma emerged universally and early on as a powerful, pernicious force that is an important barrier to prevention efforts. Paradoxically, treating HIV/AIDS as being different from other infectious diseases probably enhances stigma rather than reduces it. The emphasis that has been placed on anonymity for HIV-infected people, which is different from confidentiality and analogous to secrecy, might also have been counterproductive. Anonymity is impossible to maintain as immune deficiency progresses. The quest for secrecy promotes rather than breaks the destructive silence around HIV/AIDS, and divides the known infected from the undiagnosed and uninfected (2002:69).

Alongside this significant point about anonymity and secrecy, the silence surrounding the disease has a great deal to do with the culture of the people and how that culture responds

to issues that the disease raises. As we established in the previous chapter, all the dimensions of culture have an effect on silence. Silence exhibited in the culture therefore includes that which is around HIV and AIDS. We therefore need to establish what the silence around the disease is and how it manifests.

Ordinarily in most situations, the silence around HIV and AIDS is manifested in people refusing to say anything about the disease, even in highly infected areas or places where the clinical evidence is overwhelming. Robert Morrell in his research on “Silence, Sexuality and HIV and AIDS in South African Schools” reveals that even with a very high HIV infection rate among teenagers and young adults, it is surprising to find that students and teachers alike are very unwilling to talk about the possibility of being or becoming HIV positive (2003:41). Refraining from talking about the issues of HIV or AIDS when one is infected or affected, is just the proverbial “tip of an iceberg”⁷⁴. The silence surrounding HIV and AIDS is a societal issue that begins with individuals and their families and includes communities, government circles, churches, the work-place, in the media, the NGO sector and others.

4.2.1 UNAIDS and the “Break the Silence” Conference.

The magnitude of the problem of silence surrounding HIV and AIDS is so high, and so hampering to progress on any meaningful gains, that the world body responsible for dealing with the disease, UNAIDS, dedicated its 13th International AIDS Conference held in Durban, South Africa in 2000, to breaking the silence surrounding the disease. It is not surprising that the first ever conference on HIV and AIDS in Africa saw the need to concentrate on this theme of silence. The need to break the silence has long been identified in Africa, especially within the ranks of helping men to be open. It was for this reason that the Caring and Understanding Partners (CUP) initiative was established (Awasum et al 2001:1). According to these authors, under the banner of CUP, a campaign code-named *Break the Silence: Talk about AIDS* was designed to deliver highly motivating HIV and AIDS prevention messages to encourage men to talk about AIDS

74 The New Dictionary of Cultural Literacy, Third Edition (2002) defines the iceberg as: “A large piece of ice that has broken away from a glacier at the shore and floated out to sea”. It then explains that most of the ice in an iceberg is underwater, leaving only the “tip of the iceberg” visible—a fact that is often alluded to in discussions of subjects in which the most important aspects are hidden from view

and to develop personal game plans to prevent it. They also point out that the initiative was first proposed at the Africa Regional Conference on Men's Participation in Reproductive Health, held in Harare, Zimbabwe in 1996, with a strategy to engage and promote men as partners in family and reproductive health issues through sports (2000:1). This initiative, which was endorsed by 175 policy-makers and programme managers from 31 African nations at the Harare conference, was further endorsed by the First Conference of French-Speaking African Countries on Men's Participation in Reproductive Health, held in Ouagadougou, Burkina Faso in 1998. This enterprise, which grew into a continent-wide reproductive health and sports initiative and conducted interventions in eight countries, involving major international and national donors, NGOs, and private-sector businesses (2001:1), was a booster to the "Break the Silence" HIV/AIDS International Conference in Durban.

It is also worth noting that before this historic 2000 AIDS Conference, the General Secretary of the United Nations, Mr. Kofi Annan, delivered a speech on 6 December 1999 at a meeting on international partnerships against HIV and AIDS in Africa, and aptly stated: "The first battle to be won in the war against AIDS is the battle to smash the wall of silence and stigma surrounding it – and that official recognition of the problem is the first step towards dealing with it"⁷⁵ (World Health Organisation 2002:8).

It is important to note Annan's linkage of silence and stigma. Silence is born out of stigma and or discrimination. In the fight against HIV it is stigma and discrimination that generates silence. The International Council of Nurses (ICN). in a press release issued on 12 May 2003 in Geneva, indicated that stigma and discrimination increase the spread of the HIV and AIDS epidemic as it creates a culture of secrecy, silence, ignorance, blame, shame and victimisation (ICN 2003 paragraph 1). According to the organisation's president, Christine Hancock, "Stigma prevents societies from addressing HIV/AIDS with the appropriate health care services, legal and educational strategies.... What stops them is HIV prejudice. And all that will stop HIV prejudice is speaking openly about the facts. It is past time for governments, civil society leaders and religious institutions to end the conspiracy of silence and shame surrounding HIV/AIDS" (ICN 2003 paragraph 1). At

⁷⁵ This is a statement he re-echoed to the Security Council in January 2000 and reported in NY Times, January 11, 2000, "Gore Presides over Security Council Debate on AIDS".

the level of governments, the ICN says stigma affects their ability to respond efficiently to the brutal nature of the epidemic. At the cultural level of the people, the “fears and taboos surrounding the disease translate into silence and inaction, despite the catastrophic consequences for individuals and societies. Opportunities for prevention are missed, care and treatment remain inaccessible and the toll of death and misery climbs” (2003 paragraph 4).

Silence therefore hampers prevention as well as care and treatment efforts in the fight against HIV and AIDS. Aggleton and Parker of UNAIDS indicate that, all over the world, the shame and stigma associated with the epidemic have silenced open discussion, whether it is to do with its’ causes or with appropriate responses. As a result people infected and affected by the disease feel guilty and ashamed, not able to express their views and afraid that they will not be taken seriously. Even politicians and policy-makers in many countries deny that there is a problem, or that urgent action needs to be taken (2002:5). The writers therefore say:

Stigma and discrimination associated with HIV and AIDS are the greatest barriers to preventing further infections, providing adequate care, support and treatment and alleviating impact. HIV/AIDS-related stigma and discrimination are universal, occurring in every country and region of the world. They are triggered by many forces, including lack of understanding of the disease, myths about how HIV is transmitted, prejudice, lack of treatment, irresponsible media reporting on the epidemic: the fact that AIDS is incurable, social fears about sexuality, fears relating to illness and death, and fears about illicit drugs and injecting drug use (Aggleton and Parker 2002:5).

The call to deal with the HIV silence was so dear to Annan that even before the conference focussing on breaking the HIV silence he saw the need to address UN Alliances to help work towards the world body’s stated goal of halting, and beginning to reverse, the spread of HIV and AIDS among young people. Addressing participants at the Millennium Forum on the 22nd May 2000 at the UN headquarters in New York, Annan pleaded:

We look to you to speak up on behalf of the men, women and children affected by this epidemic; to keep spreading the message of awareness and prevention; to insist on transparency and accountability from governments and from international organizations. I have challenged leaders around the world to break the conspiracy of silence that surrounds the epidemic in some countries. I have urged them to understand that silence is death (United Nations 2000).

Annan's call, which was later to be emphasised at the World HIV and AIDS Conference in July 2000, stated that the silence surrounding HIV and AIDS has led to the deaths of many people and therefore has to be broken. The call reveals the fact that breaking the silence is the task of everyone including the infected and affected, as well as all who hold power, to be open about the disease.

'Breaking the Silence' in the case of HIV and AIDS is therefore making the disease known in every respect. It was against this background that when addressing the 21st Special Session of the United Nations General Assembly for the Review and Appraisal of the Implementation of the Programme of Action of the International Conference on Population and Development, Peter Piot, Executive Director of UNAIDS, challenged everyone present to place 'breaking the silence surrounding HIV and AIDS' on the world agenda: "... we need to break the silence around this epidemic. How can we ever win this battle without openness about sexuality and about AIDS? This requires at the same time an uncompromising fight against the stigma and discrimination associated with HIV" (UNAIDS 1999:4). Breaking the HIV and AIDS silence is indeed about being open about the disease and removing all manner of stigma and prejudices around the disease."

In planning for the historic 2000 AIDS conference, James, through the conference's website, explained that the theme of the conference, 'Break the Silence', was an acknowledgment of the many silences that surround and imprison HIV and AIDS. The silences range, "from the silence of communities which obstruct acceptance and disclosure, to the silence which prevails across nations estranged by colossal inequities and divided by towering debts." (1999). In this case the conference on breaking the silence was aimed at addressing HIV and AIDS silence from different angles.

As a first step in breaking the HIV and AIDS silence, the Durban conference, unlike previous conferences that were organised along four tracks: basic science, clinical science, epidemiology and public health, and social and behavioural science, introduced a new track known as “rights, politics, commitment and action”. According to James, this new track was to explore how policies and programmes are created, debated, applied and evaluated. In this case, the roles and responsibilities of governments, intergovernmental organisations and the private sector were to be addressed (James 1999). The conference acknowledged that the silence around HIV and AIDS will never be broken without leadership in all spheres of life. It was to bring this point home that when SAfAIDS News highlighted the UNAIDS Report on the Global HIV and AIDS Epidemic, released in June 2000, in advance of the July Durban International AIDS Conference, it pointed out that:

Although gains have been made in breaking the silence about the epidemic in Africa, more can and should be done. Religious and other civil society leaders need to speak out about social exclusion and stigmatization. Churches and other areas of civil society should help those living with HIV and AIDS to speak out too – they, and the legacy of those who have died, are the most effective at breaking the silence (SAfAIDS News 2000:13).

Breaking the silence surrounding HIV and AIDS was highlighted at the Durban conference as the ability to be open about the disease through all organs of society, especially through leadership. It was to encourage participants and leaders to make this a reality that former South African President Nelson Mandela, in his closing speech at the conference said:

The challenge is to move from rhetoric to action, and action at an unprecedented intensity and scale. There is a need for us to focus on what we know works.

- We need to break the silence, banish stigma and discrimination, and ensure total inclusiveness within the struggle against AIDS;
- We need bold initiatives to prevent new infections among young people, and large-scale actions to prevent mother-to-child

transmission, and at the same time we need to continue the international effort of searching for appropriate vaccines;

- We need to aggressively treat opportunistic infections; and
- We need to work with families and communities to care for children and young people to protect them from violence and abuse, and to ensure that they grow up in a safe and supportive environment (Afrol News 2000)

Delegates to the conference, even before departing, realised the impact that the conference had brought, especially in making the disease tangible. A survey conducted among delegates and published jointly by Health & Development Networks and the Medical Research Council of South Africa revealed that: “Durban represented a turning point in the international fight against AIDS, with increasing difficulties for political leaders in Africa and elsewhere in the South to remain silent and complacent, but also for their counterparts in the North to deny efficient support. Nobody will be able to stop the process that started there and which will bring more HIV prevention and care to the South” (Galloway et al 2001:10).

4.2.2 The Concept of “First and Second Walls of HIV and AIDS Silence

At the conference of the European Parliamentarians for Africa (AWEPA) in November 2001, Mr. Urban Jonsson, the UNICEF regional director for Eastern and Southern Africa, analysed, in his address, the progress made in implementing the AIDS 2000 concept of breaking the HIV silence a year after the conference. His analysis identified a series of important conferences where African leaders have re-committed themselves to fight the War against HIV and AIDS. He mentioned:

- (1) In December 2000, the UN/ECA organized the Second African Development Forum (ADF) where the ‘African Consensus and Plan of Action: Leadership to Overcome HIV/AIDS’ was adopted;
- (2) in April, Heads of States and Governments of the OAU met in Abuja at a Special Summit and declared AIDS a ‘State of Emergency’ and promised to allocate 15% of their annual budgets for the improvement of the health sector;
- (3) in May OAU and UNICEF organized the Pan African Forum of the Future of African Children, hosted by the Egyptian Government. For

the first time a Common African Position on children was agreed upon, in which the fight against HIV/AIDS is a top priority, (4) in June the UNGA Special Session on HIV/AIDS took place in New York, where global goals for prevention, care and support were agreed upon and realistic estimates of required funds – US\$7 to US\$10 billion per year by 2005 – were made; and (5) in July the OAU Summit in Lusaka endorsed the recommendation from Abuja and UNGASS (Balch, and Hollenberg 2002:9).

The analysis shows great strides made; indeed the global and African commitment had never been stronger. But Jonsson lamented that the gains made were only the breaking of, what he calls, the *first wall* of ‘Conspiracy of Silence’ which had been broken at the senior national and international levels. This is where the HIV and AIDS situation is openly discussed and analysed in well-organised forums and conferences. This represents the gains made by the Durban International HIV and AIDS Conference that we have alluded to before. However, Jonsson points out aspects of the battle to break the silence that are key to our research.

According to Jonsson, there is a ‘Second Wall of Silence’ which is not so well defined as the first wall, but even more damaging. “This ‘Second Wall of Silence’ includes the wall between government officials and communities; between politicians and voters; between communities and households; between households and households; between husband and wife; between parents and children; between teachers and students and between boyfriend and girlfriend.” (Balch and Hollenberg 2002:9). The first wall had more to do with people highly educated and understanding the HIV issues from the point of view of a low-context culture. They meet in conferences and workshops only for few days, understanding each other at that level, but they have no day-to-day interactions ‘on the ground’. However, the second wall of silence is about community interactions and cultures. As we have noted in the previous chapter, in Africa, the situation is a high-context culture, and this has a particular impact upon this second wall of silence.

Jonsson’s concept of the ‘Second Wall of Silence’ was well articulated and received among more than 120 senior Church Leaders from across Africa at a meeting held in the

Kenyan capital, Nairobi, to co-ordinate a response to the proliferation of HIV and AIDS by Carol Bellamy, Executive Director, UNICEF (UNICEF 2002). She said, “We may have broken a wall of silence among policy makers and decision-makers. But there is a second wall of silence out there – a wall that is keeping young people from learning about HIV, and stigmatizing those who have it. And unless that second wall of silence is brought down, all the hard-won gains of recent years will have been for nothing” (UNICEF 2002).

This is the wall that comes between human beings at a relationship level. In Africa, it is these relationships that build and strengthen communities. Bellamy points out that this wall of silence exists because of the discomfort and reluctance among the people to acknowledge the disease and the factors that drive it. Further, it exists because of the reluctance and hesitation among the people to educate the young about sexuality and the dangers of growing up, together with the inability of the people to dispel the stigma and counter the discrimination surrounding it. To her “this second wall of silence is about intimacy, sexuality, relationships - things we usually hold deeply personal, hidden and private. It is this ‘hiddenness’ that is driving the epidemic” (UNICEF 2002). Therefore this unseen wall of silence has to be engaged with, exposed and broken to help deal with the HIV and AIDS situation.

The silence around HIV and AIDS in the communities is a hindrance to efforts to respond to the pandemic. To acknowledge the existence of the second wall of silence around the pandemic, while making an attempt to break it at the grassroots level, South Africa's veteran Zulu leader Mangosutho Buthelezi, announced publicly that he has lost two children to AIDS. According to Cartillier (2006), the Inkatha Freedom Party leader, in an interview with *Agence France-Presse*, said of Africa, the pandemic-blighted continent, should stop sweeping the disease under the carpet. He advised the people rather to lift the stigma and taboos surrounding the disease in Africa as soon as possible.

At the beginning of 2008, a project by name Kwa Mashu Community Advancement Project (K-CAP), was established in the township to address the silence around HIV and

AIDS that is still reining in the community after the death of Gugu Dlamini⁷⁶. Edmund Mhlongo, the project's leader, explains the inspiration for this project:

K-CAP is a community based organization in Kwa Mashu Township, where HIV/AIDS is highest. Some K-CAP members are HIV/AIDS positive and there is a lot of silence and stigma about HIV/AIDS positive people – hence the importance of this project.

This is just an example of the second wall of silence that exists in the communities where attempts are made to uproot.

This wall of silence is hidden in the medium of communication. In proposing the significance of incorporating the subject of HIV and AIDS into universities in Africa, Kelly suggests that the nature of universities as “thinking-caps” of society is important. They provide resources and freedoms to do the hard work of reflection on society's behalf, and this is immediately needed in relation to HIV and AIDS (2003:5). He says this is because improvement in the understanding of HIV as a virus and of AIDS as a biomedical condition has helped in the development of antiretroviral (ARV) therapies that may, in time, produce therapeutic and preventative vaccines. However, he hints that “there has been no corresponding growth in the understanding of HIV/AIDS as a social phenomenon or intellectual challenge. The disease continues to flourish behind a wall of silence, while fear of stigma and discrimination prevents its being brought out into the open by those living with the disease” (2003:5). Kelly mentions the lack of *appropriate communication* that takes cognition of the culture of the people. The wall of silence operates within this communication vacuum:

The discourse of AIDS is characterised by a language of conflict and struggle that works in synergy with a language of exclusion, leading to a dehumanisation of affected or infected individuals and a marginalisation of HIV/AIDS concerns. For over two decades, information, communication, and education campaigns have attempted to influence AIDS-relevant behavior but have failed because they were based on

⁷⁶Kwa Mashu is a township of Durban, South Africa where in 1998 a 36-year-old Gugu Dlamini was stoned to death by several men for breaking her HIV silence by publicly declaring her HIV positive status in an AIDS awareness gathering.

inappropriate communication models and did not take adequate account of cultural and spiritual values (2003: 5-6).

To expose this wall of silence hindering the efforts to battle against HIV and AIDS, culturally appropriate communication is needed. This is because, as we have seen in chapter 3, there is a powerful relationship between culture and silence, and only communication codes familiar to a particular culture will be able to engage with it and thereby expose it, so that it may be 'broken'. Therefore an important aspect of the quest to break the wall of silence that hinders efforts to provide HIV prevention, education and care for people infected by the virus, is having appropriate communication skills that respect the coded and uncoded elements of a specific culture. This means to break the second wall of silence on HIV and AIDS, recognition must be given to the fact that it is in the form of fertile (coded) and barren (uncoded) silence and that the various dimensions of culture contribute to it. Practitioners and activists in the field of HIV therefore need to be learners to acquire the knowledge and skills that take cognition of fertile and barren silence. In the light of this, Lessard-Clouston advises that "learners will also need to master some skills in culturally appropriate communication and behaviour for the target culture. Finally, cultural awareness is necessary if students are to develop an understanding of the dynamic nature of the target culture, as well as their own culture" (1997: para. 25).

From the discussion above it is clear that the wall of silence can and should be examined within the various dimensions of culture that we discussed in the previous chapter, within which the appropriate communications operate. Sithole and Dastoor (2004) bring this out through their study of the national culture of South Africa. They undertook an all-inclusive examination of the cultural values of South African national culture by surveying Whites, Coloureds, Asians, and Blacks, knowing that Geert Hofstede's (1980) was a result of a study that surveyed white English speakers only. In this study, the writers agreed that the dimensions of culture pointed out by Hofstede are an important instrument for culturally appropriate communication styles:

The study also tested whether or not there are cultural differences between Whites, Coloureds, Asians, and Blacks in South Africa. This up-to-date information on South Africa's multi-cultural background and its collective

influence on its national culture has several potential benefits. It can provide both the scholastic and corporate world with better insights into the dynamics of the new South African society and its culture. It relates to appropriate communication styles, recruitment, training, promotion and indeed the profitability of local and multi-national companies operating in the country (Sithole and Dastoor 2004:110).

We will therefore look at how the HIV and AIDS silence is located within the four dimensions of culture proposed by Hofstede that we considered in Chapter 3, (we noted that the silence derived from Hall's dimension of 'time orientation' merges into Hofstede's uncertainty avoidance dimension.) This will be done by employing analysis of the field data on how the various dimensions of culture contribute to the barren silence.

4.3 The Dimensions of Culture and the HIV and AIDS Silence.

One of the major gains of the Durban HIV and AIDS International conference was the awakening of policy makers to their obligations in being a major part of the fight against HIV and AIDS⁷⁷. Indeed it is good to have policies in place at the senior national and international level, to help break the silence surrounding HIV and AIDS. However, it is more important to recognise the many impediments to assisting the ordinary man or woman in the street, in a township, or on a bush path in a village, to understand these policies. Looking at what Jonsson has to say about breaking the silence, the point we made above holds that the 'second wall of silence' – indicated in this thesis as barren silence, surrounded by a thick fertile silence – that needs to be exposed is that springing from various dimensions of culture. This assertion can be substantiated from the issues Jonsson raises when dealing with ways to break the HIV and AIDS silence at grassroots level. He considers this assertion as the Second Wall of Silence.

4.3.1 High/Low-Context and the HIV and Aids Silence.

Jonsson firstly posits the "Second Wall of Silence" hindering the fight against HIV and AIDS in the social context of the people. Specifically he says: "These walls reflect the social context in which individuals construct and re-construct their roles. These walls

⁷⁷ See Africa Action (www.africaaction.org)

hinder necessary development and information. These walls must be removed in any successful fight against HIV and AIDS.” (Balch and Hollenberg 2002:9). This point raised by Jonsson is consistent with Hall’s concept of High/Low-context within which we have located the existence of barren and fertile silence, in a continuum. Specifically we have discovered the existence of mainly fertile silence, surrounding a small barren silence, in the area in which this research is carried out. The cultural dimensions proposed by Hofstede contribute in various ways to this silence. In our study we see Hall’s insight into the matter showing that the social context of any culture affects the transmission of information within the community. In reflecting on Edward and Mildred Hall’s 1990 work of *Understanding Cultural Differences*, Gannon relates Hall’s work to the social context:

His theoretical framework also includes a concept known as the context of culture or communication. Basically Hall argued that there is a continuum extending from a low to high degree of intense socialization within cultural groups. According to Hall, low socialization requires a culture in which information must be transmitted orally and/or in written form, since members do not otherwise know what to do. High socialization indicates that messages are transmitted subtly, since everyone knows what to do. For example, one Japanese saying is "silence is communication," which means that group members know what to do based on the length of each silence. While the same amount of meaning can be conveyed in a low-socialized or low-context culture as in a high-socialized or high-context culture, the means would be different. Germany and the United States stand at the low end of Hall’s context dimension while Japan and Saudi Arabia are on the other end (2001:71).

Dissemination of information is a key factor in any meaningful attempt to fight the HIV and AIDS pandemic, to reveal or expose any form of silence around the disease. It is important that people, locals and visitors alike, understand how information is transmitted within the community so as to ensure that everyone understands the issues at hand.

In assessing whether or not the cultural context of the people contributes to the HIV silence, 78.5% of those who answered the questionnaire, indicated that the culture of the

people does contribute to the HIV and AIDS silence. The results of the interviews (*see*: Appendix 5C1 - Appendix 5C9) and the focus group discussions on the issue (*see*: Appendix 5J1) also indicated that culture contributes to the HIV and AIDS silence. These responses confirm that culture is perceived to be a major contributor to the silence.

In a high-context culture such as our area of focus in this study where there is a strong element of fertile silence, information is expected to be available to all people but in a coded form. It is therefore incumbent upon the information seeker to decode meaning from whatever signals he or she is receiving. Until the information is decoded and exposed, it remains silent, even though, it may be physically evident before your eyes. In this cultural setting, people are usually not explicit or specific in what they say (Hall, 1977:113). This situation was confirmed in the interview with the CCP staff person. She said that the culture of people includes subjects that are not to be spoken about in public, which means they are coded and not in the public domain. Issues such as sex are seen as taboo subjects and have to be coded in words that those within the context can understand. In this regard she said “There are taboos that create silence around the disease. A number of things are considered as family matters. An issue such as sex is one that is considered taboo to talk about in public. Since everyone in the community considers HIV and AIDS as a sexually transmitted disease, this means that it cannot be discussed publicly; nor can one publicly discuss witchcraft as it too is linked with the disease” (*see*: Appendix 5C9). Baba Ernest Zikhali likewise intimates that it is unacceptable and shameful to talk openly and blatantly about issues considered taboo in the culture. The best one could do is to use proverbs or symbols to present them publicly. He says using this procedure draws people to listen to you and have confidence in you. When the confidence is built, you win the people and gradually introduce open and frank discussions (Personal interview, 20-09-2004).

With a significant majority of the respondents affirming that the culture of the people contributes to the HIV and AIDS silence, they were asked to justify their assertion with ways in which they see culture contributing to the silence. Of the 53 respondents, the inability of the elderly to speak openly with the young ranked highest with 22.6%, followed by lack of openness on sexual issues with 18.9%, then judgmental attitudes with 13.2%, myths and beliefs 11.3%, taboos and its consequences 9.4% and belief in

witchcraft also with 9.4%. All the reasons put forward, apart from judgemental attitude, are taboo issues. Such issues cannot be presented openly, but rather in symbols, giving rise to a barren silence and a fertile silence on the issue.

Our study has pointed out that silence is culturally specific. Jaworski (1993:22-23) has also pointed out that silence may be both situation-specific or culturally-specific. The silence that emerges in the HIV and AIDS situation can be both situation specific and culturally specific and leads to anxiety. The HIV and AIDS situation causes anxiety in infected people as well as affected families, and may give rise to silence (Jaworski 1993: 21). Referring to research undertaken in schools, Jaworski pointed out that high levels of anxiety in the classroom are likely to be manifested in silence, regardless of the cultural backgrounds of students and the teaching objectives (1993:21). Jaworski's work shows the potential that HIV and AIDS have to create silence.

Now, when one contracts HIV in a high-context environment, such as that of our research area, the likelihood of keeping silent about the disease is high. With a disease which carries with it stigma as well as physical symptoms which show that one is not well, people infected in high-context cultures will tend to be furtive, to expect others to discern that they are not well. In this way the culture itself demands a subtle or restrained transmission of information. This means that a high-context culture is good soil for keeping HIV and AIDS issues concealed. Keeping silent over issues may not be intentional but a way of life which is underpinned by various dimensions of culture that support a fertile silence. This situation has to be understood by anyone seeking to help break the HIV and AIDS silence with which our communities are faced. Focus group discussions with people living with HIV also provide insights from their own experiences into the way that culture contributes to the silence. They pointed out "In our culture, any disease that is linked with sexual intercourse is stigmatised and the same applies to a disease that has no cure. Incurable disease is linked with witchcraft and so when people know you have an incurable disease, they will shun you and you are alone. In this case when one has got HIV or AIDS she or he will not mention it. It is in our culture to save the face of the family and so you will not tell family members for fear the elders will question your behaviour before they can protect you or help you" (*see*: Appendix 5J1).

In order to break the HIV and AIDS silence in high-context cultures, both people within the culture and those coming from outside need to understand that a high-context culture has a strong element of fertile silence. It is “characterised by relying less on verbal communication and more on shared experiences, history, and implicit messages. High-context cultures pay attention to non-verbal cues, rely more on hierarchies, and may perceive excessive talking as insensitive. Also, high-context cultures respond to pressure by speaking less, making less eye contact, and withdrawing from interaction” (Alameda 2005:3). This being the case, in a high-context culture, people who are themselves HIV positive and are under a lot of pressure socially as to whether or not to make their status known, are likely to be silent about their situation, keeping barren silence about it and rather presenting other things (fertile silence) that are not related to the disease. As will be brought to light in Chapter Six, people who are themselves living with the disease need to be engaged with through relationship building for them to open up and break their silence.

Barren and fertile silence are displayed in various ways by individuals infected with the disease and their families. In the questionnaires and interviews, respondents were asked to indicate what infected individuals and families do to keep the disease a secret, besides not talking about it. The results showed that most infected people, even when they know that they have tested positive to HIV, ascribe their sickness to witchcraft, in the knowledge that others will not question spiritual issues. In this case, there is a barren silence on the HIV issue itself. There is no communication about HIV or AIDS and there is no discussion around it. However, there is a fertile silence, presented in the form of witchcraft, through which people are able to discuss the health of the individual that will expose the barren silence on HIV and AIDS that we desire to break.

It was found that when seeking medical attention for their HIV and AIDS problem, some people will attend hospitals and clinics far from where they stay, or they will seek help with private doctors instead of public ones, in order not to be seen by neighbours or familiar people in the community. Here too a barren silence on HIV is created whereby as a result of HIV, a person does not attend the clinic or hospital that he is used to and familiar with, rather spend more money perhaps in private clinics and transport fares to avoid being seen by familiar people who will suspect him. When one is far away

attending clinics and hospitals away from home, that new environment creates a fertile silence for other people to use to interact with the patient. Discussions with the Support Group members revealed that most PLWHAs who attend clinics for ARVs, try to hide their medicines from the rest of the family to avoid being questioned and suspected.

Some of the Support Group members indicated that they use Bible holding bags to collect their medications at the clinics. This serves two purposes. The one purpose is to prevent anyone at all from knowing the kind of medication they have collected. Secondly, (which is a shockingly new evidence) is to prevent criminal and drug abusers from attacking them. It was revealed during the in-depth interviews with some of the support group members that some young people abuse ARVs – Stocrin. They revealed that these youngsters mix these ARVs with dagga or tobacco and smoke them. In this case some of these young people hang around clinics and attack people they suspect to have collected these ARVs. A search through the internet confirmed this situation happening elsewhere in Kwazulu Natal:

Efavirenz is one of the anti-retroviral drugs, called ARVs, that are used both here in South Africa, which has one of the highest HIV infection rates in the world, according to ABC News. The KwaZulu-Natal province, where “Nightline” viewed the effects of Efavirenz on a teenaged addict, has a 40 percent HIV infection rate.

Efavirenz is a potent nervous system stimulant marketed under the name Sustiva, and it’s “really a pivotal drug in places like South Africa” says Dr. Daniel Baxter, chief medical officer at the Ryan Community Health Center. Abusing the drug began several years ago in South Africa, Baxter says. He says there have been instances in which an AIDS or HIV patient in South Africa has had the prescribed drug stolen from them by a gang as they left the pharmacy. The drug might then be mixed with other substances and offered to mostly poor, young South Africans, Baxter says (Black 2009).

Another report from Health Jackal, Jacksonville says “KwaZulu-Natal, South Africa teens are increasingly abusing the anti-retroviral drug, Efavirenz, by crushing it and smoking it to get high. The drug, which is used to treat cases of HIV, has no medical

benefit when smoked, is causing more and more teens to become addicted and people are seeming to look the other way when it comes to the teens and this drug” (healthjackal 2009). The report further points out that abuse of the drug is becoming cause for alarm to authorities and specifically mentions Dr. Njabulo Masabo, of the AIDS Healthcare Foundation, who retorted: “It’s extremely ... discouraging because on one end you’re trying to fight this epidemic that has ravaged the world so much ... the results are catastrophic.” (Health Jackal 2009).

Respondents indicated also that some infected people, in a bid to hide the disease, avoid discussions on HIV and AIDS and become defensive of HIV issues or change the subject any time it is raised. Even in situations where they seek information, they ask personal questions as if they are asking on behalf of their friends. Some even go to the extent of hiding in their homes during most of the day.

Though most people do not inform family members of their HIV status, the respondents indicated that when family members get to know of the status of their relative who is HIV positive, they give their support, including even helping them to keep their status a secret. In an interview with the youngest Support Group member it was revealed that the family of the infected person do not want one to tell anyone else of the relative’s condition. Family members would do anything possible to keep the disease a secret. He indicated that even when the relative was sick and in the bedroom, family members would tell people that the sick person was away elsewhere. Respondents pointed out that sometimes family members accuse neighbours of bewitching the infected person. Family members do they very same things that an individual does to keep the disease a secret.

The key underlying cultural behaviour of high context cultures of saving the face of the family, contributes a lot to these various ways of keeping the disease a secret, resulting in silence. In some cases it is the natural thing to do for the sake of one’s family. In this case people from high-context cultures themselves need to be helped to understand these aspects of their behaviour. Because it is part of their make-up and life they do not see anything wrong with it. Even in situations where one needs to run to seek help, the natural inclination here would be to recoil into one’s shell and withdraw from any interaction. One may not know that help is needed in one’s life.

People from outside the culture who seek to offer help in breaking the HIV silence within the culture must also understand the fertile silence of the high-context culture as well as the withdrawal norms; and they must develop ways of building relationships, as this is a key component of engaging and exposing silence to be broken. Relationship-building for the sharing of experiences leads to people opening up to being helped. This is exactly what Morrell (2003) discovered in his research in schools in KwaZulu-Natal which included 97% of learners who spoke Zulu as a home language. Looking at the subject of silence, sexuality and HIV and AIDS, he openly confessed that the reluctance to talk about AIDS was his personal initial experience of silence. It was when he later built a relationship with the people that they collaborated in the research. He points out that all his direct questions to groups big and small yielded the same order of answer: that AIDS was a problem. Yet he was confronted by silence about the disease with people initially reluctant to talk about it (2003:43). Through his work he came to the conclusion that: “The silence around HIV status is not the only silence that bedevils efforts to limit HIV transmission. In many schools there is a culture of silence. Certain subjects are taboo for discussion and teachers and learners are guarded, unable or unwilling to reflect personally on issues of gender and sexuality. Such school cultures seriously undermine AIDS prevention initiatives and place learners and teachers at risk of sexually transmitted diseases and HIV and AIDS” (2003:42).

Though Morrell may refer to this silence around HIV and AIDS as “school culture”, I see it as the demonstration of a high-context culture of the people, as a barren silence that lacks communication surrounded by a thick fertile silence that needs to be engaged with and exposed through interaction and relationship building. No wonder the results of the case studies and interviews, as well as the various programmes conducted by Morrell, revealed that after he had related to and engaged with the learners on a human relational level, they opened up and exposed the silence surrounding HIV and their sexuality. It is this same result that CCP interventions achieved in getting infected people to disclose their status (see chapter 6 below).

It is clear from the above that, generally, the silent nature of a high-context culture is seen in the HIV situation. The field research has shown the existence of barren silence and fertile silence around HIV and AIDS. The field study as will be seen in Chapter six

indicates that through interactions with the people infected and affected by HIV and AIDS and building of trust one is able to engage with the fertile silence and expose the barren silence to be broken. It is therefore important to note that the social context of the people has a significant role to play in the HIV and AIDS silence. It must be pointed out again, as we saw in Chapter 3, that the other dimensions of culture works within the high context dimensions. In this case, all the manifestations of barren and fertile silence demonstrated in the high context situation, cuts across the other dimensions of culture to be considered below.

4.3.2 Uncertainty Avoidance and the HIV and AIDS Silence.

Jonsson's concern for breaking the wall of silence around HIV and AIDS can be seen in the area of uncertainty avoidance, which springs from the cultural orientation towards the future, and which has a bearing on the levels of risks that are taken. As we pointed out in the previous chapter, most cultures in Africa have low uncertainty avoidance and with this comes fatalism. In the understanding of many traditional Africans, all time is reduced to the now - and not the future. A popular proverb in Ghana says: "The future is unknown". It is interesting that Jonsson raises issues that link with HIV and AIDS and uncertainty avoidance when he says:

We all know that sub-Saharan Africa with less than 5% of the world's population has 75% of the HIV and AIDS problem, and that Eastern and Southern Africa has the largest portion. This fact requires an answer on why HIV has spread so fast in sub-Saharan Africa. We cannot avoid any longer to try to answer this question. First, poverty is definitely one of the key factors, creating fatalism and a special world-view ideology that 'we will all die one day'. The extended time between infection and disease seems long enough to allow other factors to cause death (Balch and Hollenberg, 2002:10).

No doubt poverty is an issue that drives HIV infections.⁷⁸ However, Booysen and Summerton, whose study specifically targeted women, and who agreed that women are more at risk of HIV infections, say "There is little evidence that poverty is associated

78 See Centre for AIDS Development, Research and Evaluation (Cadre) 2000, Human Sciences Research Council. 2002. Booysen, Frederik le R. and Summerton, Joy 2002 Casale, Marisa and Whiteside, Alan. 2006

with risky sexual behaviour, although poorer women are slightly less likely to have necessary knowledge on HIV and AIDS, which, of course, in itself increases the vulnerability of poor women to HIV” (2002:287).

What Jonsson calls ‘a special world-view ideology’ is the risky nature of the African culture emanating from its low uncertainty avoidance dimension. A low level of uncertainty avoidance has, attached to it, a high level of fatalism and high risky behaviour in the African culture. This was affirmed through the field work. When asked if uncertainty avoidance contributed to HIV silence, 90 % of the respondents to the questionnaire answered “yes” while only 10% answered “no”. This response suggests that the high risk-taking behaviour of the people or the low uncertainty avoidance dimension of the culture contributes to the HIV and AIDS silence.

Respondents advanced various reasons why they think that uncertainty avoidance contributes to the HIV and AIDS Silence. 45.3% of respondents believe that, as a result of uncertainty avoidance, people take risks and when infected, they remain silent about their status, thinking things will be better with time. 28.3% of respondents think people employ a carefree and fatalistic attitude and keep their infection status to themselves. 20.8% of respondents fear being questioned about their carefree and risky life and so remain silent about their situation. 5.7% of respondents think people are ignorant and as a result of the low uncertainty avoidance nature of the culture, they simply move on with life, maintaining silence about what they are going through.

In suggesting a reason why taking risks contributes to the HIV silence, a Support Group member in an interview said: “When you are sexually active you don’t mind the risks you take and you have sex for fun and financial gain and because of the money you get you become disrespectful to those who can help you and so when you get HIV, you dare not say anything to anyone” (*see*: Appendix 5G1). In the same line of thinking, the pastor during the interview said that when people have taken risks and things do not go well, they are ashamed to expose their folly. She said even though most people are not very well educated on HIV and AIDS issues, they are aware of the dangers of being infected with the disease. Yet, because they live in a state of perpetual poverty they will do anything for money. Even when this includes risking their lives, they persist with any

money-generating activities. She concluded that in all this when they contract HIV through these activities, they do not want anyone to know the negative results of the risks they have taken, and are ashamed of themselves (*see*: Appendix 5C7). In our case study with Thuli, it was encouraging to see her come through her illness as she became part of the PLWHA that CCP looked after and she joined the Support Group. However, the power of risk-taking became evident when she returned to her old way of life. She began going out with the boys, and failing to take her medications regularly although she knew that her life depended on them. It was the low uncertainty nature of the culture which usually exhibits itself in risk taking that made Thuli live in denial of HIV, going back and forth with the realisation that she was sick. This observation made the CCP staff point out the following as they tried to find a way to help her:

- She has been in denial and doesn't accept she's really ill.
- She has been sick and got better too many times and so takes her health for granted.
- She does not realise how sick she is.
- She has been stubborn and difficult on a number of occasions (*see*: Appendix 5B2).

Some of the Support Group members in responding to the question of the low uncertainty nature of the culture indicated some issues that puts Thuli's situation in perspective: "As a result of the risky behaviour we have grown up with, we don't listen especially when we make up our minds that we want some stuff and realise that you will fall into HIV. Then when you get HIV, you feel so defeated that you don't want to talk about your status to any one". Others said that when one is sexually active one doesn't mind the risks one takes. When one has sex for fun and financial gain, one becomes disrespectful to those who can help. So when one gets HIV, one dares not say anything to anyone (*see*: Appendix 5G1).

It seems that with risks-taking being part and parcel of the culture, people do not take notice of the consequences of the risk they are taking. In the era of HIV and AIDS the risk factor is a serious impediment to breaking the barren silence. When people are told of their positive HIV status, they take further risks in keeping silent about their status,

instead of seeking help. It is for this reason the CCP staff member who has worked with many PLWHAs lamented: “People of my culture are high risk-takers and this also contributes to the silence around HIV. This behaviour contributes to the higher rate of infection as people do not stop to consider the risks that their behaviour brings to them. Most people have heard about HIV from different sources, and yet they have unprotected sex and contract HIV, thereby risking their own lives. By this they gamble with their own lives. Even when it comes to the silence on the disease, both the infected and most families take risks by remaining silent when they know there is help available to them. They allow what they call ‘family pride’ to take preference over the lives of people” (*see*: Appendix 5C9).

This furtherance of risk taking after being infected leads to fatalism. Fatalism is the feeling that one cannot have control over the future or change anything. As some of the pastors pointed out, “when people are told that they are HIV-positive, there is a fatalistic attitude of saying ‘everyone will die anyway, so what can I do? Let things sort themselves out’” (*see*: Appendix 5D1). Some of the caregivers on their part said a lack of concern about the future makes people take risks that lead to HIV infections. These people are only concerned about the “now”. They become fatalisti saying that death can come any time, anywhere, through any means and so are not concerned about HIV. And since these people are vocal about their stance, when they get infected they keep it a secret (*see*: Appendix 5F1).

The issue of women in this situation of low uncertainty avoidance and high risk-taking, demands special attention. The need to help people, especially African women, to avoid risking their lives in the era of HIV and AIDS cannot be over emphasised. Risks, even if they are calculated risks that take cognisance of social factors rather than one’s own health, have the potential to perpetuate the silence surrounding HIV and AIDS. Thus, for example, exposed to a variety of risks, women will weigh up the situation and make their judgement based on social disgrace avoidance. By this they avoid situations that will bring shame on the family even if it means risking one’s life. Issues that are linked with shame and taboos are considered worth taking risks for and people will keep silent about them. In their article “The Culture of Silence: Reproductive Tract Infections among

Women in the Third World”, Dixon-Mueller and Wasserheit throw light on the risks that women face:

It can be very difficult both for women in non-marital relationships as well as for married women to ask a man to be tested for an STD, to seek treatment, or even to use a condom, especially where the use of condoms connotes prostitution. Fears of social consequences often take priority over fears of health consequences, making infected women reluctant to inform their male partners of their diagnosis, and non-infected women reluctant to inquire about the health status or other sexual involvements of the men they are with. For many women, the perceived risk of being beaten, divorced or abandoned, or of losing a source of emotional or financial support, far exceeds the perceived health risk of acquiring an STD (1991:13).

In the overall responses to ways through which uncertainty avoidance contributes to the HIV and AIDS silence, it was found that: i) 46.34% of women, compared to 19.51% of men, considered taking risks and keeping silent in the hope that things will be better; ii) 44.44% of men, compared to 33.33% of women, considered carefree and fatalistic attitudes as a key factor. This confirms that for fear of social consequences the existence of gender inequality and power distances (that will be considered below) women will risk their lives in the era of HIV and AIDS. They even have a considerable level of showing carefree and fatalistic attitudes. Men on the other hand assume care free and fatalistic attitudes. 26.83% of them feared of being questioned about carefree risky life compared to 22.22% of women.

The low uncertainty avoidance and risk taking culture which we are working with contributes to the barren HIV and AIDS silence through fatalism, a carefree attitude and a fear of being questioned about one’s risky life. The various fertile silences that are exhibited, must be engaged through relationship building for the barren HIV and AIDS to be exposed and broken. Chapter six will look at how this could be done.

4.3.3 Individualism/Collectivism and the HIV and AIDS Silence.

In his endeavour to provide ways for exposing the wall of silence around HIV and AIDS, the next issue that Jonsson raises is that responses to HIV and AIDS have long been

dominated by perceiving the disease as an individual problem. The wall of silence around HIV and AIDS is one we have considered to be a barren silence and surrounded by a large fertile silence. Here he was pointing to one of the major dimensions of culture which needs to be considered when dealing with HIV and AIDS, namely the cultural dimension of individualism/collectivism.

As we saw in the previous chapter, in the individualism/collectivism continuum, African cultures are more collectivistic. Jonsson's point is therefore a reminder that in cultures such as those in Africa, focussing on the individual when dealing with issues of health, such as HIV and AIDS, does not work:

This has led to health-services interventions and communication efforts to change individuals' behaviour. Most of these efforts have failed. It is high time that we recognize HIV and AIDS as primarily a social problem. Individuals have serious difficulties to change their behaviour in the context of poverty, gender exploitation and peer-group pressure. The social context determines individual behaviour and not the other way round (Balch and Hollenberg, 2002:10).

Jonsson's point of recognising the wall of silence around HIV and AIDS as a social problem, to be tackled within the social context rather than with the individual, also acknowledges the various cultural contexts within the social context. Theissen notes that: "Cultural context is always at the same time "social context." If we want to place special emphasis on this social aspect, we can limit the general concept of "cultural context" a second time and speak of "social context" as a special form of "Cultural milieu." (2004: 10). Our cultural context, which could be seen as the social context, harbouring this wall of silence therefore is one of collectivism. In most cultures in Africa, dealing with silence around HIV and AIDS cannot be in the context of the individual as:

Culture plays a vital role in determining the level of health of the individual, the family and the community. This is particularly relevant in the context of Africa, where the values of extended family and community significantly influence the behaviour of the individual. The behaviour of the individual in relation to family and community is one major cultural factor that has implications for sexual behaviour and HIV/AIDS

prevention and control efforts. As the impact of HIV/AIDS in Africa remains unabated, a culture-centered approach to prevention, care and support is increasingly recognised as a critical strategy (Airhihenbuwa and Webster, 2004:4).

Any strategy of exposing the second wall of silence must be considered within the collective rather than with just the individual. When respondents were asked, through questionnaires, as to whether or not the communal behaviour of the people of the culture contributes to the HIV and AIDS silence, of the 78 who answered, 91% agreed that communalism contributes to the HIV and AIDS silence while only 9% disagreed. This response by the overwhelming majority of respondents saying “yes” to the question indicates that the cultural dimension of communalism does contribute to the HIV and AIDS silence and must therefore be considered if we are to expose the barren silence.

Silence in the collective culture of the area we are researching, results from the spirit of *ubuntu* that attract members to each other. *Ubuntu* emphasises the reality that the fullness of an individual can only be ascertained within the association of family and community relationships. In this manner individuals have to uphold the principles of *ubuntu* by being loyal and committed to family and community values. Strict adherence to cultural norms and taboos is maintained in order to save the face of the family and community (Hostede 1997:61). This also recognises the family as one unit, within which members share the pains and joys of each other. The focus group discussion with the Support Group members revealed that the practice of *ubuntu* makes people ready to offer help when the sick person needs it. At the same time the help does not come, because the culture does not have a way of teaching people about modern diseases and always links diseases to traditions that expose the sick person to ridicule when he or she is not getting well (*see*: Appendix 5J1). This situation leads to many ways in which the community nature of the culture of the people contributes to the HIV and AIDS silence, which must be looked into and exposed.

To help us look into this situation and explore how the collectivism dimension of culture impacts on the HIV and AIDS silence, respondents were asked an open-ended question to explore ways in which the community nature of the culture of the people contributes to the HIV and AIDS silence. Of the total of 68 respondents, 42.6% pointed out that because

of the community nature of the culture, people gossip among family members or community. 29.4% said the communal nature makes it possible for infected people to encounter stigma from family members or community. 14.7% of respondents said people communicate issues on HIV easily without proper education on the subject. 13.2% of respondents said HIV-positive people are suspicious of the community. All these factors make people who are HIV-positive and to some extent family members, keep silent about the HIV situation they face.

Issues of gossip are very common among the people as people in communities easily get information and start telling others without the expressed permission of the one who gave the information. The interview with the young woman revealed how through gossip, she got to know that her mother was dying of AIDS and so when her mother passed away, she was in denial for a long time (*see*: Appendix 5C11). Because of the lack of proper education on the disease in the community, gossipers spread wrong information which leads to infected people being discriminated against or sometimes being abused. This confirms the Penn State Public Broadcasting (PSPB) finding that the lack of education about the disease in Africa has contributed to its spread, as people are stigmatised and discriminated against. Therefore those who are infected keep silence, leading to Africa having about 12 percent of the world's population living in it and yet having 83 percent of all AIDS-related deaths (2004: 13-14). In hailing the principles of ubuntu, the CCP staff member in her interview outlined a number of issues that lead to gossiping, stigmatisation and discrimination – the backbone of HIV and AIDS silence in the community:

Ubuntu and the caring nature of the African culture is gradually fading away. Even though the spirit of helping others is there, people are inquisitive and eager to know what is wrong with them. Since community members know the seriousness of the HIV but lack proper education, when people, through the practice of ubuntu, learn that one is HIV-positive, they gossip about it to others. For this reason infected people are not willing to disclose their status until they are confident that the person they reveal their status to, will not stigmatise, discriminate or gossip about them. Most people these days, with the shift to modernisation, do not have the real ubuntu spirit of genuinely wanting to care for sick people, though it is in their blood to help.

Because the real ubuntu is not there, gossip easily overcomes that innate desire to help a sick person (*see*: Appendix 5C9).

In the interview with the female pastor, she pointed out that in the community when someone is known to be HIV-positive, for lack of education, “people shun away from the person and even make sarcastic comments in the face of the person. In this case people would rather keep silent about their status, saying to themselves that if they tell people they will be silenced by the behaviour of people and so why open up” (*see*: Appendix 5C7).

Different Support Group members during interviews shed light on the various aspects of how the ubuntu and communal nature of the culture contributes to silence on the disease. For a male Support Group member, the communal nature of the culture leads to rumour-mongering and gossiping, which leads to stigmatisation and discrimination. As a result infected people keep silent about their status (*see*: Appendix 5C1); A female Support Group Member said ubuntu “makes it easy for people to interact with you and listen to what you have to say, and they go and share with others and before you know, everyone is pointing a finger at you. Because of this you keep silent on issues relating to your HIV status (*see*: Appendix 5C2); A young Support Group member pointed out that the African culture makes people willing to help a person when she or he is sick because they know that when it is their turn to get sick that person will be there for them. But the respondent said when these sympathisers find out that a person is HIV-positive or has AIDS, they know that the person is dying and will have nothing to contribute back in the lives of others, except to give them HIV; so they stigmatise the infected person. He therefore concludes that ubuntu is good but it makes people eager to know more about the lives of others before they are ready to hear what others have to say. (*see*: Appendix 5C3); and a Female PLWHA (Non-Support Group Member) also said, the communal nature of the culture leads to a lot of gossip within communities and this leads to stigmatization and so people who are HIV-positive would not open up even if people show their ubuntu and caring natures. It is only when they build relationships with people and trust them that they can open up (*see*: Appendix 5C5).

Another aspect of the collective culture that promotes the silence that surrounds HIV and AIDS is the pressure on individuals to maintain the sense of belonging they have in the in-group. As a major source of one's identity and belonging, providing security for life, one is expected to give back lifelong allegiance and commitment that will not bring the family's name into disrepute (Hofstede 1997:50). In the Zulu culture, premarital sex is said to cast shame on the family. It is for this reason that Khathide says "in South Africa, among the amaZulu – a people whose culture I am closely associated with – people know what is culturally acceptable as right. For example, a young woman who is discovered to have lost her virginity before the wedding is said to have caused *ihlazo* (shame) for her people" (2003:2). When one is infected with the HI virus, which the community knows is an STI, the one knows s/he will bring shame to the family if it is known. This will constitute disloyalty to the family.

It is for this reason that some of the Church Trainees said "In our community the only thing those elders know about HIV and AIDS is that you get it through indiscriminate sexual encounters, and so if you tell them you are positive they see you as an outcast who does not deserve to stay in the family and you will be chased. Some are even killed for their status" (*see*: Appendix 5E1). During the focus group discussions, the Support Group members also pointed out that the relationship between the older generation and younger generations is not smooth, as the elders are always suspicious of the behaviour of the young. This makes the young afraid to let the elders know that they are HIV-positive as their sexual behaviour will be questioned. They noted as well that in the culture, any disease that is linked with sexual intercourse is stigmatised as a disease that has no cure. An incurable disease is linked with witchcraft, and so when people know that one has an incurable disease, they shun the sufferer and he or she is left alone. Because of this, when one has got HIV or AIDS one will not mention it. They confirmed "It is in our culture to 'save the face' of the family and so you will not tell family members for fear the elders will question your behaviour before they can protect or help you" (*see*: Appendix 5J1).

As a result of the shame associated with the stigma, and the fear of being associated with the stigma and discriminated against, the research by *Journ-AIDS* also indicates that a person who believes that he or she is infected with HIV might not even want to be tested or seek treatment, because of the fear of other people's response to their situation. The

report quotes a woman living with HIV as saying: “Some PLHAs just cannot find it in themselves to disclose because of the stigma. They just have so much to lose - the respect of their community and family. Their friends will reject them. So they live in silence. It is an enormous burden to be scared of stigma” (Journ-AIDS, undated).

In a collectivistic culture such as that of the amaZulu, the way children and the young are treated within the family also promotes silence around HIV and AIDS. The power distant nature of the culture combines with its collective nature to place children at the bottom of the ladder of attention. It is customary for children to learn in silence and not to ask questions. Thus in a tourism brochure describing Zulu culture we read:

Children learn to show respect to their parents and all elders from an early age (with the help of a good hiding as a ‘tool of coercion’ if necessary). It is the mother’s sole duty to raise the children and teach them respect and their place within the family. Children quickly learn that entering the men’s world is only allowed by invitation or when told to do so. All instructions given are carried out quickly and are received on one’s knees, respectfully and silently (though nowadays, if you bend over, it is acceptable: the respect is the most important thing). In rural areas, no child may address an adult unless first spoken to (even when sent to give a message, you may not just barge in and deliver the message, you wait until you are addressed or acknowledged) (Zululand Eco-Adventures, 2007: para. 23).

In this case children or the young person cannot ask questions even when they are at risk or when something is bothering them. The relationship between young people and their fathers is very formal, where the mothers act as go-between in the communication between children and fathers (Strelitz, 2001: para. 3). Strelitz’ point and the silence that it creates is illustrated in an interview he had with Khulani, a male student at Rhodes University, who grew up in a strongly traditional Zulu family in Empangeni in Kwa-Zulu Natal:

If I’m maybe short of money, I have to go to my mother. If my mother has passed away, my father will have to get another wife to supplement. If I’m short of money, I can’t go to my father because that would be so rude. So I

have to go to my mother. My mother is a liaison officer...so there's that distant relationship between ourselves and our fathers. I think with our mothers we are so close because each and every time we share our problems. I can't go to my father with any problems. I can ask from him, but only through my mother. My mother will liaise on my behalf. We do not call our fathers by their names, or any elder person by their first names because that's being disrespectful. We also don't look at them in the eye as this is also seen as a sign of disrespect (Strelitz, 2001: para. 4).

With this in the era of HIV and AIDS, where there are a number of orphans, these children and young people have lost their mothers and have nobody to intercede with their fathers on their. In such situations grandmothers or other caregivers take over. Orphans are more silenced through the practice of *ukuhlonipha* (children becoming silent participants in family issues (Denis, 2003:7). According to Denis, within this HIV and AIDS silence, the child's psychosocial situation worsens as the grandmother or caregiver assumes that if child does not ask questions he or she does not have concerns to discuss, or his or her silence is attributed to being young. Possibly, in actual fact, this child could be consumed with many thoughts by knowing more than she or he is able to divulge about the parents' condition: "Sometimes children overhear adult conversation or, more simply, they discern the truth by discussing matters with peers. Some children, for example, know that their mother is HIV-positive even though the issue was never discussed openly in their presence" (Denis 2003:8-9).

In this research young people were asked about what makes it difficult for them to disclose their HIV status to older people. Among other things, they said that if a younger person told an elder that s/he was HIV positive there is the fear that the elderly people would consider the young person as a living dead, thereby being discriminated against. They said that parents could chase the infected one from home if told and will not give money to the child. Some elders may shout at the young persons and accuse them of prostitution. Such a situation causes the elders in the community to be ashamed of such young people. The young also said they do not disclose their HIV status to the elderly because the latter do not have any training on HIV to help them understand the disease. According to the young people, it is not culturally acceptable for the young to go to the

elderly and disclose any sexually transmitted diseases. Even if they did, the elderly will use the disclosure to prove that the young are disobedient or sexually active (*see*: Appendix 5I1).

Its clear from the above that it is difficult for young people to talk and voice issues of concern about HIV, as the disease raises questions of sex and sexuality. Within the collective culture, intergenerational discussions on even health issues that are linked with sex are not possible, especially between the youth and elders. Culturally speaking, children do not have a voice at all. As the Caregivers lamented, “Our culture does not allow children to raise their opinion and knowledge on the so-called taboo subjects such as sex. This makes young people silent about sex and HIV issues” (*see*: Appendix 5F1). It is because of the children’s silence that occurs within this collective environment but goes unnoticed, that the Executive Director of UNICEF, Carol Bellamy stated that: “The silence that surrounds children affected by HIV/AIDS and the inaction that results is morally reprehensible and unacceptable. If this situation is not addressed, and not addressed now with increased urgency, millions of children will continue to die, and tens of millions more will be further marginalised, stigmatised, malnourished, uneducated, and psychologically damaged” (2002: para. 3)

The main tension between the youth and elders around the issue of HIV and AIDS is that of sex, which stems from cultural taboos. In the era of HIV, taboos become a major source of silence within a collective culture, such as our area of research. The worst taboo that creates silence around HIV is that of discussions around sex and sexuality. Airhihenbuwa and Webster (2004:9) refer to a situation where a minister of state cannot break the taboo of sex:

The former Health Minister of Zambia, Dr Luo, expressed this cultural value in an article in *The New York Times* (McNeil, 2002, p. A11) where she was quoted as saying that ‘in my country, it’s taboo for a person like me to discuss sex with someone younger’

Even men, who are expected in most African cultures to take leadership, do not talk about sexual issues. In a report-back of the regional conference on *Men, HIV and AIDS*, organised by the Regional AIDS Initiative of Southern Africa (RAISA) of Voluntary

Service Overseas (VSO), February 11-13 2003, it was realised from the seventy-one participants, mostly from Southern African countries with a few from East and West Africa, that there is persistent silence surrounding male sexuality: “Parents don't talk about sex with their children. Husbands don't talk with their wives. Men generally feel uncomfortable discussing intimacy. Their reproductive health needs to remain invisible” (Sayagués 2003: 5). As a result of the taboo on discussing issues of sexuality and ‘saving their faces’ as men, it was reported that at the National Association for People Living with HIV/AIDS in Malawi (NAPHAM), nine out of ten male members would not disclose their HIV status to their spouses. These silences brought anxiety, risk of infection for their wives through unprotected sex, and the inability to change their lifestyles and live positively.

Khathide demonstrates how strong these sexual taboos are when he points out that even Church pastors end up advocating these taboos:

But the flipside of the coin is that culture has fostered the conspiracy of silence. Generally, in most African cultures talking about sex in public is considered culturally taboo. If you do so, you are bound to be called names. Even those who try seriously to address sexual matters are shouted down. And it is worse if you are a church minister: ministers are expected to talk about heaven and God, and if they have to talk about sex it is in hushed tones behind closed doors. They are afraid that if the congregation or their superiors find them talking openly about sex they will be disciplined or suspended. Consequently, church ministers end up being simply agents of culture rather than ambassadors of the truth. The conspiracy of silence continues (Khathide 2003:2-3)

Our research found issues of sexual taboos it to be a major factor contributing to the HIV and AIDS silence. As the Church Trainees pointed out, those who hold power in the culture are ashamed of people who violate cultural taboos on sexual practices. They pointed out for example that family members who are involved in sexwork are reprimanded by the elders. This makes people who are HIV-positive keep silent to avoid castigation (*see*: Appendix 5E1). As a result of the consequences of a broken taboo on the entire community, the various taboos are policed within the collective culture. The

Support Group spoke of the fear that people have of being accused of breaking taboos. The shame that is attached to breaking taboos within the culture, makes people keep silent over their HIV status (*see*: Appendix 5G1). It is this fear of breaking taboos that makes women keep silent in the house even when their husbands come late or sleep around. They believe it is taboo to talk to him about where he has been (*see*: Appendix 5E1).

It can be seen from the discussion that the collective nature of the culture with its taboos, especially those on sex, works with the demand for loyalty and ‘face saving’, to promote silence around HIV and AIDS. This is a barren silence that has no communication at all, for fear of being accused of breaking taboo and facing the cultural consequences. In the midst of all this, children are encouraged by the cultural norms to keep silent. However, in a collective culture within a high context, a fertile silence is created that gives cues to people to be able to expose barren silence so that it can be broken.

4.3.4 Power Distance and the HIV and AIDS Silence

By addressing the family dynamics between children, mothers and fathers, elders etc., we are led to think about the next dimension of culture that needs to be considered as having a bearing on HIV and AIDS silence, namely, that of ‘power distance’. What we are looking at here is the extent to which people in a given community accept the proposition that power and influence are, and should be, distributed unequally (Hofstede, 2001:97-98). When Jonsson lamented the need to address issues of inequality and polarisation in the community, and the need to seek the empowerment of the poor and marginalised as a way to dismantle the second wall of HIV and AIDS silence, he also pointed to what we have identified as the cultural element of power distance. Jonsson says:

Youth, as all other people, live in communities. Communities are not homogenous - they are most often very heterogeneous, with poor and less poor people, with different kinds of exploitation, with despair and hope. Community empowerment must therefore primarily mean that communities are transformed to allow the poorest, the most marginalized the most exploited, to empower themselves; that they can re-construct their roles in society. Individual empowerment means that the “dominance of circumstance and chance over people’s choices is replaced by the

individual's dominance over circumstances and chance" (Balch and Hollenberg, 2002:10).

The scenario described by Jonsson, which is typical of our research community, is one that contributes to the HIV and AIDS silence. The silence stems from the unequal relationships between the youth and the elderly, the poor and the less poor, the educated and the illiterate, the ordinary people and those with political authority. Hallman, looking at *Socioeconomic Disadvantage and Unsafe Sexual Behaviours among Young Women and Men in South Africa* confirms that an understanding of how factors such as age, gender, and socioeconomic status bestow vulnerability to unsafe sexual behaviours among young people, is vital for designing suitable health, social, and economic development policies and programmes. To Hallman the issue is especially significant in South Africa because of the high HIV prevalence rate that exists in combination with high levels of poverty and inequality. Though a decade has passed since Apartheid crumbled, the writer highlights that economic deprivation persists in dominating policy discussions in South Africa. Although ranked as a middle-income nation, South Africa has the eighth most unequal income allocation in the world (2004: 4). In the era of HIV and AIDS it is the youth, the poor (who are mostly women)⁷⁹ and those with less political power who get infected with the virus but, as a result of prevailing power relations, keep silent about their conditions.

In the field, respondents were asked whether they think that the unequal distribution of power in their culture and the hierarchical order of relationships such as uncles and elders having authority to make decisions on behalf of the entire family, contribute to silence on HIV and AIDS. Of the 77 respondents, 84.4% agreed that power distance contributes to the HIV and AIDS silence. 15.6 % did not agree. The response primarily indicates that the cultural dimension of power distance does contribute to the HIV and AIDS silence.

In most African societies, because of their hierarchical power differences, there is very little immediate rapport between the powerful and less powerful. This is especially true between the old and the young. A wall of silence is created between them. The silence

⁷⁹ See United Nations Development Fund for Women (UNIFEM)'s Progress of the World's Women 2000: UNIFEM Biennial Report

stems from the unequal relationships between the two. There is a control that silences the young people and makes them unable to contribute to decision-making in the community:

Also, many traditional societies have a strict hierarchy governed by a principle of age. Elders in the communities maintain control over major assets and decision-making, such as the allocation of land, labour, and marriage. Youth tend to be excluded from decision-making in these communities and their participation is discouraged during community meetings (The World Bank 2006:15).

In the collectivistic nature of the Zulu culture which we have discussed above, the power distance interplay between children and the elderly promotes silence, in the sense that when the youth get infected with the HI virus, they are unable to approach the elderly for help. “Stigma and a culture of silence surrounding HIV/AIDS creates difficulties for youth to engage in constructive dialogue with their parents and elders on issues of sexuality, safety and self-protection” (Cook and duToit, 2004:41). Other reasons for HIV and AIDS silence as a result of the power distance were pointed out in the field research.

With a good majority of the respondents agreeing that power distance contributes to the HIV and AIDS silence, respondents were further asked to identify how this occurs. Out of the 64 respondents who answered this question, the majority (34.4%) saw the lack of opportunity, in the culture, to express oneself as the main reason why people maintain silence about their HIV status. 21.9% of respondents considered the way those in power put fear into people as another cause of people remaining silent about their status. Another 20.3% of respondents saw intimidation by those who are in authority as contributing to the HIV silence. Suppression of people comes next at 10.9%, the need to obtain permission before speaking was 7.8% and the exclusion of people was 4.7%. These results agree with the characteristics of high power distance outlined in chapter three [see: 3.2.2]. In the case of HIV and AIDS the results show that as a result of power distance, the culture does not allow people to speak freely about their HIV and AIDS status.

Through the power distance dimension of the culture, there is a widening generational gap between the youth and older people in the era of HIV and AIDS. This is because HIV

is known in the community as the young people's disease (*see*: Appendices 5B2, 5C4, 5C7 and 5C10). Being considered as a young people's disease, HIV and AIDS have created a kind of "us and them" situation between the elderly and the young people. Young people are considered as disobeying cultural norms and violating taboos, hence incurring the wrath of the ancestors and bringing in this deadly disease – AIDS. The elderly therefore feel they have no link with the disease. It was for this reason that the oldest member of the Support Group at first refused to agree that her husband died of AIDS. She said "it was not possible because my husband was old, with grey hair, and in my understanding, it is impossible for such a man to die of a disease that everyone in the community regarded as young people's disease" (*see*: Appendix 5C4). When it comes to HIV and AIDS discussions, as long as the youth and the elderly are concerned, there is no opportunity for dialogue

These characteristics of power distance were expressed by the youth as the main reason why they fail to disclose their HIV status to the elderly. They maintained that if they disclosed their status, the elders would intimidate them. They have cultural power and would consider them as better dead than alive and so would discriminate against them. The elders would shout at them and regard them as people who have been prostituting themselves. The elders and parents, if they knew, would chase them away and treat them differently from other people. They are concerned that the elders and parents will use their disclosure to accuse the young people being disobedient or sexually active (*see*: Appendix 5E1). These contribute to the creation of silence from the youth and widening of the generational gap.

This widening generational gap between the youth and older people became evident when the Social Aspects of HIV/AIDS and Health programme of the Human Sciences Research Council conducted a Rapid Appraisal Study on HIV and AIDS in KwaZulu-Natal, the Eastern Cape and Limpopo. The ensuing report, which looked at a number of areas causing the silence on HIV, indicated that the research activities helped bridge the gap between the older and the younger generations to foster open discussions on the disease. One elderly man remarked: "The fact that these meetings combine elders and the youth in one joint discussion is a huge advantage. It helps us understand each other better than we have done before. Now we can help our children cope better..." (Tamasane and

Seager, 2004:30-31). A young facilitator made the following observation with excitement:

As a Community Facilitator, I have learnt how to listen to others, and how to gain good knowledge from the elders that can help us to work better especially in this area. One of the best outcomes from Community Conversations has been the breakdown of the age barriers between elders and the youth on sexuality issues. Now we are able to engage each other better than ever before. Our community has hope now that things will change, especially to link the community with their Local Municipalities... (Tamasane and Seager, 2004: 31).

Indeed closing the generational gap between the youth and the elderly, in this culture under study will go a long way to provide an atmosphere for engagement within the fertile silence for the barren HIV and AIDS silence to be exposed and broken.

Conversely another issue that creates silence on the part of the elderly is the expectation of them being the ones to provide answers to situations in the home, and yet in the era of HIV and AIDS they are not able to provide this help, due to a lack of education and proper knowledge. Reflecting on this scenario, Phiri says:

There is an African proverb which says that wisdom comes with age. This proverb encourages the community to treat elderly people with respect because of their wisdom that was accumulated over years through experience. However, in the era of HIV/AIDS, there are a lot of assumptions that are wrong and lead to the discrimination of old people in many ways. It is assumed that old people are responsible for taking care of their children when they have AIDS. Yet they do not get information about HIV/AIDS (2003:343).

This issue of lack of education and proper knowledge on the part of the elderly was raised by the youth through the questionnaire. Among the issues that they mentioned as contributing to the HIV and AIDS silence is fact that in their Zulu culture it is not allowed for children to be too inquisitive about sexual issues and so they keep silent on such issues. Moreover, the culture does not allow young people to get information in

anyway on how to behave sexually; one has to approach the elderly people through schools such as the virginity testing otherwise one has to keep quiet. This then means that education and information on issues of HIV and AIDS are supposed to be handled by the elders, yet the elders do not have knowledge about the disease. The youth are concerned that in their culture people believe that experience is the best teacher; as a result people who are old find it difficult to learn from the young through discussions. They want to learn from their own experience and silence the young (*see: Appendix 5I1*). There is a creation of a double silence - when the elderly do not have the necessary knowledge and education on HIV and AIDS, the obvious thing to do is for them to keep silent, in order not to show their ignorance, while they suppress the young people into silence.

In the midst of HIV and AIDS in the context of power distance, without positive input from the elderly, the younger generation become more daring and usually think they cannot be infected. As the Surgeon General's report to the American public on HIV infection and AIDS indicates: "the teen years are often a time of experimentation with alcohol, drugs, and sex. Some teenagers don't believe they can become infected with HIV because they rarely see people their own age who have AIDS. Teens need to understand this discrepancy. Because the time between getting infected with HIV and developing AIDS can be 10 years or more, many people with AIDS who are in their 20s (currently 1 of 5 reported with AIDS) were infected while they were teenagers" (CDC WONDER 2007: para. 31). In this case when the young people contract the disease, they are too scared and ashamed even to mention it.

Cultures of high power distance perpetuate silence in the sense that information is not easily given away to the general public or to others, especially from the elderly to the young. In the era of HIV and AIDS there is a widening generational gap between the youth and the older people, making each of the generations keep information on the disease to themselves. The lack of education and proper knowledge about HIV and AIDS on the part of the elderly, and the culture's reluctance to allow of children to ask questions, (especially on issues of sex) exacerbates the silence on the disease. Family members will keep silent over issues if they know that making such information available will bring shame on them and incur the wrath of those in authority. Permission or clearance from the family elder or leader is required for one to divulge such information.

It is therefore clear that the silence over the HIV and AIDS situation is perpetuated by the higher power distance nature of the African culture.

4.3.5 Masculinity/Femininity and the HIV and AIDS Silence.

One of the major issues that Jonsson points out as having a serious effect on the HIV and AIDS silence is gender inequality. This emerges from the cultural dimension of masculinity/femininity. He also sees gender inequality as a key reason for women's poverty, which in turn pushes them toward HIV infection, as people who are poor are often dominated by circumstances and chance. He says: "This is most clear when it comes to gender relationships. As long as our society legitimizes the subordination of women by men, women cannot re-construct their roles as confident partners in the negotiation of when, where and how to have sex." (Balch and Hollenberg, 2002:10). The writer has no doubt that the continuing and silent dominance of men over women is a primary social cause of the rapid spread of HIV and AIDS in the African continent - through the second wall of silence.

Masculinity/femininity, as we saw in the previous chapter, can be seen in two aspects of the African culture we are dealing with. The first is the finding that most of the cultures in Africa are feminine in terms of *assertiveness*. This refers to the hospitable and caring as well as the humane nature of the African people, which makes the cultures to be generally grouped as feminine cultures. This is usually positive and in the HIV and AIDS situation fosters care in the community. At the same time, however, the cultures are masculine in terms of *gender egalitarianism*. This refers to roles assigned to males and females that lead to gender imbalances and abuse of human rights in many cases.

In their bid to help overcome obstacles to HIV and AIDS prevention and care the UNESCO and UNAIDS jointly organised a round table entitled "HIV and AIDS, stigma and discrimination: an anthropological approach" which was held in November 2002. This conference brought together anthropologists specialising in HIV and AIDS, and provided an excellent opportunity for bringing the cultural underpinnings of issues of discrimination and stigma into focus:

Linked to sociocultural concepts (such as sexuality, health and death), stigma is rooted in the breeding ground of power, domination and social

inequalities (including those of gender and ethnic origin), which it then serves to reinforce. Prompting fear and denial in connection with questions that are frequently taboo, it is a source of shame, lowered self-esteem and despair; and, on the basis of these negative perceptions, persons living with - or presumed to be living with - AIDS are excluded from certain public places (hospital, work, village, place of worship, etc.) and deprived of some of their rights, no matter how fundamental (UNESCO 2003:i).

Generally, the African feminine assertiveness is exhibited in the lives of individuals in the way that people who are sick are cared for. However, in situations of HIV infection, the femininity of the African culture combines with other cultural dimensions to promote HIV and AIDS silence. In response to the questionnaires on issue of contribution of femininity in terms of assertiveness to the HIV and AIDS silence, 83.8% of the 83 respondents, agreed that femininity in terms of assertiveness contributes to the HIV and AIDS silence, while only 16.2% disagreed. This response confirms our suspicion that the cultural dimension of femininity in terms of assertiveness contributes not only to silence in general, as pointed out in chapter 3, but also contributes to the HIV and AIDS silence.

Airhihenbuwa and Webster acknowledge the role that African cultures have played in caring for the sick, even in the area of mental health and helping to prevent diseases (2004:5). However, the writers point out how, mainly because of stigma attached to the disease, HIV has either eroded or threatened many positive traditional responses to disease prevention in African cultures: “One example is the isolation (resulting from stigma) of the sick HIV-infected person in cultures where the sick are traditionally cared for by families and communities. This reality makes it even more critical that we understand the role of culture in defining, regulating and maintaining behaviour in the context of health in general and HIV in particular” (2004:5).

Having pointed out that femininity in terms of assertiveness contributes to the HIV and AIDS silence, the respondents indicated ways in which the caring nature of the culture of the people contributes to the HIV and AIDS silence. Of the 60 respondents who pointed out these ways, 66.7% said through the caring nature of the culture, people and families who are infected and affected by HIV and AIDS fear the leaking of information, and the

possibility of gossip, and so maintain a silence about information on the disease. 20% said while the sick are cared for because of the caring nature of the culture, the sick share personal information with their carers, and that this can lead to problems for the carers. 13.0% said that through the caring nature of the culture, people have easy access to personal information from the sick and do not know how to handle this information. In all, through the caring nature of the culture carers are able to know or suspect the HIV and AIDS situation of the infected person and that leads to stigmatisation and discrimination. Against the backdrop of stigma, individuals and even families, realising that a member is infected, keep the patient away from the public eye in order to prevent isolation and the disgrace of the entire family. Therefore there is the creation of silence on the disease.

Marcus points out that caring for people with HIV and AIDS by friends and relatives, within the families in homes, is often promoted as fitting in best with 'African tradition'. However, considering the nature of the disease, with its connection to shame and silence, she acknowledges that the urge to care is limited: "it should not be assumed that extended families have the capacity or the will to care for relatives with AIDS, especially where there may be more than one sick person in a family." (1993:28). Freudenthal also proposes that, though the caring nature of the African extended family still operates, the HIV and AIDS epidemic has not only caused enormous strains on health systems, but has also put a strain on families and local communities, as there is continuous increase in home-care for the sick, as well as care for the increasing number of orphans (2001:13). The scale of the caring to be done does not match the humanness of the caring people, and the tiredness gives way to silence that is situational specific (Jaworski 1993:22).

This shows that in the midst of economic pressure and other pressures that family members face, the caring nature of the culture is pressed to its limit. Out of frustration people complain, insult, insinuate and then the sick person feels the pressure and knows if s/he points out that s/he is HIV positive, the situation will worsen. The sick person therefore keeps silent on the disease. It is for this reason that the CCP staff member in her interview, when explaining how the caring nature of the culture contributes to the HIV silence, said that in these days of modernisation, most people do not have what she termed as "the real ubuntu spirit of genuinely wanting to care for sick people" even

though the desire to help is still in the blood of people. However, because the real ubuntu is not there, the temptation to gossip easily overcomes the innate desire to help the sick (*see*: Appendix 5C9).

On this issue, the Support Group speak from their own experiences and note that the caring nature of the culture makes people sympathise with the sick person as long as they are unaware that this person is HIV-positive. When they learn that the sick person they are caring for might be HIV positive, they immediately start to stigmatise the sufferer. This causes infected people to remain silent about their status to continue to receive sympathy and care from others, until they build trust with the carer. In addition to this, the group identified that a lack of education on HIV and AIDS issues in the community, combines with the caring nature, to make people speculate and gossip, using myths⁸⁰ of bewitchment and a misconstruction of events (*see*: Appendix 5G1). This revelation from the Support Group, shows that such gossip can cause HIV infected individuals to become silent. However, a person who is culturally sensitive can recognise the figures of speeches and other cues which provide an opportunity to build relationships with people to be able to expose the barren silence on the disease so that it can be broken.

In Steinberg's (2008a), *Aids and Aids treatment in a rural South African setting*, the story of Sizwe and Jake well demonstrates how the barren and fertile silence operates in a caring culture in the midst of myths:

Jake grew ill some two years before his death. Among his symptoms was an agonising skin infection that began above his pelvis before progressing to his groin and genitals. It was assumed among those close to him that he had been bewitched by an uncle who was jealous of his success. His skin infection corresponded to a well-known form of witchcraft. The jealous one purchases a medicine and surreptitiously puts it in his victim's lover's food. The next time the victim has intercourse with his lover, he imbibes the poison. His illness begins with a rash in the two tiny indentations between the hips and the pelvis. From there it spreads to the groin and the genitals

⁸⁰ Morrison and Smith note witchcraft as one of the myths about HIV and AIDS

Sizwe nursed Jake while he was ill. When he was close to death, Jake confided in Sizwe that he had been tested for HIV on the mines and that the doctor had told him he was positive. He made this acknowledgment in a moving and complicated way. Sizwe has long dreadlocks of which he is very proud. Sizwe recalled that Jake, lying on his sickbed, pointed at Sizwe's hair and said, 'You are a Rasta. Look at your hair. You are a Rasta.'

Sizwe said: 'Yes, I have dreadlocks.'

'You are a Rasta,' Jake said. 'Nowadays, the times are bad. Your dreadlocks talk. They say you are looking for girls. They say you are beautiful and you want girls. This hair of yours is attracting girls because you are looking beautiful.'

'I understood what he was saying,' Sizwe told me. 'He was in trouble. In his mind, his trouble was becoming my trouble. He was so angry. He was so upset. He was looking at me and crying. He was desperate to protect me. He pleaded with me to cut my hair.' (2008a: 8-9).

In the story we see that Sizwe nursed Jake for two years during which Jake kept a barren silence about his HIV status, until he was close to death. In the meantime those close to Jake were speculating that their friend was bewitched. Between the two friends a trust was built and Jake's silence became what Steinberg calls "acknowledgment in a moving and complicated way", allowing opportunity for engagement. Talking about Rastas, dreadlocks and beauty, the barren silence on HIV was exposed and broken. Jake put the records straight to Sizwe, though coming from a high context culture, he did not put it in an explicit manner that: "he had contracted his illness through sex and not through witchcraft . He set aside his shame and broke his silence in order to issue this warning to his close friend: 'Don't believe it was witchcraft ; look after yourself'" (Steinberg 2008a: 9)

The above shows that the femininity, in terms of assertiveness of the culture, contributes to the barren silence around HIV and AIDS. When people care for the sick they come

across information, and this can lead to various forms of stigmatisation of the sick. In this case infected people withdraw any information on HIV and AIDS.

In terms of gender egalitarianism, the cultural understanding of femininity and masculinity also helps in understanding the creation of the HIV and AIDS silence. The World Health Organisation's (WHO) Review Paper on Integrating Gender into HIV and AIDS Programmes indicates that the dominant ideology of femininity in most societies sees women in a "subordinate, dependent, and passive position with virginity, chastity, motherhood, moral superiority, and obedience as key virtues of the ideal woman" (2003:11). When it comes to HIV and AIDS, the paper intimates that this cultural belief allocates certain roles to femininity and masculinity:

This ideology often assigns to women particular roles (as vectors of disease or merely as bearers of unborn children) that substantially influence the design of HIV/AIDS interventions that are ultimately harmful and counterproductive. In sharp contrast, the dominant ideology of masculinity characterizes men as independent, dominant, invulnerable aggressors and providers, whose key virtues are strength, virility and courage (2003:11).

This kind of ideology of gender differentiation leads to inequality and an understanding that promotes a barren HIV and AIDS silence. When respondents were asked if gender inequality contributes to the HIV and AIDS silence, 91.1% of the respondents agreed that it did; only 8.9% of respondents disagreed. This response with an overwhelming majority agreeing that gender inequality contributes to HIV and AIDS silence answered one of the major field research questions formulated for the study. With this ideology in mind, society sees women as the carriers of the virus, and so when women learn of their infection they keep it undisclosed for fear of being accused of spreading the virus around. On the part of men, when they get infected, they realise their vulnerability, which they see as contrary to their cultural belief and so would not want anyone to know their status. It is interesting to observe that amongst the 26 male respondents, 92.3% agree that gender inequality contributes to the HIV silence, compared with 90.6% of the 53 female respondents doing so. Men, who can be seen as perpetrators of gender inequality,

themselves see gender inequality as contributing to the HIV and AIDS silence more than the women do.

Respondents were asked to point out ways in which gender inequality is seen to contribute to the HIV and AIDS silence. The response indicated that 36.1% of respondents agreed that women, when they disclose their status, are blamed for bringing HIV into a relationship and this makes them unwilling to disclose their status in a relationship. 31.1% of respondents said that women are abused when they disclose their status. 13.1% of respondents said that, in a relationship, the first to disclose their status is considered to be the source of the HIV infection, and so couples keep their status to themselves to avoid any blame. 11.5% said among couples who know their status, the women are usually forced by their husbands not to disclose their status to others, even if they wanted to. 8.2% said men's silence on the disease causes women also to maintain silence. From the above insights it is clear that, in terms of gender, women are forced by circumstances to stay silent about their status more than men.

On the issue of gender inequality, one female Support Group member said "The inequality between men and women in our culture leaves room for fewer discussions, which leads to misunderstandings on HIV issues. In the end when you mention anything about HIV your partner gets angry. Even when you suggest the use of condoms you are considered a prostitute. Therefore there is silence on HIV" (*see*: Appendix 5G1). There is a whole complex cycle of silence at work here, as the first to disclose is considered as having brought HIV into the family. This is the same as the issue that came out in the interview with the male Support Group member whose girlfriend accused him of having brought HIV in the family because his CD4 count was lower than hers (*see*: Appendix 5C1). The men are not ready to disclose their status, and yet they will not allow the women to disclose theirs. To break this silence, men must be in the forefront. This finding confirms the UNAIDS campaign to engage men as partners in the prevention and care efforts in the HIV and AIDS fight, by using the "Men make a difference campaign" (UNAIDS 2001: 5).

Even though we have pointed out that the African culture is a caring one, our cultural understanding of masculinity and femininity lays the task of the caring for sick persons

on women. The World Health Organisation's study has shown that women are generally more vulnerable to the effects of AIDS morbidity and mortality (2003:19). It has been shown that the prevalence of women who are either themselves HIV-positive, or are living with and caring for others who are HIV-positive within the family, or both, is on the rise (WHO 2003:19). This genuine desire to care for the sick makes women vulnerable in keeping silence about their own HIV status:

Because women are more likely to wait longer periods of time before seeking services and treatments during the course of an illness, they are more likely to be at an advanced stage of HIV infection and present related opportunistic infections before they actually seek out treatment and services. Thus, they are far less likely to take advantage of whatever treatments are available. They are also more likely than men to serve as the primary caretakers of others who are infected and to remain silent about their own health problems when other family members are in need of caring - whether ill or not. From data in high prevalence settings in Africa it is known that the combined physical and emotional burdens of caring for sick family members and ensuring their food security under harsh economic conditions often takes a toll on women's own health and wellbeing (2003:19-20)

It is because of apportioning of blame to women that they keep silence about their own HIV status while caring for others. As the CCP Staff member pointed that the silence on HIV and AIDS can be attributed to the practice within families in the African culture, that when things go wrong the female is blamed. For example, a woman could be blamed for a child being HIV positive in the sense that she was not strict enough. The apportioning of blame within the family onto females, cultivates secrecy and silence on issues such as HIV in the family (*see*: Appendix 5C9). In this way, caring for someone who is HIV positive and pointing out that you are HIV positive yourself, could be interpreted as you giving HIV to the sick person you are caring for.

Gender disparity has a great effect on the HIV and AIDS silence. HIV is a heterosexual disease in Africa. This has brought with it the shifting of blame in many families infected and affected by the disease. It would seem that in most cases the blame is pushed onto the

women therefore women keep their status silent. On the other hand, because men are always blaming women, when they find out that they are HIV positive, they also keep their status silent.

4.4 Summary

By engaging the literature and data from the field work, this chapter has pointed out that the HIV and AIDS silence is deeply rooted in the dimensions of the culture of African people. We also argue that within the high-context dimension of the culture, there is a thick layer of fertile silence surrounding a small barren silence. People infected with the HI virus keep silent about their status whilst presenting other things (fertile silence) that if engaged with, would expose the barren HIV silence to be broken. Within the high context culture, various dimensions of culture operate in different ways to contribute to the HIV and AIDS silence.

A low uncertainty avoidance culture makes it possible for people to risk their lives by keeping silent about their HIV and AIDS status when they know they are positive and require help. When it comes to the collectivistic dimension of the culture, there are three major source of silence. They include the taboos within the culture, the desire of members not to shame the family name when infected, as well as placing children at the lowest scale of the ladder so that they don't have a say in family matters,. Power distance between people induces HIV silences based on fear and unrealistic expectations. In the area of the femininity of the culture, the desire to seek care for the infected in the midst of stigmatisation leads to families keeping the disease a secret. The vastness of the burden of care leads to people not wanting to talk about it. The cultural apportioning of gender roles, making it more masculine in terms of gender egalitarianism, increases gender imbalance that in many ways lead to HIV and AIDS silence. In conclusion, this chapter has helped us to answer fully the second research question, as to what extent the various dimensions of culture contribute to the silence around HIV and AIDS.

CHAPTER FIVE: STIGMA AND DISCRIMINATION: THE NEGATIVE EXPRESSION OF CULTURAL DIMENSIONS TO FUEL THE FERTILE/BARREN HIV AND AIDS SILENCE

5.0 Introduction

In the previous chapters we have noted that the area of this research is a high context culture within which exists a great deal of fertile silence and a small barren silence. The barren silence, which has no talking and no communication at all about an issue at stake, is surrounded by a thick fertile silence. Even though they are not talking about the issue at stake, people still communicate around it through various non-verbal signs, or through coded language (See figure 2.4.1). In this culture therefore, on matters of HIV and AIDS, even though people would not talk directly about the disease, they do communicate other things around the disease. If this is engaged with, it would lead to the exposure and breaking of the barren silence that surrounds HIV and AIDS.

In chapter four we explored the various ways in which the dimensions of culture, within high context conditions, contribute to the barren and fertile silence around the disease.

In researching the ways in which the dimensions of culture contribute to silence around HIV and AIDS, an important issue was that of stigma and discrimination. The dimensions of culture create an environment of silence that fuels stigma and discrimination. This chapter therefore engages the theme of stigma and discrimination together with the concept of Barren and Fertile Silence. The understanding of Barren and Fertile silence will help provide clues for understanding the HIV and Aids silence and the factors underlying it, and contribute to discussions about stigma and discrimination.

5.1 HIV and AIDS Stigma and Discrimination

Aggleton *etal* indicate that right from the start of the AIDS epidemic, stigma and discrimination have fuelled the transmission of HIV and have significantly increased the negative impact associated with the disease. On a rather escalated scale the writers say, “HIV-related stigma and discrimination continue to be manifest in every country and region of the world, creating major barriers to preventing further infection, alleviating impact and providing adequate care, support and treatment” (2005: 4). In this way, HIV

and AIDS stigma and discrimination are a powerful force driving the silence surrounding the pandemic. The seriousness of the situation attracted UNAIDS devoting two consecutive World Aids Days of 2002 and 2003, to addressing HIV and AIDS related stigma and discrimination, under the theme “Live and Let Live” (UNAIDS 2002b). The main objective of the two-year World AIDS Campaign was to help prevent, reduce, and do away with stigma and discrimination wherever it occurs and in all forms. The campaign targeted those who are both infected and affected and addressed all types of stigma and discrimination confronting other populations, like sex workers, drug users, and others who are vulnerable (UNAIDS 2002b).

The difference between stigma and discrimination⁸¹ is a thin one and most writers consider stigma negatively as leading to discrimination: “Negative effects of stigma include status loss, discrimination, internalisation and failure to take advantage of social, economic and healthcare opportunities because of expected stigma and discrimination. Indirect effects of stigma such as internalisation and fear of stigmatisation are extremely important in reducing PLWHA access to key health services and a better quality of life” (Deacon 2006: 424). However, the two are considered to link together, as will be seen in the discussions later in the chapter.

On the World AIDS Day 2002, the then UN Secretary General, Kofi Annan, in his message, outlined the effects of stigma: “The fear of stigma leads to silence, and when it comes to fighting AIDS, silence is death. It suppresses public discussion about AIDS, and deters people from finding out whether they are infected. It can cause people – whether a mother breastfeeding her child or a sexual partner reluctant to disclose their HIV status – to risk transmitting HIV rather than attract suspicion that they might be infected” (WHO 2002). In rural Kwazulu Natal, the OXFAM research on HIV and AIDS stigma and discrimination showed the existence of the problem. It established who in the communities were willing to talk about the problem, where they were willing to have discussions; and what they were prepared to discuss in terms of the issues surrounding the problem. Also of concern to them in the rural community, was to what extent fear of

⁸¹ It is not the intension of this thesis to get into the details of the differences between Stigma and Discrimination around HIV and AIDS. For a more detailed work on this see HIV-AIDS and Discrimination: A Discussion Paper by Theodore de Bruyn. <http://www.comminit.com/en/node/209758/36>

stigma and discrimination was affecting both prevention and treatment. (Mboyi *et al* 2005: 4).

In our research area, whilst looking into the ways the dimensions of culture contribute to the HIV and AIDS silence, issues and themes that respondents raised, in many ways, pointed to stigma and discrimination as being the main cultural drivers for the silence around the disease. The members of the Support Group, who are themselves living with the disease, pointed out that if there were no stigma and discrimination attached to HIV and AIDS, there would be little silence on the disease. Both responses to interviews and answers to the questionnaires hinted that stigma and discrimination are a powerful cultural force driving the silence surrounding the pandemic.

In analysing the data from the various in-depth interviews, questionnaires, and focus group discussions on ways in which the various dimensions of culture contribute to silence surrounding HIV and AIDS, it was found that respondents frequently used particular words to describe and explain the situation. Below Table 5.1 contains the list of the common words⁸² used in the field data that on analysis provides evidence of stigma and discrimination as fuelling the silence on the disease:

Word	Frequency
Stigma/stigmatised /stigmatisation	- 88
Reject/rejection	- 66
Gossip/Gossiping	- 47
Witchcraft/bewitched/bewitchment	- 40
Shame/ashamed	- 38
Blamed/Blaming	- 27
Discrimination	- 26
Secrets/secretive/Secrecy	- 26
Judge/judgemental	- 21
Suspect/Suspicion/suspicious	- 18
Taboo/Taboos	- 17

⁸² Some of the words are grouped with others words as used by respondents to mean the same thing e.g. stigma is sometimes used as stigmatized or stigmatization. Hence the groupings – Stigma/ stigmatized/ stigmatization, Reject/rejection, Gossip/Gossiping, Witchcraft/bewitched/bewitchment etc

Education	- 10
Abuse/abusing	- 8
Beating	- 6
Curses	- 4
Isolated/isolation	- 4
Openness	- 4
Criticism	- 3
Forced	- 3
Fatalism/fatalistic	- 2
Laughing stock	- 2
Punish/punishment/punishing	- 2
Intimidate/Intimidation	- 1
Suppress/Suppression	- 1
TOTAL WORDS	- 464

TABLE 5.1: The list of words linking stigma and discrimination

Some authors use these words to link more with stigma, whilst the others link more with discrimination. Sometimes some of the words are used interchangeably with stigma or with discrimination or both. All this is because of the close link between stigma and discrimination.

The most frequently used word, *Stigma*, *stigmatised* or *stigmatisation*, is used synonymously by authors with shame/ashamed, blame, gossip, witchcraft/bewitched/bewitchment, rejection. Aggleton *etal* (2005: 5) describe how shame and blame are linked to stigma: “The shame associated with AIDS – a manifestation of stigma that has been described by some writers as ‘internalized’ stigma – may also prevent people living with HIV from seeking treatment, care and support and exercising other rights, such as working, attending school, etc. Such shame can have a powerful psychological influence over how people with HIV see themselves and adjust to their status, making them vulnerable to blame, depression and self-imposed isolation”. Lesko (2005: 62) has demonstrated how people initially do not have intentions to stigmatise others living with HIV, yet through their own actions, such as laughter, gossip or the use of derogatory words, they stigmatise.

When it comes to the link between stigma and witchcraft most people do not make that association, however, Ashforth's work puts it in perspective:

To talk of a "stigma" attached to AIDS in contemporary South Africa without understanding the witchcraft dimensions is, in my view, to risk misunderstanding both the nature of community power relations and the impact of the epidemic. For even as they lie dying, most people do not know they or their loved ones have the disease. Nor would they want to know, or be wise in so desiring. (Ashforth 2002:135).

To Ashforth (2002:135), "sexual misdemeanors are shameful, sometimes, but commonplace" in the South African communities. Therefore the use of such words as shame/ashamed, blame, gossip, witchcraft/bewitched/bewitchment, within the various dimensions of culture, leads to the promotion of stigma in the era of HIV and AIDS. It is worth noting that 'stigma' is often used with 'discrimination' and can be used with some of the other words listed above as well.

The next most frequently used word, *rejection*, is used more often in line with discrimination and judgemental attitudes and in relation to stigma. It is for this that Link and Phelan (2001: 367) say, "Stigmatization is entirely contingent on access to social, economic and political power that allows the identification of differentness, the construction of stereotypes, the separation of labelled persons into distinct categories and the full execution of disapproval, rejection, exclusion and discrimination". Deacon *etal* (2005: 38) link moral judgement to discrimination, saying where people who are living with HIV and AIDS are judged to be promiscuous or immoral they are likely to experience varying sorts and degrees of loss of status, discrimination and exclusion. Our fieldwork, presented in chapter four, illustrated this on a number of occasions.

The other frequently used words, secrets/secretive/secretcy, suspect/suspicion/suspicious and taboos are often used in combination with both stigma and discrimination. In their advice to the Church to fight stigma and discrimination, the *Diakonia Council of Churches*, reminds the Church of its important role in rejecting any such traits as they have lasting effect on individuals:

The stigma can have further more lasting effects. It can cause them to lose hope, to believe it is not worth living positively with the disease, to stop fighting for their life and their health. They keep their status a secret and lose trust that there is any help for them. To maintain such secrecy takes great emotional effort, and causes stress which, coupled with poverty and malnutrition, lowers the immune system, and enables the disease to spread even further. The church has a hugely important role to play in confronting stigma and discrimination itself, and the effects on the person (2008: 39).

HIV and AIDS is still considered a taboo in many cultures, especially in Africa as it is linked with sex. The fear of being labelled a taboo breaker makes people be silent and secretive of their status. The article by *HIVandAIDS.in* says: “A major cause of the rise in the number of HIV positive cases has been the stigma attached with it. Although many facts have been revealed about HIV/AIDS, it is still considered a taboo. Due to this reason, people with HIV infection often have to face a number of discriminations both at the work place, as well as the personal front” (U/D).

The above analysis indicates that of the 464 words frequently used by respondents to explain the ways in which the dimensions of culture contribute to HIV and AIDS, 411, (88.6%) is directly linked to stigma and discrimination. The issues or themes raised by the respondents in the field around stigma and discrimination are taken and discussed in light of other research to establish how the dimensions of culture create barren and fertile silence around HIV and AIDS. This we will do by looking at the concept of stigma and discrimination, noting what they mean, how they overlap or link, and some distinctiveness of issues around them. This may help to clarify the ways in which the dimensions of culture contribute to the fertile and barren silence around HIV and AIDS.

5.2 Issues of Stigma and Discrimination

In looking at ways in which the dimensions of culture contribute to the silence around HIV and AIDS, which we have seen to exhibit itself in barren and fertile silence, the respondents used words including gossip, witchcraft, shame, blame, rejection, judgemental, secrecy, suspicion and taboo that are linked with stigma and discrimination. This section looks at what stigma is as well as what discrimination is and how the most

frequently used words contribute to stigma and discrimination. The section also looks at how the findings of this research compare with other research.

5.2.1 What is Stigma

Erving Goffman (1963), was the first to elaborate on the concept of ‘stigma’ and posited a definition of stigma that is relevant in helping us analyse and understand the issues that respondents raised as contributing to the silence in and around HIV and AIDS. He defined stigma as “an attribute that is significantly discrediting” (1963: 3). Stigma is in the minds of others and reduces the person being stigmatised, from a whole and usual person to a tainted, discounted one. He explains that stigmatization is a process of assigning stigma to the person identified to be targeted. In the eyes of society, therefore, stigma serves to reduce the person who possesses it, thereby making the individual to be seen as a person with an undesirable difference. He explained further that stigma is used by society through rules and regulations that results in a situation that is considered as a kind of “spoiled identity” for the person concerned: “By definition, of course, we believe the person with a stigma is not quite human. We construct a stigma-theory, an ideology to explain his inferiority and account for the danger he represents” (Goffman 1963: 5). In this case, stigma sanctions the treating of stigmatized individuals or groups less humanely than those not stigmatized; it assigns certain specific negative characteristics, such as weakness, passivity, incompetence, dependence, powerlessness, and so to them.

Looking at stigma in the era of HIV and AIDS, Goffman’s assertion that stigma is not a static attribute of the person, but something that is attributed to the person in a social relations, is worth noting. This is because, as he said, the consideration of the ‘normal’ and the ‘stigmatised’ are perspectives, rather than persons (1963: 3). A person is therefore stigmatised with a linkage to HIV and AIDS and not as a personality. This therefore has a higher potential to detach stigma from individuals with proper understanding of HIV and AIDS. In terms of HIV and AIDS, Goffman’s (1963: 4-5) distinction between three different types of stigma help bring stigma around the disease in focus. Owusu (2007: 18) analyses these three types as dimensions of stigma and points to the first one as *abomination of the body*, which refers to disfiguring conditions and physical handicaps such as rashes and leanness. The second, *blemishes of individual character*, refers to

individual traits and/or actions that are deemed unacceptable in the culture (e.g. unaccepted sexual practices) and thirdly, *tribal identity* refers to group membership in marginal groups, e.g. sex-workers, migrant workers, the poor and women. Lorentzen and Morris (2003) add that HIV and AIDS fits all three of Goffman's stigma types, in that:

The progressive nature of HIV/AIDS and the fact that the individual ultimately will succumb to cancers or opportunistic infections is in itself stigmatising, reflecting Goffman's stigma "abomination of the body". The fact that HIV/AIDS primarily is transmitted through heterosexual contact coincides with Goffman's dimensions of blemishes of individual character. This modus of transmission can in itself contribute to stigma, since sexuality, as already illustrated, is a sensitive subject and often surrounded by taboo in many contexts HIV/AIDS can be understood as proof of sexual promiscuity and is often conceptualised as a "prostitutes disease"....women, sex workers and people living in poverty are, as mentioned, especially at risk from HIV-infection. These are already stigmatised groups, and their "tribal identity" often contributes to multiple stigmas (Lorentzen and Morris 2003: 15-16).

A male Support Group member in an interview said HIV and AIDS is regarded as a disgusting disease by most people in the community, making the disease fit into the "abomination of the body" categories, and therefore it is stigmatised (*see*: Appendix 5C1).

In the focus group discussion with some of the Support Group members, it came out that the disease is often seen as one that infects people who are immoral and engage in indecent sexual activities so that people who are living with the disease are considered to deserve their fate (*see*: Appendix 5J1). This constitutes the dimensions of blemishes of individual character pointed out. In our research area as well, the labelling of the disease as a young people's disease or prostitutes' disease, as indicated in the comments below, make infected people have a 'tribal identity':

- People think HIV and AIDS is for people who are promiscuous, such as prostitutes (Pastors, *see*: Appendix 5D1).

- Our culture always groups people with STIs as prostitutes and so when you are HIV-positive people think of you as a prostitute, which carries a bad connotation of shame and filth (Church Trainees, *see*: Appendix 5E1).
- Infected people are afraid that people will say they have prostituted themselves and now they are worse sinners if they tell them they are HIV-positive (Caregivers, *see*: Appendix 5F1).

In terms of relating stigma to HIV and AIDS or other issues, other theorists have considered the subject beyond the scope that Goffman considered.⁸³ The concept of stigma has been applied to an exceptionally wide range of different circumstances, particularly in relation to health, sociology, anthropology etc. This research follows the trend of looking into stigma from a broader perspective and definition to help us identify the various forms of stigma to help us deal with it in the era of HIV and AIDS. Stigma is therefore not only considered in its conceptual and abstract nature but linked to the *discrimination* that stigma uses as outlet for action. It is for this reason that Parker and Aggleton (2003: 19) propose that HIV and AIDS activists and researchers, “reconceptualize issues of stigmatization and discrimination within a broader political economy of social exclusion as it functions in the contemporary world. It is within this broader context that a new agenda for research and action in response to HIV and AIDS-related stigma, stigmatization and discrimination must ultimately be developed”. Attention is therefore turned to what discrimination is and its link to stigma.

5.2.2 What is Discrimination

Discrimination is closely linked to stigma. UNAIDS says discrimination follows stigma and is the unfair and unjust treatment of an individual based on person’s real or perceived HIV status. It takes place when “a distinction is made against a person that results in their being treated unfairly and unjustly on the basis of their belonging, or being perceived to belong, to a particular group” (2003b). As we pointed out earlier, stigma assigns to identified individual(s) or group(s) the possession of certain specific negative characteristics, such as weakness, passivity, incompetence, dependence, powerlessness,

⁸³ See Sheldon & Caldwell, 1994; Opala & Boillot, 1996; Crocker, Major, & Steele, 1998; Corrigan & Penn, 1999; Fife & Wright, 2000; Phelan, Link, Steuve, & Pescosolido, 2000; Link & Phelan, 2001 and Ashforth, A. 2001.

etc. To tarnish their identity. But discrimination involves an action on a pre-existing stigma that results in the isolation, rejection, judging or unfair treatment of people or group of people (Naidoo 2004: 42). This means stigma is followed by an action of discrimination, making the two go together. Naidoo (2004: 42) illustrates the stigma and discrimination link in the diagram 5.3.1.1 below:

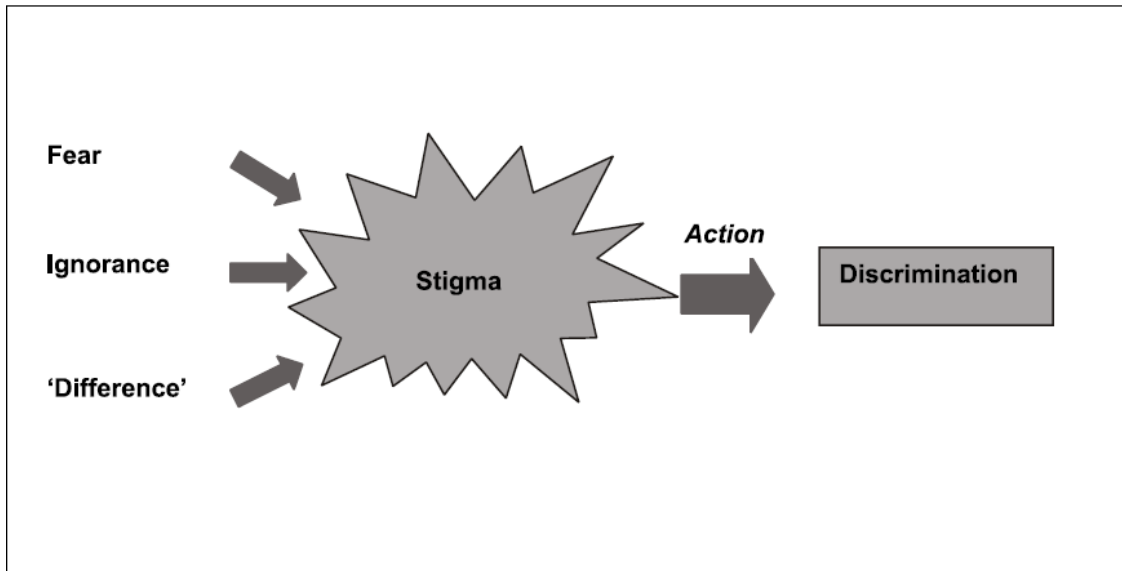


FIGURE 5.3.1.1: The link between stigma and discrimination (Adopted from SARPCCO Training: HIV/Aids Module 4 (Naidoo 2004: 42)

The diagram illustrates how fear, ignorance and ideas of ‘difference’ lead to stigma which, when translated into action, becomes discrimination. Therefore, “discrimination is a response to stigma and is manifested in tangible actions such as segregation, loss of jobs, and loss of rights. This may occur at an individual, community or societal level” (Mboyi *et al* 2005: 7). Stigma is therefore, considered invisible and somehow abstract in concept, and will be considered as linked with discrimination to make it visible. Stigmatized individuals possess a characteristic that labels them as different in a negative way. Society exercises a variety of discriminatory tactics against people they stigmatize. (Carr and Gramling 2004: 31)

Discrimination has been one concern for the Support Group. Just a little over a year after the group was formed members saw the need to educate the stakeholders of CCP about discrimination. They took advantage of the June and July holidays, when CCP had a

week of community analysis⁸⁴, to do this. Following the suggestion from the Support Group, the week was dedicated to educating the stakeholders on the need to break the HIV silence through talking and practically helping infected people to feel encouraged to disclose their status, knowing that they will be helped and not discriminated against. The Support Group played a crucial role in helping understanding of what it means to be discriminated against in the church. During the prayer day on 1st July 2005, members of the Support Group had an opportunity to share their hearts with those gathered to pray about HIV and AIDS. A member, while giving a testimony about his life, thanked the gathering for giving him back his voice. He pointed out that when he was diagnosed with HIV he lost his voice because he could not tell anyone about his condition, knowing how people react to issues of HIV and AIDS. But by being a member of the Support Group, he had been given the necessary tools needed to stand against any opposition and discrimination about his condition. He also pointed out that normally when one discloses one's status to people, one no longer has a voice to speak because people who come to one are always speaking and one has to listen. "But," he said "here I am speaking, with people giving me a listening ear. Thank you for giving me back my voice" (*see*: Appendix 5B1).

Indeed through discrimination, infected people are silenced on two levels when people know them to be infected. In the first place because of discrimination infected individuals are sidelined or marginalised and not giving opportunity at all on a platform to say what they have to say. Sometimes people who hold key positions and contribute greatly to society are not taken seriously as soon as it becomes known that they are HIV-positive. As USAID concluded that the majority of those affected by HIV have one thing in common, that they are in some way or another marginalized within society (2006: 3). On HIV discrimination, the Church Trainees indicated the root cause as coming from the culture of the people that views HIV as shameful, a punishment from ancestors and as such has no cure. It was pointed out that only diseases relating to curses do not have a cure and so the moment people hear that a person has an incurable disease, they begin to avoid that person, even though the desire to care for that person is in them. They said that

⁸⁴ This is a week set aside during the June/July schools holiday when CCP engages its stakeholders to feed back into the organisation. These times help CCP to tackle various issues that they have picked up through their work and to look at community based and culturally sensitive solutions from the stakeholders.

until HIV has a cure or community members become well educated on the disease, it will be related to diseases originating from curses, making infected people discriminated against. Similarly, until TB had a cure it was seen as a curse and people were isolated and discriminated against for having the disease (*see*: Appendix 5E1).

On the other level, HIV positive people are silenced on the premise of people advocating on their behalves. As the Support Group member said, his voice was taken away from him. Family members and loved ones to whom they have disclosed their HIV status, shield them and become their mouthpieces. Members of the Support Group pointed this out as a way in which families keep the disease a secret. Some families even tell infected persons not to tell anyone about their status because having HIV is a disgrace. Some even go to the extent of locking sick people in their rooms to prevent them from having outside contact, let alone allowing them speak for themselves. Instead family members talk on behalf of the sick person, saying the relative is asleep or not at home or sometimes that, he or she has travelled. This is also a form of discrimination of the sick person as he or she is being considered a shame and disgrace to the family.

As a result of discrimination, infected people will keep silence on their HIV status. Yet this silence includes a fertile silence that can be engaged with, as others become educated about the disease and slowly build trust and relationships with the infected. This situation can help the infected gain their voice back and break all manner of silences.

5.2.3 Reject/rejection

“Reject/rejection”, the second most frequent word used by respondents to indicate how the various dimensions of culture contribute to the HIV and AIDS silence, is another powerful way of indicating the effects of stigma and discrimination. Stigmatization related to HIV and AIDS ranges from subtle actions and discriminatory practices to the most extreme degradation, rejection, abandonment and physical violence (Visser *etal* 2006: 43-44). According to Gashishiri (2003) one concrete aspect of HIV related stigma and discrimination is found in the formal sector employment which includes rejection, backbiting and gossiping about people living with AIDS (PLWAs). When it comes to stigma and rejection, Lorentzen and Morris (2003) stress the concept of felt stigma – the

feelings the individual has about his or her condition, and the fear of how others will react to this condition – and say:

Felt stigma and fear of rejection can impair the individual's perception of available support, and the individual can become vulnerable to signs of possible rejection, possibly misinterpreting the behaviour of others as rejecting. Felt stigma can often lead to the individual isolating him- or herself, because he or she anticipates no support and possible rejection, thereby excluding him or herself from social support (2003: 21)

When asked what makes it difficult for people who are HIV-positive to tell others freely about their HIV status, each group in the field had respondents saying its because of fear of rejection. One Support Group member said, "It is the thought that people will reject me and I will not have a place to stay". Another said "The fear that what I have seen happen to my neighbour who is HIV-positive will happen to me. The rejection from people and her own friends when they learnt that she was HIV-positive" (*see*: Appendix 5G1). A non-Support Group PLWHA said "the fear of rejection as most people are not educated about the disease and do not know their own status and so they discriminate against you". Felt stigma resulting from the fear of rejection can affect PLWHA's view of themselves, and of the people around them, who are presumed by the infected individuals to invoke enacted stigma. "This perception and the fear of enacted stigma, can lead to avoidance behaviour. Felt stigma can be seen as a survival strategy to limit the occurrence of enacted stigma, such as when people deny their risk of infection or fail to disclose their stigma in order to avoid being banished" (Lorentzen and Morris 2003: 20).

The concept of enacted and felt stigma proposed by Lorentzen and Morris (2003: 20-21) explains why infected individuals conceal their HIV-status. The way enacted and felt stigma enables infected individuals to experience the HIV and AIDS-related stigma, and suffer its impacts, without having been an actual target of enacted stigma, is related to barren and fertile silence. For fear of rejection from enacted stigma, infected individuals experience felt stigma, and so maintain barren silence about their HIV status. The fertile silence is the place where initial 'conversations' can take place that can confirm or overcome the 'felt stigma'. If this is overcome, then the barren silence may be broken.

5.2.4 Gossip/Gossiping

The use of the word *gossip* by respondents to indicate how the various dimensions of culture contribute to the HIV and AIDS silence, accounted for 47 out of the 464 regarding stigma and discrimination. Kakoko *etal* (2006: 3) intimates that various studies⁸⁵ done on how society responds toward people who are known or suspected to have HIV or AIDS include gossip. According to the writers, “anticipation of gossip from significant others if they would be suspected or known to have HIV/AIDS may be attributed to the lack of openness surrounding sexuality and HIV/AIDS” (2006: 9). By this, they point out that people who get AIDS are therefore vulnerable to gossip - as target of rumours or hearsay about their incurable and “shameful” disease. People, who gossip, do so feeling they have social power within their world-views, to point out what is right against what is wrong or what is healthy against that which is sick. Therefore, they use their power to devalue others by verbally degrading those who are wrong, or unhealthy (Hinshaw 2007: 25). In their power to devalue others, gossipers, in the era of HIV and AIDS, through such actions as laughter, rumour mongering and use of derogatory words, gossip about infected people or families, thereby perpetuating stigmatising behaviours. A male Support Group member said that because the disease is considered a disgusting one, if people become aware that you are HIV-positive they gossip amongst themselves about you. This is one of the main reasons why people who are HIV-positive will not tell anyone of their condition (*see*: Appendix 5C1).

Gossip is a cultural tool that utilises the collectivistic dimension (community nature) of the culture to stigmatise and discriminate against others. The respondents shared sentiments about the way gossip within the culture contributes to HIV and AIDS silence. Of the 11 people who were engaged in in-depth interviews, six pointed out various ways that the culture uses gossip to stigmatise infected people and their families and how this leads to silence in and around HIV and AIDS (*see*: Appendix 5C1, 5C4, 5C5, 5C8, 5C9 and 5C11). As one Church Trainee said, “Our culture is fueled with gossip, especially women, so if a person knows that the whole community will know about his or her status, she or he keeps silent” (*see*: Appendix 5E1). When asked what has been the difficulty for them in telling people freely that they are HIV-positive, some of the Support Group

⁸⁵ These studies include: Biswalo and Lie (1995); Kohi and Horrocks (1994); Lie and Biswalo (1994) and Powell et al (1998).

members said they are worried that people would gossip about them, making them feel scared that they will become a laughing stock in the community and be judged (*see*: Appendix 5G1). All these, according to the respondents stem from the community nature of the culture.

Each group in the questionnaires were asked to indicate ways in which the various dimensions of culture contribute to the HIV and AIDS silence. When it comes to the collectivism dimension or the community nature of culture, all the groups had respondents saying that it is mainly through gossip that the community nature of the culture contributes to the HIV and AIDS silence. The Support Group members indicated that people begin to gossip about a person when they merely suspect that the person is HIV positive, and they stigmatise and discriminate against the person when it is confirmed that the person is HIV positive. “The community nature makes everyone in the family ready to help you in one way or another, and yet they go and gossip about you as they see you slim and slim and if they confirm that you are HIV that is when they begin to stigmatise and discriminate against you” (*see*: Appendix 5G1).

Infected individuals would like to have an opportunity to share what they are going through with other people, but because of gossip and calling of names, they would not do that. According to a male Support Group member who was interviewed, gossip within the Zulu culture contributes to the reason why HIV infected people visit traditional or witchdoctors and pour out their hearts to them. He said most infected people would keep silent before family members and even before those who could offer true HIV and AIDS help, as they are aware that people could gossip about their conditions to others, whereas the traditional doctor is placed in a sacred situation where he is expected not to discuss his patients HIV condition (*see*: Appendix 5C1).

Gossip therefore contributes to people being stigmatised and discriminated against because of HIV and AIDS. People living with the disease are going through a lot in their daily experiences that they would want to share with other people for comfort and consolation but because of gossip they are not able to do that. They are able to open up to traditional healers whom they trust not to gossip about them. This is confirmation of our findings in the previous chapters that trust through relationship building is key for people

living with HIV and AIDS to open up. Until this is done, infected people will keep silence on their HIV situation. Yet this is a fertile silence that can be engaged with, as trust and relationship building slowly takes place.

5.2.5 Witchcraft/bewitched/bewitchment

Next to gossip, the other stigma and discrimination-related word used by respondents was “witch” – or witchcraft, witchdoctor, bewitchment etc. From the table those words accounted for 40 out of the 464 noted for stigma and discrimination. Ashforth’s *An epidemic of witchcraft? The implications of Aids for the Post-Apartheid State*, deals adequately with the subject of AIDS and witchcraft. As we have noted before the issue of witchcraft is spiritual in nature and is ascribed to the action of invisible powers. Within the South African context, witchcraft is considered as “the manipulation by malicious individuals of powers inherent in persons, spiritual entities, and substances to cause harm to others” (Ashforth, 2002: 126). Because of its nature, issues of witchcraft can only be cured or dealt with by traditional or spiritual methods through traditional healers or witchdoctors (Ashforth, 2002: 131). The discussions of the Support Group on the 18th April 2006 which centred on the place of HIV and AIDS among the different illnesses in the African culture, confirmed that the disease belongs to a group of incurable diseases that are linked to the spirits. The group explained that such diseases come through spirits and make a person loses weight (and that is what AIDS does). An affected individual can only get help through the *Sangoma*, who pleads on one’s behalf for the ancestors to save one (*see*: Appendix 5B1: Case 1).

The Support Group members, who themselves acknowledged having visited a witchdoctor or two, for relief from their illnesses, felt that HIV has not yet been given a concrete cultural interpretation. It was revealed that some traditional healers separate the disease from spiritual diseases that come through the casting of spells, witchcraft, etc, while the majority link them. The group was of the view that it is because more and more, traditional healers are being educated about the disease and so understand the medical aspect of it that some of them are separating the disease from being spiritual. However, they pointed out that in the minds of the people of the community and even family members, the disease is seen as a spiritual one. To them this understanding contributes to the silence around the pandemic because spiritual issues should not be discussed by

ordinary people. It is the role of the traditional healers to look into such spiritual issues believed to come about because of curses through witchcraft or breach of a taboo that incur the wrath of the ancestors, etc. (*see*: Appendix 5B1: Case 1).

This insight from the Support Group about the linkage of the disease to issues of curses through witchcraft or breakage of taboos etc. constitutes stigmatisation, just as Ashforth intimates:

With cases of witchcraft, silence and discretion are the norm. No-one wants to publicize the fact that they have been cursed. Such publicity would not only be embarrassing, but dangerous, because it would enable the witch to gain intelligence of the efforts being made to counteract his or her occult assault. Such knowledge allows the witch to redouble his or her efforts or seek out other avenues of attack; for this reason, traditional healers typically enjoin their clients to silence. (2002:135)

The stigma associated with witchcraft in the era of HIV and AIDS comes as the disease plunges families into debt and poverty as a result of seeking health care. When the disease results in death, community members are afraid to associate with the affected families, thinking that they may incur the wrath of the witch and be cursed as well. This leads to stigmatising and discriminating against the entire family. An orphan who came into contact with CCP in 2004 was found to be stigmatised and accused of being a witch by her caregivers. CCP learnt that both of her parents died of AIDS and she was taken on by her auntie (a widow), who subsequently died of AIDS as well. The family members and the community considered her a witch who was killing the people with whom she stayed. If it was not for an uncle who understood the HIV situation in the family and took her to Johannesburg, she would have been stigmatised and left to live alone.

Another major contribution to the silence created around HIV and AIDS that creates stigmatisation, is the suspicion of ‘bewitchment’ by individuals and families living with the disease. In an attempt to keep silent about their HIV status or to keep it a secret from others, infected people and their families use bewitchment to explain their sicknesses. In the questionnaire respondents were asked the question: “When we say people are keeping silent about their HIV status, apart from not talking about the disease, what do they do to

keep the disease a secret?” They were asked to consider the infected person her/himself, and also the family of the sick person. Interestingly enough, respondents from each group, including the Support Group, mentioned that both the sick person and their families explain the sickness as a result of being bewitched just to cover up the sickness. One Support Group member said “You hide from your neighbours. In the clinic you hide the pills you are using and lie to people and tell them that you are bewitched” (*see*: Appendix 5G1). In terms of the family members, some of the Church Trainees intimated that family members just say that the infected person is suffering from something else rather than mentioning HIV. With the backing of the African culture they say that the infected one has been bewitched (*see*: Appendix 5E1). An in-depth interview with a female pastor who has been working with people and families living with the disease for a long time, confirmed the reasons given:

These days when people are sick, they keep changing jobs, and moving from place to place. When one is bed-ridden, he or she will go to be nursed by relatives in rural areas whom they trust. More often than not, they confide in the person they trust, who will then hide them from the public eye. If anyone accidentally notices the sick person or if it becomes obvious that he or she cannot be hidden, the family will provide different reasons for their ill-health to suspicious neighbours. The major reason often cited is that their child has been bewitched, or that the child is being called by the ancestors to become a *Sangoma*, and hence the apparent sickness (*see*: Appendix 5C7).

Suspecting or accusing people of using witchcraft to cast spells on others or cursing others, is a situation that causes a lot of problems in the community. “For when suspicions of witchcraft are in play in a community, problems of illness and death can transform matters of public health into questions of public power, questions relating to the identification and punishment of persons deemed responsible for bringing misfortune to the community, that is: witches” (Ashforth 2002:122). In this case as one pastor said, community members stigmatise and avoid people who are suspected of being sick spiritually. The situation is even worse between the elderly and the sick young persons, as the elderly are more often accused of using witchcraft. An interesting scenario that emerged during the focus group discussion is the fact that respondents were not happy to

be labelled as bewitched and so needed the intervention of the witchdoctor. However, respondents agreed that they preferred to be considered bewitched rather than to be known in the community as being HIV-positive because of the stigma and discrimination shown to the disease. This scenario is in line with other research findings elsewhere⁸⁶.

Considering themselves as bewitched is just a cover-up for being HIV-positive and no one wishes to be “bewitched” in the real sense of the word. However, for family members who do not understand HIV and AIDS or do not know that the sick person is HIV-positive, it is a serious case of bewitchment and the intervention of a witchdoctor is imminent. It came out through the discussion that being taken to the traditional healer or a witchdoctor is very stigmatising. One feels very isolated especially when the witchdoctors recommend that a hut is to be built outside the main house for the sick person to stay in when receiving attention from the witchdoctor.

It can be seen that the linkage of HIV and AIDS with witchcraft, despite infected individuals and family members using it to cover up the disease, has itself a number of stigmatising effects. The slimming effects of the disease make people think that it is spiritual and only traditional healers or *Sangomas* are capable of dealing with it. Though as pointed out in the previous section, HIV-infected individuals (in the context of culture) would visit traditional healers trusting and believing in the sacred or spiritual nature of the vocation. However, when family members take the sick person to the healers, the manner in which they are dealt with, makes the sick people feel stigmatised, especially when they are isolated from others.

In situations where the sick person and family members accused others of bewitching the sufferer, a situation is created where community members stigmatise the sick person and the family to avoid being accused of bewitchment. This whole scenario makes infected individuals put up a silence around the disease.

⁸⁶ See Campbell, Nair, Maimane, and Nicholson (2007); Wood, and Lambert (2008); Muyinda, Seeley, Pickering, and Barton, (1997); and Hatchett, Kaponda, and Chihana (2004).

The confidence and trust that infected people have in witch doctors is something that pastors or church leaders the church, can learn from and build on to be able to offer meaningful pastoral counselling and care to people living with the disease. The research shows that 89.7% of Support Group members who are living with the disease said they attend church. But in this group, whose members attend CCP's monthly prayer meeting regularly and publicly come forward to be prayed for their HIV situation, only 57.7% have made their HIV-positive status known to their churches. When asked what makes infected people in the church keep silent about their status within the church, the following came up from the 27 Support Group respondents:

- Four were scared that the pastors/elders of the church would criticise them, talk about them or preach about them. One of them cited a situation where she disclosed her status to her brother, who is a leader in the church, and he preached about her in church and then called all her brothers to talk openly about her status.
- Eight mentioned the fear of stigma and discrimination in the church and
- Seven indicated church members talking or gossiping about them.

If the church leadership and its members through education on HIV and AIDS issues would understand what people living with the disease are going through and build relationships with them, infected people would open up and break their barren silence on the disease.

5.2.6 Shame/ashamed

The words *shame or ashamed* accounted for 38 out of the 464 relevant words noted for stigma and discrimination, that respondents frequently used to indicate how the various dimensions of culture contribute to the HIV and AIDS silence. The statement by Peter Piot, UNAIDS' Executive Director, to Plenary of the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance in 2001, is true:

HIV/AIDS-related stigma comes from the powerful combination of shame and fear - shame because the sex or drug injecting that transmit HIV are surrounded by taboo and moral judgement, and fear because AIDS is relatively new, and considered deadly (Piot, 2001).

In Africa there is shame around sex; therefore any sexually transmitted illness brings shame to the infected person, resulting in stigmatisation. As many scholars have noted, HIV and AIDS draws with it negative social baggage and stigmatisation, all because of its sexually transmitted and incurable nature (Deacon and Simbayi 2006: 34). Campbell *etal* agree that the most potent determinant of stigma in the era of HIV and AIDS is its sexual nature, as in their study communities, sex and sexual relations were regarded as something shameful, not to be mentioned or discussed (2007: 19). This is exactly what the respondents in our area of research alluded to. Commenting on the aspects of the Zulu culture that contribute to the HIV and AIDS silence, the female pastor in the interview pointed out that by nature the culture is not an open one. She felt that the culture has a number of taboos that make people feel obliged not to discuss certain issues until they are grown and mature, which is mostly after marriage. Until then one cannot freely speak one's mind. One has to be mindful of what one says lest one incurs the wrath of the elders regarding bringing shame on the family. To her the major area of silence is to do with sexual issues, and since HIV is a venereal disease, it is even more shameful to talk about this (*see: Appendix 5C7*).

The Support Group members agree that until one has really understood what HIV and AIDS is, especially through such avenues as support groups, one feels so ashamed and dirty when one thinks one's status being public. The main issue is that there is a general idea in the community that people who are sexually active and sleep around are the ones who get infected; everyone believes that before they know they are infected. One male member said "when you get infected, you feel like sexually exposed. It is like the way people feel so ashamed when they are caught having sex. This is something that you do not want people to see about you" (*see: Appendix 5G1*).

Respondents intimate that "sex is cool" among the youth as long as it not linked with STIs, especially HIV. The young girls pointed out that it has become a fashion to have a baby before finishing matric. A principal in one of the schools that CCP works in had a problem of teenage pregnancy in her school. She was reliably informed that pregnancy is a way for the girls to opt out of "sugar daddy" relationships. According to the pupils, when they enter junior high schools they hook up with older men for their day to day provisions. When they get to senior high school and want to opt out of these

relationships, the men would not want to let them go until they are pregnant; then the man would run away. The above explains Ashforth (2002:135) sense that sexual misbehaviours are shameful but common in the communities:

This wilful ignorance arises not simply from fear of the name “Acquired Immunodeficiency Syndrome,” nor from shame over the sexual licentiousness that presumably gave rise to the infection in the first place. After all, there is hardly a family in the country that does not have children giving birth to children, sons being sought to support their offspring, or fathers finding long lost progeny they secretly sired many years back. Sexual misdemeanors are shameful, sometimes, but commonplace. And while the disease was first registered in South Africa amongst white homosexuals, nobody identifies it now as a “gay disease” or stigmatizes its victims for their sexual orientation. The silences, and stigma associated with symptoms of the diseases decimating villages and townships in the wake of HIV/AIDS, however, make much more sense if their witchcraft dimensions are taken into account (Ashforth 2002:135).

Even though getting involved sexually and having a baby might not be that shameful and stigmatising, the explanations from the people who are living with the disease indicate that being HIV positive makes the infected person feel ashamed and stigmatised. One caregiver explained that the lack of fluid relationships between parents and children makes young people dare to go and try anything, especially sex. Then, when they have engaged in risky behaviour and they contract HIV, they are too ashamed and too afraid to tell anyone (*see*: Appendix 5C8). Steinberg’s work in Lusikisiki makes a connection between stigma and sexual shame as a result of HIV. He points out the seeming capacity of the HIV virus to manufacture sexual shame where, apparently, none had existed before (2008a: 39). The stigma that accompanies HIV and AIDS according to Steinberg is fueled by both sexual shame and the deadly nature of the disease:

It does so by virtue of the fact that it is deadly, it is sexually transmitted, and it is killing large numbers of people. It both unmasks and inflames a sense of disgrace that was previously managed with great care. That the logic of the accusation against the infected is circular in no way reduces its power. The circularity of the accusation is approximately the following:

What you have done is shameful because it is deadly. And the reason it is deadly is that it is shameful. (2008a: 44)

In the community today, people can be sexually active and even get pregnant but will not feel that ashamed. However, once a person realises that he or she is HIV positive that individual begins to feel naked and ashamed. The infected person would not want to feel so exposed before others and so will keep silence over his or her status. Yet again, we are aware that this silence has fertile aspects to it that can be engaged.

5.2.7 Blame/Blaming

Blame/blaming is another word that respondents used frequently to indicate how the various dimensions of culture contribute to the HIV and AIDS silence that is stigma and discrimination related. In her work to help understand HIV and AIDS stigma, Joffe (1999: 3) came up with what she calls the ‘not me – others are to blame’ trend. This understanding has led to her and others to define Stigma as a “blaming and othering response, a cognitive justification for an emotional reaction of fear. Stigma allows people to distance themselves from the risk of infection by blaming contraction of the disease on characteristics normally associated with outgroups” (Deacon and Simbayi 2006: iii). Blaming is stigmatising and blaming individuals or certain groups of people for having an illness such AIDS, providing stigmatisers with an opportunity to distance themselves and their in-groups from risk of infection (Deacon 2006: 424). This represents a primary cause and instrument for stigma within society.

Blaming and othering, in the era of HIV and Aids is therefore a phenomenon that is common in the world. In South Africa in general, blaming and othering for HIV and AIDS is refracted through the multiple prisms of race, religion, gender, homophobia and xenophobia (Petros et al 2006: 70). According to the writers:

South Africans from different racial backgrounds blame each other as either being the source of HIV or being responsible for spreading the disease. Whites accuse Blacks, and Blacks accuse Whites, of having brought AIDS into South Africa. This finger pointing creates a false sense of security through denial of one’s own racial group’s exposure and vulnerability to HIV (Petros et al 2006: 71).

In our area of research, in investigating the issue of HIV and AIDS silence, from a cultural perspective, respondents reflected on blaming in areas of gender and witchcraft. No issues of race, religion, homophobia and xenophobia were raised by respondents. Each of the four groups that answered questionnaires had respondents who attributed the cause of HIV and AIDS silence to blaming of one kind or another, when asked: *In which ways does inequality between men and women contribute to the HIV and AIDS silence?* Most respondents indicated that men usually blame women as those who bring HIV into the relationships, so that women keep silent about their status to avoid unnecessary punishment and abuse. Within marriage, respondents indicated that wives are scared of their husbands; every time a problem arises a wife is the one blamed. Even if the wife knows she is HIV-positive she will keep silent about it just to protect herself (*see: Appendix 5E1*). In the same token it was reported that men keep silent about their status because they are the ones who use their power and masculinity to blame women all the time, and for bringing HIV into the relationship. They are also afraid to be blamed by their female partners for bringing HIV into the relationship. Petros et al (2006: 72) predicted, “the low socio-economic status of most women and their dependency on men for economic support places them in a vulnerable position for HIV infection and may cause them to carry the blame for AIDS in South Africa”. The Non Support Group Member PLWHA in an interview confirmed that as long as men have both financial and social power over women, there will continue to be silence from both men and women. Males will maintain silence about their HIV status for fear of losing their power and pride, as by disclosing their status they will be blamed and stigmatised. The women will continue to keep silence on their status for fear of being blamed and rejected for spreading HIV, as they are accused of sleeping with men for financial gain (*see: Appendix 5C5*).

Again when it came to issues of witchcraft, respondents pointed out that there is apportioning of blame. This is mainly by families of infected individuals towards neighbours. Respondents, including the Support Group members, felt blaming neighbours was a way of covering up or keeping the disease a secret. Some Support Group members indicated that some families take the sick person far away from the sight of neighbours and blame them for bewitching the sick family member. The family will not bring the sick person back until he or she gains some weight or recover. Others pointed out that the

family blames neighbours for having used *muti* or something poisonous on the sick person through witchcraft (*see*: Appendix 5E1). This situation is consistent with the blaming of *muti* or witchcraft on neighbours. It is consistent with the accusation indicated in Ashforth's work in Soweto that:

The form of witchcraft most frequently invoked in Soweto as the cause of death where the symptoms suggested AIDS (whether or not the AIDS diagnosis has been made by a medical practitioner) is *isidliso* or *idliso* (poison/poisoning in isiZulu; *sejeso* is the Sesotho equivalent). In a letter to the editor of *City Press* in August 2001, a reader, Tshwaranang Tshule, wrote, "It is extremely disturbing that many young people are dying and in black communities almost all cases are blamed on *muti* or some incomprehensible bad spell (*sejeso* topping the lists)." *Idliso*, sometimes translated as "Black" or "African" poisoning to distinguish it from other toxic substances, is a term used to cover a great many symptoms, most commonly anything that affects the lungs, stomach, or digestive tract or that leads to a slow wasting illness (2002: 129).

The Pastors and Caregivers, who usually do the caring and counselling of people living with HIV and AIDS, confirmed that initially when you ask what is wrong with the sick person, family members cover up the sickness by blaming neighbours or workmates for using black magic or witchcraft. It is when they work with the sick person for sometime and trust and confidence is built in each other that either the sick person or a family member (usually the one responsible for care giving who is aware of the sick person's HIV status) discloses to them the true sickness of HIV. This is an example of breaking the barren silence by attending to the fertile silence.

The habit of blaming others for HIV infection or making them feel responsible for HIV infection in others is stigmatising and discriminatory. This creates an 'us' and 'them' scenario where the blamed is cut off from the rest of the others. In situations where women – wives, girlfriends, maids etc. – are blamed and othered by men, abuse increases. In view of this, infected women keep their status to themselves as a barren silence with no room for discussion. Yet understanding of culture and silence allows us to see that there is also a fertile silence For the sake of saving the face of families, infected

individuals would still maintain the barren silence on the disease even when they see their family members accusing others of using witchcraft or Muti. However, when they build relationships, the fertile silence is engaged, allowing the barren silence to be exposed and broken. This is exactly the scenario the Pastors and the Caregivers were talking about above.

5.2.8 Secrets/secretive/Secrecy,

Then use of the word secret (secretive or secrecy) like discrimination accounted for 26 of the 464 words frequently used by respondents to explain how the various dimensions of culture contribute to the HIV and AIDS silence that is stigma and discrimination related. In the first place, the linkage of the disease to witchcraft, as considered above, introduces secrecy issues pertaining to HIV and AIDS, given the inherent secrecy of the act of witchcraft itself (Ashforth 1996: 1206). The members of the Support Group confirm that the way the culture sees HIV and AIDS as a disease linked with witchcraft makes people keep it as a secret. It is expected that only the traditional doctor can help you when you have it. Even having this secret brings internal stigma to the person keeping the secret. Members of the focus group discussion said it is this aspect of the African culture that contributes to the HIV and AIDS silence:

According to our culture, when someone is sick, the parents send that person to the traditional doctor, who always says it is the ancestors sitting on you (maybe because of your behaviour or something you have done against them) and so you need to pacify them with a goat. This is a sacred and a shameful situation that you have to keep secret. The sick person will try by all means to avoid this by keeping his sickness from the entire extended family scrutiny. Even if one goes through this procedure with the *Sangoma*, it is kept even more secret because of the stigma on sacred pacification, with all the slaughtering and rituals that go with it (*see*: Appendix 5J1).

Respondents consider the Zulu culture as a secretive one which contributes to silence on the disease. Respondents indicated that the culture is very secretive which encourages and allows people to keep deep issues secret to prevent the family from being disgraced and stigmatised. A young Support Group member in an interview was certain that the Zulu

culture is the underlying factor pushing people into silence on HIV and AIDS, especially in that the culture does not expect people to express their feelings, especially when it comes to sex. He confessed that it was because of what he learnt from his peers, and from the TV, about sex, which no one in the family had properly explained to him, that made him become sexually active at an early age (*see*: Appendix 5C3).

The secretive nature of the culture on issues of sexual and other taboos, coupled with the secret nature of witchcraft has a huge impact on the silence in and around HIV and AIDS. As noted earlier, HIV and AIDS are a source of stigma which results in secrecy around the disease. Keeping secret about the disease also has a huge effect on the infected people, who try by all means to maintain silence. When asked what he understands by an HIV-infected person keeping silent about his or her status, a young Support Group member said that it meant carrying a big burden of secrets. “One had to make sure that the people closer to one did not have any cause to suspect one. The medication one is taking, documentation from clinics and the clinics that one attends must not be seen by those who are closer” he said. Speaking from his own experience he maintained that the family of an infected person, if they know you are infected, would not want one to tell anyone else of one’s condition. Family members would do anything possible to keep the disease a secret (*see*: Appendix 5C3). Family silence about the disease increases the stress suffered by the infected one.

This stress that ensues as a result of the maintenance of secrecy around the disease is pointed to by Lorentzen and Morris (2003) whose findings show that the effort and strain that secrecy entails can take its toll on both the psychological and physical well-being of the infected individual:

The constant risk of discovery can turn into a major stress factor, creating a considerable amount of psychological distress, and negative impacts on the physical condition. Choosing silence thus burdens the individual with secrecy, at the same time as it deprives the individual of potential sources of social support (2003: 38)

As a result of the secretive nature of the culture around issues of sex and the secrecy around witchcraft, HIV and AIDS, which is linked with both, becomes a secret disease

with stigma. Infected people in keeping the disease a secret are putting up a silence that needs to be exposed and broken. For this to happen, family members and trusted significant others need to engage the fertile silence through building relationships to expose and break the silence, thereby sharing the burden of secrecy that individuals carry.

5.2.9 Judge/judgemental

People being judged or shown a judgemental attitude is another theme that respondents used to indicate ways in which the dimensions of culture contribute to the HIV and AIDS silence that is stigma and discrimination-related. On her part, Paterson (2005: 33) links judgement directly to stigma: “Stigma is a social process or related personal experience characterized by exclusion, blame, or devaluation that results from an adverse social judgment about a person or group. The judgment is based on an enduring feature of identity attributable to a health problem or health-related condition, and this judgment is in some essential way medically unwarranted”. Moral judgements give rise to what Deacon *etal* (2005: 85) refer to as symbolic stigma – one that arises from value-based beliefs that make moral judgements of others to affirm the ingroup’s moral identity. Such stigmatisation involves blaming people for getting infected with HIV because they sleep around or drink alcohol or use drugs. Moral judgement is generally experienced in the community. However, the use of the word by respondents is more related to the church.

In her interview when asked as to why people who are HIV-positive find it difficult to tell others freely of their condition, the pastor thought it was the fear of being stigmatised and judged by others because when people in the community know that a person is infected, he or she is automatically considered to be immoral. This attitude in the community is seen even more in the church. Respondents from each group indicated ‘judgement’ as the main reason why people who are infected keep silent about their status in the church. A female Support Group member said she goes to church but no one in the church knows that she is HIV-positive. She revealed that it is known amongst most people living with the disease that the church is a place where HIV-infected people are judged as being naughty or sleeping around. It is for this reason that she is afraid to tell any one of her status. She believes the church should be a place where HIV is not talked about in a judgemental way (*see*: Appendix 5C2 and). For the Church Trainees, infected individuals are scared to disclose their status because of the stigma and judgment attached to the

disease, which is also in the church. They pointed out that some are afraid of being judged as sinners because of their sickness. Campbell *etal* (2005: 810) point out that the link made by many between sex, sin, and immorality, for which the church is the main contributor, has been ammunition for symbolic stigmatization. Obviously for fear of stigmatisation and discrimination, infected individuals will always be silent about the disease.

5.2.10 Suspect/suspicion/suspicious

Another stigma and discrimination related words that respondents used in their bid to indicate ways in which the dimensions of culture contribute to the HIV and AIDS silence were “suspect” or “suspicion” or “suspicious”. Niyonzima (2003: 1) has pointed out that “HIV/AIDS-related stigmatization starts as soon as information (accurate or not) regarding a person’s serostatus is known. It is the process whereby the person is looked at in many different ways, all of them negative and judgmental soon after he/she is known or suspected to be HIV positive”. According to the respondents one of the ways people who are living with HIV and AIDS try to avoid being stigmatised is to avoid being suspected of being HIV positive. A female Support Group member pointed out that “infected people don’t talk about the disease at all, so as to avoid saying something that could be seen to suggest that they had a personal reason for their interest in the subject. Besides not talking about it, the infected person, in order to avoid suspicion, does other things to conceal his or her status, such as hiding from familiar people or avoiding public places when one is ill” (*see*: Appendix 5C2).

The major area of suspicion in the era of HIV and AIDS is between the elderly and the young people. During the focus group discussions, it came out that the aspects of the Zulu culture that cause silence about their HIV status is that the relationship between the older and younger generations is not smooth, with the elders always being suspicious of the behaviour of the young. This makes the young fear the elders knowing that they are HIV-positive, and questioning their sexual behaviour (*see*: Appendix 5J1). This confirms CINDI’s finding that older people are suspicious of the younger generation, blaming their new ways and condoms for the spread of the virus (2007: 31).

People living with HIV and AIDS also become suspicious of, and do not trust the people around them. The caring nature of the culture makes people come to a sick person to care. However, the respondents said this situation makes the sick person become suspicious. He or she does everything to avoid confirming one's HIV status, such as hiding medications, lying about what the doctors are saying and accusing others of witchcraft. Here again, the infected person creates a silence on the disease and does not talk about it. Cautiously, however, through the accusations of witchcraft, talking about what the doctors are saying etc., there is a fertile silence for possible engagement that will lead to exposure of the barren silence and break it.

5.2.11 Taboo/Taboos

Taboo is the last of the various themes that the respondents named as they discussed ways in which the dimensions of culture contribute to the HIV and AIDS silence that links with stigma and discrimination. Most of the issues that give rise to stigma and discrimination are linked in one way or another to issues of taboo or the breaking of taboos. As noted before, the culture of the people is full of taboos and since taboos are not issues for discussion, people naturally keep silent on certain issues such as sex and witchcraft to avoid breaking taboos that have consequence and lead to stigma. A caregiver who was interviewed believed that the Zulu culture contributes in many ways to the silence around HIV in this direction. For her, the culture has too many taboos, especially those which children and young people must observe. She lamented that one cannot ask questions about sex at home; one can only do this with one's friends or during lessons at school (*see: Appendix 5C8*). This finding agrees with Lorentzen and Morris (2003: 6) that "moral and social norms connected to sex, and therefore also to HIV/AIDS, substantiate the taboo of sex, and create a fertile climate for stigma, silence, and the further spread of the disease. HIV/AIDS-related stigma can thus appropriate and reinforce pre-existing sexual stigma associated with sexually transmitted diseases (STDs)".

In all of this the respondents brought to light that HIV and AIDS is itself considered taboo. Some of the pastors linked to CCP have said that the consideration of HIV and AIDS as taboo in the community makes people so afraid of the disease that if they know that someone has it, they don't want anything to do with that person and discriminate against him or her. To them, the HIV taboo and the fear attached to it mainly comes from

the disease's links not only to sex that is shameful to talk about, but also witchcraft and death, which cannot be dealt with ordinarily but only through spiritual means. The cumbersome procedure through witchdoctors and the shame attached to it, deepens the silence on the disease. This then adds a third dimension to Posel's (2003: 19) duo, *death by sex* – making it a trio, *death by sex and witchcraft* so that:

It should come as no surprise, then, that AIDS deaths are largely unmentionable – rendered unspeakable by the intensity of stigma and taboo associated with them. Despite vast amounts of money invested in HIV/AIDS education campaigns – which have generally produced high levels of awareness of the epidemic- along with growing numbers of AIDS related deaths and dedicated, energetic efforts by a growing number of community organisations to tackle the stigma of HIV/AIDS, the subject of AIDS tends to remain heavily veiled. In many parts of the country, known AIDS sufferers have been ostracised, publicly humiliated or – in at least one prominent case – murdered by an angry mob. To admit to being HIV positive, let alone an AIDS sufferer, therefore becomes an act of public heroism. Public acknowledgement of death or dying of the virus is all the more difficult, so that the cause of an AIDS death is seldom admitted (Posel 2003: 19).

The fear of being exposed as having broken a sexual taboo, evidenced by HIV infection, the thought of being considered bewitched needing to be cleansed by the *Sangomas*, the dangers of death that goes through one's mind, all make an infected person stage a silence about his or her HIV status, for the reasons advanced by the focus group of infected people:

In our culture, those who lead us and have power are ashamed of people who violate cultural taboos such as those on sexual practices or consulting the ancestors on your own. If, for example, a family member is proved to be sleeping around or involved in sex work, that person will be reprimanded by the elders. If that person is suspected to be sick because of breaking any of the cultural taboos, it is arranged for this person to be taken to a sangoma for spiritual cleansing. This is a shameful ritual involving slaughtering of goats to appease the ancestors who have been

offended through one's careless life. This makes people who are HIV-positive keep their status a secret to avoid castigation and blame as a taboo breaker (*see*: Appendix 5J1).

However as pointed out by the Support Group and non Support Group PWLHAs, there is a fertile silence that culturally aware people can engage and that can lead to breaking the HIV and AIDS silence. It is for this reason that non Support Group PWLHA confessed: "the HIV and AIDS journey is a lonely and a burdensome one. When one has this ailment there is much one would want to share with people, but cannot do so for fear of rejection. One cautiously keeps a door open for interaction to build relationship and trust with someone to share the burden with" (*see*: Appendix 5C6).

5.3 Summary

The chapter identified themes from the fieldwork data on how the dimensions of culture that are stigma and discrimination-related contribute to the HIV and AIDS silence. The most frequently used words and related words in the transcripts and questionnaire are: Stigma, Rejection, Gossip, Witchcraft, Shame, Blame, Discrimination, Secrecy, Judgement, Suspicion and Taboo. What stigma and discrimination are and how they are linked were looked at. Stigma was considered to be an invisible and abstract concept, and needs linking with discrimination to make it visible. Discrimination acts on a pre-existing stigma leading to the isolation, rejection, judging or unfair treatment of others.

The various themes listed above were considered in relation to stigma and discrimination as researched by other authors. It was found that each of the themes had something to do with stigma and discrimination, and leading to infected persons keeping silent about their HIV and AIDS status. However, in each case, it was found that people living with the disease made room for engagement through a fertile silence that is able to expose the barren silence and break it. The understanding of Barren and Fertile silence in this way provides clues for dealing with the HIV and AIDS silence and understanding the current debate on silence, stigma and disclosure.

To a larger extent the chapter has helped us in preparing to look into the third research question of this study: Can the interventions provided by the Community Care Project suggest constructive ways of engaging with and breaking the silence around HIV and AIDS in the Pietermaritzburg area? The study now looks at how the CCP Model provides examples on how to engage the fertile silence for the barren silence to be exposed and broken.

CHAPTER SIX: ENGAGING THE FERTILE SILENCE: LESSONS FROM A CASE STUDY OF THE COMMUNITY CARE PROJECT (CCP)

6.0 Introduction

This study was undertaken to investigate and identify cultural factors underlying the silence that surrounds the HIV pandemic and to determine whether these factors could indicate how the HIV silence could be broken. The following problem statement was therefore identified: *Can the cultural reasons underpinning the HIV and AIDS silence be identified to provide clues for engaging with and breaking the silence and providing a way forward for dealing with the HIV and AIDS epidemic?* The problem statement therefore led to three field research questions formulated for the study, which included:

- (a) Does the culture of the people contribute to the way silence ‘works’?
- (b) To what extent do cultural dimensions contribute to the silence around HIV and AIDS?
- (c) Can the interventions provided by the Community Care Project suggest constructive ways of engaging with and breaking the silence surrounding HIV and AIDS in the Pietermaritzburg area?

Chapters 2, 3 and 4 helped us to answer the first two research questions. We have argued for a more comprehensive understanding of silence. By examining the barren and fertile silence, and recognising the depth of fertile silence in African culture, we have begun to identify clues for breaking the silence and enabling the church and community to move from stigma and discrimination (chapter 5). This current chapter aims at answering the third research question by looking at the operations of CCP and investigating how it engages with the fertile silence in various ways in order to unearth the barren HIV and AIDS silence that may be broken. The *CCP model* is not proposed as the perfect model. It is a case study which brings to light how the fertile silence can be engaged in order for the barren silence to be exposed and broken, allowing individuals and families affected the disease to begin to overcome stigma and discrimination. It deepens our understanding of how the HIV and AIDS silence works in a high context culture.

Broadly the chapter has three parts, addressing the questions:

- i) ***What is the CCP Model?*** – Following on the history of CCP that was covered in chapter 1, this section considers such issues as what is CCP? What has CCP achieved through its operations? In which ways has CCP developed this model?; This is covered in section 6.1.
- ii) ***What are the key elements of the CCP Model that engage with the Fertile silence?*** – This section operationalises the concept of engaging the fertile silence. It demonstrates that by paying attention to the cultural elements of the high context culture in the Pietermaritzburg area in which we work, and designing a programme that takes into consideration the fertile silence, we will be able to pick up clues to open up the barren silence. The CCP model provides us with six ways to do this including: culturally sensitive education; the filtration principle; the 2x2x2 principle; individual and family care; Support Group; and Prayer meetings. This is covered in section 6.2.
- iii) ***What does it mean to Disclose HIV Status and Break the Silence?*** – This last section links the process of HIV and AIDS disclosure to engagement with the fertile silence and breaking the HIV and AIDS silence. This is covered in section 6.3.

6.1 What is the CCP Model?

The CCP model is an example of the *Church in Action* in breaking the silence surrounding HIV and AIDS. The model pays critical attention to the cultural context of the people and takes into consideration the day to day encounters and experiences of individuals, families and communities living with the disease.

6.1.1 What is CCP?

As noted in chapter 1, the Community Care Project (CCP) was set up in 1999 by the Pietermaritzburg Christian Fellowship (PCF) as a Faith-Based Organisation to operate under the umbrella of the Project Gateway. In 2006 it was registered as a Trust with three of the elders of the church, including myself, as trustee. Its main purpose was to be a legal entity for creating HIV and AIDS awareness in Churches and schools. This included seeing the need for their members/learners to be trained in HIV and AIDS issues, helping trained churches initiate HIV and AIDS programs and being the expression of the Church

attending to HIV and AIDS issues in the community within which the Church resides. I was mandated by the elders of the church to manage the CCP, through an organisation called Newfrontier Aid Trust (NAT), which I had set up in 2005 as a tool to facilitate community-based organisations, churches and schools that are involved in HIV and other community initiatives.

CCP operated with a strategic plan from 2001 until 2005. After a strategic plan review the current 2006-2010 plan was put in place. The plan aims at mobilising the community, through the churches and schools, to be trained to break the silence that hinders interventions into the pandemic. Five objectives were set to help CCP become a holistic and practical base for the fight against the spread of HIV and AIDS and a vehicle for breaking the silence and reducing the effects of the disease:

- Providing hands-on practical wellness⁸⁷ training for Home-Based Care (H-BC), childcare training and support to selected members of churches in and around Pietermaritzburg.
- Providing HIV and AIDS prevention education and leadership development in HIV and AIDS issues in selected schools in the Pietermaritzburg area.
- Providing a *Future Hope* for Orphans and Vulnerable Children filtered through the churches and schools programmes.
- Facilitating churches to initiate Community Based Organisation (CBOs) or projects to work with affected families (those identified families whose PLWHAs and OVCs CCP works with) to manage the disease.
- Establishing Sustainability Programmes with stakeholders to help them start some businesses or gardens, to receive spiritual supervision, and to help those families who qualify to access government grants to sustain the family.

In carrying out this strategic plan, CCP operates with 20 paid staff members. Eight are part of the management team and 2 are seconded from NAT to help manage the project. The rest of the staff are in the field. CCP mainly works through its 80 trained community

⁸⁷ CCP's wellness training programme involves helping trainees to understand the need to take responsibility for, and making choices that directly contribute to their own well-being and that of the common good, and transferring this knowledge to others, especially individuals and families infected and affected by HIV and AIDS. It includes understanding HIV and AIDS, including STIs; an active lifestyle; proper nutrition; healthy lifestyle choices; Emotional/Psychological Health and health promotion.

volunteers known as HIV Support Personnel⁸⁸, who are on various levels of internship and bursaries and receive stipends ranging between R500 and R3000 a month. These HIV Support Personnel work directly with communities including churches and religious leaders, schools, children (both in & out of school), and PLWHAs. They also mobilize families affected by HIV to contribute in addressing some of the challenges posed by the disease on a community-wide scale. The organization also works with Caregivers⁸⁹ in their homes. The greater part of CCP's work focuses on community outreach on HIV and AIDS, targeting areas that include townships in and around the city where the majority of people infected and affected by HIV and AIDS live.

Currently CCP operates on an annual budget of 3.47 million Rand of which 77.8% comes from PEPFAR through partnership with the CINDI network, 16.0% from Dorcas AIDS International, 5.7% from EngageHIV Foundation⁹⁰ and 0.5% from churches such All Saints Church in Pietermaritzburg. However, over the years CCP has attracted funders including: SIM, HopeHIV, Geneva Global, KNH, DCI, the UK Trust, NAMPAK, National Lottery, NABTA, ABI, AAC Trust, Irish AID, and various individuals and Churches.

6.1.2 What has CCP achieved through its operations?

In order to appreciate whether we can learn anything about barren and fertile silence from the work of CCP we need to know whether it has achieved anything of value. The work that CCP has done and continues to do is in line with its strategic plan, with activities emanating from the five objectives. CCP offers a family and community based holistic approach to meeting the complex needs and challenges faced by different groups of

⁸⁸ HIV Support Personnel comprise of Support Interns, Support Workers, Support Facilitators and Pastoral Support Workers. Support Interns are trained local church and community individuals on apprenticeship with CCP for a minimum of six months. Those Support Interns who prove themselves through the apprenticeship period are mentored by CCP to work as Support Workers, co-facilitating with CCP staff in the schools and communities. Having co-facilitated with CCP staff, Support Workers who avail themselves for training and gain the needed experience become Support Facilitators and facilitate on their own. In addition Pastors, Church leaders and available skilled personnel in trained churches and communities who show keen interest in CCP work and are willing to get involved are trained and considered Pastoral Support Workers.

⁸⁹ Caregivers are trained local church members or individual community members taking care of orphans and vulnerable children and stay with them or in close proximity within the community and they are constantly assisted in the communities by the HIV Support Personnel and CCP staff.

⁹⁰ EngageHIV Foundation was formerly known as iThemba AIDS Foundation.

people infected and affected in various ways by HIV and AIDS. The work that CCP does with OVCs becomes the hub that links all the others areas of intervention in which the organisation is involved. The activities of the project focus on building the capacity of communities, churches, schools, families and individuals in meeting and supporting the needs of families, adult and children (especially those orphaned and vulnerable due to HIV and AIDS), for them to manage and break the HIV and AIDS silence. Activities cut across from one objective to another as a result of the holistic and collaborative nature of the project. The work done by CCP is therefore considered under the various set objectives.

As the central hub, all CCP's work links to that of the OVCs with the view to offer a *future hope*⁹¹ to these children as they grow in the environment of this complex pandemic. CCP has an overall aim to provide good quality, comprehensive and compassionate care, focusing on HIV prevention among youth and OVCs within a family context. In line with this, CCP offers a range of services to help manage and address the various challenges posed by HIV and AIDS that include: facilitating OVCs access to education; offering HIV wellness to children and adults living with HIV and AIDS; psychosocial support to children, youth and adults; facilitating establishment of support groups for People Living with HIV and AIDS (PLWHAs); sustainability and livelihood programmes through food and nutrition services, including establishment and management of nutritional gardens in homes, communities, schools and church grounds, and referrals to accessing governments grants and documentation; community development and capacity building through training; spiritual support through prayer; provision of voluntary counselling & testing (VCT) services and referral to antiretroviral treatment (ART); school-based psychosocial support, HIV and AIDS education and prevention work targeting learners; and mentorship of community-based organizations (CBOs) involved in HIV and AIDS work.

⁹¹ "A Future Hope" is the overall project name for CCP. Future hope stems from the Bible in Proverbs 23:18 "there is surely a future hope for you, and your hope will not be cut off". Provision of such hope is what the Community Care Project seeks to offer to OVCs and families infected and affected by HIV and AIDS.

6.1.2.1 Wellness Training for Home-Based Care (H-BC) and Childcare Training and Support

Training has as its main objective empowering people to care for others infected and affected by HIV and AIDS. Activities aimed at training cut across all the various objectives of CCP. When CCP started, as a result of the shame and stigma attached to the disease, people who were suspected as being infected with the HIV were left by family members to die shameful deaths. As a response to the developing HIV issues affecting the wider community, CCP initiated a Home-Based Care (H-BC) programme primarily to look after the needs of these people dying in their own homes as a result of AIDS. This service offered basic nursing care, spiritual support through prayer and provision of food. It bridged the gap in offering support that was sensitive to the culture of the people, to the stigmatised individuals, with the hope that if they die it will be with dignity. It offered opportunity and tools for individuals and families to begin to discuss and talk about HIV and AIDS and to begin to deal with the silence around the disease.

CCP staff members and volunteers would go into homes and bath patients and provide solace for them. Volunteers from the churches were then trained in H-BC and child care so that they could attend to the sick and cater better for them and their children in their homes. This happened until the strategic plan review in 2005. During this time CCP partnered with ECAP to train the members from the churches in both H-BC and child care.

From 2005, with progress in the Support Group that was started the previous year, CCP changed its approach to caring for the sick in the communities and began to train and empower the Support Group members to be able to care for each other and others in the community that they knew were HIV positive. Through this approach, CCP was helping PLWHAs engage each other through the Support Group and to be open to one another and talk about issues of HIV and AIDS. Before this time CCP was helping the sick with the assumption that they were HIV positive, based on the clinical signs. Very few clients of CCP had done VCT. CCP started teaching the Support Group members and volunteers “Wellness for H-BC” rather than “H-BC training”.

In line with the changing arena of HIV and AIDS and its impact on the community socially, medically and economically, CCPs approach to training changed significantly. It took its cues from the success of the wellness training with the Support Group, that saw the group grow from its founding 4 members to 32 at the end of 2004. The members of the Support Group were trained to care for their own and to train others to care as well, thus applying the 2x2x2 principle. This is the underlying principle guiding the current strategic plan that makes training in CCP aim at interacting with trainees in all areas, to help them manage the disease, to be open about it and to teach others the very things they learn. Teaching others what they have learnt until they too can teach others the same things is what NAT developed for CCP as the 2x2x2 Principle (see section 6.2.3 below for details of the principle).

With increased accessibility to antiretroviral therapy (ART) CCP has been focusing more on empowering the local community and those infected with HIV. New training packages were developed in a number of areas with emphasis on 'wellness' for adults, and for caregivers looking after HIV positive children and for the HIV positive children themselves. Training also involves field medical support through health management for HIV positive adults and children. This involves many aspects of care, including compliance to ART regimes, other medical interventions and home-based and chronic care for the very sick. The availability of ART has made training in wellness more relevant. The training package and emphasis on wellness for H-BC rather than offering H-BC, helped in CCP being registered as a VCT site with the Municipality in February 2007.

With the current training came the enrolment of Support Personnel rather than volunteers as a way of offering a career path for trainees. Training in this way has become more intensive with trainees signing an internship contract with CCP for a year as Support Interns. After a year of service those who do well become Support Workers and out of those come Support Facilitators.

The training has helped raised men and women who are passionate about dealing with the HIV and AIDS silence and who desire to see it broken. Through the training, they have

come to learn how to engage with the fertile silence in a culturally sensitive way in order to expose the barren silence to be broken.

Table 6.1.2.1 below shows the progress that has been made so far through training the churches.

ACTIVITY RESULTS	2000/1	2002	2003	2004	2005	2006	2007	2008
TRAINING AND SUPPORT IN CHURCHES								
Number of new Churches who changed their attitudes towards HIV and AIDS and sent members for CCP training. <i>(Seen as Church in Partnership with CCP from 2006 onwards)</i>	5	14	20	17	23	10	11	17
Number of Communities educated on HIV and AIDS issues and allowing carers to work in (commulative) – <i>By 2006 communities did not need to be convinced to allow carers to work.</i>	4	12 (8 New)	20 (11 New)	23	25	All the Area to the Pietermaritzburg is seen to be open to the HIV education		
Number of church members trained as volunteers (home-based carers) to do caring in the communities and Families <i>(Seen as the various Support Personnel from CCP Partner Churches from 2006 onwards)</i>	71	200	269	235	218	287	526	156
Number of clients identified and cared for holistically and provided with food and medication.	15	372	397	62	125	198	256	281
Support Group Membership	-	-	-	32	76	105	148	193
Wellness Training for Adults	-	-	-	74	154	285	526	156
Training in Gender-Based Violence and Child Protection Issues	-	-	-	-	-	155	375	104

Table 6.1.2.1 Progress in Churches Training and Support

6.1.2.1A Training Beyond Pietermaritzburg

In line with the vision of Project Gateway to be a resource to other churches beyond Pietermaritzburg, CCP has assisted five churches in parts of KwaZulu-Natal, the Free State and Zambia. The Grace Community Church in Matubatuba and the Dihlabeng Church in Clarens were supported with the needed skills, seed finance and oversight from CCP to facilitate the smooth operation of their HIV and Aids projects, which CCP helped to establish in 2006.

6.1.2.2 Schools HIV and AIDS Education and Leadership Development in HIV and AIDS Issues

The start of CCP's OVC work in 2003 led to the link with schools. Over the years different schools have partnered with CCP for different interventions, with learners involved in different activities. Partnership with schools have included:

- i) seeking the psychosocial and economic related welfare of OVCs in the schools,
- ii) training learners in HIV Prevention Education and Life Skills to help identify OVCs who needed home visitation and interventions with entire households for management of HIV and AIDS related issues,
- iii) using the Generation of Leaders Discovered (GoLD⁹²) programme and Schools AIDS Programme (SAP⁹³) to raise peer educators to facilitate HIV education in the schools and;
- iv) offering general HIV information to the entire schools through Schools Assemblies.

Educators are engaged with and workshopped to understand issues pertaining to OVCs and how to work with them. Table 6.1.2.2 below shows progress made in these areas.

Working into schools began as a result of CCP's social workers identifying psychosocial problems with CCP OVCs, especially to do with children with learning difficulties, and making follow-ups with the authorities of the schools they were attending. Besides the psychosocial issues, some of the orphans could not pay school fees, others had

92 This is a programme that CCP partnered with GoLD based in Cape Town to pilot in 2 schools, Kwapata High School and Sqongweni High School for Peer Education programmes

93 SAP is a group formed in the schools that uses NAT's 2x2x2 principle to train learners to disseminate HIV and AIDS information to their peer at school and siblings, friends and family members at home. It started in Russell High Girls School in 2006.

disciplinary problems in the schools. CCP had to go into the schools to remedy the situation. For the school fees, CCP successfully negotiated for non payment of fees, with CCP in turn linking with the schools to offer psychosocial support to learners who needed it. In this way CCP had to link and work with Gateway Christian School and Izwilesizwe Primary School – Imbali Unit BB, 2 schools that 15 of the OVCs were attending. This initial work continued for 2 years in the same schools. With the work becoming too much for the social workers, in 2004 CCP employed two staff members to be responsible for the growing schools work. Again with the 2X2X2 principle, the social workers began to empower CCP staff and volunteers in social work. Arrangements were put in place for CCP staff and some volunteers to receive training in memory work by the Sinomlando Centre for Oral History and Memory Work in Africa between 2003 and 2006. Through the four-day training workshop the trainees learned basic bereavement counselling skills and the methodology of the memory box. The partnership with Sinomlando helped one young man heading a house of 3 siblings to be trained as a community worker in memory work at the University of Kwazulu Natal in 2004-2005. The memory work skills were augmented with various workshops and training in play skills and bereavement counselling by the Rob Smetherham Bereavement Service for Children (RSBSC)⁹⁴ in 2004.

The skills gained helped the psychosocial CCP team to initiate bereavement counselling and play skills in 2005 in 5 primary schools including: Gateway Christian School, Izwilesizwe Primary School – Imbali Unit BB, Sbongamandla Primary School – Edendale, Henryville Primary School – Dambuza, Fanizwile Primary School – Dambuza. In all, 142 bereaved children were helped to deal with their problems. The work in the primary schools laid the ground work for CCP's work in high schools when the Generation of Leaders Discovered (GoLD) partnered with CCP to pilot a peer education programme in 2 schools in September 2005. In this way the primary schools work, apart from the Gateway school where 35 learners were helped, were left for other organisations to continue. The GoLD programme carried on until mid 2007 and from

⁹⁴ The Rob Smetherham Bereavement Service for Children focuses on developing skills in organisations to bring hope and healing to bereaved children, their caregivers, families and other caring community members.

then on PEPFAR partnered with CCP through CINDI to initiate HIV Prevention Education and Life Skills in high school. So far 14 schools have embraced the prevention programme.

The HIV and AIDS work in the schools and the churches is an entry point into intervening in the havoc that the disease has inflicted in the community as a result of the silence and secrecy around the disease. It has been the experience of CCP that people in the communities are able to tell you they are sick with any disease except HIV or AIDS. However, working with the learners through the 2x2x2 principle, helps the children to take issues discussed back to their homes, which opens dialogue on the disease at home for the parents, caregivers and other guardians to discuss HIV and AIDS issues. Learners who are OVCs or have problems around HIV and AIDS are identified and with issues on the disease already discussed at home, a pathway is created for the CCP team and trained Support Personnel from the churches to visit these homes. This is the net effect of the filtration principle (see section 6.2.2 below for the details of this principle).

Table 6.1.2.2 below shows the progress made in the schools' HIV and AIDS education and Leadership Development.

TRAINING AND LEADERSHIP DEVELOPMENT IN SCHOOLS	2000/1	2002	2003	2004	2005	2006	2007	2008
No of School partnered with CCP	-	-	2	6	4	4	9	16
No of learners trained (involved in programme)	-	-	15	142	99	89	3024	6574
Schools involved in GoLD Peer Education Programme	-	-	-	-	2	2	2	-
No. of Learners involved in GoLD Peer Education Programme	-	-	-	-	64	64	61	-
Educators HIV and AIDS workshops/Training	-	-	-	-	20	20	120	150
No. of school with SAPs	-	-	-	-	-	1	1	1
Schools AIDS Programmes	-	-	-	-	-	25	120	195
Schools with HIV Prevention Education and Life Skills	-	-	-	-	-	-	5	14

TRAINING AND LEADERSHIP DEVELOPMENT IN SCHOOLS	2000/1	2002	2003	2004	2005	2006	2007	2008
Learners attending HIV Prevention Education and Life Skills	-	-	-	-	-	-	2843	6454
OVCs identified through prevention Education and Life Skills	-	-	-	-	-	-	1724	4100
Learners Receiving General HIV Information through Schools Assemblies	-	-	-	-	2500	2500	5000	9500

Table 6.1.2.2: Progress in Schools and Leadership Training

6.1.2.3 Orphans and Vulnerable Children (OVC) Programmes (*Future Hope*)

CCP's OVC work commenced in 2003 when a couple who are social workers by profession, Robert and Deborah Ng Yu Tin, were seconded by SIM to CCP. Their major interest was to help CCP initiate an orphans and vulnerable children component of the work. CCP's work at this time was mainly training home-based carers and looking after the sick in the community. As the couple went into the field with the Home-Based Carers, and as they continued working with sick and dying adults (in this case predominantly women), Rob and Debbie realised that there were large numbers of children being orphaned and traumatized by the death of their primary carers and without any intervention into their situation. The main aim of the OVC component of the CCP work was to make the children understand the issue of HIV and AIDS and involve them in dealing with the silence around it. To arrest the situation, CCP began a basic orphan care programme, looking initially at the nutritional and educational needs of children orphaned through HIV and AIDS. Linking and training with Sinomlando Centre for Oral History and Memory Work helped to involve the children, addressing HIV and AIDS issues, and attending to some of their psychosocial needs.

Having begun working with the children and as the needs of these children increased, CCP undertook a mapping exercise in November 2003 so as to understand the situation clearly. The mapping exercise revealed that both family profile and needs of the H-BC families and the OVC families were similar. CCP therefore saw the need to amalgamate

both HBC and OVC work calling it “FAMILY INTERVENTION”. By the end of the year, CCP was working with 39 families comprising of 137 OVCs. The mapping showed that 14 of these OVCs were HIV positive themselves, all were under 8 years and 3 of the families were child-headed households. Table 6.1.2.3 below shows the progress in OVC and Family Support.

OVC AND FAMILY SUPPORT	2000/1	2002	2003	2004	2005	2006	2007	2008
Number of Families empowered to cater and provide for their PWAs and OVCs	10	15	39	61	75	126	168	320
Number of OVCs holistically cared for and provided with food, medication and educational support in homes, as siblings of OVCs in schools	-	13	137	161	191	285	316	660
HIV Positive OVCs	-	-	14					
Bereavement Counselling and Play Skill	-	-		40	90	15	21	24
VCT	-	-		14	38	44	4	120
CD4	-	-		11	19	30	1	40
Disclosure of HIV Status to Children	-	-		14	18	22	2	-
Memory Box Training	-	-		20	1	12	-	-
Memory Box Work with Families	-	-		11	8	5	-	-
Child-headed households	-	-	3			18	25	32
Youth Programme	-	-		30	210	146	61	-

Table 6.1.2.3: Progress in OVC and Family Support

The above situation needed immediate intervention. In early 2004 CCP began to advertise for new staff to join the organisation for the family intervention programme to cater for the OVCs. The appointment of new staff members was followed by the Bereavement and Play Skills training with RSBCS, which ushered new activities into the OVC interventions. In addition to OVCs in schools, CCP had play skills for 40 bereaved OVCs in the communities. The 14 under-eight children were taken to the clinics for testing where it was confirmed that they were HIV positive. This led CCP to initiate the first-ever disclosure work with these children, to help them understand that they are living with HIV. This was developed by the CCP nursing team. It began with pre-test counselling with the carers of these children, some of whom knew that they were orphaned through AIDS. Others were only suspicious, and hoped that their children were not HIV positive.

The pre-test counselling therefore helped to prepare the carer for and involved them in the test itself and the disclosing of the status to the child.

The disclosure work, which utilised play skills, formed part of wellness for the children in understanding their bodies, the place of hygiene, the medication they need to take, and the times to take them, compliance with medication etc. The most important thing about disclosure is the reason for disclosure – firstly to benefit the HIV positive child, in terms of the support they will get and the sense of liberation they will feel thereafter, NOT a sense of duty or being pushed into doing it before they feel ready. The pioneering work of HIV disclosure to children gained prominence and took the centre stage at the CINDI 10 year anniversary conference that was held in Pietermaritzburg, from the 3 - 7 April 2006, when Emma Camp and Thabile Duma⁹⁵ presented their work. This work continued until 2007. Another aspect of the work of disclosure to children, as part of the family intervention, was disclosing the HIV status of adults to children, which skills from the memory work facilitated.

Through home visits and community care CCP found that most of OVCs were catered for by grandmothers (*gogos*) who were struggling to look after children where their developmental milestones had not been met, due to their HIV status. CCP initiated training for these *gogos* and they formed a support group to help one another.

The home visits to CCP families led to the discovery of 30 young OVCs between the ages of 12 and 20 years. CCP began Art classes with them. They used this medium to expressing their thoughts, feelings and hope. The highlight of the youth work for 2004 was when on the 6 July four CCP staff and three members of a team from Northern Ireland took 13 teenagers to the Sani Pass for two nights. The aim of the trip was to build the trust and friendship which were developing within the group, to teach life skills and to have fun. One member of the group wrote of her experiences of the trip: “At Sani Pass I enjoyed lots of things that we had been doing. The most important thing that I enjoyed was the sexual health topic. We asked questions based on that topic and we had answers

⁹⁵ Emma Camp was the CCP nurse from UK and Thabile Duma was the Community Child Care Worker who led the disclosure work.

for that topic. Another thing that I enjoyed is when we talked about how we can avoid stress in our lives. I also enjoyed the games that we had been playing because some games had the message e.g. trust game.” (Northern Ireland Team Report to CCP, July 2004)

The youth work that has become a major component of CCP to date, aims at using the 2x2x2 principle to help the youth deal with and manage their own HIV and AIDS situation and use their experience to help other OVCs. CCP youth work includes:

- General youth development with fun activities
- Cultural Dance
- Poetry
- Drama
- Inculcating work ethics in the youth whilst helping them to understand play, fun and music in their lives.

A 3-hour weekly Friday meeting for the youth was put in place from 2004 until 2007, when funding for that aspect of the work dried up. The sessions of the meetings included English learning to encourage confidence building, greater understanding of English to boost school work; *Boys and Girls Time*. Soccer was introduced for the young men, especially done to allow an environment conducive to young men struggling to have “halftime team talk”. Team talk is a time set aside for discussions during the halftime of the match that covered different aspects of their lives. The girls had their *Tell It As It Is Time* where they discussed new happenings in their lives ranging from sexual health, to nutritional health. The yearly camps for the group of young people covered:

- leadership skills
- gender sensitive life skills
- team building
- sex and sexuality and HIV
- Future Hope

Besides the various psychosocial activities that the OVCs are involved in, a number of services are also provided to these OVCs in the family setting. Services include:

6.1.2.3A Access to health care (Including counselling and testing)

Through the various group activities, CCP identifies Orphans and Vulnerable Children who require basic health services, and refers them to the appropriate health care centres. Where appropriate, the trained Caregivers and HIV Support Personnel, under the supervision of the CCP nurse, provide home-based treatment of Orphans and Vulnerable Children for some of these diseases. CCP closely work with the Department of Health and the other relevant agencies in monitoring the health situation of the Orphans and Vulnerable Children and take corrective measures on a timely basis. Since 2006, in consultation with parents of OVCs that CCP identifies to have not met their developmental milestones, which are found not to have been caused by the common child-killer diseases and malnutrition, are tested in the homes by CCP's mobile VCT service. The youth are always encouraged to do VCT as well. CCP works as a partner with Lifeline in the schools to do VCT as part of the May'kethele Project⁹⁶. OVCs diagnosed HIV positive are followed up with further counselling, referrals for CD4 counting and treatment, and nutritional support. They are regularly monitored to protect them from further infection or abuse in the family and the general community.

6.1.2.3B Child protection interventions (legal assistance with inheritance problems & against abuse, and access to identity documents).

CCP engages in a number of child protection activities. These range from linking Orphans and Vulnerable Children to organizations that provide free legal assistance, and assisting Orphans and Vulnerable Children in obtaining legal documents such as birth certificates and identity documents. In instances where CCP has encountered abuse of OVCs and family members, either sexually or physically, or issues over inheritance disputes with members of their extended families, CCP has referred them to organizations that provide free legal services, to be represented in courts of law when necessary. Such organizations have included Lifeline, Esther House, Department of Social Development and Child Welfare.

⁹⁶ May'kethele (meaning Our Choice, Our Future) is a programme of a partnership between CINDI and four of its members: Community Care Project, Lifeline, Sinani and Youth for Christ and funded by USAID's President's Emergency Plan for AIDS Relief (PEPFAR) to support and care for orphan and vulnerable children through school and family intervention

6.1.2.4 Facilitating Churches to initiate Community Based Organisation (CBOs) or Projects

CCP works through churches as an inroll into the communities. By the end of 2008, people from 117 churches in the Pietermaritzburg area have been trained, with 23 churches having Home-Based care related projects within the communities. The difficulty though has been getting these churches to become registered Community Based Organisations (CBOs), which CCP has sought to do with the help of NAT. So far the church projects that have become CBOs include the Zamimpilo Drop in Centre of the 7th Day Adventist France in France, GIMRF of the Revival of Grace Faith Church in Dambuza, Duduza Centre of the New Zion Church and Senior Citizen's Group of the Brethren Church in Imbali Unit J.

The story of the Zamimpilo Drop in Centre has been a long and successful one. Bongiwe Virginia Msomi from France who leads the 7th Day Adventist Church, trained with CCP in home-based care and child care in 2004. As she cared for the sick in her community in France, she began a creche to take care of the children in these families who were vulnerable as a result of HIV, the majority themselves HIV positive. These children are between 2years and 5years old. In April 2005, she did an advanced home-based course, comprising the new wellness course that CCP just started. During the course, she shared what she was doing with CCP. When a team from CCP undertook a follow-up visit to her home, they found that she had built a small extension on to her little house and had started a crèche that she calls a drop-in centre which was not registered. It was only 4 walls with no toys or stimulants, but it provided a safe place where about 40 pre-school children could be safe and fed every day rather than roaming around the street or sitting at home alone with a dying parent. She was using her own pension money to buy food for the children.

CCP began to work with Bongiwe, whom the CCP team affectionately calls Mama Msomi, to provide toys, clothes, blankets, monthly food parcels and occasional financial gifts to the crèche. Having shown interest in her work through this essential provision, CCP began to plan with her and her helpers for the crèche by helping her to develop her vision. They formed a committee from the church and the community and registered the crèche with the department of social welfare. The need for Zamimpilo to network with

other organizations was stressed. The crèche began to work with other organizations, such as ECAP for provided HIV educational support and training, King Pie – Bread, Sakhisizwe e Afrika – Training, SOS Children’s village – tables and chairs, and Msunduzi Municipality – cooked meals.

In June 2005 CCP applied for funding from KNH⁹⁷ through CINDI and put in a bid for funding to mentor Zamimpilo for three years. CCP was successful in the application. With a strategic plan in place, Zamimpilo began its full activities including:

- ***Orphan Care (From Birth to 6 years)***

Caring for OVCs who are not able to go to school because they have sick and unemployed parents who have no money for school fees and expenses and no access to child support grants. Zamimpilo visits the parents to refer them to social workers for help in accessing grants. OVCs more than 6 years old are referred to orphanages. The OVCs in care are given basic education, provided with meals 3 times a day and snacks in between the meals for nourishment. They are taught drawing and painting and make educational visits to museums, Botanical gardens etc.

- ***After Care Service***

Aftercare service up to 18H00 is provided to non-OVCs whose parents are working. Parents pay for these services to fund the project.

- ***Youth development***

Zamimpilo has formed a group of teenagers called the Kingdom Gospel Group, who sing gospel music to keep them away from the streets. They have a keyboard, amplifier and sound speaker. Zamimpilo uses this opportunity to educate them on issues of HIV and AIDS and to apply CCP’s 2x2x2 to teach their peers in the France community.

- ***HIV Adult health***

Zamimpilo does home-based care in the community from Phase One to Phase 5 in the France Location. In homes that are led by children, Zamimpilo takes the younger siblings to the drop-in Centre to allow the school age child to go to school daily. Once

97 KNH stands for Kindernothilfe, a German donor, who provided funding for CINDI member organisations

again using the 2x2x2 principle, other members of the community are trained to become “Care givers” and provided with first aid boxes to use. The Care givers also teach community based wellness to community members. Care givers assist patients who are on Anti Retro Viral drugs and other medications, to do so timeously with their meals.

- ***Nutritional sustainability***

Zamimpilo has developed its own food garden, which helps feed the children and community members.

- ***Spiritual support***

Zamimpilo teaches Sunday school and uses Bible teaching to comfort the sick and discouraged. The children and clients are encouraged to gain strength and support from the Bible. Zamimpilo prays with its clients and children and joins the monthly prayer at CCP.

Zamimpilo has run several community events and this has raised the profile of the project. In 2006 the Municipality provided an abandoned house on a plot of land to Zaminpilo to renovate and use for its activities. CCP contacted a soft drink making company by the name of ABI, who promised R10,000 donation and labour to renovate the place. Other Pietermaritzburg-based hardware businesses including Musa’s, Natal Associated Agencies, Makro, PMB Auctions, FEDS DIY, Southgate Build It, provided building materials to the tune of about R6500 to help the renovations. It was with joy that on Tuesday 27th February 2007, 14 staff from ABI and the staff of CCP went to the site to renovate the place. Lunch and cool drinks provided by ABI went down very well and Mama Msomi and her The Zaminpilo committee said a thank you by doing some Zulu dancing. The Natal Witness newspaper was there to cover the event, which was in the newspaper the next day.

The renovations were sufficient to allow Zaminpilo to transfer into its new site, a big area with a fence. Therefore Zaminpilo is no longer just a crèche but a fulfilled vision for a community centre, with many facets to reach out to meet local needs. CCP is encouraged by this as a fulfillment of its hope of seeing satellites of CCPs in the communities. It

looks forward to seeing other CBOs expand in this fashion and more churches become CBOs.

6.1.2.5 Sustainability and Economic Strengthening Programmes with Beneficiaries.

CCP has moved through different phases. It has moved from the point of being overwhelmed by the HIV and Aids situation (which presented one of the biggest challenges the city has ever had to contend with) to responding by offering care to only the identified infected individuals in the communities. At the beginning PLWHAs were offered food parcels, clothes, blankets, bed linen, commodes, towels, medical supplies from Bethany House, with CCP staff on their own providing care for the sick. However, when the strategic plan was put in place, the need to involve trained personnel from the churches to help in the care and provide for the sick was identified. Still all that the sick person needed was supplied by CCP. There were a number of times when patients were near death and instead of family members phoning the Government ambulance at no cost, they will phone CCP to come and take their patient.

During CCP's community analysis in 2003, a question was posed to the stakeholders as to what they could do to help CCP should funding run out, or what they could do to fight HIV in the community if CCP was no longer available. Most of the caregivers indicated that they could plant vegetable gardens and sell the produce to support the work of CCP if only they had an expert who could help them plant the gardens. Acting on this Mr Thabani Ndlovu was appointed in March 2004 to help initiate food gardens with families with which CCP works. During the year, 5 families in Imbali Unit 14 and Mpumzuza were assisted to plant Cabbage, Spinach, Brinjal, Sugar Beans, Beetroot, Green Beans, Peas Cabbage, Spring Onion, Carrot and Turnip in their gardens. In 2005, the gardens were extended to Imbali Unit BB, Dambuza, Willowfontein, Edendale and Sobantu, with 9 more families planting vegetables. The arrangement with families was that they should contribute 10% of their profit to help other families to start their gardens, (if they sell their produce) or to give 10% of the vegetables to child-headed household that have been identified.

During the strategic review in 2005, it was decided that families would be empowered to manage their own HIV situation for the sake of sustainability. The households of OVCs who needed nutritional support would be trained on how to establish and maintain nutritional gardens in their homes, schools and communities to produce fruit and vegetables to supplement their nutritional requirements and be a source of income generation. Notwithstanding the sustainability plan to help families help themselves, provision of food parcels has taken place in emergency situations in the families and for child-headed households. In the area of food and nutritional gardens, progress has been slow. The table 6.1.2.5.B below show the progress that has been made so far.

SUSTAINABILITY AND ECONOMIC STRENGTHENING	2000/1	2002	2003	2004	2005	2006	2007	2008
No of people trained in Food Garden Training	-	-	-	5	21	28	100	150
No of Food Gardens Planted	-	-	2	5	21	17	21	30
No of Families accessing Government Grants	-	-	-	2	3	8	50	70
% Families Trained in Gardens				8.3	28	22	59.5	46.8
% Trained Families in Gardening				100	100	60.7	21	20

Table 6.1.2.5: Progress in Sustainability and Economic Strengthening

6.1.3 In which ways has CCP developed this model?

The CCP model has developed over the years. It arose out of the need in the communities to have an HIV and AIDS Programme that would help families deal with an unprecedented baffling pandemic. Experience gained in the field as the years go by and partnership with others in the field has contributed to the development of the model. At the moment being part of the CINDI network, CCP is in contact with over 200 NGOs and CBOs. The stakeholders of CCP make a huge contribution to the model and its outworking during the community analysis weeks as they critique the work of CCP. By CCP staff attending workshops and conferences, they are exposed to best practice models elsewhere and that has contributed to the building of the CCP model.

What this first section of chapter six has made clear is that the CCP model has achieved much in the struggle against stigma and discrimination. Without claiming too much, it

would be true to say that it has managed to ‘break the silence’ surrounding HIV and AIDS, and allowed for people’s dignity to be respected, and livelihoods to be supported. CCP has achieved this through paying attention to the cultural context of silence, in other words, by dealing with what we have called the ‘fertile silence’ in this dissertation. To underlie this further and to strengthen the argument of the dissertation, we need to examine how CCP has done this and draw out further lessons for our claims in the previous chapters.

6.2 What are the key elements of the CCP Model that engages with the Fertile silence?

Following the outcomes of the activities of CCP outlined in section 6.1.2 above in terms of what CCP has achieved over the years, I now draw mainly on the responses from those involved day by day with the project in the field, to answer the third research question: *Can the interventions provided by the Community Care Project suggest constructive ways of engaging with and breaking the silence surrounding HIV and AIDS in the Pietermaritzburg area?* In this way I will be looking at how the CCP model enables the community to deal with the HIV silence and attempts to break it in the light of the cultural underpinnings.

So far in the thesis, I have argued that there is the existence of both a barren and fertile silence. In a high context culture such as in the Pietermaritzburg area, the HIV and AIDS silence we desire to break is a barren silence that is wrapped up in a thick fertile silence. However I have argued that this large fertile silence can be engaged with, allowing the barren silence to be uncovered and broken. Therefore, any attempt to break the HIV and AIDS silence must take into consideration the fertile silence. I have also shown how the HIV and AIDS silence links with stigma and discrimination. There are cultural barriers underpinning the HIV and AIDS silence in the form of taboos, myths, witchcraft, etc. It is these barriers that lead to stigma and discrimination being applied to the disease making infected people and families maintain silence around it.

Now, to further strengthen the arguments made, in this section I want to show how the CCP model which we have introduced above, by focussing on the fertile silence, rather

than on the barren silence, has enabled us to journey with people through the fertile silence and ultimately break the barren silence. The section draws on data obtained mainly from the Support Group members who are living with HIV and others living with the disease but who do not belong to the group. It will also draw on others including pastors who work with CCP and have been offering spiritual and psychosocial support to people living with HIV and AIDS. The pastors also support and their families, caregivers and family members of PLWHAs who have been caring for PLWHAs in different ways, trainees who were about to qualify to care for people living with HIV and AIDS; and staff from CCP. I will also draw from my own observations as well.

The aim of this section therefore is to find out how the CCP model overcomes the cultural barriers by engaging with the fertile silence that is present so that the silence around HIV and AIDS, what we have identified as the barren silence, is exposed and broken through the process of disclosure. It is only when PLWHAs and families infected and affected by the disease disclose their HIV and AIDS status that the HIV and AIDS silence is broken. The various methods and strategies that are used by the CCP model are pointed out and examples are drawn from the data to explain them. We have done this in six ways:

1. Culturally sensitive HIV and AIDS education.
2. Intervention: the filtration principle
3. Training: the 2x2x2 principle
4. Home visitations and family interventions
5. The Support Group
6. The monthly HIV prayer meeting

Let us examine each one in greater detail.

6.2.1 Culturally sensitive HIV and AIDS Education

According to the respondents, a lack of culturally sensitive education on HIV and AIDS in the communities contributes greatly to the stigma and discrimination that causes in silence surrounding the disease. One pastor explained that because of improper education on HIV in the community, people end up exaggerating whatever information they receive

or give their own incorrect versions to others. When people are discussing someone's HIV situation they make it look so alarming and hopeless. Therefore people who are infected do not want to expose themselves to such ill-treatment and keep silent (*see*: Appendix 5D1). For a Support Group member, lack of education on the disease makes the caring nature of the culture unfruitful. He said “the caring nature of our culture and the lack of education, which makes people cling to their misunderstandings and myths, lead to silence on the disease. This is because as people draw to you to care for you, their lack of education on HIV will make them gossip about you if they know that you are HIV-positive or even turn to drive you out of the house” (*see*: Appendix 5G1).

This shows that continuous culturally sensitive education about the disease in schools, churches, during funerals, etc will go a long way to help people understand the disease and be of help to infected people rather than stigmatising and discriminating against them. After working with the Support Group since its inception and being a nurse working in the communities, a CCP staff member in an interview confirmed from her own experience, that breaking the HIV and AIDS silence hinges on education in the community, education that is based on good relationships and therefore culturally sensitive. She noted that the *Indunas* and *iNkosis*⁹⁸ were good educators and used to organise meetings for the education of the people to help them change their attitudes. With the use of the filtration principle, CCP educates people in the schools, churches and other community events in which they can partake, such as funerals. With the good relationship that CCP built with Thuli and her family, when she passed away her funeral offered an opportunity for education in HIV and AIDS (*see*: Appendix 5B1 and Appendix 5B2). Her mother pointed out that she felt the openness about HIV at her daughter's funeral was a big help for the young people who were there, as well as the

⁹⁸ During colonial times, indigenous people were ruled by a King (who inherited their authority), *iNkosis* (or chiefs) and *iNdunas* (or headmen). www.ukzn.ac.za/heard/research/ResearchReports/2005/Environment%20Report/Sec%20B_intro.pdf. *Inkosis* or *fumes* (chiefs) are other lords with fewer vassals. <http://www.1911encyclopedia.org/Monomotapa>. *InDuna* (plural: *izinDuna*) is a Zulu title meaning advisor, great leader, ambassador, headman, or commander of group of warriors. It can also mean spokesperson or mediator as the *izinDuna* often acted as a bridge between the people and the king. The title was reserved for senior officials appointed by the king or chief, and was awarded to individuals held in high esteem for their qualities of leadership, bravery or service to the community. The *izinDuna* would regularly gather for an *indaba* to discuss important issues. <http://en.wikipedia.org/wiki/InDuna>

people in the community as whole who often consider the disease to be only a young people's disease. Even during the Support Group discussions after the funeral, each of the members wanted a message about HIV and AIDS to be preached at their funerals and pointed out that it will help to make people aware that they did not die of witchcraft, as is normally suggested when one dies of AIDS. The CCP staff members who are from the community themselves were convinced that the message at the funeral would help the family and the entire community to understand HIV and change their attitudes. To a large extent they believed the funeral opened a way for people to be open about HIV.

The HIV and AIDS presentations to churches during their Sunday services by CCP have helped reduce stigma within those churches. In answering the question as to why infected people in churches keep silent about their status, some respondents pointed out that there is a lot of discrimination in the church because of a lack of education, which makes people to think that shaking hands can bring infection (*see*: Appendix 5F1). However after CCP's motivational HIV and AIDS presentations in the churches, a lot of members offer themselves for training so that they could care for PLWHAs. When asked how the pastors got to know those who are HIV positive in their churches, one pastor declared that after CCP's presentation he started showing love towards those in his church who are sick and started continuously praying for sick people. Then people came forward and disclosed to him their HIV status. In the Full Gospel church on 18th June 2006, after CCP's motivational presentation on HIV and AIDS, one lady who is HIV positive came forward to be prayed for. That was the first time she ever told somebody else that she was HIV positive. The love that she received from the church members overwhelmed her. This breakthrough began at HIV and AIDS ministry in the Church.

Culturally sensitive education on HIV and AIDS is therefore key in helping people to understand issues pertaining to HIV and dispels all the myths around the disease. It also helps people to feel free to talk about the disease and to help in every way possible people infected and affected by the disease. Culturally appropriate education is not just information-giving such as handing out pamphlets etc. Rather it is the use of interactive drama, poetry, traditional songs and dancing, HIV and AIDS related games, crafts, etc. It means, as well, visits to HIV and AIDS sites to be involved with the lives of individuals

living with the disease and hearing their testimonies. In this way all the work that CCP does, whether training, interventions or sustainability, is directed by cultural appropriateness. Churches and schools become places where fertile silence can be appropriated through culturally sensitive education. This is because there is commonality among the people within these places. In the churches there is a common language, willingness to gather, the use of the same Bible, the desire to pray, etc. In schools, there is common language, same age groups, willingness to learn etc. The fundamental principle is that to engage the fertile silence is to engage those spaces where we have access to commonality that makes people free to communicate. This works well in schools and churches and further into families and individuals within the community.

This experience of CCP lends credence to our theory that if we deal with and engage the fertile silence, the barren silence will be open and broken.

6.2.2 Intervention: The Filtration Principle

The filtration principle begins with the culturally appropriate education that we have just dealt with, but provides an intentional way in which this education spills out in the open, in culturally appropriate ways, facts about HIV and AIDS to the entire population of the school or church. From the schools and churches, information filters down into the community. In this way the filtration principle comes into effect, as shown in figure 6.2.2 below:

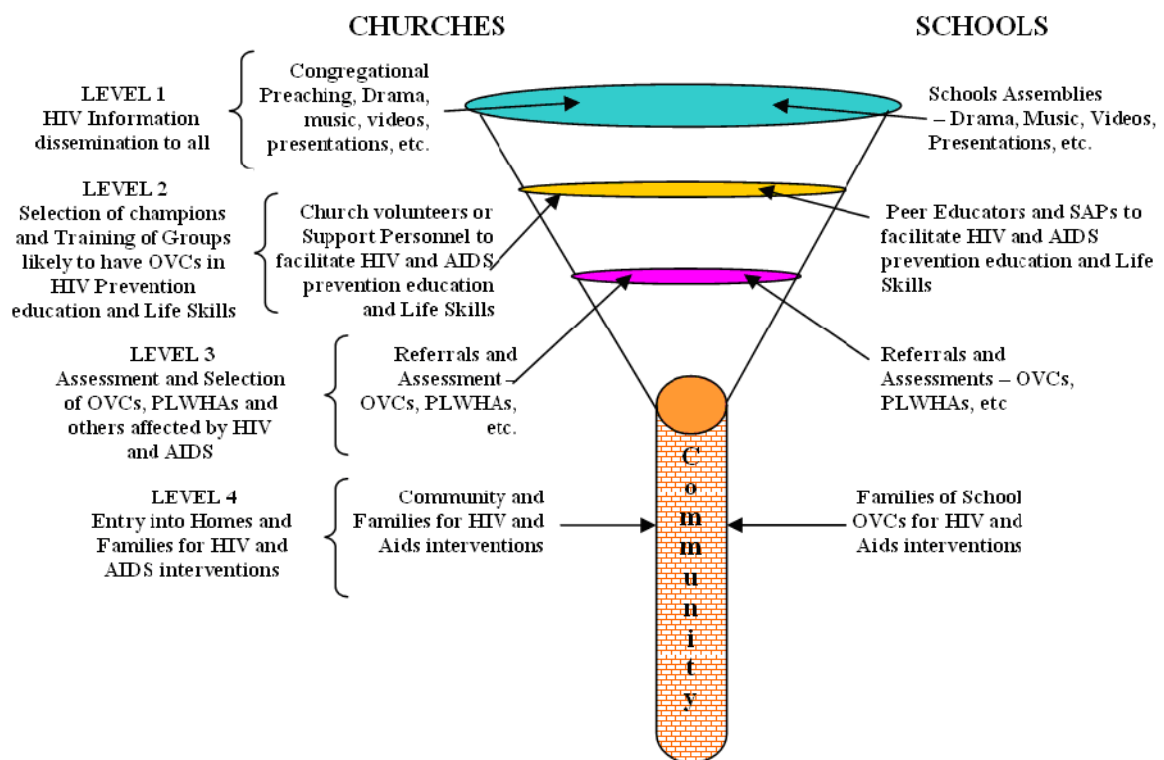


Figure 6.2.2: The Filtration Principle – Adopted from Benson Okyere-Manu, NAT

The Filtration Principle considers the mobilisation of churches (on the left column of the diagram) and the mobilisation of the schools (on the right column of the diagram) as entry points into the community for HIV and AIDS work. Like a funnel for filtration, the opening is broad (Level 1). This is at the congregational level (in the case of the church) or at the assembly level (in the case of the school) where HIV and AIDS information is disseminated to all the people present. As we noted in the previous section on culturally sensitive education, in the schools the assembly of all learners, educators, non teaching staff etc., is provided with HIV and AIDS information using drama, videos, music and so on. In the churches usually CCP uses preaching to bring out information on HIV.

At level 2, the size of the funnel becomes smaller than the entry point. In this case the journey to the community to tackle HIV and AIDS issues enters the level of selecting champions who can help in facilitating HIV and AIDS training as well as identifying areas that may produce orphans and other children made vulnerable by HIV and AIDS. Such children are those who live in households in the community that are grappling with

issues of HIV and AIDS the most, but are keeping silent, when in actual fact they need the help that CCP offers. In the schools these groups would consist of the grade 8s and 9s as they are likely to meet the UNICEF definition of OVC⁹⁹, whilst in the churches, it would be the youth groups. These groups are given HIV Prevention Education and Life Skills to help them understand the HIV situation and assess their own situation.

The level 3 is closer to the opening where the filter is. This is the assessment and identification level, where the OVCs are identified and selected from within the groups to lead CCP into their homes in the communities. So far in the schools that CCP has worked in within the Pietermaritzburg Area, the identification process showed about 62% of the learners are OVCs.

Level 4 in the funnel analogy is the opening where pure solvent comes out. This is the entrance into the community. The identified OVCs at this point lead CCP into their communities and into their own homes. Family assessments are done to identify needs so that the required HIV interventions can be rendered. For the homes that the OVCs have led CCP into, there is an average of 3 siblings who are also OVCs.

This principle therefore utilises networks within the community to forge the HIV and AIDS needs into the individual community person's agenda. This is a key understanding in addressing the stigma and discrimination that fuels the silence around the disease. The filtration principle utilises the Church and Schools as a trusted network within the community, with an available audience that can easily be mobilised. In the community, people take leaders of these institutions seriously and trust them. Pastors and school principals are held in high esteem in the communities as leaders of good standing. These qualities of the institutions make them a good place to begin culturally sensitive education to help tackle issues of HIV and AIDS silence, rather than the taxi ranks,

⁹⁹ UNICEF (2005) defines an OVC as below the age of 18 and i) has lost one or both parents, or ii) has a chronically ill parent (regardless of whether the parent lives in the same household as the child), or iii) lives in a household where in the past 12 months at least one adult died and was sick for 3 of the 12 months before he/she died, or iv) lives in a household where at least one adult was seriously ill for at least 3 months in the past 12 months, or v) lives outside of family care (i.e. lives in an institution or on the streets).

billboards, TV adverts or in political rallies. The filtration principle uses resources that are available in the community and common to the people.

As noted, this principle begins with culturally sensitive education. It is a broad move to make as many people as possible aware of the HIV and AIDS situation and the need to break the silence around the disease, using culturally appropriate methods. In this way it deals with all manner of myths and with issues of stigma and discrimination. People are made to understand that HIV and AIDS is a problem for everyone and that everyone is either infected or affected or both. The fact that HIV and AIDS affect everyone is stressed at this point so that the disease is not seen with a contemptuous eye but a sympathetic one.

As training begins with the various classes or groups, deeper issues are dealt with both in HIV prevention education and psychosocial support. This makes the learners and church members willing to talk about their own HIV and AIDS situations, which leads to the selection of orphans and other children made vulnerable by the disease. At this point the learners are willing to discuss issues pertaining to the disease at home with their caregivers, because of the trust and relationship that has been built between CCP and the learners. When caregivers are invited to CCP following discussions with their children on the disease, they come and plans can be made for various interventions that CCP can offer to them in their own homes and communities. Once interventions begin in the homes, CCP begins to engage with the fertile silence, using culturally appropriate means such as discussions on various diseases that have affected the family over the years, issues of hospital bills, issues of poverty, food and nutrition. Once CCP begins to discuss issues of HIV and AIDS, the families are always admit having been dealing with the disease for a long time. Relationships and trusts are built with the people, and when they have understood the message, they become the bearers of the message. Messages are not thrown at the schools and churches, but through culturally appropriate methods, people are strengthened on some of the messages they know already. By this the barren silence is exposed and together with the interventions in the family the silence on the disease is broken. The case studies on Thuli and Mama Zulu attest to this (*see*: Appendices 5B2: Case 2 and 5B3: Case 3 respectively). Both Thuli and Mama Zulu were able to disclose

their HIV status to family member as a result of CCP intervening in their lives. The relationship becomes life-long as it will continue with the family members even after Thuli and Mama Zulu passed away.

This experience of CCP in terms of the filtration principle lends further credence to our theory that if we deal with and engage the fertile silence, the barren silence will be open and broken.

6.2.3 Training: The 2x2x2 principle

The use of the 2x2x2 principle as the basis of training and empowerment in CCP stemmed from the analysis of the organization's training results up to 2005. It was noted that the project trained 922 home-based carers from February 2002 when it established a formal working relationship with ECAP, until the end of 2005. Before then, CCP trained 71 carers between 2000 and 2001, a time when people found it very difficult to discuss anything about HIV and AIDS in the communities. These volunteers came from 79 churches within the Pietermaritzburg Area. More than 80% of the volunteers over the years got employment with the government and other organizations, in places within the province and beyond. There were two volunteers who went to the UK and used the skills obtained to work in nursing homes with people who were HIV positive. Those who remained and worked in their churches and with CCP cared for 971 clients in their homes within the communities until December 2005. During the same period, CCP attended to 412 clients at the project base. Bethany House, who passed through and could not be followed up. A number of these clients were counselled and referred to other organizations, as mostly they were not Pietermaritzburg residents. It was noted during the planning review in 2005, that the clients had put CCP in touch with 2864 adults and 2352 children within their families. Of all the adults encountered during the period, only 274 were employed (9.6%). Sadly during the period, 861 deaths had been recorded in the families with whom CCP worked. CCP then needed a programme that would help the organisation reach more people to break the silence around the disease.

The 2x2x2 Principle is a Biblical multiplication principle for reaching out to people. The number 2-2-2 stems from the verse in the Bible where this Principle is derived:

2 Timothy 2 verse 2: “And the things YOU HAVE HEARD me say in the presence of many witnesses ENTRUST TO RELIABLE MEN AND WOMEN who will also be QUALIFIED TO TEACH OTHERS”

The Principle says what you have learned, entrust to or teach to reliable people until they too (become like you, having the same knowledge that you have) and so are qualified to teach others (who will also become like themselves and you are). This means these others will be qualified to teach new others for the process to continue. It is also a training of a trainer’s approach.

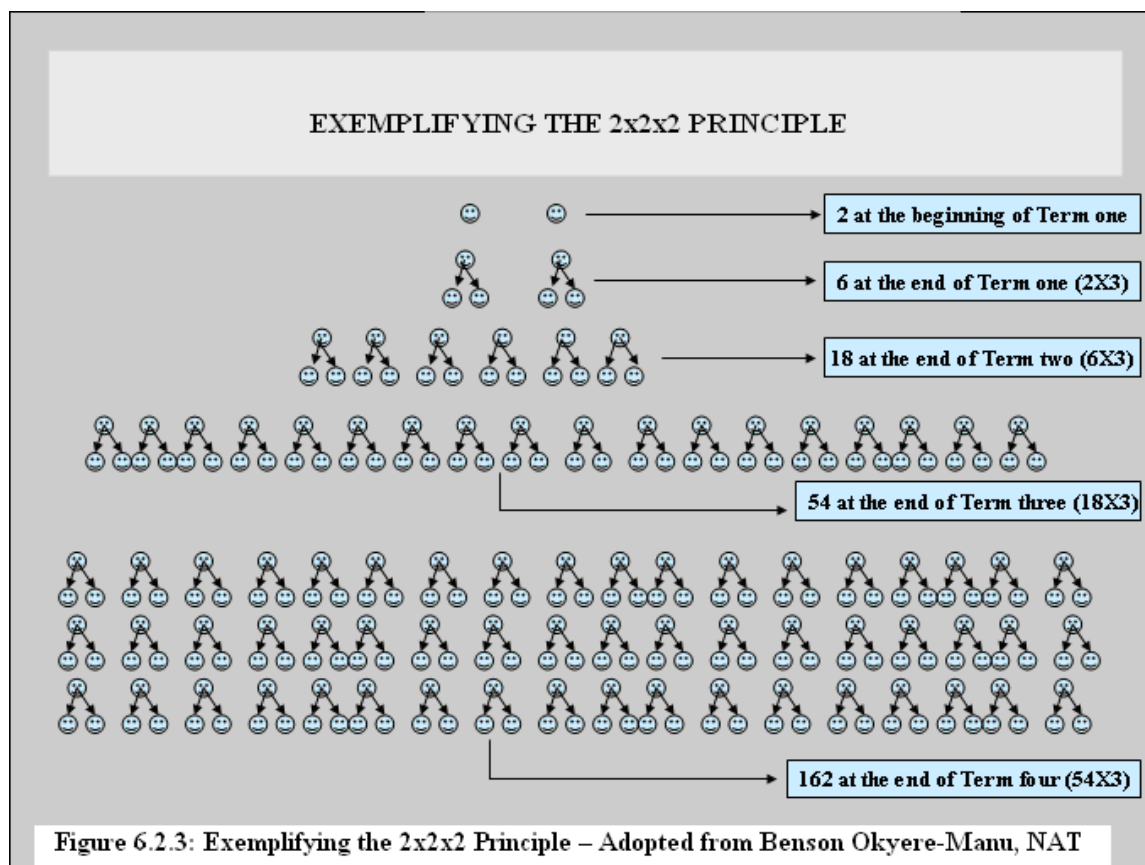


Figure 6.2.3 above exemplifies the 2x2x2 Principle:

Let’s consider HIV prevention training in a school situation. We begin the process with 2 learners whom we have trained during the last term of the previous year, until they became facilitators in their own right in HIV and Aids prevention issues. We began with 2 learners because the Principle is 2x2x2. Now if the 2 facilitators are to replicate

themselves within a term by teaching and training 2 learners each, then at the end of the term one, there will be 6 HIV and Aids facilitators (i.e. $2 \times 3 = 6$). (See figure 6.2.3 above). The 6 will replicate themselves the following term to 18, the 18 replicate themselves to 54 the next term and the 54 will replicate themselves to 162 HIV and Aids facilitators by the end of the fourth term.

By this principle, people are encouraged to share information about the disease with others in a culturally sensitive way. It is a step in the right direction in overcoming the HIV and AIDS silence. This is the principle that underscores every training that CCP undertakes, whether formal or informal in the homes of clients in the communities.

The data gathered from the field indicates that silence in and around the disease is due to lack of education and proper dissemination of information and facts about the disease. The 2x2x2 principle is a peer to peer interaction that helps people to interact very well and overcome boundaries easily. It inculcates an urgency in trainees to pass on the information and facts they have acquired to other people, whether in schools, churches, workplace or in the community. The principle encourages movement from sharing information through peer to peer interventions, to the sharing of information through family to family interactions, and to the community at large. In this way once the message is learnt, it's passed on to peers and family members and the community at large in culturally sensitive ways. By this the spread of the message is not controlled by the programme and mass mechanisms became automatic. The message is passed on at horizontal levels rather than a vertical or top-down approach. It makes people use a language that they know the receivers understand and in a more culturally appropriate way, with the sensitivity that is needed.

The principle in this way uses insiders and eliminates the fear of outsiders or top-down approaches. This already has cultural elements that help in accessing cues for breaking the barren silence. It has trust, relationship, common language or lingua franca, local culture, word of mouth what is familiar to people. It does not begin with handing out pamphlets, which directly attack the barren silence and make people unwilling to welcome what might be contained in them. As people read in between the lines in high

context culture, they feel if others see them holding HIV pamphlets, it would suggest they have got HIV. This is in sharp contrast to a low context culture where people read and absorb things easily without respect to what others say or think. This makes the use of TVs, internet etc help break the silence more easily in a low context culture. Therefore in a high context, a culturally sensitive information sharing method is key in engaging with the fertile silence in order to expose the barren silence to be broken.

The use of 2x2x2 principle has seen an increase and expansion in all spheres of work in CCP. The Prevention Education and Life Skills in schools utilise the principle and it has helped in engaging with the fertile silence and breaking the silence around HIV and AIDS. The prevention education takes place in the schools when CCP staff and Support Facilitators go into individual classes to discuss various issues pertaining to HIV and AIDS with the learners. In these discussions learners begin to understand HIV and AIDS issues and relate to them in a culturally sensitive manner. Some of them write poems that relate to their situation, some sing songs that are pointers to how they have been affected by HIV and AIDS, some tell stories which are indicative of HIV and AIDS situations in their homes. These are cues and fertile silences with which the CCP staff and the facilitators engage. They build relationships with the learners, who begin to open up about HIV and AIDS situations in their homes, their own sexual endeavours and those of their friends.

These deep encounters with the learners lead to a number of them deciding to go for VCT. Using the 2x2x2 principle, the learners educate their friends about what they have learnt. The report from the Russell High School is an example of how the Prevention Education and Life Skills in Schools works (*see: Appendix 6A1*). Of interest is the open rapport that the learners had with the CCP team, to be able to discuss sensitive issues with them. The acknowledgement by the school management that teenage pregnancy (which was a major problem in the school) has been reduced since the CCP programme was initiated is an indication of the effectiveness of the programme in the school. Table 6.1.2.2 above shows that in the 16 schools in which CCP worked at the end of 2008, 6454 learners took part in the Prevention Education and Life Skills programme

of which 4100, saw themselves to be vulnerable to HIV and AIDS, needing interventions in their homes.

The application of the 2x2x2 principle has been observed in the work of the youth. As OVCS themselves, they all know that they have to plow back the services they have received to others who face the same predicament but are younger. It was for this that during the 2004-2005, the youth, as part of their 2x2x2 project, adopted the Ekhujabuleni crèche in Edendale, to help children, most of whom are OVCs and HIV positive, in various activities.



Photo 6.2.3: CCP Youth doing activities with children at Ekhujabuleni

Using this principle, the youth were able to disseminate HIV and AIDS information to other children at Ekhujabuleni. It is the same principle that has helped Zaminphilo in its expansion and success. The use of the principle opens up discussions in various areas of HIV and AIDS, making people talk about the disease as they build relationships and trust.

In this way any fertile silence exhibited by those who are infected, is engaged with for the barren silence on HIV and AIDS to be exposed and broken.

The principle has also guided the CCP's sustainability programmes. The staff member responsible for sustainability programmes trained the Support Personnel in sustainability issues. They also involved them, together with any CCP staff members experienced in gardens and other sustainability measures, to help provide training for the identified families in the efficient management of the nutritional gardens. In the new strategic plan, CCP has helped family members and households with such inputs as seeds and fertilizers and in some instances fencing. At the project base, CCP has been maintaining demonstration plots/gardens¹⁰⁰ for more families to learn from and replicate in their own homes.

This principle has also led to expansion in the work of CCP beyond Pietermaritzburg. CCP trained 20 members of the Dihlabeng Church in 2006 to help initiate a project in Clarens, 'Batho ba Thepo' meaning People of Hope. By 2007, they were able to care for 138 families, consisting of 350 PLWHAs and 100 OVCs. With the 2x2x2 principle, they have managed to train over 60 Home-Based Carers and pre-counselled over 500 people for HIV testing in the clinic in Clarens. This church has also helped another Newfrontiers Church in Ladybrand, a town about 100 kms away. The people in Clarens have been amazed at the openness and the change in the lives of people infected and affected by HIV and AIDS as a result of our interventions.

In 2005 CCP trained a couple, Dave and Pam Lyons, from the Grace Community Church in Matubatuba. Further visits from CCP to Matubatuba helped the church to establish the Shikishela Project in Matubatuba in 2006, located in a remote rural area of the Kwazulu Natal province. They provide care and education activities for the infected and affected people in the community. HIV prevention education using the 2x2x2 principle led to the start of a support group of 30 infected people by mid 2006. Members had the opportunity to learn more about the disease, empower each other in various income generating

¹⁰⁰ Demonstration plots/gardens are expertly managed and are a show of good practice in the establishment and management of nutritional gardens. They are established jointly by community members under the supervision of CCP.

activities and discuss the Bible to seek comfort and hope from God. The support group initiated a feeding scheme that caters for over 200 OVCs from the area on Saturdays. The project counsels identifies sick people to get tested and CD4 counted, and works with medical staff at Kwamsane and Hlabise clinics, as well as local social workers and welfare people. The weekly support group meetings are run by the members themselves.

Members from the Oasis Ministries in Amanzimtoti, in KwaZulu-Natal and the Disciples Ministries in Harrismith, Free State, were also trained in various aspects of HIV and AIDS which has helped them to initiate their own HIV and AIDS projects.

In Zambia, a team from the Christian Community church (CCC), on hearing the work that CCP is doing in breaking the HIV silence among the churches, sent a team in 2005 to Bethany House for a two week training. Thereafter, a team from CCP travelled to Zambia to help them to their situational analysis, strategic plan and the initiation of their HIV and AIDS project in Sachibondu, in the North West Province near Angola. The project was called the Sachibondu HIV & AIDS Prevention and Education (SHAPE) project, established with our assistance in 2005. With constant visits from CCP to the project, 24 Christian Community Churches have been assisted and trained in various aspects of HIV and AIDS through out the province. All 24 churches trained are involved in home-based care, OVC care and support, farming for the sustainability of the project and the spiritual care of PLWHAs. In addition in 2007, 18 people were trained in Kabwe, the central part of the country, to help run a project that will facilitate the establishment of HIV & AIDS projects in 180 CC Churches across the country.

This 2X2X2 principle of CCP lends further credence to our theory that if we deal with and engage the fertile silence, the barren silence will be open and broken.

6.2.4 Home Visitations and Family Interventions

The combination of the filtration principle and the 2x2x2 principle helps to identify OVCs in the schools and churches that leads on to home visitations and family interventions. Having engaged with the fertile silence in the schools and churches to be able to identify OVCs, the home and family visitations are to engage with the fertile

silence and unearth the HIV and AIDS barren silence to be broken. The fertile silence requires one-on-one family care.

Through the filtration principle, OVCs are identified from within the large school and church population. As a result of the culturally sensitive education that they go through with CCP in the schools and churches, these identified OVCs are not afraid to discuss the HIV and AIDS situations that they find themselves in. Through open discussions in the classroom with their peers, learners begin to know that the disease affects everyone and it is not something to be ashamed of. Rather it is an issue to be tackled by all. The life skills sessions offer tools to the learners to confront and deal with the fears they have about the disease. The 2x2x2 principle helps the learners to share the information they have received with others, especially family members at home. Having gone home to share the information with family members, the report back sessions give an indication of the kind of silence that the families display. A number of families would say, for example, that they do not have problems with HIV and AIDS; instead they have problems with lack of food.

What we have learnt is that such families as these, are keeping barren silence around their HIV situation, and exhibiting a fertile silence by blaming lack of food. In this way CCP would engage with the fertile silence by going to the family with food parcels and begin interactions and discussions with members on the issues of poverty, hunger etc. Depending on how fast relationships are built, discussions on HIV and AIDS enable CCP to assess and determine which further interventions to offer. Then other families are invited for workshops in which the families that CCP has worked with before are invited to share their testimonies. They share how the CCP programme has helped them in dealing with or to come out of the HIV and AIDS predicaments that baffled them. Through the sessions and building of relationship with the families they begin to open up to HIV and AIDS discussions, to accept the situations and to allow CCP to work with them.

As CCP begins to work with the families, members are trained in various skills and coping mechanisms such as wellness, bereavement counselling, memory work,

sustainability and enterprise development etc. Facilitating Orphans and Vulnerable Children to access economic support (access to social grants) is one of the major challenges CCP encounter in the visit to homes. OVCs and their families lack financial resources to support themselves with basic needs in the home. CCP has been helping families of OVCs in accessing government social grants from the Department of Social Development. Progress in this area has been slow as a result of backlogs of applications in the department, the cumbersome nature of the application procedure and especially the requirement of documentation for the department of Home affairs, such as birth and death certificate, ID documents, etc. Nevertheless the few whose applications have been successful have seen an upgrading their financial security.

In the long run, to help families deal with these financial challenges, CCP empowers families through sustainability and economic strengthening programmes. The sustainability programme has mainly been through the training of people in the planting of gardens for them to start their own gardens. The economic strengthening on the other hand is teaching families how to access government social grants from the Department of Social Development, rather than CCP doing it for them. The CCP HIV Support Personnel have been trained in the basics of the social grants application process. They help OVC families to fill out the grants application forms and encourage them to follow up on their applications. In the last few years CCP has managed to help many families to access social grants from the government. It is interesting to note that there is an increase in the number of families trained to establish their own gardens when there is an increase in access to social grants. However, from Table 6.1.2.5.B above, these increases are matched with decreased in the number of families who actually plant gardens, despite all the efforts by CCP staff and Support Personnel to assist families with all the inputs needed. According to the CCP staff, whenever families are successful in accessing government grants they begin to give excuses for not planting their gardens. Some give excuses that animals and birds are destroying their gardens. Some even say it takes a long time for their produce to mature. One can only speculate that it is difficult to do the gardens but easier to queue to receive grants.

Between 2006 and 2008, 614 families were empowered with such skills to cater and provide for their PLWHAs and OVCs, of which 75 were child-headed households (see Table 6.1.2.3). During this period, 735 PLWHA and 1261 OVCs were holistically cared for and the families provided with food, medication and educational support in homes (see Tables 6.1.2.1 and Table 6.1.2.3). 168 members of these families saw the need to go for VCT and 71 of those who were HIV positive were assisted to go for their CD4 count. There were 24 children in these families who tested positive to HIV and their status had to be disclosed to them.

The home visits and family intervention component of the CCP model has helped in engaging with and breaking the silence around HIV and AIDS in these families. One family in KwaMpumuza that CCP engaged with its fertile silence, was through provision of shelter. In 2003 and 2004 when CCP visited this family where 5 children were sick, the man in the family complained about the house falling apart and making the children sick. Indeed the house was in bad shape. However the sickness of the children was HIV related, as we came to know later. CCP engaged with the family's fertile silence through their need for housing, and supported them in building a new house. The decision to build was made in terms of needs assessment which concluded that both carers were able to offer long term support to the needs of the children in their care, and that the missing component was safe shelter. CCP staff and volunteers helped make blocks to reduce cost of building. As trust and relationship were built with the family, they revealed to CCP that the major issue in the family was HIV. They had lost three daughters to the disease and they were buried in the garden behind the house (see Photo 6.2.4 below).



Figure 6.2.4: A House that CCP helped to replace

During an interview with a member of another family in Dambuza, she mentioned how grateful she was to CCP and the team for all that they have done for her family and herself (*see: Appendix 5C10*). She recalled that when CCP came to her house, her daughter was dying of TB and could not walk at the time. But CCP helped her daughter to be well and brought back joy into her life. Through CCP, food was in the house and her children were educated as CCP paid their school fees. The respondent recounted how as a family, their experiences of HIV and AIDS has changed their cultural beliefs and practices. She said “As a family, especially between my elder daughter and I, there is the ability to talk freely about any issue, especially issues to do with sex, which we could never before discuss because of cultural beliefs”. She also felt that the gap that used to be there between her and the children has been closed. She noted that previously she and her daughter had never talked about anything to do with sex but now they all discuss it. She even made reference to the fact that I, as a man, could come to her home with another young woman and speak to her, an old woman, on issues of HIV and sex. She mentioned

that this would never have happened in her home for cultural reasons, but it is happening because of the HIV situation that they are in. She pointed out that she was happy that the family knows more about the disease.

The preaching at Thuli's funeral became a culturally sensitive education that broke the HIV silence, because the fertile silence had been engaged through the home and family visits. It was through interventions into Thuli's life that, in a moving way, she told me that she had made a great many mistakes and if her health improved again she was going to let young people and her community know about the seriousness of HIV. But should she die and not have the opportunity to do this before then, she asked that the CCP, through her funeral, inform people on the dangers of HIV (*see*: Appendix 5B2). The interventions with Thuli and her family were observed by the neighbours and community member so that people were ready at the funeral for the HIV message that was preached. The response was positive because people could identify with the situation, and the family had been prepared through the engagement with the fertile silence. As it was reported by a CCP staff: "A neighbour who spoke at the funeral thanked CCP for the support that was given to the bereaved family. She mentioned that they are a small community, but because of the support from Bethany House, they saw the community as one that changed to being a large community. She had never thought that Thuli's funeral could be so big because they are a small community and she had never thought that there could be White people at the funeral". Family interventions open doors for engagement with the fertile silence and subsequent breaking of the HIV and AIDS silence.

The attention paid to culture clues and relationship-building in the home visits and family interventions lend further credence to our theory that if we deal with and engage the fertile silence, the barren silence will be open and broken.

6.2.5 The Support Group

Central to the work of CCP is the formation of the Support Group, with the main purpose of determining whether interventions from CCP with the members, their families and relations, would have the desired effect of building relationships and trust, leading to engagement with the fertile silence and breaking the barren HIV and AIDS silence. In

doing this the major work behind the scenes, which is not specifically covered in this thesis, was the collaborative work between CCP, NAT and myself in mobilising Pastors, Schools Principals, Churches, Schools, Youth and families within affected communities. It is this collaborative work that made the training of these people possible as a way of providing leadership. For this aspect of the work, the NAT-CCP collaboration organised over 5,000 community leaders and members, as well as family members from 17 churches, 16 schools and about 614 families from 10 township communities to work with and interact with the Support Group. This was done through psychosocial activities and events such as CCP community Analysis Weeks, outings, World AIDS Day celebrations, funerals and monthly HIV and AIDS Prayer Meetings etc (*see*: Appendix 5 Series) that provided avenues for engagement with the fertile silence. The mobilisation of people to become involved and to support activities in and around HIV is in itself a break-through in the quest to break the silence around HIV and AIDS, as it involved changing a cultural mindset and attitudes towards the disease. This happened through a conscious plan to engage the fertile silence. The following sections consider the various dimensions of the Support Group and analyses how they contribute to engagement with the fertile silence and breaking the HIV and AIDS silence:

6.2.5.1 Organisation of the Support Group

At the time the Support Group was initiated on Thursday 13th May 2004, people living with HIV and AIDS were not ready to disclose their status, not even to family members whose help they would need to cope with their illness. The very real possibility of resultant stigma and discrimination, and negative utterances on the disease, discouraged them from disclosing their status. The only way that the literature suggested, considering the high-context nature of the culture, was to build relationships and trust with people to whom they could open up on the issue. In the case of people and families dealing in silence with the effect and trauma of HIV and AIDS, this option of relationship building seemed appropriate. The Support Group was therefore formed to determine whether interventions from CCP with the affected members, their families and relations, would have the desired aim of building relationships and trust leading to the breaking of the silence. Even though, initially, there were 397 sick people that CCP was working with

who could be possible members, only four people who were willing and ready started the group. For three months these people met weekly with the CCP team for discussions and prayers, which helped in the building of relationships, a willingness to test for HIV and confirm status, and improvement in health status. In retrospect, it was clear we were engaging with the fertile silence.

The solid foundation of the first three months led to the group beginning to invite others in similar situations to join them, building it for the future.

6.2.5.2 Membership

Through relationship building, the group recruited members at its own pace. There was no CCP recruitment process in place. The Support Group members, through their testimonies to others at clinics, churches, invitations to prayer meetings etc. invited others to join the group. The recruitment process in itself is a disclosure process of Support Group members disclosing to others that they are HIV positive themselves. From the initial membership of four women, the group expanded to having a membership of 120, including 15 men, and with an average weekly attendance of 40 people, by the time the research project was concluded after three years. During the research, respondents were asked about how they joined the group or heard about it. Of the 25 respondents who answered the question, 44% joined the group because someone who knew about the Support Group invited them to join; 24% were invited by other Support Group members, 24% were invited by their friends who knew about the group and 8% were invited by nurses at the clinic. This points out that from a humble beginning, the Support Group is now known about by many people who are able to invite others in need of help to join. One member pointed out that the changed lives of the members attract other PLWHAs: “I was told by the nurse who tested me for HIV at the clinic and she mentioned how some people that she knows have had their lives changed by the group” (*see: Appendix 5G1*).

In the midst of all this, there are times when the attendance at the meetings is so low that members themselves feel discouraged. When asked about why it is like this, members pointed out that when members recover, most people get jobs and so are not able to make

it for the meetings during work hours. Others have travelled outside Pietermaritzburg in search of jobs and other life opportunities. Wherever they are, they make engagement with fertile silence a priority to get people and families break their HIV and AIDS silence.

6.2.5.3 Training

The training offered by CCP to the Support Group comes in the form of Wellness, Psychosocial, Bereavement Counselling Course, Memory Box course, VCT and ARV Training, TB treatment, Spiritual training and income generation. These training sessions help build the capacities of individual group members and inform them about how to deal with socio-cultural and psychosocial issues. It sharpens as well their abilities to engage fertile silence in a more culturally sensitive way. A member confessed “There is a support group near my house and CCP also came to do the awareness training for them and the training attracted me to join the CCP Support Group” and another member indicated “The various training programmes offered by CCP to the group has helped me break my silence” (*see: Appendix 5G1*).

6.2.5.4 Benefits of the Support Group

When the Support Group’s respondents were asked to give the benefits of the group, 44.4% considered being accepted in the group to be the major benefit; 18.5% of members saw the guidance that the group provides as the major benefit; another 18.5% of members saw counselling as the major benefit of the group, 14.8% saw the atmosphere of not feeling alone as the major benefit of the group and 3.7% felt knowledge about HIV as the major benefit of the group. My personal interactions with the members of the group, over the years, is that people join the group with HIV as a huge problem in their lives, but as they join and start learning from others, sharing life experiences and feeling accepted, HIV becomes a small part of their lives. They see themselves as being alive, and not as about to die. Many PLWHAs pass away because of a lack of self-dignity arising from the stigma of the disease. They see themselves as dispensable and simply die, whereas the self-worth strategies gained through the Support Group help their members feel the need to hold on to life. In an interview, a member said: “I have now been in the Support Group for a year. I was introduced to the group by an HIV-positive lady at the TB clinic, who

saw how desperate I was and suggested that I approach the group, where I would receive guidance and support. The Support Group has helped me deal with the many stresses in my life which have occurred because of my HIV status. With members of the group, I can pour out my heart freely and, through their guidance I am now able to share my problems with others. I have learnt more about the disease and I know my rights as an HIV-positive person. The part of the Support Group that I enjoy the most is where I contribute to the work of CCP from my journey with HIV and where I in turn receive input from the CCP through their interventions with the Support Group. I enjoy the exchange of knowledge that takes place in the group” (*see*: Appendix 5G1).

The members of the group in a focus group discussion said that the group has helped create a level of boldness about the stigma of the disease. The men of the Support Group confirmed that when they go to the clinics for ARVs they see only women, and see themselves as blessed to be able to go to the clinics boldly for their ARVs. In this way, the group has helped to enable the men to help other men to be open about their HIV status, break their silence, go to the clinics and access ARVs and be helped to take them properly. They also felt the group as taught members to be true to themselves and others by being open about their status. One of the men pointed out how at the clinic he used to flirt with a nurse. Then he realised that the nurse was becoming interested in him, and so, one day, he told her that he had come to fetch his ARV medication. The lady was shocked and said, “You are the first man who has ever told me he is here to fetch ARV”. In many ways they see the Support Group is a source of hope for positive living where they give hope through their own physical strength and testimonies (*see*: Appendix 5J1).

A CCP staff member in an interview, said the area of CCP’s intervention which shows most evidence of breaking the HIV silence is the Support Group which she has been working with since its inception. She knew that not all of the members had broken their silence, as some were new and in their neighbourhood no one talked about HIV or AIDS. Some of them too did not discuss issues of HIV and AIDS within their families, and so when they came to the Support Group their friends gave them some ideas which helped them deal with the problem. Apart from these few, the rest are not ashamed to talk about, and to deal with, their status, whether or not they were stigmatised or discriminated

against. The prayer meeting is very important to them as they wish to be healed, most of them trusting that though there is no cure for the disease, God is supreme and will heal them (*see*: Appendix 5C9).

Through the Support Group, many have disclosed their HIV status. The group through various activities has engaged their fertile silence and their barren silence is broken. The members also continue to engage with the fertile silence of others to expose their barren HIV and AIDS silence to be broken.

This experience of the way the Support Group has assisted people infected and affected by HIV and AIDS lends further credence to our theory that if we deal with and engage the fertile silence, the barren silence will be open and broken.

6.2.6 Monthly HIV Prayer Meeting

One of the major activities of the Support Group which exposes them to the outside world, is the sixth way in which the CCP has sought to engage the fertile silence, namely the Monthly HIV and AIDS Prayer meeting. When members were asked about the benefits of the group, all agreed that this prayer meeting is helpful. They were then asked to outline the ways in which the prayer meeting was helpful to them:

The majority of members (70%) see the freedom in their spirit to worship God as the major help they received from the prayer meetings. Through the prayer meetings, 20% found hope for life and 10% found spiritual comfort. A male Support Group member said that even though he does not attend any church, he does attend the monthly HIV prayer meetings. He finds them to be meaningful, and enjoys the time when pastors lay their hands on him and pray for him. A female Support Group member on her part pointed out the differences between her church and the prayer meeting, to explain why she has not openly declared her HIV status in church in the way she has done at the prayer meeting. To her the major difference is that the church is known by HIV-infected persons as to be judgemental, considering PLWHAs as being naughty or sleeping around. She wished the situation in the church was similar to the monthly prayer meeting, where HIV and AIDS are preached about and people openly admit to their status and can be prayed for. The

respondent further said that, during the monthly prayer meetings, she feels as though she has never been sick and would often want the meeting to go on for longer (*see*: Appendix 5C2).

These points raised reveal the virtues of the prayer meetings that help the members to come forward, in the midst of all the people present, month by month, to be prayed for. The need for prayer is expressed by all the Support Group members. It is a fertile silence used for engagement with people until they build relationships and trust. As they boldly come up in a public arena to be prayed for, they are breaking their silence on the disease through public disclosure.

This experience of the work of CCP lends further credence to our theory that if we deal with and engage the fertile silence, the barren silence will be open and broken.

6.3 What does it mean to Disclose HIV Status and Break the Silence?

The silence around HIV and AIDS is usually encountered only after people have undergone the HIV test. The cause of the silence is the difficulty of disclosing one's status or that of a family member to relevant people, including loved ones. There is always some problem or other in dealing with the results of HIV testing. Even though there is VCT, the process at the testing centres is not adequate to deal with the situation after the test. Research indicates that HIV-positive men, in particular, do not want to utilise the services of VCT centres for fear that their HIV-positive status would be disclosed through testing, and that stigmatisation will follow (AVERT 2006). The findings from the focus group discussion with the Support Group men revealed that men have their ego at risk, are afraid of being blamed for acquiring the disease and thereby losing their wives or girlfriends and being rejected. The men agreed that "because of the way men blame their wives or girlfriends for problems in the marriage or relationship, men are afraid to be blamed for bringing HIV into the family".

Breaking the HIV silence is therefore closely linked with the process of disclosure. It is one thing taking a test and quite another thing telling others about the results of the test.

Of the 81 respondents, 63 had taken the HIV test, including all the 29 Support Group members. Although silence around HIV is still a major problem in South Africa, this research shows that, as a result of being members of the Support Group, people are able to disclose their HIV status. All the Support Group members indicated that they had disclosed their status to someone else apart from Support Group members. Each of them had the CCP monthly prayer meeting as fertile silence through which engagement facilitated exposure and breaking of the barren HIV and AIDS silence through a public disclosure. For other groups that responded in the research, we are not sure whether their status are positive or negative. The results that the Support Group members disclosed were all positive. This is what constitutes breaking the HIV and AIDS silence.

When respondents were asked if they had difficulty in disclosing their HIV status to others, all the pastors, Church trainees and caregivers showed 100% difficulty in disclosing their HIV status. However, 19 out of the 29 Support Group respondents (65.5%) indicated they find it easy to disclose their status as a result of being members of the Support Group. For the Support Group, 10.3% told someone the same day they tested, 17.2% told someone a few days after the test, 6.9% told someone between 1-3 weeks, 3.4% took a month, 44.9% took 1 to 5 years, and 17.2% took more than 5 years to tell someone else that they are HIV-positive. This means 62.1% took more than a year to disclose their status to other people. Although these Support Group members had been silent over their status for many years before joining the group, they have now all disclosed their HIV status to others and all participate in the monthly prayer meetings where people from the communities, churches and schools attend.

It is interesting to note that the largest section (24.1%) of the Support Group members disclosed to their mothers, 13.8% disclosed to a group of people such as family, Children, etc, 10.3% to their fathers and 10.3% to brothers. 6.9% Support Group members disclosed to sisters, 6.9% to friends and another 6.9% to grandmothers. Only a few (3.4%) disclosed to their husbands, boyfriends, girlfriends, sisters-in-law, aunts and nieces. Most HIV positive individuals disclosing to their mothers first follows patterns outlined by previous research on HIV-positive adults. Shehan *et al* 2005: 185) has shown that adults are more likely to tell their mothers than their fathers about their health status

because: “of all family of origin members, mothers tend to provide more support and are most often engaged by community agencies to assume support roles for their adult HIV-infected children”.

The Support Group was formed with the view that PLWHAs always display a fertile silence that needs to be embraced and engaged with in order for the silence around the disease to be broken. In this case the agenda of the group is always determined by the members themselves. The proposals by the group determine the issues to be engaged with in order to build relationship and trust with individuals for them to open up and disclose their HIV status. The men’s focus group was asked the question: *What is the role of the infected male in dealing with the HIV pandemic?* They answered:

Every infected individual, especially men, from the day he is told of his status vows not to disclose to anyone. Not even the girlfriend. There is a lot of shame and stigma around the disease. But as men we know that it is not easy to keep this secret. We always leave room for people to build relationships with us so that we can trust them and share this burden with them. The role of infected men, especially those of us who have learnt ways to engage with others and build relationships with them so that we disclose our status to them, is to lead the way and teach infected men and women how to build relationship and disclose their status in a meaningful way to trusted people (*see: Appendix 5J1*).

The case studies of Thuli and Mama Zulu (*see: Appendices 5B2: Case 2 and 5B3: Case 3 respectively*) also highlight the effectiveness of CCP’s intervention in helping to break their silence within the family context. Mama Zulu was assisted to disclose her status to her family; the family gave her the support she needed, even singing for her before she closed her eyes in death. Thuli was also helped to disclose to her mother and sisters. She agreed to her funeral being linked to HIV, something that had never been done before.

The Support Group has shown that breaking of HIV and AIDS silence can be done as a group. Besides individuals of the group disclosing their status to others, the group

as a whole, through such forums as Community analysis weeks and World AIDS days, embarks on activities such as drama, testimonies etc. that make them disclose their status to the public in order to educate them and break the silence.

6.4 Summary

This chapter has looked at ways in which the CCP model has contributed to engaging the fertile silence, thereby breaking the HIV and AIDS silence. The first section looked at the CCP model and has shown what has been achieved through the various activities in which CCP is involved. The second section operationalises the concept of engaging the fertile silence and demonstrated how the CCP model utilises six ways to do this. They include: culturally sensitive education; the filtration principle; the 2x2x2 principle; individual and family care; Support Group; and Prayer meetings. This last section has linked the process of HIV and AIDS disclosure to engagement with the fertile silence and breaking the HIV and AIDS silence.

What the analysis of CCP model has shown is that in a high context such as a Zulu culture in the Pietermaritzburg area, by focussing on the fertile silence through a series of culturally appropriate interventions, the net effect is that the silence is broken. This further strengthens the fundamental argument of this thesis, that in a high context culture such as the African culture, to break the silence means to engage the fertile silence, the silence that is present – the connotative silence. In doing that, without necessarily having to be intentional about breaking the silence, the silence will almost dissolve. The chapter has answered the third research question in the affirmative: That indeed the interventions provided by the Community Care Project suggest constructive ways of engaging with and breaking the silence surrounding HIV and AIDS in the Pietermaritzburg area.

CHAPTER SEVEN: GENERAL SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

7.0 Introduction

..... In a world beset by the devastating HIV pandemic, we are leaving young people, the flower of our church and society, to wither and die through ignorance, the absence of open, honest and compassionate sharing of vital information, our embarrassed silence and resistance to reality..... Archbishop Ndungane.

The above is a quote by the Anglican Archbishop of Cape Town, Njongonkulu Ndungane when he was speaking at a planning meeting for the Anglican Church of South Africa's HIV programme (Stewart and Parfitt 2004:13). This statement is true for South Africa as it is overwhelmed by an HIV and AIDS crisis. Yet the society and its leaders have put on what Ndungane calls an "embarrassed silence" that resists the reality of the situation. The church has a lot it can offer but, for lack of openness about the HIV situation, it is not doing enough. This silence is a major obstacle to the much-needed victory over the disease. Silence around HIV and AIDS, as indicated in our research, is fueled by stigma and discrimination around the disease in society, including the church. The HIV situation is worsening in our area of research. When releasing the 2008 results of a survey of antenatal HIV and STD in Pretoria on Monday 5th October 2009, the South African Health Minister, Aaron Motsoaledi expressed his concern about the HIV and AIDS statistics of the province of KwaZulu-Natal, especially the district within which this research took place: "Look at KZN, the area called Umgungundlovu has got a prevalence of 45%. It means 45% of the women who went to the antenatal clinic, who are pregnant, are HIV positive and that's absolutely worrying." (SABC News 2009). The minister added that "The issue of stigma is a very serious problem".

In the usual fashion, everyone expects the silence around the disease to be broken by just talking. However, breaking the silence around the disease goes beyond just talking. This is not easy, and it does not happen for many different reasons, cultural, political, and economic..

The objective of this study was to investigate whether any cultural factors underpinning the HIV and AIDS silence could be identified to provide clues for engaging with, and breaking, the silence, thereby to providing a way forward in dealing with the HIV and AIDS epidemic as a whole.

Literary studies were done to explore the cultural aspects of silence and how it contributes to the HIV silence. This led to a field study to explore how these cultural factors impinge on HIV and AIDS in the community. Questionnaires, in-depth interviews, focus group discussions and case studies were undertaken to answer the questions that could help us achieve our main objective:

- (a) Does the culture of the people contribute to the way silence ‘works’?
- (b) To what extent do cultural dimensions contribute to the silence around HIV and AIDS?
- (c) Can the interventions provided by the Community Care Project suggest constructive ways of engaging with and breaking the silence surrounding HIV and AIDS in the Pietermaritzburg area?

The Chapters 2 and 3 helped us answer the research question a) whilst Chapters 3 and 4 dealt with the question b). Chapter 5 laid the preparatory grounds for Chapter 6 to fully answer the research question c). The present Chapter summarises the various findings and conclusions from the chapters and makes recommendations for future research and actions.

7.1 General Overview of the Study

7.1.1 Summary

Chapter one is the introduction to the thesis and provides an overview of the study. The chapter reveals that HIV and AIDS pose a major crisis in South Africa, especially in the Pietermaritzburg area that is the epicentre of the pandemic. All efforts are therefore needed to deal with the crisis at hand. Stigma and discrimination fuels the silence around the disease, which in turn is hampering all efforts to deal with the epidemic effectively. The situation urgently requires the need to look into the silence in and around HIV and AIDS, which was the major issue that the World AIDS Conference in South Africa in

Durban in 2000 recognised. To take on this task, the assumption of this research is that there are cultural factors that underline the silence around the disease, and that studying these factors would help establish an effective way of dealing with the problem. To do this in the field, I set out the goal and objectives of the study and also formulated the research questions. A description of the research approach, type, design and the research procedure are outlined. A description of the Community Care Project, which is the main organization used for the study, is given. The research population, sampling methods, ethical considerations, data gathering techniques and methods are also given. Finally, the subsequent chapters of the thesis are outlined.

7.1.2 Conclusions

It was found that silence around HIV and AIDS is still a problem in South Africa, especially in the area of our research which is the epicentre of the problem. The recent pronouncement by the minister of Health reveals the problem (SABC News 2009). South Africa has an overall HIV-prevalence rate of 18% and 19% (18.8% in 2005 and 18.3% in 2006), significantly higher than the rate in sub-Saharan Africa (5.9%) and the world (1%). Estimates of HIV prevalence among antenatal clinic attendees show even higher rates of up to 30.2% in 2005. The Kwazulu Natal Province has the highest HIV infection rate in the country, averaging 40% currently, with 61.4% of the total number of people identified to be living with HIV residing in the Pietermaritzburg area (where this research was conducted at the end of 2007). In the midst of all this there is silence around the disease; even the government downplays the reality of the situation. A need for research into the underlying reasons behind the silence is desperately needed to help provide clues about how to breaking the silence. The historical and social background of the Pietermaritzburg Area highlights and gives perspective to the HIV and AIDS situation of the area. This research hypothesises cultural reasons as being the silence as needing investigation. This study can make a valuable contribution to activism in the field of HIV and AIDS as it represents a groundbreaking study in the cultural component of the silence around the disease.

7.1.3 Recommendations

Research into the various cultural underpinnings of the stigma, discrimination and silence around HIV and AIDS should increase in South Africa among the various cultural groups. Issues such as cultural taboos should be looked into to provide appropriated and culturally-sensitive ways of dealing with it.

The government should partner researchers to extend the research into larger cultural groupings such as among Zulus or Xhosas, focusing on how cultural factors have shaped silence surrounding the HIV and AIDS epidemic.

7.2 The Silence Phenomenon

7.2.1 Summary

Chapter two reveals that silence is a complex phenomenon with both connotative and denotative components. Cultures, in a continuum, show characteristics of low-context or high-context in communication. The characteristics of the culture have a direct effect on silence exhibited in that culture. The South African Black culture of the research area is high-context in nature. In this way the culture therefore generates silence that is complex - a silence that connotes presence and is expressed in symbolism, and that has to be interpreted non-verbally by the listener. This culture exhibits high-context characteristics in which there is a greater emphasis on silence as presence (fertile) than silence as absence (barren), where the fertile silence overshadows barren silence, the form that we are familiar with and desire to break. This means an analysis of silence is required within a particular cultural situation so as to help us engage with silence as both presence and absence. An analysis of the research area shows that the culture of the people in itself contributes to silence within the people. This chapter 2 helps us to answer the first research question: Does the culture of the people contribute to the way silence 'works', in the affirmative.

7.2.2 Conclusions

It was found that though silence is a complex phenomenon, it is a key component of the culture of the people in the research area. The culture of the people therefore has

every possibility of contributing to silence around HIV and AIDS. The literature reviewed showed that the context of the culture is fully charged with information in the coded form and as such people do not need to be explicit in their communication. Silence in this case is present and we have identified it as fertile silence. In keeping silent over an issue, which we call barren silence, the ‘information atmosphere’ - through non-verbal signs or through coded language speaks on a person’s behalf.

It is an important finding that in a high-context culture, the silence that we strive to break is the barren silence where people are not talking about the issue, and therefore there is no communication about the issue at all. However, the barren silence is engulfed by a fertile silence that has a presence, in various but less obvious ways. This therefore needs recognition and engagement in order to expose the hidden barren silence that needs to be broken.

7.2.3 Recommendations

In the quest to break the HIV and AIDS silence, cognisance should be given to the reality that cultural factors contribute to the HIV silence. In this case, initial attention should focus on all the tangible coded messages and actions that people unleash as this is a fertile silence that will help in breaking the barren silence.

7.3 The Dimensions of Culture and Silence

7.3.1 Summary

Chapter three shows that that silence, in any aspect of the life of the community into which we are researching, stems from a high-context culture and it is characterised by various dimensions. The study shows that in the Zulu culture, within which this research is conducted, these dimensions, include polychronic time orientation, high power distance, low uncertainty avoidance, collectivism (ubuntu). It also exhibits femininity in terms of assertiveness and masculinity in terms of gender egalitarianism in the masculinity/femininity dimension. These dimensions of culture impact on silence within the culture, creating a thick layer of fertile silence around a barren silence that we seek to break. However, it is the thick fertile silence that communicates cues through the various

dimensions of culture about the barren silence that if engaged with through trust and relationship building, it can be exposed and broken.

7.3.2 Conclusions

It is found that the various dimensions of culture contribute to silence in varying ways:

- i) The effect of polychronic time orientation on silence within the culture is seen through the way people keep silence on issues and allow a passage of time for them to build the relationship strong enough to open up.
- ii) Power distance also contributes to silence as there is fear among the people that they might violate the hierarchical powers within the culture through the release of unauthorised information. As a result, people who see themselves as subordinates keep silent on issues until permission is granted to talk about it.
- iii) The low uncertainty avoidance nature of the culture causes silence through time, relationship building, risk taking and taboos. As a result of the future having little bearing on the African, people are not in a rush to open up on issues as they first need time to build relationships. This therefore leads to people taking risks by keeping silence about issues that seriously affect them. In terms of taboos, to avoid being branded a taboo breaker and facing the consequences, people will keep silent about issues if they know those issues are linked with taboos.
- iv) Through the collectivism dimension of the culture, individuals are loyal to their families and so keep silent about issues in order to save the face of their families when they know those issues can bring disgrace to the family.
- v) The femininity in terms of assertiveness makes family members keep silent about issues in order to seek peace and harmony in the family and community. As a result of masculinity in terms of gender egalitarianism, women, in particular, keep silent in abusive relationships for fear of being accused by men of wrong-doing. Men also keep silent about situations in which they feel guilty, because they usually blame women for these situations.

There is every possibility that these dimensions of culture that contribute silence in general, will also contribute to the HIV and AIDS silence in various ways.

7.3.3 Recommendations

It is important that community and development workers in the field take note of ways in

which dimensions of culture contribute to silence, in order to be able to get the “vibes” and cues that people exhibit as fertile silence that must be engaged with in order to expose and break the barren silence.

7.4 Cultural Dimensions and HIV and AIDS Silence

7.4.1 Summary

Chapter four, combining data from literature and from the field, reveals that the HIV and AIDS silence arises in various ways through the dimensions of culture of the African people. The high-context dimension of the culture, in which there is a thick layer of fertile silence surrounding a small barren silence, makes it easier for PLWHAs to keep silent about their status whilst presenting other things that if engaged with, would expose the barren HIV silence to be broken. Within a high context culture, dimensions of culture operate in different ways to contribute to the HIV and AIDS silence. As a result of the low uncertainty avoidance dimension of the culture, people risk their lives by keeping silent about their HIV and AIDS status when in actual fact they require help in their situation. The collectivistic dimension of the culture, coupled with the taboos within the culture, make family members unwilling to put the family’s name to shame when infected, by disclosing their HIV status. The placing of children at the lowest scale of the ladder denying them a say in family matters, is a major source of silence on the disease. Power distance between people in authority and those of subordinate status induces silence on the disease that is based on fear and unrealistic expectations. Considering the femininity of the culture in terms of assertiveness, it is seen that the desire to seek care for the infected in the midst of stigmatisation leads to families keeping the disease a secret, and the vastness of the burden of care leads to situations where people do not want to talk about it. The cultural apportioning of gender roles, making it more masculine in terms of gender egalitarianism, creates gender imbalance that in many ways lead to HIV and AIDS silence.

The field study revealed that certain practices in the culture also contribute to the HIV silence. These include the inability of the elderly to speak openly with the young, taboos and their consequences, judgmental attitudes, a lack of openness on sexual

matters, the use of power by the elderly and men, the belief in witchcraft, the secretive nature of the culture, myths and beliefs and the linkage of incurable diseases with curses.

7.4.2 Conclusions

7.4.2.1 Barren and Fertile and the HIV and AIDS Silence.

The cultural context of the people contains all the ingredients that cause silence around the disease. The research area is a high-context culture and as such silence has a 'presence'. It is fertile silence. Communication is not explicit but rather shows itself in proverbs, symbols, hesitations, understatements, omissions, and different gestures. Outsiders who do not pay attention to these matters can assume that silence means that nothing is being communicated. . The research has shown that silence as absence – barren silence - is a feature of low-context cultures and so the culture has efficient ways of dealing with it. In the HIV and AIDS arena in most instances we have generally managed to deal with the, "First Wall of Silence". To a greater degree, this silence is recognised and dealt with at government and international levels but with low context lenses. This is because modern government embodies a low-context owing to official policies, communiqués, and other written documents. Silence appears as barren silence, and thus it is easier to break even in a high context culture.

However, in the HIV and AIDS arena at the grassroots level, especially in Africa which is high context, the HIV and AIDS silence is rooted in a fertile silence. It is not conspicuous and glaring and this impacts upon what has been called the 'Second Wall of Silence' that operates at the grassroots level among the ordinary people. It is that which is not recognised and as such has been neglected. The Second wall is about local silences, and this is more difficult in a high context culture. In assessing as to whether or not the cultural context of the people contribute to the HIV silence, 78.5% of those who answered the questionnaire, indicated that the culture of the people contributes to the HIV and AIDS silence.

7.4.2.2 High Power Distance and the HIV and AIDS Silence.

In a questionnaire, 77 respondents were asked if they think that the unequal distribution of power in their culture and the hierarchical order of relationships such as uncles and

elders having authority to make decisions on behalf of the entire family, contribute to silence on HIV and AIDS. 84.4% agreed that power distance contributes to the HIV and AIDS silence, and 15.6 % did not agree. The response indicates that the cultural dimension of power distance does contribute to the HIV and AIDS silence. The reasons given for this are that with those in authority exercising dominating power, in the era of HIV and AIDS this dimension of culture contributes to the silence surrounding the disease in the following ways: people lacking opportunities to express themselves, fear being put into people, people intimidated and suppressed; even when people are willing to speak they require permission to speak; people feeling excluded by those with power. This is a new area of work linking power distance to silence in general and HIV and AIDS in particular.

7.4.2.3 Uncertainty Avoidance and the HIV and AIDS Silence.

Of the 80 responses to the question as to whether or not in the research area uncertainty avoidance contributes to HIV silence, 90 % of the respondents answered “yes” while 10% answered “no”. It was found through this study that uncertainty avoidance contributes to the HIV and AIDS silence, mainly through risk-taking. It was discovered that as a result of the low uncertainty avoidance nature of the culture, people take risks and thus become infected. When this happens people keep silent about their status, thinking that things will be better with time. Through their risk-taking behaviour, a number of people present a carefree and fatalistic attitude, while remaining silent about their HIV status. The risk-taking behaviour becomes a vicious cycle when people become infected and, for fear of being questioned about their carefree and risky life-style, keep silent about their situation. It came out strongly that people are ignorant and as a result of the low uncertainty avoidance nature of the culture, they just move on with life, keeping silent about what they are going through.

7.4.2.4 Collectivism (Community Nature or Ubuntu) and the HIV and AIDS Silence.

For the 78 respondents who answered the questionnaire as to whether or not the communal nature of the culture contributes to the HIV and AIDS silence, 91% agreed that it did while 9% disagreed. This response by the overwhelming majority of respondents saying “yes” to the question indicates that the cultural dimension of

communalism does contribute to the HIV and AIDS silence and must therefore be considered if we are to expose the barren silence. Collectivism as a dimension of culture makes people show their inclusiveness and tolerance towards others. In the era of HIV and AIDS, people would want to care for the sick and share their pain and difficulty. However, in doing this, people gossip among family members or in the community about what might be going wrong with the sick person, especially if there is a hint of HIV. Sometimes infected people also encounter stigma from family or community members. The research indicated as well that people who are not obviously infected or affected readily communicate issues on HIV, without proper education on the subject, and this makes infected people silent about their status as people say anything, anywhere about the sick. In the end HIV-positive people are suspicious of the community. All these issues make people who are HIV-positive (and their informed family members) keep their silence about the situation they are in.

7.4.2.5 Gender Inequality (Masculinity in terms of Egalitarianism) and the HIV and AIDS Silence.

When the respondents were asked if Gender inequality contributes to the HIV and AIDS silence, 91.1% of the respondents agreed that gender inequality contributes to the HIV and AIDS silence, while only 8.9% of respondents disagreed. It was noted that there are ways in which gender inequality contributes to the HIV silence. It includes the fact that as a result of this dimension of culture, women are more often than not blamed for bringing HIV into a relationship when they disclose their positive status, and some women are abused when they do so. In some relationships the first person to disclose their HIV status is considered to be the source of the infection. The research indicates that in situations where women desire to disclose their status, they are usually forced by their husbands not to do so. It is found that men's silence on the disease also causes women to be silent on the disease. All of these situations contribute to the HIV silence.

7.4.2.6 Caring Nature (Femininity in terms of Assertiveness) and the HIV and AIDS Silence.

83.8% of respondents agreed that femininity in terms of assertiveness contributes to the HIV and AIDS silence, while 16.2% disagreed. The response indicates that the cultural dimension of femininity in terms of assertiveness contributes to the HIV and AIDS

silence. The caring nature dimension of culture makes people show their humane characteristics towards others through the sharing of their pain. However, in the tenderness of caring for the sick, especially when the sick person is weak and at the mercy of the caregiver, most of the details of what are wrong with the sick person are exposed. It is usually at this point that, through the caring nature of the culture, people obtain access to information on the sick person and begin to gossip and not observe confidentiality. The research indicates that infected people are aware of this situation and so keep silent about their status and sometimes move away from where familiar people are or move from the city to a village where people might not know them. Lack of understanding about the disease contributes much to discrimination and gossip and incorrect dissemination of information on the disease. It is pointed out in the research that a caring nature makes people sympathise with the sick person as long as they are unaware that the sick person is HIV-positive. When people learn of the status of the sick person they reverse their caring attitude and stigmatise the sick person. This then becomes a reason for HIV-positive people to keep silent about their status and thereby continue to receive sympathy and care from others.

7.4.3 Recommendations

7.4.3.1 Barren and Fertile and the HIV and AIDS Silence

This research recommends that in the quest to break the HIV and AIDS silence, practitioners and activists in the field should take note of the fertile silence in a high-context culture. In a high-context culture, fertile silence overshadows any barren silence that most people are familiar with and desire to break. Attention must be given to the fertile silence for engagement. This is done by attending to such things as requests for prayer by people who are sick, changing topics when one is talking about issues of HIV and AIDS, issues of witchcraft etc. Taking interest in and paying attention to such issues raised by a sick person or family members builds relationships and trust. This then leads to the exposure of the barren silence on the issue of HIV and AIDS for discussion. In this case, silence in a high-context culture needs to be engaged with and not just to be broken. Engaging with fertile silence – silence in which meaning is present - is done through building relationships with

people who are silent and with the various non verbal cues that present itself, therefore removing all the barriers that hinder progress to bring to the surface the silence as absence. The various techniques that are known for dealing with silence are then applied. (See Figure 7.4.2.4 below).

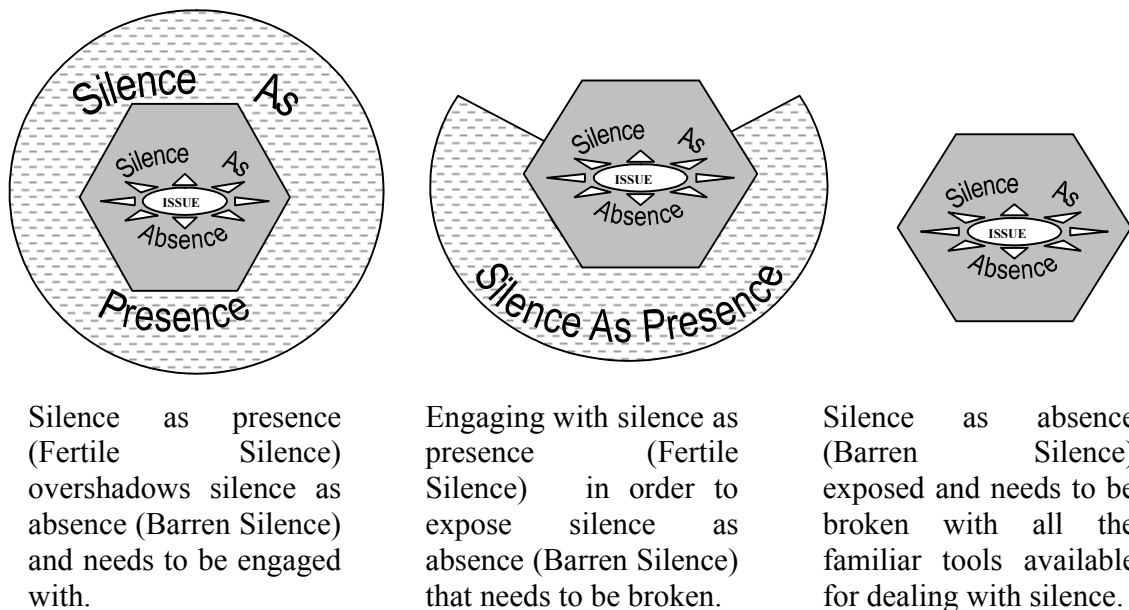


FIGURE 7.4.3.1 Engagement with Fertile Silence to expose Barren Silence

7.4.3.2 High Power Distance and the HIV and AIDS Silence.

This study recommends that practitioners in the field note that power distance exists within the culture of the people and contributes to silence around the HIV and AIDS. For this there is the need for research into ways of dealing with the characteristics of power distance, to help reduce the silence it creates in people’s lives. Similar research could be instituted to look specifically into how the characteristics of power distance could be discussed with those in authority who display them, so as to create a conducive atmosphere for people infected and affected by HIV to open up and break their silence.

7.4.3.3 Uncertainty Avoidance and the HIV and AIDS Silence.

Communities need to be educated about the effects of taking risks. Emphasis should be made on the need to build relationships with people so as to be able to help them when they need help and to avoid taking risks.

7.4.3.4 Collectivism (Community Nature or Ubuntu) and the HIV and AIDS Silence.

The Ubuntu spirit needs to be rekindled in people's lives so that they love others unconditionally no matter what is wrong with them. Research must be conducted into how the HIV and AIDS message could be conveyed in a simple way that helps people to understand that HIV is not a death sentence.

7.4.3.5 Gender Inequality (Masculinity in terms of Egalitarianism) and the HIV and AIDS Silence.

Usually, issues of gender are not discussed in African families. It is therefore recommended that gender becomes a priority in HIV discussions. Men must be involved in HIV issues and take the lead, especially in the issue of disclosure. This is where the role of infected men from the Support Groups becomes relevant. As was pointed out by the infected males in the focus group discussions, "Within families, infected men should share their stories to encourage the others to be open. In our African tradition, people keep secret about things, especially about HIV, but if the man in the house is open and not ashamed to disclose his status to his own family, it will encourage other family members. Women in particular are going to be encouraged as they are often afraid of men, even to asking questions relating to men's health and their own as well". It is important that infected men become involved in Support Groups as the research indicates that they are effective in helping to deal with the silence around HIV and in sensitivity to gender issues, being ready to change their hierarchical attitudes.

7.4.3.6 Caring Nature (Femininity in terms of Assertiveness) and the HIV and AIDS Silence.

This situation re-echoes the need for proper education on HIV and AIDS at the grassroots level, to help people understand the disease and how it is transmitted in order to alleviate fears amongst the people. The fear of catching HIV by touching infected people or coming closer to them is one of the main reasons for discrimination at grassroots level. More community education on HIV and AIDS is needed at the basic level of the people through the building of relationships. Usually HIV education is done through workshops that are alien to the people. They only attend them because of the flashiness of the

occasion – good food, good venue – but they lack ability for immediate follow-up and the practical application of HIV education which is relevant to the local setting.

7.5 Stigma and Discrimination

7.5.1 Summary

Chapter 5 identified and considered themes from the data on how the various dimensions of culture contribute to the HIV and AIDS silence that are stigma and discrimination related. Words such as: Stigma, Rejection, Gossip, Witchcraft, Shame, Blame, Discrimination, Secrecy, Judgement, Suspicion and Taboo were the most frequently used words identified. What stigma and discrimination are and how they are linked were looked at. Stigma was seen to be invisible and somehow abstract in concept and can only be seen in action through *discrimination*. Discrimination therefore acts on a pre-existing stigma and leads to the isolation, rejection, judging or unfair treatment of others.

The identified themes were considered in relation to stigma and discrimination as researched by other authors. It was found that each of the themes had something to do with stigma and discrimination, and thus makes infected persons display a barren silence about their HIV and AIDS status. However, in each case, it was found that people living with the disease made room for engagement through keeping a fertile silence that is able to expose the barren silence and break it. The understanding of Barren and Fertile silence in this way provides clues for dealing with and understanding the current debate on HIV and Aids silence, stigma and disclosure.

7.5.2 Conclusions

7.5.2.1 HIV and AIDS Silence, stigma and discrimination is still a Problem

This field research affirmed that there is a huge silence around HIV and AIDS emanating from issues of stigma and discrimination, and that this has huge implications for South Africa. 78.7% of respondents indicated that it would be difficult for them to disclose their HIV status to others. The reasons cited as to why it will be, or is, difficult include such cultural reasons as taboos on sexual issues that leads to stigmatisation, gossiping, rejection, discrimination, judgemental attitudes.

Others include the inability of the elderly to speak openly with the young; taboos and their consequences; the use of power by the elderly and men, the belief in witchcraft, the secretive nature of the culture, myths and beliefs and the linkage of incurable diseases with curses. Infected people will not disclose their status until they establish a good relationship with someone they can trust. This scenario is one of the main reasons for the escalating prevalence of HIV in South Africa, especially among the young people who do not want to be ridiculed and stigmatised by friends. South Africa is therefore faced with an HIV and AIDS crisis that makes the country's situation one of the worst in the world, affecting all sectors of society. The major conclusions here are that people go for the HIV test but keep the results to themselves.

7.5.2.2 Stigma and Discrimination fuels Silence around HIV and AIDS

Of the themes that were identified around the HIV and AIDS silence as a result of the dimensions of culture, 88.6% were directly linked to stigma and discrimination. They include: Stigma, Rejection, Gossip, Witchcraft, Shame, Blame, Discrimination, Secrecy, Judgement, Suspicion and Taboo. From the perspective of PLWHAs stigma and discrimination expressed in this fashion, makes them feel less human than others and powerless and marginalised. To avoid such situations, people keep silent and do not disclose their HIV status.

7.5.3 Recommendations

A lot has been written on stigma and discrimination in South Africa, but the issue continues to be a major problem in the community. The research shows that in many instances, people stigmatise and discriminate without knowing it. There is therefore the need to educate community members in what it means to stigmatise and discriminate against people living with HIV and AIDS. Government can partner community-based organisations on this.

7.6 Engaging the Fertile Silence with the CCP Model

7.6.1 Summary

Chapter six has operationalised the concept of engaging the fertile silence. It has illustrated how helpful it is to work with fertile silence in order to get to the barren HIV

and AIDS silence and break it. A case study of the CCP model was given looking into what has been achieved through the various activities involving CCP. Further, the chapter looked into ways in which the CCP model has contributed to breaking the HIV and AIDS silence. It was noted that the model utilises 6 ways of engagement with the fertile silence in order to expose and break the barren silence, namely: culturally sensitive education, the filtration principle, the 2x2x2 principle, individual care, Support Group, and Prayer meetings. Attention was also given to the linking of the process of HIV and AIDS disclosure to engagement with the fertile silence and breaking the silence.

In analysing the CCP model it was shown that in a high context the theory of fertile silence is practically and useful and does help break the silence. Lessons from the CCP model indicates that in such a high context culture as the Pietermaritzburg area, if we design a programme of intervention that takes into consideration and focuses on the fertile silence rather than the barren silence, the barren silence gets broken in the end.

7.6.2 Conclusions

7.6.2.1 The key elements of the CCP Model that engages with the Fertile silence

Within a high context culture, people are conditioned to be silent on issues for various required cultural reasons. But when it comes to the question of barren and fertile silence people do not deliberately put up a barren silence at one time and at another put up a fertile silence. Nevertheless, people who are culturally sensitive recognises that silence in a high context culture is barren and has fertility around it. The barren and fertile silence concept is more of analytical category rather than a real category. In a high context culture like the one we are working in, the HIV and AIDS silence that we desire to break is the barren silence where there is no communication at all. However, to get to break this barren HIV and AIDS silence, attention should be focussed on the fertile silence as it gives cues to anyone wishing to have the barren silence broken.

In this research we have found, through the case study of the CCP model, that in a high context culture such the Pietermaritzburg area we work in, if attention is paid to the cultural elements and a programme designed that takes into consideration the fertile silence, clues are picked up that help to expose the barren silence to be broken. The CCP model provides us with six ways to do this including:

- **Culturally sensitive education** – The data gathered from the field indicates that silence in and around the disease is due to lack of culturally sensitive education and proper dissemination of information and facts about the disease. This is not just general education of handing out pamphlets etc. Rather it is the use of such culturally appropriate methods as interactive drama, poetry, traditional songs and dancing, HIV and AIDS related games, crafts, visits to HIV and AIDS sites to be involved with the lives of individuals living with the disease and hearing their testimonies. In this way attention is paid to the cultural appropriateness as interactions or interventions to people take place. Culturally sensitive education on HIV and AIDS goes a long way in helping people to understand issues pertaining to the sickness and helps also to dispel myths around the disease. As a result of this education people express themselves and feel free to talk about the disease and learn appropriate ways to engage with the fertile silence.

Churches and schools become places where fertile silence can be appropriated through culturally sensitive education. The reasons are that there is commonality among the people within these places. In the church, the use of common language with the willingness of members to gather to use the Bible for instructions and the desire to pray together, etc brings them together. The school on its part is a place where there is common language, people are of same age groups and have the willingness to learn etc. The fundamental principle here is that to engage the fertile silence the need to engage those spaces with access to commonality is important. It makes people free to communicate and interact well and this works well in schools and churches and further into families and individuals within the community.

Culturally sensitive education has therefore shown that our theory that if we deal with the fertile silence, ultimately once it is engaged, the barren silence will be open and broken, is true.

- **The filtration principle** – The filtration principle is a broad move that gets as many people as possible to have the desire to break the silence around the disease, using

culturally appropriate methods. This principle utilises networks within the community to forge HIV and AIDS as a necessary agenda in each individual's life.

The filtration principle provides an entry point into the community through the schools and the churches. The use of the principle serves the following purposes:

- i) It offers HIV and AIDS education to all in the school or church so that stigma and discrimination on the disease is reduced.
- ii) It grants opportunity for two "ready-to-move audiences", the church and school to work together.
- iii) It helps in the mobilisation and training of volunteers or Support Personnel to help in the fight against HIV and AIDS.
- iv) It helps in the identification of OVCs and their training to understand their HIV and AIDS situation the find themselves in.
- v) It gives pupils and church members the opportunity to learn about the 2x2x2 principles and go into their various homes to educate their family members about the disease.
- vi) It also offers opportunity to those families infected and affected by HIV and AIDS to be helped to manage their situation.

As a result of the filtration principle, 9500 learners received culturally sensitive HIV information through Schools Assemblies in 2008, of which 6574 learners attended HIV Prevention Education and Life Skills out of which 4100 OVCs were identified. The families of these OVCs were visited and various HIV and AIDS related services were offered to them.

The filtration principle offers direct contact with individuals infected and affected by HIV and AIDS through a HIV education system that helps to engage with the fertile silence as various questions around the disease are answered first hand and in an open manner. This then is a proof that our theory that if we deal with the fertile silence, ultimately once it is engaged, the barren silence will be open and broken, is true.

- **The 2x2x2 principle** – This is an information dissemination tool at a peer to peer level. This level of interaction that helps people to communicate very well and overcome boundaries easily. The use of the 2x2x2 principle by CCP is a way to inspire trained individuals and all who are linked to the project to pass on the information and facts they have acquired to other people, whether in schools, churches, workplace or in the community. Within this principle are cultural elements that help in engaging the fertile silence for accessing cues in breaking the barren silence.

The use of 2x2x2 principle has seen an increase and expansion in all spheres of work in CCP. The study shows that with the use of this principle, work of CCP now covers the entire Pietermaritzburg area, and extends to other areas in the Kwazulu Natal province and the Free State and then to Zambia. As a result of the 2x2x2 principle, individuals and groups affiliated to CCP are able to train and disseminate HIV and AIDS information quickly:

- CCP staff having received training in memory work by the Sinomlando Centre for Oral History and Memory Work and training in play skills and bereavement counselling by the Rob Smetherham Bereavement Service for Children (RSBSC) began to train others in these skills. The Social workers also trained other staff members on social work issues as well as the Sustainability Coordinator trained Staff members and Support personnel in gardens development, who also trained family members.
- CCP Youth who have been helped through the programme inspired by the principle also help other young people such the Ekhubuleni Children's Home to transfer knowledge in HIV and AIDS to them.
- Organisations that were trained by CCP such as Zamimpilo in Pietermaritzburg, 'Batho ba Thepo' in Clarens and CCP trained 20 members of the Dihlabeng Church in 2006 to help to initiate a project in Clarens. Individuals such as Dave and Pam Lyons, from the Grace Community Church in Matubatuba expanded their work as a result of this 2x2x2 principle.
- The members of the Support Group were trained to care for one another and train others to care, as well applying the 2x2x2 principle. This helped the group of 4

- in 2004 grow up to 193 in 2008. At the time of this research, there were 5,000 community leaders and members, as well as family members from 17 churches, 16 schools and about 614 families from 10 township communities that worked with and interacted with the Support Group to learn from the group.

In all this work of expansion, the 2x2x2 principle instils into people the desire to present HIV and AIDS information to others, looking out for engagement with the fertile silence. For this the CCP model shows that the principle is effective. The 2x2x2 principle shows that our theory that if we deal with the fertile silence, ultimately once it is engaged, the barren silence will be open and broken, is true.

- **Home Visitations and Family Intervention** – Key to the engagement with the fertile silence is the home visitations and family interventions. OVCs identified through the filtration process in the schools and churches need care on the ground; this can only take place in their homes in the communities. It is in these homes that people find it more difficult to engage the fertile silence and allow the HIV and AIDS silence to be broken. Families keep barren silence around their HIV situation, and do not communicate about it. Rather, issues of poverty, lack of food, need for prayer and economic support become the main communication, even when discussing about HIV and AIDS. This is a demonstration of fertile silence which need engagement through supply of food parcels, interactions and discussions with members on the issues of poverty, hunger etc.

Depending on how fast relationships are built, discussions on HIV and AIDS enable CCP to assess and determine which further interventions to offer. The day-to-day interactions with the families and with staff CCP initiates relationship building. This builds trust and confidence void of suspicion and hidden agendas. It is the building of trust and good relationships that help to understand the HIV and AIDS situation of the family so that one can interpret the various fertile silences that surface. The families are invited for workshops in which the families that CCP has worked with before are invited to share their testimonies, and to tell how the CCP

programme has helped them in dealing with or overcoming the HIV and AIDS predicaments that baffled them. Through the sessions and building of relationship with the families they begin to open up to HIV and AIDS discussions, to accept the situations and allow CCP to work fully with them.

Once again, home visits and family interventions prove that our theory that if we deal with the fertile silence, ultimately once it is engaged, the barren silence will be open and broken, is true.

- **Support Group** – The research done through the Support Group case study has shown that in the cultural context of the research area, breaking the silence around HIV and AIDS is not a ‘quick-fix’, but a gradual building of relationships and confidence, that has quick results if properly founded. Formation of support groups is a test of whether engagement of the fertile silence of people living with HIV and AIDS leads to the breaking of the silence or not. This task was central to the work of CCP, leading to the formation of the Support Group, with the main purpose of determining whether interventions from CCP with the members, their families and relations, would have the desired aim of building relationships and trust leading to engagement with the fertile silence and breaking the barren HIV and AIDS silence. From four women who were not ready to discuss their HIV status in 2004 when the group started, the growth to a membership of 193 in 2008 of individuals who are not afraid to publicly declare their HIV status, and most of whom were on ARVs and looking healthy, is an evidence of the HIV silence broken on the part of the Support Group members.

Such activities and events as psychosocial support, CCP community Analysis Weeks, outings, World AIDS Day celebrations, funerals and monthly HIV and AIDS Prayer Meetings provided avenues for engagement with the fertile silence. The mobilisation of people around the Support Group and involvement in their activities is in itself a break-through in the quest to break the silence around HIV and AIDS, as it involved changing their cultural mindsets and attitudes towards the disease, thereby making a difference. These were conscious plans to engage

the fertile silence. At the community level, the mobilisation of people - Pastors, School Principals, Church members, students, Youth and family members - to get involved and support activities in and around HIV and AIDS as well as the Support Group, is a success in breaking the silence.

The success of the Support Group is indicating is that our theory that if we deal with the fertile silence, ultimately once it is engaged, the barren silence will be open and broken, is true.

- **Prayer meetings** – The mobilisation of churches to provide care and spiritual support for individuals and families infected and affected by HIV and AIDS, led to the establishment of the monthly Prayer Meetings. This became a major activity of the Support Group as the need for prayer is one of the major expressions of the fertile silence. The research clearly shows that all members of the Support Group saw the Monthly HIV and AIDS Prayer meeting as very beneficial, as it granted most of them the freedom in their spirits to worship God and it gave them hope for life and spiritual comfort. This deep spiritual need exposes them to the outside world at least once every month. Members were not afraid to come forward, in the midst of all the people present, month by month, to be prayed for. The boldness to come forward is an exposure of the barren silence on their HIV status that is broken through a public disclosure.

Once again what this is indicating is that our theory that if we deal with the fertile silence, ultimately once it is engaged, the barren silence will be open and broken, is true.

7.6.3 Recommendation

7.6.3.1 Culturally sensitive education

A lot of HIV and AIDS education programmes are in place, which is an important step in the right direction. However, it is important that these education programs are sensitive to the cultural context of the area. More especially, in a high context culture, the use of such methods as interactive drama, poetry, traditional songs and

dancing, HIV and AIDS related games, crafts, visits to HIV and AIDS sites for the visitor to be involved with the lives of individuals living with the disease and hearing their testimonies, are various ways of doing culturally appropriate HIV and AIDS education.

7.6.3.2 The Filtration Principle and HIV Interventions

A comparative research is needed in this approach to contrast with other community development approaches, especially approaches that have direct interaction with PLWHA.

7.6.3.3 The 2x2x2 Principle and HIV and AIDS education

With the success achieved in HIV and AIDS prevention Education in the schools, if curriculum researchers and writers could design curriculum for schools out of this model for the school system, learners would have an opportunity to model an HIV education life style. A similar undertaking could be done for churches, Sunday Schools and Youth Groups.

7.6.3.4 Home Visitations and Family Intervention

The need to immerse oneself into the communities of people that one is working with, into their homes and families is key, if we are to break the HIV and AIDS silence. In a high context culture, dealing with issues of HIV and AIDS is a family issue and not just one for an OVC or a PLWHA. Visiting homes and families to build relations and trust is a key instrument in engaging the fertile silence and breaking the HIV and AIDS silence. HIV programmes need to build this aspect in them.

7.6.3.5 Community Care Project Model for Breaking the HIV Silence

The work done by the CCP is something that the church can easily adapt to help break the HIV and AIDS silence. NAT has a way of mobilising churches and leading them through strategic planning for HIV and AIDS work and management, which has successfully assisted the CCP as a church-initiated project. The organisation is ready to help the churches in this regard.

Research must now be initiated into how the CCP-NAT collaboration worked in mobilising and providing support for churches, communities, families and schools to

become involved in breaking the HIV and AIDS silence. This would enable the project to upscale its work and to share it with others.

Churches are good at praying for the sick and it is high time that they initiated Support Groups, built on relationships and genuine love and concern for the people infected and affected by HIV, and then added the prayer component.

7.6.3.6 Prayer meetings

One of the main issues the PLWHAs, in their silence around HIV and AIDS, present before anyone who takes interest in their wellbeing, as a clear fertile silence, is that of prayer. We may refer to this as spiritual support. This is an important activity that if built into programmes, would help PLWHAs to open up about their condition as a fertile silence to be engaged with and break the HIV and AIDS silence

7.7 Summary

We have seen in this study that trust, and relationship building, taking time, using religion as a way of safeguarding silence and space, respect for people, honouring and being sensitive to the various dimensions of culture all help us tackle exposing the barren silence so that it can be broken.

In high context culture like the one in which we are working, the HIV and AIDS silence that we desire to break is the barren silence where there is no communication at all. In this culture, however, we cannot just go straight into the silence and break it. Rather we need to engage with the fertile silence – silence that is present and connotes issues that are real before our eyes – through trust and relationship building, taking time, using religion as a way of safeguarding silence and space, respect for people, honouring and being sensitive to the various dimensions of culture, so as to get the cues needed to get into the barren HIV and AIDS silence and break it. This is what the CCP model is able to provide for us.

The research has shown that HIV is real in South Africa and that there is silence that is culturally rooted around the subject. There are aspects of the culture such as taboos on sexual matters which contribute to the HIV and AIDS silence. The dimensions of culture in diverse ways also contribute to the HIV and AIDS silence, as they make

infected and affected people and families resistant to ‘opening up’ for fear of intimidation, stigmatisation, discrimination, abuse and accusation.

Our understanding of Fertile Silence and Barren Silence has provided us with clues as to how to ‘break the silence’. We have argued that owing to the strong element of fertile silence in African culture, it is not helpful to speak simply of ‘breaking the silence’. We have argued – and demonstrated through an examination of the work of CCP – that a culturally sensitive engagement with the fertile silence is necessary before the barren silence can be exposed and broken in ways that are constructive and healthy.

BLIOGRAPHY

- Adeyemi, Yinka. 2007. *Anti-retroviral therapies for HIV/AIDS in Africa: Using Advocacy to increase access and deepen impact*. www.uneca.org/mdgs/ARTforHIVinAfrica. Accessed on 27th September 2007
- Adonisi, Mandla. 1993. "African management - the career in community". In P. Christie. R. Lessem and L. Mbigi (editors), *African management: philosophies, concepts and applications*. Randburg: Knowledge Resources: 309-314.
- Africa Action. 2001. *Africa Policy Outlook 2001*. Washington: Africa Action www.africaaction.org
- Afrol News. 2000. *Nelson Mandela's reconciling speech, closes Durban AIDS Conference*. http://www.afrol.com/Categories/Health/health011_mandela_speech.htm
- Aggleton, Peter and Parker, Richard 2002. *A conceptual framework and basis for action: HIV/AIDS stigma and discrimination*. Geneva: UNAIDS.
- Aggleton, Peter, Wood, Kate, Malcolm, Anne and Parker, Richard. 2005. *HIV-Related Stigma, Discrimination and Human Rights Violations: Case studies of successful programmes*. UNAIDS Best Practice Collection. Geneva: UNAIDS.
- Airhihenbuwa, C. O. 1995. *Health and culture: Beyond the Western paradigm*. Thousand Oaks, CA: Sage.
- Airhihenbuwa, C. O. and Webster, J. DeWitt. 2004. "Culture and African contexts of HIV/AIDS prevention, care and support". *Journal of Social Aspects of HIV/AIDS Research Alliance* Vol. 1 No. 1 May 2004. Page Number: 4-13.
- Akyeampong, Emmanuel and Obeng, Pashington 1995. "Spirituality, Gender, and Power in Asante History". *International Journal of African Historical Studies* 28: 481-508.
- Alameda, Kimo. 2005. "Dialog on Diversity: High context and low context cultures". *AMHD news* (Newsletter of the Hawai'i State Department of Health's Adult Mental Health Division. Volume V. Issue 4 June 2005. Pg 3
- Albertsson, Sara and Klingenstierna, Katarina 2002. *Extending Brands to Emerging Markets - Implications for Brand Management Strategy: The Case of Volvo Construction Equipment in China*. International Business Master Thesis No 2002: 12 Graduate Business School, School of Economics and Commercial Law. Göteborg University
- Allen, C. 2000. *HIV/AIDS and youth in Tobago: silence and secrecy in a small island*. In: AIDS 2000 Abstracts-on-disk. Digital Information Management Services [MoOrD263] Northfield: Marathon Multimedia www.marathonmultimedia.com
- Ammann, Arthur J. 2005. *HIV / AIDS in Resource Poor Countries: A Tale of Two Epidemics*. West Coast Missionary Medicine Seminar pg 37-41. www.missionarymedicine.net/ Accessed on 15 July 2006.
- Appiah, K.A. and Gates H.L. 1999. *Africana: The Encyclopedia of the African and African American Experience*. New York: Basic Ciritasd Books.

- Arrindell, W. A. and Veenhoven, R. 2002. "Feminine Values and Happy Life-Expectancy in Nations". *Personality and Individual Differences*, 2002, vol 33, pp. 803-813
- Ashforth, Adam. 1996. "Of Secrecy and the Commonplace: Witchcraft and Power in Soweto". *Social Research*, Vol. 63, No. 4 (Winter 1996), pp1183-1234.
- Ashforth, A. 2001. *AIDS, Witchcraft, and the Problem of Public Power in Post-Apartheid South Africa*, paper delivered at the AIDS in Context Conference, University of the Witwatersrand, 4-7 April 2001. Also available at <http://www.sss.ias.edu/home/papers.html>
- Ashforth, Adam. 2002. "An epidemic of witchcraft? The implications of Aids for the Post-Apartheid State". *African Studies*, 61(1):135, pp121-143.
- Ashkanasy, Neal M., Wilderom, Celeste, P.M. and Peterson, Mark F. 2004. "Introduction". In: Ashkanasy, Neal M., Wilderom, Celeste and Peterson, Mark F. (Editors). *Handbook of Organizational Culture & Climate*. (Pages 1 – 18) Paperback edition. Thousand Oaks, CA: Sage Publishing.
- Augustine, Cilicia Senta. 2002. *The Social Construction of the South African Male Identity*. Masters Degree. Johannesburg: Rand Afrikaans University
- AVERT. 2006. *HIV & AIDS in South Africa*. <http://www.avert.org/> Accessed on 22nd July 2006
- AVERT. 2008a. *HIV and AIDS in South Africa*. <http://www.avert.org/safricastats.htm> Last updated June 09, 2008 Accessed on 1st July 2008.
- AVERT. 2008b. *HIV and AIDS in South Africa*. <http://www.avert.org/aidssouthafrica.htm> Last updated June 27, 2008. Accessed on 1st July 2008.
- Awasum, David, Sienché, Carol and Odwaka, Emily. 2001. *Break the Silence: Talk about AIDS*. Baltimore: Johns Hopkins School of Public Health. www.jhuccp.org/pubs/sp/20/20
- Baden, Sally, Hasim, Shireen and Meintjes, Sheila. 1998. *Country gender profile: South Africa: Report prepared for the Swedish International Development Office (Sida) Pretoria, Republic of South Africa*. BRIDGE (development - gender) Report No 45. Brighton: Institute of Development Studies.
- Balch, Jeff and Hollenberg, Geertje (Editors) AWEPA (European Parliamentarians for Africa) 2002. *Parliament and the AIDS Budget: Resources for Community Empowerment*. Report containing the Contributions, Conclusions and Recommendations of the Fourth International Parliamentary Conference on HIV/AIDS. Amsterdam: AWEPA. Internet www.awepa.org
- Barnett, Tony and Parkhurst, Justin. 2005. "HIV/AIDS: sex, abstinence, and behaviour change". *The Lancet Infectious Diseases*. Volume 5, Number 9, September 2005. Page Number: 590-593
- Basabe N. Páez, D. Valencia, J. Rimé, B. Pennebaker, J. Diener, E. and González, J.L. 2000. "Sociocultural factors predicting subjective experience of emotion: a collective level analysis". *Psicothema*. Suplemento, 12, 55-69.

- Bell, Richard H. 2002. *Understanding African Philosophy: A Cross-Cultural Approach to Classical and Contemporary Issues*. New York: Routledge.
- Bellamy, Carol. 2002. *Urgent Action for Children on the Brink*. Accessed on 20 June 2006, from http://www.unicef.org/media/media_9403.html
- Bentley, Kristina and Brookes, Heather 2005. *Human Sciences Research Council Report 2: National Stakeholder Workshop on Gender, Culture and Rights Report 2: National Stakeholder workshop on Gender, Culture and Rights*. Pretoria: HSRC. www.hsrc.ac.za/research/output/outputDocuments/1723_Bentley_Reportonnationalstakeholder
- Bernstein, B. (1975). *Class, Codes and Control*. NY: Schocken Books.
- BESG. 2003. *The Msunduzi HIV/AIDS Strategy: A Partnership Response to HIV/AIDS at Local Government Level*. Pietermaritzburg: BESG
- Bezuidenhout Ilze. 1998. *A discursive-semiotic approach to translating cultural aspects in persuasive advertisements*. Degree of Magister Artium in Applied Linguistics and Literary Theory. Accessed 18 March 2006, from <http://ilze.org/semio/index.htm>
- Bindeman, Steven Lee 1978. *The Role of Silence in the Philosophies of Martin Heidegger and Ludwig Wittgenstein*. Ph.D. Thesis, Duquesne University.
- Biswalo, P.M. and Lie, G.T. 1995. "Hospital Based Counselling of HIV-Infected People and AIDS Patients". In: K.I. Klepp, P.M. Biswalo, and A. Talle (Eds.), *Young People at Risk: Fighting AIDS in Northern Tanzania* (pp. 222-238). Oslo: Scandinavian University Press.
- Black B. (2001) "National Culture and Industrial Relations and Pay Structures." *Labour*, Vol. 15, No. 2, pp. 257-277
- Black, Rosemary. 2009 "Abusing the anti-HIV/AIDS drug Efavirenz could have devastating results for South Africans". *New York Daily News*. Tuesday, April 7th 2009. Accessed on 10th June 2009 from http://www.nydailynews.com/lifestyle/health/2009/04/07/2009-04-07_abusing_the_antihivaid_drug_efavirenz_c.html
- Blanche, Kelly and Durrheim. 2006. "Why qualitative research?". In: Blanche, Martin Terre, Durrheim, Kevin and Painter, Desmond (Eds). 2006. *Research in Practice: Applied Methods for the Social Science*. Pp 285 – 319. Cape Town: University of Cape Town Press.
- Blanche, Martin Terre, Durrheim, Kevin and Painter, Desmond (Editors). 2006. *Research in Practice: Applied Methods for the Social Science*. Cape Town: University of Cape Town Press.
- Bless, Claire and Higson-Smith 2000. *Fundamentals of Social Research Methods: An African Perspective*. Third Edition. Lansdowne: Juta.
- Bond, M. and Hofstede, G. 1989. The cash value of Confucian values. *Human Systems Management*, 8: 195-200.

- Boon, M. 1996. *The African way. The power of interactive leadership*. Sandton: Zebra Press.
- Booyesen, A.E. and Van Wyk, M.W. 2005. *Contents Chapter Xxx: South Africa Page 1. Introduction To..* Accessed on 21 December 2006, from http://www2.hsfulda.de/fb/sw/profs/wolf/One%20Culture%20Nation%20Leadership%20Studies/South%20Africa/south_africa.pdf
- Booyesen, A. E. Lize and Van Wyk, W. Marius. 2007. "Culture and Leadership in South Africa". In: Chhokar, S. Jagdeep, Brodbek, C. Felix and House, J. Robert. (Editors). *Culture and Leadership, across the World: The GLOBE Book of In-Depth Studies of 25 Societies*. Mahwah, N.J.: Lawrence Erlbaum Associates, Inc. Page 433-474.
- Booyesen, A.E. and Van Wyk, M.W. 2005. *Contents Chapter XXX: South Africa Page 1. Introduction To..* Accessed on 21 July 2007, from http://www2.hsfulda.de/fb/sw/profs/wolf/One%20Culture%20Nation%20Leadership%20Studies/South%20Africa/south_africa.pdf
- Booyesen, Frederik le R. and Summerton, Joy 2002. Poverty, risky sexual behaviour, and vulnerability to HIV infection: evidence from South Africa. *Journal of Health, Population and Nutrition* 20(4): 285-288.
- Booyesen, Lize. (2000), "Cultural differences between African Black and White managers in South Africa". Southern Africa Institute for Management Scientists 12th Annual Conference 'Africa's Century: Challenges for Management and Leadership' South Africa, 31 October – 2 November 2000 Conference Papers Produced by: Document Transformation Technologies. (See www.dev.unisa.ac.za/contents/faculties/sbl/PdfDocs/2.4.1)
- Boseley, Sarah. 2005. "South Africa told to admit size of Aids crisis". *The Guardian*. Friday February 11 2005. Accessed on 28th May 2007 from <http://www.guardian.co.uk/world/2005/feb/11/southafrica.aids>
- Bowers, J. W., Metts, S. M., and Duncanson, W. T. 1985. "Emotion and Interpersonal Communication". In M. L. Knapp and G. R. Miller (Eds.) *Handbook of Interpersonal Communication* (500-550). Beverley Hills: Sage
- Brown, Haines. 1999. *On Essentialism and 'Western Civilization'*. <http://www.hartford-hwp.com/archives/10/037.html>
- Bruneau, T. J. 1973. Communicative Silences: Forms and Functions. *The Journal of Communication*, 23, 17-46.
- Bryson, Mary and De Castell, Suzanne. 1993. "Queer Pedagogy: Praxis Makes Im/Perfect." *Canadian Journal of Education* 18:3 (1993) 285-305
- Buchel, Adriana Jacoba. 2006. *The leadership role of the principal in dealing with the impact of HIV/AIDS in South African schools*. Doctor of Education Thesis, Education Management. Pretoria: University of South Africa
- Buckingham, Jane E. Drapelick, Tony Finck, David and Hulnick, Janet 2000 CROSS CULTURAL COUNSELING: A STUDENT SERVICES PERSPECTIVE, SIT Occasional Paper Series www.sit.edu/publications/docs/counseling

- Campbell, C., Nair, Y., Maimane, S. and J. Nicholson. 2007. "‘Dying twice’: a multi-level model of the roots of AIDS stigma in two South African communities," *LSE Research Online*. October 2007. Accessed on 15th August 2009 at Library.Researchonline@lse.ac.uk
- Carney, Carolyn 2002. *White Responsibility in Racial Reconciliation: Some aspects of reconciliation are unique to our predominantly white culture*. White Responsibility in Racial Reconciliation - Student Leadership ... www.intervarsity.org/slj/article/1461 Accessed on 10th May 2006.
- Casale, Marisa and Whiteside, Alan. 2006. *The Impact of HIV/AIDS on Poverty, Inequality and Economic Growth*. IDRC Working Papers on Globalization, Growth and Poverty Working Paper Number 3. International Development Research Centre: Ottawa.
- Cele, B. H. 2005 Keynote Address at the Kwazulu-Natal Department of Transport's Annual Summit. 26-27 May 2005. [www.kzntransport.gov.za/current_feature/Summit2005Speech\(English\)](http://www.kzntransport.gov.za/current_feature/Summit2005Speech(English)). Accessed on 10th June 2006.
- Centre for AIDS Development, Research and Evaluation (Cadre) 2000. *The economic impact of HIV/AIDS on South Africa and its implication for governance: a literature review*. Johannesburg.
- Chatiza, Kudzai.(u/d). *A regional scan of Local Government Innovations and Experiences in addressing the HIV/AIDS challenge in Sub-Saharan Africa with specific focus on urban areas*. Accessed on 27 April 2009 from www.mdpafrica.org.zw/Publications/Regional%20Scan%20on%20HIV%20AIDS
- Chennels, Roger. 2004. "The Land Claim of the Khomani San of South Africa". In Roy, K. Chandra, Tauli-Corpuz, Vicky and Romero-Medina, Amanda (editors) *Beyond the Silencing of the Guns*. Baguio City: Tebtebba Foundation. Pp 211-225
- Chhokar, S. Jagdeep, Brodbeck, C. Felix and House, J. Robert. 2007a. "Introduction". In: Chhokar, S. Jagdeep, Brodbek, C. Felix and House, J. Robert. (Editors). *Culture and Leadership, across the World: The GLOBE Book of In-Depth Studies of 25 Societies*. Mahwah, N.J.: Lawrence Erlbaum Associates, Inc. Page 1-16.
- Chhokar, S. Jagdeep, Brodbeck, C. Felix and House, J. Robert. 2007b. "Methodology". In: Chhokar, S. Jagdeep, Brodbek, C. Felix and House, J. Robert. (Editors). *Culture and Leadership, across the World: The GLOBE Book of In-Depth Studies of 25 Societies*. Mahwah, N.J.: Lawrence Erlbaum Associates, Inc. Page 17-30.
- Child J. (2000) "Theorizing about Organization Cross-Nationally." *Advances in International Comparative Management*, Vol.13, pp.27-75
- Choe, Yunhee 2001. *Intercultural Conflict Patterns and Intercultural Training: Implications for Koreans*. Paper presented at the 16th Biennial World Communication Association Conference, The University of Cantabria, Spain July 1-7, 2001. segero.hufs.ac.kr/library/iar/9-6 Address of the author: Suwon P.O. Box 77, Department of Journalism and Mass Communication, the University of Suwon, Korea. E-mail: ychoe@mail.suwon.ac.kr

- Choi, Boreum, Lee, Inseong, Kim, Jinwoo and Jeon, Yunsuk A Qualitative Cross-National Study of Cultural Influences on Mobile Data Service Design. *CHI 2005*, April 2–7, 2005, Portland, Oregon.
- Christie, Peter 1996. *Stories from an Afman(ager)!* Randburg: Knowledge Resources.
- Christie, Peter, Lessem, Ronnie and Mbigi, Love-more (editors). 1994. *African management: Philosophies, Concepts and Applications*. Randburg: Knowledge Resources.
- CINDI. 2007. *Research Project: Reduction and Management of Stigma Towards Children Affected by HIV and AIDS*. Pietermaritzburg: CINDI. See www.cindi.org.za/?q=Publications
- Cirlot, J. E. 1962. *A dictionary of symbols*. New York: Philosophical Library
- Clayton, Jacklyn Blake 2003 *One Classroom, Many Worlds: Teaching and Learning in the Cross-Cultural Classroom*. Heinemann: Portsmouth
- Collins, John. 2004. *African Musical Symbolism in Contemporary Perspective*. Berlin: Pro Business
- Communities Scotland 2007. *Non-random or non-probability samples - Gathering Service Users' Views*. www.communitiesscotland.gov.uk/stellent/groups/public/documents/webpages/rics_011971.hcsp Accessed on 9th June 2007
- Cook, Philip and duToit, Lesley. 2004. *Circles of Care: Community Child Protection A Participatory Research Model Strengthening Restorative Local Governance in Support of South African Children's Rights*. Hatfield: Child and Youth Care Agency for Development (CYCAD)
- Corder, Clive Kingsmill 2001. *The Identification of a multi-ethnic South African Typology*. Doctoral Thesis, Department of Psychology, University of Pretoria: Pretoria
- Cornwall, A. and N. Lindisfarne 1995. Feminist anthropologies and questions of masculinity. In (A. Ahmed and C. Shore, eds.) *The Future of Anthropology: Its Relevance to the Contemporary World*, pp. 134-157. Athlone, London and Atlantic Highlands, New Jersey.
- Corrigan, P. W., & Penn, D. I. 1999. "Lessons from social psychology on discrediting psychiatric stigma". *American Psychologist*, 54, 765–776.
- Cox, Christoph and Warner, Daniel (Editors). 2004. *Audio Culture: Readings In Modern Music*. New York: Continuum International Publishing Group.
- Creswell, J. W. 1994. *Research design: Qualitative approaches*. London: Sage Publications.
- Crocker, J., Major, B., and Steele, C. 1998. Social stigma. In: Gilbert, D. T. and Fiske, S. T. (Eds.), *The handbook of social psychology*, Vol. 2 (pp. 504–553). Boston: McGraw-Hill.
- Dahl, Stephan 2000. *Cultural Values in Advertising: Transfer Report*. University of Luton. www.stephweb.com/capstone/TransfRep

- Damiano, Kathryn 2003. Some Thoughts on Silence www.quakerinfo.com/silence.shtml
- Document last modified on Monday, 28-Apr-2003 09:14:40 EDT)
- Dauenhauer, BP. 1980. *Silence: The Phenomenon and its Ontological Significance*.
Bloomington: Indiana UP,
- Davidson, Rochelle Renere 2004. "Life and Death in a time of HIV and AIDS".
HIV/AIDS Indaba. Special Edition for World AIDS Day: Women, Girls, HIV and
AIDS. December 2004. Pg 10-11.
- Davies, Matthew and Seiferth, Nicole 2004. Global dimensions resonate with Episcopal
Communicators Episcopal News Service
www.episcopalchurch.org/3577_41124_ENG_HTM.htm
- De Klerk, Vivian 2000. "To be Xhosa or not to be Xhosa ... That is the Question."
Journal of Multilingual and Multicultural Development Vol. 21, No. 3, 2000 Pg.
198-215
- De Mooij, Marieke. 2002. "Convergence and divergence in consumer behaviour"
Comunicación y sociedad. 2002. Convergence and divergence in consumer
behaviour Introduction The ... [www.mariekedemooij.com/articles/
demooij_2002_com_y_sociedad](http://www.mariekedemooij.com/articles/demooij_2002_com_y_sociedad) 21 May 2005, 06:06:14 PM
- De Mooij, Marieke. 2003. "Convergence and divergence in consumer behaviour:
Implications for global advertising". *International Journal of Advertising*, Vol. 22,
pp. 183–202
- De Vos, A. S. 2002. "Qualitative data analysis and Interpretation". In A.S. De Vos (Ed.),
*Research at grass roots: For the Social Sciences and Human Service
Professionals*. Second Edition. (pp. 339-355). Pretoria: Van Schaik Publishers.
- De Vos, A. S. and Fouché, C. B. 1998. "General introduction to research design, data
collection methods and data analysis". In A.S. De Vos (Ed.), *Research at grass
roots: A primer for the caring professions* (pp. 76-94). Pretoria: Van Schaik.
- Deacon, Harriet. 2006. "Towards a Sustainable Theory of Health-Related Stigma:
Lessons from the HIV/AIDS Literature". *Journal of Community & Applied Social
Psychology*. 16: 418–425 (2006)
- Deacon, Harriet and Simbayi, Leickness (Principal Investigators). 2006. *The Nature and
Extent of HIV and Aids-Related Stigma in the Anglican Church of the Province of
Southern Africa: A Quantitative Study. Report Prepared By Human Sciences
Research Council and Outsourced Insight for the Anglican Provincial Aids Office*.
Human Sciences Research Council. Accessed on 15th August 2009 at
http://aid.anglicancommunion.org/resources/docs/anti_stigma_report.pdf
- Deacon, Harriet, Stephney, Inez and Prosalendis, Sandra. 2005. *Understanding HIV/Aids
Stigma: A Theoretical and Methodological Analysis*. Cape Town: Human Sciences
Research Council.
- Deloitte & Touche. 2003. *Access to Assistive Technology in the European Union: Social
security and social integration*. Directorate-General for Employment and Social
Affairs. Unit E. 4. European Commission. Accessed on 21 December 2006, from

- [Http://ec.europa.eu/employment_social/disability/assistive_technology_study_en.pdf](http://ec.europa.eu/employment_social/disability/assistive_technology_study_en.pdf)
- Delpont, C. S. L. 2002. "Quantitative Data Collection Methods". In A.S. De Vos (Ed.), *Research at grass roots: For the Social Sciences and Human Service Professionals*. Second Edition. (pp. 165-196). Pretoria: Van Schaik Publishers.
- Denis, Philippe 2003. *Are Zulu Children Allowed to Ask Questions? Silence, Death, and Memory in the Time of AIDS*, University of Natal www.history.und.ac.za/Sempapers/Denis2003
- Department of Translation Studies, University of Tampere. Government Gazette No. 16943. 1996. <http://www.gov.za> (02 February 1996)
- DeVito, Joseph A. 2002. *Human Communication*. Boston: Allyn and Bacon
- Diakonia Council of Churches. 2008. *Churches Committing To An AIDS-free Society 2 – 5 June 2008*. Report on the Diakonia Council of Churches HIV and AIDS Summit Sierra Ranch, KwaZulu-Natal, South Africa. www.diakonia.org.za. Bishopsgate: Diakonia Council of Churches
- Diala, Isidore 2002. The Political Limits of (Western) Humanism in Andre Brink's Early Fiction. *Studies in the Novel*. Volume: 34. Issue: 4. pp 422+. Article read from Questia Media America, Inc. Accessed on 4th March 2006 from, www.questia.com
- District Municipality Reports DC22. 2003. The Umgungundlovu District Municipality, Kwazulu –Natal Province: *Adjustment Of Powers And Functions*. www.demarcation.org.za/documents/Annual_Report/2003Jun9/DC22_Final_1.doc
- Dixon-Mueller, R and Wasserheit, J. 1991. *The Culture of Silence: Reproductive Tract Infections Among Women in the Third World*, New York: International Women's Health Coalition. <http://www.iwhc.org/docUploads/CULTUREOFSILENCE.PDF>
- Dladla, Nonpumelelo. 2006. Personal Interview 4th July 2006.
- Donaldson, L. (1993). *Anti-Management Theories of Organization: A critique of Paradigm Proliferation*. Cambridge: Cambridge University Press.
- Dream Supporters*. 2006. "Inspirational Quotes" <http://dreamsupporters.com/quotes.html> Accessed on 1st July 2008.
- Dube, Musa W. 2003. "Culture, gender and HIV/AIDS understanding and acting on the issues". In: Dube, Musa W (ed), *HIV/AIDS and the Curriculum: Methods of Integrating HIV/AIDS in Theological Programmes*. Geneva: World Council of Churches Publications. Pp 86-101.
- Durrheim, Kevin. 2006. "Research Design". In: Blanche, Martin Terre, Durrheim, Kevin and Painter, Desmond (Eds). 2006. *Research in Practice: Applied Methods for the Social Science*. Pp 33 – 59. Cape Town: University of Cape Town Press.
- Easton, Harriet, Nakene, Mathabo, Naidoo, Soogandhree and Kafidi, L. Petrus 2003 *Validating the user-centred design process within a developing context*. Pretoria: CHISA

- Ellsberg, Mary, and Heise, Lori. 2005. *Researching Violence Against Women: A Practical Guide for Researchers and Activists*. Geneva: WHO Press.
- Enninger, W. 1983. "Silences across cultures". *INTUS NEWS/-NUUS*, 7 (1), 36-44.
- Enninger, W. 1987. What Interactants do with non-talk across cultures. In K. Knapp, W. Enninger and A. Knapp-Potthoff (Eds.) *Analysing intercultural communication* (pp 269-302). Berlin: Mouton de Gruyter
- Ethnographic study of cellphone users*. June 2000.
<http://www.chisa.org.za/articles/ethno.htm>
- Federschmidt, Karl, Temme, Klaus and Weiss, Helmut 2004. *Workbook on Intercultural Pastoral Care and Counselling*. Düsseldorf: SIPCC
- Felman, Shoshana, and Laub, Dori. 1992. *Testimony: Crises of Witnessing in Literature, Psychoanalysis, and History*. NY: Foutledge.
- Ferreira, A. J. 1964. On Silence. *American Journal of Psychotherapy*. 18: 109-115.
- Fife, B. L., and Wright, E. R. 2000. "The demensionality of stigma: A comparison of its impact on the self of persons with HIV/AIDS and cancer". *Journal of Health and Social Behavior*, 41, 50-67.
- Fitz, Earl E. 1987. A Discourse of Silence: The Postmodernism of Clarice Lispector. *Contemporary Literature*, Vol. 28, No. 4, After the Boom: Recent Latin American Fiction (Winter, 1987), pp. 420-436.
- Focus Group Discussions with ICBC and Full Gospel HIV/AIDS teams on 22/10/2006
- Fouché, C. B. 2002. "Research Strategies". In A.S. De Vos (Ed.), *Research at grass roots: For the Social Sciences and Human Service Professionals*. Second Edition. (pp. 270-277). Pretoria: Van Schaik Publishers.
- Fox, Susan, Fawcett, Cally, Kelly, Kevin and Ntlabati, Pumla. 2002. *Integrated Community-based Home Care (ICHC) in South Africa: A review of the model implemented by the Hospice Association of South Africa*. Cape Town: USAID
- Frank, Jonathan and Toland, Janet 2002. Email as a learning technology in the South Pacific: An evaluation. *Educational Technology and Society* 5(3) 2002.
- Freudenthal, Solveig. 2001. *A Review of Social Science Research on HIV/AIDS*. Swedish International Development Cooperation Agency (SIDA). Stockholm : SIDA, Department for Research Cooperation,. Accessed on 20 June 2006, from <http://www.hateamongstus.net/FWH/Comp/SocialScienceresearchAIDS.htm>
- Fuss, Diana. 1989. *Essentially Speaking. Feminism, Nature and Difference*. New York: Routledge.
- Galloway, M, Lombard, C, Abdool Karim, S, Mellors, S, France, T, Berry, L, Chatani, M, and Osborne, A. 2001. *Breaking the silence – the delegate survey. XIII International AIDS Conference, Durban, 9 14 July 2000 - Delegate Survey*. <http://www.hdnet.org/library/Durban%20delegate%20survey%20June2001.pdf>
- Garcia, Angela 2000. A Word from WISE. *WISE Words: HIV/AIDS, Treatment, Information And Advocacy For Women*. October 2000 Issue 6 page 1-2 San Francisco: Project Inform

- Gashishiri, B Sheila. 2003. "Stigma_and_Discrimination" *Newvision*. Accessed on 28th July 2009 from www.aidsuganda.org/pdf/Stigma_and_Discrimination_article.pdf
- Gbadegesin, S. 1991. *African Philosophy: Traditional Yoruba Philosophy and Contemporary African Realities*. New York: Peter Lang.
- Gender Links 2003. *Covering Gender Violence* www.genderlinks.org.za/docs/training/wsrep-tanzania-gendviol Accessed on 10th June 2006.
- Georgiades, D. S. and Delvare I. G. (Compilers) 1975. *Philosophy in the African Context: To be is to Participate*. Unpublished essays delivered at a philosophy seminar at the University of the Witwatersrand (Johannesburg) in July 1975.
- Goffman, Erving 1963. *Stigma: Notes on the management of a spoiled identity*. New York: Simon and Schuster.
- Greeff, M. 2002. "Information Collection: Interviewing". In A.S. De Vos (Ed.), *Research at grass roots: For the Social Sciences and Human Service Professionals*. Second Edition. (pp. 291-320). Pretoria: Van Schaik Publishers.
- Groenewald, H. J., Bornman, E., Conradie, D. P., Hall, E. Holtzhausen, U., Mynhardt, J., Nieuwmeijer, L., van Aswegan, A. H., and van Rensburg, J. J. 1988. Communication in South African Society: A Perspective on the Future. In: Marais, H. C. (ed) 1988. *South Africa: Perspectives on the Future*. Pinetown: Owen Burgess Publishers. 231-256.
- Grönroos, Stina 2004 Silence of the Finns: Speechlessness as a Means of Communication www.uta.fi/FAST/FIN/IDENT/sgsfinn.html
- Gudykunst, B. William 1991. *Bridging Differences: Effective Intergroup Communication*. Sage Series in Interpersonal communication Volume 3. Newbury Park: Sage Publications
- Gudykunst, B. William and Ting-Toomey, Stella 1988. *Culture and Interpersonal Communication*. Sage Series in Interpersonal Communications Volume 8. Newbury Park: Sage Publications
- Gudykunst, W. B. and Kim, Y. Y. 1997. *Communicating with strangers: an approach to intercultural approach*. Boston: McGraw-Hill.
- Guest, Michael. 2006. "Culture research in foreign language teaching: Dichotomizing, stereotyping and exoticizing cultural realities?" *Zeitschrift für Interkulturellen Fremdsprachenunterricht* 11: 3, 1-19.
- Gyekye, K. 1995. *An Essay on African Philosophical Thought. The Akan Conceptual Scheme*. Philadelphia: Temple University Press.
- Gyekye, K. 1997. *Tradition and Modernity: Philosophical Reflections on the African Experience*. New York: Oxford University Press.
- Habke, Audrey and Sept, Ron 1993. Distinguishing Group and Cultural Influences in Inter-Ethnic Conflict: A Diagnostic Model *Volume 18, Number 4, 1993* *Canadian Journal of Communication* Distinguishing Group and Cultural Influences [Http://info.wlu.ca/~wwwpress/jrls/cjc/BackIssues/18.4/sept](http://info.wlu.ca/~wwwpress/jrls/cjc/BackIssues/18.4/sept).

- Hagan, George P. 2000. "Modern Technology, Traditional Mysticism and Ethics in Akan Culture". In: Helen Lauer (Editor) *Ghana: Changing Values/Changing Technologies. Ghanaian Philosophical Studies, II*. Cultural Heritage and Contemporary Change Series II, Africa, Volume 5. Legon, Ghana. Accessed on 9 Nov 2006, from www.crvp.org/book/Series02/II-5/chapter_ii.htm
- Hall, Edward and Hall, Mildred. 1990. *Understanding Cultural Differences*. Yamouth: Maine, Intercultural Press
- Hall, Edward T. 1959. *The Silent Language*. Westport: Greenwood Press, Publishers
- Hall, Edward T. 1966. *The Hidden Dimension: Man's use of Space in Public and Private*. London: The Bodley Head
- Hall, Edward T. 1976. *Beyond Culture*. Garden City, NY: Anchor/Doubleday.
- Hall, Edward T. 1977. *Beyond Culture*, Garden City, N.Y.: Anchor Books.
- Hall, Edward T. 1983. *The Dance of Life: The Other Dimension of Time*. 1983, New York.: Doubleday.
- Hall, Edward T. 1989. *Beyond Culture*. New York: Anchor Books Editions.
- Hall, Edward T. 1990. *The Silent Language*. Anchor Books: New York.
- Hall, Edward T. 1998a. "Learning the Arab's Silent Language" Culture, Communication and Conflict, ed. Gary R. Weaver Needam Heights: Simon and Schuster Publishing
- Hall, Edward T. 1998b. "Three domains of culture and the triune brain". In S. Niemeier, C.P. Campbell, and R. Dirven (Eds.), *The Cultural Context in Business Communication*: 11-30. Amsterdam: John Benjamins.
- Hall, Edward T., and Hall, Mildred Reed. 1987. *Hidden Differences: Doing Business with the Japanese*. Garden City, New York: Anchor Press/Doubleday.
- Hallman, Kelly. 2004. *Socioeconomic Disadvantage and Unsafe Sexual Behaviors Among Young Women and Men in South Africa*. Policy Research Division Working Papers No. 190. New York: The Population Council, Inc.
- Hamminga, Bert. 2000. *The Western versus the African Time Concept* Internet Publication on 9th March 2000 and accessed on 11th June 2005. Website: <http://mindphiles.com/floor/teaching/timeafr/timeafrq.htm>
- Hanks, Tammy L. 2008. "The Ubuntu Paradigm: Psychology's Next Force?". *Journal of Humanistic Psychology*, Vol. 48, No. 1, 116-135 (2008)
- Haram, Liv 2001. 'AIDS and Body Politics: Gender Struggles and Competing Moral Discourses – The case of Tanzania'. In: Catharina de Kat-Reynen (Editor) 2001. *HIV/AIDS: Grasping the Reality of its Gender Dimension. APRODEV-Good - Gender Orientation on Development. Annual Conference Report 11-13 September 2000 Oslo, Norway*. Hosted By Norwegian Church Aid Brussels:Karin Ulmer. Pg. 50-53.
- Haraway, D. J. 1987. Geschelt, gender, genre: Sexualpolitik eines wortes. In K. Hauser (Ed.), *Viele Orte: Uberall? Feminismus in bewegung. Festschrift for Frigga Haug* (pp. 22–41). Berlin: Argument-Verlag.

- Hasegawa, Tomohiro and William B. Gudykunst. 1998. "Silence in Japan and the United States." *Journal of Cross-Cultural Psychology*. 29 (1998): 668-685.
- Hatchett, L. A., Kaponda, C. P. N. and Chihana, C. N. "Health-seeking patterns for AIDS in Malawi," *AIDS Care*, vol. 16, no. 7, pp. 827-833, 2004.
- Health Jackal*. 2009. "HIV Drug Abuse on the Rise Among South African Teens". Thursday, 09 Apr 2009. Accessed on 10 June 2009 from <http://www.healthjackal.com/conditions/2009/04/09/hiv-drug-abuse-on-the-rise-among-south-african-teens/>
- Hemmati, Minu and Gardiner, Rosalie 2001. "Towards Earth Summit 2002: Gender Equity and Sustainable Development." . *Gender Equity Briefing Paper*. Social Briefing No. 2. Gender Equity www.unedforum.org/policy/social/gender.pdf . Accessed on 28th May 2006
- Henning, E., Van Rensburg, W. and Smit, B. 2004. *Finding Your way in Qualitative Research*. Pretoria: Van Schaik Publishers.
- Hickson, D. J., Hinings, C. R., McMillan, J., & Schwitter. (1974). "The culture-free context of organization structure: A tri-national comparison". *Sociology*. Vol 8, 59-80.
- Hinshaw, Stephen P. 2007. *The Mark of Shame: Stigma of Mental Illness and an Agenda for Change*. New York: Oxford University Press.
- HIVandAIDS.in. (u/d). *HIV Related Stigma and Discrimination*. Accessed on 15 April 2009 from <http://www.hivandaids.in/related-stigma-and-discrimination-to-hiv/>
- HIVOS 2001. *Hivos Policy Document Gender, Women and Development*. www.hivos.nl/index.php/content/download/923/4510/file/phpjG82PF.pdf Accessed on 10th June 2006
- Ho, D. Y. F. 1996. Filial piety and its psychological consequences. In M. H. Bond (Ed.), *The handbook of Chinese psychology* (pp. 155-165). New York, NY: Oxford University Press.
- Hofstede, Geert 2001. *Culture's consequences: Comparing values, behaviors, institutions, and organizations across nations* (2nd Ed.). Thousand Oaks, Sage.
- Hofstede, Geert and Bond, Michael. 1984. Hofstede's Culture Dimensions. *Journal of Cross-Cultural Psychology*, 15, 417-433.
- Hofstede, Geert and Bond, Michael. 1988. "The Confucius Connection: From Cultural Roots to Economic Growth," *Organizational Dynamics*, pp 5-21.
- Hofstede, Geert and Hofstede, Gert Jan. 2005. *Cultures and organizations: software of the mind. Intercultural cooperation and its importance for survival*. New York, NY: McGraw-Hill
- Hofstede, Geert H. and Arrindell, A Willem. (Editors). 1998. *Masculinity and Femininity: The Taboo Dimension of National Cultures*. Thousand Oaks, CA: Sage Publications.
- Hofstede, Geert. 1980. *Culture's Consequences: International Differences in Work-Related Values*, CA: Newbury Park: Sage Publications, Inc.

- Hofstede, Geert. 1997. *Culture and organizations: Software of the mind*. New York, McGraw-Hill.
- Hollensen, S (2001) *Global Marketing: A market-responsive approach*, Essex: Pearson Education Limited
- Höritzauer-Wilhelm, Brigitte 1986. *The Role of Silence in the Psychotherapeutic Process*. Masters Degree Thesis, Pietermaritzburg: University of Natal.
- House RJ, Hanges PW, Javidan M, Dorfman P, Gupta V, eds. 2004. *Culture, Leadership, and Organizations: The GLOBE Study of 62 Societies*. Thousand Oaks, CA: Sage
- Hsu, Jeffrey. 2003. "Chinese cultures and E-commerce" In: Theerasak Thanasankit (Editor) *E-Commerce and Cultural Values* (Pages: 268 – 289). Hershey: IGI Publishing.
- Hugo, Jacques. 2000. *JHA - Contextual Inquiry of cellphone users.htm*
- Human Sciences Research Council. 2002. *Nelson Mandela/HSRC Study of HIV/AIDS*. Cape Town: Human Sciences Research Council Publishers
- Hunt, S. 1996. *An investigation into patterns of interaction in small teaching groups at Rhodes University, with particular emphasis on the effect of gender, mother-tongue and educational background*. Unpublished Masters Dissertation, Rhodes University.
- Hussein, Jeylan W. 2004. "A Cultural Representation of Women in the Oromo Society" *African Study Monographs*, 25(3): 103-147, October 2004
- Hussein, Jeylan W. 2005. "The Social and Ethno-Cultural Construction of Masculinity and Femininity in African Proverbs". *African Study Monographs*, 26(2): 59-87, August 2005
- Inkeles, Alex and Levinson, Daniel J. 1969. 'National character: the study of modal personality and sociocultural systems', in *The Handbook of Social Psychology*, 2nd edition, vol. 4, G. Lindzey and E. Aronson (eds), Reading MA: Addison-Wedey (1954).
- International Council of Nurses (ICN). 2003. *Stigma, Discrimination and the Conspiracy of Silence Are Fuelling the AIDS Epidemic*. Accessed on 15 October 2007, from www.icn.ch/PR13_03.htm
- Inter-Parliamentary Union and the United Nations Division for the Advancement of Women. 2005. *Women in Politics: 2005*. Lausanne: Presses Centrales de Lausanne.
- Jackson, David (Editor). 1996. *Taboos in German Literature*. Providence: Berghahn Books.
- Jackson, Howard. 2002. *Lexicography: An Introduction*. London: Routledge. Place of Publication.
- James, S. John 1999. *Durban Conference: February Deadlines, New Track, and Community Program*. www.aids.org/atn/a-330-05.html
- Jane, Ian on May 28, 2003. *Mr. Bean: The Whole Bean* <http://www.dvdmaniacs.net/Side/reviews.html>

- Janesick, J. Valerie 2003. "The Choreography of Qualitative Research Design: Minuets, Improvisations, and Crystallizations". In: Denzin, K. Norman and Lincoln, S. Yvonne (Editors). *Strategies of Qualitative Inquiry*. Second Edition. Page 46- 79. London: Sage Publications
- Jaworski, Adam. 1993. *The Power of Silence: Social and Pragmatic Perspectives*. Language and Language Behaviors. Vol. 1. Newbury Park: Sage Publications,
- Jesuino, Jorge Correia 2007. "Leadership and Culture in Portugal". In: Chhokar, S. Jagdeep, Brodbek, C. Felix and House, J. Robert. *Culture and Leadership, across the World: The GLOBE Book of In-Depth Studies of 25 Societies*. Mahwah, N.J.: Lawrence Erlbaum Associates, Inc. Page 583-622
- Jobes, G. (Ed.) 1962. *Dictionary of Mythology, folklore and Symbols*, Part 2. New York: Scarecrow.
- Johansen, Anna. 2004. *HIV/AIDS and prevention: A Minor Field Study of discourses of HIV/AIDS and the framework for a rights based response in Mozambique*. Masters Thesis. Göteborg: Göteborg University.
- Johnson, Burke and Christensen, B. Larry. 2004. *Educational research: Quantitative, qualitative, and mixed approaches*. Second edition, Boston: Pearson/Allyn and Bacon.
- Journ-AIDS. Undated. *Journ-AIDS: Factsheet - The Politics of HIV/AIDS in South Africa: "AZT Toxicity"* (1999/2000). Accessed on 27th September 2007, from <http://www.journaids.org/politicsofhiv.php#azt-toxicity>
- Journ-AIDS. Undated. "Living with HIV-AIDS." *Journ-AIDS Factsheet*. Accessed on 10 November 2007, from <http://www.journaids.org/livingwithhivaids.php>
- Junod, A. Henri. 1962. *The Life of a South African Tribe*. New York: University Books, Inc.
- Kakoko, D.C.; Lugoe, W.L and Lie, G.T. 2006. *Paper II:Prevalence and factors associated with anticipation of HIV/AIDS-related stigma among Tanzanian teachers who have never voluntarily tested for HIV: an exploratory study, (pre-print)*. Submitted to AIDS and Behavior. Accessed on 30th July 2009 at <https://bora.uib.no/dspace/handle/1956/1902?mode=simple>
- Kallinen, Timo 2005. "'A prayer for prosperity": Authority outside the hierarchies". *Journal of the Finnish Anthropological Society*. Volume 30 Number 1 March 2005. pp 39-52
- Kane, Leslie (1984) *The Language of Silence: On the Unspoken and Unspeakable in Modern Drama*, London/Toronto: Associated University Press.
- Kelly, J. Michael. 2003. "The Significance of HIV/AIDS for Universities in Africa" *Journal of Higher Education in Africa (JHEA)*. Volume 1, Number 1, 2003, pp. 1–23
- Kelly, Kevin. 2003. *Supporting Local Government Responses to HIV/Aids: Positions, Priorities, Possibilities*. Grahamstown: CADRE, Rhodes University. <http://www.cadre.org>

- Kelly, Kevin 2006. "From Encounter to Text: Collecting Data in Qualitative Research". In: Blanche, Martin Terre, Durrheim, Kevin and Painter, Desmond (Eds). 2006. *Research in Practice: Applied Methods for the Social Science*. Pp 285 – 319. Cape Town: University of Cape Town Press.
- Khapoya, V. B. 1994. *The African Experience: An Introduction*. New Jersey: Prentice Hall.
- Khathide, G. Agrippa. 2003. "Teaching and Talking about Our Sexuality a Means of Combating HIV/AIDS". In: Dube, W. Musa (Editor). *HIV/AIDS and the Curriculum: Methods of Integrating HIV/AIDS in Theological Programmes*. Page 1-9. Geneva: WCC Publications.
- Khoza, R. 1994. 'The need for an Afrocentric management approach - A South African-based management approach'. In P. Christie, R. Lessem and L. Mbigi, L (eds.), *African Management. Philosophies, Concepts and Applications*, 117-124. Pretoria: Sigma Press.
- King, Rudith, Inkoom, Dan and Abrampah, Kodjo Mensah 2001. *Urban Governance in Kumasi: Poverty and Exclusion*. Urban Governance, Partnership and Poverty - Working Paper 23. Birmingham: The University Of Birmingham
- Kluckhohn, C. 1962. *Culture and Behavior*. New York: The Free Press of Glencoe.
- Kluckhohn, F.R., and Strodtbeck, F. L. 1961. *Variations in value orientations*. Evanston, III: Row, Peterson.
- Knight, Margy Burns and Melnicove, Mark. 2000. *Africa is not a Country*. Brookfield: The millbrook Press.
- Kohi, T.W. and Horrocks, M.J. 1994. "The Knowledge, attitudes and perceived support of Tanzanian nurses when caring for patients with AIDS". *International Journal of Nursing Studies*, 31(1), 77 - 86.
- Krawitz, Lilian 2007. *South Africa's Axial Religious Transformation: The Utilization of the Axial Hebrew Prophets' Response Models in the Revision of South Africa's Maladaptive Pre-Axial Response Models*. Master of Biblical Archaeology Thesis. Pretoria: University of South Africa
- Krieger, Stefan H. 2001 "A Time to Keep Silent and a Time to Speak: The Functions of Silence in the Lawyering Process" in *Oregon Law Review* Spring, 2001 - Volume 80, Number 1, pg 199-266.
- Kubota, R. 1999. "Japanese culture constructed by discourses: implications for applied linguistics research and ELT". *TESOL Quarterly*, 33/1, 9-35.
- Kwenda, Chirevo V. Mndende, Nokuzola and Stonier, Janet. 1997. *African Religion and Culture Alive*. Pretoria: Collegium.
- Labour, Michel, Juwah, Charles, White, Nancy and Tolley, Sarah 2002 *Culture and Ethics: Facilitating Online Learning* <http://otis.scotcit.ac.uk/eworkshop.htm>
- Larbi, Emmanuel Kingsley 2002 "The Nature of Continuity and Discontinuity of Ghanaian Pentecostal Concept of Salvation in African Cosmology" *Asian Journal of Pentecostal Studies* 5:1 (2002), pp. 87-106

- Larsen, Dave. 2005. Personal Discussion at Eldership Camp. 25 November 2005
- Larsen, David and Lanham, Claire. 2002. *I was Hungry and you Fed me: Project Gateway 10 years on*. Pietermaritzburg: The Blue Box
- Lau, Amy and Ma, Ronald. 1997. "A broad Perspective on Financial Reporting in Pacific Asia." In: Ma, Ronald (Ed.). *Financial Reporting in the Pacific Asia Region*. Singapore: World Scientific Publishing.
- Lefevere, Patricia . 2000. *S. African bishops to fight AIDS silence*. Accessed on 20 August 2008 from http://findarticles.com/p/articles/mi_m1141/is_18_36/ai_60104478
- Lemke, Stefanie 2003. "Empowered Women and the Need to Empower Men: Gender Relations and Food Security in Black South African Households" *Stuies of Tribes Tribals*, 1 (1): 59-67 (2003)
- Lesko, Igor. 2005. *Attitudes and Beliefs around HIV and AIDS Stigma: The Impact of the Film "The Sky in Her Eyes"*. Masters in Development Studies Thesis. Cape Town: University of the Western Cape.
- Lessard-Clouston, Michael. 1997. "Towards an Understanding of Culture in L2/FL Education". The Internet TESL Journal, Vol. III, No. 5, May 1997. Accessed on 30th September 2007 from, <http://iteslj.org/Articles/Lessard-Clouston-Culture.html>
- Lessem, R. 1990. *Developmental Management: Principles of Holistic Business*. Oxford: Basil Blackwell.
- Lessem, R. 1994. "Four worlds – The Southern African businessshpere". In: Christie, P, Lessem, R & Mbigi, L. (Eds) *African management: Philosophies, Concepts and Applications* (pp 17-40). Randburg: Knowledge Resources.
- Lessem, R. 1996. "The Southern African businessshpere". In: M. E. Steyn and K. B. Motshabi (Eds) *Cultural Synergy in South Africa*. (pp 185-208). Pretoria: Sigma Press.
- Levine, Lou (Editor). 1999. *Faith in Turmoil: The Seven Days War*. Pietermaritzburg: PACSA
- Li, J. 2003. The core of Confucian learning. *American Psychologist*, 58, 146-147.
- Lie, G.T. and Biswalo, P.M. 1994. "Perceptions of the Appropriate HIV/ AIDS Counsellor in Arusha and Kilimanjaro Regions of Tanzania: Implications for Hospital Counselling". *AIDS Care*, 6(2), 139 – 151.
- Lim L. and Firkola P. (2000) "Methodological Issues in Cross-Cultural Management Research: Problems, Solutions and Proposals." *Asia Pacific Journal of Management*, Vol.17 pp.133-154.
- Link, B and Phelan, J. 2001. "Conceptualizing Stigma". *Annual Review of Sociology*. Vol. 27: 363–385.
- Link, B. G., and Phelan, J. C. 2001. "Conceptualizing stigma". *Annual Review of Sociology*, 27, 363–385.
- Lopez-Claros, Augusto and Zahidi, Saadia 2005. *Women's Empowerment: Measuring the Global Gender Gap*. Geneva: World Economic Forum

- Lord, R., & Maher, K. J. (1991). *Leadership and information processing: Linking perceptions and performance*. Boston: Unwin-Everyman.
- Lorentzen, K. and Morris, S. (2003). *The Enigma of HIV/AIDS-related Stigma. A Theoretical Exploration of HIV/AIDS-related Stigma in Sub Saharan Africa*. <http://www.ub.uib.no/elpub/2003/h/320001/Hovedoppgave.pdf>. Accessed on 13th May 2007
- Louw, Dirk J. 2001. "Ubuntu and the Challenges of Multiculturalism in Post-Apartheid South Africa". *African Journal of Philosophy QUEST (Quest)* Vol. XV No. 1-2, 2001 pp 15-36
- Loxton, Lynda 1997. Call to subsidise small business loans: More funds are needed to support the small business sector. *Electronic Mail & Guardian* February 28. Created on 17th Jun 1999 accessed on 23rd October 1999. Website: <<http://www.mg.co.za/mg/news/97feb2/28feb-mallbusiness.html>>.
- Lundy, J. David. 1999. "Moving Beyond Internationalizing the Missionary Force". *International Journal of Frontier Missions* Vol. 16:3, Fall 1999. page 147-155.
- Lustig, Robin 2000. *Overview: Breaking the silence* http://news.bbc.co.uk/1/hi/english/static/in_depth/africa/2000/Aids_in_africa/overview.stm -Accessed on 30 April 2003, 09:59:42 AM
- Maas, Gideon and Herrington, Mike. 2006. *Global Entrepreneurship Monitor: South African Executive Report 2006*. Cape Town: University of Cape Town
- MacKinnon, Dolly 2002. *The Tyranny of Talk: The Multiple Functions of Silence in Teaching and Learning*. The University of Queensland The University of Queensland Brisbane, Queensland 4072 Australia www.tedi.uq.edu.au/conferences/teach_conference99/papers/mackinnon.html
- Maeger, Anne. 2003. *Men and Masculinities Conference: Building effective Partnership between Men and Women for the achievement of Gender Equality*. Cape Town: Gender Education and Training Network GETNET
- Mail and Guardian Online*. 2005. "How many really died in the tsunami?". Accessed on 18th May 2006 from <http://www.mg.co.za/comment/2005-12-01-how-many-really-died-in-the-tsunami>.
- Malcolm, A., Aggleton, P., Bronfman, M., Galvão, J., Mane, P., & Verrall, J. 1998. HIV-related stigmatization and discrimination: Its forms and contexts". *Critical Public Health*, 8(4), 347–370.
- Mall, Faith. 2008. *The impact of HIV/AIDS on older people*. Overseas Development Institute (ODI). www.odihpn.org/report.asp? Accessed on 27th July 2008
- Maluleke, Tinyiko Sam. 2003. "Towards an HIV/AIDS-Sensitive Curriculum" in Musa W. Dube (Ed). 2003. *HIV/AIDS and the Curriculum Methods of Integrating HIV/AIDS in Theological Programmes*. Geneva: WCC Publications. Pg 60-78
- Manci, Thembayona Paulus Emmanuel. 2005. *The Response of African Religion to Poverty, with specific reference to the Umzimkhulu Municipality*. DTh (RELIGIOUS STUDIES) Thesis. Pretoria: University of South Africa

- Mandiriza, Thulani. 2009. *KZN Aids and Deaths Data*. Unpublished Data from Quantec Regional Database through email contact (mandirizat@kznded.gov.za). Pietermaritzburg: KZN Department of Economic Development
- Mani, M. Nithyani 2002 *Country Profiles: USAID Multi-Sectoral Programmes*. USAID Bureau for Africa, Office of Sustainable Development. www.afrsd.org/HIVAids/HivPublications.htm Geeta Rao Gupta, Gender, Sexuality and HIV/AIDS: The What, the Why and the How, plenary address, 13th international AIDS conference, Durban, South Africa, 2000, pp.1-8, www.icrw.org.
- Mapping Science Committee, National Research Council. 2002. *Down to earth: geographic information for sustainable development in Africa*. Washington, D.C.: National Academies Press.
- Marais, H. C.(ed) 1988. *South Africa: Perspectives on the Future*. Pinetown: Owen Burgess Publishers.
- Marcus, Rachel. 1993. *Gender and HIV/AIDS in Sub-Saharan Africa: the cases of Uganda and Malawi*. Brighton: Institute of Development Studies.
- Marshall, Catherine and Rossman, B. Gretchen. 1995. *Designing Qualitative Research*. Second Edition. London: Sage Publications
- Mbigi, L. 1995a. "A new dimension for business", *Enterprise*, November.
- Mbigi, L. 1995b. "Ubuntu." *Enterprise* (November).
- Mbigi, L. 1997. *Ubuntu: The African Dream in Management*. Johannesburg: Knowledge Resources.
- Mbigi, L. 2000. *In search of the African Business Renaissance*. Randburg, South Africa: Knowledge Resources.
- Mbigi, Lovemore and Maree, Jenny. 1995. *Ubuntu: The Spirit of African Transformation Management*. Randburg: Knowledge Resources.
- Mbiti John S. 1990. *African Religious and Philosophy (2nd ed.)*. Oxford: Heinemann.
- Mbiti, John. 1986. *Bible and Theology in African Christianity*. Nairobi: Oxford
- McClelland, D. C. (1985). *Human Motivation*. Glenview, IL: Scott, Foresman.
- McMillan, J.H. and Schumacher, S. 2001. *Research in Education* Fifth edition New York: Harper.
- McMurray, A.J. 2003. "Country of Origin: A Critical Measure in Work Commitment Studies within Multi-Cultural Contexts." *Journal of American Academy of Business*, March, pp.479-485
- Meeding, I. 1994. *Leadership values on middle management level: Similarities and differences between groups*. Unpublished MBL research report, Graduate School of Business Leadership. Pretoria: University of South Africa.
- Menkiti, I. 1979. "Person and Community in Traditional African thought". In: R. Wright, editor, *African philosophy*. New York: University Press of America.

- Mkabela, Queeneth 2005. "Using the Afrocentric Method in Researching Indigenous African Culture". *The Qualitative Report*. Volume 10 Number 1 March 2005 178-189
- Mnculwane, Jabulani Pastor. 2006. Personal Interview. 23rd June 2006
- Mngweba, Akhona. 2000. Interview 17th May 2000.
- Monomotapa - LoveToKnow 1911*. [http://www.1911encyclopedia.org/ Monomotapa](http://www.1911encyclopedia.org/Monomotapa). Accessed on 13th October 2007.
- Moore, H.C. and Sanders, T. (eds). 2001. *Magical Interpretations, Material Realities*. London: Routledge.
- Moran, R. T. (1991). Successful international business negotiations. Houston: Gulf.
- Morna, Colleen Lowe, Hardy, Chloe, Khan, Zohra, Motara, Shireen, Made, Patricia and Mumba, Tafadzwa (Compilers) 2002. Culture, Religion and Gender: A Training Manual for the Media. Harare: Inter Press Service
- Morrell, Robert 2003 "Silence, Sexuality and HIV/AIDS in South African Schools". *The Australian Educational Researcher*, Volume 30, Number 1, April 2003 pg 41-62
- Morrison, Karen and Smith, Michael. 2004. *Myths and Mysteries about HIV and AIDS*. Johannesburg: Heinemann Educational Publishers
- Mosha A.C. 2001. "Africa's Future: Africa's cities must be transformed if the continent is to keep pace with the rest of the developing world". *FORUM for Applied Research and Public Policy*. Summer 2001 pg 28-33
- MSNBC. 2005. *First lady addresses Africa's tough AIDS issues: Laura Bush frank on the connection between infection and sexual equality*. Accessed 14th September 2007, from <http://www.msnbc.msn.com/id/8545466/>
- Muchaneta, L. 2000. *The impact of HIV/AIDS on household and community and the response of the religious community*.
- Mufune, Jennifer 2005. *African Human Rights Court: will it make a difference for women?* Accessed on 10th June 2006 from, www.misa.org/documents/rightscourt
- Mulemfo, M.M. 1996. "Palaver as a Dimension of Communal Solidarity in Zaire: A Missiological Study on Transgression and Reconciliation". *Missionalia*. (Vol. 24:2 August 1996 pp. 129-147)
- Munter, Mary 1993. "Cross-cultural communication for managers". *Business Horizons* May/Jun93, Vol. 36 Issue 3, p69
- Murphy Elizabeth 2000. "Qualitative research methods in health technology assessment: a review of the literature". *The Research Findings Register*. Summary number 87. Accessed June 2007, from <http://www.ReFeR.nhs.uk/ViewRecord.asp?ID=87>
- Muyinda, H., Seeley, J., Pickering, H. and Barton, T. "Social aspects of AIDS-related stigma in rural Uganda," *Health and Place*, vol. 3, no. 3, pp. 143–147, 1997.
- Naidoo, Dayalan (Capt). 2004. *SARPCCO Training: HIV/Aids Module 4. Stigma and Discrimination*. Accessed on 28th July 2009 from http://www.iss.co.za/dynamic/administration/file_manager/file_links/SARPCCOHIVMOD4.PDF?

- Nakane, C. 1970. *Japanese Society*. Berkeley: University of California Press.
- Nasif E.G., AL-Daeaj H., Ebrahimi B. and Thibodeaux M.S. 1991. "Methodological Problems in Cross-Cultural Research: an Updated Review." *Management International Review*, Vol.31, Issue 1, pp.79-91
- National Women's Education Center of Japan (NWEC). 2005. *News Letter* Vol.22 No.1, September 2005
- Ndingaye, Xoliswa Zandile. 2005. *An evaluation of the effects of poverty in Khayelitsha: a case study of site C*. A mini-thesis submitted in partial fulfillment of the requirements for the degree of Masters of Arts in Development studies under the Institute For Social Development. Bellville: University of Western Cape.
- Ndwandwe, H. C. N. 2000. Reading 1 John in a Zulu Context: Hermeneutical Issues. PhD thesis. University of Pretoria: Pretoria.
- Neuman, William Lawrence. 1997. *Social Research Methods: Qualitative and Quantitative Approaches*. Third Edition. Needham Heights: Allyn and Beacon
- News24. *Antiretrovirals 'dramatic': South Africa: Aids Focus: News24*. www.news24.com/News24/South_Africa/Aids_Focus/0,,2-7-659_1843092,00.html Accessed on 27th September 2007
- Ngcamu, S.A. (Pastor), Mthembu (Rev), Sibiyi, Rev, Dlamini, Ntombi Beauty (Rev) 1999, Focus Group Discussion, with Benson Okyere-Manu and Paulos Nkonyane in Sobantu on the 21st October 1999.
- Ngobese, B.E. 1981. The role of the Priest in African Traditional Life. Imbali: FEDSEM (Unpublished Paper).
- Ngubane, Harriet. History of Medicine: Zulu Medicine. Harriet Ngubane, *Mind and Body in Zulu Medicine* (London 1977) 23-29 (excerpted). Accessed on 27th September 2007. www.classics.und.ac.za/ngubane.htm
- Nicolay, Nathea. 2008. "Summary of Provincial HIV and Aids Statistics for South Africa" *Metropolitan*. www.metam.co.za/documents_v2/File/RedRibbon_2009/Provincial%20HIV%20and%20AIDS%20statistics%20for%20... – Accessed on 23 April 2009.
- Niehaus, Isak Bodies, 2002. "Heat, and Taboos: Conceptualizing Modern Personhood in the South African Lowveld". *Ethnology*. Volume: 41. Issue: 3. 2002. Pg189+.
- Niyonzima, Salvator. 2003. *Understanding HIV-Related Stigma*. Accessed on 15th August 2009 at http://www.developmentgateway.org/node/130685/special/hiv/HIV_Special-Expert_Perspective.pdf
- Njogu, Kimani and Orchardson-Mazrui, Elizabeth Gender Inequality And Women's Rights In The Great Lakes: Can Culture Contribute To Women's Empowerment? [Http://portal.unesco.org/shs/en/file_download.php/9247b89a724deacb9dcdf070cb9d7a4bPresentation+-+Liz+Orchardson](http://portal.unesco.org/shs/en/file_download.php/9247b89a724deacb9dcdf070cb9d7a4bPresentation+-+Liz+Orchardson).
- Njoroge, R., and Bennaars, G. 1986. Philosophy and education in Africa: An introductory text for students of education. Nairobi: Transafrica Press.

- Nkrumah, K. 1964. *Consciencism: Philosophy and Ideology for Decolonization and Development with Particular Reference to the African Revolution*. London: Heinemann.
- Noelle-Neumann, E. 1974. "The spiral of silence: A theory of public opinion". *Journal of Communication*. 24: 43- 51.
- Nothern Ireland Team. 2004. *Report to CCP*. July 2004
- Ntuli, Antoinette, Ijumba, Petrida, McCoy, David, Padarath, Ashnie and Berthiaume, Lee. 2003. *HIV/AIDS and Health Sector Responses in South Africa, Treatment Access and Equity: Balancing the Act*. Equinet Discussion Paper Number 7. September 2003. Health Systems Trust. <ftp://ftp.healthlink.org.za/pubs/equity/equinet7> Accessed on 30 May 2007
- Nyerere, J. K. 1968a. *Freedom and Socialism*. New York: Oxford University Press.
- Nyerere, J. K. 1968b. *Ujamaa - Essays on Socialism*. Dar-es-Salaam: Oxford University Press.
- Nyerere, J. K. 1976. *Freedom and Development*. Nairobi: Oxford University Press.
- Nyerere, J. K. 1996. "Socialism and Rural Development". In: English, Parker & Kibujjo M Kalumba (eds). *African Philosophy: A Classical Approach*. Upper Saddle River, NJ: Prentice Hall.
- Obermeyer, Carla M. (1997) Qualitative methods: A key to a better understanding of demographic behavior? *Population and Development Review* 23(4):813-818.
- Office of the Premier. 2004. *Provincial Profile*. Accessed on 30 July 2005, from www.kwazulunatal.gov.za/premier/speeches/premier/ProvincialProfile
- Okafor, F. U. 1995. "Human Rights and Justice: The African Perspective". In Coetzee, PH and MES van den Berg (eds). *An Introduction to African Philosophy*. Pretoria: Unisa Press.
- Okolo, C. B. 1995. "The African Person: A Cultural Definition". In: Coetzee, PH & MES van den Berg (eds). *An Introduction to African Philosophy*. Pretoria: Unisa Press.
- Okoye, M. 1990. "The African Context of Human Rights: Development, Equality and Justice". In: Shepherd, GM & MOC Anikpo (eds). *Emerging Human Rights: the African Political Economy Context*. New York, Greenwood.
- Okyere-Manu, Benson and Nkonyane, Paulos organized a focus group discussion for pastors in Sobantu on the 21st October 1999.
- Okyere-Manu, Benson. 2003. "Hope in a time of AIDS". *International Congregational Journal* 3 (2003) 169-183.
- Opala, J., and Boillot, F. 1996. "Leprosy among the Limba: Illness and healing in the context of world view". *Social Science & Medicine*, 42, 3-19.
- Owusu, Evelyn Tawiah. 2007. *Women, Sexual Rights and HIV in the Kumasi Metropolitan area of Ghana*. M.Phil. Thesis submitted to the Norwegian University of Science and Technology (NTNU). Trondheim: NTNU

- Parker, R. and Aggleton, P. 2003. "HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action". *Social Science & Medicine*. 57 (2003) 13–24
- Parker, Warren and Birdsall, Karen. 2005. *HIV/AIDS, Stigma and Faith-based Organisations: A review*. Washington: DFID/Futures Group MSP
- Paterson, Gillian. 2005. "HIV and AIDS: the challenge and the context Conceptualizing stigma". In: UNAIDS (Ed). *A report of a theological workshop focusing on HIV – and AIDS – related stigma 8th–11th December 2003, Windhoek, Namibia / supported by UNAIDS*. (pp 32-40). Geneva: UNAIDS.
- Pattanayak, Biswajeet. 2005. *Human Resource Management*. Third Edition. New Delhi: Prentice-Hall of India Pvt Ltd
- Penn State Public Broadcasting (PSPB) 2004. *What's in the News #2627-Feature: The Challenge of AIDS*. Accessed on 30 December 2007, from http://www.witn.psu.edu/materials/2627_materials.pdf
- Pennycook, A. (1998), *English and the Discourses of Colonialism*. New York: Longman.
- Petros, George, Airhihenbuwa, O. Collins, Simbayi, Leickness, Ramlagan, Shandir and Brown, Brandon. 2006. "HIV/AIDS and 'othering' in South Africa: The blame goes On". Short Report. *Culture, Health and Sexuality*. January–February 2006; 8(1): 67–77
- Phelan, J. C., Link, B. G., Steuve, A., and Pescosolido, B. 2000. "Public conceptions of mental illness in 1950 and 1996: What is mental illness and is it to be feared". *Journal of Health and Social Behavior*, 41, 188–207.
- Phiri, Isabel Apawo. 2003. "Services on Age Based Discrimination". In: Dube, W. Musa. (Editor). 2003. *Africa Praying a Handbook on HIV/AIDS Sensitive Sermon Guidelines and Liturgy*. Page 340-346. Geneva: World Council of Churches. Accessed on 09 July 2006, from <http://www.e-alliance.ch/stigmacd/docs/2.1AfricaPraying.doc>
- Piot Peter. 1999. Mobilizing against the AIDS epidemic in the context of the International Conference on Population and Development +5 (ICPD+5): The Hague Forum. Geneva: UNAIDS. www.un.org/popin/icpd/icpd5/hague/un aids.pdf -
- Piot, Charles 1999. *Remotely Global: Village Modernity in West Africa*. Chicago: The University of Chicago.
- Piot, Peter 2001. Plenary Presented at: *World conference against racism, racial discrimination, xenophobia and related intolerance*. Durban South Africa, 5 September 2001. Accessed on 15th July 2006 at <http://www.unaids.org/whatsnew/speeches/eng/piot040901racism.htm>.
- Population Reference Bureau (PRB). 2001 *Conveying Concerns: Media Coverage of Women and HIV/AIDS*. Washington: Population Reference Bureau www.prb.org/pdf/ConveyConcerns3_Eng Accessed on 9th June 2007
- Posel, Deborah 2003. *A Matter of Life and Death: Revisiting 'Modernity' from the Vantage Point of the 'New' South Africa*. (unpublished paper, dated November 2003.) Wits Institute for Social and Economic Research, University of the

- Witwatersrand, Johannesburg.
http://deepblue.lib.umich.edu/bitstream/2027.42/61711/1/cdecotea_1.pdf
- Powell, J.L., Christensen, C. Abbot, A.S. and Katz, D.S. 1998. Adding Insult to Injury: Blaming Persons with HIV Disease. *AIDS and Behavior*, 2 (4), 307-317.
- Power, Robert 1998. "The role of qualitative research in HIV/AIDS". *AIDS*. EDITORIAL REVIEW. Vol 12 No 7 Page Number 687–695
- Practical Action* 2005. 2005. Europe's chance to help light up Africa: Energising poverty reduction in Africa. www.itdg.org/docs/advocacy/energising_poverty_reduction.
- Pratt, Brian and Loizos Peter. 1992. *Choosing Research Methods: Data Collection for Development Workers*. Development Guidelines No. 7. Oxford: OXFAM.
- President's Emergency Plan for AIDS Relief (PEPFAR). 2008. *Country Profile: South Africa*. <http://www.pepfar.gov/documents/organization/81668.pdf>
- Prime, N. 1994. *Culture, temps et négociation commerciale*. Ph.D Thesis in Business Administration, Université Pierre Mendès France, Ecole Supérieure des Affaires: Grenoble.
- Prime, Nathalie 1999. *Cross-Cultural Management in South Africa: Problems, Obstacles, and Agenda for Companies*. ESCP-EAP
[Http://marketing.byu.edu/htmlpages/ccrs/proceedings99/prime.htm](http://marketing.byu.edu/htmlpages/ccrs/proceedings99/prime.htm)
- Primo, Natasha. 2003. *Gender Issues in the Information Society*. Paris: UNESCO
- Profile Analysis*. www.kwazulunatal.gov.za/premier/speeches/premier/ProvincialProfile.
- Raghu Nath and Kunal K. Sadhu, 1988. "Comparative Analysis. Conclusions, and Future Directions". In: Raghu, Nath (Editor). *Comparative Management: A Regional View*: Cambridge MA: Ballinger Publishing Company.
- Rattray, R.S. 1923. *Ashanti Law and Constitution*. OUP: London.
- Réamonn, Páraic (Editor) 2004. "Mission, Justice, Covenant". *Reformed World*. Volume 54 No.1 March 2004. Geneva: World Alliance of Reformed Churches
- Reik, T. 1968. The Psychological meaning of Silence. *Psychoanalytic Review*, 1968, 55: 172-186.
- Rich, Adrienne. 1984. *The Fact of a Doorframe: Poems Selected and New 1950-1984*. NY: Norton.
- Rose, Gregory, Warkentin, Merrill Gefen, David and Pavlou, Paul 2003. The Role and System Characteristics of Internet-Voting in the Republic of South Africa: Looking Inside a Multi-cultural, Nascent Democracy. www.accenture.co.za
- Rubin, A and Babbie, E. 1997. *Research methods for social work*. Third Edition. New York: Brooks/Cole Publishing Company.
- Ruch, E. A. 1975 "Towards a theory of African Knowledge". In: Georgiades, D. S. and Delvare I. G. (Compilers) 1975. *Philosophy in the African Context: To be is to Participate*. Unpublished essays delivered at a philosophy seminar at the University of the Witwatersrand (Johannesburg) in July 1975.

- Russell, Sabin. 2004. *Unanswered Questions Epidemic imperils the future Nation could face Africa-like disaster*. Pertinent Articles on the AIDS Pandemic Family Care Foundation. Thursday, July 8, 2004. Accessed on 18 July 2006, from http://familycare.org/whatwedo/aids_articles.htm
- SABC. 1998. "Black Men Healing". South African Broadcasting Corporation, SABC 3, 23 November 1998 at 22:50 hours. SABC Programme guide. accessed on 22nd April 2006, from <http://www.dispatch.co.za/1998/11/23/tvradio/TV.HTM>
- SABC News. 2009. *HIV/Aids prevalence in KZN and Mpumalanga remains a worry*. October 07 2009, 9:37:00. Accessed on 11 October 2009 from <http://www.sabcnews.com/portal/site/SABCNews/menuitem.5c4f8fe7ee929f602ea12ea1674daeb9/?vgnnextoid=84ea5d00ddd24210VgnVCM10000077d4ea9bRCRD&vgnnextfmt=default%20&channelPath=South%20Africa%20%3E%3E%20Health>
- SADC. 1999. *Gender Mainstreaming at SADC: Policies, Plans and Activities*. Gaborone: SADC.
- SAfAIDS News*. 2000. "UNAIDS Focus: Africa's Children at the Forefront of the AIDS Epidemic". September 2000 Vol 8 No 3. Pg. 13.
- Said, E. 1978. *Orientalism*. New York: Pantheon Books
- Saleh, S. and Gufwoli, P. 1982. The transfer of Management Techniques and Practices: The Kenyan Case. In: Rath, R. et al (eds), *Diversity and Unity in Cross-Cultural Psychology*. Lisse: Swets and Zeitlinger.
- Samovar, L. A. and Porter, R. E. 2001. *Communication between Cultures*. Fourth Edition. Belmont: Wadsworth/Thomson Learning.
- Sánchez-Colberg, Ana. u/d. "Tacit Borders: On Silence, Presence and Resistance in Contemporary Latin American Performance". *On silence* www.autores.org.ar/spre/Creacion/Adaptaciones/pies/silence.htm
- Saville-Troike, Muriel. 1985. The place of silence in an integrated theory of silence. In: Tannen, Deborah and Saville-Troike, Muriel (eds) 1985. *Perspectives on Silence*. Norwood, NJ: Ablex, pp 3-18.
- Sayagués, Mercedes. 2003. "Executive Summary". In: Paton, Marcelle (Editor). *Men, HIV & Aids: Regional Conference 2003 Report back*. Pretoria: Voluntary Service Overseas.
- Schafer, Murray R. 1980. *The Tuning of the World*. Philadelphia: University of Pennsylvania Press.
- Schirch, Lisa. 2004. *Women in Peacebuilding Resource and Training Manual*. West African Network for Peacebuilding and Conflict Transformation Program. Harrisonburg: Eastern Mennonite University
- Schmierbach, Mike, Boyle, Michael P. and McLeod, Douglas M. 2005. "Civic Attachment in the Aftermath of September 11". *Journal of Mass Communication & Society*, 2005, 8 (4), 323–346
- Schmitz, Ulrich 1994. *Eloquent silence*. www.linse.uni-essen.de/linse/publikationen/silence.html

- Schubert, Ralph Ipyana. 2007. *A Christian-Ethical Comparison Of Leadership Styles in The West and in Tanzania and their Impact on Cross-Cultural Partnerships*. Master of Theology Thesis. Pretoria: University of Pretoria.
- Schutterhoef, Arie van 1984. SOUND-DRAMA: a definition www.xs4all.nl/~schreck/html/sounddr.html
- Schwartz, S. H. 1994. Cultural dimensions of values; Toward an understanding of national differences. In U.Kim, H.C.Triandis, C.Kagitcibasi, S. C. Choi, G.Yoon (Eds), *Individualism and Collectivism: Theory, Method and Applications*. Sage.
- Seekings, Jeremy. 2007. *Poverty and Inequality after Apartheid*. CSSR Working Paper No. 200. Centre for Social Science Research. Cape Town: University of Cape Town
- Sekaran U. 1983 “Methodological and Theoretical Issues and Advancements in Cross-Cultural Research.” *Journal of International Business Studies*, Vol. 14, Issue 2, pp. 61-73
- Sem, Daniel 2004. *The Enlightenment: Interpreting Kant in Traditional West African Religious Context*. University of Saskatchewan. www.theihs.org/pdf/materials/662
- Senghor, L. S. 1964. *On African Socialism*. Mercer Cook (trans). New York: Praeger.
- Senghor, Leopold. 1965. *On African Socialism*. New York: Stanford.
- Senosi, Swanki Stephinah 2004. *The support for learning provided by the parents of foundation phase learners in a township school*. Doctoral Thesis. Pretoria: University of Pretoria.
- Shabazz, Daaim 2000. “Electronic Commerce: A New Paradigm for the African Business Sector” in *Journal of African Business*, Vol. 1(3) 2000 pg 29 – 47) -E 2000 by The Haworth Press, Inc. All rights reserved.
- Shafii, M. 1973. Silence in the Service of Ego: Psychoanalytic study of meditation. *International Journal of Psychoanalysis*, 54: 431-442.
- Shehan, L. Constance, Uphold, R. Constance, Bradshaw, Patrick, Bender, Joyce, Arce, Natalie and Bender, Bradley. 2005. “To Tell or Not to Tell: Men’s Disclosure of Their HIV-Positive Status to Their Mothers”. *Family Relations*, 54 (April 2005), 184–196.
- Sheldon, K., and Caldwell, L. 1994. “Urinary incontinence in women: Implications for therapeutic recreation”. *Therapeutic Recreation Journal*, 28, 203–212.
- Simon-Meyer, Janine. 2000. *Children in Distress. (CINDI)*. HIV/Aids Best Practice Series. Pretoria: Department of Health
- Singelis. Theodore, Triandis, C Harry, Bhawuk, P. S. Dharm and Gelfand, J. Michele. 1995. “Horizontal and vertical dimensions of individualism and collectivism: a theoretical and measurement refinement”. *Cross-Cultural Research*, 29(3): 240-275.
- Singh, Shawren and Kotze, Paula 2003. “The Socio-Political Culture of Users”. *Human-Computer Interaction – INTERACT’03*. IOS Press, IFIP, 2003 Pg 900-903.

- Singh, Shawren and Kotze, Paula 2003. "The Socio-Political Culture of Users. In: Rauterberg, M. et al (Eds), Human-Computer Interaction ... INTERACT '03. IOS Press(c) IFIP. www.idemployee.id.tue.nl/g.w.m.rauterberg/conferences/INTERACT2003/INTERACT2003-p900.pdf
- Sister Cities International*. 2001. "Elements of a Successful Exchange: What to do to ensure that your international exchange or project has the broadest possible positive impact on your participants, community and sister city". www.kcsistercities.org/articles/General_Exchange_Programs Accessed on 30 December 2005, 08:00:56 AM
- Sithole, Michael Mbheki and Dastoor, Barbara. 2004. "The Impact of Demographic Heterogeneity on the National Culture of the Republic of South Africa". Academy of International Business Southeast USA. *AIB-SE (USA) 2004 Annual Meeting, Knoxville, TN*. pp 109-113. Accessed on 23 April 2006 from, <http://www.aibse.org/zProceedings/Proceedings%202004/table%20of%20contents.asp>
- Solomon, Larry J. 1998. *The Sounds of Silence: John Cage and 4'33"*. Accessed on 29th February 2008, from <http://solomonsmusic.net/4min33se.htm>.
- Sontag, S 1966. The aesthetics of silence. In *Styles of radical will* New York: Farrar, Straus (pg 3-34)
- South African Cities Network (SACN). u/d. *Msunduzi Municipality (Pietermaritzburg)*. Accessed on 27 April 2009 from <http://www.sacities.net/cities/msunduzi.stm>
- Spack, R. 1997. "The rhetorical construction of multilingual students". *TESOL Quarterly*, 31, 765-774.
- Steady, F.C. 1987. "African feminism: Worldwide perspective". In: (R. Terborg-Penn, S. Harley, and A.B. Rushing, eds.) *Women in Africa and African Diaspora*, pp. 3-24. Washington: Howard University Press.
- Steinberg, Jonny. 2008a. "Aids and Aids treatment in a rural South African setting". *Monograph* 149. August 2008. Institute for Security Studies. Accessed on 15th August 2009 at http://www.iss.co.za/dynamic/administration/file_manager/file_links/M149NOTES.PDF?
- Steiner, George. 1975. *After Babel*. Oxford University Press.
- Stewart, Sarah and Parfitt, Louise (Editors). 2004. *God's children are dying of AIDS: Interfaith dialogue and HIV*. Working paper. London: Christian Aid
- Storti, Craig. 1999. *Figuring Foreigners Out*. Yarmouth, ME: Intercultural Press.
- Strauss, A and Corbin, J. 1998. *Basics of qualitative research: Techniques and procedures for developing grounded theory*. London: Sage Publications.
- Stremersch, Stefan and Tellis, Gerard J. 2004. Understanding and managing international growth of new products. *International Journal of Research in Marketing* 21 (2004) 421-438 www.elsevier.com/locate/ijresmar

- Stremersch, Stefan and Tellis, J. Gerard 2004. "Understanding and managing international growth of new products" *International Journal of Research in Marketing*. Volume 21 Page Number: 421–438.
- Sundermeier, Theo 1998. *The Individual and Community in African Traditional Religions*. Hamburg: Lit Verlag
- Sung-he Kim 2003. "A Ticket to a World Trip: A world tour, investigating the cultural differences through currency". *ANNALS*. annals.yonsei.ac.kr/news/read.php?
- Susser, B. 1998. "EFL's othering of Japan: Orientalism in English language teaching". *JALT Journal*, 20, 49-82.
- Sutton, Colleen Marianne. 2008. *Urban Open Space: A Case Study of Msunduzi Municipality, South Africa*. Masters Thesis. Queen's University. Kingston: Queen's University
- Suvanto, Mari 2002. "Images of Japan and the Japanese: The Representations of the Japanese Culture in the Popular Literature Targeted at the Western World in the 1980s – 1990s". *Jyväskylä Studies in Communication 16*. Jyväskylä: University of Jyväskylä
- Synnot, Siobhan 2004. *A bean in his bonnet*. <http://scotlandonsunday.scotsman.com/comment>
- Tamasane, Tsiliso and Seager, John 2004. *Rapid Appraisal of the Community Capacity Empowerment Programme and Leadership Development for Results: Components of the Enhancing an Integrated Response to HIV, AIDS and Poverty Programme*. Pretoria: UNDP
- Tannen, Deborah and Saville-Troike, Muriel (eds) 1985. *Perspectives on Silence*. Norwood, NJ:
- The Society. 2004. "Chatter balotts questions and answers" *The Pharmaceutical Journal* (Vol 273) 24 July 2004 pg. 127 – 134 www.pjonline.com
- The World Bank. 2006. *Youth-Responsive Social Analysis: A Guidance Note. Incorporating Social Dimensions into Bank-Supported Projects*. Social Development Department. Washington: The World Bank. November 2, 2006
- Thomas, Adèle and Bendixen, Mike 2000. "The Management Implications of Ethnicity in South Africa". *Journal of International Business Studies*. Vol 31. Third Quarter. Pg 507-519.
- Thomson, Phil 2003. *Sounding Out Silence in and as the Social* www.sfu.ca/~pthomson/Thomson,Phil-Sounding.Out.Silence.
- Thuli. 2006. Personal Interview. 14th of June 2006
- Tomaselli, G. Keyan. 1996. *Whatever Happened to Struggle Part 2?* Accessed on 19th June 2006 www.mcc.murdoch.edu.au/ReadingRoom/4.1/Tomaselli.html
- Triandis, H. C. 1972. *The analysis of subjective culture*. New York: John Wiley and Sons.
- Triandis, H. C. 1977. *Interpersonal behavior*. Monterey: Brooks/Cole.

- Triandis, H. C. 1988. "Collectivism vs. Individualism". In: Verma, G. and Bagley, C. (eds.), *Cross-cultural studies of Personality, Attitudes and Cognition*. London: Macmillan.
- Trompenaars, F. 1993. *Riding the Waves of Culture: Understanding Diversity in Business*. London: Economist Books 1993.
- Trompenaars, Fons and Hampden-Turner, Charles. 1998. *Riding the Waves of Culture: Understanding Cultural Diversity in Business*. 2nd edition. London: Nicholas Brealey Publishing.
- Tutu, Desmond Mpilo. 1999. *No Future without Forgiveness*. Johannesburg: Rider.
- Tylee, Jennifer. 2006 "Cultural issues and the online environment" *SOMS Internal Subjects Workshops Resources: April - June 2006*. Accessed on 17th February 2007 from http://www.csu.edu.au/division/celt/resources/documents/cultural_issues.pdf
- UNAIDS. 1999. *21st Special Session of the United Nations General Assembly for the Review and Appraisal of the Implementation of the Programme of Action of the International Conference on Population and Development: Statement by Peter Piot Executive Director*. New York: UNAIDS.
- UNAIDS. 2001. *Working with men for HIV Prevention and Care: UNAIDS Best Practice Collection*. Geneva: UNAIDS
- UNAIDS 2002a. "Sub-Saharan Africa". *Fact Sheet 2002*. http://www.unaids.org/worldaidsday/2002/press/factsheets/FSAfrica_en.doc
Accessed on 30th April 2003
- UNAIDS. 2002b. *World AIDS Campaign 2002-2003 – Global*. World AIDS Campaign site. <http://www.unaids.org/wac/2002/index.html>. Accessed on 30th April 2003
- UNAIDS. 2003a. Symposium of Catholic Bishops Conference Africa and Madagascar – SECAM. Dakar 6-7 October 2003. Statement by Marika Fahlen Director, Social Mobilization and Information Joint United Nations Programme on HIV/AIDS http://data.unaids.org/Media/Speeches02/fahlen_secamdakar_07oct03.pdf
- UNAIDS. 2003b. *Fact Sheet December 2003, Stigma and Discrimination*. Accessed on 28th July 2009 from http://data.unaids.org/publications/Fact-Sheets03/fs_stigma_discrimination_en.pdf
- UNAIDS. 2007. *AIDS epidemic update: December 2007*. Geneva: UNAIDS
- UNAIDS/WHO. 2006. *UNAIDS/WHO 2006 Report on the global AIDS epidemic*. Accessed on 16th May 2007 from http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp
- UNESCO. 1999. *A Cultural Approach to HIV/AIDS Prevention and Care: UNESCO/UNAIDS Research Project Zimbabwe's experience*.

- UNESCO 2001. *Cultural Approach to HIV/AIDS Prevention and Care. UNESCO/UNAIDS Research Project. Field Work: Building Local Response.* Methodological Handbooks, Special Series, Issue No. 3 Division of Cultural Policies. UNESCO. unesdoc.unesco.org/images/0012/001255/125586e.pdf
- UNESCO. 2003. *HIV/AIDS Stigma and Discrimination: An Anthropological Approach. Proceedings of the round table held on 29 November 2002 at UNESCO – Paris.* Studies and Reports, Special Series, Issue No 20. UNESCO/UNAIDS Research Project. Paris: UNESCO.
- UNICEF 2002. *Speeches To African Religious Leaders' Assembly on Children and HIV/AIDS.* UNICEF - Press centre. www.unicef.org/media/media_9438.html Accessed on 19-05-2007
- UNICEF. 2005. *Guide to monitoring and evaluation of the national response to children orphaned and made vulnerable by HIV/AIDS.* New York: UNICEF
- UNICEF. 2006. *Africa's Orphaned and Vulnerable Generations: Children affected by AIDS.* New York: UNICEF
- United Nations. 1995. *United Nations Fourth World Conference On Women A/CONF.177/20...* www.arabhumanrights.org/unconf/women/beijing-95e Accessed on 23rd June 2006.
- United Nations. 2000. *Secretary-General, addressing Participants at Millennium Forum, calls for Intensified 'Ngo Revolution'* Press Release SG/SM/7411 GA/9710, 22 May 2000. New York: United Nations www.un.org/News/Press/docs/2000/20000522.sgsm7411.doc.html Accessed on 16th September 2006
- United Nations. 2003. *Economic, Social and Cultural Rights: Access to medication in the context of pandemics such as HIV/AIDS.* Report of the Secretary-General. Document E/CN.4/2003/4816, January 2003. New York: United Nations.
- United Nations Development Fund for Women (UNIFEM). 2000. *of the World's Women 2000: UNIFEM Biennial Report.* New York: UNIFEM
- United Nations Development Programme (UNDP). 2006. *Youth and violent conflict: Society and Development in Crisis?* New York: UNDP.
- Van Binsbergen, Wim 2001. "Ubuntu and the Globalisation of Southern African Thought and Society". *African Journal of Philosophy QUEST (Quest)*. Vol. XV No. 1-2, 2001 pp 53-89.
- Van den Berg, M.E.S. 1996. On a Communitarian Ethos, Equality and Human Rights in Africa. International Humanist and Ethical Union. The world union of Humanist organizations. Accessed on 21 July 2007, from <http://www.iheu.org/node/2360>
- Van der Riet, Mary and Durrheim, Kevin. 2006. "Putting design into Practice: Writing and Evaluating Research Proposals" In: Blanche, Martin Terre, Durrheim, Kevin and Painter, Desmond (Eds). 2006. *Research in Practice: Applied Methods for the Social Science.* Pp 80 – 111. Cape Town: University of Cape Town Press.
- Van Dyk, Alta. 2001. *HIV/AIDS Care and Counseling: A Multidisciplinary Approach.* Cape Town: Pearson Education.

- Van Vlaenderen, H. 2001. "Group problem solving among grassroots development activists in South Africa: A process of horizontal mediated action". *Mind, Culture, & Activity*, 8(2), 148-173.
- Verluyten S. Paul. 1997 *Some Cultural Aspects of Thai Companies, with Recommendations for Westerners*. CAS Discussion paper No 14 November 1997 Bangkok: Centre for ASEAN Studies
- Vihakara, Anne. 2006. *Patience and Understanding: A Narrative Approach to Managerial Communication in a Sino-Finnish Joint Venture*. Series A-1:2006. Turku: The Turku School of Economics and Business.
- Visser, M., Makin, J. and Lehobye, K. 2006, "Stigmatizing attitudes of the community towards people living with HIV/AIDS", *Journal of Community & Applied Social Psychology*, vol. 16, no. 1, pp. 42-58.
- Vorster, J.M. 2003. "HIV/AIDS and Human Rights". *The Ecumenical Review*. Volume: 55. Issue: 4. 2003. Page Number: 345+.
- Waddington, R. B. 1970 The iconography of Silence and Chapman's Herkules. *Journal of the Warburg and Courtauld Institutes*, 1970, 3: 248-263.
- Walton, M., Vukovic', V. and Marsden, G. 2002. 'Visual Literacy' as Challenge to the Internationalisation of Interfaces: A study of South African student web users, in L Terveen and D Wixon, *CHI2002: Changing the World, Changing Ourselves*, ACM Press.
- Warburton Dan 2001. The Sound Of Silence: the music and aesthetics of the Wandelweiser Group www.timescraper.de/SOUNDOFSILENCE.htm
- Waterman, A. 1984. *The Psychology of Individualism*. New York: Praeger
- Wax, R. H. 1971. *Doing Fieldwork: Warning and Advice*. Chicago: The University of Chicago Press.
- Weller, Vail. 2008. *Sermon: Oh, Be Quiet*. Unitarian Universalists of San Mateo. Accessed on 18th September 2008 from www.uusanmateo.org/index.php/Download_document/Oh_Be_Quiet.html
- What's In The News Program Materials. 2000. *The Challenge of AIDS*. Program #2627. Initial Feed: Friday, March 26, 2004. www.witn.psu.edu/materials/2627_materials.
- Wilcox A. Adam (editor) et al (Michael Springer, Caryl Bahner-Guhin, Charles G. Blum, Martin Lasater and Steve Deschene) 2002. *Team Participation: Instructor's Edition*. Boston: Course Technology, a division of Thomson Learning.
- Wilhelm, Hans-Martin Jr. 2003. *Walking Far Together: Theological Education and Development in African Pastoral Formation*. Doctoral Thesis. Pretoria: University of South Africa
- Winslow, L. 2007. *The Days of Deals on a Hand Shake Are Gone - Now Professionalism, Networking and Compliments*. Accessed on 30 Nov 2007, from http://articles.getacoder.com/The_Days_of_Deals_On_a_Hand_Shake_Are_Gone_Now_Professionalism,_Networking_and_Compliments_753708x1194897839.htm

- Wood, K. and Lambert, H. "Coded talk, scripted omissions: the micropolitics of AIDS talk in South Africa," *Medical Anthropology Quarterly*, vol. 22, no. 3, pp. 213–233, 2008.
- World Health Organisation. 2002. *A human touch heals pain: Live and let live*. WORLD AIDS CAMPAIGN 2002. Cairo: World Health Organization. [Http://www.emro.who.int/asd/](http://www.emro.who.int/asd/)
- World Health Organization. 2003. *Integrating Gender into HIV/AIDS Programmes: a review paper*. Department of Gender and Women's Health. Family and Community Health. Geneva: World Health Organization
- World Health Organisation 2005. Message on World AIDS Day 2002 by Kofi Annan Secretary-General of the United Nations. <http://www.who.int/entity/hiv/events/wad2002/speech/en/index.html>
- Yarbrough, Tyrone 2004. *Silence*. Temple University Philadelphia www.temple.edu/isllc/newfolk/quietude.DOC .
- Yates, G. C., and Cutler, B. D. 1996. Hofstede's model of national culture: A social science contribution to international business. *Journal of Teaching in International Business*, 8 (2): 77-93.
- Yegidis, BL, and Weinbach, RW. 1996. *Research methods for social workers*. Second Edition. Boston: Allyn and Bacon.
- Zamel, V. 1997. "Toward a model of transculturation". *TESOL Quarterly*, 31, 341-352.
- Zikhali, Ernest 2004. Personal interview 20th September 2004.
- Zuber, Alexandra, Deghaye, Nicola and Pawinski, Robert. 2005. *Innovative Models of Antiretroviral Therapy in Kwazulu Natal, South Africa*. Congella: University of Natal
- Zulu, Lindiwe 1998. "Role of Women in the Reconstruction and Development of the New Democratic South Africa". *Feminist Studies*. Volume: 24. Issue: 1. Page Number: 147-157
- Zululand Eco-Adventures. 2007. *Zulu Culture*. Eshowe, Zululand. Accessed on 28 October 2007, from <http://www.eshowe.com/article/articlestatic/65/1/13>
- Zuo, Yan 2002. *Silence in Spontaneous Dyadic English Conversation: Structures, Meanings, and Functions*. Eastern Michigan University http://linguistlist.org/pubs/Tilburg_University <http://listserv.uts.edu.au/archives/sys-func/Week-of-Mon-20020610/001971.html>