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The contemporary socio-cultural barriers in HIV/AIDS prevention in South Africa and strategies to break through these barriers in order to make HIV/AIDS prevention effective.

Case study: HIV/AIDS prevention programme of the local organisation Targeted Aids Interventions (TAI) - province Kwazulu Natal, South Africa

by

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ABSTRACT

As long as HIV/AIDS cannot be cured and a vaccine does not exist, HIV/AIDS prevention is extremely important and a life saving matter. It is crucial to create a functioning society in Africa. In order for HIV/AIDS prevention to be effective, successful and sustainable, prevention programmes need to be adapted to the local socio-cultural context. Research shows that in African countries the application of existing preventive measures, such as condom use, is not that obvious in comparison with that in Western countries. The gender inequality in South Africa is a huge barrier in HIV/AIDS prevention and taboo surrounding sensitive issues, like sexuality and HIV/AIDS prevents many people from receiving information about prevention and using effective prevention tools. These barriers have as a result that the HIV/AIDS epidemic disproportionately affects women. Women are more HIV infected than men and carry the burden of HIV/AIDS, meaning they are the ones who take care of people infected and affected by the disease. Because of these barriers, the traditional prevention strategy ABC (Abstain, Be faithful and use a Condom) does not protect women and girls adequately against HIV infection. As literature states: the ABC strategy can only be a viable and effective prevention option for women and girls if it is implemented as part of a multi-faceted package of interventions that seek to redress deep-rooted gender imbalances. Interventions need to come up with strategies to break through these barriers in order to make HIV/AIDS prevention effective for women and men. A preparatory literature study regarding socio-cultural barriers and strategies to break through these barriers, served as a framework for analyzing the HIV/AIDS prevention programme of the NGO Targeted Aids Interventions (TAI), based in Pietermaritzburg, the provincial capital of KwaZulu-Natal in South Africa, and working in rural and peri-urban areas of KwaZulu-Natal.

TAI has shared its experiences in the field and everyone who is concerned with effective HIV/AIDS prevention can learn from its strategies. Data from questionnaires, participative observation, interviews and documentation and reports of TAI show that the socio-cultural barriers with which TAI is confronted in its prevention work and the strategies it has designed and implemented to break through these barriers are very similar to those found in literature, but TAI has a particular focus on working with young men through the Peer Educator Model. TAI realises the importance of targeting men because they are the ones who have to change risky behaviour, such as not wanting to use condoms, having more than one girlfriend and forcing themselves on girls and women. While men hold a position of power in social and sexual interactions, training them to use their power positively and creatively will allow men to protect themselves and thus their female partners against HIV infection. TAI targets soccer players and school learners and trains them to become peer educators and positive role models within their communities. They are powerful, have a lot of influence and can reach out to a lot of other young people, family, friends, partner, etc. Soccer as the most popular sport in South Africa provides an ideal 'vehicle' to mobilise and motivate men in AIDS related issues, while schools offer a good opportunity to address gender inequality and the link with HIV/AIDS. Adolescents in school are still negotiating their gender identities and exploring their sexuality. This period in life provides an opportune time to positively influence behaviour, choices and lifestyles. The peer educators reach out to the community through Edutainment (Education through Entertainment), for example through drama, gospel, songs, dance, debates, poetry, etc. with relevant and accurate HIV/AIDS messages, and through events and campaigns promoting condom use, positive masculinity, positive fatherhood and gender equality. Socio-cultural barriers in HIV/AIDS prevention are communicated and challenged in these cultural activities, in a language that is adapted and acceptable to youth. In training from TAI, socio-cultural barriers in HIV/AIDS prevention are challenged through personalizing the risk of HIV and the impact of HIV/AIDS, questioning, Focus Group Discussions, information transfer, activities (role plays and drawings) and discussion of case studies. This happens in a respectful and safe environment, with programme officers operating as facilitators. In short, TAI helps paving the way for communities to design and implement their own HIV/AIDS prevention programme and strategies. Once men have enough information and skills to change their patriarchal attitude towards sex and women, they can play a meaningful role in the mitigation of HIV/AIDS.

Lastly, it is worth mentioning that TAI has gradually involved girls and women into the programme, directly and indirectly. Research reveals that girls would like to become more involved. Suggestions of more ways of directly involving girls are described.

SAMENVATTING

Voor de samenvatting in het Nederlands baseer ik me op de inleiding en de algemene conclusie van het onderzoek. Referenties kunnen worden geraadpleegd in de eigenlijke tekst.

Sinds de ontdekking van AIDS begin jaren ’80, blijft het aantal HIV besmettingen toenemen, ondanks alle inspanningen om de epidemie terug te dringen. De epidemie treft vooral Afrika, maar breidt momenteel het snelst uit in Oost-Europa en Centraal-Azië. Terwijl de situatie er in de rijke landen op vooruit gaat, wordt ze in ontwikkelingslanden en landen op weg naar de markteconomie catastrofaal. Vooral vrouwen en kinderen zijn daar het meest kwetsbaar voor de ziekte. Wereldwijd zijn al meer dan 23 miljoen mensen aan de ziekte gestorven. Tegen 2010 wordt het totale aantal sterfgevallen ten gevolge van de ziekte geschat op 45 miljoen. Als we in de tussentijd geen maatregelen nemen op wereldvlak, zal het sterftecijfer bij kinderen en jongeren verdubbelen in de hardst getroffen landen.

HIV/AIDS is een mokerslag voor de samenleving en leidt tot een algemene verarming van de hardst getroffen landen omdat hun belangrijkste menselijke bronnen - leerkrachten, landbouwers, dokters, verpleegkundigen, intellectuelen, ondernemers en ambtenaren - ziek worden en zullen sterven. Hun afwezigheid laat zich heel hard voelen en de ziekte toont ons dat het in bepaalde landen decennia van ontwikkeling kan teniet doen. Vooral in landen waar voeding en openbare diensten (bijv. ziekenhuizen, scholen, enz.) vóór het opduiken van HIV/AIDS al onvoldoende aanwezig waren, is de situatie dramatisch. Als het zo blijft voortduren, is vooruitgang op het gebied van onderwijs en gezondheidszorg een onmogelijk waar te maken droom.

HIV/AIDS brengt eveneens grotere armoede en honger met zich mee. Ouders die ziek worden, kunnen soms niet meer gaan werken en moeten hun spaargeld aanspreken, hun bezittingen verkopen of geld lenen. Anderen die wel nog kunnen gaan werken hebben soms zo’n laag inkomen dat ze de gezondheidszorg en een dak boven het hoofd niet meer kunnen betalen. Bij ziekte van de ouders is het vaak zo dat de kinderen voor hen moeten zorgen en dus niet meer naar school kunnen gaan.
Tenslotte neemt het aantal kinderen waarvan de ouders gestorven zijn aan AIDS (ook wel AIDS wezen genoemd) aanzienlijk toe. De opvang voor deze kinderen is ontoereikend en velen van hen komen in grotere armoede terecht, met weinig hoop op een betere toekomst.

Zolang de ziekte niet te genezen valt en er geen vaccin bestaat, is het heel duidelijk dat preventie van HIV/AIDS uitermate belangrijk en levensreddend is! Preventie is cruciaal om in Afrika een functionerende maatschappij te krijgen. Opdat preventie van HIV/AIDS effectief, succesvol en duurzaam is, moeten preventieprogramma’s worden aangepast aan de lokale socio-culturele context. Onderzoek toont namelijk aan dat in Afrikaanse landen de toepassing van bestaande effectieve preventiemaatregelen, zoals condoomgebruik niet zo vanzelfsprekend is in vergelijking met Westerse landen. De gender ongelijkheid in Zuid-Afrika vormt een grote moeilijkheid voor effectieve HIV/AIDS preventie en moet dus worden besproken en aangepakt. Ook de taboesfeer rond gevoelige onderwerpen zoals seksualiteit, HIV/AIDS en preventie zorgt ervoor dat het overbrengen en toepassen van effectieve preventiemaatregelen wordt bemoeilijkt. Interventies moeten met deze aspecten rekening houden en strategieën bedenken om deze socio-culturele barrières te doorbreken, opdat HIV/AIDS preventie effectief is voor vrouwen en mannen.

In een eerste deel gaan we in de literatuur na wat de huidige socio-culturele barrières in HIV/AIDS preventie in Zuid-Afrika precies zijn en welke strategieën kunnen worden gebruikt om deze barrières te doorbreken. De resultaten uit wetenschappelijke artikels en rapporten van internationale ontwikkelingsorganisaties dienen als gids of raamwerk voor het terreinonderzoek. Vooraleer we in de thesis beginnen met het overlopen van de barrières en strategieën, geven we eerst een beschrijving van wat de ziekte HIV/AIDS inhoudt en hoe de verspreiding, behandeling en preventie van de ziekte verloopt. Vervolgens tonen we statistische gegevens van HIV/AIDS wereldwijd en in Zuid-Afrika, die duidelijk weergeven dat jonge vrouwen de kwetsbare groep vormen voor HIV besmetting. Tenslotte bespreken we de stand van zaken betreffende HIV/AIDS preventie op politiek vlak.

Het tweede deel bestaat uit een terreinonderzoek (gedurende een periode van tien weken) die een analyse maakt van het HIV/AIDS preventieprogramma van de lokale organisatie Targeted Aids Interventions (TAI), gelegen in Pietermaritzburg, de hoofdstad van de provincie KwaZulu-Natal in Zuid-Afrika.
De gevalstudie bestudeert met welke socio-culturele barrières in HIV/AIDS preventie de organisatie TAI wordt geconfronteerd en welke strategieën TAI heeft bedacht en geïmplementeerd om deze belemmerende factoren in preventie aan te pakken. Wat zijn bijvoorbeeld de strategieën om gender ongelijkheid aan te pakken? Hoe wordt taboe doorbroken? De resultaten zijn een concrete weergave van lokale problemen en antwoorden op de HIV/AIDS epidemie. De gevalstudie kan worden beschouwd als een praktische verificatie en specificatie van de informatie die in de literatuur is gevonden.
De meerwaarde van een terreinonderzoek, door middel van deze gevalstudie is meer te weten te komen over de ervaringen, successen en bezorgdheden van lokale gemeenschappen en van een lokale organisatie in de strijd tegen HIV/AIDS. Op die manier kunnen effectieve preventiemaatregelen, aangepast aan de socio-culturele context naar voren worden geschoven en als voorbeeld dienen voor andere HIV/AIDS organisaties die zich bezig houden met preventie en gesitueerd zijn in gelijkaardige omgevingen.
De gevalstudie situeert zich daarenboven in de provincie KwaZulu-Natal, de zwaarst door HIV/AIDS getroffen provincie in Zuid-Afrika. Ook kent de organisatie TAI een zeer innovatieve werking omdat de preventie focust op jonge mannen. Het inzicht dat effectieve HIV/AIDS preventie de betrokkenheid van mannen vereist, is relatief nieuw. Tegenwoordig worden meisjes en vrouwen eveneens bij de projecten betrokken, rechtstreeks of onrechtstreeks, maar in mindere mate. Aangezien eerder onderzoek suggereert dat de werking met mannen én vrouwen ideaal is om verandering te brengen in het huidige gender systeem, wordt tenslotte gekeken naar manieren om meisjes nog meer rechtstreeks te betrekken in het preventieprogramma van TAI.

De volgende paragrafen geven de voornaamste conclusies van het onderzoek weer.

Aan de hand van een voorbereidende literatuurstudie, ben ik op zoek gegaan naar de huidige socio-culturele barrières waarmee de lokale organisatie TAI wordt geconfronteerd in haar HIV/AIDS preventiewerk in plattelandsgebieden en gebieden rond de steden in KwaZulu-Natal, Zuid-Afrika. Data verkregen door middel van vragenlijsten, participatieve observatie, interviews en documentatie en rapporten van TAI geven volgende barrières in de preventieve aanpak van HIV/AIDS weer:

1. Gender ongelijkheid

- Mannelijke dominantie over vrouwen: mannen hebben beslissingsmacht in de seksuele relatie, bijvoorbeeld zij beslissen of een condoom wordt gebruikt of niet. Vrouwen zijn vaak niet in staat hun man of partner te overtuigen van condoomgebruik. Zij bevinden zich in een ondergeschikte positie en moeten de man gehoorzamen.
- Het seksuele discours is patriarchaal - de voorwaarden en tijdstip van seks worden door de man bepaald – en mannen hebben controle over het vrouwelijke lichaam. Patriarchale socio-culturele normen en waarden rond gender en seksualiteit zorgen ervoor dat vrouwen weinig te zeggen hebben over seksuele relaties en niet over de macht beschikken om hun eigen lichaam te beschermen tegen HIV infectie. Vrouwen zijn vaak niet in staat om seks te weigeren binnen het huwelijk of binnen een relatie.
- Ruilseks voor basisbenodigdheden of materiële producten en het fenomeen van 'sugar daddies' komen regelmatig voor in KwaZulu-Natal, aangezien vrouwen economisch afhankelijk zijn van mannen. Deze economische afhankelijkheid zorgt ervoor dat vrouwen over weinig macht beschikken om condoomgebruik te eisen tijdens seksueel verkeer. Uit schrik om verlaten te worden door de man en bijgevolg geen toegang meer te hebben tot voedsel, geld en een dak boven het hoofd, zullen vele vrouwen het risico nemen en overgaan tot onveilige seks.
- Condoomgebruik is zeldzaam binnen het huwelijk of binnen een stabiele, langdurige relatie. Het gebruik van een condoom wordt gelinkt met promiscuïteit, ontrouw en een gebrek aan wederzijds vertrouwen tussen partners. Condoomgebruik belet eveneens de mogelijkheid op zwangerschap, terwijl ouderschap sterk wordt gewaardeerd binnen de cultuur.
- Gender stereotiepen verwachten van mannen dat ze meerdere seksuele partners hebben en van vrouwen dat ze trouw blijven aan de partner en onderdanig zijn. Mannen horen ook zeer veel kennis te hebben met als gevolg dat ze niet geneigd zijn correcte informatie over HIV/AIDS preventie op te zoeken of advies te vragen hieromtrent. Socio-culturele normen ontkennen mannen de verantwoordelijkheid in reproductieve aangelegenheden.
- Geweld naar vrouwen en meisjes toe. Vrouwen worden vaak fysiek en/of seksueel misbruikt wanneer ze weigeren seks te hebben of weigeren seks te hebben zonder condoom. Mannen begrijpen vaak niet waarom het verkeerd is de vrouwelijke partner te dwingen tot seks of de vrouw te slaan. Ze zijn op deze manier grootgebracht en zien het als deel van hun traditionele rol. Ze dragen hun verantwoordelijkheid hierin niet en beschuldigen vaak de vrouw voor verkrachting of geweld naar haar toe. Vrouwen beginnen zelfs te denken dat geweldmisbruik sociaal aanvaard is.
- Schadelijke culturele mythes, bijvoorbeeld het geloof dat seks met een maagd iemand kan genezen van HIV/AIDS.
- Schadelijke culturele of gewoontepraktijken: polygamie in combinatie met migratiearbeid, het testen van de maagdelijkheid bij meisjes, het betalen van een bruidsschat (lobola).
- Stigmatisering en discriminatie van vrouwen.

2. Taboe

- Grote stilte rond HIV/AIDS en seksualiteit: praten over seks en HIV/AIDS is door de cultuur niet toegelaten, vooral niet tussen kinderen en volwassenen.
- Ontkenning dat HIV/AIDS in de plattelandsdorpen bestaat.
- HIV/AIDS wordt niet erkend als de ziekte, maar als hekserij.
- Er worden andere namen gegeven aan HIV/AIDS.

Deze socio-culturele barrières hebben als resultaat dat de HIV/AIDS epidemie een onevenredige impact heeft op vrouwen. Vrouwen hebben meer kans om besmet te worden met het HIV virus dan mannen en hebben eveneens een grotere ziektelast om dragen, ze staan namelijk in voor de zorg voor AIDS patiënten en AIDS wezen. De barrières vergroten het risico voor vrouwen en meisjes om geïnfecteerd te geraken en dragen bij tot het in stand houden van de epidemie. Omwille van de barrières, is de traditionele preventiestrategie ABC (Onthouding, trouw zijn en condoomgebruik) ontoereikend om meisjes en vrouwen adequaat te beschermen tegen HIV infectie. Vele Afrikaanse vrouwen zijn gewoonweg niet in staat om zich te onthouden van seks, trouw te zijn aan de partner of te rekenen op de trouwheid van de partner, of condoomgebruik te bespreken/toe te passen. Zoals in de literatuur omschreven: de ABC strategie kan pas effectief zijn voor vrouwen en meisjes als het wordt opgenomen binnen een breder pakket van interventies die de diepgewortelde gender ongelijkheid aanpakken. Interventies moeten strategieën bedenken om deze socio-culturele barrières te doorbreken, opdat HIV/AIDS preventie effectief wordt voor zowel vrouwen als mannen. De bestaande preventiestrategieën moeten worden verbreed, meer bepaald moeten worden aangepast aan de socio-culturele context van gender ongelijkheid en taboe, aan het leven van de vrouw. Op die manier worden onderliggende kwetsbaarheden van vrouwen opgeheven. Strategieën moeten beantwoorden aan de specifieke noden en realiteiten van Afrikaanse vrouwen en meisjes. De literatuur beveelt meerdere strategieën aan, waarvan de belangrijkste zijn:

- Het bespreekbaar maken van seksualiteit.
- Informatieoverdracht en kwaliteitsvolle educatie op het gebied van HIV/AIDS preventie en seksualiteit voor jongens en meisjes.
- Open dialoog in de gemeenschap over HIV/AIDS en seksualiteit.
- Het uitdagen van de heersende patriarchale cultuur waarvan socio-culturele normen en waarden rond gender en seksualiteit bijdragen tot een lagere sociale status van vrouwen en meisjes, en geweld jegens vrouwen en meisjes toelaten.
- Het promoten van vrouwenrechten.
- Empowerment van vrouwen en meisjes met kennis (over seksualiteit en HIV/AIDS) en vaardigheden.
- Het zelfvertrouwen van meisjes vergroten en hun zelfbeeld versterken.
- Discussiegroepen over gender identiteit, ongelijke macht, enz.
- Campagnevoering tegen geweldmisbruik van vrouwen.
- Campagnes om het gebruik van condooms en communicatie tussen partners over condoomgebruik aan te moedigen.
- Bewustmakingscampagnes om het stigma dat rust op vrouwen te verminderen.
- Vrouwen economische kansen geven.
- Tegemoet komen aan de noden van HIV positieve vrouwen.
- Participatie van jongeren in project en programma planning, implementatie, monitoring en evaluatie.
- Beroep doen op gender experten.
- Een werkrelatie aangaan met de overheid en academici.

Preventie is voornamelijk gericht op vrouwen omdat zij de kwetsbare groep vormen. Gender kwesties worden maar al te vaak beschouwd als vrouwenzaken en vele HIV/AIDS interventies hebben een nog grotere druk geplaatst op de verantwoordelijkheid van vrouwen in HIV/AIDS preventie, zonder rekening te houden met de verantwoordelijkheid van mannen. Literatuur benadrukt de nood aan actieve betrokkenheid van mannen en jongens in de strijd tegen HIV/AIDS. Zij hebben beslissingsmacht en kunnen een positieve drijfveer vormen voor verandering opdat de situatie voor meisjes en vrouwen verbetert. De rol van mannen in het promoten van gender gelijkheid en het indijken van de verspreiding van HIV is cruciaal. Zij moeten duiden op de socio-culturele normen en stereotiepen die het risico op HIV besmetting voor zowel mannen als vrouwen vergroten. Dit is ook het voornaamste standpunt van TAI.

In 1995 begon TAI zijn oorspronkelijke werking met vrouwen, maar 90% van de vrouwen die deelnamen aan de training waren niet in staat hun persoonlijke beslissingen omtrent HIV/AIDS preventie toe te passen in de thuisomgeving. De bestaande gender ongelijkheid deed de inspanningen om vrouwen te beschermen tegen HIV infectie door hen kennis en vaardigheden aan te reiken, falen. Wanneer de vrouwen probeerden de theorie om te zetten in de praktijk, ervoeren ze weerstand van hun man en vaak ook geweldmisbruik. Hoewel empowerment van vrouwen wordt aanbevolen in de literatuur, leidde deze interventie enkel tot het verder slachtofferen van vrouwen. Dit besef spoorde TAI in 1998 aan tot een ommekeer, namelijk werken met mannen. Bijna alle beslissingen worden door mannen genomen, ook beslissingen omtrent seks, geboortebeperking en preventiemethodes. Zij zijn diegenen die hun risicogedrag moeten veranderen, namelijk het condoom niet willen gebruiken, meerdere seksuele partners hebben en seks afdwingen van vrouwen en meisjes. Mannen hebben de macht in sociale en seksuele relaties en moeten worden getraind om hun macht positief en creatief te gebruiken. Dit zal hen toelaten zichzelf en tegelijkertijd hun vrouwelijke partner te beschermen tegen HIV infectie.

Om de bovenvermelde socio-culturele barrières in de preventieve aanpak van HIV/AIDS te doorbreken, heeft TAI verschillende strategieën bedacht en uitgevoerd die aangepast zijn aan de socio-culturele context van taboe en gender ongelijkheid. De tweede onderzoeksvraag – welke strategieën gebruikt TAI om deze barrières in HIV/AIDS preventie aan te pakken? – werd beantwoord aan de hand van onderzoeksgegevens, verkregen door middel van interviews, participatieve observatie, documentatie en rapporten van TAI. De strategieën die TAI toepast komen sterk overeen met de strategieën beschreven in de literatuur, maar de werking van TAI legt een bijzondere nadruk op het Peer Educator Model:

- Werking via bestaande structuren of groepen in de gemeenschap opdat de projecten worden aanvaard en gesteund door de gemeenschap en opdat de projecten een werkelijke impact kunnen hebben.
- Betrokkenheid van leidersfiguren om een ondersteunende omgeving voor HIV/AIDS preventie activiteiten mogelijk te maken.
- Antwoorden op de HIV/AIDS epidemie komen van de gemeenschap zelf en worden door de gemeenschap gestuurd, met enkel minimale begeleiding van TAI.
- Participatieve benadering: begunstigden worden betrokken bij planning, implementatie, monitoring en evaluatie van projecten. TAI erkent het belang van hun deelname om duurzame resultaten te bereiken.

- Peer Educator Model: jonge mannen en jongens worden geselecteerd, getraind en onderwezen in HIV/AIDS preventie en seksualiteit, en ze worden aangespoord om hun aangeleerde kennis en vaardigheden te verspreiden onder leeftijdsgenoten en andere mensen in de gemeenschap.
- Doelgroep: voetballers en schoolleerlingen. Zij hebben macht in de gemeenschap, hebben veel invloed en kunnen gemakkelijk andere jongeren, familie, vrienden, partner, enz. bereiken. Voetbal is de populairste sport in Zuid-Afrika en vormt een ideaal medium om mannen te mobiliseren en te motiveren in HIV/AIDS preventie. Scholen vormen de ideale plaats om jongeren kennis bij te brengen over gender ongelijkheid en de link met HIV/AIDS.
- De jeugd is de primaire focus van bewustzijnsinitiatieven en educatieve activiteiten. Jongeren vormen de kwetsbare groep maar kunnen tegelijkertijd een sleutelrol spelen in het omkeren van de HIV/AIDS besmettingen. Adolescenten op school zijn nog steeds bezig met het op zoek gaan naar hun gender identiteit en met het ontdekken van hun seksualiteit. Deze levensperiode vormt het ideale moment om gedrag, keuzes en levensstijlen positief te beïnvloeden.
- Op gang brengen van communicatie tussen jonge mannen over veilig seksueel gedrag, bijvoorbeeld condoomgebruik en vermindering in het aantal seksuele partners.
- Promoten van onthouding bij jongens.
- De jonge deelnemers worden positieve rolmodellen in hun gemeenschap. Dit maakt hen bewust van hun gedrag en attitudes en van het belang zich te gedragen volgens hetgeen ze prediken.
- Ze zijn afkomstig van de gemeenschap zelf, geen buitenstaanders. Ze kunnen andere mensen bereiken omdat ze de locale cultuur kennen en de taal spreken van het volk.
- De gemeenschap bereiken via ‘Edutainment: Education through Entertainment’ (= educatie door middel van entertainment). De peer educators drukken zichzelf uit door middel van culturele activiteiten zoals toneel, gospelliederen, liederen, dans, debatten, poëzie, toespraken, presentaties, enz. opdat de HIV/AIDS boodschappen aantrekkelijk zijn en meer impact hebben op de mensen. De socio-culturele barrières in HIV/AIDS preventie worden aangekaart en uitgedaagd in deze activiteiten, in een taal die is aangepast aan de jeugd en aanvaardbaar is voor hen.
- Het aanmoedigen van dialoog tussen jonge mannen en vrouwen over wederzijds respect, mensenrechten, seksualiteit en gedeelde verantwoordelijkheid in HIV/AIDS preventie.
- De gemeenschap bereiken door middel van evenementen en campagnes om het gebruik van condooms aan te moedigen en gender gelijkheid te promoten.
- Werken met beloningen om de deelnemers gemotiveerd te houden.
- Uitdelen van condooms door peer educators en lokale zakenhouders.
- Het aanmoedigen van open dialoog over HIV/AIDS in de gemeenschap.
- Peer educators krijgen voortdurend nieuwe informatie aangereikt en krijgen voortdurend mentorschap en ondersteuning van de voetbalcoaches, leerkrachten, ouders en TAI.
- TAI vertrekt van de kennis van de mensen, hun huidige kennis van HIV/AIDS en preventie.
- Capaciteiten worden opgebouwd door interactieve HIV/AIDS educatie, met specifieke aandacht voor de risico’s die gepaard gaan met seksueel overdraagbare aandoeningen, en alcohol- en druggebruik.
- Capaciteiten worden opgebouwd door training in levensvaardigheden.

- In de training worden socio-culturele barrières uitgedaagd door het verpersoonlijken van het risico voor HIV besmetting en de impact van HIV/AIDS, bevraging, Focus Discussiegroepen, informatieoverdracht, activiteiten (rollenspel en tekenen) en het bediscuteren van gevalstudies.
- De programmabeheerders moedigen positief, alternatief gedrag aan en leggen de voordelen van zulk gedrag uit.
- De promotie van vrouwen- en meisjesrechten.
- Het uitwisselen van ervaringen tussen peer educators versterkt hun capaciteiten en motivatie.
- Perceptie van en stereotiepen rond mannelijkheid en vrouwelijkheid worden besproken en bevraagd in een respectvolle en veilige omgeving.
- TAI maakt gebruik van een discours dat is aangepast aan de leefwereld van jongeren.
- Programmabeheerders zijn facilitators, ze leggen geen zaken op.
- Evaluatie van de impact van het programma.
- Doorverwijzing naar bekwame personen.
- Betrokkenheid van meisjes en vrouwen in het programma.
- Betrokkenheid van seropositieven.
- Werkrelatie met de overheid en academici.
- Werkrelatie met de media.

De werking met mannen kan gezien worden als een bevestiging of het in stand houden van de gender ongelijkheid, meer bepaald instandhouding van de mannelijke dominantie over vrouwen. Maar via de werking met mannen kunnen nieuwe normen en waarden van gelijkheid, rechtvaardigheid en verantwoordelijkheid worden ingevoerd in de gemeenschap. Via werking met bestaande structuren of groepen in de gemeenschap, probeert TAI verandering te brengen naar een gender gelijke maatschappij zonder HIV/AIDS. Enkel op deze manier kunnen de nieuwe normen en waarden worden aanvaard en opgenomen in de gemeenschap. De cultuur mag niet vertrappeld of verboden worden, aangezien dat nog meer weerstand met zich meebrengt naar gender gelijkheid toe, en dus ook naar effectieve HIV/AIDS preventie toe.

TAI begrijpt dat bewustmaking en gedragsverandering een geduldig en stapvoets proces is. Er is nog een lange weg te gaan, maar elke persoon die wordt bewust gemaakt en zijn gedrag verandert, is een leven gewonnen. Tot op de dag van vandaag moeten mensen in de plattelandsgebieden nog op de hoogte worden gebracht dat HIV/AIDS een werkelijke bedreiging vormt voor het leven.

Aangezien eerder onderzoek suggereert dat de werking met mannen én vrouwen ideaal is om verandering te brengen in het huidige gender systeem, – vrouwen en meisjes zetten ook druk op mannen en jongens om negatief, mannelijk gedrag te stellen, vaak uit economische overwegingen – heeft TAI vrouwen en meisjes geleidelijk aan (opnieuw) rechtstreeks betrokken in het programma. Dit is voornamelijk het geval in scholen.
Vrouwen en meisjes worden ook op een onrechtstreekse manier betrokken in het programma. Ze worden aangespoord de jonge mannen te helpen en te ondersteunen in hun rol als peer educator. Maar terreinonderzoek toont aan dat deze meisjes graag dezelfde training zouden volgen als de jonge mannen om meer te weten te komen over HIV/AIDS of graag zelf peer educator zouden willen worden. Andere interviewees stellen voor dat meisjes meer uitleg krijgen over de gevaren die gepaard gaan met ‘sugar daddies’ en het onderhouden van relaties met meerdere mannelijke partners voor materiële ondersteuning.

Vervolgens suggereert de literatuur dat goedkope toegang tot preventiemiddelen die vrouwen zelf kunnen toepassen en controleren moet worden verzekerd. TAI promoot het vrouwencondoom in de training met de jongeren. Eerst wordt het gebruik ervan gedemonstreerd en vervolgens deelt de programmabeheerder vrouwencondooms uit aan de deelnemers.

Ter besluit, TAI promoot positieve mannelijkheid en vaderschap door de nadruk te leggen op de verantwoordelijkheid van mannen om hun macht positief te gebruiken. Zodra mannen over genoeg kennis en vaardigheden beschikken om hun patriarchale houding ten opzichte van seks en vrouwen te veranderen, kunnen ze een betekenisvolle rol spelen in het bestrijden van de HIV/AIDS epidemie.

Effectieve preventiemaatregelen zijn zonet beschreven en andere HIV/AIDS organisaties die werken in gelijkaardige omstandigheden kunnen deze strategieën toepassen, opdat HIV/AIDS preventie alsmaar effectiever wordt op verschillende plaatsen. Effectieve HIV/AIDS preventie is uitermate belangrijk en levensreddend. TAI's werk kan eveneens worden geïmplementeerd in andere plaatsen in Zuid-Afrika, vooral in plattelandsgebieden en gebieden rond de steden. TAI denkt dat haar projecten ook kunnen worden toegepast in andere Afrikaanse landen en in het buitenland. Preventie is in handen van de gemeenschap en de werking met mannen kan eigenlijk overal worden ingevoerd waar gender ongelijkheid bestaat, waar mannen hun macht misbruiken en waar positieve mannelijkheid en vaderschap moeten worden aangemoedigd.

Maar er bestaan verscheidene uitdagingen waarmee rekening moet worden gehouden: armoede, ongeletterdheid en werkloosheid zijn sterk aanwezig in KwaZulu-Natal. Armoede beïnvloedt de spreiding van HIV/AIDS op verschillende manieren, zoals het belemmeren van de toegang tot condooms en behandeling van seksueel overdraagbare aandoeningen. De dienstverlening in de gebieden waar TAI werkzaam is, is beperkt of onbestaande. Niet alleen de toegang tot condooms is problematisch, maar ook de beschikbaarheid van condooms. De peer educators delen condooms uit, maar ze kunnen er nooit voldoende uitdelen. De vraag overstijgt het aanbod. De overheid moet ervoor zorgen dat de omgeving effectieve HIV/AIDS preventie voor elk individu toelaat. De overheid moet meer inspanningen doen om de toegang en de beschikbaarheid van mannen- en vrouwencondooms te verzekeren en om mythes en misvattingen rond condooms te bestrijden. De dienstverlening in ziekenhuizen en gezondheidscentra moet ook meer gericht zijn naar de jeugd. Tenslotte moet de werking met mannen op een evenwichtigere manier gebeuren. Kortom, consistent leiderschap met betrekking tot HIV/AIDS en een sterk engagement van de gemeenschappen zijn noodzakelijk om de ziekte te bestrijden.

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LIST OF ABBREVIATIONS

ABC	Abstain, Be faithful, and use a Condom
ANC	African National Congress
APAC	Australia in partnership with African countries
AIDS	Acquired Immunodeficiency Syndrome
ARV's	Anti Retrovirals
CEDAW	UN Convention on the Elimination of All forms of Discrimination Against Women
GAF	Gender Aids Forum
HIV	Human Immunodeficiency Virus
JOHAP	Joint Oxfam HIV and AIDS Programme
NGO	Non-governemental organisation
OVC	Orphaned and vulnerable children
PE's	Peer educators
PLWHA	People living with HIV/AIDS
SAFA	South African Football Association
STI's	Sexually Transmitted Infections

TAI	Targeted Aids Interventions
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations International Children's Emergency Fund
VCT	Voluntary Counselling and Testing

INTRODUCTION

Since the discovery of AIDS in the early eighties, the number of HIV infections has continued increasing, despite all the efforts made to reduce the epidemic. The epidemic can be found mostly in Africa, but at the moment it is spreading fastest in Eastern Europe and Central Asia (FOD, 2006). While the situation in rich countries is improving, it becomes catastrophic in developing countries and countries developing to a market economy. Especially women and children are most vulnerable to the disease. Worldwide, there are already more than 23 million people who have died of the disease. In 2010, the total number of AIDS deaths is estimated to be 45 million. If we do not take global measures in the meantime, the death rate among children and youth will double in the countries most affected by HIV/AIDS (UNICEF[1] Belgium, 2005).

HIV/AIDS forms a dramatic blow for society and leads to impoverishment of those countries which are hit the worst by the epidemic. The most important human resources – teachers, farmers, doctors, nurses, intellectuals, entrepreneurs and officials – become sick and will eventually die. Their absence is deeply felt and the disease shows us that it can destroy decennia of development in certain countries. Especially in countries where nutrition and public services (for example hospitals, schools, etc.) were already insufficient before the epidemic, the situation becomes dramatic. If the situation remains unchanged, further development in education and health care will never be more than a dream (UNICEF Belgium, 2005).

In addition, HIV/AIDS leads to more poverty and hunger. Some parents who become sick cannot go to work anymore and as a consequence have to spend their savings, need to sell their belongings or have to borrow money. Others who still can go to work are sometimes given a very low income which means that they cannot afford a place to stay and decent health care (UNICEF Belgium, 2005). It often occurs that children have to take care of their sick parents, which prevents them from going to school.
Finally, the number of children whose parents have died of AIDS (also called AIDS orphans) is increasing dramatically (Sanders, 2003). The care of these children is inadequate and many of them end up in very poor conditions, with little hope for a better future.

As long as the disease cannot be cured and a vaccine does not exist, it is very clear that HIV/AIDS prevention is extremely important and a life saving matter! It is crucial to create a functioning society in Africa. In order for HIV/AIDS prevention to be effective, successful and sustainable, prevention programmes need to be adapted to the local socio-cultural context. Research shows that in African countries the application of existing preventive measures, such as condom use, is not that obvious in comparison with that in Western countries. The gender inequality in South Africa is a huge barrier in HIV/AIDS prevention and thus needs to be discussed and challenged. Furthermore, taboo surrounding sensitive issues, like sexuality and HIV/AIDS, prevents many people from receiving information about prevention and using effective prevention tools. Interventions need to come up with strategies to break through these socio-cultural barriers in order to make HIV/AIDS prevention effective for women as well as men.

[1] United Nations International Children's Emergency Fund fights for the well being of children and for respecting their rights (UNICEF Belgium, 2005).

In a first part, we look up in literature what the contemporary socio-cultural barriers in HIV/AIDS prevention in South Africa are and which strategies can be used to break through these barriers. Results from scientific articles and reports of international development organisations can serve as a guideline or framework for field research. Before we start describing the barriers and strategies, we first give a description of what the disease means and how it can be transmitted, treated and prevented. Further, we give statistical data on HIV/AIDS worldwide and in South Africa, which indicate clearly that young women are most vulnerable to HIV infection. Finally, we talk about HIV/AIDS prevention at political level.

The second part is a field research (of a period of ten weeks) which makes an analysis of the HIV/AIDS prevention programme of the local organisation Targeted Aids Interventions (TAI), based in Pietermaritzburg, the provincial capital of KwaZulu-Natal in South Africa.
The case study looks at the socio-cultural barriers in HIV/AIDS prevention with which the organisation TAI is confronted and at the strategies that TAI has designed and implemented to deal with these difficulties. For example, what are its strategies to deal with gender inequality? How is taboo being broken? The data gathered by interviews, questionnaires, participative observation and documentation of TAI (see also the paragraph regarding methodology) are a concrete reproduction of the local problems and answers to the HIV/AIDS epidemic.
The merit of field research through a case study is learning more about the experiences, successes and concerns of local communities and of a local organisation in the fight against HIV/AIDS. In this way, effective preventive measures adapted to the socio-cultural context are put forward and can be an example to other HIV/AIDS organisations working in similar conditions. They can learn from these practical experiences so that HIV/AIDS prevention becomes more and more effective in different locations.
Moreover, the case study is situated in the province KwaZulu-Natal, the province affected the most by HIV/AIDS in South Africa. The organisation TAI also knows an innovative way of working because prevention is targeted towards boys and young men. The understanding that effective HIV/AIDS prevention needs the participation of men, is relatively new. Nowadays, girls and women are also involved in the projects of TAI, directly and indirectly, but to a lesser extent. Since previous research (Lindegger & Maxwell, 2005) had suggested that working with men and women is the best way to change the gender system, more ways of directly involving young women are finally explored.

LITERATURE RESEARCH

1. HIV/AIDS EPIDEMIC IN SOUTH AFRICA

1.1. A short general description of the disease

1.1.1. What is HIV/AIDS?

HIV means Human Immunodeficiency Virus and AIDS stands for Acquired Immunodeficiency Syndrome. Someone who is infected with the virus HIV, is called positive. The HIV virus attacks the human immune system. When the immune system of the body weakens and illnesses come up, the person has entered the AIDS phase. The illnesses that appear are also called opportunistic diseases. These can be cancer, tuberculosis, and other life threatening diseases (UNICEF Belgium, 2005).

1.1.2. Symptoms

A lot of people do not know that they are infected with the disease because it can take a couple of years before symptoms of infection appear. Others loose weight and are tired, symptoms that look very much like these of the flu. It also happens that people have a constant fever, head ache, infections or some suffer from mental disorder (UNICEF Belgium, 2005).

1.1.3. Transmission: Focus on transmission through sexual encounter

HIV is transmitted in different ways. First, it is transmitted through unprotected sex with an HIV positive person, meaning through infected semen or vaginal secretion (De Koker, 2006; UNICEF Belgium, 2005). Worldwide, HIV is mostly transmitted through heterosexual contact which has deepened the impact of HIV/AIDS on women (The Global Coalition on Women and Aids[2], 2006c; Erb-Leoncavallo et al., 2004).

[2] The Global Coalition on Women and AIDS is a new initiative launched in 2004 by the international organisation Joint United Nations Programme on HIV/AIDS (UNAIDS). The coalition works at global and national levels. It highlights the effects of AIDS on women and girls and stimulates concrete and effective action to prevent the spread of HIV. The organisation has a coalition with civil society groups, Non-Governmental Organisations (NGO's), the private sector, networks of HIV positive women, government officials, and UN organisations that support effective prevention activities for women and girls. Coalition partners seek to address some of the fundamental gender inequalities that fuel the epidemic. Efforts are focused on preventing new HIV infections, improving the availability of the female condom and microbicides, promoting equal access to care and treatment, ensuring universal access to education for girls, addressing legal inequities (through the promotion of property and inheritance rights for women), reducing the violence against women, and valuing women's care work within communities (The Global Coalition on Women and AIDS, 2006b,c; Erb-Leoncavallo et al., 2004).

This is especially the case in Southern Africa, where more than 20% of pregnant women is infected with HIV (Erb-Leoncavallo et al., 2004). An explanation for this huge impact on women is that sexuality is linked with gender inequality, which will be described in detail in the following chapter.

Secondly, HIV is transmitted through infected blood or blood products (blood transfusion) and through the use of non-sterile, thus HIV infected injection needles, for medical use as well as used within drug addiction (FOD, 2006).

Lastly, the virus can be transmitted from mother to child during pregnancy, birth or breastfeeding (UNICEF Belgium, 2005).

1.1.4. Treatment: Anti Retrovirals (ARV's)

HIV/AIDS cannot be cured, only treated. HIV causes AIDS, a deadly disease. Medicine, meaning ARV's can only suppress the development of the HIV virus and in this way can delay the outbreak of AIDS. Early treatment of HIV/AIDS can already make a whole difference. In rich countries most sick people receive ARV's. In poor countries most people do not because they cannot pay the high cost price. Treatment for one month costs as much as a medium month wage and it is just in these countries that most sick people are to be found (UNICEF Belgium, 2005). Because ARV's cannot kill the virus, HIV positive people need to take the medicine their whole life with the risk of the virus becoming resistant (Lamboray, 2006).

1.1.5. Prevention

Comprehensive prevention is the first line of defence against HIV/AIDS (The Global Coalition on Women and Aids, 2006c). Every individual needs to be able to access the necessary information and tools that can prevent infection with and transmission of the HIV virus (UNICEF Belgium, 2005).

Prevention needs to be actively obtained in different ways. First and foremost, the right information needs to be disseminated through several channels. Qualitative information, also adapted and accessible to youth, is about HIV/AIDS, sexuality and the emotional life. It is information about modes of HIV transmission, care and treatment of sick people, developed research and different prevention and contraception possibilities. This information needs to be presented regularly. It is better to inform and educate people permanently instead of doing an intensive campaign for only one month. Good ways of spreading the message is through media and television, internet and pop stars. Prevention campaigns need to be attractive and intelligent, without making it a banality (UNICEF Belgium, 2005).

Secondly, prevention is about condom use during sexual intercourse. Condoms (male or female condom) are the best tool to prevent HIV infection while having sex. Access to condoms needs to be ensured and accommodating information on how to use the condom correctly is necessary (Erb-Leoncavallo et al., 2004). Some programmes use peer educators (PE's) to distribute and promote condoms. Apparently, this has a positive impact on condom use among young people.

In Africa, only 1.3 per cent of married women of reproductive age use condoms. There are many reasons why usage figures are so low, but one key obstacle is lack of access to condoms. Condoms may simply be unavailable (partly because of the global shortage of supplies); people may not know where to go to get them, or they may feel embarrassed about acquiring them (The Global Coalition on Women and Aids, 2006a).

Sexual relationships are very much determined by socio-cultural norms and values. The socio-cultural context does not make it easy to apply existing (Western) preventive measures, such as condom use, in African countries. Some traditional prevention strategies have tended to focus predominantly on ABC: "Abstain, Be faithful and use a Condom". While the ABC strategy has undoubtedly prevented many people from becoming infected, many of the African women are simply not in a position to abstain from sex, to be faithful or to rely on faithfulness of their partner, or to negotiate condom use[3]. The strategy as such lacks in adequately protecting women against HIV infection. The ABC strategy can only be a viable and effective prevention option for women and girls if it is implemented as part of a multi-faceted package of interventions that seek to redress deep-rooted gender imbalances (The Global Coalition on Women and Aids, 2006a).

Thirdly, delay in onset of sexual activity and reduction in the number of sex partners are preventive measures that protect people from getting infected with HIV (FOD, 2006). But as the ABC strategy, these behavioural changes are not that easily attained in the African (socio-cultural) context[4].

Fourthly, it is important to effectively prevent and treat Sexually Transmitted Infections (STI's). People with such an infection are 2 to 5 times more vulnerable to HIV infection than people without a STI (Erb-Leoncavallo et al., 2004). Most STI's can be prevented by using condoms and many bacterial infections are easily and inexpensively treatable with antibiotics. Unfortunately, the knowledge and services to protect against such infections are inadequate in many African countries, significantly increasing the spread of HIV (The Global Coalition on Women and Aids, 2006d).

Furthermore, Voluntary Counselling and Testing (VCT) can facilitate behaviour change that contributes to a reduction in HIV transmission. Studies show that VCT can contribute to a decrease in unprotected sexual relations, a reduction in the number of sex partners, an increase in condom use and more people choosing abstinence. VCT is also critical for reducing the number of infants born with HIV (Erb-Leoncavallo et al., 2004).

Finally, mother-to-child transmission can be prevented by giving birth through caesarean section, and after delivery by feeding the child with powder milk instead of breastfeeding. Furthermore, the HIV virus in the mother's body during pregnancy is kept under control with ARV's. While in the West, this preventive measure is obvious, in African countries it is more difficult. In Kenya for example, not breastfeeding your child means you are infected with HIV/AIDS. A woman who wants to buy powder milk for her baby risks being stigmatized and excluded from the community (Verstraete, 2006).

[3] Detailed explanations in the following chapter will make this more clear.
[4] Idem note 3.

1.2. Number of HIV infections and AIDS deaths worldwide

Now follows a summary of data, gathered worldwide for the year 2006 (UNAIDS/WHO AIDS Epidemic Update, 2006a):

- Number of people with HIV: Total **39,5 million (**34,1-47,1 million)
  Adults **37,2 million** (32,1-44,5 million)
  Women **17,7 million** (15,1-20,9 million)
  Children under 15 years old **2,3 million** (1,7-3,5 million)
- Number of new HIV infections: Total **4,3 million** (3,6-6,6 million)
  Adults **3,8 million** (3,2-5,7 million)
  Children under 15 years old **530 000** (410 000-660 000)
- Number of AIDS deaths: Total **2,9 million** (2,5-3,5 million)
  Adults **2,6 million** (2,2-3,0 million)
  Children under 15 years old **380 000** (290 000-500 000)

(The numbers between brackets are the boundaries wherein the real numbers are to be found. The bold numbers are only estimates of the real numbers).

The above numbers show clearly that the HIV/AIDS epidemic takes many lives. Women and children under 15 years old are the vulnerable groups. Of all the regions, Sub Saharan Africa is hit the worst by the epidemic. This is shown by the numbers in the following table (table 1: Regional HIV/AIDS statistics and feature for the years 2004 and 2006). In 2006, almost two thirds (63% - 24,7 million) of all persons infected with HIV worldwide (39,5 million) are living in Sub Saharan Africa. An estimated 2,8 million adults and children became newly infected with HIV in 2006, more than in all other regions of the world combined. The adult HIV prevalence rate[5] is 5,9% in Sub Saharan Africa in 2006 and 1,0% globally. Finally, adult and child deaths due to AIDS is estimated to be 2,1 million in Sub Saharan Africa in 2006 and 2,9 million globally. The number of AIDS deaths in Sub Saharan Africa represents 72% of global AIDS deaths (UNAIDS/WHO AIDS Epidemic Update, 2006a, 2006b). Maps with global HIV/AIDS estimates are also presented in attachment 1.

[5] HIV prevalence rate is the number of people living with HIV in a certain country divided by the total number of people living in that particular country. In this way, a percentage is obtained and percentages of the total number of people living with HIV can be compared between countries.

Table 1: Regional HIV/AIDS statistics and feature for the years 2004 and 2006 (collected from UNAIDS/WHO AIDS Epidemic Update, 2006a: 12)

Regional HIV and AIDS statistics and feature, 2004 and 2006

	Adults and children living with HIV	Adults and children newly infected with HIV	Adult prevalence (%)*	Adult and child deaths due to AIDS
Sub-Saharan Africa				
2006	24.7 million [21.8–27.7 million]	2.8 million [2.4–3.2 million]	5.9% [5.2%–6.7%]	2.1 million [1.8–2.4 million]
2004	23.6 million [20.9–26.4 million]	2.6 million [2.2–2.9 million]	6.0% [5.3%–6.8%]	1.9 million [1.7–2.3 million]
Middle East and North Africa				
2006	460 000 [270 000–760 000]	68 000 [41 000–220 000]	0.2% [0.1%–0.3%]	36 000 [20 000–60 000]
2004	400 000 [230 000–650 000]	59 000 [34 000–170 000]	0.2% [0.1%–0.3%]	33 000 [18 000–55 000]
South and South-East Asia				
2006	7.8 million [5.2–12.0 million]	860 000 [550 000–2.3 million]	0.6% [0.4%–1.0%]	590 000 [390 000–850 000]
2004	7.2 million [4.8–11.2 million]	770 000 [480 000–2.1 million]	0.6% [0.4%–1.0%]	510 000 [330 000–740 000]
East Asia				
2006	750 000 [460 000–1.2 million]	100 000 [56 000–300 000]	0.1% [<0.2%]	43 000 [26 000–64 000]
2004	620 000 [380 000–1.0 million]	90 000 [50 000–270 000]	0.1% [<0.2%]	33 000 [20 000–49 000]
Oceania				
2006	81 000 [50 000–170 000]	7100 [3400–54 000]	0.4% [0.2%–0.9%]	4000 [2300–6600]
2004	72 000 [44 000–150 000]	8000 [3900–61 000]	0.3% [0.2%–0.8%]	2900 [1600–4600]
Latin America				
2006	1.7 million [1.3–2.5 million]	140 000 [100 000–410 000]	0.5% [0.4%–1.2%]	65 000 [51 000–84 000]
2004	1.5 million [1.2–2.2 million]	130 000 [100 000–320 000]	0.5% [0.4%–0.7%]	53 000 [41 000–69 000]
Caribbean				
2006	250 000 [190 000–320 000]	27 000 [20 000–41 000]	1.2% [0.9%–1.7%]	19 000 [14 000–25 000]
2004	240 000 [180 000–300 000]	25 000 [19 000–35 000]	1.1% [0.9%–1.5%]	21 000 [15 000–28 000]
Eastern Europe and Central Asia				
2006	1.7 million [1.2–2.6 million]	270 000 [170 000–820 000]	0.9% [0.6%–1.4%]	84 000 [58 000–120 000]
2004	1.4 million [950 000–2.1 million]	160 000 [110 000–470 000]	0.7% [0.5%–1.1%]	48 000 [34 000–66 000]
Western and Central Europe				
2006	740 000 [580 000–970 000]	22 000 [18 000–33 000]	0.3% [0.2%–0.4%]	12 000 [<15,000]
2004	700 000 [550 000–920 000]	22 000 [18 000–33 000]	0.3% [0.2%–0.4%]	12 000 [<15 000]
North America				
2006	1.4 million [880 000–2.2 million]	43 000 [34 000–65 000]	0.8% [0.6%–1.1%]	18 000 [11 000–26 000]
2004	1.2 million [710 000–1.9 million]	43 000 [34 000–65 000]	0.7% [0.4%–1.0%]	18 000 [11 000–26 000]
TOTAL				
2006	39.5 million [34.1–47.1 million]	4.3 million [3.6–6.6 million]	1.0% [0.9%–1.2%]	2.9 million [2.5–3.5 million]
2004	36.9 million [31.9–43.8 million]	3.9 million [3.3–5.8 million]	1.0% [0.8%–1.2%]	2.7 million [2.3–3.2 million]

Figure 1 also gives a clear view on the HIV/AIDS epidemic worldwide and in Sub Saharan Africa, from 1985/1990 to 2005. The number of people living with HIV seems to increase, globally as well as in Sub Saharan Africa. This is probably also due to population growth. The adult HIV prevalence trend appears to be stable in the last years in Sub Saharan Africa (Report on the Global AIDS epidemic, 2006).

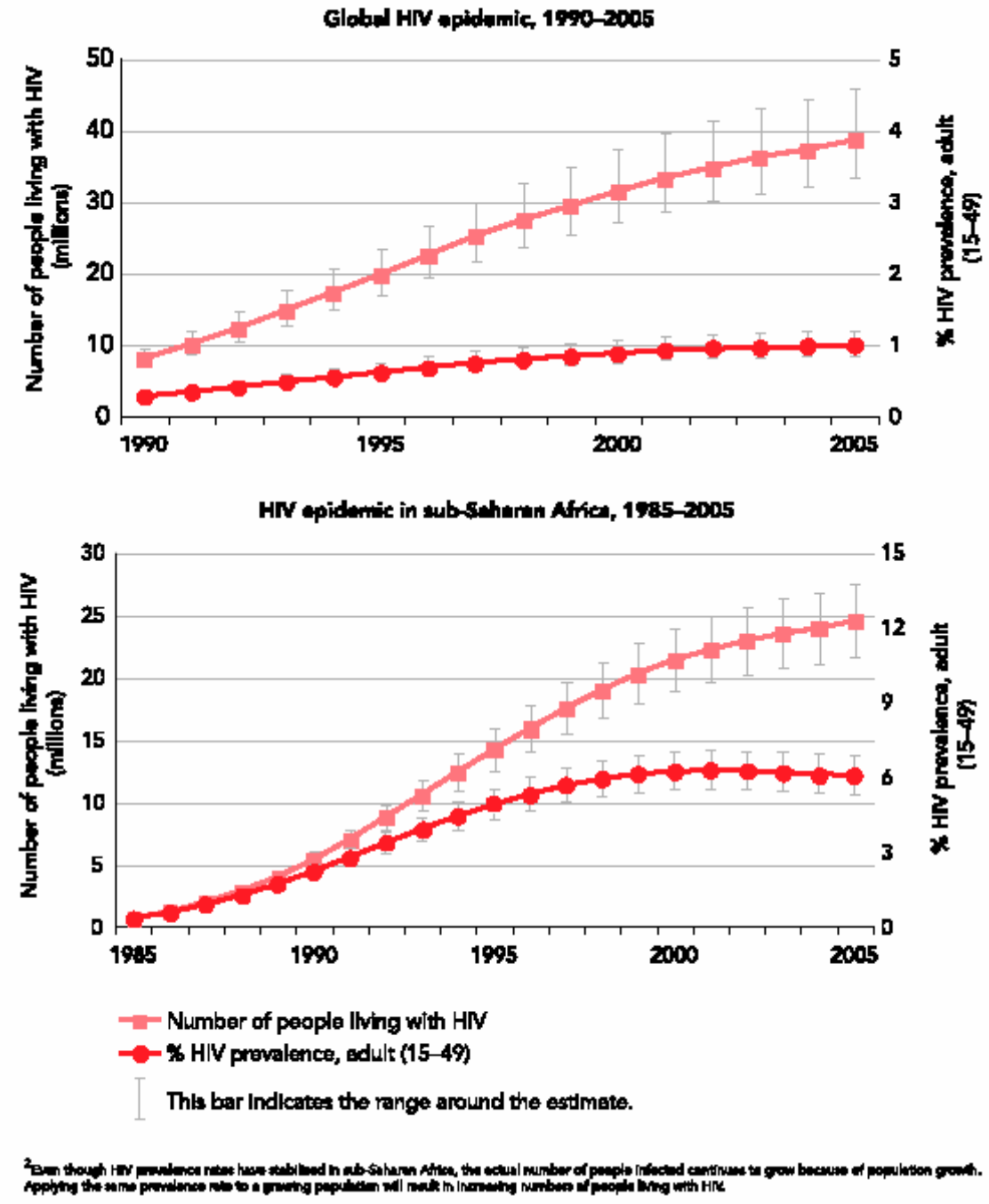

Figure 1: Number of people living with HIV and adult HIV prevalence rate, globally and in Sub Saharan Africa, from 1985/1990 to 2005 (collected from Report on the Global AIDS epidemic, 2006: 12)

In Sub Saharan Africa women bear a disproportionate part of the AIDS burden: not only are they more likely than men to be infected with HIV, but in most countries they are also more likely to be the ones caring for people infected and affected by HIV/AIDS (UNAIDS/WHO AIDS Epidemic Update, 2006b).

While there is evidence that some epidemics in this region are diminishing, most country trends appear to be stable. In essence, this reflects equilibrium: the number of people newly infected with HIV roughly equal the number of people dying of AIDS (UNAIDS/WHO AIDS Epidemic Update, 2006b).

Provision of Antiretroviral therapy has expanded dramatically in Sub Saharan Africa, including South Africa (see also following paragraph 1.4.). More than 1 million people were receiving treatment by June 2006, a tenfold increase since December 2003. But it is still not enough. The scale of need in this region is very high and it means that a little less than one quarter (23%) of the estimated 4,6 million people in need of antiretroviral therapy are receiving it (UNAIDS/WHO AIDS Epidemic Update, 2006b).

Even more detailed, Southern Africa remains the epicentre of the global HIV/AIDS epidemic: 32% of people with HIV globally live in this sub region and 34% of AIDS deaths globally occur here (UNAIDS/WHO AIDS Epidemic Update, 2006b).

The distinct differences in regional HIV/AIDS trends in terms of modes of transmission and burden of disease – and the social, cultural and economic environments in which these exist – must be taken into account in helping regions, nations and local communities design effective interventions (Erb-Leoncavallo et al., 2004).

1.3. HIV prevalence in South Africa

HIV data gathered in the country's extensive antenatal clinic surveillance system suggest that HIV prevalence has not yet reached a plateau. The latest data show a continuing, rising trend nationally in HIV infection levels among pregnant women attending public antenatal clinics (see figure 2: HIV prevalence by age group among antenatal clinic attendees in South Africa, 2000-2005). The numbers are shocking: 40% of pregnant women between 25 and 30 years old is infected with HIV (in 2005). The HIV prevalence rate among young people however may be stabilizing. Antenatal surveillance suggests that HIV prevalence among 15 to 24 year-old pregnant women has remained relatively stable since 2000, from 14% to 16% among 15 to 19 year-olds and from 28% to 31% among 20 to 24 year-olds (UNAIDS/WHO AIDS Epidemic Update, 2006b).

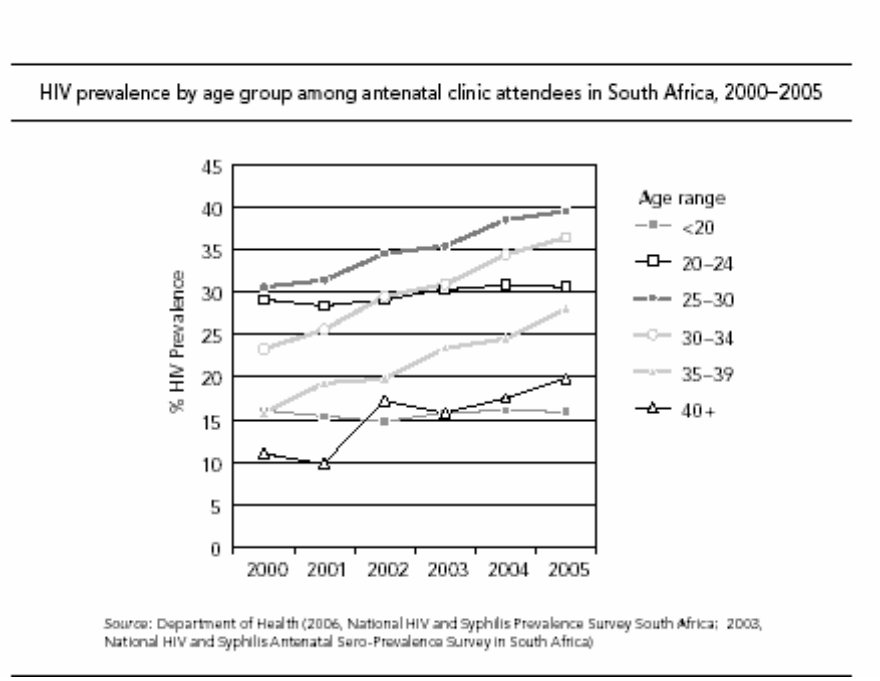

Figure 2: HIV prevalence by age group among antenatal clinic attendees in South Africa, 2000-2005 (collected from UNAIDS/WHO AIDS Epidemic Update, 2006b: 13)

Following figure shows the national HIV prevalence rate among pregnant women attending antenatal public clinics in South Africa, 1990-2005. Nationally, 30,2% of pregnant women was infected with HIV in 2005 while in 2004 the prevalence rate was estimated to be 29,5%. An increasing trend in national HIV prevalence is noticeable (Department of Health in South Africa, 2005).

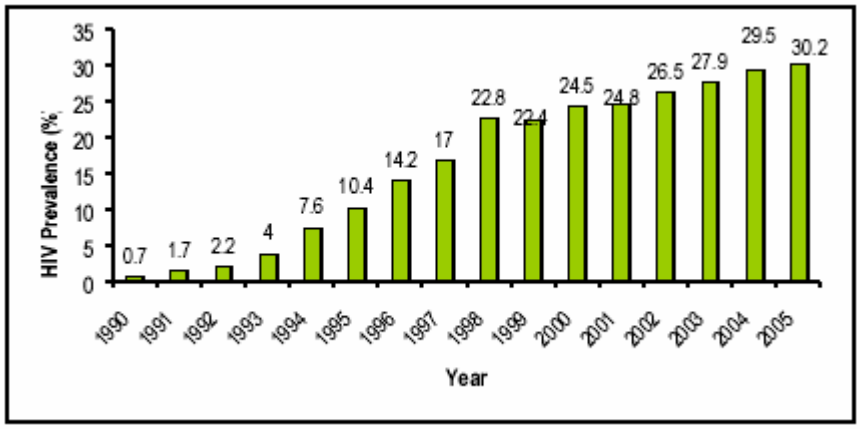

Figure 3: National HIV prevalence rate among pregnant women attending antenatal public clinics in South Africa, 1990-2005 (collected from the Department of Health in South Africa, 2005).

On a population of 45 million people in South Africa, more than 5 million (more than 1/9) people live with HIV (FOD, 2006). These numbers are worrying and affirm that effective HIV/AIDS prevention is necessary. As in the rest of Sub Saharan Africa, the HIV/AIDS epidemic in South Africa disproportionately affects women. Young women of 15 to 24 years old are four times more likely to be HIV infected than young men of the same age. South Africa's epidemic has now reached the stage where increasing numbers of people are dying of AIDS (UNAIDS/WHO AIDS Epidemic Update, 2006b).
The consequences are even that bad that the increasing death toll has driven life expectancy below 50 years in three provinces, namely KwaZulu-Natal, Free State and Eastern Cape (Actuarial Society of South Africa, 2005).

Despite these findings, a large proportion of South Africans do not believe that they are at risk of becoming HIV infected. This has as a result that people are not motivated to take an HIV test. Approximately two million South Africans living with HIV do not know that they are infected and believe they face no danger of becoming infected - therefore are unaware that they can transmit the virus to others. In the absence of an increase in HIV testing uptake, HIV infected persons typically would only become aware of their positive status when they become symptomatic (AIDS stadium), which can also limit the potential benefit of antiretroviral treatment (UNAIDS/WHO AIDS Epidemic Update, 2006b).

1.4. HIV/AIDS prevention at political level

The HIV/AIDS policy of Mbeki, the current president of South Africa, includes 2 parts: prevention and treatment. Prevention of HIV/AIDS in South Africa does not yet have a grip on the spreading of the disease. Treatment, on the contrary, knows progress. More and more people who are infected with HIV receive antiretroviral therapy (Report on the Global AIDS epidemic, 2006).

But let us restrict to prevention for the purpose of the research. Considering raising awareness and education on the one hand and condom distribution on the other hand, the implementation of policy goes rather well. Through condom distribution and raising awareness on condoms, an increase in condom usage has been specified, however this increase is still small. Free delivery of ARV's to prevent HIV infection among rape victims and HIV transmission from mother to child has only been approved since April 2002. The delay was due to the government of Mbeki judging ARV's as poisonous. In the very same period the government also confirmed the link between HIV and AIDS. Before, it denied this link and saw poverty and undernourishment as the main causes of AIDS in Africa. Regarding VCT, it also took the government a long time to realize the importance of turning into action. VCT is nonetheless crucial for raising awareness on the disease and for preventing stigmatization. The establishment of services that can provide VCT freely is running quite slow (Sanders, 2003).

A remark on the HIV/AIDS policy of Mbeki is that programmes and campaigns are too much directed at youth. The general opinion is that more attention should be given to those of 25 and older who do not know a decrease in the number of HIV infections (Sanders, 2003). In addition, programmes must be far more closely related to the local socio-cultural context (Piot, 2006; Sanders, 2003).

To conclude, a more efficient and effective HIV/AIDS policy is possible when there is more political will and a greater engagement of people at the top. Political leaders need to take their responsibility in the fight against HIV/AIDS (Sanders, 2003). HIV/AIDS needs to be kept high on the political agenda of national policy and budgets need to be made available. Extra financing and policy measures are necessary to stave off the development reversals and to restore both capacity and human capital (Piot, 2006). Government has to implement AIDS plans as promised. Furthermore, the troubled relation between the government and the NGO sector needs to be resolved. After all, only in a multi-sectoral way and through good cooperation and communication between different actors, the HIV/AIDS epidemic can be dealt with efficiently and effectively (Sanders, 2003).

2. THE CONTEMPORARY SOCIO-CULTURAL BARRIERS IN PREVENTION OF HIV/AIDS IN SOUTH AFRICA

2.1. Gender inequality and the link with HIV/AIDS

South Africa is a middle income country in global terms and wealthy within the African context, but it is one of the most unequal societies in the world (Albertyn, 2003). The inequality is expressed in many forms. This study highlights one of them, namely gender inequality. This inequality between men and women is one of the root causes of the spread of HIV infection, especially among young women, and is thus seen as a socio-cultural barrier in HIV/AIDS prevention. The context of gender inequality makes the application of existing preventive measures very difficult. HIV prevention programmes can only be effective when they take this issue into account and deal with it properly.

First, we give explanations on the concept ‘gender’ in combination with gender roles, gender stereotypes and gender appreciation. Following, we discuss the socio-cultural gender inequality in South Africa.

2.1.1. The concept Gender

Often the terms ‘sex’ and ‘gender’ are mistaken one for the other. This is not surprising as the concept ‘gender’ is only recently discovered. The origin is English and it makes a distinction between the biological identity and the socio-cultural interpretations and definitions of masculinity and femininity. The term ‘gender’ is used to describe the various characteristics assigned to women and men by a given society. The differences between men and women are culturally defined. It is a definition of what it means to be a man or a woman in a certain society. The term ‘sex’ refers to biological differences between men and women. ‘Gender’ is socially constructed and learned. Children learn how to behave as a boy or a girl in a particular community. ‘Sex’ is given by birth. ‘Gender’ can change over time and varies from culture to culture, local context to local context, generation to generation, etc. It also depends on religion or ideology, culture or sub culture, political/economic/social structure, the historical context, the legal context, sort of people (nomads, hunters, urban people, etc.), age, and social class or cast. ‘Sex’ on the contrary is invariable and universal. Let us explain with an example of ‘sex’ and ‘gender’ respectively. Only women can give birth to children and only men can ejaculate and thus impregnate women (→ sex). Women and men can work as a teacher, an engineer, a labourer, etc. (→ gender) (Van Geertruyen, 2006).

The concept ‘gender’ refers to certain gender roles, stereotypes and appreciation. Gender roles are roles, tasks and responsibilities of men and women as determined by society. The gender roles can be influenced and changed individually as long as the personal changes are acceptable within the hegemonic norms and values of society.
Gender stereotypes are attitudes, actions and behaviours that are typically masculine or feminine according to the cultural norm in a certain society. For example, men are expected to be dominant while women are expected to be discrete, or men are rational while women are rather emotional.
Gender appreciation refers to the social position of men and women, the appreciation that is given to masculinity and femininity in society. For example, the opinion of a man equals three opinions of a woman; or in the mask culture a man is in possession of the mask (power), while a woman is not allowed to see the mask. If a woman has seen the mask, she will be killed (Van Geertruyen, 2006).

Gender relations and roles as such are not problematic. After all, ‘gender’ is a socio-cultural construction that a group of people or a community needs to organise and structure living together. ‘Gender’ as such is a neutral word. The gender relations and roles become problematic when one of the two genders (men or women) is socio-culturally, economically and/or socio-politically harmed, discriminated against, marginalized or suppressed in relation to the other gender, precisely on the basis of gender identity. It is problematic when this is done in such a way that he or she is excluded from development in the sense of being able to give direction to his or her life and future. In many countries, a woman is in a marginalized position in relation to the man. This demands a certain focus because it is important that women can sustain their basic needs, can participate in society and have the right of self-determination (Van Geertruyen, 2006).

2.1.2. Socio-cultural gender inequality as barrier

2.1.2.1. Dominance of men over women and vulnerability of women

There still exists an enormous gender inequality in South Africa. Men think that women are subordinate to men and that women need to obey men. Men think they have the right to use their power over women and as a result have the right to exact sex from women. This male dominance over women is embedded in local culture and social life (De Bok, 2003).

Gender inequality makes women more vulnerable to HIV infection than men and explains the increasing HIV prevalence among women, and especially among young African women. The vulnerability of women to HIV/AIDS is affected by many factors including (social and economic) gender inequality, poverty[6], race[7], age[8], physiology[9], marital status[10], geographic location[11], work-related issues[12], migration and being a refugee (Albertyn, 2003).
These factors are more or less discussed in the following paragraphs because many are linked with each other. Yet, economic gender inequality and poverty are explained now. These two factors have a clear link with socio-cultural gender inequality.

Due to poverty – African women predominate among the poor (Budlender, 2002) – many women enter the sex industry or engage in a short- and long-term sexual relationship to sustain their basic needs such as shelter, food or other basic necessities, as a means of survival (Collins & Rau, 2000). It even occurs that older men search for school girls' sexual services in exchange for school money (money to pay school books, a school uniform or school fees) and food (Erb-Leoncavallo et al., 2004; Lewis, 2003). These older men are also called 'sugar daddies'. They prefer young girls because they believe that these girls are less likely to be HIV infected (Lewis, 2003).
Commercial sex workers sell sex in order to feed and provide for their families. Their illegal and unequal position as sex workers means that they face intense stigmatization and are intensely vulnerable to violence and exploitation by police and clients. As a result, they are most often unable to protect themselves against HIV/AIDS by insisting on the use of a condom and by accessing health services (Nairne & Delany, 2001; Vetten & Dladla, 2000).

When a woman is economically dependent on a man and the man does not want to use a condom in the sexual relationship, the woman will take the risk of not using a condom, out of fear that the man will leave her and thus she will loose his economic support when she keeps insisting on condom use.

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[6] Poverty can lead to transactional sex and prostitution, without the use of a condom.
[7] It is suggested that HIV prevalence in the black African population is high because of the social effects of forced removals, the migrant labour system, and the gradual breakdown of the traditional value systems. Besides this, the patriarchal culture plays a determining role in the way sexual relationships are performed (Johnson & Budlender, 2002).
[8] Women tend to become infected in their teens and early twenties. Men attract more sexual partners as they enter employment and acquire socio-economic status, and hence get infected at older ages on average (Johnson & Budlender, 2002).
[9] It is suggested that women are 2 to 4 times more susceptible to HIV/AIDS than men (Albertyn, 2003).
[10] Married women and widows have particular vulnerabilities (Albertyn, 2003). See also further.
[11] Rural women have special vulnerabilities (Albertyn, 2003). See also further.
[12] Sex workers, women in mobile professions such as nursing or teaching, etc. (Albertyn, 2003).

As mentioned before, many girls and women are involved in sexual activities with men as a survival strategy. HIV/AIDS is not such a concrete threat as the fear of living in the streets without food (Adams & Marshall, 1998). The costs of avoiding risk would be too high (Albertyn, 2003). Economic dependency of women and vulnerability of women is shown in the following answer which a South African woman received from her husband when she asked to use a condom: "*If you want me to have sex with a condom, I won't give you any money for food"* (quoted in Lewis, 2003: 11).

Further research suggests that the meaning and practice of sex in Africa is viewed more objectively and instrumentally than in many Western societies. In South Africa, social norms of bartering sex are seen both in accessing necessary goods (food, shelter and school fees) and in other forms of transactional sex in which women (especially young women) exchange sex for material goods (cell phones, designer brand clothing or buckets of take-away chicken). The latter form of transactional sex has little to do with poverty in se (Leclerc-Madlala, 2000, 2001). Economic realities and social pressures to have the 3 C's - 'cell phones, cash and cars' – make refusing these advances of men difficult, and girls may actively seek out men for this kind of relationship (Lewis, 2003). Research argues that this form of transactional sex emerges from income inequality and consequently economic dependency on men, combined with inherited cultural norms around sexuality that make it more difficult for young women to resist sexual advances of older men. In short, the exchange nature of sexual activity in South Africa puts girls and women at increased risk of HIV infection and plays a major role in sustaining the HIV/AIDS epidemic (Leclerc-Madlala, 2000, 2001).

2.1.2.2. Socio-cultural norms and values around gender and sexuality

In South Africa, it has been suggested that patriarchal social and cultural norms result in women having little say over sexual relations and almost deny women autonomy and equality in the private sphere.

> As Barbara Klugman writes:
> "*If a husband initiates sex, his wife may not refuse him; the same applies in relationships outside of marriage. This makes it impossible for women to protect themselves from HIV/AIDS by initiating non-penetrative sex…or insisting on fidelity or condom use. Women are…also products of this culture and may themselves have internalised ideas of manhood that make it appropriate for men to have many partners and to manage sexual relations while they accept their partner's dominance and remain faithful."* (quoted in Albertyn, 2003: 599-600)

A number of researchers have identified widespread social acceptance of these power relations where the conditions and timing of sex are defined by male partners, giving women little or no opportunity to discuss or practice safe sex (Wood & Jewkes, 1998). Women do not have the power to protect their own bodies and to determine their sexual life. It is assumed that men take all the decisions, such as relating to condom usage (Maharaj, 2001). Again, this confirms women's vulnerability to HIV infection. The way in which sexuality is experienced is modifying in transmission of the virus.

It also becomes more and more clear that many women who are infected or at risk of becoming infected with HIV do not practice high risk behaviours, but are frequently married or in a monogamous relationship. They are vulnerable, largely because of the behaviour of others, through their limited autonomy (UNAIDS, 2006b).
Often couples assume their marriage is monogamous and stop using condoms as a sign of faithfulness (Erb-Leoncavallo et al., 2004). A study of Maharaj (2001) in KwaZulu-Natal (South Africa) declares that condom use in steady, long-term relationships may be interpreted as a clear sign of infidelity or lack of trust between partners. Condom use is associated with promiscuity. The perceived emotional benefits of unprotected sex may be seen as more important than the risk of HIV/AIDS.
Some of the reasons for the high rates of HIV infection among married women are linked with the very same reasons that some people marry: they want to have children. They frequently put themselves at risk of HIV infection because motherhood/fatherhood is socially appreciated (Erb-Leoncavallo et al., 2004). Often the husband will insist that the wife should not worry about falling pregnant and passing the virus on to the child because she has a marital duty to produce children (Leclerc-Madlala, 2000).

2.1.2.3. Stereotypical behaviour of men and women

In many parts of the world, traditions tolerate and even encourage men to have multiple sexual partners. Women on the other hand, are expected to abstain or to be faithful to their partner (The Global Coalition on Women and Aids, 2006b).

Men resort to sexual manifestations, as having multiple sexual partners and the use of sexual violence (see the following paragraph 2.1.2.4.) to protect their manliness and to boost their self esteem. Due to economic circumstances, men can no longer fulfil gender expectations of being the breadwinner and the head of the household. They feel disempowered. Manliness has developed over the years and nowadays it focuses on sexuality because herein men feel they still have control. The current ideal of manhood is the broad manifestation of the double sex moral (men can have multiple sex partners while women are expected to remain faithful to their partner) and control over women, especially their sexuality. Men use the tradition of polygamy to legitimate the many sexual partners they strife for. A good example of control over women's sexuality is virginity testing among young, unmarried girls (Van Hoe, 2005).

Furthermore, gender expectations dictate that young men gain experience in sexual matters before marriage while young women remain virgins until marriage. As a consequence, young women often receive little sex education (De Bruyn, 2002). They are expected to know little about sex, sexuality or HIV/AIDS, and remain dangerously uninformed (The Global Coalition on Women and Aids, 2006b). Gender roles make it difficult for women to discuss sex with their husband and for men to admit they are worried about STI's. Simply by fulfilling their expected gender roles, men and women are likely to increase their risk of HIV infection (Erb-Leoncavallo et al., 2004). In addition, education on reproductive matters may often only target girls, leaving men with no sense of responsibility in this area and a lack of information on issues such as contraception, emergency contraception, the risks of early pregnancy and unsafe abortion (De Bruyn, 2002).

2.1.2.4. Violence against women and girls

Gender inequality is also expressed through (sexual) violence against women. If we look at the historical background of South Africa, several phases have made violence to be included in the notion of manhood: the work in the mines (physical strength, roughness, violence and risk behaviour were emphasized), repression and resistance during Apartheid (political, militant violence was encouraged) and gang ups in townships (violence is rewarded with honour and respect). These phases form the breeding ground of using and accepting violence to resolve conflicts or to express dissatisfaction. The notion that violence is inherent to masculinity and the notion that women need to be held under control make certain forms of violence against women acceptable (Van Hoe, 2005). The most prevalent forms of violence against women are perpetrated by their intimate partners. Social norms in many countries condone domestic violence and see it as a private, even normal matter (The Global Coalition on Women and Aids, 2006d).

Marriage in the South African context often involves the payment of bride wealth by the prospective husband's family to the family of his future wife. Implicit in this exchange is the transfer of decision-making authority to the husband and his family. This leaves women particularly vulnerable to physical violence if they refuse to submit to the sexual demands of their husband. Many men feel that the payment of bride wealth entitles them to demand sex whenever they desire. If the wife refuses, the man has the right to have forced intercourse with her. In this context, women have few opportunities for refusing sex or insisting condom use to protect their health (Maharaj, 2001). This is confirmed by another researcher, Suzanne Leclerc-Madlala (2000). Young men and women believe that a man has a right, or even a duty, to force himself on to a woman who displays reluctance or shyness. Gender-based violence itself is often seen as a sign of affection, showing how deeply the man cares.

Sexual violence makes effective prevention of HIV/AIDS totally impossible. The documentary 'Real men do not rape' of Karen de Bok (2003) highlights the issue of rape in South Africa. The rape incidence in South Africa is incredibly high. At least one in three South African women will be raped in her lifetime (Moffett, 2006). Almost half of perpetrators are HIV positive. Prevention of HIV/AIDS can only be effective when the issue of rape is being dealt with. Namely, several men who are infected with HIV want to spread the virus on purpose. They select girls who look nice and smart, the so called 'crème de la crème' of society. These girls are being raped and are exterminated by the virus within time.
Rape is also a way of impressing friends or other men. When for example a group of friends sees a girl passing, they might impress each other and compete with each other on who is going to get her. Once a young man steps forward in order to seduce the girl, he certainly wants to score to be in favour of his friends. If the girl refuses to have sex with the boy, the boy might rape her. Once back in the group, his friends will applaud his sexual act. This enthusiasm will only reinforce further rape (De Bok, 2003). In post-Apartheid, democratic South Africa, sexual violence has become a socially endorsed punitive project for maintaining patriarchal order. Men use rape to inscribe subordinate status on to an intimately known 'Other' - women (Moffett, 2006).

Some men are convinced that women are to be blamed for rape and men do not see their responsibility in this issue. They say that women provoke rape by wearing seductive clothing (like a mini skirt) (De Bok, 2003).

As mentioned before, women are often economically dependent on men which has as a result that women are often victims of abuse of power. Violence and the threat of it limit women's ability to protect themselves against HIV/AIDS. They risk violence when they insist on condom use. They may give in to male demands for unprotected sexual relations, even when they know the danger, and may stay in violent relationships because they have nowhere else to go (Erb-Leoncavallo et al., 2004; Maharaj, 2001).

Studies show that there is a clear link between sexual violence against women and girls and HIV infection. The physiological susceptibility of women and girls plays a role. During forced vaginal penetration, abrasions and cuts commonly occur, thus facilitating the entry of the virus through the vaginal mucosa. These conditions are magnified for young girls. Their reproductive tracts are not fully developed and are therefore prone to tearing during sexual activity. Moreover, they are more likely to experience sexual coercion than adult women (Erb-Leoncavallo et al., 2004).

All what is described above makes it clear that the ABC approach misses the point for the majority of women and girls in many cultures and situations. The strategy in se is inadequate to protect women and girls against HIV infection. Abstinence is meaningless to girls and women who are coerced or forced into sexual activity. Faithfulness offers little protection to wives whose husbands have several partners or were infected before they were married. Condoms require the cooperation of men, who may refuse to use them. Furthermore, married couples or couples in steady, long-term relationships frequently do not use condoms either because they want to have children or because condoms would indicate infidelity or a lack of trust between partners. It is frequently difficult for women, especially young women with older husbands, to refuse sexual relations. They may fear violence, rejection and abandonment, or they may simply believe that they are required by marriage to be sexually available (Erb-Leoncavallo et al., 2004).

2.1.2.5. Cultural myths

In South Africa, many cultural myths that people strongly believe are spread around villages and cities. These myths are a socio-cultural barrier in prevention of HIV/AIDS because they reform the accurate messages about effective HIV/AIDS prevention and mislead people with wrong and confusing information. An example of such a myth is the cultural superstition that sex with a virgin cures HIV/AIDS. It is said that this belief has directly increased incidences of rape of girls, even babies by HIV positive men. Catherine Albertyn (2003) expresses in her article that gendered cultural norms around HIV/AIDS portray women as both cause (sexual promiscuity) and salvation (virginal purity). In both instances, women's subordination and vulnerability is increased.
Also the South African government has sent wrong and meaningless messages about HIV/AIDS into the world, for example messages of ex-vice president Jacob Zuma[13] and of minister of Health Care Manto Tshabalala[14].

[13] Ex vice-president Jacob Zuma was cleared of rape of a female friend on the 9th of May 2006. The trial left many AIDS organisations in South Africa with a feeling of disappointment. Jacob Zuma declared in court that he did not use a condom while having sex with the woman and while knowing she was HIV positive. He was convinced that a shower after sex would protect him adequately against HIV infection. This was very shocking news as Zuma used to be the chairperson of the South African National AIDS Council and used to be the face of different other campaigns that promote sexual values. Many South Africans saw him as thé authority when it comes to HIV/AIDS. Since his declaration, many young people call the AIDS line to ask if a shower can protect

2.1.2.6. Cultural or customary practices

Some cultural or common practices increase the vulnerability of women and girls to HIV infection. A common practice that affects a large number of women occurs when migrant workers, who have a customary wife at home in the rural areas, marry or cohabit with urban wives. This enhances the vulnerability of both wives (Albertyn, 2003).

In many countries, including several with high rates of HIV infection, girls are married in their teens – often as a poverty-reduction strategy and against their will. Today, the majority of sexually active girls, aged 15 to 19, in developing countries are married. Ironically perhaps, these girls have significantly higher rates of HIV infection than their sexually active, unmarried peers (The Global Coalition on Women and Aids, 2006a). A possible explanation is that young married women are more sexually active than their unmarried counterparts, and abstinence and condom use are generally rare options. Hence, men are encouraged by culture to have many sexual partners. When married men are unfaithful, they risk becoming infected and can then pass the virus on to their wife (The Global Coalition on Women and Aids, 2006d). It is also said that young girls are particularly susceptible to HIV infection because of their early stage in physical development. When they marry older men – that is often the case because financially older men are better off than young men – the risk of infection becomes even higher. Older men are likely to have had previous sexual partners and therefore are more likely to have been exposed to HIV, and are also less predisposed to use condoms than younger males. Unmarried but sexually active girls are more likely to have relationships with younger men, who are more inclined to favour condom use (The Global Coalition on Women and Aids, 2006a).

2.1.2.7. Stigmatization and discrimination

There is growing evidence in South Africa that HIV/AIDS deepens the stigmatization of women. They are blamed for AIDS and are portrayed as vectors of the disease who contaminate their partners and children. Blaming women has as a result that men do not take their responsibility in the spread of HIV/AIDS (Albertyn, 2003) which hampers effective prevention. When men deny their responsibility in the spread of HIV, they will not be keen to use condoms in sexual encounters. Stigmatization of women hinders behavioural change among men.

Disclosing the HIV positive status in the community can have serious consequences for women whereas some have been abused, beaten, abandoned, thrown out of their homes and jobs and some have even been killed (Erb-Leoncavallo et al., 2004). These ill practices in the community have certainly an impact on other HIV infected women. It inhibits those who know they are infected from sharing their diagnosis and taking action to protect others and from seeking treatment and care for themselves (UNAIDS, 2006a).

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them against HIV infection. Lovelife, an organisation concerned with education on HIV/AIDS says that they have to restrict the damage and fears years of campaign being lost (Hancké, 2006). At the moment, Jacob Zuma is presidential candidate.

[14] Last year, minister of Health Care Manto Thsabalala thought that AIDS could be treated with garlic, red beets, potatoes and lemon juice. According to Peter Piot, UNAIDS director, this declaration has caused a lot of damage to effective HIV/AIDS prevention (Delepeleire, 2006).

In addition, stigmatization of women hampers effective HIV/AIDS prevention in such a way that many people do not take an HIV test. People are afraid of the results and young women may face stigmatization when they are seen entering VCT services because of speculations about their morality (De Bruyn, 2002). Moreover, many women and girls are reluctant to seek advice from sexual and reproductive health centres, for fear of stigmatization. They may also be deterred by the unhelpful and discriminatory attitude of staff in some centres (The Global Coalition on Women and Aids, 2006a).
Discrimination against women is a fact of life in all regions of the world, to varying degrees, and manifested in varying ways, for example in the access to economic opportunities. Women face difficulties finding and keeping paid work or earning a wage that is equivalent to men's. In some regions, they are not allowed to inherit or own property or are discouraged from doing so. In short, a woman has very few ways to support herself or her children without male protection (Erb-Leoncavallo et al., 2004). Such situations lead single women into poverty and being a possible victim of sexual exploitation by men.

2.2. Taboo and the link with HIV/AIDS

After Apartheid, sexual freedom became suddenly a right and there was more openness towards discussing gender equality. Yet, the other side of the picture included deep silence and denial of sexuality within certain themes, such as HIV/AIDS. Sexuality in se needed to be discussed, although not in association with certain subjects (De Koker, 2006). In this way, it is very difficult to talk about HIV/AIDS, sexuality and effective prevention because these are very sensitive topics when brought together. Cultural taboos surrounding these sensitive issues prevent many young people, especially young women from receiving or using information about prevention, services and effective prevention tools, such as condoms (The Global Coalition on Women and Aids, 2006d). HIV/AIDS prevention, sexual health and reproductive health are all susceptible to taboo (Erb-Leoncavallo et al., 2004).

3. STRATEGIES TO BREAK THROUGH THESE SOCIO-CULTURAL BARRIERS IN ORDER TO MAKE HIV/AIDS PREVENTION EFFECTIVE

The disproportionate impact of HIV/AIDS on women is an alarming issue. Urgent action is necessary and effective prevention of HIV/AIDS needs to start working for women and girls!

In a first part, general strategies to break through taboo and socio-cultural gender inequality are discussed. HIV prevention programmes in South Africa need to adopt those strategies to come to effective prevention in the field. We also describe what has been realised at state level concerning gender equality and what still needs to be accomplished. We end this part with a description of specific work with women and men.
In a second and last part, we give a short explanation on the female condom and microbicides as two (possibly) effective prevention tools over which women have more control.

3.1. Strategies aimed at taboo and socio-cultural gender inequality

3.1.1. In general

3.1.1.1. Taboo

Making sexuality debatable is a first necessary step in dealing with HIV transmission (De Koker, 2006). Research reveals that when young people receive quality education about sexuality, they are more likely to delay sexual activity and practice safe sex. They also tend to have fewer sexual partners. These positive results reduce the risk of HIV infection. There is thus an urgent need for increased investment in sexual and reproductive health services, information transfer and education (The Global Coalition on Women and Aids, 2006b)! This can be in combination with campaigns to promote condom use to break through taboo and feelings of shame (UNICEF Belgium, 2005).
Furthermore, more efforts must be made to offer primary and secondary education to boys and girls. Information about sexuality, puberty, reproductive health, human rights, HIV/AIDS and prevention must be part of life-skills curricula in all schools (The Global Coalition on Women and Aids, 2006d). In addition, information about where to go with questions or to ask advice on issues above needs to be part of programmes for boys and girls. Programmes need to ensure that extra emphasis is given to certain risk situations (for example alcohol abuse and using the condom wrongly) and to information that can have the greatest impact on reducing the vulnerability to HIV/AIDS (for example using sterile needles when taking drugs). Finally, programmes need to recognise and explain the link between STI's and HIV/AIDS and must emphasize the importance of treating such infections. HIV/AIDS education needs to follow a holistic approach. For example, when adolescents are victims of rape, early antiretroviral therapy may help protect them against HIV infection (De Bruyn, 2002).

Besides information transfer on sexuality and HIV/AIDS prevention, it is also necessary that women, girls, men and boys have the means to protect themselves against infection (Erb-Leoncavallo et al., 2004). Access to condoms needs to be ensured.

Closely related to breaking taboo, it is important to raise popular awareness on the risks marriage poses to teenage girls, and to encourage families to try to delay marriage for as long as possible. Many parents are still marrying their daughters younger and younger in the mistaken belief that this might protect them from infection. If families are unable to delay marriage for economic reasons, efforts should be made to ensure that young brides have access to both reproductive and sexual health services, and stay in school. This will enable them to continue to develop skills that will help them support themselves and their families in later life, and help increase their self-esteem. As described above, the link between level of education and safe sexual behaviour always needs to be taken into account. Finally, there is an urgent need for guidelines to be established about the links between child marriage and HIV infection. National AIDS strategies can then highlight these, and provide information to legislators that supports delaying the legal age of marriage. Even postponing a young girl's marriage by one year could greatly reduce the likelihood of her becoming infected (The Global Coalition on Women and Aids, 2006a).

Another way of talking about HIV/AIDS and prevention more easily is by better integrating HIV information and services into antenatal care and existing sexual and reproductive health services (The Global Coalition on Women and Aids, 2006d).

Encouraging dialogue between young men and young women will help ensure that young men are sensitized about respect and appropriate and inappropriate sexual behaviour, and that women are able to articulate what they want as well as what makes them comfortable.

Children should be socialized from an early age to respect the human rights of girls and women, to take responsibility and to reject gender discrimination and violence (Adams & Marshall, 1998; Erb-Leoncavallo et al., 2004). Thus campaigns should also be directed more towards parents, because they raise and socialize their children. Young people rarely talk about sex and STI's with their parents, although it is very important that they are able to do so (UNICEF Belgium, 2005).

In short, breaking the silence around above mentioned sensitive issues will raise awareness among people to turn into effective action (Erb-Leoncavallo et al., 2004). Making such topics debatable seems more easily acceptable and feasible for a community than immediate change of the norm and value system. Breaking taboo is a first step towards deeper, broader and sustainable change in gender relations, traditional practices and sexual behaviour.
It means that open dialogue in the community and between communities might be the most effective way of achieving change in social norms and values. It is suggested that values of equality are engaged within cultural conversations that enable the development of indigenous ideas of equality, freedom and autonomy. A simple 'trumping' of equality over culture, will not lead to sustainable results (Bronstein, 1998).

Depending on what is locally relevant and feasible, prevention campaigns can be very specific, for example discouraging concurrent partnerships. African community people should be given detailed information on socio-cultural barriers, the HIV/AIDS epidemic and its consequences. Instead of mobilizing the community, African villagers would need to be informed so that they can mobilize themselves (Hanson, 2005). An example of mobilization is Peer Education. This is an effective and efficient method whereby young people receive education about HIV/AIDS and are motivated to engage themselves in the fight against HIV/AIDS. They start an out-reach programme to educate peers. With good education, peer educators can talk to other young people about HIV/AIDS and prevention, can inform them about myths and at the same time can correct these myths, can spread correct information on HIV/AIDS and prevention in a language that is acceptable and adapted to youth. A well informed girl or boy shares its knowledge with class mates, family, etc. Exchange between schools could be organized because young people can reach other young people better and they can talk better to each other about sensitive topics (UNICEF Belgium, 2005). Peer education is also very effective as it gives people the opportunity to own HIV prevention and it is less controlled by top-down processes (Adams & Marshall, 1998).

3.1.1.2. Socio-cultural gender inequality

Socio-cultural gender inequality is dealt with by confronting the current culture of male dominance over women and the patriarchal norms and values – in which gender identities that render women extremely vulnerable to HIV infection in the family and community are being constructed, reinforced and reinvented. By questioning these norms and values (for example in Focus Group Discussions) change towards gender equality will eventually arise. Therefore, socio-cultural norms and values surrounding gender and sexuality need to be fully understood (Albertyn, 2003). It is important to believe that change is possible. Gender equality, empowerment of women and responsibility taken by men can be achieved, if sufficient attention, commitment and resources are available (Erb-Leoncavallo et al., 2004; UNAIDS, 2006b).

Strategies highlighted by the UN Task Force on Women, Girls and HIV/AIDS in Southern Africa (Erb-Leoncavallo et al., 2004) are:
- Challenging social norms and values that contribute to the lower social status of women and girls and condone violence against them. This can be realized through the use of drama and community-based educational initiatives.
- Increasing the self-confidence and self-esteem of girls through life-skills training and other school-based programmes in which girls are full participants. These programmes should discuss the risks of violence against girls and of intergenerational sex. Empowerment lessons for girls that emphasize assertiveness, leadership, critical reflection, communication and negotiation (of condom use) can also be implemented.
- Strengthening the legal and policy frameworks that support women's rights to economic independence. These rights include the right to own and inherit land and property for women. This can be realized by restructuring justice systems, enacting laws and training NGO's to popularize these laws.

- Ensuring access to health services and education, in particular life skills and sexuality education for both boys and girls, men and women (Erb-Leoncavallo et al., 2004), but also for HIV positive people and members of vulnerable groups such as young brides and sex workers (The Global Coalition on Women and Aids, 2006a). Health workers and teachers need to be trained to be gender sensitive, and health and education systems need to be participatory and community-centred, rather than bureaucratic and hierarchical (Erb-Leoncavallo et al., 2004).
- Empowering women and girls economically. This is possible by providing them with access to credit and economic opportunities. They can also learn business, entrepreneurship and marketing skills (Erb-Leoncavallo et al., 2004).

Gender inequality is also dealt with by addressing the specific needs and realities of women and girls (for example the risk of HIV infection within marriage) and by making men and boys aware of their tasks and responsibilities (Erb-Leoncavallo et al., 2004).
Reproductive and sexual rights are still too often ignored, at local and national level. Possibilities to fill this gap are awareness campaigns for men and women separately. For men, campaigns could be focussed on condom use and communication with the partner. For women, more attention could be given to strengthening self-confidence and communication skills. Discussion groups with men and women together could also encourage communication and mutual respect (De Koker, 2006). Hereby, it is very important that men and women are motivated to cooperate. Eventually, gender equality has to come from them and this could be stimulated by critical self reflection, debating, etc.
It is also good when sexual and reproductive rights are promoted within a Peer Education Model (Erb-Leoncavallo et al., 2004).

Following, gender-based violence as an expression of gender inequality needs to be addressed to prevent further spreading of HIV/AIDS. Education and promotion of human rights are two important strategies, but it is especially the cooperation of men that can fight violence against women and girls. Actively involving men in campaigns against gender-based violence and in campaigns that address masculine norms and behaviours that heighten the risk for both men and women of HIV infection is critical. Also when community and religious leaders are engaged in dialogue about human dignity and negative effects of violence against women and girls, they can set an example for the community. Besides this, broad-based media campaigns are another strategy to combat violence against women and girls. These campaigns should promote zero tolerance for gender-based violence at the community and household level (Erb-Leoncavallo et al., 2004). Finally, legal steps must be taken to protect women and girls against sexual coercion and violence in marriage or in a relationship outside of marriage (The Global Coalition on Women and Aids, 2006d). (Also see paragraph 3.1.4.)

Furthermore, harmful cultural myths, traditional practices and stereotypical notions of masculinity and femininity that underlie destructive behaviours and attitudes must be questioned and challenged in order for these to change (Erb-Leoncavallo et al., 2004).

Moreover, to remove some of the obstacles caused by stigmatization or fear of stigmatization, sensitization programmes can help reduce stigma, and training activities for health service staff can make services more user- and gender-friendly. HIV prevention strategies should also meet the needs of women living with HIV/AIDS. HIV positive women need to be able to access sexual and reproductive health services, without fear of stigma and discrimination.

When people living with HIV/AIDS can feel comfortable about being open about their status and where they can receive counselling and treatment to keep them healthy for longer and have a safe and satisfying sex life, they are far less likely to pass the virus on to others (The Global Coalition on Women and Aids, 2006a). When HIV positive people mobilize themselves, they can fight stigmatization and discrimination (UNAIDS, 2006a).
Health centres should provide VCT in a sensitive, respectful and safe environment (The Global Coalition on Women and Aids, 2006a). VCT reduces stigma, discrimination and violence against women and it encourages couples to take an HIV test and to remain faithful to each other (Erb-Leoncavallo et al., 2004).
Often men are discouraged from attending health services because of attitudes that contraception and reproduction is women's business. There is a need to make services more appropriate, accessible and available for boys and girls, without any form of stigma or discrimination. Programmes must ensure that persons of both sexes are welcomed (De Bruyn, 2002).

To conclude, the HIV/AIDS epidemic shows that efforts should focus simultaneously on individual behaviour change (ABC) and on wider social, cultural and economic changes. Strategies must be found that address the triple challenge of poverty, gender inequality and HIV/AIDS. Every aspect of effective prevention must address the critical role that gender plays in sexual and reproductive life and how it affects HIV prevention (Erb-Leoncavallo et al., 2004).

3.1.1.3. Creating a supportive environment

Prevention programmes, initiatives, activities, etc. that are supported by the local community have a greater chance of sustaining success. Assistance and advocacy from local community members can help a programme overcoming obstacles and help ensure that the programme addresses the needs of the local residents. Efforts to gain the support of community leaders, senior community members, religious leaders, parents, teachers, employers, and health sector staff should be made to ensure policies, activities and services that address the needs of young women and men equally (De Bruyn, 2002). People belong to all sorts of communities, and within such communities, they share values and influence each other. Change at community level is closely related to change at individual level and vice versa (Lucas, Rader, Duongsaa, Mphuka & Campbell, 2002). Community support can help legitimise the programme and provide many voices to help overcome possible resistance, especially relevant when the programme deals with very sensitive issues such as HIV/AIDS and gender inequality. Programmes can help sustain community support by organising interventions designed to assist those community members who influence youth and by providing community members with regular feedback on monitoring and evaluation results. Best practice programmes also allow young people to participate in project and programme planning, implementation and evaluation of organisations (for example NGO's) and of health services, so that these programmes become truly youth-orientated and youth-friendly. One way to achieve this is to ensure that at least some female and male adolescents are included in advisory committees that guide projects. It may be necessary to have a separate advisory committee of young women and young men so that young people have more support to participate. Participants can explore risk situations and negotiate strategies to promote sustainable behaviour change. Project leaders can emphasize the importance of the cooperation of young people by saying that their input and participation can reduce the spread of HIV/AIDS.

If young people are to be successful in adopting behaviours and practices that protect them from HIV and STI's, they must receive support from adults around them, such as praise and encouragement when they demonstrate gender awareness and sensitivity. In addition, young people should receive permission from adults to join in organised prevention efforts such as peer education (De Bruyn, 2002). Experience teaches us that youth, also HIV positive youth is very good in communicating the disease, in defending HIV prevention and in transferring knowledge. They can give an extra dimension to prevention campaigns (Erb-Leoncavallo et al., 2004).

3.1.1.4. Capacity building

A project should build on the strengths of people to realise individual, social, cultural and economic changes. People should be seen as subjects of their own development rather than objects of intervention. It is better to start from their capacities and knowledge and reinforce these. In this way, people come up with and implement local solutions, adapted to the socio-cultural context, with possible local guidance to deal with local problems effectively and sustainable. Local people and community-based organisations can develop effective prevention strategies as they are the ones who are confronted daily with socio-cultural gender inequality and other socio-cultural barriers. By listening to their experiences and concerns and by encouraging them in their fight against HIV/AIDS, people get more confidence and hope for a better future (The Constellation for AIDS Competence, 2006). Thus, those who advocate for change should better be members of a particular cultural or religious community, or work with activists from a particular community. This facilitates out-reach to other people in the community because they know the local culture and they can change cultural practices into gender and HIV/AIDS sensitive ones. It is also important not to focus on just one specific culture. Eventually, the democratic values of equality need to be implemented in whole society (Albertyn, 2003).
Sharing between communities to learn more about both successes and challenges in responding to HIV/AIDS through exposure to other's experiences, is an effective way of communicating the responses and concerns of one community to enlighten or stimulate the response of another. This makes HIV/AIDS prevention more effective in several places. It is logic to assume that these communities that are confronted daily with HIV/AIDS know best how to deal with the epidemic, instead of the answer coming from an external expert who is less aware of the local context (Lucas, Rader, Duongsaa, Mphuka & Campbell, 2002). Latter situation can only be relevant when a gender expert conducts a thorough gender analysis of the situation and designs a response to meet the different requirements of men, women, boys and girls. To expand the capacities of communities and of those working on HIV/AIDS programmes, the UN Task Force on Women, Girls and HIV/AIDS in Southern Africa recommended the following:
- Make an appeal to gender experts, as just explained.
- Address the fears and resistance that surround gender in order to prioritize initiatives that seek to challenge the current gender context.
- Support and strengthen local women's movements and organisations, and partnership between governments, women's organisations and community-based organisations.
- Increase public awareness and debate about the relationship between gender inequality and HIV/AIDS.
- Address the causes of gender inequality, not only the consequences
(Erb-Leoncavallo et al., 2004).

3.1.2. At state level

Now, a short review of what has been realised at state level concerning gender equality and what still needs to be accomplished. The article of Catherine Albertyn (2003) is our reference.

In April 1994, political power in South Africa shifted from the white minority government to one elected by all South Africans, from the Apartheid regime to liberal democracy with the African National Congress (ANC) in power and Nelson Mandela as president. A new Constitution was formed. A significant feature of this new democracy was the place it accorded women, envisaging a society in which there would be equality between women and men, and people of all races, promoted by an independent constitutional body (for example the Commission on Gender Equality). The equality between men and women was ensured by the development of policies and laws that accorded rights to women in the public and private spheres.
In the constitution of 1996, the ANC helped to secure more detailed rights for women, including rights to freedom and security of the person that are explicit on bodily autonomy, freedom from violence, reproductive choice, etc.
By 2000, women in South Africa enjoyed unprecedented political and legal equality in the form of political participation and entrenched human and legal rights.
The constitution also provided equal socio-economic rights for men and women, although until today these rights are still not accomplished for women. This is predominantly due to the fact that problems are too much addressed within the public sphere, meaning at state level (for example by laws and policies for equality). The problems also need to be addressed in the private sphere, meaning at family, community and cultural level. Hereby, attention must be given to patriarchal socio-cultural norms and values which hold women in positions of subordination in the family and community. It is necessary that laws are adequately implemented in society (Albertyn, 2003).
This is confirmed by the South African lobby group, the Gender Aids Forum (GAF) which is calling for a stronger emphasis on addressing gender inequalities. GAF says that South African law protects women's rights and supports gender equality on paper, but these laws are poorly enforced. The lobby group thinks more pressure needs to be put on the police (Irin PlusNews, 2004).

It is important to question if the new democracy has the capacities to spend budgets – if adequate budgets are available - and implement programmes. Often the political commitment to address women's private inequalities in sexual rights is present, however structural constraints make this impossible (for example weak provincial governments, bad service delivery, inefficient coordination, other priorities, inadequate capacitated staff, etc.). Removing the structural constraints will not be enough to achieve gender equality. It will take time to overcome these shortages, as well as to transform the deep, inherited inequalities in South African society. Deepening poverty among women, high rates of violence against women and high rates of HIV/AIDS among women show that the fight against gender inequality is not yet won (Albertyn, 2003).

For a review of initiatives globally (and nationally) for more gender equality and an effective response to the HIV/AIDS epidemic, see attachment 2.

3.1.3. Work with women

A new challenge for South African women's movement is to reach social and cultural environments. Until this day, the women's movement has no alliance with certain cultural or religious communities. For women's voices and demands to be heard, women need to be mobilized at all levels of society and alliances need to be rebuilt between community women, activists, and academics/researchers. Most crucially, it means supporting and assisting women, including HIV positive women, to organise collectively to fight gender inequality. Hereby, the link between gender inequality and vulnerability to HIV infection needs to be emphasized (Albertyn, 2003). By listening to women, critical changes in strategies, policies and laws can be discussed and implemented (Erb-Leoncavallo et al., 2004).

Active participation of women can define and give meaning to existing norms and values that govern social, cultural and political life. Cultures are social processes characterized by continuous change, activity and progress. Cultural meanings on gender identity have been contested and reinvented throughout history (Albertyn, 2003). At the moment, this is gradually happening again. The HIV/AIDS context challenges the current socio-cultural context and brings it necessarily to change and development.

The Global Coalition on Women and Aids stresses that women are not victims. Their vulnerability does not stem from inherent physical or psychological weaknesses. Their resilience in the face of hardship and difficulty must be recognized and strengthened (UNAIDS, 2006b). Moreover, women need to be empowered and their rights need to be promoted. Addressing the current unequal gender norms that reduce young women and girls' ability to make informed choices about their own sexuality is key to reversing the dramatic upward trend of HIV infection among young women and girls (The Global Coalition on Women and Aids, 2006a).

When women have the knowledge to protect themselves from HIV infection, they also need to have the power and the means to prevent HIV infection. Women need to learn how to discuss abstinence, unwanted sex and safe sex with their partner (Erb-Leoncavallo et al., 2004). Off course, men must be willing to listen to their partner.
In addition, it is necessary for women to find ways to start earning their own money. Here fore, income-generating projects are a good solution. This will give them more confidence to discuss condom use with their partner, because they will have less fear of loosing men's economic support (Erb-Leoncavallo et al., 2004), or it will allow them to escape from the violent relationship. Here again, men need to agree with their partner that she wants to earn her own money.

3.1.4. AND work with men

Although many HIV/AIDS organisations only consist of female staff or only work with women, luckily there are also South African men who share the same opinion as women and who think the subordination of women must come to an end. As shown in the documentary 'Real men do not rape', male street workers are concerned with the issue of sexual violence against women and girls and the link with HIV/AIDS. They confront other men and women with these issues and hold group discussions in taverns, schools, etc. In these conversations, several topics are discussed regarding gender identity, gender inequality, HIV/AIDS, effective prevention, rape, etc. and cultural beliefs, myths and attitudes are challenged. People are encouraged to reflect on these issues and to question daily life situations. Drama in schools and street theatre are effective ways of making people aware of gender inequality and the link with HIV/AIDS. The documentary even shows a fragment wherein a male street worker is talking to the women's movement (De Bok, 2003). Men should be encouraged to spread their opinion of gender equality and to organise themselves. They should be more actively involved in combating violence against women and girls. Men are the perpetrators of violence as well as the solution to violence. In some places, they gradually start to organise themselves and to analyse their behaviour and attitudes. Men should indicate the socio-cultural norms and stereotypes that increase the risk of HIV infection for both men and women (Erb-Leoncavallo et al., 2004).

Gender is not just about women and their rights, but also about the power relations between men and women. GAF says that women cannot take away the power of men, unless men are willing to cooperate. The role of men in promoting gender equality and in curbing the spread of the disease is critical, as existing interventions have so far concentrated on women (Irin PlusNews, 2004)! Programmes targeting women must embrace men as partners in order to help nurture social structures that are more supportive to women (The Global Coalition on Women and Aids, 2006d). If programmes only work with women, the social hierarchy and the lack of participation of women will never change and yet achieved improvements for women will never last (Van Geertruyen, 2006).

Men, boys and wider communities must be encouraged to fulfil their potential as positive forces for change in improving the situation of women and girls. Efforts to foster more equitable and respectful gender relations are essential (UNAIDS, 2006b). Men and boys can be a powerful force in challenging and recasting harmful stereotypes of masculinity, confronting violence against women and taking their share of responsibility for HIV prevention within intimate relationships (The Global Coalition on Women and Aids, 2006d).

3.2. The female condom and microbicides

This paragraph will give a short explanation on the female condom and microbicides as two (possibly) effective prevention measures over which women have more control.

Given the HIV/AIDS epidemic's disproportionate impact on women, there is a critical need to develop prevention options that women can use with, or when necessary without, their partner's knowledge and consent. Unless women gain greater access to effective prevention tools that they can control, global and national efforts to halt the spread of the disease cannot succeed. Improving prevention options for women requires both broadening current prevention strategies (as mentioned above: moving beyond ABC), and developing new technologies that enhance women's ability to protect themselves against HIV infection. This can reverse the trend whereby women get HIV infected in a monogamous relationship or marriage. In other words, the existing prevention strategies must be adapted to the socio-cultural context to address underlying vulnerabilities faced by women, and affordable access to prevention options that women can initiate and control must be ensured (The Global Coalition on Women and Aids, 2006c).

A first example of such a prevention option is the female condom. It remains an under-exploited option. While efforts to improve on existing models and to reduce the cost price are welcome, the female condom in its current form is still the only viable option that permits women to take the prevention initiative (The Global Coalition on Women and Aids, 2006a).
When used correctly and consistently, the female condom dramatically reduces the risk of HIV transmission. The female condom offers women a valuable alternative, especially for those whose partners refuse to use male condoms. Given its effectiveness, it allows women to place greater control over HIV prevention (The Global Coalition on Women and Aids, 2006c). Reproductive health workers in developing countries indicate that the demand for female condoms is high. But they also indicate that where the female condom would be more readily and cheaply available, many more women would be able to protect themselves from HIV and STI's. In Sub Saharan Africa for example, many women are contracting HIV and STI's from their husbands and desperately need to be able to protect themselves (The Global Coalition on Women and Aids, 2006a). Besides the availability that must improve, it is also necessary to provide more information and training to women and men on its use (The Global Coalition on Women and Aids, 2006c).
But in all this, it is important to question if a man will accept the use of the female condom by his partner. Maybe some men see the use of the female condom as undermining men's authority and as a result they can react with violence against their partner. Further research is recommended and results will probably vary along culture.
Finally, governments and international partners must invest more in boosting the supply and marketing of female condoms so that they become a more affordable and widely used HIV/AIDS prevention option (The Global Coalition on Women and Aids, 2006d).

Microbicides are a second option. The benefit of microbicides is that they are undetectable and can be inserted with relative ease several hours before sexual intercourse (Erb-Leoncavallo et al., 2004). Women insert the product in their vagina to prevent HIV transmission during sexual intercourse. The effectiveness of protection against HIV infection is 40% or more (Verstraete, 2006). But microbicides are still undergoing human trials in several sites. Researchers predict that a microbicide that is only 60% effective can prevent

more than 2,5 million infections within three years of its introduction (Erb-Leoncavallo et al., 2004).
Microbicides could take the form of a gel, cream, film, suppository, sponge, or vaginal ring that releases the active ingredient gradually. Microbicides would block or disable the HIV virus from the moment it enters the body, before it spreads (IPM, 2007). With increased investment in scientific research, a safe and effective microbicide could be developed within five to seven years (IPM Press Releases and statements, 2005).
Two types of microbicides are needed. One would be able to prevent pregnancy as well as HIV transmission. The other would act against the virus only and thereby offer the hope of conceiving while minimizing the risk of HIV transmission between partners and to an unborn child. The desire or pressure to conceive has stopped many women and men from using condoms even though they know they or their unborn child might become infected with HIV/AIDS (Erb-Leoncavallo et al., 2004).
Microbicides are intented as part of a broader package of prevention options. They would complement – not replace – options such as abstinence, mutual faithfulness and condom use, and yet would address a gap in current prevention packages – female control. This comprehensive HIV prevention package will eventually include HIV vaccines as well (The Global Coalition on Women and Aids, 2006c).
But still, it always remains necessary to give attention to the socio-cultural context. When microbicides in the form of a gel seem effective, people must also be willing to use them. In Kenya for example, the practice of dry sex, i.e. sex with a woman whose vagina is dry, is very common. When the gel will be marketed, there is a risk that Kenyan women will not buy or use the product because it can be felt as a lubricant. The product can be unattractive to people. As much as the effectiveness of the product is important, it is also important to take socio-cultural aspects into account. Social and medical scientists need to be aware of this and need to work together (Verstraete, 2006).

4. CONCLUSION LITERATURE RESEARCH

By reading scientific articles and reports of international development organisations on the issue of HIV/AIDS in South Africa and how to prevent it, we have reached the conclusion that HIV prevention is not in the least that obvious as compared to prevention in Western countries. The latest data show a continuing, rising trend nationally in HIV infection levels among pregnant women attending public antenatal clinics. The existing preventive measures, such as condom use, are still not applied enough. The ABC strategy (Abstain, Be faithful and use a Condom) sounds very easy, but in practice it is a different reality due to socio-cultural barriers. The strategy as such lacks in adequately protecting women and girls against HIV infection. Abstinence is meaningless to girls and women who are coerced or forced into sexual activity. Faithfulness offers little protection to wives whose husbands have several partners, as encouraged by culture, or were already infected before they were married. Condoms require the cooperation of men, who take all the decisions in sexual relationships and who may refuse to use them. Furthermore, married couples or couples in steady, long-term relationships frequently do not use condoms either because they want to have children or are socially pressured to conceive, or because condoms would indicate infidelity or a lack of trust between partners. It is frequently difficult for women, especially young women with older husbands, to refuse sexual relations. They may fear violence, rejection and abandonment and thus loosing a man's economic support, or they may simply believe that they are required by marriage to be sexually available. The ABC strategy can only be a viable and effective prevention option for women and girls if it is implemented as part of a multi-faceted package of interventions that seek to redress deep-rooted gender imbalances. Gender inequality is one of the root causes of the spread of HIV infection, especially among young women, and is thus seen as a socio-cultural barrier in HIV/AIDS prevention. The gender inequality is expressed in many ways, such as male dominance over women, unequal power relations between men and women, patriarchal socio-cultural norms and values around gender and sexuality that lead to subordination of women in sexual relationships, harmful stereotypes, dangerous cultural myths and practices, violence against women and girls, stigmatization and discrimination of women. Women and girls are confronted with a number of HIV related vulnerability factors (socio-economic, socio-cultural and biological), with which men are not confronted.

All this makes it clear that it is necessary for the current HIV/AIDS prevention to be adapted to the context of gender inequality and to specific needs and realities of African women and girls. HIV/AIDS prevention programmes and strategies need evaluation to see if they truly work for women and girls. Prevention programmes that promote gender equality, empowerment of women and women's rights, can gradually halt the spread of the disease. Such programmes need to be expanded, receive more resources and eventually be integrated in the national AIDS policy.
But we must not forget the active involvement of men and boys in the fight against HIV/AIDS. The role of men in promoting gender equality and in curbing the spread of the disease is critical! Men and boys have decision-making power and can be a positive force in challenging and recasting harmful stereotypes of masculinity, confronting violence against women and girls, and taking their share of responsibility for HIV prevention within intimate relationships.

Strategies must be designed and implemented to break through these socio-cultural barriers in HIV/AIDS prevention, such as confronting harmful patriarchal socio-cultural norms and values, cultural myths and gender identities (for example through debates, drama, cultural conversations, etc.). There is also a need for strategies that bring about positive attitudes and stimulate behavioural change towards gender equality (for example through campaigns). People need to strife for an environment without violence against women and girls, stigma and discrimination of women.

Prevention programmes, initiatives, activities, etc. that are supported by the local community have a greater chance of sustaining success. Assistance and advocacy from local community members can help a programme overcoming obstacles and help ensure that the programme addresses the needs of the local residents. Best practice programmes also allow young people to participate in project and programme planning, implementation and evaluation of organisations.
Furthermore, a project should build on the local strengths, capacities and knowledge of community people to realise individual, social, cultural and economic changes. People should be seen as subjects of their own development rather than objects of intervention. In this way, people come up with and implement local solutions, adapted to the socio-cultural context, with possible local guidance to deal with local problems effectively and sustainable.

In short, improving prevention options for women requires both broadening current prevention strategies (moving beyond ABC), and developing new technologies that enhance women's ability to protect themselves against HIV infection, for example the female condom and microbicides. This can reverse the trend whereby women get HIV infected in a monogamous relationship or marriage. In other words, the existing prevention strategies must be adapted to the socio-cultural context to address underlying vulnerabilities faced by women, and affordable access to prevention options that women can initiate and control must be ensured.

Finally, apart from gender inequality, there are other obstacles to effective HIV/AIDS prevention. In South Africa, it is very difficult to talk about HIV/AIDS, sexuality and gender inequality because these are very sensitive topics when linked with each other. Cultural taboos surrounding these sensitive issues prevent many young people from receiving or using information about prevention, services and effective prevention tools, such as condoms. Making sexuality debatable is a first necessary step in dealing with HIV transmission. In addition, awareness must be raised on these issues through quality education, information transfer, open dialogue and campaigns promoting condom use and gender equality. Breaking taboo is a first step towards deeper, broader and sustainable change in gender relations, traditional practices and sexual behaviour.

To conclude, the possibility and capacity of South Africa to curb the spread of HIV/AIDS, is determined by the possibility and capacity to break through taboo and gender inequality at different levels.

CASE STUDY: HIV/AIDS PREVENTION PROGRAMME OF TAI - KWAZULU NATAL

1. HIV/AIDS EPIDEMIC IN THE PROVINCE KWAZULU-NATAL

Provincial HIV prevalence rates show the geographic variations in the HIV/AIDS epidemic. Table 2 shows the provincial HIV prevalence rates from 2003 till 2005. KwaZulu-Natal is the province with the highest HIV prevalence rate. In 2005, it is almost 40% among antenatal clinic attendees (Department of Health in South Africa, 2005).

Table 2: Provincial HIV prevalence estimates among antenatal clinic attendees, South Africa, 2003-2005 (collected from Department of Health in South Africa, 2005)

PROVINCE	HIV pos. 95% CI 2003	HIV pos. 95% CI 2004	HIV pos. 95% CI 2005
KwaZulu-Natal	37.5 (35.2 – 39.8)	40.7 (38.8 – 42.7)	39.1 (36.8 – 41.4)
Mpumalanga	32.6 (28.5 – 36.6)	30.8 (27.4 – 34.2)	34.8 (31.0 – 38.5)
Gauteng	29.6 (27.8 – 31.5)	33.1 (31.0 – 35.3)	32.4 (30.6 – 34.3)
North West	29.9 (26.8 – 33.1)	26.7 (23.9 – 29.6)	31.8 (28.4 – 35.2)
Free State	30.1 (26.9 – 33.3)	29.5 (26.1 – 32.9)	30.3 (26.9 – 33.6)
Eastern Cape	27.1 (24.6 – 29.7)	28.0 (25.0 – 31.0)	29.5 (26.4 – 32.5)
Limpopo	17.5 (14.9 – 20.0)	19.3 (16.8 – 21.9)	21.5 (18.5 – 24.6)
Northern Cape	16.7 (11.9 – 21.5)	17.6 (13.0 – 22.2)	18.5 (14.6 – 22.4)
Western Cape	13.1 (8.5 – 17.7)	15.4 (12.5 – 18.2)	15.7 (11.3 – 20.1)
National	**27.9 (26.8 – 28.9)**	**29.5 (28.5 – 30.5)**	**30.2 (29.1 – 31.2)**

N.B. The true value is estimated to fall within the two confidence limits, thus the confidence interval is important to refer to when interpreting data.

Figure 4 below shows HIV prevalence by province in 2004 and 2005. HIV prevalence has decreased slightly between 2004 and 2005 in KwaZulu-Natal and Gauteng, while in the seven other provinces there were slight increases, most notably in the North West province (Department of Health in South Africa, 2005).

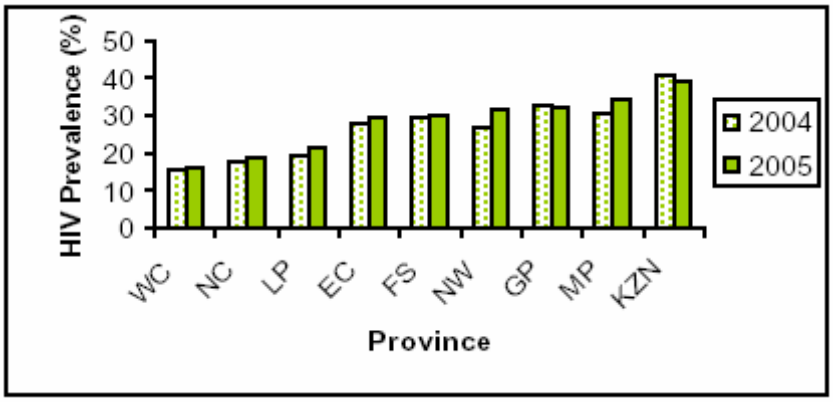

Figure 4: Provincial HIV prevalence among antenatal clinic attendees, South Africa, 2004-2005 (collected from Department of Health in South Africa, 2005).

According to the rates, the greatest impact is felt in KwaZulu-Natal, while the province least affected is the Western Cape. The HIV prevalence rates among adults and youth in KwaZulu-Natal show that women are more infected with HIV than men. This is especially the case among youth, namely 5,9% among boys and 24,4% among girls in the age category of 15 to 24 years old. Among adult men (20-64 years old) the HIV prevalence is 27%, while it is 29% among women of the same age. In general, 15,7% of the population of KwaZulu-Natal is infected with HIV – in antenatal clinics this is 40,2% - , which is a bit more than the national prevalence rate (11%). Mid year 2006, 621 000 people have died of AIDS in KwaZulu-Natal. Among adults (15-49 years old) who die, 78% is due to AIDS. Among children under 15 years old who die, 25% is due to AIDS. The average life expectancy of men is only 41,8 years old and of women 44,5 years old (Dorrington, Johnson, Bradshaw & Daniel, 2006).

2. SETTING: TARGETED AIDS INTERVENTIONS (TAI)

2.1. Choice of research location and organisation

The Non-Governmental Organisation (NGO) TAI is based in Pietermaritzburg, the provincial capital of KwaZulu-Natal in South Africa. I have chosen this organisation because it is situated in the province with the highest HIV prevalence of South Africa and because their way of working is innovative, meaning they are focused on young men and boys. Literature has proven to us that cooperation with men is necessary for effective HIV/AIDS prevention.
Also the Zulu culture is known for its gender inequality and it would be very interesting to learn from TAI's experience in dealing with this barrier in HIV prevention. These facts have convinced me to go to Pietermaritzburg and to make an analysis of TAI's HIV/AIDS prevention programme.

2.2. Introduction to TAI

2.2.1. Constructive engagement of men

Gender is about roles and responsibilities of men and women as determined by different societies. Expectations of how men and women should behave in society are learnt in families, workplace, schools and other institutions. They define appropriate but different behaviour for both men and women. Men are expected to be more powerful than women in all respects and are expected to be providers by bringing food, money and other commodities for their families (Makhaye, 2005). The provision is of material and financial kind. This provision includes providing rules and the making of decisions for the family. Women are in charge of the household work and take care of the children (Lindegger & Maxwell, 2005).

Gender inequality has contributed to the spread of HIV/AIDS in many ways. It is women who are disproportionately affected by the disease and bear the burden of responsibility for it by persuading their partners to practise safe sex, and by caring for HIV positive and terminally ill family members and for (AIDS) orphans. As a consequence, much of the work on HIV/AIDS prevention has been directed at women. Ironically, the very behavioural strategies that are likely to be most effective for reducing the spread of HIV, meaning condom use and faithfulness to one partner, are the strategies that are least in the control of women (Makhaye, 2005).

Gender issues have often been interpreted as women's issues and many HIV interventions have placed an even greater burden of responsibility on women, with a tendency of overlooking the constructive engagement of men. There is a general unwillingness on the part of men to regard HIV/AIDS as a problem that concerns them and there is a general paucity of HIV/AIDS research and intervention programmes for men. While men hold a position of power in social and sexual interactions, training them to use their power positively and creatively will allow men to protect themselves and thus their female partners against HIV infection.

If there is to be a major change in the current HIV/AIDS pandemic, it is primarily the behaviour of men that must undergo dramatic change (Makhaye, 2005).

TAI as a non-profit service provider and realising the dramatic impact of HIV/AIDS on women, began its work with women in 1995 (Makhaye, 2005). The Rural Women's project included aspects of small-scale income generation, HIV prevention and Home-based care. It was very successful in terms of income generation and care, but as many as 90 per cent of the women who participated were unable to implement their personal decisions about HIV prevention (Le Grange, 2004). TAI soon realised that the existing gender inequality made the efforts fail, efforts to protect women through empowering them with knowledge and life skills. Education on HIV transmission, prevention and the consequences of getting infected was not enough to protect women against HIV infection. When women attempted to put into practice what they had learned in training, they were met with resistance and often abuse by their male partners, which left them disempowered to make any significant change in their HIV risk (Lindegger & Maxwell, 2005; Makhaye, 2005). Some of them were even chased away from their homes or forced to have unprotected sex. The intervention led to further victimization of women (Le Grange, 2004).

This realisation in 1998 motivated TAI to shift their focus exclusively to men. Almost all decisions are made by men, including decisions related to sex, contraception and prevention methods. TAI targets young men and boys as people at risk of HIV in an attempt to involve them in protecting themselves and their loved ones from STI's and HIV/AIDS (Makhaye, 2005). Nowadays, the HIV/AIDS prevention programme includes women again, for example school girls and community women, simultaneously with a growing HIV/AIDS awareness in the communities.

2.2.2. Intervention projects

The work of TAI is divided into 4 main projects:

- ***Shosholoza AIDS project – Soccer based project***

Initiated in 1998 and sponsored by Joint Oxfam HIV and AIDS Programme (JOHAP[15]) - Oxfam Australia (organisational profile, 2006).

In order to facilitate the entry into a network of men as means of carrying out their gender-related HIV prevention work, TAI contracted with the South African Football Association (SAFA) and targeted the amateur football league in KwaZulu-Natal. Through the structures of SAFA, TAI obtained access to many local soccer clubs that capture much of the attention of many young men in South Africa. The Shosholoza project was created as a means of mobilizing and motivating young men in AIDS related issues. This project operates through the network of soccer players between the ages of 15 and 24[16], using their language, beliefs and behaviour around soccer as a creative medium for facilitating change in the risk behaviours leading to HIV infection (Lindegger & Maxwell, 2005; Makhaye, 2005).
The aim of this project is to educate young men about HIV/AIDS and prevention and to initiate communication among young men about safer sex practices, especially condom use and reduction in the number of sex partners. Other behaviours that reduce the risk of contracting HIV/AIDS are explored. There are 6 core teams involved in the project, each team delivers 15 participants (organisational profile, 2006).

- ***Inkunzi Isematholeni project – School based project***

Initiated in 2001, the project in primary schools is sponsored by ABSA Foundation and in high schools by Engen Petroleum Ltd. (organisational profile, 2006).

An important finding became apparent to TAI staff in their dealings with young soccer players. These men had already been sexually active for some time, most men had their sexual debut between 13 and 16 years old, and as a result could already be HIV positive (Le Grange, 2004). Young men are also entrenched in the local construction of masculinity which plays a major role in enhancing and maintaining much of the behaviour that put them, and their female partners, at risk of HIV infection. A second project was thus initiated, called the Inkunzi Isematholeni project. This project focuses on HIV/AIDS education among younger boys, and now also girls (age between 11 and 15 years) still at school (Lindegger & Maxwell, 2005).
Since youth is the generation highly at risk, schools offer a good opportunity to address both gender inequality and HIV/AIDS. Those at school are still negotiating their gender identities and exploring their sexuality (Makhaye, 2005).

[15] JOHAP in South Africa seeks to strengthen the civil society response to HIV/AIDS through supporting integrated community-based services for HIV prevention and care, including a focus on gender and sexuality issues and the rights of people living with, and affected by, HIV/AIDS (Lindegger & Maxwell, 2005). Several Oxfam agencies, active in South Africa, work together and form part of the program, for example Oxfam Australia, Oxfam Ireland, Oxfam Hong Kong and Novib (= Oxfam Netherlands).
[16] All the participants of TAI's projects work voluntary, they do not receive a stipend from TAI. But they receive financial support for the organisation of activities or events in the community.

The aim of the project is to influence boys and girls through education and role modelling before they become sexually active and influenced by the 'older' boys and girls with higher levels of HIV risk behaviour (Makhaye, 2005). The main focus is on delay in the onset of sexual activity, promoting abstinence and providing accurate information about prevention methods to those who decide to become sexually active (Le Grange, 2004).
There are 14 schools involved in the project (4 primary schools and 9 secondary schools) and each school has 15 participants who are dedicated to raise awareness, stimulate debates and AIDS talks at school. This helps ensure continuous engagement of all the school learners with HIV/AIDS and sexuality issues (organisational profile, 2006).

- ***Sibambiqhaza Community project – Community based project***

Initiated in 2004 and sponsored by the Australian Government (Ausaid) as part of 'Australia in partnership with African countries' (APAC), managed by Oxfam Australia (organisational profile, 2006).

This is a community based project, situated in Greytown area (Mbulwana village in Matimatolo area), which involves different adult stakeholders like religious leaders, traditional leaders, traditional healers, police officers, teachers, community health workers, representatives from different community groups (for example the vegetable garden group, the church group, etc.), etc.
The aim of the project is to create an enabling environment for the youth who participate in the Shosholoza and Inkunzi projects, to implement HIV/AIDS related activities in the community, which is struck by deep silence, stigma and discrimination, gender-based violence and abuse of women and children (organisational profile, 2006).

- ***Abafana Bebhola Bayanakekela project – OVC based project***

Initiated in 2006 and sponsored by Stop Aids Now! (a Dutch organisation) through Novib[17] (= Oxfam Netherlands) (organisational profile, 2006).

This project is recently initiated and aims to:
- Provide a safe and nurturing environment for orphaned and vulnerable children (OVC)
- Give psychosocial support to OVC
- Develop skills in young men (soccer players) to care for and support OVC through a 'big brother' system. When men learn how to care for others, the burden of caring for OVC, sick and dying family members by women will decrease. Men learn how to take their responsibility in caring activities. In this way, TAI promotes positive masculinity and positive fatherhood.
- Mobilize communities around the provision of a more supportive and strengthening environment for boys and girls affected by HIV/AIDS, neglect and child abuse (organisational profile, 2006).

Two soccer teams (30 boys) from two different villages (Mafakathini and Willowfontein) are involved in the project and each team takes care of 45 OVC (boys and girls) (organisational profile, 2006).

[17] Stop Aids Now! makes the money available and contracted Novib to manage the money and to monitor, evaluate and supervise the Abafana project.

For the purpose and the feasibility of this study, I have concentrated myself on the activities of the first two projects, mainly because these interventions have an explicit HIV/AIDS prevention programme and work through structures of young men and boys. This does not mean that I have neglected the following two. I have done interviews with people involved in these projects and I have explored socio-cultural barriers and strategies for effective prevention. The latter project has just started and still has the form of a pilot study. However, strategies to break through gender stereotypes are also found in this project and will be described in the research results.

Lastly, it is worth mentioning that TAI also has a capacity building project. TAI has been awarded a contract to build capacity in organisations in Mpumalanga, Free State, North West, Gauteng, Limpopo, Western Cape and the Eastern Cape Province in South Africa, so as to expand the TAI projects of working with young men and boys (organisational profile, 2006).

All the projects are geared towards community upliftment and empowerment. Decisions are made in participation with the communities. TAI stresses that the projects should be owned by the community with TAI providing monitoring and support when needed. TAI also constantly strives to implement projects that are innovative in their approaches. TAI was one of the first organisations that identified the need to work with men in terms of HIV/AIDS prevention and is now one of the few organisations working with young men to promote the concept of 'men as carers' (organisational profile, 2006).

2.2.3. Philosophy of TAI

TAI believes in:

- *A rights-based approach:* this means that TAI does not impose its views and beliefs on communities it works for. TAI aims to work from within the community, promoting human rights as entrenched in the constitution of South Africa.
- *Community empowerment and development:* TAI builds capacity in key skill areas which enables communities to sustain the projects, improve their circumstances and play an active role in determining their own future.
- *A holistic approach:* all the projects ensure participation across all levels (men, women, various age groups especially youth, different community groups) and TAI considers the many intricacies of the HIV/AIDS pandemic (poverty, gender relations, culture, food security) with the intent of addressing as many areas as possible within the mandate of the organisation (organisational profile, 2006).

2.2.4. Organisational structure

Every project is coordinated by a programme officer who is responsible for project planning, implementation and reporting; mentoring of participants; field visits and coordination of field workers; follow up and evaluation of the projects (organisational profile, 2006).

All the decisions related to projects, proposals, organisational development, payments and finances, etc. are made by the general director Gethwana Makhaye (organisational profile, 2006). She is a very dynamic and educated woman, motivated by the desire to contribute towards a healthy society. She founded the organisation in 1995.
At this moment, general management is being transferred to two acting co-directors, the senior administrator (Gaetane Le Grange) and senior programme officer (Pelele Mlangeni). Gradually, one co-director will become the top manager of the organisation, while the former general director will stay in an advisory capacity role and will be in charge of fundraising.

Administration is managed by a senior and a junior administrator. They are responsible for administration, financial management, project reporting, proposal writing, office management, human resource management, public relations and data capturing (organisational profile, 2006).

TAI receives help from fieldworkers and two American Peace Corps volunteers, who are in charge of Abafana Bebhola Bayanakekela. They help with coordination on the field and facilitate meetings between participants and the community committee. In addition, they help and mentor the participants in their activities.
There are also many community members who regularly volunteer their services to the organisation.

The board of directors consists of 8 members who meet annually but are consulted constantly (unofficially). They regularly visit the office and are updated telephonically. The members are people with different positions in society. Most of them have been involved in civil society activities for many years.

There are two medical doctors on board, a professional nurse, a law lecturer at the University of KwaZulu-Natal, a district manager of the Department of Health, a financial manager working in local business, a project manager of the Association For Rural Advancement (AFRA), and a legal advisor (organisational profile, 2006). The board members give overall direction to the programme, whereto it should go or on what it should focus; support staff; attend some of the events, for example provincial events to highlight TAI's work; etc.

Table 3: Equity analysis of TAI's staff (organisational profile, 2006)

Category	no.	female	male	Black	white	disabled
Board of Directors	8	75%	25%	63%	38%	13%
Permanent Staff	8	86%	14%	71%	29%	0%
Contract Staff	20	65%	35%	100%	0%	0%

Table 3 shows clearly that more black people are working for TAI and that more women than men are present in the organisation. Still 25% in the board of directors and 14% in the permanent staff is occupied by men (organisational profile, 2006). People can wonder how it is possible for women to talk to soccer players, young boys in schools or men in the communities about HIV/AIDS and prevention. Gender inequality would make it very difficult for women to be listened to. However, the practice gives a different result. A woman being the director or a programme officer is treated with respect. One reason is that youth is taught to listen to older people and to respect them. Secondly, I think that as long as the staff is aware of the existing problems in the villages, speaks the language of the community people, has been living or is living in the rural community or at least has experience with rural life conditions, treats people with respect and recognises the importance of their participation, is patient and motivated enough, community people have the will to listen and turn into action.

Lastly, TAI is working with 20 full-time contract staff members who are administered for CAPRISA, a health care and research centre in Mafakathini village. These contract staff members are responsible for fieldwork for vaccine trials and VCT promotion (organisational profile, 2006). They receive counselling training from TAI.

2.2.5. Area of operation

TAI is working in communities where poverty, illiteracy and unemployment are predominant. The service delivery in these areas is limited or non-existing and there are no or very few NGO's active in the region because of the lack of infrastructure (organisational profile, 2006). Poverty influences the spread of HIV in several ways, such as limiting access to condoms and to treatment of STI's. Poverty has also caused the erosion of family structures, especially in situations where many men have migrated to the urban centres in search of work (Le Grange, 2004).

South Africa is a country with incredibly high rates of women and child abuse (sexual, physical, mental and emotional abuse), where men are the main perpetrators of this abuse. TAI works in a context wherein it constantly asks itself the following question: "It is important to educate vulnerable groups about their rights, but what good will this do for a woman while she is being raped or being beaten by her partner (organisational profile, 2006)?"

Because TAI is doing a lot of work with soccer teams, the target areas are thus located in the SAFA regions, meaning SAFA KwaZulu-Natal Midlands, SAFA Eastern KwaZulu-Natal and SAFA Northern KwaZulu-Natal (Makhaye, 2005).
TAI operates throughout KwaZulu-Natal, especially in peri-urban and rural areas, such as Matimatolo, Mafakathini, Willowfontein, Dannhauser, Amanzimtoti, Mandeni, Swayimana, Hopewell and many others (organisational profile, 2006).

The population profile of TAI shows that most of the people involved are male black people. The following percentages make this clear (organisational profile, 2006):

- Black: 99%
- White: 0%
- Indian and coloured: 1%
- Male: 54%
- Female: 46%

2.2.6. Other relevant information

TAI is a very assertive organisation that works closely with members of the media to spread information about local problems, TAI's projects and donors. TAI has been featured in the local news and in many well-known publications, including Natal Witness, Elle Magazine[18] and the Club Together Magazine. Even in the Belgian newspaper De Morgen an article about gender-based violence in Africa quoted the director of TAI saying that the behaviour of men needs to change to realise success in the fight against HIV/AIDS. Several videos have been made about TAI, including a film by MTV for the May 2006 United Nations General Assembly Special Session (UNGASS) conference and for the GAF. TAI also piloted a traditional healer's project in KwaZulu-Natal and produced a workbook for Churches and AIDS, sponsored by the Department of Health (organisational profile, 2006).

[18] The director of TAI was nominated as one of the top ten finalists in the Elle Magazine "Visible Difference Award" 2002, as a result of the work she has been doing in the Shosholoza AIDS project. The award is aimed at highlighting the incredible contribution women are making to South African society, often without resources, recognition or financial reward and who work tirelessly to make a visible difference in their communities (organisational profile, 2006).

3. THE ACTUAL RESEARCH

3.1. Research questions

The following field study makes an analysis of the HIV/AIDS prevention programme of the local organisation TAI in KwaZulu-Natal. It is interesting and relevant to learn more about the experiences and concerns of local people and of a local community-based organisation in their fight against HIV/AIDS. Effective prevention strategies are highlighted and other HIV/AIDS organisations can learn from it. The analysis will give an answer to the following questions:

1. What are the contemporary socio-cultural barriers in the prevention of HIV/AIDS in KwaZulu-Natal? In other words, with which socio-cultural barriers in HIV/AIDS prevention is TAI confronted?

2. How does TAI take these barriers into account in its HIV/AIDS prevention programme? Which strategies does TAI use to break through these barriers in prevention? How does TAI deal with gender inequality in its programme? How does it try to break the silence surrounding sexuality, HIV/AIDS and prevention?

Before leaving to the research field, I was convinced that TAI had an *exclusive* focus on young men. The focus is still on young men, but nowadays they involve girls and women as well, with a simultaneous growing HIV/AIDS awareness in the communities. School girls form part of the PE groups in the Inkunzi Isematholeni project and community women organise activities and campaigns in the Sibambiqhaza project. First, I wanted to examine ways of directly involving girls and women in the prevention programme, mainly because previous research had suggested that working with women and men is the best way to change the gender system. But because TAI has moved towards a programme that includes girls and women, I have spent less attention to this issue, although I have explored the possibility of and participant's opinion on more ways of directly involving girls.

3.2. Methodology

I have chosen for a combination of a qualitative and quantitative research method. Within the qualitative option, I have chosen for open individual interviews with staff members and participants, open group interviews with participants, participative observation of the ongoing prevention programme and activities, and analysis of documentation and reports of the organisation TAI. Within the quantitative option, I have worked with a self-constructed questionnaire with assumptions on the local socio-cultural context wherein the HIV/AIDS prevention programme of TAI is situated. I have investigated the programme thoroughly, focusing on several factors and this for a period of 10 weeks.

3.2.1. Questionnaire

The self-constructed questionnaire was taken from staff members of the organisation to get a more detailed view on their working environment in a fast and efficient way. I constructed this questionnaire to learn as much as possible about the local socio-cultural context, more specifically about the aspects that make HIV/AIDS prevention difficult.

Staff members (7), two men and five women, were asked to evaluate assumptions about the socio-cultural context in which TAI operates. They had to judge if the assumptions were applicable or not in peri-urban and/or rural KwaZulu-Natal. The assumptions used were taken from literature review and were placed together according to several themes regarding gender inequality and taboo. Per theme, staff was given the opportunity (by open questions) to add other relevant socio-cultural situations that make HIV/AIDS prevention difficult, and/or they could give more information or could clarify things in a conversation afterwards. As noticeable, the questionnaire is partly qualitative in its set-up.

There is a long version and a short version (see attachment 3, questionnaire: long version and attachment 4, questionnaire: short version). The long version goes much more into detail and was taken from the general director/founder of TAI (Gethwana Makhaye), the programme officer in charge of the Inkunzi Isematholeni project (Pelele Mlangeni) and the programme officer in charge of the Shosholoza AIDS project and the Sibambiqhaza project (Buhle Mahlase). The short version without open questions but with an attached interview was taken from the programme officer of the Abafana Bebhola Bayanakekela project (Lindiwe Xulu), 2 field workers of Abafana project (Ma-u Mafu, Jetro Mchunu) and the senior administrator (Gaetane Le Grange).
There are several reasons why I have worked with two versions. One of them is that the long version is directed at key people in my research. The general director/founder of TAI has built up her experience in the field for over ten years and has a general, broad and detailed knowledge of the different projects and their impact. The 2 programme officers focus their work on HIV prevention which is also the research focus. They have a deep knowledge of the field and are in close contact with the participants who live in rural and peri-urban communities. By filling in the questionnaire, they can share with me their experiences, knowledge and perspectives.

Another reason for them to fill in the long version is that I spent a lot of time with them, so an appointment for a following in-depth interview on another occasion could be easily made. The short version was designated to staff members working in the Abafana project. This project is still a pilot study and does not have a specific focus on HIV/AIDS prevention. As mentioned above, I have paid less attention to this project. Long distances, busy schedules, etc. were reasons why one appointment suited the subjects better. As a result, the questionnaire was shortened and an interview followed immediately. Due to medical health problems, the programme officer of the Abafana project filled in the short version at home and was interviewed when back at the office.

Because the sample is very small, only 7 respondents, generalizations cannot be made, but it gives a very good impression of the context in which TAI is operating and of the socio-cultural barriers in HIV/AIDS prevention work in rural and/or peri-urban KwaZulu-Natal.

3.2.2. Participative observation

During the first week, I got acquainted with the organisation and staff members. On the second day at the office, I was already given the opportunity to meet people from Novib (= Oxfam Netherlands) who were visiting TAI. I attended a meeting between TAI, soccer players in the Abafana project, community women and Novib. After the meeting, we visited a grandmother in Willowfontein who takes care of her five orphaned grandchildren without any access to a pension grant or social grants, due to lacking of an identity document and birth certificates of the children. Media were called by TAI to highlight these problems because other families identified by TAI are in the same need of support. The relevant government departments were present at the grandmother's house with some of the birth certificates and the identity document and told the press that they would do more efforts to help other people facing the same problems. At that time, I felt very fortunate being able to experience the gathering and I was looking forward to learning more.

During my stay, I spent a lot of time with the programme officer of the Inkunzi Isematholeni project (Pelele Mlangeni) and I followed him in his activities. When he left the office for a meeting with PE's, school teachers or the school principal, I came along with him and observed the happening. I visited most of the schools involved in the project (see attachment 6 for the schools and soccer teams visited), observed refresher courses given to the PE's by the programme officer (and on some occasions with help from a voluntary teacher) and observed an HIV/AIDS grade competition (with debating, poetry, gospel, cultural dance, drama, etc.) in a school organised by the PE's.
Within the Shosholoza AIDS project, I attended monthly meetings between the programme officer (Buhle Mahlase) and the soccer teams, I observed drama evaluation of a soccer team, and at the end of my stay a two-day Shosholoza tournament of soccer and HIV/AIDS competitions was organised. Further, I followed the programme officer in her contacts with the community men and women participating in the Sibambiqhaza project. We were invited by them for a gender-based violence campaign in Greytown, Mbulwana village. Lastly, I also joined a Human Rights Day event organised by the soccer team and OVC of the Abafana project in Mafakathini village, I observed the track suit delivery for the OVC in Willowfontein and I attended TAI's staff meetings.

During observation, I considered what I observed and I examined the information gained on its significance. I loved the contact with local rural community people and the staff members of TAI. They gave me the opportunity to really see what the projects are all about. Observation was participative in a way that for example I helped a programme officer with groceries for the participants' lunch, I prepared plates with food and served drinks for the PE's after the refresher courses, I sometimes made a report of a meeting and shared it with the programme officer, I had a lot of informal conversations during car rides with the programme officers and we shared insights and meaningful information, we discussed about TAI related issues and concerns, etc. By passing so much time with staff members, I really started to have a genuine personal contact with them. This was a very interesting experience. I stood beside them as much as possible to have a clear and real perception of the situation. This went very smoothly because TAI accepted me in the organisation from day one and they involved me as much as possible in their activities, without me losing the awareness of my objective position as researcher. I found it really important to stress that I wanted to learn from them and that I was not there to evaluate their activities. I told them my stay needed to be seen as them sharing experiences and knowledge with me. So gradually, I built up my insights and knowledge of the programme by seeing and hearing as much as I could. I can say now that I have a good sense of the working environment of the organisation, the activities of the programme and the people they work with.

3.2.3. Interviews

I conducted 8 individual semi-structured interviews with staff members, 1 individual semi-structured interview with a board member, 6 open group interviews with participants of TAI's prevention programme, 3 individual semi-structured interviews with guardian educators of the Inkunzi Isematholeni project, 2 open group interviews with girlfriends[19] and sisters of soccer players involved in the prevention programme[20] and one individual semi-structured interview with a clinical psychology professor working at the university of KwaZulu-Natal who has done research – and still does - in cooperation with TAI (see attachment 6 for the interview questions). In total, I have data from 21 interviews with different kinds of people to have a clear and complete sight on the programme.

The staff members (8) and board member (1) interviewed are key informants, i.e. people who are knowledgeable about the topic of interest and about the local culture. They provided me with general and detailed information on the HIV/AIDS prevention programme and the specific prevention strategies adapted to the socio-cultural context.

[19] 4 girlfriends of soccer players were interviewed. These soccer players belong to the soccer team 'Hopewell Pillars'. The 3 sisters interviewed are sisters of soccer players belonging to the soccer team 'Real Madrid'. Both teams were also interviewed, 6 soccer players from 'Hopewell Pillars' and 3 from 'Real Madrid'.
One of the girlfriends interviewed is mother of a 3-week old baby and is only 16 years old. She tells that she wanted to use a condom but that her boyfriend did not want to use one. This happened before her boyfriend became a member of Shosholoza. Now that he has joined the Shosholoza AIDS project, he knows that he acted wrongly.

[20] Participants and educators involved in the several projects were kept anonymous because of the sensitivity of the matters discussed. Staff, the board member and the professor gave me the permission to use their names for the purpose of the research.

Staff members are the senior administrator (Gaetane Le Grange), field workers/coordinators (Paul Bradley Gibbs, Jetro Mchunu and Ma-u Mafu), programme officers of the different projects (Pelele Mlangeni, Buhle Mahlase and Lindiwe Xulu) and the general director/founder (Gethwana Makhaye) of TAI. The board member (Thabo Manyathi) is a project manager for the Association For Rural Advancement (AFRA).

The participants interviewed in group are soccer players of 3 different teams involved in the Shosholoza AIDS project (3), schoolboys and girls who act as PE's from 3 different schools in the Inkunzi Isematholeni project (2) and community women participating in the Sibambiqhaza project (1). From them, I gained practical data on the prevention activities organised in the villages and schools. This information was enriched with data from interviews with 3 guardian educators who support the PE's in the school (2 female, 1 male). Next to this practical information, I also examined what they see as barriers in HIV/AIDS prevention.

The open group interviews (2) with girlfriends and sisters of the soccer players were conducted to explore the possibility of *more* direct involvement of girls and women in TAI's prevention programme. As from the participants, I also wanted to learn from them what they see as socio-cultural barriers in HIV/AIDS prevention.

Finally, the interview with the clinical psychology professor (Graham Lindegger) was very interesting as he gave me his academic view on TAI's strategies and methods.

The individual interviews with staff members took longer than the other interviews, generally 90 minutes to 45 minutes respectively. The questions were put in logical order and some of them were standard over the total number of interviews. These questions concerned TAI's strategies to break through socio-cultural barriers in HIV/AIDS prevention. The questions were asked in a flexible way, adapted to the answering of the subjects.

I chose to get the perspective of different kinds of people who all know the programme and have personal experiences with it. The organisation of the interviews with participants and the choice of subjects were always in dialogue with TAI, most of the time with the programme officers and sometimes with the director. The programme officers helped me tremendously with the arrangements and introduced me to the participants. Other interviews were also easily arranged, by phone or by asking people at the office. I tried to be as flexible as possible, but without losing sight on what I wanted to achieve. Whenever people had time for an interview, I immediately took the chance. When a programme officer had to go for a meeting with participants or for a refresher course with participants, I joined him or her and I conducted the group interview after or during the meeting or training.

I started every interview by introducing myself and the research properly. I explained the study participants their rights, asked for their informed consent for participation (see attachment 7) and I gave them the chance to ask questions about the interview. I stressed the anonymity of the respondents and the confidentiality of the research data. This was very important as conversations were tape-recorded and the issues discussed were sensitive. The merit of recording the interviews is that no information gets lost because of inattention or selective perception.

One difficulty I experienced with interviewing and also in observing is the language barrier. Staff members, teachers, the professor, etc. can speak English fluently, but the participants, sisters and girlfriends of the soccer players, etc. can express themselves better in the Zulu language.
When I attended meetings, campaigns, HIV/AIDS competitions, refresher courses, events, etc. it was very hard to understand what people were saying. Sometimes they used English words in their conversations, at which point I was able to understand a little bit of the context. Nevertheless, afterwards I always had to ask the programme officers what it was about. In that way, I think I missed a lot of messages that would have been of interest to my research topic.
For interviewing, an interpreter was required. Although soccer players, schoolboys and girls, community women, etc. can speak English, it is better for them to be able to express themselves in their mother tongue, the language in which they feel most comfortable. The interpreters used were the programme officers and a volunteer working for TAI. They translated my questions from English to Zulu and the answers from the participants from Zulu to English. In general, working with an interpreter went very well, but sometimes I had the impression that the interpreter was taking over the interview or was not translating consistently enough. When that happened, I tried to interfere and ask the interpreter to translate whenever a person had finished his or her answer. After this being said, the translating was more regular and consistent. Another difficulty with working with an interpreter and not understanding the language was that some participants did not answer the question and started talking about other things that were not relevant to the research. At such moments it is difficult to intervene in time and to give direction when needed.

Lastly, it is worth mentioning that I chose a group setting for the participants and the sisters and girlfriends of soccer players because a group setting gives more confidence and an interplay of ideas is possible. The group interviews varied in size. Generally, I interviewed 6 people in group and the interpreter/facilitator and myself ensured that everyone was given the chance to participate and to answer the question. Discussion was encouraged and a certain dynamic could be observed. In some occasions, the group was built up of only 3 or 4 people, due to external circumstances. For example, I did an open group interview with 4 community women instead of 6 because one person was hospitalized and the other just did not show up, or I did a group interview with 4 girlfriends of soccer players because others were too shy to participate and answer questions. The open group interviews with participants of the Inkunzi Isematholeni project were equal in gender. When 6 participants were present, 3 of them were schoolboys and 3 were schoolgirls. Finally, participants of different ages were included in the research.

3.2.4. Documentation and reports of TAI

TAI has a large data base with all kinds of reports and documentation of the organisation, such as annual reports, training/workshop reports, meeting reports, funding proposals, the organisational profile, websites, scientific articles, newspaper articles, etc. I read a lot of it at the office to get a deeper understanding of the local context and the socio-cultural barriers in HIV/AIDS prevention. I also collected a lot of information on the structure of the different projects and on the activities of PE's. By reading the reports of meetings and trainings with the PE's, I learned more about the tasks of the programme officers and their continuous engagement in the fight against HIV/AIDS. Analysis of existing documentation and reports gave me a clear background of TAI's prevention strategies and what they have achieved over the years.

3.3. Data-analysis

Through analysis of research material, I tried to give an answer to the research questions above. For this purpose, the literature study was very helpful in a way that it served as a guideline or framework. It is like a pair of glasses through which you see the prevention programme of TAI. The case study can be seen as a practical verification and specification of what has been found in literature, but the analysis may not be seen as an evaluation of TAI's prevention programme. TAI was so kind to share with us its experiences in the field and everyone who is concerned with effective HIV/AIDS prevention can learn from its strategies.

During my stay in South Africa, I wrote my findings down on my computer and I collected them in several maps. I also saved a lot of documents and reports of TAI on my USB stick and I read them at TAI's office or at my place in Pietermaritzburg. Because of the large amount of documents, I was not able to read all of them and I still had to read a lot at home (in Belgium). I wrote several interviews down or I made a summary of the most important things that were said. Every time, I made a report of the course of the interview and of things to take into account for the following interviews (for example information still needed). Before starting with the actual analysis, the data consisted of completed questionnaires, recorded interviews, interview reports, written interviews, documents and reports of TAI, a diary kept on the computer with field notes and findings, observation reports (of refresher courses, meetings, events, campaigns, etc), and an outline of strategies (only first ideas of possible categories).

For the actual analysis, I began with the examination of the completed questionnaires. The answers to the open questions were analysed on their content and information of interest was subtracted. The evaluation of the statements according to the applicable/non applicable/don't know codes were put in percentages to know how the staff thinks about their socio-cultural context and the link with HIV/AIDS. The data gathered by the self-completion questionnaire was put in a first category called 'the contemporary socio-cultural barriers in HIV/AIDS prevention in KwaZulu-Natal, seen by TAI'.
The analysis of documents and reports of TAI in search of socio-cultural barriers and prevention strategies was done by marking the information of interest in a different colour. Then, I reread this information and placed it in different categories/themes (barriers and strategies) and sub-categories/sub-themes (for example dominance of men over women, cultural myths and misconceptions, stigmatization and discrimination, the vital role of existing structures, peer education, personalizing the risk, etc).
The interviews were listened to, re-listened to, analysed and the selected information (by induction) was immediately written down in the chosen categories and sub-categories. In this stage, the summaries and full versions of the interviews were also used.

3.4. Reporting

The first part gives information about the contemporary socio-cultural barriers in HIV/AIDS prevention, seen by TAI. The local Zulu culture is known for its gender inequality, more specifically the dominance of men over women, the use of violence towards women, masculine stereotypes that give men more rights, etc. For the purpose of the study, I always kept the link with HIV/AIDS in mind. Information on these barriers was found through the analysis of the self-completion questionnaires, interviews, observation reports, documents and reports of TAI.

The second part gives knowledge about the prevention strategies that TAI uses to make HIV/AIDS prevention effective for women and men in a difficult context. This part is based on information collected from participative observation, interviews, documents and reports of TAI.

3.5. Position as researcher

Being a researcher in the field, I learned that it is very important to discuss with the local organisation what you expect from them and what they can expect from you. You explain your research objectives and ask permission for the application of your methods. It is crucial to reach optimal dialogue and understanding with the NGO. These conditions create a good environment to work in.

First, I came into contact with the general director/founder of TAI who introduced me to staff members. She suggested that for the purpose of my research I should spend a lot of time with the programme officers of the several projects. After I got to know them, they took me on the road to meetings, trainings, events, etc. Through the programme officers, I came in contact with participants of the projects. In these contacts, I did not experience any problems. If you are respectful towards people and other cultures, are willing to get to know other values and norms, are not judgemental, are friendly, open-minded and patient, have enough confidence and introduce yourself properly, people will accept you and respect your task as a researcher. This in combination with a good portion of assertiveness leads you to where you want.

As I mentioned before, I was accepted by TAI from day one and I really felt part of the organisation. At the end of my stay, they even said to me that I became a member of the family. But I must add that I stuck to my task and that I tried to stay in an objective position when I was busy with research. My critical attitude and motivation to learn more enabled me to keep the balance between distance and closeness.

Attentiveness for everything that happens around you and being conscious about it, was a more difficult point for me. It was not always easy to differentiate on the spot (for example while interviewing) between relevant and irrelevant information. You have to take so many things into account that sometimes you forget to ask more in-depth information on certain issues.

In general, I do not think that I had a serious impact on the people interviewed. I had the impression that me being a young white woman, unmarried and without children made a certain impact on some PE's: they acted shy, stared at me, fooled around with me, giggled, were curious, asked questions, etc. However, they were very open towards me in the interviews. They were willing to give their opinion on rather sensitive topics, sometimes with encouragement of the interpreter/facilitator. They were assertive, well-spoken and expressed their ideas with enough conviction.

4. RESULTS

4.1. The contemporary socio-cultural barriers in HIV/AIDS prevention in KwaZulu-Natal, seen by TAI

The analysis of the answers in the self-completion questionnaires shows clearly that findings in literature and practical experiences of TAI are similar. TAI's staff members confirm what I have found in literature about the socio-cultural barriers in HIV/AIDS prevention. I write the barriers down according to the several themes in the self-completion questionnaire. Sometimes, I add information from interviews, observation reports, documentation and reports of TAI.

4.1.1. Gender inequality

4.1.1.1. Dominance of men over women

All the staff members (7/7) find[21] that men in rural and/or peri-urban KwaZulu-Natal have the power and make the decisions in sexual relations (for example about the use of condoms). Buhle Mahlase declares that a man is the head of the family and expects to be listened to and to be respected. He is the sole provider of the family and he is also the one who protects the family. A man is expected to make all the decisions for his family. This makes it very difficult for a woman to convince her partner when it comes to sexual matters. Men see a woman like a child; you have to make decisions for it and you must protect it.
Almost the whole staff (6/7, one person marked the code 'don't know') thinks the assumptions that women are often not able to refuse sex in marriage or in a relationship outside of marriage, that women are often not able to convince their partner of using a condom and that women are often not able to convince their partner of being faithful are applicable in rural and/or peri-urban Kwazulu-Natal. The unequal power between men and women is socially accepted.

The dominance of men over women has been confirmed many times in sources of information provided by TAI as in interviews with guardian educators, participants of the projects and in the interview with the clinical psychology professor. Graham Lindegger explains that the decisions about sex and the conditions under which sex takes place are in the hands of men. Reports tell that sex is of patriarchal nature and that men control women's bodies.

[21] To make things clear: staff members had to evaluate different assumptions on the local socio-cultural context wherein the HIV/AIDS prevention program of TAI is situated. They had to evaluate for every assumption if it is applicable or not in rural and/or peri-urban KwaZulu-Natal. The given answers are not a personal expression of what they think is right or wrong. It is an expression of what they experience in the communities they work in.

4.1.1.2. Women are economically dependent on men

Although this barrier in HIV/AIDS prevention is more socio-economic than socio-cultural, it is inextricably bound up with the socio-cultural barrier of gender inequality and the vulnerability of women for HIV infection.

All the staff members, except for one man, state that women are economically dependent on men. This is also confirmed by documentation of TAI, by participants of the projects, guardian educators involved in the Inkunzi Isematholeni project and the clinical psychology professor. Two third of the staff members says that if women insist on safe sex, they might risk loosing a man's economic support. Again, this is confirmed by guardian educators telling that when a woman wants sex with a condom, the husband might tell her that he will not give her any money or that he will leave her and will look for another wife who does not insist on condom use. Because of fear of being neglected and having no food, money or a place to stay, the woman will have sex without a condom. The professor tells that women cannot stand up to men because they do not have money and do not have economic power. Socio-economic factors compound the socio-cultural factors as barriers in HIV/AIDS prevention.

Everyone thinks the assumption that women often have sex in exchange for shelter, food, school fees and other basic necessities is applicable. In addition, young women often have sex for material goods such as cell phones, brand clothing, etc.
These young women often have sex with much older men because financially older men are better off than male peers. This is confirmed by a participant of the Shosholoza AIDS project. Buhle Mahlase adds that there is high competition in material things between young women. They sleep around with older men for money without using a condom. Uneducated women mostly depend on men for money, while educated women do not because they can provide for themselves. Pelele Mlangeni says that women like to be associated with status. Therefore, they end up having sex with celebrities, namely 'one-night stands' without the use of a condom. Young women take the risk for a bit of fame. In short, they are attracted by the 4 C's: cash, cars (men with fancy cars or men providing transport), cell phones and clothes. In the interview with Graham Lindegger, I learn that women want popular men who possess these material resources, but these men are also the ones who are most likely to perform risky sexual behaviour and put women at risk of HIV infection. He adds that older men seducing young girls with money or material things are called 'sugar daddies'. Men prefer to have sex with young girls because they are less likely to be HIV infected.
In reports, I find that some parents do not even bother asking where their daughter gets money from. They even support their daughter to fall in love with older men who can support the family with money and food.

To conclude, transactional sex happens a lot in KwaZulu-Natal. The following example is very common. When a woman needs a lift to Durban, it often occurs that a truck driver offers her the lift in exchange for sex without a condom. Despite everything the woman knows about HIV/AIDS and prevention, she still needs that lift to Durban (perhaps for a job) and she will eventually accept his proposal (Gaetane Le Grange). According to Paul Bradley Gibbs, condoms are not being used in a transactional sex relation.

4.1.1.3. Negative perception on condoms

All the staff members and guardian educators interviewed say that when women insist on condom use, they are often accused of promiscuity or unfaithfulness. This statement is also linked with stigmatization of women, expressed in the belief that women are promiscuous, carriers of the HIV virus and to be blamed for HIV/AIDS. On the other hand, men are also often accused of unfaithfulness when they want to use a condom. According to Gethwana Makhaye, the latter situation only happens on a small scale. She tells that in general women will appreciate a man who wants to use a condom, on the condition that he does not say he does not trust her. It happens that when a man suggests using a condom, the woman feels personally attacked (Gaetane Le Grange). There are men who report that their female partners do not want to use a condom. The female partners respond by saying "you think I am sleeping around?" or "You think I am dirty?" (= promiscuous).
The staff members state that condom use is not common in long term relationships or marriage because the use of it is seen as a lack of trust between partners. This and the statements above are confirmed in TAI's reports, by participants of the projects and by guardian educators involved in the Inkunzi Isematholeni project. An interview with Shosholoza boys makes it clear that when a woman wants to use a condom, the man will react surprised. He will think that the woman has been sleeping around and/or he will think that she sees him as an unfaithful husband. Eventually, if the man does not want to use a condom, unsafe sex will be practiced.
In short, introducing a condom in a relationship can be tricky and awkward, especially if the couple has been having sex without using condoms.

According to the answers found in the questionnaire, staff members think that mostly men do not want to use condoms. Pelele Mlangeni makes this clear by saying that men complain that condoms are not safe because they burst. But mostly this occurs because they use it wrongly (for example not leaving space for sperm at the end of the condom) or do not check the expiry date of the condom. There are also young men who complain about the condom being too big. Mostly, these boys are only 10 to 14 years old and their body still needs to develop. Buhle Mahlase says that men complain that when they use condoms, they do not get an erection or they do not enjoy sex. The barrier is that condoms make sex less pleasurable. This is in line with the following expression used by boys (Pelele Mlangeni and a participant of the Shosholoza AIDS project): "You can not eat a sweet with the paper".
The community women participating in the Sibambiqhaza project tell in the interview that they experience a lot of difficulties in educating men about condom use. They are not listened to by men and men do not want to use condoms.
In an interview with participants, one person mentioned that women sometimes complain that condoms give them a rash or cuts in their private parts, so they prefer not to use condoms. Paul Bradley Gibbs says that if people do want to use condoms, the use of it is often inconsistently. One participant of the Shosholoza AIDS project admits in an interview that he used to use one and the same condom for about 2 days.

When this is still not enough, religion also has an impact. God told people to give birth in order to populate the earth. When people use condoms, they might throw a doctor, an academic, a lawyer, a nurse, etc. away (Buhle Mahlase). It is clear that the desire or the pressure for children is a reason why women and men do not use a condom and take the risk of becoming HIV infected. This is also reported in interviews with participants of the Shosholoza AIDS project and in an interview with a guardian educator. Shosholoza boys explain that when a couple is married, culturally it is the duty of a woman to give birth to children. They are forced by culture to have sex without a condom. Most societies believe that women must become mothers in order to be 'real women'. But the girlfriends of Shosholoza players (from a different team) say that they do not feel pressure to have children.
Sometimes men use the wish for children as an excuse for not using condoms (Buhle Mahlase).

4.1.1.4. Gender stereotypical behaviour

All the staff members state that men prove their manliness through multiple sex partners[22] and through dominance in sexual relationships. Buhle Mahlase explains that a man can have as many partners as he wants, while a woman is expected to be faithful.
The majority thinks that men also prove their manliness through relationships with young girls, physical violence and sexual violence.

Everyone says that the practice of safe sex (for example reduction in the number of sexual partners) may be felt as a threat to masculinity. There is pressure from the community to behave as a proper man. Young men in particular may feel pressured to assert their male identity. A girlfriend of a Shosholoza PE confirms this in an interview. She says that friends influence each other about having sex with girls. Another says that she also experiences pressure from female friends to have sex with her boyfriend. These friends tell her that she must have sex to have a real relationship with her boyfriend. In reports, it is stated that young men compete with each other on the number of sex partners.
Young men are not only pressured by other men. Gaetane Le Grange clarifies that when a man has only one partner, women can wonder "What is wrong with him?", or when a woman meets a single man, she can think "How come he is single?". Women also reinforce the negative masculine stereotypical behaviours that increase the risk of HIV infection.
In documentation and reports of TAI and in interviews with participants, guardian educators, Paul Bradley Gibbs, and Graham Lindegger, it is confirmed that men are seen as real men when they have more than one sex partner. It is a matter of prestige to have more girlfriends. Some men have 5 wives, so when one of them gets infected, many people, especially women get infected. The professor adds that one of the root causes for women to get infected with HIV is by being faithful to her partner.

[22] Traditional discourse of manhood:
Isoka: a man who is successful with girls
Isishimane: a man who struggles to get girls, or can possibly get only one
Isigwadi: a man who cannot get any girls

Graham Lindegger tells that the most overriding discovery in his research in cooperation with TAI (2004) was the way in which there is enormous pressure on young men and boys to conform to certain patterns of masculinity that put them and women at risk of HIV infection. There is pressure on men to be seen as to be retaining power. There was a very particular aspect of it that is called the illusion of conformity. Boys and young men create the impression of conformity for other men (for example pretending to be highly sexually active and to have multiple girlfriends), even though it seemed quite a lot of the time they do not conform.

Because of gender roles and expectations, men find it difficult to admit that they are worried about HIV/AIDS and STI's. Gethwana Makhaye says that they are afraid to talk about it. Buhle Mahlase adds that men pretend they know everything, are expected to be knowledgeable and they cannot admit when they do not know something. This really becomes a barrier in HIV/AIDS prevention in such a way that men do not want to seek out correct information or want to ask advice regarding HIV/AIDS prevention.

TAI says that girls and women are expected to be submissive and to be faithful. Girls are expected to abstain from sex and to remain a virgin until marriage. Gethwana Makhaye remarks that faithfulness for women and girls is expected by the community and men. Abstinence for girls is expected by the community and parents, not by men. The majority of the staff thinks that girls and women are expected to know little about sex, sexuality and HIV/AIDS, but they do not think that boys and men receive more education on sex, sexuality, HIV/AIDS and prevention than girls and women. Gethwana Makhaye says that it is actually vice versa because nowadays most NGO's target girls and women and in clinics girls and women receive information on family planning and reproductive health. Socio-cultural norms prevent men from participating in reproductive responsibilities.

4.1.1.5. Violence against women and girls

TAI's staff members think the assumption that girls and women may often experience (sexual) violence in marriage or in relationships outside of marriage is applicable. Pelele Mlangeni says that men see their wives as sex objects. They do not listen to their wife when she does not like a certain sexual activity. From the interviews, I learn that forced (unprotected) sex with women is common in relationships or marriage. Women get physically and/or sexually abused when they refuse to have sex or refuse to have sex without a condom. Most women do not leave their husband in such a situation because of their economic dependency on men. Buhle Mahlase says that a woman does not know that when she is married she has the right to say "no" to sex. Women also think that violence is socially accepted. Gaetane Le Grange says that this is enhanced by women saying to women that a woman needs to know her place and needs to be submissive. The beating of a woman by her husband can be seen as 'to discipline your wife'.

With the statement that violence is socially accepted, some staff members do not agree (3/7). This inconsistency is probably due to influence of personal conviction rather than considering the general norm.
Staff members are consistent about men not taking their responsibility when it comes to sexual abuse. Sexual violence against women is often seen as their own fault, for example because girls wear seductive clothing (mini-skirts, tight trousers, tops, etc.) or because they do not listen.

Gaetane Le Grange clarifies that men do not understand that it is wrong to force your partner to have sex or to beat your wife. They are socialized that way and they feel it as part of their traditional role. Men do label sex with a stranger in the bushes as rape.

From an interview with participants, I learn that some HIV positive men spread the disease on purpose by raping women and girls. They want to destroy them because they do not want to die alone.
Other stories told in townships are about babies of 3 months or 6 months old being raped by men who are HIV positive. They are doing this on purpose, because they believe that when they pass the virus on to a virgin they will be cured of HIV/AIDS.

Participants in the Inkunzi Isematholeni project report that sexual abuse often occurs in school. For example, learners from grade 12 sexually abuse learners from grade 8. These young girls who have just entered high school are seduced by older boys and during class hours they are forced into sex with them.

4.1.1.6. Cultural myths and misconceptions

TAI is often confronted with new myths and misconceptions about sex, sexuality and HIV/AIDS. In the following list you can find myths and misconceptions, gender related and non gender related, about which I have learnt during my stay in KwaZulu-Natal:

Gender related

- Having sex with a virgin or young child cures HIV/AIDS. This has as a result that a lot of young girls and even babies are being raped by HIV positive men.
- Young men are pressured by older men to have sex on an early age, more specifically at the onset of puberty. It is said that when a boy has his first wet dream, he has to have sex immediately and on a regular basis to prevent sperm built up in his head that will make him become crazy or will give him pimples. Also when a girl has her first menstruation period, she needs to start having sex.
- People believe that when a boy is circumcised, he cannot be exposed to any infection, even when he is not wearing a condom in any sexual activity (for example during anal sex).

Non gender related

- People think it is safe to have anal sex or thigh sex. However, during anal sex there can be friction and as a result contact with infected blood. Thigh sex is a traditional way of having sex without penetration. A man rubs his penis against the thighs of a woman. This way of having sex is also not 100% safe because friction can also occur.
- HIV/AIDS is only transmitted through sex.
- HIV/AIDS is only transmitted through vaginal sex. This has as a result that people start having anal sex to prevent HIV transmission and pregnancy. But anal sex even increases the risk of HIV infection.
- People believe that they can get the virus when they share food, utensils, etc. with an HIV infected person or when they kiss or touch an infected person. Also they believe that the use of public toilets can lead to transmission of the virus.
- HIV/AIDS is a punishment of God.

- White people put the HIV virus on condoms to get rid of black people.
- White people spread HIV/AIDS among black people through infected needles.
- There is a story of a white doctor called Basone who infected black South Africans with HIV during apartheid.
- Traditional healers heal STI's and people believe some might heal HIV/AIDS. There are traditional healers who say they have herbal medicine to cure HIV/AIDS, and people go there and pay a lot of money for it (sometimes 200Rand for a bottle, and you have to go back when the person does not get better and then you have to pay again or you go to another healer).
- People are born through sex and will die through sex. It is okay to die through something that created you. The circle is then made round.
- Thin people have HIV/AIDS, big or fat people have not.
- People have fear to go for an HIV test. They think that once they know their status as being positive, they will die the following day. As a result some people hang themselves when they know their HIV positive status. It does not come to their minds that if they know their status, they can prevent re-infection, start with ARV's and prolong their life. They just do not know.
- Doing physical exercises makes the HIV virus in your body to disappear.
- Condoms themselves are carrying HIV/AIDS.
- Condoms carry insects or maggots.
- Condoms freely made available by the government are not to be trusted. The suspicion of low quality of the governmental condoms is based on the fact that there are frequent breakages.

4.1.1.7. Cultural or customary practices

The practice of polygamy is still applicable in rural and/or peri-urban KwaZulu-Natal. This is in combination with labour migration. Buhle Mahlase shares that men leave their partners for bigger cities in search of work. They come back after a long period of time or only during "bigger" holidays (once or twice a year). In the cities they have other partners. They bring these new partners home, leave them there and go back to the city where they will have another one. They do not use condoms because they are faithful to each other (that is what they say to each other).
It is also common that migrant workers have a rural wife at home and an urban wife in the city. It is not difficult to guess that men also find their sexual satisfaction by paying for it. The fact that married men who work in the big cities (like Johannesburg) have sex partners there is also widely reported in TAI's documents and confirmed in interviews with guardian educators, participants and Paul Bradley Gibbs. The wives who stay at home are also not necessarily faithful to their husband, often for economic reasons.

According to Buhle Mahlase, there are places where the practice of virginity testing among girls is conducted. Older women believe that if this cultural practice is maintained, girls will not have sex and as a result this practice will bring a change in the AIDS epidemic. But girls have anal sex instead which increases the risk of HIV infection even more. They do not use condoms, because they think that the virus cannot be transmitted through anal sex.

According to Suzanne Leclerc-Madlala (2001), virginity testing is consistent with commonly held beliefs that the epidemic is the result of women being sexually 'out of control'. It is an attempt to manage the AIDS epidemic by exerting greater control over women and their sexuality. In addition, virginity testing of girls helps to draw attention away from the role of men in the maturing epidemic, a role that has been conspicuously absent in the popular discourse on AIDS in South Africa at all levels of society.

In an interview with a guardian educator involved in the Inkunzi Isematholeni project, I learn that men pay lobola[23] to marry a woman. Paying lobola means that the woman needs to obey to whatever the husband tells her. Another guardian educator says that parents encourage their daughter to get married at a very young age. Sometimes the girl is only 13 years old. In marriage, it is not expected to use condoms. As already declared in the literature study, intergenerational sex (sex between teenage girls and older men) increases the risk of HIV infection among teenage girls. Some of the staff members find that a lot of girls are married in their teens (often as a poverty-reduction strategy) and that young brides are mostly married to much older men.
The educator adds that the husband does not want to use condoms because he has paid lobola for his wife and it is her responsibility to have children. Reports say that men who have paid lobola have the right to force their wives to have sex.

Lastly[24], the culture of 'ukuthwala' is described in reports, even though it is now on the decline. According to this culture, a man sends his male delegation to 'kidnap' a woman of his choice. They bring her to his home with the intention to make her his wife. On the following day, the man sends the delegation to the woman's home to report marriage. If the girl does not want to become his wife, the man forces her to have sex with him so that she is no longer a virgin. This is to discourage her from running away.

4.1.1.8. Stigmatization and discrimination

The majority of the staff members – few mark the code 'don't know' – agree that many women and girls experience stigmatisation, noticed by:

- HIV/AIDS is referred to as a woman's disease
- HIV/AIDS is referred to as a prostitute's disease
- Women are seen as sexually out of control (promiscue)
- Women are not to be trusted
- Women are seen as carriers of HIV/AIDS
- Women are blamed for HIV/AIDS
- Disclosing the HIV positive status has direct consequences for women: some of them have been abused, abandoned or thrown out of their homes and jobs.

The latter is confirmed by Pelele Mlangeni telling that there was once an HIV positive woman killed to prevent her from spreading the disease. It also occurs that HIV positive women get chased away from their communities.

[23] Lobola is a brideswealth.

[24] Another cultural practice as stated in many interviews and reports but not gender specific, that puts many people at risk of HIV infection is 'healing with razor cuts'. A traditional healer gets invited by a family belonging to a certain surname to make razor cuts in the faces of boys and girls. The practice is very dangerous in this manner that the traditional healer uses only one razor blade for several people. If one person receiving razor cuts is infected with HIV, the others following will get infected as well. The virus transmits a 100% through blood. The traditional healers do not use plastic gloves to protect themselves while performing the cuts.

Buhle Mahlase adds that it often occurs that an HIV positive woman gets sexually abused by her partner when she discloses her positive status. The husband is convinced that she got the virus from somebody else, surely not from him. He then abuses her for bringing in the virus, without using a condom because he does not care. The blame is placed on women. Men do not see their responsibility in the spread of the disease. A guardian educator confirms this by telling that when a woman discloses her positive status to her husband, he will ask her from where she got it. The husband does not look at himself as the possible transmitter of the virus. This is in line with what the clinical psychology professor mentioned. He says that women carry the responsibility around HIV/AIDS.

All the staff members agree that stigma inhibits people from getting tested, people from disclosing their HIV positive status, HIV positive people from seeking treatment and care, and HIV positive women from buying powder milk for their baby.
Staff members, Gaetane Le Grange and Pelele Mlangeni, say that a lot of people do not want to disclose their HIV positive status because of discrimination. They fear that they would get chased away from the community. This is also noticed by a guardian educator telling that people fear that they would be neglected by family and loved ones. People do not tell when they are HIV positive and keep on having sex with their husband or wife without using a condom.

Girls and women often experience discrimination, such as the unequal access to economic opportunities. Also women do not have the right to own or inherit land. Nowadays, this is changing and Gethwana Makhaye declares that a single woman can buy land.

4.1.2. Taboo

TAI says that HIV/AIDS, sex and sexuality are susceptible to taboo. Some of the staff members think that cultural taboos prevent many young people, particularly young women, from receiving or using prevention information, services and tools (such as condoms). Pelele Mlangeni admits that people living in rural areas do not believe that HIV/AIDS exists in their communities.
From the interviews, I learn that especially elderly people believe that HIV/AIDS is not present in rural villages but only exists in urban areas. People still do not realize that the risk is there, although a lot of men come from the big cities where they work and have many girlfriends, to their wives in rural villages. People just cannot accept the fact that HIV/AIDS is also present in their villages.

Some see the disease as witchcraft, not as HIV/AIDS. When somebody is ill, he or she does not think of HIV/AIDS. He or she thinks that some other person has bewitched him or her. As described above, people look for somebody to blame. Some people claim that a person infected with HIV has been given something to eat (‘idliso’) which makes him or her sick. Once it is inside the body, it becomes poisonous and it eventually kills the person.

Because of taboo, there are also people who give the disease other names. A guardian educator tells that people use the word Z3 (as the car brand) for HIV, 3 stands for the three letters in HIV. This is also mentioned in the interview with girlfriends of Shosholoza boys.
People talk about the opportunistic diseases such as TB and pneumonia, but not about HIV/AIDS.

According to Pelele Mlangeni, some HIV positive people are locked in their home by their parents. Because HIV/AIDS is associated with sex, the family of the infected person is ashamed. They do not want the sick family member to be seen by the community. Because they do not want others to know, they hide the sick family member. HIV/AIDS and the link with sex are made taboo.

Analysis of interviews makes it clear that parents do not talk about sex and HIV/AIDS to their children. Youth is discouraged to discuss sex with their parents or adults in general. Between partners it is also very difficult to talk about these issues. Culture does not allow talking about sex.

4.2. Analysis of the HIV/AIDS prevention programme of TAI: strategies adapted to the socio-cultural context (of taboo and gender inequality) in order to make HIV/AIDS prevention effective

4.2.1. The vital role of existing structures or groups

Projects receive broad acceptance and support from the community when local structures or groups are involved from the very beginning and when these structures or groups are included in decision-making, planning, implementation, monitoring and evaluation of the projects.

4.2.1.1. Targeted group

- The Shosholoza AIDS project

The main emphasis of TAI is on the fact that young men can be positive agents of change within their communities by being role models to others. Men have the power and they need to learn how to use this power positively and creatively. The changes they will realise will positively affect the women and girls in the community. By working with young men, TAI wants to promote positive masculinity and fatherhood.

TAI looked for places where young men could be found. Through the structures of SAFA, TAI obtained access to many local soccer clubs that capture much of the attention of many young men in South Africa. TAI uses soccer players as role models who are powerful in the community. Some soccer players from Durban play for the national team and they have a lot of influence on their supporters.

Soccer is the most popular sport in South Africa, especially now with the World Cup coming in 2010. It is mostly played by black men, the race group that knows the highest prevalence of HIV infection. By using the popularity of soccer to spread HIV/AIDS messages, TAI tries to win the hearts and minds of young people and says “if you want to become a professional, you need to consider HIV/AIDS”. To touch young men on an emotional level and to make them realise the importance of addressing HIV/AIDS related issues, TAI had to gain a deep insight and understanding of the sub-culture of soccer. TAI uses the language of soccer which is acceptable and powerful.

The soccer players within one team are people from the same community and when they reach out to other people in the community, they understand the culture, norms, values, dynamics and they speak the language of the community. These young men are known in the community, are based in the community, are a resource that stays in the community and people can access them at any time. They gain trust from community people and have credibility.

- The Inkunzi Isematholeni project

A school is an opportune place to give HIV/AIDS education to many boys and girls. But as an organisation, it is difficult to educate each person individually. Therefore, TAI decided to work with a selected group of young people who receive a comprehensive HIV/AIDS training and disseminate what they have learnt to the other school learners.

Adolescence is a critical phase for intervention because in this period of life, boys and girls consolidate their gender identities. Adolescence provides the opportune time to positively influence behaviours, choices and lifestyles.

In this project, primary schools (grade 1-7, 6-13 year olds) and high schools (grade 8-12, 14-18 year olds) are involved. In the high schools, some of the participants are older than the focus group of 10 to 15 year olds. Some of them are already 17 to 19 years old. The reason to also work with older boys and girls is to create an enabling environment for the young participants in high school. Younger boys and girls need the support from older ones to obtain a real impact in the school and at the same time the older ones are effective role models for peers and younger school learners. Older boys and girls can help encourage the younger ones to abstain from sex. Most of the young participants in high school were first participants in primary school. They were kept in the project when they graduated from primary school and moved to high school.

- The Sibambiqhaza community project

Before the start of this project, youth who participate in the Shosholoza and Inkunzi projects experienced a lot of problems with accessing free condoms in the clinic. Nurses would give them a really hard time or threatened that they would tell their mothers. Also community people had a lot of difficulties with youth talking about sex related issues. To support youth in their initiatives for HIV/AIDS prevention, adults from the community were asked to help them and to create an enabling environment for HIV/AIDS prevention. These adults do lobbying, advocacy and mainstreaming work relating to HIV/AIDS, but also organise events and campaigns in the community to raise awareness on the socio-cultural barriers in HIV/AIDS prevention, with a special focus on gender-based violence, stigmatization and discrimination. In general, more women (70%) participate in the project than men (30%) and most adults come from existing groups or structures (for example the vegetable garden group, church leaders, the South African Police, etc.). A reason for this imbalance is that men leave the project when they find employment, and in Greytown area most men are working in the big cities.

Some of the adults participating are people who have certain power in the community, for example the Inkosi and Induna[25], but also religious leaders, traditional healers, teachers, police officers, etc. It is important that leadership figures are involved to give more credibility to the HIV/AIDS message and to obtain a better result in raising awareness and in mobilizing people to turn into action. They function as role models. It is important that the messenger is somebody from the community itself, not an outsider, who is able to reach people's minds and knows the local culture.

[25] The Inkosi is the traditional leader of a village or a rural area. He receives help from several Induna. The Induna report the community issues to the Inkosi and together they solve them.

- The Abafana Bebhola Bayanakekela project

Two soccer teams from two different villages were approached by TAI, because young men need to be more actively involved in caring activities. Women are faced with the increasing burden of caring for OVC, sick and dying family members with little or no help from male family members. This is because 'caring' is seen as 'women's work'. Young men need to learn how to care for others and need to realize that it is okay to care. The young men serve as 'big brothers' for the children who live in absence of male role models. As already stated above, soccer players have a lot of influence and can be role models to the community.

It is worth mentioning that the names of the different projects are chosen by the participants. The name 'Shosholoza' is derived from the national soccer anthem which is sung for the national soccer team to 'pull together' in their efforts. This song has roots in migrant labour history and was used during times when a team of workers needed to synchronise their strength to pull, or push, in unison. In TAI's context, the name signifies the need to 'pull together' as a nation in the fight against HIV/AIDS.
Inkunzi Isematholeni means 'how the calf is raised will determine the quality of the bull', Sibambiqhaza means 'we support each other', and finally Abafana Bebhola Bayanakekela means 'soccer players being carers'.

4.2.1.2. Selection of participants

- The Shosholoza AIDS project

The participants (15) are selected by the team owners and the team managers (stimulates ownership). The teams are selected by SAFA. The criteria used by TAI are a certain age (between 15 and 24 years old) and the ability to speak to a group.

- The Inkunzi Isematholeni project

First, a school (school governing body[26] and school management team[27]) gets informed by TAI about the lay out of the project and what the project is about. If the school is interested, the selection of participants is done by the school management team. The school management team chooses its own criteria of selection (this stimulates ownership), besides the criterion that TAI's work is focused on young men.

Per school 15 learners are selected. The project in the primary schools is funded by ABSA Foundation and started in 2001, the project in the secondary schools is funded by Engen Petroleum and started at the end of 2005. In the primary schools, the project works with 15 boys as PE's, representing different grades. In the secondary schools, the project works with 10 boys and 5 girls as PE's, representing different grades. TAI started working with school girls because the demand of girls wanting to participate became so high. They can assist the boys in their work and together contribute towards a more gender equal environment.

[26] School governing body are parents of school learners.
[27] School management team is the school principal and head of departments (= teachers).

- The Sibambiqhaza community project

The people involved in this project are selected by the community itself (a community committee with the Inkosi) or others volunteer. A criterion of selection is that the adults are preferable from an existing group in the community. There are about 50 adults participating in the project.

- The Abafana Bebhola Bayanakekela project

With permission of SAFA, TAI selected 2 teams from a list of teams given by the traditional leaders and the advisory committee from the areas. All these teams were first submitted to Focus Group Discussions and a questionnaire. Secondly, a panel of 3 TAI judges selected the 2 teams with the best responses.
Two teams (30 boys) are responsible for 90 OVC, so each boy takes care of 3 children. The soccer players are young men between 15 and 23 years old, the OVC are boys and girls from the age of 5 to 10. The OVC have been identified by the advisory committee (some members work at the local health centre). The causes of death of the parents are not known but it is assumed that it is HIV related. These kids stay with their grandmothers or guardians. Most of the time it is with their grannies who often do not have the energy to help these kids.

4.2.2. Working with men to help women

TAI challenges community and cultural norms and values and changes mindsets around gender orientated issues, such as the belief that a man has to take all the decisions in sexual relations, that a man is a real man when he has more than one sex partner, that there is a need to discipline your wife or partner through beatings, that when a woman says “no” she actually means “yes”, that caring and household activities are women’s work, etc. TAI promotes a greater understanding around the rights of women and children and emphasizes that these rights are human rights. TAI promotes positive masculinity and fatherhood in a way that supports women and alleviates the burden that they face due to the HIV/AIDS epidemic. TAI promotes activities that further entrench women’s rights such as encouraging men to help with chores around the house, encouraging men to participate in caring activities and teaching men communication, decision-making and negotiating skills (see also further) (organisational profile, 2006).

4.2.3. Capacity building: Shosholoza, Inkunzi and Sibambiqhaza project

4.2.3.1. Training

- Start from where people are

Before training is given to participants, TAI conducts a base-line study to know what their current understanding is of HIV/AIDS and prevention. According to the knowledge they have, the training gets prepared. Additional research (through focus group discussions and questionnaires) can be necessary to form the content of the training, for example about the factors that put youth at risk of HIV infection or about the current understandings of domestic violence in the community. A listening survey is also a good idea to find out more about people's main concerns and needs. Therefore, TAI needs to approach the participants with an attitude of learning, not one of judging or pointing fingers. It is important to go to each community or group with a clean slate and not having assumptions about what they know or about what their experiences are. Even during training, when questions are being asked to participants, the programme officer works with the answers, examples and ideas that the participants give.

Workshops aimed at traditional healers use very different materials and approaches compared to workshops aimed at young people. The training structure is very adaptable, so that the expectations of the participants are met and their goals are achieved. Training addresses the real issues as felt by the group.

- Personalizing the risk of HIV infection and the impact of HIV/AIDS

One of the core strengths of TAI's training is that the organisation does risk assessments. The training walks the participants through a process of looking at how at risk they could be by filling in a self evaluation questionnaire, as well as how they think being HIV positive would influence the achievements of their future goals. One of the reasons why people engage in risky sexual behaviours is that they do not have a future goal in mind, like tomorrow does not matter. Participants learn how to visualise their goals and dreams for the future and TAI helps them understand how behaviour today can impact that future. Participants become then a lot more receptive to trying to protect themselves and their loved ones. They are able to see the benefits of positive sexual behaviour, positive masculinity and fatherhood for reaching their own future goals and for the future of their female partners.
Apart from that, participants reflect on the possible and observable impact of HIV/AIDS in the schools, families and communities. It makes people realize that taking part in the fight against HIV/AIDS becomes a necessary and life saving matter.

Nowadays, many participants find it very important to preserve life and to take care of themselves in order to be present at the World Cup of football in 2010, which is hosted by South Africa. The soccer players might also be the potential stars of the World Cup in three years time.

- Interactive HIV/AIDS education and giving options

TAI presents the participants with correct and relevant information about HIV/AIDS and related issues that helps them to make their own informed decisions. Programmes that are aimed at youth focus on abstinence, but very often youth does not abstain from sex. Instead of telling things that they do not think they can do, TAI presents different options and they choose what is best for them.
Educational training is about:

- Growing up, puberty: body changes among boys and girls (pimples, wet dreams, menstruation, etc.), myths and misconceptions
- Masculinity and femininity
- Relationships, meaning of love, sexuality
- Reasons of having sex and the consequences
- HIV/AIDS: difference between HIV and AIDS, origin, symptoms, modes of transmission, myths and misconceptions, ARV's, etc.
- STI's (what, kinds, symptoms, transmission, etc.) and link with HIV/AIDS
- The importance of treating STI's
- Different kinds of sex (vaginal, anal, oral) and the different risks for HIV infection
- Prevention methods
- VCT
- Support of HIV positive people
- Human rights (especially relating to girls and women)
- Gender-based violence
- Rape and abuse: effects on the victim, what to do when you are being raped, what to do after rape, etc.
- Alcohol and drug (ab)use as contributory factors to HIV infection.

In short, all the relevant information is given in a way that they understand it, for example by using metaphors (the immune system being attacked by the HIV virus is compared with the country being attacked by enemies and the soldiers being killed), drawing pictures of the body changes, using role play, etc. The participants also come up with their own ideas of explaining the disease.

The programme officer does not impose on the participants. All the information (answers) comes from them. The facilitator's input consists of correcting wrong information or filling in the gaps, i.e. adding missing information.

- Condom demonstration

To break myths and misconceptions about condoms, the programme officer shows the participants how the condom looks like and how they should use it correctly. The programme officer also gives advice on where to keep the condom and on the importance of checking the expiry date. He or she also gives a demonstration of the application of a female condom. After demonstration, the programme officer distributes male and female condoms to the participants.

- Raising awareness on socio-cultural barriers through questioning and Focus Group Discussions

To deal with socio-cultural barriers in HIV/AIDS prevention, TAI asks the participants a lot of questions to make them aware of certain issues. For instance, when they fill in a questionnaire, a lot of information is gained from the participants, but at the same time the questions make them think about certain topics.
Also by having the participants involved in Focus Group Discussions they start to think about these barriers and give their perceptions and opinions. The programme officer, operating as a facilitator asks questions that challenge experiences and previous knowledge of sexuality, HIV/AIDS, prevention, etc. For example, the facilitator asks questions about what exposes youth/women/men to HIV/AIDS, why women are mostly infected, what rape is, what domestic violence is, what it means to be a proper man or woman and the link with HIV/AIDS, etc. Where the group is formed by boys and girls, the discussions become even more interesting. Boys learn from the perspective of girls and vice versa. Each one grows in personal understanding by discussion and reflection on real life situations. In addition, discussion is a means by which to identify the issues that are pertinent to the participant's lives. These issues are being explored, for example issues regarding relationships, health, sexuality, etc.

Masculinity and fatherhood are being questioned. As TAI wants to promote positive masculinity and fatherhood, the programme officer asks the participants to reflect on things they like and dislike about being a man and on what kind of fathers and husbands they would like to become. They think about what it means to be a responsible and good husband, partner, father, brother, colleague, etc. This intervention can facilitate the development of a culture of self-respect and respect for others.

- Raising awareness on socio-cultural barriers through activities and information transfer

The programme officer works with role plays to challenge gender inequality. For example: a boy plays a girl and plays certain conversations or scenarios in which he is asked how he feels to be treated in the same way as a woman is being treated, such as not being able to take part in decision-making or being discriminated against.

Participants are sometimes asked to draw pictures, for example of rape. This strategy is about making the participants think about certain issues (like forced sex, dominance of men over women, stigmatisation and discrimination, etc.) whereas before they really did not give it much thought.
While drawing pictures of body changes, many myths and misconceptions (for example about pimples, see also the paragraph above about myths and misconceptions) come to the surface and can be discussed. The programme officer helps them work through these issues internally.

Challenging socio-cultural issues is not easy as for example boys and girls have been taught their whole live that forced sex or multiple sex partners are acceptable. Their fathers who discipline their wives through beatings or who have more than one sex partner are their role models. There is an enormous pressure on young men to conform to certain patterns of behaviour that put them and their female partner at risk. TAI asks about their feelings when they are confronted with such issues.

TAI helps them understand why it is not acceptable or why it puts them and their female partner at risk of HIV infection, not by telling them that it is wrong or by prescribing them what to do, but by giving them correct information and by letting them do activities that make them think about it. In addition, the programme officer provides positive substitute behaviours and explains the benefits.

Regarding myths and misconceptions, it is very important to give participants the correct information. Participants receive an information kit attached to a training manual in Zulu language. In discussions, the programme officer is able to offer information about HIV/AIDS and related issues at any time. The programme officer does not force participants to change in behaviour or attitudes but gives them the accurate information why they should maybe consider changing. Finally, it is up to them to make the right informed decisions.

- Raising awareness on socio-cultural barriers through case studies

Stories are discussed in group. For example: a story about a good teacher thrown out of school because she is HIV positive (a case of discrimination of HIV positive people). Questions for discussion are posed by the programme officer such as:
What are the consequences for the teacher?
How was the situation dealt with? Do you (dis)agree?
How could you support the teacher? What can you do to prevent such a situation?
Etc.

- Creating a safe environment

TAI creates a safe space wherein non-conformity to gender stereotypical behaviour can be admitted and discussed. Young men and boys are able to examine their beliefs and attitudes around masculinity, to re-negotiate their meaning of masculinity and to develop alternate patterns of masculine behaviour.
Through working with a safe forum, TAI tries to discuss, question and challenge perceptions of masculinity and femininity which reinforce gender inequalities and fuel the spread of HIV/AIDS.

The provision of a platform gives participants the chance to express themselves and to talk about topics that are sometimes very painful and rarely discussed within their families and culture. Hereby, trust is very important. The group establishes a code of conduct, which includes rules stipulating the confidentiality of what is discussed in group.

- Incorporation of skills

To become positive agents of change within the community, TAI provides the participants with the skills they need to do that. The participants learn communication, decision-making and negotiating skills. The training sessions are engaging and allow the participants to practise those skills. Through the use of role plays, communication about condoms and sex and negotiating with the partner about condom use is being practised. Also communication about family planning and social issues between men and women is encouraged. The participants learn that within the communication it is important to listen to each other and to treat each other as equals. They learn to respect their partner’s choices.

Furthermore, participants learn how to run a meeting because they need this skill to network with community structures and stakeholders. They learn how to draw up their agenda, how to make a presentation, how to write a proper business letter to invite stakeholders to a meeting, how to market the organisation, etc. They learn how to address the community and how to speak to a large group of people. They learn how to be confident in expressing themselves in HIV/AIDS and related issues.

Lastly, the participants learn project management skills which enable them to implement and manage their own initiatives (see also further 'make a plan of action').

- Participatory approach

TAI does not do things for the participants. They learn how to do it themselves. As already mentioned in the previous sections, TAI does not impose things but it lets participants think for themselves about certain issues through Focus Group Discussions, drawings, role plays, answering questions, giving ideas and examples, etc.

In line with the participatory approach, the participants are involved in decision-making, planning, implementation, monitoring and evaluation of the programme. Their input is very valuable. They can advice TAI whether it is going the right way or not and what the new themes and vibes are among the peers. Jointly with the programme officers, they think about what it means to be a good husband, partner, father, brother, etc. They build a joint understanding of positive masculinity and fatherhood.

In training, participants have questions themselves to ask the programme officer. The programme officer will let the participants think about the possible answer. TAI believes that the answers should come from the people, not from them. A programme officer operates as a facilitator and in this way fosters the development of responses built on local understanding and local strengths.

- Language of youth

TAI uses the language of youth to mobilize and motivate young men, school boys and girls in HIV/AIDS related issues. Within the Shosholoza AIDS project, the language, beliefs and behaviour around soccer are used as a creative medium for facilitating change in the risk behaviours leading to HIV infection. For example, they use the slogan "scoring goals against HIV/AIDS!", "No condom…no game!" or "Score your goals, not HIV!". In order to effectively educate boys and girls about HIV/AIDS, it is necessary to employ the discourse that is most familiar to them. This makes it easy for people to identify with the message and at the same time it offers participants a way of communicating HIV/AIDS prevention to their peers, for example "wear your shin pads!" (within soccer) as referring to condom use.

- Make a plan of action

On the last day of training, participants make a plan of action. They discuss in group what they are going to do in the community and make concrete decisions. They look at the theme they want to address. In the Inkunzi project, the participants divide themselves according to the number of grades.
TAI follows up the plan. Again, TAI does not tell them what to do. The participants decide themselves about who is going to do what, when and how. They incorporate time frames.

Role plays give the participants the chance to practise how they will spread the message to the community. For example they explain to a friend what the workshop was about, they explain to a friend how to use a condom, etc. After implementation of the plan, they report to the programme officer how it went and they discuss further steps.

4.2.3.2. Ongoing mentoring, support and engagement from TAI

- Mentoring and support

After training, the participants receive ongoing mentoring and support from TAI. The programme officer meets them once a month. During the meeting, the programme officer gives the participants additional information that they might need, they discuss personal decisions and challenges that the participants faced and how they can overcome these challenges (for example if a young man has not been able to use a condom, they look together at why this was difficult and what can be done to do it better) and they reinforce successes.
Once the participants are comfortable with all the issues relating to HIV/AIDS and are confident enough, they start an outreach programme (see following paragraph) according to the plan of action. This outreach programme also gets monthly evaluated and discussed by looking at the challenges and successes.

- Continuous engagement

TAI is aware that you can not just walk into a community, hold a workshop, leave and expect that everything will change. To gain success, a continuous engagement is necessary (a commitment of at least 3 years). The 3 day training is the foundation of TAI's work which is followed by ongoing mentoring, Focus Group Discussions, refresher courses (at the start of every year), etc. The socio-cultural barriers need to be discussed and worked through and this is not made possible in a short period of time. To challenge stereotypical behaviour and cultural norms and values that define the identity of a community and the identity of each individual living in that community, a lot of patience, effort, dedication, skills, perseverance and motivation is needed. Talks and activities concerning socio-cultural themes will raise awareness on the problems day by day and thus will eventually lead to behaviour change. It is important to understand that raising awareness and behavioural change are processes that take time. It requires the programme officers to be open, patient and non-judgemental.

- Monthly topics

TAI works with monthly topics, for example the topic 'rape and abuse' and 'alcohol and drug abuse and the link with HIV/AIDS'. During one month, the programme officer holds Focus Group Discussions and workshops with the participants relating to the chosen topic.
After discussion, information transfer and participation in activities, the participants are given the task to make a plan of action to also educate other people in the community about the topic. These monthly topics vary per community. The topics discussed depend on the present and relevant problems in the community, reported by the people living there, and are close to the local culture. Possible answers to problems come from the participants themselves. The programme officer[2] acts as a facilitator.

4.2.4. Peer education: Shosholoza and Inkunzi project

From now on, the participants are called Peer Educators (PE's) because they start sharing their knowledge and skills gained with peers, friends, partners, parents, family and other people in the community. They reach out according to a plan of action and become positive role models within their communities. The Peer Educator Model allows prevention messages to reach the whole community.

4.2.4.1. Continuous outreach to and involvement of neighbouring soccer teams, school learners, community structures or groups, businesses and community people

- The Shosholoza AIDS project

Soccer teams involved go to neighbouring soccer teams, train them and mentor them. They also form partnership with local businesses (for example taxi associations, tavern owners, farmers, etc.) and community groups or structures (for example a women's group, agricultural group, forest group, church group, local development structures, local clinics, local leadership, schools, etc.). In one village, the soccer team has a partnership with the local research and health care centre (CAPRISA). The PE's meet regularly with them and look at how they can best reach out to the community as a whole. The businesses and structures help the soccer players to disseminate information about HIV/AIDS and prevention in order to have a real impact in the community. They hold events, campaigns and community meetings, wherein messages spread are more towards sexually active people. At these events, speakers from the different structures or groups give speeches about HIV/AIDS in the community. The soccer players also give speeches and stimulate community people to go for an HIV test and to reduce the number of sex partners. They distribute condoms in cooperation with tavern owners, the taxi associations and the schools in order to get condoms closer to the people. The Shosholoza boys talk to the local traditional leaders about the project and they speak to traditional healers in community meetings.

- The Inkunzi Isematholeni project

Selected PE's in primary and secondary schools educate school learners from every class within every grade. Not every grade is represented among the PE's but they reach every grade in the school.
In the primary schools, this happens through the grade representatives, a boy and a girl identified in each class of every grade. The PE's share their knowledge and skills with the grade representatives and these representatives are given the task to share the information with the learners in their classes. Some grade representatives receive direct training from TAI or are involved in meetings and discussions with the programme officer. The representatives were introduced into the programme to make sure the information was spread enough and to involve girls who can assist the boys in their work.
In the secondary schools, the information is shared through the PE's (male and female) directly. Young people feel more comfortable talking about sex and HIV/AIDS among each other instead of an adult talking to them about sex. Young people also relate better to the information when it is given by people of the same age. The PE's present themselves in the schools and they tell the learners that they can always ask the PE's questions, ask them advice and tell them stories about HIV/AIDS. Lastly, PE's are encouraged to educate people in the community and in nearby schools.

4.2.4.2. Ways of reaching out

- Edutainment (Education through Entertainment)

Another strategy that TAI uses is 'Education through Entertainment'. When the PE's educate others about HIV/AIDS, prevention and barriers, the PE's internalise all that information. They develop edutainment (cultural) activities like drama, poetry, gospel, Isicathamiya (Zulu dance[28]), songs, speeches, monthly debates, etc. which carry relevant messages about HIV/AIDS and related issues. A drama can express a theme, like the importance of abstinence from sex at a young age, the need to go for a blood test to know your status, alcohol abuse and the link with risky sexual behaviour, men not wanting to use condoms and their wives getting infected, a woman being raped and as a result infected with HIV, communication between partners about condom use, migrant workers having sex partners in the city and getting infected, giving support to an HIV positive person, the need to report when you are raped, etc. Sensitive issues are openly addressed. Debate for example is about: "Are women to be blamed for the spread of HIV/AIDS?" Debating is also a good way of identifying and challenging myths and misconceptions about HIV/AIDS.

Edutainment is not only a reinforcement of what the PE's have learnt, at the same time they reach others' minds. The PE's disseminate correct and relevant information and educate people about HIV/AIDS by using creative mediums close to the local culture. They use mediums they are familiar with and the activities are a reflection of social reality. Edutainment is much more attractive than a lecture. It is great fun and has more impact on the people. It makes people think about certain issues and raises awareness in the community on socio-cultural barriers in HIV/AIDS prevention. The audience is left with the feeling that there is a need to change their attitudes and behaviours. It also promotes dialogue and problem solving. The PE's themselves become more confident and the activities boost their self-esteem.

In addition, PE's draw posters with different HIV/AIDS awareness messages – sometimes to announce events or campaigns - or design various themed slogans for banners, pamphlets, T-shirts, etc. They encourage learners in the school to do the same. At the moment, Shosholoza teams are designing a slogan for the World Cup 2010. The PE's also go to local clinics to ask for materials that they can distribute, for example booklets, pamphlets, posters and condoms.

Finally, PE's divide themselves in small groups and give soccer team-to-soccer team or class-to-class presentations about HIV/AIDS and prevention. They incorporate the relevant information and explain the disease, the risks and prevention methods to others in a way that they can understand it. They hold discussions about several topics linked with HIV/AIDS. What comes up from the learners is discussed (participative interaction). In the schools, teachers are not present in the class in order for the learners to speak freely. PE's also give speeches, presentations and information about HIV/AIDS during morning assemblies in the schools.

[28] This dance is culturally only performed by men. One stands in front and leads the group. The dance is in combination with singing. A popular feature of Isicathamiya is that the meaning of the song is expressed through the body. For example, they put one finger up, expressing the importance of having one girlfriend, or are wearing gloves to express that HIV is also transmitted through blood.

- The organisation of events and campaigns

Within the Inkunzi Isematholeni project, PE's organize grade competitions in the school. All the school learners are involved (as spectators or as participants). Also the teachers and the school principal are present and each grade comes up with creative activities regarding HIV/AIDS. The PE's do not participate in the activities because it is now the school learners' turn to show what they have learnt from them. The PE's guide and support them in their preparations. There are several cultural categories: poetry, drama, gospel, Isicathamiya and debate (chosen by the PE's). Within each category, there is a winner who gets selected by a jury of teachers. The group with the most relevant and meaningful messages about HIV/AIDS, prevention and socio-cultural barriers wins and receives a trophy. Each participant receives a medal. Grade competitions are a good way of reinforcing the information about HIV/AIDS and prevention and of reaching the entire school on a single afternoon. It is a fun event and everyone enjoys the activities. There is no taboo and HIV/AIDS related issues are recognized.

When events are organized, parents (in agreement with the PE's), team coaches, traditional leaders, community people, etc. receive an invitation to come. TAI's staff members are also present. If an event takes place in the community, for example on World Aids Day, Human Rights Day or Youth Day, TAI looks for a speaker to come address key issues regarding HIV/AIDS and the socio-cultural context. On Human Rights Day for example, equal rights and responsibilities of men and women are promoted. The speaker can be someone from the provincial government (department of health), the mayor, a representative of a community structure or group, a social worker, a nurse, etc. Speakers encourage community people to abstain, to condomize, to be faithful and to go for VCT, but they also highlight the issues of gender inequality. This is followed by performances and creative activities of the PE's as mentioned above.

The event or campaign gets announced in the community, so that many people come and many minds are reached. The venues of the events or campaigns are community halls, school halls, churches and clinics. Due to the high public attendance at soccer matches, stadiums are perfect venues for the PE's to promote HIV/AIDS prevention.

At times people give personal testimonies about HIV/AIDS. On a voluntary basis people come speak to the community about their personal experiences. For example: a woman being HIV positive admits her status to the community and tells stories about her being discriminated against in her village. Another example: a little girl talking about rape of young ones by older men (fathers, uncles, etc.) who want to be cured of HIV/AIDS and about children becoming HIV positive before reaching the age of 10.
These testimonies have a serious impact on people and really confront them with the socio-cultural barriers in HIV/AIDS prevention. It is very moving and powerful. Afterwards, people feel they need to change and need to turn into action.

During events and campaigns, the participants of the projects wear T-shirts with HIV/AIDS messages written on the back and the logo of the project on the front. The certain 'uniform' makes the community people aware of the project and its objectives. They also hang banners with HIV/AIDS messages and the project's name.

PE's within the Inkunzi Isematholeni project and Shosholoza AIDS project organise soccer tournaments. On such event, the PE's start with a briefing session on the objectives of the tournament, linking it up to the HIV/AIDS prevention programme. The tournament is like an HIV/AIDS prevention campaign with one special theme. After the tournament with handing out of medals and the winner's trophy, there is time for a round of discussion on HIV/AIDS related issues.

Link and learn events are for the Shosholoza soccer teams and the Abafana soccer teams to meet and learn from each other. This is also organised for the PE groups in the Inkunzi Isematholeni project. To hear others, similar to one self, talking about their experiences, challenges, successes, and future plans in peer education is an absolute incentive. The sharing of experiences and learning from each other builds up capacity of participants.
The several groups strengthen each other and they are motivated by seeing that they do not stand alone. They belong to a family, the Shosholoza or Inkunzi family. By seeing others involved, they realize the importance of contribution to the fight against HIV/AIDS.

4.2.4.3. Incentives as motivation

During competitions with edutainment activities, a medal is given to each participant and a trophy is awarded per category (poetry, gospel, dance, drama, debate, etc.) to the group which spread the most relevant and accurate messages about HIV/AIDS. The rewarding is very effective and participants do their best to create relevant messages in order to win the competition.

After training, refresher course, meeting or event, food and drinks are served for the participants.

SAFA will give free tickets for the World Cup 2010 to the soccer teams involved in the projects. It is a future goal to reach for. Also for games in national competition they receive tickets from SAFA. When they go to the games, they implement activities, for example condom distribution.

Furthermore, the participants receive T-shirts, bags, track suits, etc. with the logo of the organisation.

4.2.4.4. Enabling environment: support from soccer team coaches, guardian educators and parents

It is important to understand that when working with young people, you also need to work with the adults around them who can provide extra support. Otherwise, young people have to take a lot of fire and have to deal with a lot of criticism. It is unfair to put that amount of pressure on them, so you have to work with the individual within its context.

As at the start of the Inkunzi Isematholeni project, PE's reported a lot of problems with school principals, teachers and parents of school learners blocking them in implementing their HIV/AIDS related activities in the schools. Although teachers were made aware of the project and had agreed to make efforts, they did not plan well enough and did not allocate time to the PE's. TAI learned from this experience and recognized the need to train the school management teams and the school governing bodies.
The training is on a higher level than the one with boys and girls. It looks more at the possible impact of HIV/AIDS in the school environment (on teachers and learners) and makes principals, teachers and parents understand why HIV/AIDS is a problem to them and why it is important to act and have programmes in the school. For example: a possible reason for a school learner not coming to school is that she has to take care of a sick or dying parent, suffering from AIDS. TAI also helps them identify school learners that are infected or affected by HIV/AIDS and teaches them how to support the Inkunzi PE's in their efforts, for example allowing the PE's to enter the class and to give an information session about HIV/AIDS prevention.
To specifically monitor the project, guide the PE's, report to and motivate the school management team, ask teachers to allocate time to the PE's, report to TAI, assist the PE's in the implementation of the HIV/AIDS activities in the school, help in problem solving, facilitate ongoing meetings between PE's, ensure that learners participate in the activities and coordinate the events, guardian educators (one or two) are selected by the school and receive training from TAI. Communication with the school and the arrangement of meetings between TAI and the school or PE's is facilitated by guardian educators.

In the Shosholoza AIDS project, TAI works with the soccer team coaches and the parents of soccer players. Parents mobilize community people to come to events. The soccer team coach and the PE group report back to the programme officer about the progress of the programme. At Shosholoza tournaments, SAFA members and team coaches are present.

4.2.4.5. Enabling environment: mainstreaming HIV/AIDS by Sibambiqhaza project

Representatives from different community groups (for example the vegetable garden group, the church group, etc.) and structures (for example police, schools, traditional healers, traditional leadership, local clinics, religious leadership, etc.) mainstream HIV/AIDS within the community by going back to their regular meetings within their respective structures and groups and allocating time to HIV/AIDS related issues.

Secondly, men's Imbizo's are organised in cooperation with the traditional leaders[29]. These are meetings where men from the community come together and discuss certain issues such as gender imbalances, gender-based violence, condom use and men's responsibility to respond in the fight against HIV/AIDS. Condom use is especially encouraged among migrant workers who come back from the big cities (like Johannesburg and Durban) and visit their rural wives. Condoms are distributed through taverns, shops and taxi ranks and people are informed about how to use condoms. When abuse of women and children was increasing in the area, a lot of Imbizo's and door-to-door campaigns were held.

The increase of abuse in the area was also the reason why TAI started working with police officers. The problem was that police would find out second hand about rape or abuse. Often victims do not report rape or abuse because they are afraid that the perpetrator will not be accused and will take revenge by abusing the victim a second time. As a result, the police started stimulating people to report cases of rape and abuse with the emphasis on confidentiality, and they started explaining the rights of women and children and what to do when raped[30].

Because of stigmatization and discrimination being so high in Greytown area, nurses from mobile clinics get lobbied about a more private delivery of services (for example for VCT or ARV treatment). As it is now, people do not go stand in line and wait for ARV's or a test, because then everyone in the community will see who is or might be HIV positive.

Traditional healers involved share their knowledge with other traditional healers. They need to recognize the disease and need to recognize that HIV is also transmitted through blood.

Community people who received training in health work, home-based care and counselling do home visits and organize discussion groups regarding HIV/AIDS related issues. They also help infected people with their ARV treatment and Tuberculosis treatment.
They educate the community about HIV/AIDS and prevention and help raise awareness on the socio-cultural barriers through campaigning (door-to-door, in church, or during events), such as on gender-based violence, stigmatization and discrimination. In 2005, there was a huge event on rape and abuse of women and children in Matimatolo area. More than 7000 people attended the campaign.

[29] A certain protocol needs to be followed when you want to organise an activity in the community, for example a men's meeting. You need to consult the traditional leaders and ask for their permission. If they agree, they will call for the meeting in the community.
[30] Off course, the judicial system needs to be effective as well and perpetrators need to get punished. Sometimes, report documents get lost or perpetrators get released soon after the crime. The court and report systems need to be improved. As the adults involved in the project also do lobby and advocacy work, the police officers can lobby for policy changes.

People who are HIV positive are encouraged to disclose their status to their family and if possible to the community to try to break through taboo and make the disease acceptable. This is in combination with giving people correct information about modes of transmission and prevention of HIV/AIDS.

4.2.5. Strategies in the Abafana Bebhola Bayanakekela project

Because the Abafana Bebhola Bayanakekela project is still a pilot study (started at the end of 2006), does not have an explicit HIV/AIDS prevention programme and is not working through a Peer Educator Model, I have decided to describe the strategies of this project in a separate paragraph. The project has most strategies in common with the other projects.

4.2.5.1. Capacity building of soccer players and OVC in training

- Start from where people are
- Personalizing the risk of HIV infection and the impact of HIV/AIDS
- Interactive HIV/AIDS education and giving options (training): the soccer players receive education about HIV/AIDS and prevention because some OVC are HIV positive. They also know how to use a condom, so when OVC might ask them questions about HIV/AIDS and prevention, they can give explanations.
- Condom demonstration
- Raising awareness on socio-cultural barriers through questioning, Focus Group Discussions, activities and information transfer in training: the barriers discussed are especially stigmatization and discrimination of OVC and HIV positive people, gender stereotypical behaviour, domestic violence and the abuse of women and children. The soccer boys learn what the signs of abuse and violence are and what to do when they are confronted with such cases. They learn how to be a good man by respecting women and children and by taking care of them. Training is gendered in a way that they are given activities to do which are considered women's work and they look at gender equality, more specifically the sharing of responsibilities in caring and household activities.
  The OVC also discuss gendered issues, like how to treat girls and how to help in the household.
- Raising awareness on socio-cultural barriers through case studies (especially about abuse): for soccer boys and OVC.
- Creating a safe environment.
- Incorporation of skills: the soccer players learn how to act as 'big brothers' for OVC and how to give them psycho-social support. Often it is assumed that men do not care but TAI believes that they just do not know how to do that. They learn several skills such as consoling someone, providing basic health care, how to take care of a young child, how to talk to the young ones, etc. skills that women take for granted. These skills facilitate change in traditional gender roles. In addition, soccer players learn how to recognize signs of abuse and neglect, and what to do when they are confronted with it, how to talk about it with the child, how to report it, etc.
  OVC learn life skills (twice a month).
- Participatory approach
- Make a plan of action
- Ongoing mentoring, support and engagement from TAI

4.2.5.2. Outreach programme

- Outreach to OVC in the community: the soccer players sometimes give information about HIV/AIDS and prevention to the OVC in an informal way, not explicit. Some of the OVC are only 5 years old. For instance, it can occur that a soccer player says to an OVC that it might be dangerous to touch blood because of the disease HIV/AIDS. OVC are also made aware of the disease when people in the community die from AIDS. In this way, taboo is being broken.
  The caring activities towards OVC and family members who are sick or dying from AIDS, help break down the traditional gender roles that 'caring' is only done by women. The OVC can count on the soccer boys for psycho-social support.
  The soccer boys talk with the OVC about violence and abuse with the emphasis on the need to come out when they are confronted with such crimes. The soccer boys show the OVC that they support them emotionally and care for them. They are role models for the OVC and other people in the community by showing the importance of caring for others and that men can do it too. For example, when a soccer boy visits the home of an OVC, he can explain to the child that it can help his or her grandmother in the household work, like cleaning, washing the school uniform, etc. and the soccer boy can give the child skills to do these tasks. The OVC are socialized in a way that will lead to gender equality.
  During weekly home visits, the soccer boys play games with the OVC and these activities together give an opportunity to talk about several things. During home visits, the soccer boys see to it that OVC are well kept, get enough food and clothing, go to school, do their homework, etc. The soccer boys teach the OVC life skills that they need when growing up.
- Outreach to the community through the holding of events: On Human Rights Day, there was an event to show the community that men can also care for children and can do household work (for example cleaning, washing the dishes, buying the groceries, cooking, etc.). This awareness event was in combination with messages about HIV/AIDS, prevention and socio-cultural barriers. The participants also organise dance, music, drama and soccer games to make people aware of the project and its objectives.

4.2.5.3. Incentives as motivation

Participants receive T-shirts, bags and track suits with the logo of the organisation and after training, meeting or event, food and drinks are served for the participants.

4.2.5.4. Enabling environment

Support is given by parents of the soccer players, OVC guardians, the advisory committee in the community, teachers of the OVC, social workers, a doctor[31] and other NGO's that are working with children.

[31] A doctor has visited the OVC and has examined them.

4.2.6. Referring to relevant people

A case of child abuse that has been reported from peer to PE will be reported to the guardian educator or programme officer who will warn the relevant people, specialized in such crimes. When everything goes well, the perpetrator gets punished. It stimulates other victims to do the same and it shows the community that rape and abuse of children is not tolerated.

If somebody wants to take an HIV test, TAI can conduct basic counselling and testing. If the person needs more counselling, TAI will refer him or her to professional VCT counsellors.

4.2.7. Evaluation of the impact

To make sure that the projects are running well, are effective and have the expected results, evaluation of the impact of the projects is conducted in many ways and on several moments in time.

4.2.7.1. Stakeholder feedback

All stakeholders (direct and indirect beneficiaries) are asked for their input into the project (before, during and after implementation). TAI regularly consults with all the relevant stakeholders to determine the impact, the successes and challenges of the projects and possible recommendations or needs for the future (organisational profile, 2006). For example, the Shosholoza AIDS project has received a lot of positive feedback from the player's parents and their female partners. Teachers in the Inkunzi Isematholeni project report back to TAI about the progress of the programme and the activities organised by the PE's.

4.2.7.2. Stories of significant change

TAI uses anecdotal evidence to measure the impact of its work.
For example, there have been some amazing cases of young men involved in the Abafana Bebhola Bayanakekela project providing basic home-based care for their dying parents. These men felt so glad that they could do so despite the difficulty of the situation.

TAI receives many letters from parents who write about the positive changes in their children.

Within the several projects, the PE's experience that there is a bit of status attached to belonging to a project. The idea of being a role model has a huge impact on their behaviour and the majority reports a reduction in the number of sex partners, where before many of them had about 5 partners. They also report remarkable changes in their drug use behaviour or alcohol abuse. They used to sniff glue, smoke weed and drink a lot, but now they realize that by doing that they risk their lives and future. They often say that the project has opened their eyes and that they now know how to preserve life. Further, they report that they used to discriminate HIV positive people or blame them of sleeping around. Now they know better and they accept them.

The community in Greytown area (Sibambiqhaza project) can now speak openly about HIV/AIDS and sexual abuse. People start to report cases of rape and abuse to the police and they start to disclose their HIV positive status.
HIV/AIDS and issues of sexuality are increasingly discussed by youth in the presence of adults and teachers. Adults, including parents of PE's, benefit because youth passes on new information.

4.2.7.3. Pre and Post Focus Group Discussions

Based on the Focus Group Discussions in the beginning of the project and after months of participation, a change in thinking and understanding among participants can be noticed. It seems that the PE's start to realize the need for abstinence from sex at an early age, for condom usage, respect towards women, communication about sex and HIV/AIDS, resistance to peer pressure, etc. In addition, discussions show a gradual emergence of 'caring' as acceptable and appropriate behaviour for men.

4.2.7.4. Regular assessment and observation

Assessments are taken from PE's on their behaviour and attitudes before and after training. The results show a change towards more positive, responsible sexual behaviour and attitudes. In a questionnaire about condom use boys report using condoms all the time. They also report that they discuss sexuality and sex with their female partners and that they negotiate condom use with them. This is confirmed by female partners. Off course, social desirability of the answers needs to be considered. It is always difficult to measure behavioural change by asking questions to the person. This is why the behaviour of participants is double checked by asking questions to people in their surrounding environment, for example parents, partners, friends, guardians, teachers, etc. The behaviour of PE's involved in the Inkunzi project is double checked through assessments of the school learners with whom the PE's should interact. TAI asks the school learners what they have learnt from the PE's, and because PE's are expected to be role models, TAI asks the school learners if the PE's practice what they preach.

By seeing that the trainings and workshops are well attended, it is shown that the participants are motivated. The attendance rate at events is a criterion to see if the programme is attractive and has a possible impact. HIV/AIDS events, slogans and activities are also a criterion of evaluation.

One guardian educator says that behavioural change, more specifically the use of condoms, in school and in the community can be measured by looking at the rate of pregnancy. He thinks that condom usage is still low because there is a high rate of pregnancy among teenage girls in his community.

Condom distribution by Shosholoza teams in their respective communities seems to have an impact. Teams observed that condoms – used or unused – did not lie around everywhere as before. The boys found this encouraging. It was a sign that people use the condoms and dispose them correctly. People also came asking for more condoms.

Some Shosholoza boys have committed themselves to testing before encouraging other people to test. Testing is still a very sensitive issue. Participants are afraid of the results. In the Inkunzi Isematholeni project, the majority of the PE's has not yet gone for a test.

4.2.7.5. Documentation system and record keeping

Accurate records of all group activities, events, campaigns and meetings are kept by the participants and TAI (organisational profile, 2006). This helps the participants and the organisation to see the progress of the programme.

The police involved in the Sibambiqhaza project keeps statistics of reported cases of abuse, violence and rape and shares them with TAI.

4.2.8. Ownership

TAI encourages participants to develop and implement their own strategies to prevent the spread of HIV in their schools and communities, with only minimal guidance from TAI. The participants are in control of the projects. School principals and teachers also own the project and they can continue with it, even when TAI is not around. The same applies to the community in Greytown and the Shosholoza teams and coaches. Participants are involved in decision-making, planning, implementation, monitoring, and evaluation to ensure the ownership.

In short, TAI helps paving the way for schools and communities to design and implement their own HIV/AIDS prevention programme and strategies.

4.2.9. Involvement of girls and women

Because experience shows that girls and women also put a lot of pressure on boys and men to behave in a certain way that enforces the negative male stereotypes, and that failure to perform in this way renders boys as unsuccessful in their masculinity and in their relationships with girls, it is important to gradually involve girls and women as well. TAI has done this over the years and can now say that its prevention programme includes both sexes directly to have a greater impact on gender inequality. For example, in the Inkunzi Isematholeni project, girls are also trained to become PE's - most of them before they become sexually active - and are expected to behave as role models in the school and in the community. Most of the guardian educators who support the PE's in their activities are female. In the Sibambiqhaza project, women organise campaigns and events to raise awareness on socio-cultural barriers and the link with HIV/AIDS. In addition, girls and women are also involved in an indirect way, such as the women's group that has a partnership with Shosholoza boys, the female grade representatives and school learners, and the female partners or sisters of PE's. The girls are encouraged to support the PE's in their role and to assist them where help is needed, for example they play a role in drama. Their support makes it easier for the male PE's to resist peer pressure.

Besides the work done by male PE's, more ways of directly involving girls and women is possible through[32]:

- Empowerment projects for girls and women
- Involving young women in soccer teams or netball teams.
- Educating girls to be assertive, to be able to say 'no' to sex, confidence-building.
- Direct training from TAI to receive more information on HIV/AIDS, prevention and related issues and to learn relevant skills. In the interview with 3 sisters of Shosholoza PE's, it is said that the soccer boys might forget to pass on certain information. They say they do not learn enough from them or from the activities that they organise in the community. They would like to learn more about the origin of HIV/AIDS.
  The girlfriends interviewed in group feel that they have learnt a lot. When their boyfriends follow a workshop, they share the gained knowledge with them. But they would like to learn more about mother-to-child transmission, the symptoms of HIV/AIDS and the origin of HIV/AIDS.
- Discussions between boys and girls on sexuality, HIV/AIDS, prevention, etc. One sister says that girls can teach boys how to treat a lady and what a girl likes, and boys can teach girls what boys like. By talking to each other, boys and girls can understand each other better and can influence each other's thinking.
- Educating girls and women about the factors that put them at risk of HIV infection, for example about the hazards related to 'sugar daddies' and having multiple boyfriends for material support.
- Involving girls in training with boys. This will make boys to behave and think in a different way. For example, when boys are together, there is pressure put on each other not to show any kinds of emotion. When girls are introduced into the group, boys are much more willing to show their emotion and that they are upset by certain things. They feel the freedom to acknowledge their sadness, anger and distress for instance towards their father who hits their mother.

The sisters think it is good to have only boys involved as PE's. One says that in black communities boys are the ones who approach girls. They take initiative and they make the decisions in the sexual relationship. They decide to have sex and they give information about sex to girls, not vice versa. They teach girls how to do sex. In an interview with 3 Shosholoza boys, it is agreed upon that it is better to have men in the project because they have the power in the relationship and can force girls to have sex without a condom. Culturally, a man does not take what a woman tells him, she must take what he is telling her. This is in line with what girlfriends of soccer players say, namely boys are the ones who force girls to have unprotected sex. They have the final word in condom use. Boys can teach other people to conduct preventive behaviour. They are leading figures in doing sex. Girls would not be listened to by men.

[32] Suggestions are withdrawn from interviews with participants and staff.

But besides this, the sisters and girlfriends would like to be involved in the Shosholoza AIDS project, either by receiving training in order to get the very same information about HIV/AIDS and prevention as the boys, or by being a PE themselves. They believe that people will also start listening to them. One girlfriend says that it would be good for her, being a possible PE, to educate other girls about HIV/AIDS and prevention because girls also stimulate each other to start having sex and to have more than one boyfriend for material things.
The soccer teams interviewed agree with involving girls in some kind of way, through direct meetings with them, by educating them in the same way or by training them to become PE's. One team thinks it is a good idea to have girls involved as PE's because they can reach the minds of girls who do not want to hear about HIV/AIDS. When they hear other girls talk about it, they will listen. A player from another team says that women can assist them in their activities, and that women will be able to target other women, while they are targeting men. A third team feels the need for girls to be educated more about HIV/AIDS and prevention.

4.2.10. Involvement of people living with HIV/AIDS (PLWHA)

HIV positive people are involved in such a way that there is a support group for PLWHA within the Sibambiqhaza project. These people have disclosed their HIV positive status to the participants of Sibambiqhaza. They have not yet disclosed to the community because of fear of stigmatization and discrimination. They learn how to prevent quick progression to AIDS by applying healthy life styles and by taking ARV's. TAI assists the group with facilitation of discussions to find out what their needs and possible solutions are. They make informal contributions to the project and their suggestions are considered when adding or changing project elements. A recent project with them is the making of a documentary of their experiences. This documentary will be used in awareness activities.

4.2.11. Work relation with governance

TAI works together with the provincial government, especially the departments of Health, Home Affairs, Social Welfare, Social Development and Education. TAI is a resource to them in terms of ideas and for the organisation of events. TAI highlights community problems and needs and lobbies the governmental officials to do more efforts in the fight against HIV/AIDS and poverty. At the moment, TAI and the Sibambiqhaza structures are starting an advocacy campaign for accessible health services.

4.3. Difficulties and challenges for TAI

4.3.1. Lack of commitment from soccer team coaches, guardian educators, teachers and parents

Some parents of PE's or parents of school learners are sceptical towards the prevention programme of TAI. They believe that when young people are encouraged to talk about sex and HIV/AIDS, you encourage them to start having sex. But TAI believes that young people will have sex anyway, whether you talk about it or not. It is better to talk about sex related issues and HIV/AIDS with young people and at the same time educate them about how to protect themselves.

Sometimes when events are organized for school learners in the weekends, the school management team and the school governing body are not present. When refresher courses are given on a Saturday, the guardian educator is sometimes also not present. They do not want to work during the weekend and hereby they do not show exemplary behaviour. They are not committed enough. In addition, it often occurs that meetings with TAI are cancelled in the last minute.
Some soccer team coaches are not present during meetings or at HIV/AIDS events, organised by their teams.

The basic life skills that are taught in TAI's workshops are skills that teachers should give to their learners. Although HIV/AIDS, prevention, sexuality, puberty, life skills, etc. are supposed to be part of the school curriculum learning area 'life orientation', it is still not being taught enough.

In short, the lack of commitment is a lack of ownership because some people still do not see that HIV/AIDS is a problem that affects everyone.

4.3.2. Pressure from the community

Sometimes fathers put pressure on their sons to have a girlfriend at a young age (14 or 15 years old) or to have more than one sex partner. Once it happened that a father wanted his son to stop participating in the project because he found that his son was broken by the project. The son only had one partner left instead of the previous 5 and his father could not handle the situation. It is difficult for TAI to deal with different family situations. There is also a lot of pressure from peers towards boys and girls to engage in sexual activities.

Stereotypes are still very difficult to break. Some women see a man as a real man when he has more than one girlfriend or when he has something to offer (like a car, a cell phone, etc). Some women feel offended when a boy asks to clean the dishes, because they believe it is a woman's job to wash the dishes and it should not be done by men. As mentioned above, it is known that girls and women put pressure on boys and men to behave in a certain way that enforces the negative male stereotypes.

The pressure on young men to perform when it comes to girlfriends, rooted in traditional constructions of masculinity, often results in resistance to the messages that male PE's share with other men and boys, for example to the message which stresses the need for reduction in the number of sex partners.

People in the community can be harsh towards the PE's. Sometimes, the PE's are laughed at and are given names, for example 'the homosexuals'. Some people think that they are the ones who are infected or are spreading HIV/AIDS.

Other PE groups report that it is sometimes very difficult to convince adults of the relevance of their work. These adults think that they are still too young to talk about sex and HIV/AIDS. Some find it not respectful to encourage older men to reduce the number of partners or to use a condom. The elderly are difficult to deal with because they demand obedience to their final word.

4.3.3. Condom availability and access is problematic

Condom availability is a problem for TAI. Although condoms are distributed by the participants, they can never distribute enough condoms. The demand is a great deal higher than the supply. If male condoms are available, they are free. Female condoms are not free, even 'expensive' and their availability is worse.

Condoms are also placed inconveniently and the access is not youth-friendly. In rural areas, free condoms are only available at the clinics and condoms are placed in a box, so whenever you take some patients and nurses can see you. There is no privacy when collecting condoms. Some young people are afraid to go to the clinics because of the bad attitude of the nurses. In addition, the access to the clinics is a problem because the clinics are far away from the villages and people have no money to pay the public transport to get there and back. Mobile clinics only come once a month to the villages.

4.3.4. Lack of funding

There is not enough funding for TAI to do what needs to be done. To get funding for working with men is very difficult because criticism says that men already have so many resources. Because (young) women are the group most at risk of HIV infection, a lot of funding is channelled towards working with them.

Donors decide to work with a certain amount of PE's. Many others are interested in the project and want to participate, but TAI can not follow their enthusiasm due to donor demands and lack of funding.

4.3.5. Lack of sustainability

The purpose of TAI is to provide soccer teams and schools with skills and relevant information regarding HIV/AIDS and prevention. Eventually, TAI wants to move its resources to new soccer teams and schools in order to capacitate as many people as possible. This means that soccer teams and schools already participating in the programme for several years need to start owning the programme. In this way, the work of TAI becomes sustainable and education on HIV/AIDS and prevention keeps on lasting. But in practice, it is a different reality. Some schools are still not committed or interested enough. This is also the reason why TAI started with more than 20 schools and ended up with 14 schools. The lack of sustainability is linked with a lack of ownership. The schools still expect too many answers and input from TAI.

When a PE graduates from high school, he or she is no longer a participant in the Inkunzi Isematholeni project, but he or she has all the useful skills and knowledge that he or she can still share with other people in the community. To make this happen, he or she can form a group with other community people where they discuss HIV/AIDS related issues or he or she can organize events through existing structures in the community. Another option (only for the boys) is to join a Shosholoza team or to create a new Shosholoza team (like in Dannhauser). But sadly this is not done enough. Far too often the project stops with the participant leaving it. More needs to be done to help these boys in finding a way to share their knowledge and skills when leaving the project.

Lastly, is the difficulty that people move a lot. PE's change schools, graduate from primary school to high school, or change soccer teams and then again a useful, capacitated person goes away. Others leave the community for education or career.

4.3.6. Poverty

Although TAI has started income-generation projects with some participants, TAI is confronted daily with participants, schools, OVC guardians, etc. asking for food parcels, clothes, school uniforms, school fees, resources, etc. TAI is able to help the ones who are most in need but can not afford to help everyone.

Secondly, TAI is confronted with people asking for birth certificates or identity documents, because without these papers they cannot apply for children's grants or pension grants. Grandmothers who look after their orphaned grandchildren experience a lot of these problems. They live in poor conditions – they do not have running water, electricity, etc. - and live in mud houses.

A further cause of poverty is that young girls want to get pregnant to receive a child's grant. Sometimes even parents put pressure on their daughters to fall pregnant in order for them to receive money.

Some PE's who graduate want to go to university or want to do another specialized study, but they do not have enough money to pay the studies. It is sad because they have been focusing on school, their future goals and have been positive role models to school learners and community people. Now, they do not have the money to achieve their goals and dreams.
They have been loyal to the project and expect TAI to support them financially. This is very difficult for TAI because it is not possible to support everyone.

Participants, especially the ones involved in the Shosholoza AIDS project and the Sibambiqhaza project, hope to get employed by TAI. But TAI is unable to pay out salaries. Sometimes, this issue makes the progress of the programme difficult.

4.4. General challenges in HIV/AIDS prevention

Working with men is very important for effective HIV/AIDS prevention and it needs to be done in a more balanced way. Men need to address the issue of their responsibility and their impact in the HIV/AIDS pandemic. Nowadays, most of the work is directed at (young) women and only a small percentage is working with men. Most of the NGO sector is run by women and every day they are faced with women who suffer. Women are being beaten, raped and even killed by their partners. As a result, NGO's become quite militant about women's needs and about men being abusers and rapists. A men-hating environment develops. They criticise working with men as taking resources away from working with women and as only further empowering men (with knowledge and skills), while men already hold the balance of power.

Secondly, the environment needs to enable HIV/AIDS prevention. If we want people to use condoms, we must make sure that condoms are available to everyone and that condoms are easily accessible. The government has to do more efforts on ensuring the access to and availability of male and female condoms and on challenging the myths and misconceptions about condoms. When condoms are made available and accessible, people must be made aware of where they can get the condoms.
Furthermore, the government needs to implement more prevention strategies and educational programmes that are effective and the government has to deal with other developmental issues that affect the spread of HIV/AIDS. For example, it needs to deal with issues as infrastructure, lack of access to basic services, clean water, food, ARV's, clinics, etc. People living in difficult circumstances often have other issues to worry about, which are more important to them than HIV/AIDS. Access to food for example is a more concrete and immediate concern than HIV/AIDS. Lastly, the service delivery in clinics and health centres need to be youth-friendly.
For all this to achieve, consistent powerful leadership around HIV/AIDS is necessary.

Thirdly, the economic situation of girls and women needs to improve. Transactional sex in exchange for food, shelter or school fees will then gradually decrease. If you offer economic opportunities and alternatives to girls and women, they can survive on their own without being sex objects to men.

Furthermore, people need to be encouraged to go for VCT. The fear, stigmatization and discrimination around VCT need to disappear. The number of people getting tested has increased over the years, but it is still not enough.

Finally, the illiteracy and unemployment rates are still very high in KwaZulu-Natal. High levels of illiteracy result in people having difficulties accessing health information, like HIV prevention messages. Regarding the unemployment, it is estimated that about 40% is unemployed in KwaZulu-Natal. Unemployment further impacts on health status, morale and confidence. A lot of women start to work as commercial sex workers in order to survive.

4.5. Is TAI's work applicable in other places?

TAI is working in other provinces than KwaZulu-Natal, meaning Mpumalanga, Free State, North West, Gauteng, Limpopo, Western Cape and the Eastern Cape Province in South Africa. It builds capacity in organisations (including the South African Scouts Association) and rolls out the Inkunzi and Shoholoza projects in those areas. TAI's work can also be implemented in other places in South Africa, especially in rural and peri-urban areas.

TAI thinks that its projects can work in other African countries or places abroad. The approach is community-driven and owned, and the work with men can be implemented in every place where gender inequality is a reality, where men are abusing their power and where positive masculinity and fatherhood needs promoting.

5. CONCLUSION FIELD RESEARCH

The results show that the contemporary socio-cultural barriers with which TAI is confronted in its HIV/AIDS prevention work are similar to those found in literature. The environment is struck by gender inequality and deep silence around HIV/AIDS and sexuality. These aspects fuel the HIV/AIDS epidemic, especially among young women.

Men have the decision-making power and decide if a condom is used or not in the sexual relationship. Women do not have the power to refuse sex or to demand condom use in marriage or in a relationship outside of marriage. The sexual discourse is of a patriarchal nature and men control women's bodies.

The unequal relation between men and women is also expressed in women's economic dependency on men. As a result, transactional sex happens a lot in KwaZulu-Natal which increases the risk for women and girls of becoming infected with HIV/AIDS. Women and girls have unprotected sex with men - mostly older men because they are financially better off – in exchange for money, food, school fees, transport, brand clothing, cell phones, etc. The phenomenon of 'sugar daddies' where men seduce girls with money or material things is a daily reality.
When women insist on condom use in a relationship or marriage, they might risk loosing a man's economic support. Because of fear of being neglected and having no food, money or a place to stay, they take the risk of having unprotected sex.
The fact that condoms are linked with promiscuity, unfaithfulness and lack of trust between partners makes prevention even more difficult. This is compounded with the cultural obligation of a couple to have children.

Gender stereotypes are very effective in fuelling the HIV/AIDS epidemic. Men are expected to have multiple girlfriends in order to be a real man while women are expected to be faithful and submissive to their partner. Pressure from the community to behave according to these stereotypes makes change to gender equal behaviours very difficult.
Violence against women is common. Women even start to think that violence is socially acceptable. The beating of a woman is regarded as 'to discipline your wife'. Men do not take their responsibility when it comes to rape, violence or HIV/AIDS. They blame women for wearing seductive clothing, for not listening and for the spread of the disease. Men do not understand that it is wrong to force your partner to have sex or to beat your wife. They are socialized that way and they feel it as part of their traditional role.
Young children, even babies are raped because of the myth that having sex with a virgin cures HIV/AIDS. The rape incidence is very high in KwaZulu-Natal. The existence of other gender related myths and misconceptions expresses the ignorance of people about the disease and how to prevent it. It leads to a deeper impact of HIV/AIDS on women and girls. The cultural practices of polygamy in combination with labour migration, virginity testing, and paying lobola are other examples of gender inequality and the link with HIV/AIDS.

These mentioned barriers exist in a context of stigmatization and discrimination of women, and in a context where rural people do not believe that HIV/AIDS is present in their villages. They think it only exists in urban areas. HIV/AIDS is not recognized as the disease whereas some people believe it is witchcraft. They look for someone to blame. Taboo makes people to give the disease other names. Culture does not allow talking about sex and HIV/AIDS, especially not between adults and children.

To deal with these socio-cultural barriers in HIV/AIDS prevention, TAI has developed several strategies that are adapted to the socio-cultural context in order to make HIV/AIDS prevention effective for women and men. TAI realises the importance of targeting men because they are the ones who have to change risky behaviour, like not wanting to use condoms, having more than one girlfriend and forcing themselves on girls and women.

TAI works through existing structures or groups (for example the South African Football Association, schools, traditional leadership, the police, church group, etc.) in the community to receive broad acceptance and support of the projects. These local structures or groups are involved from the very beginning and are included in decision-making, planning, implementation, monitoring and evaluation of the projects in order for them to own the project. TAI helps paving the way for schools and communities to design and implement their own HIV/AIDS prevention programme and strategies.
Leadership figures are involved to create an enabling environment for youth's initiatives for HIV/AIDS prevention, to give more credibility to the HIV/AIDS messages and to obtain a better result in raising awareness and in mobilizing the community to turn into action. They function as role models.

Secondly, TAI works with young men and boys through a Peer Educator Model. Within this model, young men and boys are selected, receive training and education and are encouraged to share the knowledge and skills learnt with others in the community. The model allows the prevention messages to reach a whole community. The targeted group - soccer players and school learners - is powerful, has a lot of influence and can reach out to a lot of other young people. The main emphasis of TAI is on the fact that young men and boys can be positive agents of change within their communities. The changes they will realise will positively affect the women and girls in the community.
Soccer as the most popular sport in South Africa provides an ideal 'vehicle' to mobilise men in order for them to begin to recognize that AIDS is a threat to life and to begin to take responsibility for prevention and care efforts.
Since youth is the generation highly at risk of HIV infection, schools also offer a good opportunity to address both gender inequality and HIV/AIDS. Adolescents in school are still negotiating their gender identities and exploring their sexuality. This period in life provides an opportune time to positively influence behaviour, choices and lifestyles.
These young participants become positive role models within their community and start an outreach programme regarding HIV/AIDS prevention and gender equality, according to a plan of action. They are from the community itself, not outsiders, who are able to reach people's minds because they know the local culture and speak the language of the community people. They call for other men to take a more active role in preventing HIV/AIDS and to share a greater portion of the burden of HIV/AIDS, like caring activities. They promote positive masculinity and fatherhood, in a way that supports women.

Youth can reach youth better and they raise awareness in a fun manner. A strategy that TAI uses is called Edutainment: Education through Entertainment. Peer educators express themselves through cultural activities like drama, gospel, songs, dance, debates, poetry, speeches, presentations, etc. to make the HIV/AIDS messages more attractive and thus make them have more impact. It makes people think about certain issues and raises awareness in the community on socio-cultural barriers in HIV/AIDS prevention. The audience is left with the feeling that there is a need to change their attitudes and behaviours.

They continuously out reach to and involve neighbouring soccer teams, school learners, community structures or groups, businesses and community people. They also hold events and campaigns to promote condom use and gender equality. During the process, peer educators receive more information and are given continuous mentoring and support from soccer team coaches, guardian educators, parents and TAI.

In training, TAI starts from where people are, their current knowledge of HIV/AIDS prevention, and their capacity is built through interactive HIV/AIDS education and skills training. Some of these skills facilitate change in traditional gender roles.
The socio-cultural barriers in HIV/AIDS prevention are challenged through specific strategies such as HIV risk assessments, questioning, Focus Group Discussions, information transfer, activities (role plays and drawings) and discussion of case studies. In addition, the programme officer provides positive substitute behaviours and explains the benefits. Within a respectful and safe environment the participants are encouraged to discuss, question and challenge perceptions of and stereotypes around masculinity and femininity which reinforce gender inequality and fuel the spread of HIV/AIDS.

The 3 day training is the foundation of TAI's work which is followed by ongoing mentoring, Focus Group Discussions, refresher courses (at the start of every year), etc. The socio-cultural barriers need to be discussed and worked through and this is not made possible in a short period of time. It is important to understand that raising awareness and behavioural change are processes that take time.

In order to effectively educate boys and girls about HIV/AIDS, TAI employs the discourse that is most familiar to them. This makes it easy for young people to identify with the message and at the same time it offers participants a way of communicating HIV/AIDS prevention.

Because girls and women expect many of the traditional negative male behaviours and reinforce them, often because of their economic vulnerability and need, the prevention programme has gradually involved them directly to have a greater impact on gender inequality. This is especially the case within schools. Women and girls are also involved indirectly (for example sisters or girlfriends of soccer players) and are motivated to assist and support the young men in their role as peer educator. They admit that it is good to have young men in the programme because they have decision-making power in the sexual relationship, but still they would like to follow the same training to learn more about HIV/AIDS or would like to become a peer educator. They believe that people will also start listening to them.

Within the process, the programme officers operate as facilitators, not as imposers. They facilitate the development of alternate patterns of masculine behaviour which protect young men and their female partner against HIV infection. They focus on the responsibility of men to use their power positively and creatively in the fight against HIV/AIDS.
TAI promotes a greater understanding around the rights of women and children and emphasizes that these rights are human rights. Once men have enough information and skills to change their patriarchal attitude towards sex and women, they can play a meaningful role in the mitigation of HIV/AIDS.

GENERAL CONCLUSION

Literature research was a very good basis for conducting the field research. The socio-cultural barriers in HIV/AIDS prevention and strategies to break through these barriers in order to make HIV/AIDS prevention effective described in scientific articles and reports of international development organisations, served as a framework for analyzing the HIV/AIDS prevention programme of the NGO Targeted Aids Interventions (TAI), working in rural and peri-urban KwaZulu-Natal (South Africa). The case study can be seen as a practical verification and specification of the information found in literature. TAI has shared its experiences in the field and everyone who is concerned with effective HIV/AIDS prevention can learn from its strategies.

The first research question - with which socio-cultural barriers in HIV/AIDS prevention is TAI confronted? – is answered through data gathered by questionnaire application, interviews, participative observation and documentation and reports of TAI. Following barriers which fuel the HIV/AIDS epidemic, especially among (young) women, were highlighted:

1. Gender inequality

- Male dominance over women: men have decision-making power in the sexual relationship, for example about condom use. Women often do not have the power to convince their partner of using a condom. Women are in a subordinate position.
- The sexual discourse is of a patriarchal nature – conditions and timing of sex are defined by men - and men control women's bodies. Due to socio-cultural norms and values around gender and sexuality, women have little say over sexual relations and do not have the power to protect their own bodies. Women are often not able to refuse sex in marriage or in a relationship outside of marriage.
- Transactional sex and the phenomenon of 'sugar daddies' are very common in KwaZulu-Natal, due to economic dependency of women on men. This dependency denies women the power to insist on condom use. Because they fear being neglected by the male partner or husband and having no food, money or a place to stay, women take the risk of having unprotected sex.
- Condoms are often not used in marriage or in steady, long-term relationships because they are linked with promiscuity, infidelity and lack of trust between partners. In addition, they do not allow conceiving children.
- Gender stereotypes expect men to have multiple sex partners in order to be a real man and women to be faithful and submissive to their partner. Men are expected to be knowledgeable. This prevents men from seeking out correct information or asking advice regarding HIV/AIDS prevention. Socio-cultural norms also prevent men from participating in reproductive responsibilities.
- Violence against women and girls. Women get often physically and/or sexually abused when they refuse to have sex or refuse to have sex without a condom. Men do not understand that it is wrong to force their partner to have sex or to beat their wife. They are socialized that way and they feel it as part of their traditional role. They do not see their responsibility and often blame women for rape and violence against them. Women even start to think that violence is socially acceptable.
- Harmful cultural myths, for example: having sex with a virgin cures HIV/AIDS.
- Harmful cultural and customary practices: polygamy in combination with labour migration, virginity testing among girls, and payment of a bride's wealth (lobola).
- Stigmatization and discrimination of women

2. Taboo

- Deep silence around HIV/AIDS and sexuality: talking about sex and HIV/AIDS is not allowed by culture, especially not between adults and children.
- Denial of HIV/AIDS existing in rural areas.
- HIV/AIDS is not recognized as the disease, it is witchcraft.
- HIV/AIDS is given other names.

These barriers have as a result that the HIV/AIDS epidemic disproportionately affects women. Women are more HIV infected than men and carry the burden of HIV/AIDS, meaning they are the ones who take care of people infected and affected by the disease. The barriers put women and girls at increased risk of HIV infection and play a major role in sustaining the epidemic. Because of these barriers, the traditional prevention strategy ABC (Abstain, Be faithful and use a Condom) does not protect women and girls adequately against HIV infection. African women are simply not in a position to abstain from sex, to be faithful or to rely on the faithfulness of their partner, or to negotiate condom use. As literature states: the ABC strategy can only be a viable and effective prevention option for women and girls if it is implemented as part of a multi-faceted package of interventions that seek to redress deep-rooted gender imbalances. Interventions need to come up with strategies to break through these barriers in order to make HIV/AIDS prevention effective for women and men. The current prevention strategies need to be broadened, meaning adapted to the socio-cultural context of gender inequality and taboo to address underlying vulnerabilities faced by women. Strategies need to be adapted to the specific needs and realities of African women and girls. Literature suggests many strategies of which the most important are:

- Making sexuality debatable.
- Information transfer and quality education about HIV/AIDS prevention and sexuality for boys and girls.
- Open dialogue in the community about HIV/AIDS and sexuality.
- Confronting the current patriarchal culture with its socio-cultural norms and values around gender and sexuality that contribute to a subordinate status of women and girls and condone violence against them.
- Promoting women's rights.
- Empowerment of women and girls with knowledge (of sexuality and HIV/AIDS) and life skills.
- Increasing the self-confidence and self-esteem of girls.
- Discussion groups about gender identity, unequal power, etc.
- Campaigns against gender-based violence.
- Campaigns that promote condom use and communication between partners regarding this condom use.
- Challenging harmful cultural myths, gender stereotypes and traditional practices (for example through debates, drama, cultural conversations).
- Sensitization programmes to reduce stigmatization of women.
- Equal access to economic opportunities for women.
- Meeting the needs of women living with HIV/AIDS.
- Participation of young people in project and programme planning, implementation and evaluation.
- Gender analysis of the situation by gender experts.
- Work relationship with governance and academics.

Most of the HIV/AIDS prevention work has been directed, and still is, at women because they are the vulnerable group. Gender issues have often been interpreted as women's issues and many HIV interventions have placed an even greater burden of responsibility on women, with a tendency of overlooking the responsibility of men. Literature emphasizes the great need for active involvement of men and boys in the fight against HIV/AIDS. They have the decision-making power and can be a positive force in improving the situation of women and girls. The role of men in promoting gender equality by indicating socio-cultural norms and stereotypes that increase the risk of HIV infection for both men and women is critical. This is also the main emphasis of TAI.

In 1995, TAI started its work with women but as many as 90 per cent of the women who participated were unable to implement their personal decisions about HIV prevention. The existing gender inequality made the efforts fail, efforts to protect women through empowering them with knowledge and life skills. When women attempted to put into practice what they had learned in training, they were met with resistance and often abuse by their male partners. Although empowerment of women is promoted in literature, the intervention led to further victimization of women. This realisation in 1998 motivated TAI to shift their focus to men. Almost all decisions are made by men, including decisions related to sex, contraception and prevention methods. They are the ones who have to change risky behaviour, such as not wanting to use condoms, having more than one girlfriend and forcing themselves on girls and women. While men hold a position of power in social and sexual interactions, training them to use their power positively and creatively will allow men to protect themselves and thus their female partners against HIV infection.

To deal with above mentioned socio-cultural barriers in HIV/AIDS prevention, TAI has developed and implemented several strategies adapted to the socio-cultural context of taboo and gender inequality. The second research question – which strategies does TAI use to break through these barriers in prevention? – is answered through data gathered by interviews, participative observation, and documentation and reports of TAI. The strategies used by TAI are very similar to those found in literature, with a particular focus on the Peer Educator Model:

- Working through existing community structures or groups to receive broad acceptance and support from the community and to have a real impact in the community.
- Involvement of leadership figures to create an enabling environment for HIV/AIDS prevention.
- Responses to HIV/AIDS are community-led and owned with only minimal guidance from TAI.
- Participatory approach: beneficiaries are included in planning, implementation, monitoring and evaluation of projects. TAI recognizes the importance of their participation to obtain sustainable results.
- Peer Educator Model: young men and boys are selected, trained and educated about HIV/AIDS prevention and sexuality, and they are encouraged to share the knowledge and skills learnt with peers and other people in the community.
- Targeted group: soccer players and school learners. They are powerful, have a lot of influence and can reach out to a lot of other young people, family, friends, partner, etc. Soccer as the most popular sport in South Africa provides an ideal 'vehicle' to mobilise and motivate men in AIDS related issues, while schools offer a good opportunity to address gender inequality and the link with HIV/AIDS.

- Youth is the primary focus of education and awareness drives, in recognition of the vulnerability of young people and the key role they can play in turning the tide of new infections around. Adolescents in school are still negotiating their gender identities and exploring their sexuality. This period in life provides an opportune time to positively influence behaviour, choices and lifestyles.
- Initiating communication among young men about safer sex practices, especially condom use and reduction in the number of sex partners.
- Promoting abstinence among younger boys.
- Young participants become positive role models within their communities. This makes them aware of their behaviour and attitudes and of the need to practice what they preach.
- They are from the community itself, not outsiders, who are able to reach people's minds because they know the local culture and speak the language of the community people.
- Outreach through Edutainment: Education through Entertainment. Peer educators express themselves through cultural activities like drama, gospel, songs, dance, debates, poetry, speeches, presentations, etc. to make the HIV/AIDS messages more attractive and thus make them have more impact. Socio-cultural barriers in HIV/AIDS prevention are communicated and challenged in these activities, in a language that is adapted and acceptable to youth.
- Encouraging dialogue between young men and women about mutual respect, human rights, sexuality and shared responsibility in HIV/AIDS prevention.
- Outreach through events and campaigns promoting condom use and gender equality.
- Incentives as motivation.
- Condom distribution by peer educators and local businesses.
- Encouraging open dialogue about HIV/AIDS in the community.
- Peer educators receive continuous information and are given continuous mentoring and support from soccer team coaches, guardian educators, parents and TAI.
- TAI starts from where people are, their current knowledge of HIV/AIDS and prevention.
- Capacities are built through interactive HIV/AIDS education with particular attention given to the risks of Sexually Transmitted Infections, and alcohol and drug abuse.
- Capacities are built through skills training.
- In training, socio-cultural barriers in HIV/AIDS prevention are challenged through personalizing the risk of HIV and the impact of HIV/AIDS, questioning, Focus Group Discussions, information transfer, activities (role plays and drawings) and discussion of case studies.
- Programme officers provide positive substitute behaviours and explain the benefits.
- Promotion of women's and girls' rights.
- Sharing of experiences between peer educators builds up capacity and motivation.
- Perceptions of and stereotypes around masculinity and femininity are discussed and challenged in a respectful and safe environment.
- TAI employs the discourse that is most familiar to young people.
- Programme officers operate as facilitators, not as imposers.
- Evaluation of the impact of the programme.
- Referring to relevant people.
- Involvement of girls and women.
- Involvement of people living with HIV/AIDS
- Work relation with governance and academics.
- Work relation with media.

Working with men can be seen as maintaining gender inequality, meaning maintenance of male power over women. But by working with men, new norms and values of equality, justice and responsibility can be implemented in communities. By working through existing community structures or groups, TAI tries to achieve a gender equal society, free from HIV/AIDS. Only in this way, new norms and values can be accepted and introduced in the community. It is not right to forbid a certain culture because this will only result in more resistance towards gender change and thus effective HIV/AIDS prevention.

TAI understands that raising awareness and behaviour change are processes that take time. There is still a long way to go, but each mind reached and behaviour changed, is a life saved. Until this day, people still have to be made aware that the disease is a real threat to life in their rural villages.

Because literature suggests that working with women and men is the best way to change the gender system, TAI has gradually involved them (again) directly. This is especially the case within schools.
Women and girls are also involved indirectly and are motivated to assist and support the young men in their role as peer educator. But field research reveals that these girls would like to follow the same training as men to learn more about HIV/AIDS or would like to become a peer educator themselves. Others suggest that girls need to be educated more about the factors that put them at risk of HIV infection, for example about the hazards that are related to 'sugar daddies' and having multiple boyfriends for material support.

Furthermore, literature suggests that affordable access to prevention options that women can initiate and control must be ensured. TAI promotes the female condom in training with participants. The use of it is demonstrated and the programme officer distributes female condoms to the participants.

To conclude, TAI promotes positive masculinity and fatherhood by focussing on the responsibility of men to use their power positively. Once men have enough information and skills to change their patriarchal attitude towards sex and women, they can play a meaningful role in the mitigation of HIV/AIDS.

Effective prevention strategies are just highlighted and other HIV/AIDS organisations working in similar conditions can apply them, so that HIV/AIDS prevention becomes more and more effective in different locations. As long as the disease cannot be cured and a vaccine does not exist, HIV/AIDS prevention is extremely important and a life saving matter. Prevention is crucial to create a functioning society in Africa. TAI's work can also be implemented in other places in South Africa, especially in rural and peri-urban areas. TAI also thinks that its projects can work in other African countries or places abroad. The approach is community-driven and owned, and the work with men can be implemented in every place where gender inequality is a reality, where men are abusing their power and where positive masculinity and fatherhood needs promoting.

But there are several challenges that need to be taken into account: poverty, illiteracy and unemployment are predominant in KwaZulu-Natal. Poverty is a major challenge and influences the spread of HIV in many ways, such as limiting access to condoms and treatment of sexually transmitted infections. The service delivery in the areas where TAI works is limited or non-existing. Not only the access to condoms is problematic, but also the availability. Participants of the projects distribute condoms, but they can never distribute enough. The demand is a great deal higher than the supply. Government must ensure that the environment enables effective HIV/AIDS prevention for every individual. The government has to do more efforts on ensuring the access to and availability of male and female condoms and on challenging the myths and misconceptions about condoms. The service delivery in clinics and health centres also needs to be youth-friendly. Lastly, working with men needs to be done in a more balanced way. In short, consistent powerful leadership around HIV/AIDS and strong commitment from community people to fight the disease are necessary.

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ATTACHMENTS

1. Maps with global HIV/AIDS estimates

(Source: UNAIDS/WHO AIDS Epidemic Update, 2006c)

FIGURE 2.4 A global view of HIV infection
38.6 million people [33.4–46.0 million] living with HIV, 2005

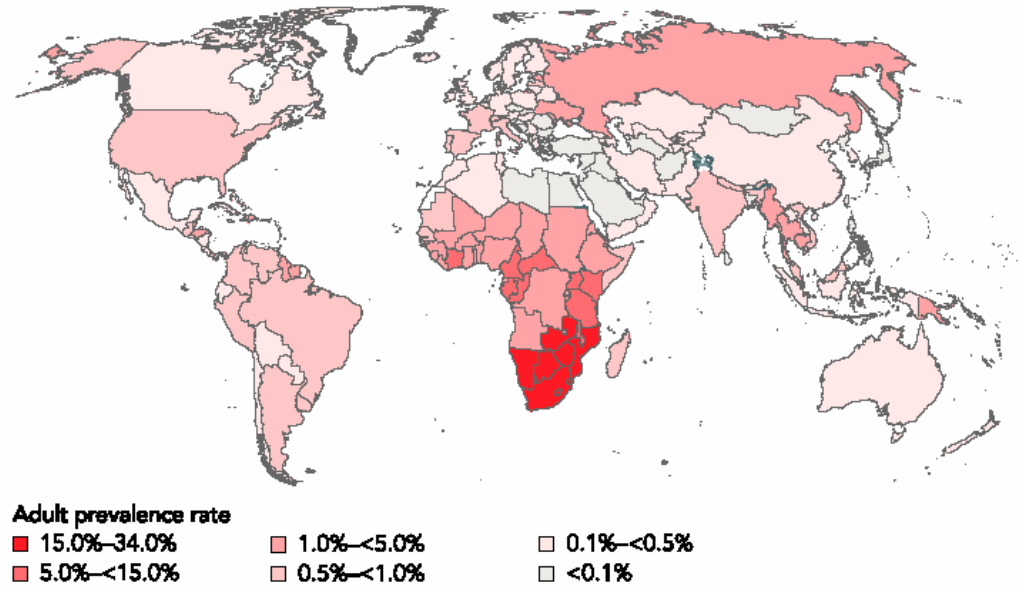
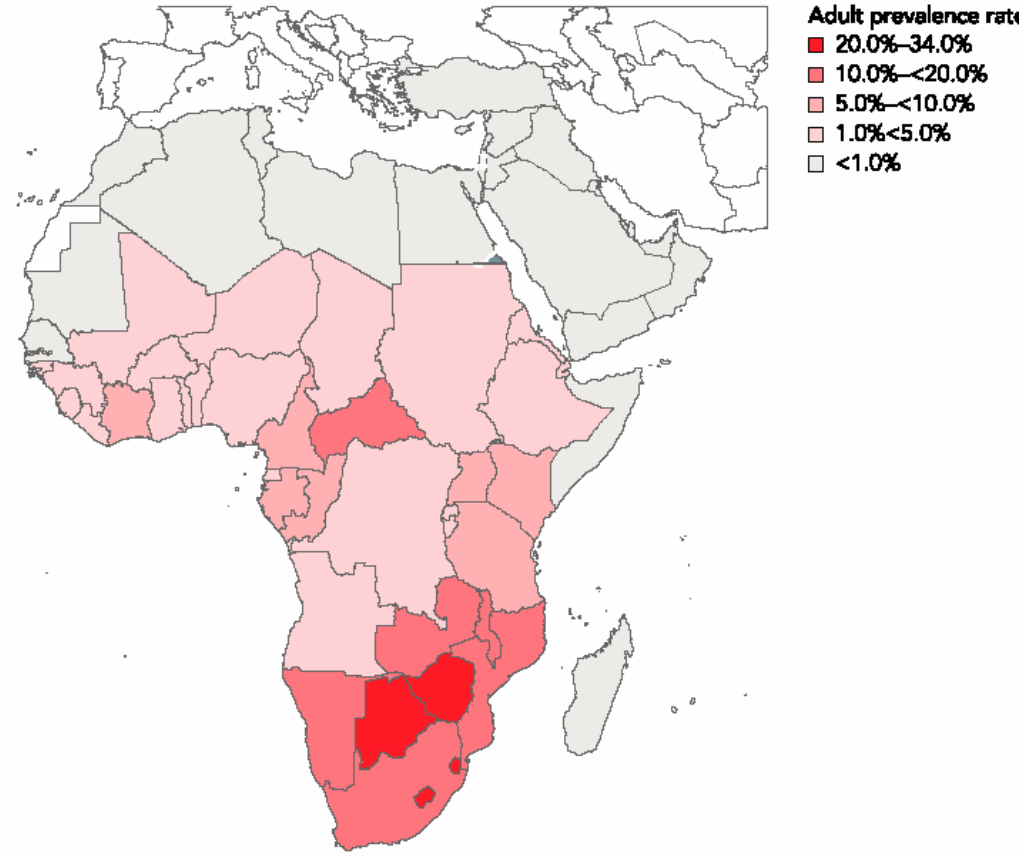


FIGURE 2.5 HIV prevalence (%) in adults in Africa, 2005



(collected from Report on the global AIDS epidemic, 2006:14)

2. Global initiatives for more gender equality and an effective response to the HIV/AIDS epidemic

At global level, the UN General Assembly Special Session (UNGASS) on HIV/AIDS in June **2001** made the gender dimensions of the epidemic explicit. Delegates from over 180 countries committed themselves to intensify efforts to challenge gender stereotypes and attitudes, and gender inequality in relation to HIV/AIDS, encouraging the active involvement of men and boys. The UNGASS Declaration broadens the Millennium Declaration, adopted by world leaders in **2000**, in which leaders pledged to promote gender equality and the empowerment of women as effective ways to combat poverty, hunger, and disease. Millenium Devleopment Goal 3 focuses on gender equality and women's and girls' autonomy and empowerment, while Goal 6 aims at reducing the impact of HIV/AIDS, malaria and other diseases. All the goals are mutually reinforcing (Erb-Leoncavallo et al., 2004).

1979 *UN Convention on the Elimination of All forms of Discrimination Against Women (CEDAW)*

1994 *International Conference on Population and Development*: states agree to share the costs needed to make basic reproductive health care available to all by 2015

1995 *Fourth World Conference on Women:* states agree that the human rights of women include the right to decide freely and responsibly on matters related to their own sexuality, and recognize that social vulnerability and unequal power relations block efforts to control the spread of HIV.

2001 *United Nations Declaration of Commitment on HIV/AIDS:* member states agree that gender equality and women's empowerment are fundamental to ensuring an effective response to HIV/AIDS and commit themselves to a set of time-bound targets, a number of which relate specifically to women.

2005 *World Summit:* global leaders commit to a massive scaling up of HIV prevention, treatment and care with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all who need it.
(The Global Coalition on Women and Aids, 2006d)

3. Questionnaire: long version

I am Camille Collin, Belgian, 25 years old and doing a master in Conflict and Development. For my study, I am here in KwaZulu-Natal doing research about **HIV/AIDS prevention and on how to do it effectively.**

So today, I would like you to fill in this questionnaire with **assumptions on the local socio-cultural context** in which the HIV/AIDS prevention programme of TAI is situated. I want to learn as much as possible about the **local context, more specifically about the aspects which make HIV prevention difficult.**

First, I would like you to evaluate if the assumption is applicable or not in peri-urban and/or rural KwaZulu-Natal. Afterwards, you will be able to clarify things in a conversation with me.

I will record the conversation, because that is easier than writing everything down. But I assure you that all the information you give me, by filling in this questionnaire and by conversation will be kept **confidential**. The information is only for you and me. I will ask you to give me your name. But you will be **anonymous** in the report. Your name will be removed.

I trust on your honesty when filling in this form. Don't think too long about the answer. Your first thought is mostly the best.

Please, don't see this as a test or interrogation. See it more as the **sharing of experiences**, perspectives, knowledge, etc.

Your participation will not be compensated in any way, nor will you experience a negative result when you are not willing to participate. You have the right to refuse to answer questions that you feel uncomfortable with and you are able to withdraw from participation at any time.

Do you have any questions? Please ask.

Name:	**Date:**
Date of birth:	**Sex: M / F (underline what is right)**

Please indicate if the assumption is applicable or not in peri-urban and/or rural KwaZulu-Natal, by crossing the right box.

DOMINANCE OF MEN OVER WOMEN?

ASSUMPTION	*APPL*	*NOT APPL*	*DON'T KNOW*
Men have the power in sexual relations.	❒	❒	❒
Men make the decisions in sexual relations. (For example about the use of condoms)	❒	❒	❒
Women are often not able to refuse sex in marriage or in relationships outside of marriage.	❒	❒	❒
Women are often not able to convince their partner of using a condom.	❒	❒	❒
Women are often not able to convince their partner of being faithful.	❒	❒	❒
Unequal power relations, in advantage of men are socially accepted.	❒	❒	❒

Other socio-cultural situation, relating to dominance of men over women that makes HIV/AIDS prevention difficult?
Give me a short description of this barrier in HIV/AIDS prevention. You will also be able to give more information in the following conversation.

ECONOMIC DEPENDENCY ON MEN?

ASSUMPTION	*APPL*	*NOT APPL*	*DON'T KNOW*
Women are economically dependent on men.	❒	❒	❒
Often it happens that:			
• *If women insist on safe sex (for example by using a condom), they risk losing men's economic support.*	❒	❒	❒
• *Women have sex in exchange for shelter, food, other basic necessities and school fees.*	❒	❒	❒
• *Women engage in short- and long-term sexual relationships to sustain their basic needs.*	❒	❒	❒
• *Young women have sex for material goods, such as cell phones, brand clothing, etc.*	❒	❒	❒
• *Young women have sex with much older men (intergenerational) because financially older men are better off than male peers.*	❒	❒	❒

Other socio-cultural situation, relating to economic dependence of women on men that makes HIV/AIDS prevention difficult?
Give me a short description of this barrier in HIV/AIDS prevention. You will also be able to give more information in the following conversation.

CONDOM USE?

ASSUMPTION	*APPL*	*NOT APPL*	*DON'T KNOW*
When women insist on using a condom, they are often accused of promiscuity or unfaithfulness.	❒	❒	❒
Men are often accused of unfaithfulness when they want to use a condom.	❒	❒	❒

ASSUMPTION	*APPL*	*NOT APPL*	*DON'T KNOW*
The desire, or pressure for children may be a reason why women and men do not use a condom and take the risk of becoming HIV infected.	❒	❒	❒
Mostly, men don't want to use a condom.	❒	❒	❒
Mostly, women don't want to use a condom.	❒	❒	❒
Condom use is not common in long term relationships/marriage because the use of it is seen as a lack of trust between partners.	❒	❒	❒

Other socio-cultural situation, relating to condom use that makes HIV/AIDS prevention difficult?
Give me a short description of this barrier in HIV/AIDS prevention. You will also be able to give more information in the following conversation.

GENDER STEREOTYPICAL BEHAVIOUR

ASSUMPTION	*APPL*	*NOT APPL*	*DON'T KNOW*
Men prove their manliness through:			
• *multiple sex partners*	❒	❒	❒
• *unfaithfulness*	❒	❒	❒
• *relationships with young girls*	❒	❒	❒
• *dominance in sexual relations*	❒	❒	❒
• *physical violence*	❒	❒	❒
• *sexual violence*	❒	❒	❒
Men find it difficult to admit they are worried about HIV/AIDS or other sexually transmitted infections.	❒	❒	❒
The practice of safe sex (for example reduction in the number of sexual partners) may be felt as a threat to masculinity.	❒	❒	❒

ASSUMPTION	*APPL*	*NOT APPL*	*DON'T KNOW*
Young men in particular may feel pressured to assert their male identity.	❒	❒	❒
Young men are expected to gain sexual experience before marriage.	❒	❒	❒
Girls and women are expected to be submissive.	❒	❒	❒
Girls are expected to abstain from sex.	❒	❒	❒
Girls and women are expected to be faithful.	❒	❒	❒
Girls and women are expected to know little about sex, sexuality and HIV/AIDS.	❒	❒	❒
Girls are expected to remain a virgin until marriage.	❒	❒	❒
Boys and men receive more education on sex, sexuality, HIV/AIDS, and prevention than girls and women.	❒	❒	❒

Other socio-cultural situation, relating to gender stereotypical behaviour that makes HIV/AIDS prevention difficult?
Give me a short description of this barrier in HIV/AIDS prevention. You will also be able to give more information in the following conversation.

VIOLENCE

ASSUMPTION	*APPL*	*NOT APPL*	*DON'T KNOW*
Girls and women may often experience (sexual) violence in marriage or in relationships outside of marriage.	❒	❒	❒
Violence towards women is socially accepted.	❒	❒	❒
Sexual violence against women is often seen as their own fault, for example because girls wear seductive clothing.	❒	❒	❒

Other socio-cultural situation, relating to violence that makes HIV/AIDS prevention difficult?
Give me a short description of this barrier in HIV/AIDS prevention. You will also be able to give more information in the following conversation.

CULTURAL MYTHS AND PRACTICES

ASSUMPTION	*APPL*	*NOT APPL*	*DON'T KNOW*
The existence of cultural myths surrounding sex, sexuality and HIV/AIDS (for example sex with a virgin cures HIV)	❒	❒	❒
The existence of cultural or customary practices:			
• *Polygamy*	❒	❒	❒
• *Migrant workers who have a rural wife at home and an 'urban wife' in the city*	❒	❒	❒
• *A lot of girls are married in their teens (often as poverty-reduction strategy)*	❒	❒	❒
• *These young brides are mostly married to much older men*	❒	❒	❒

Other socio-cultural situation, relating to cultural myths and practices that makes HIV/AIDS prevention difficult?
Give me a short description of this barrier in HIV/AIDS prevention. You will also be able to give more information in the following conversation.

STIGMATIZATION AND DISCRIMINATION

ASSUMPTION	*APPL*	*NOT APPL*	*DON'T KNOW*
A lot of women and girls experience stigmatisation. This is noticed by:			
• *HIV/AIDS is referred to as a women's disease*	❒	❒	❒
• *HIV/AIDS is referred to as a prostitute's disease*	❒	❒	❒
• *Women are seen as sexually out of control (promiscue)*	❒	❒	❒
• *Women are not to be trusted*	❒	❒	❒
• *Women are seen as carriers of HIV*	❒	❒	❒
• *Women are blamed for HIV/AIDS*	❒	❒	❒
• *Disclosing the HIV status has direct consequences for women: some of them have been abused, abandoned or thrown out of their homes and job*	❒	❒	❒
Stigma inhibits people from getting tested.	❒	❒	❒
Stigma inhibits people from disclosing their HIV positive status.	❒	❒	❒
Stigma inhibits HIV positive people from seeking treatment and care.	❒	❒	❒
Stigma inhibits HIV positive women from buying powder milk for their baby.	❒	❒	❒
Girls and women often experience discrimination This is seen by:			
• *They have unequal access to economic opportunities*	❒	❒	❒
• *Women don't have the right to own or inherit land*	❒	❒	❒
Men don't see their responsibility in the spread of HIV/AIDS.	❒	❒	❒

Other socio-cultural situation, relating to stigmatization and discrimination that makes HIV/AIDS prevention difficult?
Give me a short description of this barrier in HIV/AIDS prevention. You will also be able to give more information in the following conversation.

TABOO

ASSUMPTION	*APPL*	*NOT APPL*	*DON'T KNOW*
HIV/AIDS, sex and sexuality are susceptible to taboo.	❒	❒	❒
Cultural taboos prevent many young people, particularly young women, from receiving or using prevention information, services and tools (such as condoms)	❒	❒	❒

Other socio-cultural situation, relating to taboo that makes HIV/AIDS prevention difficult?
Give me a short description of this barrier in HIV/AIDS prevention. You will also be able to give more information in the following conversation.

OTHERS?

Give me a short description of this barrier in HIV/AIDS prevention. You will also be able to give more information in the following conversation.

THANK YOU FOR YOUR COOPERATION!!! I appreciate it a lot!

4. Questionnaire: short version

The introduction is the same as in the long version above.

Name:	**Date:**
Date of birth:	**Sex: M / F (underline what is right)**

Please indicate if the assumption is applicable or not in peri-urban and/or rural KwaZulu-Natal, by crossing the right box.

DOMINANCE OF MEN OVER WOMEN?

ASSUMPTION	*APPL*	*NOT APPL*	*DON'T KNOW*
Men make the decisions in sexual relations. (For example about the use of condoms)	❒	❒	❒
Women are often not able to refuse sex in marriage or in relationships outside of marriage.	❒	❒	❒
Women are often not able to convince their partner of using a condom.	❒	❒	❒
Women are often not able to convince their partner of being faithful.	❒	❒	❒

ECONOMIC DEPENDENCY ON MEN?

ASSUMPTION	*APPL*	*NOT APPL*	*DON'T KNOW*
Women are economically dependent on men.	❒	❒	❒
Often it happens that:			
• *Women have sex in exchange for shelter, food, other basic necessities and school fees.*	❒	❒	❒
• *Young women have sex for material goods, such as cell phones, brand clothing, etc.*	❒	❒	❒

ASSUMPTION	*APPL*	*NOT APPL*	*DON'T KNOW*
• *Young women have sex with much older men because financially older men are better off than male peers.*	❒	❒	❒

CONDOM USE?

ASSUMPTION	*APPL*	*NOT APPL*	*DON'T KNOW*
When women insist on using a condom, they are often accused of promiscuity or unfaithfulness.	❒	❒	❒
Men are often accused of unfaithfulness when they want to use a condom.	❒	❒	❒
Mostly, men do not use a condom.	❒	❒	❒

GENDER STEREOTYPICAL BEHAVIOUR

ASSUMPTION	*APPL*	*NOT APPL*	*DON'T KNOW*
Men prove their manliness through:			
• *multiple sex partners*	❒	❒	❒
• *unfaithfulness*	❒	❒	❒
• *relationships with young girls*	❒	❒	❒
• *dominance in sexual relations*	❒	❒	❒
• *physical violence*	❒	❒	❒
• *sexual violence*	❒	❒	❒
The practice of safe sex (for example reduction in the number of sexual partners) may be felt as a threat to masculinity.	❒	❒	❒
Girls are expected to abstain from sex.	❒	❒	❒
Girls and women are expected to be faithful.	❒	❒	❒
Girls and women are expected to know little about sex, sexuality and HIV/AIDS	❒	❒	❒
Girls are expected to remain a virgin until marriage.	❒	❒	❒

VIOLENCE

ASSUMPTION	*APPL*	*NOT APPL*	*DON'T KNOW*
Girls and women may often experience (sexual) violence in marriage or in relationships outside of marriage.	❒	❒	❒

ASSUMPTION	*APPL*	*NOT APPL*	*DON'T KNOW*
Violence towards women is socially accepted.	❒	❒	❒
Sexual violence against women is often seen as their own fault, for example because girls wear seductive clothing.	❒	❒	❒

CULTURAL MYTHS AND PRACTICES

ASSUMPTION	*APPL*	*NOT APPL*	*DON'T KNOW*
The existence of cultural myths surrounding sex, sexuality and HIV/AIDS (for example sex with a virgin cures HIV)	❒	❒	❒

STIGMATIZATION AND DISCRIMINATION

ASSUMPTION	*APPL*	*NOT APPL*	*DON'T KNOW*
A lot of women and girls experience stigmatisation. This is noticed by:			
• *HIV/AIDS is referred to as a women's disease*	❒	❒	❒
• *HIV/AIDS is referred to as a prostitute's disease*	❒	❒	❒
• *Women are seen as sexually out of control (promiscue)*	❒	❒	❒
• *Women are not to be trusted*	❒	❒	❒
• *Women are seen as carriers of HIV*	❒	❒	❒
• *Women are blamed for HIV/AIDS*	❒	❒	❒
Stigma inhibits people from getting tested.	❒	❒	❒
Stigma inhibits people from disclosing their HIV positive status.	❒	❒	❒
Men don't see their responsibility in the spread of HIV/AIDS.	❒	❒	❒

TABOO

ASSUMPTION	*APPL*	*NOT APPL*	*DON'T KNOW*
HIV/AIDS, sex and sexuality are susceptible to taboo.	❒	❒	❒

Do you have some more remarks?

THANK YOU FOR YOUR COOPERATION!!! I appreciate it a lot!

5. Schools and soccer teams visited

ABSA schools:

Of the 5 primary schools involved, I visited all of them:

4.2.4. Tetelegu primary school – Mpumuza, Umgungundlovu district: observation of meeting.
4.2.5. Nottingham Combined – Nottingham Road, Umgungundlovu district: observation of meeting.
4.2.6. Mgwempisi Fabase Combined – Greytown, Umzinyathi district: observation of meeting.
4.2.7. Annieville primary school – Dannhauser, Amajuba district: observation of meeting.
4.2.8. Iphunguphungu primary school - Dannhauser, Amajuba district: observation of meeting.

ENGEN schools:

Of the 9 high schools involved, I visited 7 of them:

1. Gobizembe High school – Wartburg, Swayimana village, Umgungundlovu district: observation of refresher course and grade competition.
2. Sibongumusa High school - Wartburg, Swayimana village, Umgungundlovu district: observation of refresher course.
3. Mpolweni High school – Mpolweni, Umgungundlovu district: observation of refresher course and group interview with 3 PE's (1 boy and 2 girls).
4. Trustfeed High school – Pietermaritzburg, Umgungundlovu district: observation of refresher course and group interview with 3 PE's (2 boys and 1 girl).
5. Mcoseleli High school - Pietermaritzburg, Table Mountain, Umgungundlovu district: observation of refresher course and group interview with 6 PE's (3 boys and 3 girls).
6. Mbambangalo High school – Pietermaritzburg, Table Mountain, Umgungundlovu district: observation of refresher course
7. Swayimana High school - Wartburg, Swayimana village, Umgungundlovu district: visited.
8. Mayizekanye High school - Wartburg, Swayimana village, Umgungundlovu district: *not visited.*
9. Masijabule High school – Pietermaritzburg, Umgungundlovu district: *not visited.*

Soccer teams:

Of the 6 soccer teams involved, I visited 5 of them. At the Shosholoza tournament that I attended, all the teams were present, also the 2 soccer teams of the Abafana Bebhola Bayanakekela project.

Shosholoza teams:

1. Abavikeli – Dannhauser, Amajuba district: observation of meeting.

2. Mighty Rovers – Mandeni, Zululand: observation of meeting.
3. Inembe Citizen – Mandeni, Zululand: observation of meeting and group interview with 6 PE's.
4. Hopewell Pillars – Hopewell, Natal Midlands: observation of meeting, group interview with 6 PE's, and observation of drama evaluation.
5. Real Madrid – Mafakathini village, Natal Midlands: group interview with 3 PE's.
6. Royal Coastal – Durban: *not visited*.

Abafana teams:

1. Barcelona – Mafakathini village, Natal Midlands: observation of Human Rights Day event in Mafakathini and observation of drama evaluation.
2. Amatsatsatsa – Willowfontein, Natal Midlands: observation of track suit delivery to OVC.

6. Interviews

Individual semi-structured interview with the senior administrator of TAI (Gaetane Le Grange)

1) Since when are you working for TAI?
2) What is your job at TAI?
3) What are your specific tasks?
4) Describe the prevention activities of TAI.
5) Which strategies in the prevention programme deal with gender inequality? Dominance of men over women?
6) With stereotypical behaviour for men and women?
7) With violence against women?
8) With cultural myths and misconceptions?
9) With stigmatization and discrimination?
10) With taboo surrounding sex, sexuality, and HIV/AIDS?
11) Do you think the participants change in behaviour, thoughts and feelings because of TAI's prevention programme? How?
12) Are women and girls involved in the programme? How?
13) What do women and girls learn? Enough?
14) Should they also need training from TAI? In what? How?
15) Do they also want to become peer educators and organise their own initiatives? Which ones?
16) Are PLWHA involved in the programme? How?
17) Does TAI encourage women and girls to use female condoms?
18) What are strong points of the total prevention programme?
19) What are still challenges in prevention?
20) What are difficulties in prevention? How are they solved?
21) Are the projects running well? What are for you criteria to see that the projects are running well?
22) What do you think is very important for effective HIV/AIDS prevention?
23) Is TAI's prevention programme also applicable in other places in South Africa? Which places? Or abroad?

Ok, these were all my questions. Do you still have some remarks or questions that you would like to ask? *This question was asked at the end of every interview.*

Individual semi-structured interview with a fieldworker/coordinator – Abafana Bebhola Bayanakekela project (Ma-u Mafu and Jetro Mchunu)

1) Since when are you working for TAI?
2) What is your job at TAI?
3) What are your specific tasks?
4) Does the Abafana project have to do with HIV/AIDS prevention? What?
5) Which strategies of the project deal with dominance of men over women?
6) With stereotypical behaviour for men and women?
7) With violence against women?
8) With cultural myths and misconceptions?

9) With stigmatization and discrimination?
10) With taboo surrounding sex, sexuality, and HIV/AIDS?
11) Do you think the participants change in behaviour, thoughts and feelings because of the project? How?
12) Are girls and women involved in the programme? How?
13) What are strong points of Abafana?
14) What are still challenges?
15) What are difficulties? How do you solve them?
16) Is there follow up by TAI? How? Enough?
17) Is the project running well? What are for you criteria to see that the project is running well?
18) What do you think is very important for effective HIV/AIDS prevention?
19) Is the Abafana project also applicable in other places in South Africa? Which places? Or abroad?

Individual semi-structured interview with the programme officer of TAI – Inkunzi Isematholeni project (Pelele Mlangeni)

Intro:
1) Since when are you working for TAI?
2) What is your job at TAI? What are your specific tasks?
3) How did you get your knowledge about HIV/AIDS and prevention? Did you get training from TAI?

HIV/AIDS Prevention:
4) Describe the HIV/AIDS prevention activities of your project, Inkunzi Isematholeni. ABSA/ENGEN
5) Since when did the Inkunzi project start?

Selection:
6) How many participants are in the project right now? Relation boys-girls? ABSA/ENGEN
7) How are the participants selected? What are the criteria of selection?
8) Do they receive training from TAI? Boys and girls together or separate?
9) Do boys agree if girls too become directly involved as PE's?
10) Are teachers involved in the project?
11) And parents?
12) How are they selected?

Training:
13) What kind of training do you give to participants? Also to teachers/parents?
14) Difference between ABSA/Engen schools?
15) How do you give the training? Which materials do you use? Toolkit, manual?
16) How long does a training session take? For PE and for teachers/parents?
17) How much training do they receive in one year?
18) Does training help PE's with the conduct of safe sexual behaviour? How?
19) Do they find it difficult to implement preventive behaviour?
20) Is training adapted to the socio-cultural context? I mean:
- Is it focused on male power over women? Explain.
- On stereotypical behaviour of men and women?

- On violence against women?
- On cultural myths and misconceptions?
- On stigmatization and discrimination?
- On taboo surrounding sex, sexuality, and HIV/AIDS?
- On other barriers?

Activities:

21) What do PE's do after a training has finished? And teachers?
22) What kind of activities do they organise in the schools? In the community?
23) Which activities deal with male power over women?
24) With gender stereotypes?
25) With gender based violence?
26) With myths and misconceptions?
27) With stigma and discrimination?
28) With taboo?
29) Do they reach a lot of people with their activities? Who?
30) Do they get support from school/community?

Evaluation:

31) Is there follow up by TAI? How?
32) Do you think people change in behaviour, thoughts and feelings because of the project? How? Can you give me some examples of remarkable changes?
33) *Many of the traditional behaviours of boys and men are expected by girls and reinforced by girls. When a boy fails to perform according to these stereotypes and norms, he is unsuccessful. One of the major challenges for intervention programmes is the development of strategies that can foster gender change without undermining the sense of masculine security and identity.* Do you agree/disagree? Has TAI yet developed such strategies? Which ones?
34) What are advantages of **peer educating**, in the face of socio-cultural barriers?
35) What are disadvantages of peer educating, in the face of socio-cultural barriers?
36) Are there difficulties among the PE's? How are they solved?
37) Do you think the PE's are doing a good job? Could they do things better?
38) Are PLWHA involved in the project? How?
39) Does TAI encourage girls to use female condoms?
40) What are 3 strong points of the **total project?**
41) What are still challenges?
42) What are difficulties in prevention? How do you solve them?
43) What do you think is very important for effective HIV/AIDS prevention?
44) Is TAI's prevention programme also applicable in other places in South Africa? Which places? Or abroad?
45) How do you see TAI's future?

Individual semi-structured interview with the programme officer of TAI – Shosholoza AIDS project and Sibambiqhaza community project (Buhle Mahlase)

Intro:

1) Since when are you working for TAI?
2) What is your job at TAI? What are your specific tasks?
3) How did you get your knowledge about HIV/AIDS and prevention? By whom did you get trained?

HIV/AIDS Prevention:

4) Since when did Shosholoza project start? And Sibambiqhaza?
5) In what kind of areas are the projects implemented?
6) Describe the HIV/AIDS prevention activities of your two projects. First Shosholoza and secondly Sibambiqhaza.

Selection:

SHOSHOLOZA

7) How many teams are in the Shosholoza project right now?
8) How are the soccer players selected? What are the criteria of selection? Existing teams?
9) Are parents involved?
10) Who else? girls? PLWHA? Community structures? Directly or indirectly?

SIBAMBIQHAZA

11) How many participants are in the Sibambiqhaza project? Relation women-men?
12) How are they selected? What are the criteria of selection?
13) Do they receive training from TAI? Women and men together or separately?
14) PLWHA involved?

Training:

SHOSHOLOZA/SIBAMBIQHAZA

15) What kind of training do you give to the soccer players? To parents/community structures?
    And to the community people of Sibambiqhaza?
16) How do you give the training? Which materials do you use? Toolkit, manual? Difference between Shosholoza training and Sibambiqhaza?
17) How long does a training session take? Shosho/Sibambi?
18) How much training do they receive in one year? Shosho/Sibambi?
19) Is training adapted to the socio-cultural context? Shosho/Sibambi?

I mean:

- Is it focused on male power over women? Explain.
- On stereotypical behaviour for men and women?
- On violence against women?
- On cultural myths and misconceptions?
- On stigmatization and discrimination?
- On taboo surrounding sex, sexuality, and HIV/AIDS?
- On other barriers?

Activities:

SHOSHOLOZA/SIBAMBIQHAZA

20) What do PE's do after a training has finished? And the community people in Sibambi?
21) What kind of activities do PE's organise in the community? And community people?
22) How do activities promote positive masculinity?
23) Do activities make people aware of gender based violence? How?
24) Of myths and misconceptions? How?
25) Do activities address stigma and discrimination? How?
26) Taboo? How?
27) Do they reach a lot of people with their activities? Who? Also girls and women?
28) Why are young men directly involved and trained by TAI and girls not?

29) Do you agree when I say that boys can reach boys better and girls girls?
30) *Many of the traditional behaviours of boys and men are expected by girls and reinforced by girls. When a boy fails to perform according to these stereotypes and norms, he is unsuccessful. One of the major challenges for intervention programmes is the development of strategies that can foster gender change without undermining the sense of masculine security and identity.* Do you agree/disagree? Has TAI yet developed such strategies? Which ones?
31) Do soccer players get support from the community? How? By structures?

Evaluation:

SHOSHOLOZA/SIBAMBIQHAZA

32) Is there follow up by TAI? How?
33) Do you think people change in behaviour, thoughts and feelings because of the project? How? Can you give me some examples of remarkable changes?
34) Do PE's experience some difficulties with implementing preventive behaviour? Which ones?
35) How are they helped to do better?
36) What are advantages of **peer education**?
37) What are still difficulties with peer education? How are they solved?
38) What are strong points of Shosholoza? And of Sibambiqhaza?
39) Which things still need to be improved?
40) What do you think is very important for effective HIV/AIDS prevention?
41) What are still challenges in prevention?
42) Is TAI's prevention programme also applicable in other places in South Africa? Which places? Or abroad?
43) How do you see TAI's future?

Individual semi-structured interview with the programme officer of TAI – Abafana Bebhola Bayanakekela project (Lindiwe Xulu)

Intro:

1) Since when are you working for TAI?
2) What is your job at TAI? What are your specific tasks?
3) How did you get your knowledge about HIV/AIDS and prevention? By whom did you get trained?

HIV/AIDS Prevention:

4) Since when did Abafana start?
5) Where is it implemented? Why in these specific areas?
6) Describe the HIV/AIDS prevention activities of your project, Abafana Bebhola.

Selection:

7) How many participants are in the Abafana project right now? Relation boys-girls (OVC)?
8) How are the soccer players selected? What are the criteria of selection? And the OVC?
9) Are parents or other relatives involved?
10) Who else? Community committee? Are PLWHA involved in the programme? How?

Training:

11) Do you give training to the soccer players? And to OVC kids/parents/CC?
12) What kind of training do you give to the soccer players? And to the OVC kids/parents/CC?
13) How do you give the training? Which materials do you use? Toolkit, manual? Also for OVC kids/parents/CC?
14) How long does a training session take? And for OVC/parents/CC?
15) How much training do they receive in one year? OVC/parents/CC?
16) Is training adapted to the socio-cultural context?

I mean:

- Is their a section about male power over women? Explain.
- About stereotypical behaviour for men and women?
- About violence against women and abuse of women and children?
- About cultural myths and misconceptions?
- About stigmatization and discrimination?
- About taboo surrounding sex, sexuality, and HIV/AIDS?
- About other barriers?

Activities:

17) What do the soccer players do after a training has finished?
18) Do they organise activities in the community to make people more aware of HIV/AIDS?
19) Do they talk about HIV/AIDS and prevention to the OVC kids?
20) Do the soccer players promote positive masculinity? How? Towards the OVC?
21) Do they talk about violence towards women and abuse of women and children? How?
22) About myths and misconceptions? How?
23) About stigma and discrimination? How?
24) About taboo? How?
25) Do they also reach other people besides OVC? Who?
26) Do they get support from the community? How?

Evaluation:

27) Is there follow up by TAI? How? Enough?
28) Do you think people change in behaviour, thoughts and feelings because of the project? How? Can you give me some examples of remarkable changes?
29) *Many of the traditional behaviours of boys and men are expected by girls and reinforced by girls. When a boy fails to perform according to these stereotypes and norms, he is unsuccessful. One of the major challenges for intervention programmes is the development of strategies that can foster gender change without undermining the sense of masculine security and identity.* Do you agree/disagree? Has TAI yet developed such strategies? Which ones?
30) What are strong points of Abafana?
31) Which things still need to be improved?
32) What are difficulties? How are they solved?
33) What do you think is very important for effective HIV/AIDS prevention?
34) What are still challenges in prevention?
35) Is Abafana also applicable in other places in South Africa? Which places? Or abroad?
36) How do you see TAI's future?

Individual semi-structured interview with the general director/founder of TAI (Gethwana Makhaye)

Intro:

1) Since when are you working for TAI?
2) What is your job at TAI? What are your specific tasks?
3) How did you get your knowledge about HIV/AIDS and prevention?

HIV/AIDS prevention:

4) Since when did TAI start?
5) Where is it implemented? Why in these specific areas?
6) Describe the prevention activities of every project of TAI.

Strategies:

7) Which strategies in TAI's prevention programme deal with gender inequality? Male power over women? How?
8) Focus on stereotypical behaviour for men and women? How?
9) On violence against women? How?
10) On cultural myths and misconceptions? How?
11) On stigmatization and discrimination? How?
12) On taboo surrounding sex, sexuality, and HIV/AIDS? How?

Involvement of girls, PLWHA, community:

13) How did you get knowledge of the sub-culture of the PE's in the beginning of the programme?
14) How are the participants selected? What are the criteria of selection?
15) Are girls and women involved in the projects? How? Directly or indirectly?
16) In the Inkunzi project there are female PE's and female grade representatives involved. In the Shosholoza project there are only young men directly involved. Why are girls not directly involved and trained by TAI in the Shosholoza project?
17) What do you do if girls too want to become peer educators and want to organise their own initiatives?
18) Do you agree when I say that boys can reach boys better and girls girls?
19) *Many of the traditional behaviours of boys and men are expected by girls and reinforced by girls. When a boy fails to perform according to these stereotypes and norms, he is unsuccessful. One of the major challenges for intervention programmes is the development of strategies that can foster gender change without undermining the sense of masculine security and identity.* Has TAI yet developed such strategies? Which ones?
20) Are PLWHA involved in the programme? How?
21) Is the community involved? Parents, schools, etc?

Training:

22) What kind of training does TAI give to participants? Is it based on a theory (KAMSEE)?
23) How is the training given? Which materials are used? Toolkit, manual?
24) Is training adapted to the socio-cultural context?

Activities:

25) What kind of activities do PE's organise in the schools/communities?
26) Do they reach a lot of people with their activities? Who?
27) Do PE's get support from the school/community? How?

Evaluation:

28) Is there follow up by TAI? How?
29) Do you think people change in behaviour, thoughts and feelings because of the prevention programme? How? Can you give me some examples of remarkable changes?
30) Do PE's experience some difficulties with implementing preventive behaviour? Which ones?
31) How are they helped to do better?
32) What are advantages of **peer education**?
33) What are still difficulties with peer education? How are they solved?
34) Do you think PE's are doing a good job?

- What are they doing well?
- Could they do things better?

And the community people of Sibambiqhaza?

35) What are strong points of the **total prevention programme**?
36) What do you think is very important for effective HIV/AIDS prevention?
37) What are still challenges in prevention?
38) Does TAI encourage girls to use female condoms?
39) What are lessons learned?
40) Is TAI's prevention programme also applicable in other places in South Africa? Which places? Or abroad?
41) How do you see TAI's future?

Individual semi-structured interview with a board member of TAI (Thabo Manyathi)

Intro:

1) Since when are you a board member for TAI?
2) What are your specific tasks as board member?
3) How did you come in contact with TAI?

HIV/AIDS prevention:

4) Describe the HIV prevention activities of the different projects of TAI.

Strategies:

5) Which prevention strategies promote positive masculinity?
6) Which prevention strategies address violence against women and abuse of women and children?
7) Cultural myths and misconceptions?
8) Stigmatization and discrimination?
9) Taboo surrounding sex, sexuality, and HIV/AIDS?

Involvement of girls, PLWHA, community:

10) In the Inkunzi project there are female PE and female grade representatives involved. In the Shosholoza project there are only young men directly involved. Why are girls not directly involved and trained by TAI in the Shosholoza project?
11) What does TAI do if girls too want to become peer educators and want to organise their own initiatives?
12) Do you agree when I say that boys can reach boys better and girls girls?
13) Are PLWHA involved in the programme? How?
14) Is the community involved? Parents, schools, etc?

Evaluation:

15) Is there follow up by TAI? How?
16) Do you think people change in behaviour, thoughts and feelings because of the prevention programme? How? Can you give me some examples of remarkable changes?
17) What are advantages of **peer education**?
18) What are still difficulties with peer education? How are they solved by TAI?
19) What are strong points of the **total prevention programme**?
20) What do you think is very important for effective HIV/AIDS prevention?
21) What are still challenges in prevention?
22) Is TAI's prevention programme also applicable in other places in South Africa? Which places? Or abroad?
23) How do you see TAI's future?

Open group interview with soccer players – Shosholoza AIDS project

1. What is important for effective HIV/AIDS prevention?
2. Is HIV prevention difficult or easy? What makes it difficult or easy? For men/women? (social and cultural barriers) Refer to local culture!
3. Why are women, especially young women exposed to HIV/AIDS?
4. What do you learn in training from TAI? Skills?
5. Do you organise HIV/AIDS related activities in the community? Can you give me some examples?
6. In the activities that you organise in the community, do you talk about male power over women, violence/abuse, positive masculinity? Harmful stereotypes of men and women? Do you try to change myths and misconceptions about HIV/AIDS? Do you try to change stigmatization and discrimination towards PLWHA or women? Do you try to break taboo surrounding sex, sexuality, and HIV/AIDS? HOW, strategies?
7. Do you think you have changed in behaviour since you are a participant in the Shosholoza project? How?
8. To whom do you spread the message? Parents, girlfriend, community structures: church leaders, traditional leaders/healers, other NGO's, businesses (taxi), taverns, health clinics?
9. Why are there only men in the Shosholoza project?
10. How can TAI also involve women?

Open group interview with girlfriends/sisters of soccer players – Shosholoza AIDS project

1. How can you prevent HIV/AIDS effectively?
2. Is HIV prevention difficult or easy? What makes it difficult or easy? For men/women? (social and cultural barriers) Refer to local culture!
3. What do you think of your boyfriend/brother as a peer educator?
4. Does the team organise HIV/AIDS related activities in the community? Which ones?
5. Do you learn from it? What? Enough?
6. Do you learn about male power over women? Do they talk about harmful stereotypes of men and women? Do they try to tackle violence against women, abuse of women and children? Do they try to change myths and misconceptions about HIV/AIDS? Do they try to break stigmatization and discrimination towards HIV positive people or women? Do they try to break taboo surrounding sex, sexuality, and HIV/AIDS? HOW, strategies?
7. Do you think your boyfriend/brother practices what he preaches?
8. Do you think you change in behaviour and in thinking because of the Shosholoza project? How?
9. Would you prefer peer education by girls, or by girls and boys, or is it just fine like it is now, only boys?
10. Would you like to become a peer educator and organise your own activities? Which activities would that be? How can TAI also involve women?

Open group interview with community women – Sibambiqhaza community project

1. You have the forerunners and the community committee? What is the difference?
2. What is your role in the Sibambiqhaza project?
3. Are there things in the social and cultural environment that make HIV/AIDS prevention difficult? For men/women? Which ones?
4. What do you learn in training from TAI? Skills?
5. Do you organise HIV/AIDS related activities in the community? Can you give me some examples?
6. In the activities that you organise in the community, do you address male power over women? Violence towards women or abuse of women and children? Harmful stereotypes of men and women? Do you try to change myths and misconceptions about HIV/AIDS? Stigmatization and discrimination towards PLWHA or women? Taboo surrounding sex, sexuality, and HIV/AIDS? HOW, strategies?
7. What is the impact of the Sibambiqhaza project in the community? Can you give me some examples of positive changes (in behaviour) since the project?
8. To whom do you spread the message? Church leaders, schools, health clinics, taverns, etc.?

Open group interview with school boys and -girls – Inkunzi Isematholeni project: Engen schools

1. What is important for effective HIV/AIDS prevention?
2. Is HIV prevention difficult or easy? What makes it difficult or easy? For men/women? (social and cultural barriers) Refer to local culture!
3. What do you learn in training from TAI? Skills?

4. Do you organise HIV/AIDS related activities in the school? Can you give me some examples?
5. In the activities that you organise in the school, do you talk about male power over women, violence/abuse, positive masculinity? Harmful stereotypes of men and women? Do you try to change myths and misconceptions? Do you deal with stigmatization and discrimination? Do you try to break taboo surrounding sex, sexuality, and HIV/AIDS? HOW, strategies?
6. Do you think you have changed in behaviour and in thinking since you are a participant in the Inkunzi project? How?
7. To whom do you spread the message? Learners, parents, brothers/sisters, girlfriend/boyfriend?

Individual semi-structured interview with a guardian educator – Inkunzi Isematholeni project: ABSA schools

1. Since when are you a guardian educator for TAI?
2. What are your specific tasks as guardian educator?
3. Did you get training from TAI? How long was the training? What did you learn? Skills?
4. What do you think is very important for effective HIV/AIDS prevention?
5. Is HIV prevention difficult or easy? What makes it difficult or easy? For men/women? (social and cultural barriers) Refer to local culture!
6. Do the PE's organise HIV/AIDS related activities in the school? Which ones?
7. What is the role of the grade representatives in the Inkunzi project?
8. Which strategies does the Inkunzi project use to promote gender equality? Does it address violence against women, abuse of women and children? Does it address harmful stereotypes of men and women? Does it try to change myths and misconceptions about HIV/AIDS? Stigmatization and discrimination towards PLWHA or women? Taboo surrounding sex, sexuality, and HIV/AIDS? HOW, strategies?
9. Is there an impact of the Inkunzi project in the school, or even in the community? Can you give me some examples of positive changes since the project?
10. What are still challenges in HIV prevention?
11. Within the Inkunzi project, is there partnership with other people or structures in the community? For example: traditional healers/leaders, businesses (taxi), church leaders, health clinics, etc.

Individual semi-structured interview with a guardian educator – Inkunzi Isematholeni project: Engen schools

1. Since when are you a guardian educator for TAI?
2. What are your specific tasks as guardian educator?
3. Did you get training from TAI? How long was the training? What did you learn? Skills?
4. What do you think is very important for effective prevention?
5. Is HIV prevention difficult or easy? What makes it difficult or easy? For men/women? (social and cultural barriers) Refer to local culture!
6. Do the PE's organise HIV/AIDS related activities in the school? Which ones?
7. Do you give support with that? How?

8. Which strategies does the Inkunzi project use to promote gender equality? Does it address violence against women, abuse of women and children? Does it try to break harmful stereotypes of men and women? Does it try to change myths and misconceptions about HIV/AIDS? Stigmatization and discrimination towards PLWHA? Taboo surrounding sex, sexuality, and HIV/AIDS? HOW, strategies?
9. Do you think the PE's and learners change in behaviour and in thinking since the Inkunzi project? How? Can you give me some examples of changes?
10. Do learners talk about their problems to the PE's or ask them advice, information about HIV/AIDS and prevention?
11. What are still challenges in HIV prevention?

Individual semi-structured interview with an American Peace Corps Volunteer/ fieldworker/coordinator – Abafana Bebhola Bayanakekela project (Paul Bradley Gibbs)

1. Since when are you a volunteer for the Abafana project?
2. What are your specific tasks as a volunteer?
3. Did you get training from TAI? How long was the training? What did you learn? Skills?
4. What do you think is very important for effective HIV prevention?
5. Are there social and cultural barriers in HIV/AIDS prevention? For men/women? Which ones?
6. Do the soccer players organise HIV/AIDS related activities in the community? Which ones?
7. Does the Abafana project promote positive masculinity? Does it address violence against women, abuse of women and children? Does it try to change myths and misconceptions about HIV/AIDS? Stigmatization and discrimination towards OVC, PLWHA or women? Taboo surrounding sex, sexuality, and HIV/AIDS? HOW, strategies?
8. What is the impact of the Abafana project in the community? Can you give me some examples of positive changes since the project?
9. Has there been an event to raise awareness on Abafana and positive masculinity in the community?
10. Within the Abafana project, is there partnership/cooperation with other people or structures in the community? Which ones? For example: guardians, traditional healers/leaders, other NGO's, police, church leaders, schools, health clinics, media, etc.

Individual semi-structured interview with a clinical psychology professor who has done research in cooperation with TAI (Graham Lindegger)

1. What do you do at the university? In what study domain are you specialized?
2. How did you come in contact with TAI?
3. When have you conducted a research in cooperation with TAI?
4. What were the objectives of the research?
5. What were your main conclusions?
6. What were your recommendations?
7. What are the main socio-cultural barriers in HIV/AIDS prevention in KwaZulu Natal?
8. From your experience, what does TAI do to make HIV prevention work?

9. What kind of training does TAI give to the participants who will operate in the projects as peer educators?
10. Is training adapted to the socio-cultural context? How?
11. Which strategies does TAI use to break through gender inequality?
12. Stereotypical behaviour for men and women?
13. Violence against women?
14. Cultural myths and misconceptions?
15. Stigmatization and discrimination?
16. Taboo surrounding sex, sexuality, and HIV/AIDS? On other barriers?
17. What is the impact of their work in the schools/communities?
18. What kind of initiatives are organised by the peer educators in the communities/schools that focus on the issues we have just discussed?
19. Your suggestion is that TAI should involve girls as well? How do you see that happen? Do you have recommendations on that?
20. What makes TAI different from other organisations?
21. Which things still need to be improved?
22. What do you think is very important for effective HIV/AIDS prevention?
23. What are still challenges in prevention?
24. Is TAI's prevention programme also applicable in other places in South Africa? Which places? Or overseas?

7. Informed consent

For staff members, guardian educators and the university professor

Dear,

My name is Camille Collin. I am 25 years old, live in Belgium and study a Master in Conflict and Development. For my study, I am here in KwaZulu-Natal doing research about **HIV/AIDS prevention and on how to do it effectively.** It is for this study that I invite you to participate.

More specifically, the study focuses on the local culture and social environment, of which certain aspects make HIV prevention very difficult (for example gender inequality, taboo surrounding HIV/AIDS, cultural myths, etc).
I want to explore the **strategies of TAI** that try to break these barriers in order to make HIV prevention more effective for women and men.

Therefore, I would like to ask you some questions about the **HIV/AIDS prevention programme of TAI**. The interview will take about 45 minutes[33]. It will be recorded, because that is easier than writing everything down. But I assure you that all the information you give me will be kept confidential. The information is only for the purpose of the study. I will ask you to give me your name. But you will be anonymous in the report. Your name will be removed.

By participating in this study and answering my questions, you will help increase my understanding of HIV/AIDS prevention and its context. I hope that the results of the study can be used by TAI, other HIV/AIDS organisations and policies that try to make HIV/AIDS prevention more effective.

Your participation in this study is voluntary. You have the right to refuse to participate or answer any questions that you feel uncomfortable with. I would greatly appreciate your participation but you will not be compensated in any way, nor will you experience a negative result when you are not willing to participate. If you change your mind about participating during the course of the study, you have the right to withdraw at any time. The decision to withdraw will not affect you in any way.

Please don't see this interview as an evaluation exercise of TAI's prevention programme. See it more as the **sharing of experiences**, perspectives, knowledge, etc. I just want to learn as much as possible from local knowledge and **responses to the HIV/AIDS epidemic.**

If there is anything that is unclear or if you need further information, please ask and I will be delighted to answer.

MANY THANKS IN ADVANCE!!!

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[33] This varied per interview. I wrote down 30 minutes, 45 minutes or 90 minutes depending on which person I would interview that day.

I have understood the purpose of the study.

I have read the above information or it has been read to me.

I have had the opportunity to ask questions about it and any questions that I have asked, have been answered to my satisfaction.

I consent voluntarily to participate as a subject in this study and understand I have the right to withdraw from participation at any time without any negative result.

Signature of volunteer: **Signature of researcher:**

Date:

Name:

Sex: M / F (underline what is right)

Date of birth:

Consent form for soccer players involved in the Shosholoza AIDS project, for girlfriends and sisters of soccer players

The introduction was the same as in the long version above, but I explained it verbally in a more simple way. I will only give the example of consent form for soccer players. The other forms (for girlfriends and sisters of soccer players) have the same format with slight adaptations.

Date: _____

Soccer team: _____

Description subjects: _____

Place of interview: _____

I consent voluntarily to participate in this study and understand I have the right to withdraw from participation at any time without any negative result.

Name	**Age**	**Number of years in Shosholoza**	**Signature**
Your name will be removed from any report!			
1.			
2.			
3.			
4.			
5.			
6.			

MANY THANKS!!! I appreciate it a lot!!!

Consent form for schoolboys and –girls involved in the Inkunzi Isematholeni project

Date: _____

School: _____

Description subjects: _____

Place of interview: _____

I consent voluntarily to participate in this study and understand I have the right to withdraw from participation at any time without any negative result.

Name	**Sex**	**Age**	**Grade**	**Number of years in Inkunzi**	**Signature**
Your name will be removed from any report!	**F/M**				
1.					
2.					
3.					
4.					
5.					
6.					

MANY THANKS!!! I appreciate it a lot!!!

Consent form for community women involved in the Sibambiqhaza community project

Date: _____

Description subjects: _____

Place of interview: _____

I consent voluntarily to participate in this study and understand I have the right to withdraw from participation at any time without any negative result.

Name	**Sex**	**Age**	**Struct/sector**	**N° of years in Sibambiqhaza**	**Signature**
Your name will be removed from any report!	**F/M**				
1.					
2.					
3.					
4.					
5.					
6.					

MANY THANKS!!! I appreciate it a lot!!!