

**Social Factors Affecting HIV Protective Behaviour among Male Pakistani Migrants  
Residing in Greater Johannesburg and Surrounding Areas**

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## ABSTRACT

Knowledge of HIV has for the most part not halted its advance, yet HIV prevention interventions still overwhelmingly rely on increasing people's levels of HIV knowledge with the expectation that they will act rationally and in accordance with their knowledge to protect themselves from HIV. The current study contends that social factors intercede in the translation of HIV knowledge into health behaviour change. Even though people may have HIV knowledge, social factors such as gender, culture, religion and stigma, to name a few, may constrain individuals' ability to engage in HIV protective behaviour. This study therefore aimed to investigate the social factors which affect HIV protective behaviour among male Pakistani Migrants residing in Johannesburg. The study was specifically concerned with exploring the impact of gender, culture, religion, migration and xenophobia on the HIV protective behaviour of Male Pakistani migrants. This study also examined the current level of HIV knowledge and perception of HIV risk among male Pakistani migrants.

Qualitative thematic content analysis was used to analyze the transcribed responses, of nine male Pakistani migrants, to open-ended questions relating to the study's research questions. Three thematic categories emerged: HIV knowledge; Perception of HIV risk; and Social factors and HIV protection. Analysis suggested that while participants' do have an awareness of HIV, HIV knowledge is rudimentary and inadequate. It is also concluded that participants' low perception of HIV risk, based on social factors such as stigma; religion and culture, place them in a vulnerable position with regards to HIV. This study provides some important suggestions for HIV education programme design

suited to the Pakistani migrant community. It also highlights interesting variables and potential hypotheses for future research.

**LIST OF ABBREVIATIONS**

**AIDS** - Acquired ImmunoDeficiency Syndrome

**HBM** - Health Belief Model

**HIV** - Human Immunodeficiency Virus

**IMO** - International Organisation for Migration

**PCP** - Pneumocystis carinii pneumonia

**STI** - Sexually Transmitted Infection

**SCT** - Social Cognitive Theory

**UNAIDS** - Joint United Nations Programme on HIV/AIDS

**DECLARATION**

I declare that this research report is my own unaided work. It is being submitted for the degree of Master of Arts in Community Based Counselling Psychology at the University of Witwatersrand, Johannesburg. It has not been submitted before for any other degree or examination at any other university.

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**Natasha Govender**

**28 November 2008**

**DEDICATION**

For Mervin, who continues to be the guiding light in my life.

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## CHAPTER 1: INTRODUCTION

HIV-prevention science continues to be focused on individual factors, such as age, number of partners, awareness of condoms and knowledge about HIV to understand and explain HIV transmission and hence vulnerability (MacPhail & Campbell, 2001). However, experience has shown that addressing individual factors such as HIV knowledge has not halted its advance (Norman & Carr, 2003; MacPhail & Campbell, 2001; Thornton, 2008). This study departs from a focus on individual risk factors for HIV and aims to explore the social factors which, research suggests, may contribute to HIV vulnerability. Adding to this focus, the study also engages another area of scholarship, i.e. migration, with a specific focus on Pakistani migrants living in Johannesburg. By way of introduction, a rationale for the study is presented followed by an explication of the aims of the study. Next a brief discussion of the history of the HIV pandemic is entered into. Also included in this introduction to the study is information regarding the socio-political context of South Africa and Pakistan as well as details regarding HIV prevalence in these countries.

### **Rationale**

Every day, over 6800 persons become infected with HIV and over 5700 persons die from AIDS (UNAIDS, 2007). 33.2 million people are currently living with HIV and in 2007; 2.1 million deaths were due to AIDS. The HIV pandemic remains the most serious of infectious disease challenges to public health (UNAIDS, 2007). Nowhere is this more

true than in sub-Saharan Africa, where AIDS remains the leading cause of death (UNAIDS, 2007).

More than two out of three (68%) adults and nearly 90% of all children infected with HIV live in sub-Saharan Africa, and more than three in four (76%) of AIDS deaths in 2007 occurred within this region (UNAIDS, 2007). This is in spite of the fact that sub-Saharan Africa is home to just over 10% of the world's population (UNAIDS, 2005).

Southern Africa is one of the world's epicentres of the HIV pandemic (Thornton, 2008). This area alone accounted for almost one third (32%) of all new HIV infections and AIDS deaths globally in 2007 (UNAIDS, 2007).

South Africa is the country with the largest number of HIV infections in the world (UNAIDS, 2007). In South Africa, it has been said that AIDS accounts for almost 50% of all deaths (Dorrington, Johnson, Bradshaw & Bradshaw in Thornton, 2008). HIV prevalence has reached 39% in the country's worst affected area, Kwa-Zulu Natal. The pandemic varies considerably between provinces, from 15% prevalence in the Western Cape to 39% in KwaZulu-Natal (UNAIDS, 2007). A 2006 estimate based on HIV prevalence among antenatal clinic attendees places HIV prevalence in Gauteng at 30.8 % (UNAIDS, 2007).

In light of the above statistics, it is not surprising that it has become a truism in South Africa, that even if one is not infected by the HI virus, one is certainly affected by it. In many countries, and especially in South Africa, HIV has penetrated every aspect of social, political, economic and cultural life (Thornton, 2008). In addition to its devastating toll on human life, the HIV pandemic continues to have enormous economic and social consequences for South Africa (IOM, 2005). Current global figures estimate

that 16 million children under 15 have already lost either one or both parents to AIDS (UNICEF, 2007). In South Africa, an estimated 40% of the 1,400,000 children orphaned by AIDS are cared for by grandparents and a significant proportion are cared for by older siblings (UNICEF, 2007). Problems encountered by such grandparent and child headed households include enormous difficulties in obtaining basic necessities such as food, housing, health care and education. This together with a the lack of necessary parental guidance through crucial life-stages of identity formation and socialisation into adulthood severely limits the ability of these children to later in life participate constructively in social and economic life and contributes to social problems such as increased poverty, crime, violence and substance abuse to name a few (Squire, 2007).

Within the public sector HIV is overwhelming health and social services as well as demoralising their providers (Squire, 2007). Ever increasing numbers of skilled industrial and agricultural workers, teachers and health workers are dying from AIDS. As a result it is estimated that Africa as a whole can expect a third less growth in Gross National Profit by 2025 because of HIV (Ankrah in Williamson, 2004). More concerning than the current impact of HIV and AIDS mentioned above, is the fact that the true toll of the disease cannot be estimated until the full evolution of the epidemic (Squire, 2007).

The need for South Africans in all spheres of life to contribute toward the fight against HIV cannot be overemphasised. Academia certainly seems to be active in the effort to curb the spread of HIV. There are literally hundreds of publications from various disciplines, dealing with the subject of HIV and AIDS. This study aspires to contribute to this important body of knowledge regarding HIV, which is essential in order to stop the spread of HIV, particularly in South Africa.

Perhaps more concerning than the current high HIV prevalence rate in South Africa is the fact that the pandemic continues to evolve at an astounding speed. National prevalence which was less than 1% in 1990, rocketed to almost 25% within 10 years (UNAIDS, 2005). The complexity and scale of HIV and its spread has thus far eluded effective explanation. Factors ranging from poverty to sexual networking have been studied in an effort to explain the high prevalence as well as rapid spread of HIV in South Africa (IOM, 2005). A neglected factor in understanding the rapid spread of HIV in South Africa, seems to be the role of migration (IOM, 2005). A number of studies have found that migrants are at particular risk for contracting HIV (IOM, 2005; Lurie et al., 2003; Williamson, 2004).

Since its transition to democracy in 1994, South Africa has become the primary destination for tens of thousands of migrants and refugees from across the African continent and beyond, seeking protection, prosperity or passage, and mostly settling in the country's urban centers (Landau, 2007; Landau & Jacobsen, 2004). Estimates by the Wits Forced Migration Studies Programme (FMSP) locate the numbers of foreign migrants at around 1 million (Landau, 2005). Given the research which suggests a link between migration and HIV, as well as the significant levels of migration into South Africa, it seems important to study migration as a factor in the epidemiology of HIV. While there appears to be no shortage of researchers conducting studies on HIV vulnerability among South African citizens, very little research has been conducted into the HIV vulnerability among migrants. It seems this is yet another arena in which migrants are marginalised. This is especially concerning given the fact that migrants have been shown to be particularly at risk of contracting HIV.

One of the top eight countries of citizenship for refugees and asylum seekers to South Africa is Pakistan (Landau, 2007). Illegal Pakistani immigrants in South Africa are second on the list of the UN High Commission for Refugees in the country, topped only by Nigerians. With the current political upheaval in Pakistan, including the assassination of opposition leader and former Pakistani Prime Minister Benazir Bhutto in December 2007, South Africa is likely to see an increase in the number of Pakistani refugees to South Africa. It is with the above in mind that this study will examine HIV vulnerability, as it relates to social factors which may impact the ability of Pakistani migrants to protect themselves from HIV infection.

It is primarily through knowledge and education regarding HIV that we can hope to reduce HIV risk behaviour and thus stop the spread of HIV (Ambati, Ambati & Rao, 1997). This is the premise upon which the overwhelming number of prevention interventions are based. These HIV interventions aim at providing information about HIV, with the expectation that people will use this knowledge to take action to protect themselves from HIV infection (Campbell, 2004). The expectation then is that knowledge about HIV and risky sexual behaviour will translate into self protective behaviour. However, experience has shown that HIV knowledge does not necessarily translate into protective behaviour change (Norman & Carr, 2003).

Despite being confronted with masses of information regarding HIV everyday, in the form of glitzy and costly advertising campaigns, such as LoveLife and Soul Buddyz, HIV prevalence in South Africa continues to rise. Surveys suggest that nearly 100% of South Africans have HIV knowledge (Thornton, 2008), however knowledge of HIV has for the most part has not halted its advance. It seems that HIV prevention interventions

have been hugely successful in increasing knowledge about HIV, but not in curbing the spread of HIV.

A key question then in the fight against HIV and a question, with which this study is concerned, is why it is that HIV knowledge does not translate into HIV protective behaviour. Campbell (2004) suggests that an answer may be found by shifting attention away from the individual to the social domain. Social factors, such as gender, poverty, stigma, cultural and religious identity and power dynamics can and often do impact on an individual's ability to translate HIV knowledge into HIV protective behaviour (Campbell, 2004). Based on this thesis, the present study was concerned with investigating the social factors that affect Pakistani migrant's freedom to engage in HIV protective behaviour. In doing so, this study aimed to highlight important factors which may play a role in the HIV vulnerability of Pakistani migrants. An understanding of these factors is important for HIV prevention efforts in this community. The study, in as far as it's focus is on migrants, may also give an indication of the factors which may constrain HIV protective behaviour among other migrants and perhaps South Africans in general.

### **Aims**

The study sought to investigate the HIV vulnerability of Pakistani migrants, as it relates to social factors which may undermine these migrants ability to act in ways that protect their sexual health (Campbell, 2004). Specific research aims related to an exploration of how social factors such as gender, culture and religion, as well as xenophobia/marginalisation may affect Pakistani migrants' ability to protect themselves from HIV. Exploration of the level of HIV knowledge among Pakistani migrants and

their perception of HIV risk was also entered into. The findings of this study highlighted factors which should be addressed through HIV prevention interventions in the Pakistani migrant community. Hence, this study aspires to inform relevant HIV prevention interventions that address the specific needs of this community. The findings of this study may be used in order to develop HIV prevention interventions that specifically target those factors at a social and community level that may make it difficult for Pakistani migrants to engage in HIV protective behaviour.

## **Background to the present study**

### ***History and background of HIV/AIDS***

A report published by the Atlanta based Centre for Disease Control and Prevention (CDC) in June 1981 marked the emergence of what was to become the deadliest pandemic in the history of human kind (Abdool Karim, 2005). This report described the occurrence of *Pneumocystis carinii* pneumonia (PCP) in five gay men in Los Angeles, USA (Abdool Karim, 2005). At first it was thought that the disease only affected homosexuals but it soon became evident that it affected other groups when the first cases of PCP were reported among injecting drug users and haemophiliacs in December 1981 (Abdool Karim, 2005). In 1982, the disease was named Acquired ImmunoDeficiency Syndrome (AIDS) and in 1983, Dr Luc Montagnier and Dr Robert Gallo isolated the virus believed to cause AIDS, the Human Immunodeficiency Virus (HIV) (Sadock & Sadock, 2003).

AIDS is defined as a terminal neuromedical disorder resulting from damage to the human immune system caused by HIV (Sadock & Sadock, 2003). HIV is a constantly



mutating retrovirus that gradually destroys the T-cells that protect the body against infections (Schafer, 1991). This condition progressively reduces the effectiveness of the immune system and leaves individuals susceptible to opportunistic infections, such as Kaposi's sarcoma, PCP and tumors (Sadock & Sadock, 2003).

Since its inception HIV has been socially constructed according to moral categories in a way that few other diseases have ever been (Yeo, 1991). In the past, sexual impurity and disease have often been linked, where disease was thought to be the consequence of sexual 'sin' (Schafer, 1991). HIV inherits this legacy, since one of the primary means of HIV transmission is through sexual activities. Hence, HIV became associated with deviance, promiscuity, shame, guilt and with the moral judgements which accompany these terms (Schafer, 1991). While it must be acknowledged that progress has been made in terms of challenging the construction of HIV in terms of punishment for wrong doing, given the stigma that still surrounds the disease there is still a lot of work to be done in this arena.

### ***HIV and AIDS in South Africa***

The first reports of AIDS in South Africa emerged in 1983, with an article in the South African Medical Journal describing two identified cases of AIDS among homosexual men (Abdool Karim, 2005). During the early part of the epidemic in South Africa (1982-1987), AIDS was mainly associated with the homosexual male population (Abdool Karim, 2005). It was only by the end of 1989 that a number of surveillance studies started to detect the entry of HIV into the heterosexual population in South Africa (Abdool Karim, 2005). Between 1990 and 1994 it became abundantly clear that HIV was as much

a heterosexual as a homosexual problem (Abdool Karim, 2005). The AIDS epidemic has continued to rise steadily since.

At first, the response to the HIV epidemic developed slowly. HIV was seen as a gay epidemic at the time of its emergence in the mid 1980's. Its status as a disease confined to a select group of what was then considered social deviants, meant that HIV evoked minimal response from government (Abdool Karim, 2005). The realisation of HIV as an epidemic which impacted homosexuals and heterosexuals alike came at a time when the post apartheid government was faced with the urgent need for reconciliation and nation building (Campbell, 2003). This took precedence over the need to accord HIV the necessary priority and commitment (Campbell, 2003). Hence, it is only recently that a response to HIV was seriously undertaken. However, even this has not been without problems. The current government continues to be strongly criticised for its "litany of errors in AIDS policy" (Abdool Karim, 2005, p. 35). The South African government has become entangled in a series of AIDS controversies. For example, former President Thabo Mbeki in his quest to draw attention to the valid link between poverty, the legacy of apartheid and HIV, has sought support from widely discredited 'dissident' scientists who argue that HIV does not cause AIDS and even that AIDS does not exist as a specific clinical condition (Campbell, 2003).

### ***Brief history and background of South Africa***

As mentioned above, the socio-political history of the country has had an influence on the response to HIV in South Africa, hence it is perhaps necessary to explore some of the salient aspects of this history. The holding of the first ever non-racial general election and

installation of the government of national unity in May 1994 ushered in a new era for South Africa (Adedeji, 2007). Prior to this, the nationalist government operated under a system of institutionalised racial segregation, i.e. apartheid. It was under this system of rigid racial hierarchy that a range of atrocities were committed, not the least of which was allocation of public resources along racial lines, with the majority of public resources and social services, such as education, health, welfare and housing allocated to whites and non whites receiving the least (Adedeji, 2007). The effects of apartheid are still being felt today, most notably in the fact that of the 44 million South Africans, the majority continue to live below the poverty line (van der Walt, Bowman, Frank & Langa, 2007). As during apartheid, black South Africans continue to be disproportionately represented among the poorest of the poor (van der Walt et al., 2007).

From the above it is clear that South Africa is a country in transition, one attempting to transform the structure of society while still grappling with the legacy of apartheid (Kiguwa, 2006). Democracy has brought with it significant social, political and economic changes for the country, among them, the establishment of a new constitution; affirmative action programmes to redress racial inequalities in the workplace as well as various initiatives aimed at improving resources for those previously disadvantaged under the apartheid government (Kiguwa, 2006). Despite the many changes in South African society, there remains many challenges, as mentioned before. The majority of South Africans continue to live below the poverty line (van der Walt et al., 2007). Crime is an ever increasing problem and government is criticised for lack of response in this regard as well as corruption within its ranks (Adedeji, 2007). Not only does HIV add to the above problems, placing a greater burden on the fledgling democratic nation of South Africa but

the existence of these problems serve to hamper the nations efforts to curb the spread of HIV.

### ***Brief history and background of Pakistan***

Pakistan, as one of the top eight countries from which refugees and asylum seekers to South Africa originate from (Landau, 2007) has a number of things in common with South Africa. Though South Africa's government is clearly much younger than that of Pakistan, Pakistan too is a country in transition. Pakistan was born on 14 August 1947, when the Partition of British India and the decolonisation of Southern Asia resulted in the birth of two separate states, India and Pakistan (Jaffrelot, 2004). Referred to as the 'land of the pure', Pakistan is the outcome of the Muslims of British India wanting to defend their interests against the Hindu majority by claiming an independent territory (Jaffrelot, 2004). Hence, some regard Pakistan as a slice of India that has drifted away. The violence which accompanied the mass exodus of Muslims from India into Pakistan at its inception led to strained relation between the two (Jaffrelot, 2004). Since achieving its independence in 1947, Pakistan has had three constitutions and experienced four military coups (Jaffrelot, 2004).

Pakistan is situated at the confluence of three regions, South Asia, the Arab-Persian world and Central Asia. With a population of one hundred and forty million, it has the sixth largest population in the world. The annual population growth rate is 2.03% (Bhurgri, 2006). The population is young, the median age being 19.44 years in males and 19.74 years in females. In contrast to South Africa, which is well known for being one of

the most diverse countries in the world, Muslims comprise 97% of the population with Christians, Hindus, and other religions comprising 3% of the population (Bhurgri, 2006).

As in South Africa, poverty is a serious problem in Pakistan, with an estimated 28.35% living in poverty (Siddiqui, Ismail & Allen, 2008). However, unlike South Africa where religion and the state are divided, in Pakistan Islamic law dictates traditional family values and is enmeshed in the legal system (Siddiqui et al., 2008). For example, the Hudood Ordinances, part of the 1979 campaign to Islamise Pakistani society, focuses mainly on women, their dress, behaviour and legal status (Siddiqui et al., 2008). These ordinances consist of several ordinances including the Zina ordinance which dictates punishments for various sexual offences, such as Zina (fornication and adultery), Zina-bil-jabr (rape), kidnapping and abducting (Siddiqui et al., 2008). Under this ordinance non-marital sex as well as adultery is illegal and punishable by the maximum sentence of death by stoning (Siddiqui et al., 2008). The evidence required for punishment under this ordinance is the eye witness account of adult male Muslims (Siddiqui et al., 2008).

The above exploration of both the South African and Pakistani context reveals both commonalities and difference between the two countries. These differences are also evident with regards to HIV in these countries.

### ***HIV and AIDS in Pakistan***

In stark contrast to South Africa, in Pakistan HIV prevalence is relatively low in the general population (under 1%). However there has been an increase in prevalence among injecting drug users (UNAIDS, 2007). One study in Karachi showed an increase in HIV prevalence among injecting drug users from under 1% in early 2004 to 26% in March

2005 (Emmanuel, Archibal & Altaf in UNAIDS, 2007). Among female sex workers in Karachi, HIV prevalence in 2005 was 2% while it was below 1% in Lahore and Rawalpindi (Ministry of Health Pakistan, 2005; National AIDS Control Program Pakistan in UNAIDS, 2007).

The apparent low prevalence of HIV within Pakistan and the fact that the infection is still confined to pockets of high risk groups may be due to one or more of the following reasons: an actual low level of HIV infection; the epidemic still being in its earliest stages; widespread under-reporting of cases due to inadequacies in the surveillance system (Emmanuel, Akhtar, Attarad & Kamran, 2004). Pakistan is thus considered to be in a 'high risk-low prevalence' situation, where an explosion of the HIV epidemic can occur if urgent steps in primary prevention are not taken (Bhurgri, 2006; Emmanuel et al., 2004).

In one of the most comprehensive studies of HIV in Pakistan to date, Hyder and Khan (1998) undertook a structured review of published, unpublished, and government literature to collate all available information and present a descriptive profile of HIV in Pakistan. Findings included data that within patients with sexually transmitted diseases the seroprevalence was as high as 6100 per 100 000 (6.1%); in men with extramarital contacts, 5400 per 100 000 (5.4%). The average age of onset was reported as 30 years. It is estimated that if all incident cases of AIDS were to die, there would be at least 5000 deaths annually attributable to HIV (Hyder & Khan, 1998). The study concluded that the extremely low awareness of HIV in Pakistan coupled with a growing number of cases, means that the AIDS epidemic is poised to take a hold in Pakistan. The study further concluded that the presence of additional risk factors such as unscreened blood, and low

condom use rates make the situation fertile for AIDS to become a major public health issue (Hyder & Khan, 1998).

Pakistan is a vulnerable country, with increasing levels of poverty; low levels of literacy (especially among women); low levels of condom use; low levels of awareness among health workers; a large mobile population including refugees in border areas; internal and external migrants; social and economic disadvantages (particularly for women and girls); a booming commercial sex industry; widespread indulgence in commercial sex with low levels of condom use; high prevalence of STIs with limited access to good-quality STI care; and a large proportion of young people with low levels of knowledge about HIV transmission and prevention (Bhurgri, 2006). Incidentally, these are also the factors which have been identified as being linked to the high risk of HIV in South Africa (IOM, 2005). It seems that the similarities between the South African and Pakistani contexts extend to vulnerability to HIV. However it is the difference in HIV prevalence rate between the two countries, with South Africa having a high prevalence and Pakistan a relatively low rate which is significant. The fact that Pakistani migrants have moved from an area of relatively low HIV prevalence, to South Africa, an area of extremely high HIV prevalence and risk, may place Pakistan migrants in a more vulnerable position in terms of HIV. A number of factors ranging from lack of HIV knowledge and awareness, to greater stigma and low perception of risk, could contribute to this vulnerability. This highlights the importance of studying this group within the South African context.

## **Chapter Organisation**

The study is presented in five chapters. The introductory chapter provides a rationale for the study, sets out the aims of the study and provides salient information regarding the history of HIV. Background information relating to the history as well as current socio-political context of both South Africa and Pakistan is also presented.

A review of the relevant literature is presented in Chapter 2. The aim of this chapter is to provide a framework for understanding the current study. Continuing from the rationale for the study presented in Chapter 1, the chapter goes on to explore firstly the link between HIV and migration and secondly the apparent lack of association between HIV knowledge and change in HIV-risk behaviour. Finally this chapter reviews the literature relating to social factors such as gender, culture and religion, xenophobia and the role these may play in individuals' ability to engage in HIV protective behaviour.

Chapter 3 describes the methodology of the study and contextualises the way in which the research was approached and carried out. Included in this chapter is the conceptual rationale for adopting a qualitative design as well as the research questions, data gathering procedures, participants, methods of analysis and finally issues of reflexivity.

Chapter 4 presents the themes which emerged from analysis of the interview data. The themes presented are categorised into three broad themes relating to the research questions, these include 1) HIV knowledge, 2) Perception of HIV risk and 3) Social factors affecting HIV protective behaviour.



Chapter 5 continues the discussion of dominant themes in relation to the research questions which was begun in chapter 4. The researcher also reflects on the limitations of the study, as well as makes recommendations for intervention and future research.

## **CHAPTER 2: LITERATURE REVIEW**

### **Introduction**

This study engages a number of different areas of scholarship. It is located at the junction of three broad fields of study i.e. HIV prevention, migration and social factors which structure society. Hence the current chapter provides a review of literature within these areas of study deemed relevant to the current research undertaking. Beginning with the argument that HIV is not merely a physical disease but one that thrives in particular social contexts, a discussion about the link between HIV and poverty is entered into. Adding to the rationale for the study, literature relating firstly to the link between HIV and migration and secondly the apparent lack of association between HIV knowledge and change in HIV-risk behaviour, is explored. The argument is made that social factors such as gender, culture and religion, migration, xenophobia and stigma play an important role in individuals' ability to engage in HIV protective behaviour, hence knowledge is not sufficient for behaviour change. In this regard, literature relating to the ways in which gender, culture, religion, migration and xenophobia each may constrain an individual's ability to protect themselves from HIV is presented. It is this literature which guided the focus of the study and determined the research questions.

### **Behaviour Change and HIV Prevention**

In order to prevent HIV it is necessary to stop the transmission of the virus before it enters the human body. Behaviour change is key to achieving this (Fan et al., 2007). In order to prevent the virus from entering one's body, one must refrain from behaviour

which puts one at risk of coming into contact with the virus. Much work has gone into researching this area of health behaviour change and particularly in investigating the factors which cause people to be resistant to such change in their behaviour, in order to prevent contracting the HIV virus (Fan, Conner & Villarreal, 2007). Health promotion and disease prevention researchers have organised their findings in this regard into several models, which highlight important factors in health behaviour change (Fan et al., 2007). Included among these models are the health belief model (HBM), social-cognitive theory (SCT) and the theory of reasoned action (Ogden, 2004). These three health behaviour change models are briefly described below.

The health belief model, the oldest of the health behaviour change models, identifies three main variables in explaining the absence of health behaviour change (Fan, et al., 2007). The first variable is the person's susceptibility to a health threat, such as HIV. According to the model, if a person does not believe himself or herself to be at risk for contracting a disease that person will not begin the process to protect him or herself from contracting the disease (Ogden, 2004). The second important variable in the health belief model is an individual's assessment of the severity of the disease in terms of threat. If a person judges the severity of a disease to be low or as posing minimal threat there is not much incentive to take protective action. Hence with regards to HIV protection it is important that the person know, understand and accept the severity of HIV in order to take action to protect themselves (Fan et al., 2007). The final variable is a person's evaluation of the effectiveness of recommended illness preventing action, such as for example condom use, in preventing a disease (Fan et al., 2007). The model argues that if the recommended action is clearly effective it is easier for a person to decide to take

action (Fan et al., 2007). To summarise this model proposes that perceived severity, susceptibility and evaluation of action are crucial factors in health behaviour change.

Social cognitive theory as applied to health behaviour change, is based on Albert Bandura's triadic reciprocal model of causality, which assumes that personal attributes, the environment, and behavioural determinants operate as interchanging mechanisms to influence ones motivation for health behaviour change (Bandura, 1994). This theory suggests that while knowledge of a health risk, such as HIV, as well as the benefits of health behaviour change are a prerequisite to change, additional self-influences are also necessary for change to occur (Munro, Lewin, Swart & Volmink, 2007). Among these self influences are beliefs regarding personal efficacy, as well as the expected outcomes, both positive and negative, of health related behaviour (Munro et al., 2007). Self-efficacy beliefs are peoples' judgements of their capability to successfully organise and execute courses of action (Bandura, 1994). According to social cognitive theory, if people have confidence in their ability to execute HIV protective behaviour and perceive that there are few external barriers to executing this behaviour, they will be more likely to enact health behaviour change in order to protect themselves (Munro et al., 2007). Health behaviour is also affected by outcome expectations (Munro et al., 2007). Whereas self-efficacy beliefs refer to "Can I do it", outcome expectations refers to beliefs about "Will I like the results if I do it" (Bandura, 1994). According to social cognitive theory people are more likely to attempt behaviours that they expect will lead to desirable outcomes (Bandura, 1994). Expected outcomes may be natural or social, including expectations of family and social acceptance and approval (Munro et al., 2007).

The theory of reasoned action assumes that most socially related behaviours are under conscious control and that one's intention to perform a particular behaviour is the most important determinant of that behaviour (Munro et al., 2007). In other words behavioural intention leads to action (Fan et al., 2007). Similar to social cognitive theory, the intention to perform a behaviour is influenced by one's expectations of the positive or negative outcomes of the behaviour (Fan et al., 2007). Behavioural intention is also influenced by subjective norms, including the perceived expectations of important others such as family, members of one's culture and work colleagues. However subjective norms are only significant in determining behavioural intention if there is motivation to comply with such subjective norms, i.e. the wishes of others (Munro et al., 2007).

It is clear that the afore mentioned models focus on cognitive variables as playing a crucial role in health behaviour change, and share the assumption that individual attitudes and beliefs are major determinants of health related behaviour (Munro et al., 2007). In addition these theories all share the premise that knowledge of a particular health condition or risk is a prerequisite for preventative behaviour (Barden-O'Fallon et al., 2004; Ogden, 2004). While there is no doubt that there is value in these models, it is also recognised that they have significant weaknesses. Critics argue that one of the greatest weaknesses of these models lie in the above mentioned focus on individual factors in HIV related behaviour change (Munro et al., 2007). These models seldom look beyond the level of the individual, ignoring other factors that may impact on health behaviour change, such as power relationships as well as other factors in the social realm (Munro et al., 2007). This criticism of the models of health behaviour change will be

taken up again later. However, first two important components of these models, i.e. perception of risk and knowledge will be explored in greater detail.

### **Perception of HIV Risk and Behaviour Change**

As mentioned above psychosocial frameworks such as the theory of reasoned action and the health belief model, among others, have used HIV knowledge and risk perception as key components of the process leading to behaviour change (Barden-O'Fallon et al., 2004). The health belief model posits that preventative action is more likely among those who feel vulnerable to a disease (Ogden, 2004). The importance of HIV risk perception in contributing to behaviour change has been examined in a number of contexts. These studies suggest that while a causal link between risk perception and behaviour change is not well established (Barden-O'Fallon et al., 2004), perception of risk does influence behaviour (Gregson, Zhuwau, Anderson & Chandiwana, 1998; Lindan et al., 1991; Spira et al., 2000). These studies have found that higher levels of perception of risk were associated with effective behaviour change.

Studies suggest that knowledge has a mediating effect on risk perception (Barden-O'Fallon et al., 2004; Macintyre, Rustenburg, Brown, & Karim, 2004). For example, Barden-O'Fallon et al., 2004, found that knowledge of HIV is a significant determinant of perceived risk. However, very low perception of risk, even in relatively high prevalence situations, has been reported in a number of settings (Macintyre et al., 2004; MacPhail & Campbell, 2001; Sarker et al., 2005). For example, in a study involving 1041 Tanzanian students, Maswanya et al. (1999) found that while most participants (99%) thought that AIDS is a very dangerous killer disease, only 25% of participants felt that they

themselves were personally at risk of acquiring HIV. Likewise, Macintyre et al. (2004) concluded that while many of the participants in their study recognized that HIV is a terrifying epidemic, translating this knowledge into a perception of being personally at high risk required significant changes in thinking.

### **HIV Knowledge and Behaviour Change**

HIV prevention interventions have overwhelmingly relied on increasing peoples' level of HIV knowledge, with the expectation that they will act rationally and in accordance with this knowledge to protect themselves from HIV and therefore reduce their vulnerability (Thornton, 2008). In most cases the majority of empirical research has focused on age, number of partners, awareness of condoms and knowledge about HIV to understand and explain HIV transmission and hence vulnerability (MacPhail & Campbell, 2001). In a review of HIV-prevention science, Waldo and Coates (in Campbell, 2003) highlight the fact that HIV prevention research is similarly focused on individual factors, such as level of HIV knowledge to explain sexual behaviour.

However, ironically in light of the focus on increasing of HIV knowledge both in the research arena and in HIV prevention practice, the overwhelming body of evidence seems to point to the fact that knowledge of HIV has not halted its prevalence. Despite high levels of HIV knowledge, prevalence continues to grow. In fact, Thornton (2008) argues that there is a high level of HIV knowledge in South Africa, some surveys suggest close to 100% levels of HIV knowledge, however behaviour seems not to have changed.

There clearly seems to be a disconnect between what people know about HIV and what they do. The research suggests that in many cases knowledge of HIV does not

translate into protective behaviour change (Norman & Carr, 2003). Mbulo, Newman and Shell (2007) report that despite the fact that 98% of Zambians are aware of HIV and its mode of transmission, only an estimated 11.1% of Zambian students in their study reported using condoms during intercourse. Likewise, MacPhail and Campbell (2001), in a study of 44 young males and females in the town of Khutsong, south west of Johannesburg, reported 89.9% accurate knowledge about HIV prevention methods and transmission and the sexual health-enhancing benefits of condoms, but low condom use. 69% of participants reported they never used condoms, 16.7 % said that they sometimes used them and only 14.3 % said they always used condoms. In a study of HIV knowledge and HIV-risk behaviour of sub-Saharan migrants in Sweden, Steel, Herlitz, Snyder, Mazzaferro and Theorell (2004) found that although the participants had a high degree of HIV-related knowledge they still continued to engage in risky sexual behaviour. All of these results seem to consistently support the conclusion that there is little association between HIV knowledge and change in HIV-risk behaviour (Amadora-Nolasco, Alburo, Aguilar & Trevathan, 2001; Stall, Coates & Hoff in Steel et al., 2004).

There have been some studies that report that higher levels of HIV knowledge were associated with effective behaviour change (Gregson et al., 1998; Lindan et al., 1991). However, the overwhelming majority seems to point to the fact that while HIV knowledge is a necessary condition for behaviour change and lack of HIV knowledge is certainly a risk factor for HIV infection (Bhattacharya, 2005; Simbayi et al., 2005), HIV knowledge is by no means sufficient for behaviour change. A primary concern for this study, then is what are the factors that may intercede in the translation of HIV knowledge into behaviour change.



## **Social Context and HIV**

Perhaps the most noteworthy aspect of HIV is the fact that it is not merely a physical disease (Yeo, 1991). AIDS is caused by a retro-virus which shows an unprecedented ability to undermine the human body's immune system and for which no cure or vaccine has yet been found, however viral diseases do not all become epidemics (van Niekerk, 2005). To become an epidemic and progress to a pandemic, HIV required a social context which allowed it to flourish (van Niekerk, 2005). Contextual factors which make it possible for HIV to thrive, include unequal power relations, particularly gender inequality, a history of oppression as well as various cultural practices (Campbell, 2004; van der Walt et al, 2007). These contextual factors will be discussed later, but attention will now be turned to one of the most recognised social factors associated with HIV and AIDS, i.e. poverty.

One need look no further than the fact that the vast majority of the worlds HIV positive population live in low and middle income countries (UNAIDS, 2008), in order to see the link between poverty and HIV. In South Africa, where in some provinces up to 70 percent of the population live below the poverty line, the HIV pandemic cannot be separated from the issue of poverty (van der Walt et al., 2007). The relationship between poverty and HIV is complex and does not involve a one way linear relationship (van der Walt et al., 2007). Poverty is implicated in the spread of HIV but is also a consequence of the disease. For example, in a South African survey of seven hundred households with at least one person already sick with AIDS, two thirds of participants reported loss of income as a consequence of HIV and half reported not having sufficient food (van Niekerk, 2005).

With regards to the link of poverty to the spread of HIV, it is recognised that poverty has accompanying side-effects, such as poor education, living conditions and health as well as the trading of sex for survival (van Niekerk, 2005). It is these side effects which are major contributors to the current spread of the disease (UNAIDS, 2008; van Niekerk, 2005). Low income contexts are usually characterised by malnutrition, which makes the body more susceptible to the HI virus by compromising the skin and mucus membranes of the genitals (van der Walt et al., 2007). Poverty may encourage women in low income contexts to engage in sex in exchange for money and food (van der Walt et al., 2007). Furthermore, the lack of power held by women in such circumstances make it very difficult for them to negotiate safe sex practices (UNAIDS, 2008). Finally poverty acts to hasten an HIV positive person towards AIDS and ultimately death by creating conditions which compromise the immune system and hinder adequate access to treatment (van der Walt et al., 2007).

### **Social Factors and Behaviour Change**

As mentioned above a few authors suggest that in order to understand the apparent failure to translate HIV knowledge into positive behaviour change, it is necessary to look beyond individual factors. Eaton, Flisher and Aaro (2003), have developed a useful conceptual framework for the factors that act as barriers to safe sex practices. This model distinguishes between three levels of factors which overlap and reciprocally influence each other (Eaton et al., 2003). These consist of personal factors, factors in the proximal context and factors in the distal context, including structural and cultural factors (Eaton et al., 2003).

Campbell (2004) argues that individual behaviour, such as whether to engage in safe sex practices, including condom use, are heavily shaped by the social context in which a person is located. Sexual connections and thus choices are necessarily social, and are for all humans a fundamental part of social structure (Thornton, 2008).

As argued by Thornton (2008) sex is not simply “behaviour” of individuals but rather an “action”, more accurately it is a form of social action. In other words, as with other forms of social action the way in which people act with regards to sex, takes into account the behaviours (social norms, values, etc.) of others. As per Max Weber’s concept of “Social Action”, action is socially constructed. New knowledge and information, including regarding sexual risk, will always be interpreted through and be mediated by existing social systems of meaning that tell us how to act (Parker, 2001).

In other words there must be a realisation that sexual behaviour and choices are embedded in the social environment of all humans and thus will be informed by social values, structures and norms. In the same vein choices about whether to engage in HIV protective behaviour are of necessity informed by the social context of an individual. Factors in the social context of the individual can either hinder or enable an individual’s ability to act in ways that will protect them from HIV infection, i.e. to translate HIV knowledge into HIV protective behaviour.

As with all social action, a range of social factors such as gender, culture, religion, poverty, stigma, xenophobia, have been identified as having the capacity to impact on peoples’ ability to engage in HIV protective behaviour (Campbell, 2004).

## **Social Factors Affecting HIV Protective Behaviour**

### *Stigma*

HIV related stigma is as central to the global AIDS challenge as the disease itself (Skinner & Mfecane, 2004). 'Stigma' is a Greek word denoting a mark that, in ancient times was burned or cut into the flesh of an unsavoury character (Holznermer & Uys, 2004). Thus the term HIV related stigma denotes prejudice, discounting, discrediting and discrimination that is directed at people living with HIV or AIDS and at individuals, groups and communities with which they are associated (Holznermer & Uys, 2004). Various factors have been identified as contributing to HIV related stigma. These include the fact that HIV is often associated with behaviours, such as promiscuity and drug use, which are already stigmatised in many societies (Holznermer & Uys, 2004). Hence judgemental moral discourses which label HIV as God's punishment for sinners are often documented (Skinner & Mfecane, 2004). The view that people living with HIV have contributed to their own problems, therefore commonly underlies HIV related stigma (Skinner & Mfecane, 2004).

Stigma imposes significant hardships on those living with HIV, leaving no doubt that it amplifies the complexities of living with HIV (Peretti-Watel, Spire, Obadia & Moatti, 2007). Stigma often leaves those living with HIV alone and distanced from the rest of their communities and even family, denying them care and support when they need it most (Spire, de Zoysa & Himmich, 2008). For persons living with HIV, stigma is one of the most common barriers affecting access to treatment and care (UNAIDS, 2008). A number of researchers have found that fear of stigma and discrimination influences

decisions to seek HIV treatment and also negatively impacts adherence to antiretroviral treatment (Kalichman & Simbayi, 2003)

While stigma against people living with HIV has significant impacts on those immediately affected, it also has a number of implications for the spread of the epidemic and broader society (Skinner & Mfecane, 2004). In fact, it has been argued that stigma fuels the HIV epidemic in numerous ways (Rankin, Brennan, Schell, Laviwa & Rankin, 2005).

It is widely known that HIV testing reduces high risk sexual practices and can decrease rates of HIV infection (Kalichman & Simbayi, 2003). HIV testing is therefore central in curbing the spread of HIV. However, stigma can create significant barriers to HIV testing (Peretti-Watel et al., 2007). Several studies have shown that fear of stigma and discrimination is associated with lower uptake of HIV testing (Rankin et al., 2005; Spire, de Zoysa & Himmich, 2008). For example, in a US study 59% of participants who had never been tested for HIV cited fear of negative social consequences as a leading reason for not seeking testing (Fortenburt, McFarlane & Bleakly, 2002). Likewise, Kalichman and Simbayi (2003), in a study examining HIV testing attitudes among 250 people living in a Cape Town township concluded that HIV related stigma created significant barriers to seeking voluntary testing and counselling. Participants in the study who had not been tested for HIV held significantly more HIV related stigmatising beliefs than people who had been tested (Kalichman & Simbayi, 2003).

In addition to creating significant barriers to HIV testing, there is growing evidence that HIV related stigma and fear of discrimination contribute to risky behaviours in both HIV positive and negative individuals (Peretti-Watel et al., 2007;

Spire et al., 2008; UNAIDS, 2008) by acting as a barrier to HIV protective behaviour (Nyblade et al., 2003 in UNAIDS, 2008). The use of condoms has become a signifier of the epidemic, leading to possible rejection of those who initiate their use (Link & Phelan, 2002). Hence it has been documented that in some cases stigma makes people reluctant to use condoms for fear of being identified with the disease or with marginalised populations that are most heavily affected (Nyblade et al., 2003 in UNAIDS, 2008). In a recent large scale study using a national cross-sample of HIV positive people in France, 18% of participants reported unsafe sex during the previous 12 months, despite being aware of their HIV positive status (Peretti-Watel et al., 2007). Peretti-Watel et al. (2007) found that living in a couple was the only significant predictor of unsafe sex among participants and concluded that fear of rejection and discrimination from one's partner not only led to non-disclosure of HIV positive status but unprotected sex, so as not to arouse suspicion about one's HIV positive status. Numerous others studies have similarly shown that fear of stigma makes people living with HIV less likely to disclose their HIV status to sexual partners (UNAIDS, 2008). Stigma further undermines prevention efforts, contributing to the spread of the HIV epidemic, by making people reluctant to seek information about how to protect themselves from infection (Spire et al., 2008; UNAIDS, 2008).

### ***Culture***

Cultural and religious norms and values often deeply influence one's sexual choices (Campbell, 2004). Research shows that, worldwide, sexual behaviour is strongly shaped by social and cultural forces (Marston & King, 2006). Hence, the link can clearly be

made that in so much as cultural norms and values shape behaviour, culture has the capacity to impact peoples' ability to engage in HIV protective behaviour. However, only a handful of researchers have examined the relationship between cultural values and HIV protective and risk behaviour (Wilson & Miller, 2003).

'Culture' is said to be one of the most complex words in the English language (Eagleton, 2000). Ironically, the use of the word has gained such popularity that it is impossible to describe the most common place details of everyday life without using the word (Inglis, 2004). We often speak of a culture of violence, consumer culture and ethnic cultures, all of which mean very different things. It is therefore not surprising that there is much debate around the definition of culture, in particular about what activities can be said to constitute culture (Eagleton, 2000). Nonetheless, culture is most commonly defined as the complex of values, customs, beliefs and practices which constitute the way of life of a specific group (Eagleton, 2000). It is these values, beliefs, norms and traditions which tell individuals within a specific group what are valued and appropriate behaviours (Wilson & Miller, 2003). In this respect, culture is often a matter of following rules or social conventions pertaining to appropriate behaviours for a particular group (Eagleton, 2000).

Despite the widespread use of the word culture, culture as a construct is often misused. Culture has become a common synonym for identity, an identity marker and differentiator (Benhabib, 2002). In other words it has always been a mark by which people are constructed as different from others (Benhabib, 2002). One criticism of the use of culture in distinguishing one group from another is that there is an assumption that a cultural group is a unified and homogeneous entity (Benhabib, 2002). Benhabib (2002)

further contends that dominant discourses about culture essentialise the idea of culture as badges of group identity such that culture is constructed as an untouchable entity that is beyond the reach of critical analysis. The reluctance to critically interrogate cultural practices is highly problematic given the fact that a range of atrocities have in the past and continue to be carried out under the guise of culture (Benhabib, 2002). Included among these atrocities are female genital mutilation, sexual violence, and various forms of abuse, to name a few.

Social arrangements manifested in cultural practices often entail relationships of dominance and subordination between different racial and ethnic groups, different social class or caste groupings and between males and females (Turiel, 1998). In other words, it can be said that culture is often the vehicle through which dominant power relations within a particular society are maintained (Turiel, 1998). Hence, often times relationships of dominance and subordination entails privileges and freedoms of choice afforded to one group but not another, based on cultural convention. Nowhere is this more evident than in gender relations, where it is often noted that many cultural practices such as arranged marriage, polygamy, dress codes and methods of divorce serve to favour men while disadvantaging women (Turiel, 1998).

As mentioned above, culture has particular relevance for the spread of HIV in so far as sexual behaviour is strongly shaped by social and cultural forces (Marston & King, 2006). Hence HIV research has begun to move away from sexual behaviour, in and of itself, to the cultural settings within which such behaviour takes place and the cultural symbols, meaning and rules that organise it (Parker, 2001).



Cultural practices such as ‘wet’ and ‘dry’ sex, widow inheritance, funeral ritual intercourse has been reported as being conducive to HIV transmission (Obbo, 1995). A study conducted by Ortiz-Torres, Serrano-Garcia and Torres-Burgos (2000) illustrates the way in which culture may serve to constrain HIV protective behaviour. Participants in this study reported that many of their female Latino participants, who come from a culture characterised by the values of chastity and virginity for females, indicated that they would not carry a condom for fear of rejection and being branded as immoral and dirty. This is a clear illustration of cultural norms and values impeding peoples’ ability to protect themselves from HIV. It seems that regard for one’s reputation within one’s culture may put one in danger of HIV infection, due to its restrictions on peoples’ ability to take measures to protect oneself from HIV.

Focus group discussions conducted with women in the Ugandan capital, Kampala revealed that in an environment where barren women are pitied and there is social pressure on women to prove their fertility, condom use was perceived as threatening to womens’ reproductive health and social security (Obbo, 1995). All Ugandan societies practice patrilineal descent, i.e. children whether legitimate or not, are affiliated to the man’s group. This means that a woman gains access to social status and resources by bearing children for particular groups (Obbo, 1995).

In the previously mentioned study of youth in Khutsong, one of the six factors which mediated the relationship between HIV knowledge and condom use was the approval or disapproval of sex and condoms by adults (MacPhail & Campbell, 2001). This study concluded that social norms encroached on the extent to which young people were able to carry condoms with them and also gain access to condoms due to a fear of

being reprimanded and labelled as promiscuous. Male participants reported that parents' disapproval was often the reason that they did not use condoms at all. Clearly conservative cultural views about sexuality are a constraint to protective behaviour.

### ***Religion***

Religion may be defined as an organised system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/reality) and to foster an understanding of one's relation and responsibility to others living together in a community (King & Crowther, 2004). It is generally accepted that there is a distinction to be made between the religious and the cultural, with religious practices considered to be those that are required by religious institutions and scriptures (Benhabib, 2002). However, it must be noted that the cultural and the religious realm overlap significantly such that when confronted with a particular practice it is often difficult to tell whether it is a cultural or religious practice (Benhabib, 2002). For example, Baobaid (2006) reports that in most Muslim countries the teachings of Islam have been mixed with inherited cultural traditions.

Susser and Stein (2000), report that of the pastors they interviewed in the Ovambo-Speaking region of Namibia, many stated that condoms were associated with sin, not being chaste and promiscuity. Of the 223 participants interviewed by Volk and Koopman (2001), in Kisumu, Kenya, 62% of the respondents noted that AIDS is a punishment for sins and 30% reported that AIDS is caused by a failure to uphold customs or violation of social taboos. While these beliefs were not found to be related to condom use in this study, it is reasonable to hypothesise that beliefs such as these within a culture,

may discourage people within that culture to access services related to HIV protection for fear of chastisement and discrimination (Volk & Koopman, 2001).

El Feki (2006) describes the opinions about HIV voiced by some of the grand imams (Muslim religious leaders) within the Arab region. These, much like those mentioned above, include beliefs that AIDS is a punishment from God and that condoms promote adultery. There is a strong association of AIDS with commercial sex work and homosexuality, which are activities that are cultural taboos and illegal in the region (El Feki, 2006).

Given the above, it seems that one may expect to encounter strong cultural and religious based stigma against HIV, amongst members of the Islamic faith. Since Pakistani migrants are predominantly of Islamic faith, it is necessary to investigate the intersection between cultural sexual taboos and stigma and how this may influence an individual's freedom to engage in HIV protective behaviour such as, obtaining condoms, getting tested for HIV or receiving treatment for sexually transmitted infections. The religious and cultural acceptability of HIV prevention methods can have a huge impact on whether members of the religion or culture will make use of these methods. This study was interested in how this may play out in the Pakistani migrant community.

### ***Gender***

Whereas the term 'sex' denotes the concept of biological or anatomical differences between men and women (Giddens, 1992), gender is a societal construct made up of widely shared ideas, norms, beliefs, practices and expectations of what it means to be male or female (Makahye, 2008). In other words, gender denotes the understanding of

social, cultural and psychological difference between men and women (Giddens, 1992). The concepts of masculinity and femininity while used without much thought in everyday language, on logical examination prove to be remarkably elusive and difficult to define (Connell, 2005). For one, the concept of gender is thought to be culturally specific as different cultures tend to hold different ideas about gender roles (Gupta, 2000). Hence, vast differences with regards to acceptable and unacceptable behaviours for men and women exist across cultures (Gupta, 2000).

It is argued that the cultural variability of gender roles points to the social construction of the concepts of masculinity and femininity (Connell, 2005). Social constructionists maintain that actual, objective realities are unimportant and, indeed, unobtainable, so called reality merely represents group consensus about the meaning of particular things and events (Burman, 1994). In other words, notions of the meaning of masculinity and femininity are a product of social, historical and political context (Gupta, 2000). Social constructs of masculinity or femininity are the social prescriptions attached to being either male or female and include how members of each gender group should behave and the responsibilities they should fulfil (Burman, 1994).

As with culture and religion, gender roles and norms have an impact on peoples' ability to engage in HIV protective behaviour. Research in the area of HIV and gender focus on the fact that even if women have knowledge about HIV and perceive that they may be at risk, they are frequently unable to successfully negotiate 'safer' sex practices, such as condom use because of unequal power relations within relationships (Marston & King, 2006; Mbulo, et al., 2007; Ortiz-Torres et al., 2000; Parker, 2001; Shefer, 2004; Susser & Stein, 2000; Volk & Koopman, 2001). In other words, in many cases unequal

power relations and traditional female gender roles, undermined a woman's ability to assert her rights to sexual health and thus request that her partner use a condom (Campbell, 2004). Hence while there is a growing awareness and focus on the importance of gender at the centre of the HIV epidemic, gender issues are more often than not interpreted as women's issues (Makahye, 2008). However, as van der Walt et al. (2007) point out, men are also victims of traditional gender roles, which can put them in a precarious position when it comes to HIV vulnerability.

Many patriarchal norms of masculinity encourage men to engage in risky sexual behaviour, such as having multiple partners and may discourage the use of HIV protective measures such as condoms (van der Walt et al., 2007). The often popular construction of male sexuality as "overwhelmingly strong, urgent, and uncontrollable" (Shefer, 2004, p. 187), can lead men into having sex with multiple partners. For example, in a systematic review of 268 qualitative studies of young peoples' sexual behaviour published between 1990 and 2004, Marston and King (2006) found that an important theme around reputations and social displays of sexual activity emerged. The general theme seemed to be that young men's social status and reputation can suffer if they are not seen to push for sexual access and numerous female partners. Also, non-display of such behaviour can lead to accusations of being "gay". For example, MacPhail and Campbell (2001) report that in their study, "young men who attempt to withstand dominant discourses of masculinity by avoiding sex are subjected to taunting and teasing" (MacPhail & Campbell, 2001, p. 1620). Similarly, Noland (2008), in a study of Puerto Rican men's constructions of masculinity and HIV vulnerability, found that all 17 participants reported that a macho construction of masculinity was a prevailing constraint

in their lives. Qualities, in this study associated with being macho included the expectation of promiscuity regardless of marital status, multiple concurrent partners and boasting of these conquests to other males. Men who did not circumscribe to these norms were, not seen as “real men”, teased by male friends, accused of being gay and called old women, who can’t measure up (Noland, 2008). Makahye (2008) reports that The Targeted AIDS Intervention project, in their intervention with boys in South Africa found, that one of the marks of a successful man is sexual prowess and performance and the ability to satisfy multiple partners.

Notions of masculinity also bring together ideas of bravery and fearlessness (Campbell, 2003). The literature certainly points to the fact that there is enormous pressure on men to prove their virility through what is often high risk HIV behaviour, in order to avoid teasing by other men and accusations of being gay. Living up to social construction of what a real man is places pressure on men to indulge in high risk sexual behaviour despite knowledge of HIV. Hence we see that the notions of what it means to be a man, poses significant challenges to HIV prevention efforts targeted at promoting monogamy and fidelity.

It is perhaps worth noting that the pressure to live up to these notions of masculinity does not only come from other men. Women and girls make an important contribution towards the maintenance of the gendered system (Makahye, 2008). For example, many of the traditional masculine behaviours of men are expected by women, reinforcing them and failure to conform to these leaves these men unsuccessful in their relationships with women (Makahye, 2008). In a study of rural women in KwaZulu Natal it was found that women did not believe that they had a right to refuse sex, additionally

more women thought that their male partner had a right to have multiple partners (Abdool Karim, 2008). This suggests that sex may be viewed as a conjugal right and male prerogative (Abdool Karim, 2008), by both men and women.

Another aspect of macho constructions of masculinity is the association of risk taking behaviour with ideas and practices of masculinity (Kometsi, 2004). In many societies, while women are cast in a subordinate, dependent and passive role, masculinity is cast in terms of aggression, dominance and invincibility, where the key virtues are strength, courage and virility (Abdool Karim, 2008). Hence failure to use a condom may be related to the idea that men should not be afraid to take risks. While in most societies women are expected to be dependent on men to make decision and access resources, often less emphasised is the fact that men are socialised to be self reliant and an expectation of invulnerability may lead to not only a denial of risk but failure to engage in health-seeking behaviours (Abdool Karim, 2008).

One argument that has also been put forward and that has particular significance for migrant men is that one of the main markers of masculine identity is participation in family leadership (Waldo & Coates in Campbell, 2003). It is argued that for migrant men who are often bereft of this act of masculinity on a day to day basis, risk taking fearless behaviour may act to compensate for reduced opportunities for assertion of masculine identities (Waldo & Coates in Campbell, 2003).

Another important assumption about masculinity that may in fact victimise men is the idea that men should know everything, hence preventing them from seeking advice or using appropriate sources of information (Makahye, 2008).

### *The intersection of gender, religion and culture*

The status of women and their relationships with men and society remains controversial in the lives of Muslims (Baobaid, 2006). In many Islamic countries both Islam and culture have been practiced in a manner biased in favour of men (Baobaid, 2006). It is reported that within the Islamic tradition, men have the responsibility of protecting female members and the family as a whole (Baobaid, 2006). Women on the other hand are defined by their role as keepers of the family honour (Baobaid, 2006). Yet, while women represent the family's honour, men exercise control over the content and definition of honour (Baobaid, 2006). Thus, within many conservative patriarchal Islamic societies the male role of family protector is enacted in a manner that gives him authority over the behaviour of women to defend family honour (Baobaid, 2006). This often leads to a situation in which a women's independence is limited by submission to her husband, father or male family members (Baobaid, 2006). It due to gendered practices such as this that women in Pakistan, women remain the most ignored and isolated section of civil society (Malik, 1997).

The above discussion elucidates how social factors such gender, culture and religion may individually affect Pakistani migrants' ability to engage in HIV protective behaviour. However is necessary to note that these social factors do not exist in isolation, rather there is an intersection between gender, culture and religion. They are each structuring mechanisms that order social life according to accepted definitions of what it means to be male or female, what it means to be of a particular religious orientation, e.g. Muslim and a particular culture, e.g. Islamic. Gender, culture and religion do not impinge on a small area of social experience, it structures the entire social gamut, from



interpersonal relationships to the relationships people have with institutions (Ajrouch, 2004). Therefore through their roles as stratifying forces in society, that gender, culture and religion constantly intersect with each other (Ajrouch, 2004).

To illustrate, Ajrouch (2004) concluded that the values of Islam have shaped and confirmed Arab cultural values and thus continue to influence, however indirectly, the expectations of those who do not participate directly in religious activities. This is especially true in the definition of gender roles and in setting the parameters for what constitutes proper social interaction between the sexes. Ajrouch (2004), in a study of a group of Arab American adolescents, found that though they were not particularly “religious” (in the sense that they do not adopt an Islamic identity above all other identities), interpretations of religion guided their understandings of what it meant to be Arab, and guided what was considered to be “girl” behaviour.

The above mentioned study highlights the fact that culture impacts on religion in such a way that one religion, such as Islam, may be expressed in diverse ways depending on differing cultural contexts (Asad, 1996). In other words religion often operates in tandem with cultural identity (Rafudeen, 2002). The history of the Islamic world has shown that there are in fact diverse forms of Islam, each different expressions of the same religion, with different things being regarded as Islamic in different cultural contexts (Asad, 1996).

To illustrate the above, it has been argued that in Pakistan the vision and teaching of Islam has been interpreted in such a way so as to further the pursuit of patriarchal power agendas (Ouzgane, 2006). Therefore, in the name of Islam the behaviour and bodies of Pakistani women are under the strict control of the state (Ouzgane, 2006).

Women in Pakistan as enforced by law, occupy an inferior position to men (Ouzgane, 2006). Patriarchal religious practices to some extent continue to discriminate against Muslim women in South Africa, however it cannot be denied that there have been great strides made in the status of women in Muslim society in South Africa (Ahmed, 2002). It may be argued that Islam as practiced in South Africa is much more liberal when compared to Pakistan (Kurzman, 1999). In South Africa, corresponding to the principles of democracy and equal rights for all under the constitution, Muslims adhere to principles which could be described collectively as "Liberal Islam" (Kurzman, 1999). This refers to interpretations of Islam that have a special concern regarding such issues as democracy, separating religion from political involvement, women's rights, freedom of thought, and promoting human progress (Kurzman, 1999).

### ***Migration***

Various studies have attempted to investigate the link between migration and HIV (IOM, 2005). The literature suggests that there is a correlation between migration and risk of contracting HIV (Williamson, 2004). Research on the link between various mobile populations and HIV in the Southern African region has found that migrants are among the groups most vulnerable to the disease (Rijks, 2006). In a study of 196 migrant men and 64 non-migrant men in South Africa, Lurie et al. (2003) found that 25.9% of the migrant men as compared to 12.7% of the non-migrant men were infected with HIV. It was concluded that a significant risk factor for HIV infection is being a migrant. Likewise, Lurie (in IOM, 2005) found that migrant couples were more than twice as likely as non-migrant couples to have one partner who is HIV positive.

There seems to be agreement that migration is tied to HIV vulnerability by the social, economic and political marginalisation of migrants (IOM, 2005; Rijks, 2006; Williamson, 2004). In other words the often dire situations that migrants find themselves in, such as poverty, poor living conditions, unemployment and marginalisation, increase their vulnerability for contracting HIV (Williamson, 2004). To illustrate, Peltzer (2003) shows that in conditions of extreme poverty, sex for money or goods are often used by women as a survival tool. On the other hand, gender-related norms around men as breadwinners together with economic need force men to migrate without their families in search of work, fostering conditions for multiple sexual relationships and therefore increased HIV risk (Abdool Karim, 2008). Hence the literature reflects growing agreement that the more socially and economically marginalised a population, the greater its vulnerability to infection (Altman, 2005). A note of caution, the fact that migration is linked to HIV vulnerability should not become a platform for blaming the spread of HIV on migrants. Rather, as pointed out by Lazarus (2007, p. 70) "Risk is a statement about social contexts, *not* people". In other words, migrants are vulnerable to HIV because of the contexts, including but not limited to, social and economic marginalisation, that they find themselves in and not because of who they are as people.

Research has found a significant correlation between level of social support and safe sex (Campbell, 2003). Campbell reports that in situations where people felt lonely and isolated, flesh to flesh sexual contact may often come to symbolise a form of emotional intimacy which they do not have in other aspects of their lives (Campbell, 2003). This has particular significance for migrants.

### ***Xenophobia and marginalisation***

Xenophobia, defined as a dislike, hatred or fear of foreigners has become one of the most significant features of post apartheid South African society (Harris, 2002). Illegals, border jumpers, aliens and amakwere-kwere, are but some of the disparaging names which migrants have come to be known by (Motsemme, 2003). In South Africa, as pointed out by Harris (2002) xenophobia is not merely confined to negative attitudes towards foreigners but also denotes the routine violence and physical abuse experienced by many foreigners in South Africa. This was illustrated by the series of violent attacks against mainly African foreign nationals which broke out in Alexandra Township in Gauteng, on Sunday, 11 May 2008 (South African Parliament, 2008). The attacks which spread to other areas in Gauteng and subsequently also to other provinces, claimed the lives of sixty two people and saw an estimated thirty two thousand foreign nationals displaced from their homes while being accommodated in tents, community halls and churches (South African Parliament , 2008). While arguably the most serious incidents of attack on foreign nationals, these attacks were not a new phenomena in South Africa. Since 1994, there has been a national trend towards organized, mass violence against foreigners, particularly in townships and informal settlements (Crush & Williams, 2005; FMSP, 2008). Attacks on Somali nationals in the Western Cape Province have often been reported in the media in recent years (Crush & Williams, 2005). In Gauteng alone, between December 2007 and April 2008 there were five reported fatal attacks on migrants (FMSP, 2008).

Xenophobic attitudes and attacks on migrants are often based on the perception that migrants take away South Africans' jobs, 'women' and housing that should go to

South Africans' (South African Parliament, 2008). Based on this observation, one of the explanations for xenophobia which has been put forward is the scapegoating hypothesis. This hypothesis links xenophobia to the frustration and relative deprivation experienced by South Africans whose high expectations of post apartheid South Africa have not been realised in the climate of social transition and change following the establishment of a democratic government in 1994 (Harris, 2002). According to this hypothesis migrants become easy scapegoats to blame for the ongoing deprivation and poverty experienced by many South Africans because they are seen as a threat to jobs, housing, education and health care (Harris, 2002).

The isolation hypothesis regarding xenophobia in South Africa argues that South Africa's seclusion from the international community under apartheid resulted in the majority of South Africans having minimal contact and interaction with those outside the country (Kiguwa, 2006). It is this isolation from the international community that caused South African's intolerance and even fear of difference and thus foreigners (Harris, 2002). It is argued under the isolation hypothesis that the increasing numbers of migrants in the country have brought South Africans into direct contact with previously unknown foreigners, this interface has created a space for hostility to develop (Harris, 2002).

While the above hypotheses are both compelling, a number of authors have pointed out that they do not fully account for an important aspect of xenophobia in South Africa, i.e. the fact that not all foreigners are uniformly victimised (Harris, 2002). Black foreigners, particularly those from Africa, comprise the majority of victims of xenophobia in South Africa (Kiguwa, 2006; Harris, 2002). Migrants from Europe and Asia are not immune to xenophobia, but relative to African migrants, they do appear to be

at lower risk for violence (Harris, 2002). One explanation has been put forward by Harris (2002) who contends that the presence of the African migrant in South Africa is seen as a threat to the nation and an impediment to the 1994 nation-building process. This is evident from the depiction by both government and the media, of African migrants as illegal aliens ‘flooding’ into South Africa (Harris, 2002). In addition, the language of disease and contamination is often used in describing migrants, particularly those from Africa, with migrants being seen as a disease or plague descending onto the country (Harris, 2002). The post-apartheid nation building process covers a range of policies, objectives and discourses in post-1994 South Africa. An important related discourse is that of the ‘New South Africa’, this discourse involves concepts such as reconciliation, unity and reconstruction as well as nation building and defines South Africa in terms of national borders. Nationality is a fundamental feature of this discourse and a South African identity prevails (Harris, 2002). While nationalism is generally considered to be a positive phenomena, Harris (2002) warns that notions of nationalism and nation-building necessarily includes constructs of similarity and difference as well as specifications of inclusion and exclusion. Hence, the phenomena of xenophobia cannot but be intrinsically be tied up with the project of nation building, it is implicit to the current nationalist agenda (Harris, 2002). In other words, xenophobia is the negative face of nationalism, one side of the nationalist coin (Wetherell & Potter in Harris, 2002).

Harris (2002) also suggests that the construction of xenophobia as something abnormal, pathological and to be condemned, particularly by those in power within South Africa, is central to the nationalist discourse of the new South Africa. It is through condemning xenophobia, that the new South Africa can be seen as promoting peace and

tolerance, when in fact all indications are that South Africa has a culture of violence in which violence persists as the dominant means to solve problems (Harris, 2002). The condemnation of xenophobia masks this fact.

While violence remains one of the most serious ways in which xenophobia manifests in South Africa, xenophobia has increasingly taken on more sinister and menacing, but subtle forms, with public servants selectively victimizing refugees, asylum seekers and even those South Africans whom they mistake for foreigners (Crush & Williams, 2005). Random and often humiliating inspections and arrests by police have become common place in South Africa (Motsemme, 2003). Landau (2007) points out that many refugees and asylum seekers report being refused access to treatment at clinics and hospitals (Landau, 2007). For many it seems xenophobia, especially within the public health system, results in a denial of rights to services (Landau, 2007). Landau (2007) states that his research reveals that frontline staff (clerks and nurses) are most likely to turn refugees and asylum seekers away.

There is also confusion amongst public health care providers regarding the services migrants are entitled to and the fees to be paid (Landau, 2007). For example, refugees are exempt from most fees but current guidelines are ambiguous for asylum seekers (Lazarus, 2007). This confusion, also contributes towards the denial of services to migrants.

The denial of health care services to migrants has huge implications in terms of the HIV protective behaviour of migrants. An inability to access health care services, as described above, severely constrains the options available to migrants in terms of HIV protective behaviour. It is primarily in public health care settings such as hospitals and

community clinics, that free HIV testing, STI treatment and condoms are available. It is reported that close to 40% of migrants are unemployed and over a quarter of employed migrants are employed in the informal sector, with petty trading and hawking combining to make up migrants most significant occupation (Landau & Jacobsen, 2004). It seems clear that the majority of migrants in South Africa are in an economically disadvantaged position, and they would therefore have to rely on free HIV services in order to protect themselves from HIV. With this option often closed to them due to an inability to access the public health system, this may mean that for many migrants their ability to protect themselves from HIV is severely compromised.

The formal workplace is one of the few other places where adults might obtain free condoms and HIV services. Hence, another consequence of the fact that very few migrants are employed in the formal sector is that this avenue in terms of HIV protection is closed to the vast majority of adult migrants. From the above it can be argued that the social and economic marginalisation, and especially xenophobia which is an everyday reality for many migrants may limit the choices open to migrants with regards to HIV protection.

## **Conclusion**

The literature reviewed shows that social factors are implicated in almost every aspect of the HIV and AIDS, providing fertile ground in which the disease is able to thrive. Not only do social factors impact on the ability of those living with HIV to obtain treatment but social factors also limit individuals' ability to protect themselves from HIV. The literature reviewed above focussed particularly on the way in which religion, culture,



gender, xenophobia and marginalisation related to migration, as well as stigma may act to constrain individuals' ability to protect themselves from HIV. Based on the body of literature discussed above, specific research questions for the study were formulated. The next chapter presents these research questions and goes on to describe the method undertaken in order to answer these questions.

## **CHAPTER 3: METHOD**

### **Introduction**

Since very little is known about HIV prevalence, knowledge, vulnerability or risk behaviour among Pakistani migrants, the present research study was exploratory. The study did not seek to make causal or relational inferences but rather aimed to develop an understanding of the social factors, which by impacting on Pakistani migrants' ability to engage in HIV protective behaviour, may lead to HIV vulnerability in this group. A qualitative research design was therefore adopted (Neuman, 1997). This chapter aims to provide a conceptual rationale for employing a qualitative research design. The chapter also describes the methodology of the study including the research questions which guided the study, data gathering procedures, participants, ethical issues and methods of analysis. Finally, the researcher explores issues of reflexivity and shares personal reflections on the experience of conducting the study.

### **Research Paradigm and Design**

The study was qualitative in nature and rooted in the interpretative paradigm of research. This paradigm holds that the way people experience reality is determined by their context (Neuman, 1997). In contrast to the positivist paradigm which sees the world as material and argues that objective knowledge about the world is possible (Swart & Bowman, 2007), the interpretative paradigm holds that objective knowledge about the world is not possible. Rather any information about the external world necessarily goes through a process of interpretation, whereby an individual organises, categories and applies various

concepts or ideas to this information in order to make sense of it (Collins, 2003). In other words our experience of the external world is shaped by the systems of meaning which we apply in order to interpret sensory information and make sense of the external world (Collins, 2003). In addition, it follows that, it is peoples' interpretation of phenomena in the external world and not the phenomena in and of itself which determines individuals' reaction to and behaviour in relation to the external phenomena. It is for this reason that the interpretative paradigm holds that rather than measuring a phenomena it is more useful to look at how people interpret this phenomena and their behaviour in relation to the phenomena. This is the only knowledge that it is possible to gain about the phenomenon of interest and this is the best way in which to actually intervene in order to change the phenomena. The task of the researcher is to uncover the categories, concepts and systems of explanation that people apply in order to interpret or make sense of a phenomenon. This has particular relevance for the current study because the aim of the study was not simply to measure the incidence of HIV protective behaviour among Pakistani migrants but rather to uncover the ways in which Pakistani migrants interpret HIV and HIV protective behaviour. It is this information about the meaning which is applied to HIV and HIV protection rather than information about the incidence of HIV protective behaviour which will help us to understand the reasons behind why Pakistani migrants may or may not engage in HIV protective behaviour. Hence the researcher saw it as important in order for the results of this study to be meaningful and useful in preventing the spread of HIV among Pakistani migrants, that the study provide a deep understanding of the meaning of HIV and HIV protective behaviour for Pakistani migrants as well as what they see as being the factors, which affect their HIV knowledge,

perception of risk and ability to take preventative action against HIV. In other words this study was interested in gaining an understanding of the worldview of Pakistani migrants with regards to HIV and employed research methods which were aimed at getting inside the ways they see the world (Neuman, 1997).

The interpretative paradigm is based on the hermeneutic tradition which holds that all understanding is hermeneutical, i.e. our interpretations or understanding of the external world is to a large extent determined by our history and culture (Rowan & Reason, 1981). In other words, the categories, concepts and systems of explanation which as mentioned before shape our experience of the external world are given to us by our society and culture through language (Collins, 2003). This is essentially the thesis of this study, i.e. that social factors such as gender, religion and culture shape peoples' experience with regards to HIV protective behaviour. Hence it is fitting that the methodology for the study be based on the interpretative paradigm.

### **Research Questions**

This study attempts to answer the following questions:

1. What do male Pakistani migrants know about HIV modes of transmission and prevention methods?
2. What do male Pakistani migrants perceive as their risk of contracting HIV?
3. What are the social factors which affect male Pakistani migrants' ability to engage in HIV protective behaviour?
  - How does culture and religion affect male Pakistani migrants' ability engage in HIV protective behaviour?

- How does gender affect male Pakistani migrants' ability engage in HIV protective behaviour?
- How does marginalisation and xenophobia affect male Pakistani migrants' ability engage in HIV protective behaviour?

### **Operational Definitions**

Definitions of key terms used in this study are as follows:

*Pakistani migrant* - A person born in Pakistan and who lived in that country for the majority of his/her life.

*HIV protective behaviour* - Behaviour which reduces an individual's exposure to the HIV virus. This includes refraining from HIV risk behaviours as well as the use of protective measures during sexual intercourse, such as use of a condom.

*HIV risk behaviour* – Behaviour which increases the likelihood that an individual will contract the HI virus. This includes unprotected sex; having multiple sexual partners; needle sharing.

*Perception of HIV risk* – The degree to which an individual believes he/she or others are vulnerable to contracting HIV.

### **Participants**

Non-probability convenience sampling was the sampling strategy employed in this study. Pakistani migrants were a difficult group to access, as there did not seem to be a particular association of Pakistani migrants through which access could be negotiated. Pakistani migrants also appear to be relatively dispersed around South Africa, and do not

seem to congregate in large groups in any one area. Hence, one participant was identified and further participants recruited through a process of snowball sampling.

Nine Pakistani migrants, residing in Greater Johannesburg and surrounding areas were selected to participate in the study. As mentioned before, there appears to be no substantive literature on Pakistani migrants in South Africa, however, the researcher's observations were that Pakistani migrants tend to be young men, who migrate without their families. The participants for this study therefore consisted of only males. In addition, the study was also interested in how constructions of masculinity may influence HIV protective behaviour in Pakistani migrants, hence the study focussed only on male participants, between the ages of 18 and 40.

### **Method of Data Collection**

The method of data collection employed was individual semi-structured interviews, which consisted primarily of open-ended questions. Interviewing has been described as one of the most common and powerful ways in which to understand fellow human beings (Breakwell, Hammond & Fife-Schaw, 1995), it provides special insight into lived experience (Seale, Gobo, Gubrium & Silverman, 2004). Since this study was particularly interested in the lived experience of the Pakistani migrants, with regards to HIV, interviewing appeared to be the most appropriate method of data collection. In addition, the study aimed to gain elaborated and detailed answers (Seale et al., 2004), since HIV is still considered by many to be a sensitive topic, interviewing seemed to be the method best suited to establishing rapport and facilitating honest and detailed disclosure of

Pakistani migrants lived experience, with regards to HIV. Thus making for a richer understanding of the participants.

The interview questions were based on the research questions for this study, mentioned above (See semi structured interview schedule, Appendix D, attached). Interviews were audio taped and individual interviews ranged from 45 minutes to 1 hour in length. Interviews were conducted at two locations. Three interviews were conducted in a room at the Mayfair clinic, on the outskirts of the Johannesburg CBD. Previous research had been conducted by researcher at the Mayfair clinic, hence permission to conduct interviews at the clinic was obtained relatively quickly. However, significant challenges were encountered in accessing the sample, because it was found that very few Pakistani men visit the Mayfair clinic in order to access health care services. As will be discussed below, this appears to be due to the loss of income which Pakistani migrants, the majority of whom are self employed, may encounter by having to wait in long queues. Hence, only three participants were interviewed at the Mayfair clinic. Given the difficulty with recruiting participants at a clinic, the decision was made to visit Pakistani migrants at their place of business. Hence, the researcher visited a number of Pakistani run small retail businesses in order to recruit participants. Many of those who were asked to participate in the study refused claiming that they did not speak sufficient English. Following a challenging first visit to various businesses, the researcher was accompanied on subsequent visits by an individual who lived in the Benoni areas and who was known among Pakistani migrants. This assisted the researcher in negotiating access to the Pakistani migrant community in this area. Nevertheless, it was only after numerous visits

to various small businesses in the area that six interviews were conducted with participants residing in Benoni, located East of Johannesburg.

### **Data Analysis**

This study explored the themes that emerged from Pakistani migrants' discourses around what they saw as the factors that affect their ability to engage in HIV protective behaviour, as well as their perceived level of HIV knowledge and vulnerability to HIV/AIDS. In eliciting and exploring these themes, the study employed thematic content analysis as a method of data analysis. This method allowed for interview data to be organized and interpreted in terms of categories relevant to the research questions of the study (Breakwell et al., 1995; Seale et al., 2004).

The method of thematic content analysis utilised in the current study was qualitative in nature and must be distinguished from thematic content analysis used in the quantitative sense. Thematic content analysis in a quantitative sense is a statistical technique concerned with the frequency of occurrence of given content within a set of data (Krippendorff, 2004). Here, the goal is to produce counts of key categories and measurements of the amount of data relevant to these categories (Neuendorf, 2002). In other words quantitative thematic content analysis has as its goal a numerically based summary of a set of data (Neuendorf, 2002). Qualitative thematic content analysis on the other hand is concerned with providing a much more rich, detailed and complex account of data than only a numerical account of the frequency of occurrence of pieces of content (Braun & Clarke, 2006). This type of thematic content analysis is essentially about searching across a set of data to find repeated patterns of meaning, represented as themes



(Braun & Clarke, 2006). A theme represents some level of patterned response or meaning within a data set (Braun & Clarke, 2006). In other word, qualitative content analysis is concerned with providing a rich account of the form and meaning of a set of data (Braun & Clarke, 2006). This form of thematic content analysis also often extends to identifying or examining the underlying ideas, assumptions, and conceptualizations and ideologies that are theorized as shaping or informing the semantic content of the data (Braun & Clarke, 2006).

Whereas with quantitative thematic content analysis the number of times one or more pieces of content occurs is essential for the purposes of drawing research conclusions (Krippendorff, 2004), with qualitative thematic content analysis the importance of a theme is not necessarily dependent on quantifiable measures of how frequently the theme occurs but rather on whether it captures something important in relation to the overall research question.

Based on the description of qualitative thematic content analysis above, the content analysis of interview data followed the following steps: Firstly, transcribed data from each of the interviews conducted was divided into broad categories relating to the research questions. Next data in each of these broad categories was studied in order to identify recurring themes or ideas within the data, a process called inducing themes (Terre Blanche, Durrheim & Kelly, 2006). Recurring themes identified were then sorted and organized into an index of main themes and sub-themes.

As suggested by Ritchie, Spencer and O'Connor (2003), numerical labels were then assigned to each theme and sub-theme. The transcribed data was then be re-examined and marked or coded as instances of, or relevant to one or more of the themes

or sub-themes, identified during the process of inducing themes (Terre Blanche et al., 2006). For the purposes of this study, latent content of the data was coded. In other words not only the concrete terms or words contained in a piece of data were taken into consideration when coding, but the overall meaning of that piece of data was also coded (Babbie, 2004). The data was then sorted so that data similar in content and thus relevant to a specific theme were clustered together (Ritchie et al., 2003). Each of these data clusters were then summarized, using a technique called thematic charting (Ritchie et al., 2003). During this process key points of each piece of data was summarised, retaining as much as possible of the context and language in which it was expressed. These summaries were then placed in a thematic matrix or chart under a particular theme and sub-theme (Ritchie et al., 2003). Finally, the thematic charts were examined and interpreted. During this crucial stage each theme and sub-theme was closely investigated, this included looking within each theme and sub-theme, across all cases in the study and noting similarities, differences and recurrences in views, experiences and perceptions and drawing conclusions relevant to the research questions and also literature discussed above (Ritchie et al., 2003).

### **Ethical Considerations**

A thorough verbal explanation of the nature and purpose of the study was given to each of the participants in the study, individually. In addition participants were given an information sheet detailing the purposes of the study (See Appendix A). It was made clear to participants that participation in the study was voluntary and that they could withdraw from the study at any time (See Appendix B).

Consent forms were used in order to obtain written permission to conduct and audio record the interviews (See Appendix B and C). Despite earlier concerns that lack of proficiency in English may impact on the ability to ensure informed consent, the researcher was able to recruit participants who are proficient enough in English to provide written consent. Audiotapes were transcribed and processed by only the researcher. Audio tapes and all other documents containing participants' identifying information will be kept in a secure location and will be destroyed after the research report has been assessed.

Given the qualitative nature of the study, participants were informed that complete confidentiality and anonymity cannot be guaranteed, however every effort would be made to ensure the confidentiality of participants' names and identities. Participants were further informed that in the handling of data, each participant would be represented by a number, so that participants' names would be known to only the researcher. No identifying information was used in either the transcripts or the research report.

Social, economic and political marginalization is often experienced by migrants (Williamson, 2004), hence Pakistani migrants may constitute a vulnerable group. It is with this in mind that extra care was taken in order to ensure that participants were not exploited or harmed in the carrying out of this study. It is the researcher's view that the likelihood of harm to participants in this study was no greater than that typically experienced in everyday life (Rosnow & Rosenthal, 1999). However as a precaution, participants were debriefed by the researcher on their experience of the interview process to assess for any distress resulting from participation in the study. None of the participants reported suffering any psychological distress as a result of participation in the

study, nevertheless contact details for relevant and free counselling services, including the AIDS Helpline, Lifeline and the Islamic Careline, as well as the researcher's contact details were, in the event of psychological distress at a later stage.

### **Issues of Reflexivity**

Within the context of this study, the researcher did not aim to be a “discrete distant observer” of the phenomenon under enquiry (Guba & Lincoln, 1983). Rather it was expected that the participants and the researcher would interact to influence one another (Guba & Lincoln, 1983). As pointed out by Breuer, Mruck and Roth (2002), the process of research and its outcome depends on the characteristics of the persons involved, that is on their biological, mental, social, cultural, historical make up and condition. Thus the researcher is cognisant of the fact that personal and demographic characteristics of the researcher influenced what the researcher observed and how this was interpreted (Eagle, Hayes, & Sibanda, 2006). Likewise the characteristics of the participants and how they perceived the researcher also had a bearing on their responses.

The gender difference between the researcher and participants may have had an impact on the responses of the participants. Given the fact that the researcher is a female who was interviewing male participants regarding what can be considered a sensitive topic, participant's responses may be have been different from what it would have been had the researcher been male.

The cultural differences between the participants and the researcher may also have had an affect on how the researcher interacted with participants and vice versa. The researcher is an English speaking, Indian South African, thus the researcher's

identification or disidentification with a participant/s and vice versa may also have influenced the research process and results (Eagle et al., 2006). The fact that the researcher does not belong to the Islamic faith may likewise have affected the responses of participants. Finally, it is important to also note that the researcher's educational, cultural, and historical background may also have influenced the analysis and interpretation of the research data (Eagle et al., 2006).

In light of the difficulty with accessing the research sample, the experience of carrying out the research was extremely challenging. Pakistani migrants who were approached to participate in the study were extremely wary of strangers and thus they were reluctant to participate in the study. Pakistani migrants regarded the researcher with suspicion, as a result participants were not asked personal information, especially regarding their reasons for leaving Pakistan. Given that the research was conducted in the weeks following the xenophobic attacks, mentioned before, that took place in May 2008, it is reasonable to assume that one of the reasons for Pakistani migrants' suspicion was the tension which existed at the time between migrants and South African citizens. However, despite participants' suspiciousness of the research, it was interesting that a number of participants' made overtures of a romantic nature towards the researcher. This was experienced as very uncomfortable by the researcher especially given that the subject matter of the interviews concerned issues relating to sex and sexuality.

## **Conclusion**

In addition to providing a description of the research methodology and procedures employed in this study, the current chapter also aimed to provide a rationale for the

location of the study within the interpretative paradigm. In accordance with this paradigm, a portion of this chapter is dedicated to presenting the researchers experience of conducting this study. The following chapter is concerned with presenting the analysis of the data obtained through utilisation of the methodology and procedures described above.

## **CHAPTER 4: PRESENTATION OF FINDINGS**

### **Introduction**

As highlighted in the previous chapter, thematic content analysis was employed by this study as the method of data analysis. This chapter will present the findings of the analysis which was carried out on data gathered from semi-structured interviews conducted with Pakistani migrants in order to elicit and explore salient themes. The dominant themes have been categorised into the following broad content areas: 1) HIV knowledge; 2) Perception of HIV risk; and 3) Social factors and HIV protection. Themes related to each of these overarching categories are discussed below, with quotes included to support and illustrate conclusions reached. These findings are also discussed in relation to relevant literature as well as the research questions which guided the study.

### **HIV Knowledge**

Participants demonstrated basic awareness of HIV, primarily obtained through media sources while in South Africa. However, HIV knowledge was rudimentary with the scope of knowledge regarding modes of HIV transmission and prevention limited to a narrow range of possible modes of transmission and prevention methods. Accurate knowledge about HIV was complimented by inaccurate knowledge and misconceptions about the transmission of HIV which reveals stigmatising perceptions about HIV. Information gleaned about HIV knowledge therefore suggests that Pakistani migrants do not have sufficient knowledge to protect themselves from HIV.

*Knowledge of modes of HIV transmission*

Typically knowledge regarding modes of HIV transmission was confined to two categories. Primarily, it was asserted that HIV is transmitted through promiscuous heterosexual sex but some participants also made mention of HIV being transmitted through contact with HIV infected blood.

It frequently emerged that HIV is transmitted through promiscuous heterosexual sex, with promiscuous sex referring to sex with multiple sexual partners concurrently. For example, participant 8 stated that some one who sleeps around will inevitably contract the disease, while participant 5 and 7 went further by specifying that HIV is contracted though having sex with between two or more sexual partners.

This one girl, she has been sleeping with one man, second man, third man, too much of men and I think of HIV (Participant 5)

Two three boys...girlfriends. One chick, four...six boyfriends (Participant 7)

If you sleep around, you gonna get it, you will get it (Participant 8)

Unlike participant 8 who merely states that HIV is transmitted by sleeping around, participants 5 and 7 dramatically depict HIV as transmitted through sex with multiple sexual partners in deviant terms. Underlying these two participants' use of words seems to be a moral judgement regarding having more than one sexual partner. This rhetoric seems to suggest that HIV cannot be contracted through "normal" behaviour, such as sex with one sexual partner. Rather it is contracted through morally deviant behaviour.

Rhetoric around HIV and AIDS as being associated with deviance, promiscuity and with the moral judgements which accompany these terms is well established in discourses around the disease (Rankin et al., 2005; Schafer, 1991; Skinner & Mfecane,



2004). This discourse regarding HIV will be discussed later with regards to participants' perception of HIV and AIDS. For now, it is necessary to point out that although sex with multiple partners increases the risk of coming into contact with and contracting the HI virus, sex with multiple partners is not a mode of HIV transmission per se. Rather, HIV is contracted through sex with an HIV positive individual. Hence it is possible to contract HIV by having sex with only one person, if that person is HIV positive. Participants' construction of HIV as contracted through sex with multiple partners seems to deny the possibility of contracting the disease through sex with a single partner. The implication of this is that participants may falsely believe that all that is needed in order to remain safe from HIV is to refrain from sex with multiple partners. They may, thus, not feel that it is necessary to engage in HIV protective behaviour, such as using a condom, when having sex with only one individual. There is therefore a need for HIV education initiatives within the Pakistani migrant community which make explicit the fact that HIV may be contracted through sex with even only person, if that person has an HIV positive status.

In addition to citing promiscuous sex as a primary mode of HIV transmission, some participants added that HIV may also be transmitted through contact the HIV positive blood.

Maybe someone is having HIV and you hit me, punch me and there is bleeding and you are bleeding together and it touch the blood (Participant 5)

You go for example to the clinic if you make a mistake like for example my blood has touched on your blood, you will catch (Participant 6)

The above quotes illustrate that even though there is an awareness that HIV is transmitted through blood, the specifics of exactly how contact with HIV infected blood may lead to

becoming HIV positive is not clear. Hence participants' knowledge regarding blood transmission as a mode of HIV transmission is limited to vague awareness of this as a primary mode of transmission. While transmission through medical instruments such as needles was briefly mentioned this did not appear to be considered as a significant mode of HIV transmission. Participants also omitted to mention other important modes of HIV transmission such as mother to child transmission. Adding to this participants did not show awareness of some of the biological risk factors for HIV transmission, such as the fact that an untreated sexually transmitted infection (STI) in either partner increases the risk of HIV transmission during unprotected intercourse ten-fold (CDC, 2008). Hence it can be said that there are significant gaps in HIV knowledge among participants.

In addition to the gaps in HIV knowledge mentioned above, participants demonstrated inaccurate beliefs about how HIV is transmitted. For example,

Kissing is too much, also AIDS (Participant 7)

They using, no is washing, no is this stuff...also Islam first time is use sex...he, she is sex after is washing (Participant 7)

Also guy is washing, she is washing. Is clean. Sex is after is washing (Participant 7)

When you're having sex, she doesn't wash or something (Participant 6)

Second man come, third man come, fourth man come, disease come. Four, five people got different sickness, this man got different, this man got different, and I got different. They all come together and it's a great disease (Participant 6)

Participant 7 expresses a commonly held myth that HIV may be contracted through kissing, while participant 6 on the other hand expresses the peculiar view that HIV in an individual might be caused by an amalgamation of various illnesses contracted from

multiple sexual partners. Both participant 6 and 7 also express the view that HIV occurs as a result of not washing after sex, with the implication that washing after sex may prevent HIV. The existence of these myths around HIV is interesting in light of the fact that evidence suggests a decrease in HIV transmission myths among South Africans. In one of the most recent studies of HIV knowledge among South African citizens conducted in Cape Town, it was found that participants demonstrated few of the HIV myths, such as that HIV may be transmitted through kissing, which were prominent in South Africa just a few years ago (Kalichman, Simbayi, Cain & Jooste, 2008). This suggests that while HIV education initiatives have been successful in reducing HIV myths among South African citizens, the same cannot be said for Pakistani migrants. Thus, this once again points to the need to develop HIV education programmes aimed specifically at the Pakistani migrant community. Such education is crucial because inaccurate beliefs about the transmission of HIV may place Pakistani migrants in the precarious position of being ill informed of the ways in which they may contract and protect themselves from HIV.

### ***Knowledge of HIV prevention methods***

Participants typically spoke about two ways of preventing HIV. On the one hand it was mentioned that condoms may be used in order to prevent HIV and on the other hand adherence to Islamic religious tenets, specifically related to sexual relations, was cited as a means of preventing HIV. Only adherence to Islamic tenets, however, was considered to be an effective method of prevention with condoms by and large being constructed as ineffective in preventing HIV.

As mentioned above, a key argument evoked with regards to HIV protection is that adherence to Islamic religious tenets which relate to sex and sexual relations is the only effective method of prevention HIV. For example, both participant 1, 4 and 3 argue that adherence to Islamic tenets which prohibit sex before marriage prevents HIV.

Prevention is like, religion. Like the Muslim people, part of you must be used to your wife, that's the right and simple way and you can tell yourself (Participant 3)

You see, our religion...they're not allowed to go with other women to have sex (Participant 4)

The other thing is the religion, my religion is not allowing me to party all around and go for the looser things (Participant 2)

In the Muslim religion (for) those people who don't marry sex is illegal (Participant 1)

Later it will be argued that the belief that adherence to religious tenets prevents HIV is problematic because it may lead to the notion that belonging to the Islamic religious faith renders one invulnerable to HIV.

While condoms were mentioned as a method of HIV prevention, this was considered to be an ineffective method of preventing HIV. For example, participants 4, 6 and 8 refer to the ineffectiveness of condoms in preventing HIV.

Well, I know a bit about condoms, a few people wear condoms... I read in the news, they talk about condoms (Participant 5)

We have the condom, there is a condom that they use but that is not safe anymore (Participant 4)

The condom, it doesn't stop (HIV) (Participant 6)

I don't know. They say the condom, but condom is not legal protection, you know (Participant 8)

While condoms do not offer 100% protection from HIV, it is widely accepted that properly used latex condoms provides a high degree of protection against a variety of sexually transmitted diseases, including HIV infection (CDC, 2008; Fan et al., 2007). The participants quoted above do not seem to share this view. Rather it seems that the line of reasoning employed by participants is that if condoms do not offer 100% percent protection then, as mention by participant 6, condom do not stop HIV. In other words, for participants, if condoms do not provide 100% protection then they do not provide any protection. This form of dichotomous thinking with regards to condoms is not unique to this study. Other studies have concluded that for some people if condoms are not completely effective then they are not considered an effective HIV prevention device (Fan et al., 2007).

In terms of the health belief model, the belief that condoms are ineffective in preventing HIV has negative implications for condom use (Fan et al., 2007). As mentioned before, the health belief mode contends that a crucial variable in a person's decision to engage in health protective behaviour such as using a condom, is the person's evaluation of the effectiveness of condoms in preventing HIV. If a person underrates or denigrates the value and effectiveness of condoms in preventing HIV, there is less likelihood that he or she will use condoms as a means of HIV prevention (Fan et al., 2007). Therefore, it may be concluded from this, that the likelihood of the above participants using condoms in order to protect themselves from HIV is poor. This is further substantiated by the fact that in their discourses above the participants clearly construct condoms as something which is related to the "other", i.e. non Pakistanis. For example, both participant 5 and 8 speak of condoms as something which "they" claim

prevents HIV, while participant 4 constructs condoms as something which “they” use to prevent HIV. Underlying this use of words seems to be participants’ desire to distance themselves from condoms and their use.

Participants’ desire to distance themselves from condom use may be related to stigmatising beliefs held about the disease, which as discussed below were abundant in the discourses of participants. As per the literature reviewed in chapter 2, there is evidence to suggest that stigma may make people reluctant to use condoms for fear of being identified with the disease or with marginalised populations that are most heavily affected (Nyblade et al., 2003 in UNAIDS, 2008).

### *Sources of HIV knowledge*

Corresponding to other studies (Barden-O’Fallon et al., 2004; Bhattacharya, 2005), the main sources of HIV knowledge for participants in this study was the media, particularly print media and television.

Because if he comes from Pakistan to South Africa, he will know some things because in the TV there is something about the HIV (Participant 6)

What I heard and what I know and what I have seen in the newspaper (Participant 1)

...there is a lot of media that they can learn from (Participant 2)

Sometimes you will see an advertisement (Participant 3)

Given what has already been said about participants’ inadequate level of HIV knowledge, information about participants’ main sources of HIV knowledge is important so as to ensure that programmes aimed at increasing HIV knowledge among Pakistani migrants

are able to harness important sources of knowledge for this population in the diffusion of HIV prevention messages and HIV-related knowledge. However, it must also be borne in mind that even though media seems to a main source of HIV knowledge, from the rudimentary nature of participants' HIV knowledge, clearly the media is not adequately serving the needs of this population with regards to HIV education. Hence, there is a need to research and develop HIV education programmes which meet the specific needs of Pakistani migrants.

In summary, analysis of the various sub-themes which make up the theme here called HIV knowledge highlights a number of factors which place Pakistani migrants in a vulnerable position with regards to HIV. While participants have a basic awareness of HIV, knowledge regarding HIV transmission and prevention methods is rudimentary, with participants also holding a number of myths about HIV transmission. This points to an urgent need to develop HIV education programmes aimed specifically at meeting the HIV education needs of Pakistani migrants.

### **Perception of HIV Risk**

A number of recurring themes suggest that participants have a poor perception of HIV risk. Firstly, number of stigmatising beliefs regarding HIV, serve to provide a sense of invulnerability to the disease. Secondly, the seemingly low prevalence of HIV in Pakistan as compared to the high prevalence in South Africa, seems to contribute to participants' construction of HIV as a disease which affects South Africans. Finally, as will be highlighted later, participants rely on perceived social differences, such as religion and

culture, between South Africans and Pakistani's in their construction of HIV as a South African disease.

### *Stigmatising beliefs about HIV and AIDS*

Stigmatising beliefs regarding HIV and AIDS revolved around two themes. Firstly, there is the belief that HIV is a punishment for wrongdoing and secondly that HIV is a death sentence.

In the abstracts below, drawing on religious discourses, participants clearly present HIV as a punishment for wrong doing. For example, participant 3 states that it is believed by Pakistani migrants that HIV is a punishment from God. While the participants do not specify what wrongdoing HIV is a punishment for, based on the overall content of interview data it is assumed that wrongdoing relates specifically to sexual wrongdoing. As mentioned elsewhere, judgemental moral discourses which label HIV as God's punishment for sexual sinners are often documented (Rankin et al, 2005; Schafer, 1991; Skinner & Mfecane, 2004).

They are doing something wrong (Participant1)

You can secure by the HIV if he goes the perfect ways (Participant 2)

If you go the wrong way, you can get the wrong thing... If you go the right way, you don't get it. (Participant 3)

We think it is a punishment from God (Participant 3)

One implication of the argument that HIV is a punishment from God is that it leads to the belief that the righteous are safe from HIV. Both participant 2 and 3 explicitly make the



claim that the righteous are invulnerable to HIV. The construction of HIV as a punishment for wrong doing divides society into 'us' and 'them'; 'saved' and 'sinner'(Skinner & Mfecane, 2004). This makes it possible to characterise HIV as a disease of 'others' whose wrong actions are responsible for the disease (Campbell, 2003). 'Othering' serves as a psychological defence, protecting the individual from anxiety through externalisation of the threat on to identifiable out groups, resulting in a false sense of security from the disease (Campbell, 2003). As will be discussed later, the out group which Pakistani migrants have identified HIV with and onto which they have externalised threat of the disease onto are South African citizens, particularly South African women.

Perceptions that HIV is a dangerous and lethal disease abound. For example, in a recent study South African adolescents likened HIV to having a knife at one's throat (Dias, Matos & Goncalves, 2006). Participants in this study seemed to share this view of HIV, equating it with death and misery. For example, participant 3 states that if one contracts HIV one's life is over.

You kill yourself (Participant 3)

It is also like an illness that is killing (Participant 2)

If you make a mistake like this, your life is gone (Participant 3)

They going to die (Participant 8)

While there can be no doubt that HIV is a serious disease, the notion that HIV is a death sentence is misleading. This notion is underpinned by the belief that HIV and AIDS are one and the same thing. Certainly, participants in this study make no distinction between

HIV and AIDS. However, there clearly is an important distinction to be made. HIV is the virus which causes AIDS, which in turn makes the body vulnerable to opportunistic disease that may lead to death (Fan et al., 2007). Hence, HIV does not mean imminent death.

Advancements in medical science, specifically with regards to antiretroviral drug treatment have transformed HIV from what was previously thought to be a death sentence into a manageable chronic condition (UNAIDS, 2008). For example, recent studies in Denmark suggest that a young man newly diagnosed with HIV is likely to live an additional 35 years with available medications, a tripling of the life expectancy for people with HIV (Lohse et al. in UNAIDS, 2008).

In light of the above, it is becomes evident that participants' perceptions of HIV are excessively pessimistic and ominous. These perceptions of the disease as a death sentence increases fear and stigmatisation, making it more likely that people will employ psychological defences such as denial of vulnerability to the disease, in order to cope with their exaggerated fear of the disease (Campbell, 2003). In conclusion, participants' stigmatising beliefs around HIV contribute to a false sense of invulnerability from the disease. As discussed before, both research and theories of health behaviour change show that a sense of invulnerability, or poor perception of risk of HIV, decreases the likelihood of engaging in HIV protective behaviour.

### ***HIV prevalence in Pakistan versus South Africa***

The first response of many participants when asked about HIV was to point out the seemingly vast difference in HIV prevalence between Pakistan and South Africa.

Participants however differed with regards to their reports of the prevalence rate of HIV in Pakistan. Reports ranged from claims that there is no HIV in Pakistan to claims of the HIV prevalence rate being anything from 1 to 15%.

In Pakistan, HIV is not even 1% (Participant 8)

I think its about 180 million of us in our country and there is only that 40 (with HIV/AIDS) (Participant 2)

AIDS, ten, fifteen percent sometimes, this country, hundred percent (laughs) (Participant 7)

Because you see in our country there isn't (Participant 9)

There's none of that in Pakistan, we don't have it there (Participant 4)

This AIDS is too much...too much. My country, the Pakistan nothing (Participant 7)

Participants' tendency to respond by citing the difference between HIV prevalence in South Africa and Pakistan when first asked about HIV, communicates a low perception of HIV risk. Contained in participants tendency to respond in this way appears to be the unspoken argument that because HIV prevalence in South Africa is high, South Africans are vulnerable to the disease, on the other hand because HIV prevalence in Pakistan is low, Pakistani people are not as vulnerable to the disease. In other words, participants' low perception of risk is in part due to the vast difference in HIV prevalence which they perceive between South Africa and Pakistan.

Participants' use of the difference in HIV prevalence between South Africa and Pakistan and South Africa to argue for their low risk of contracting the disease is interesting in light of the fact that HIV prevalence in Pakistan may not be as low as

reported. As pointed out by Emmanuel et al. (2004) the apparent low prevalence of HIV within Pakistan may be due to epidemic still being in its earliest stages as well as widespread under-reporting of cases due to inadequacies in the surveillance system. In addition, due to a number of factors in the Pakistani context, including poverty, low levels HIV knowledge and a booming sex industry, Pakistan is considered to be in a 'high risk-low prevalence' situation (Bhurgri, 2006; Emmanuel et al., 2004).

### **Social Factors and HIV Protection**

Dominant themes relating to religion, culture and gender reveal that these factors are likely to affect HIV protective behaviour in a number of ways. Primarily, religion and culture affect HIV protective behaviour through their influence on participants' perception of HIV risk. As mentioned before, participants' base their sense of invulnerability to HIV on the social differences, in terms of religion and culture, between South Africans and Pakistani's. Hence in this way HIV is constructed as a South African disease. Models of health behaviour change tell us that poor perception of HIV risk decreases the likelihood of HIV protective behaviour. Hence the attitude that HIV is a South African disease undoubtedly has negative effects on the likelihood that participants will engage in HIV protective behaviour. Analysis also revealed that religious prohibitions against sex before marriage, appear to serve as a barrier to condom use among unmarried male Pakistani migrants, due to concerns about being perceived negatively by other Pakistani migrants.

### ***Religion***

As discussed before, adherence to Islamic religious tenets which relate to sex and sexual relations is considered by participants to be the only effective method of HIV prevention. Participants' extend the argument that adherence to Islamic religious tenets is a means of HIV prevention to make the claim that Islam protects from HIV. For example:

...because we are Muslim in our religion, we won't have sex before marriage which will help to protect ourself (Participant 1)

So especially the Muslim people, they can protect themselves very easily (Participant 3)

You know our religion, Muslim ... God will sort out my problems... That's why I don't worry, my life, my life is in God's hands. My life, I don't worry too much, I have faith (Participant 5)

Participants 1 and 3 clearly make that claim that by virtue of their religion, Muslim people are able to protect themselves from HIV. The claim by participant 3 that Muslims are easily able to protect themselves from HIV, as well as the statement by participant 5 that he does not worry too much about HIV because of his faith in God, indicates that participants' assessment of their vulnerability to HIV is strongly mediated by the belief that the Islamic religion protects one from the danger of contracting HIV. These participants seem to believe that HIV is not something which they need to worry about, since they are protected by their religion.

The above captions illustrate that for the participants the Islamic religion affords protection from HIV by placing certain restrictions on behaviour, most notably as, pointed out by participant 1, by prohibiting sex outside of marriage. This view seems to be substantiated by literature on religion and health which typically concludes that

religious involvement does have positive effects on health. Religious involvement, especially in more morally conservative denominations, has been shown to be associated with lower levels of HIV risk behaviour (Agadjanian & Menjivar, 2008). However, there is also growing research which shows that, as is the case in the current study, religious involvement has a negative effect on perception of HIV risk (Agadjanian & Menjivar, 2008; Akwara et al., 2003). As mentioned before, it is argued that religious people tend to consider HIV to be a disease that affects those who have transgressed against God (Akwara et al., 2003). There is a denial of HIV risk because it is associated solely with high risk groups (Akwara et al., 2003).

In light of evidence that perception of HIV risk is a crucial factor in HIV prevention, it might be argued that any benefits afforded by religion in reducing HIV risk behaviour is counterbalanced by the detrimental effect which religion may have on perception of risk. Research shows that highly religious individuals may be particularly unlikely to report using condoms and that this may be linked to low perception of HIV risk (Agadjanian & Menjivar, 2008). Hence, while religious beliefs may act to deter participants in the current study from engaging in high risk sexual behaviour, such as sex with many partners, it may also contribute to their vulnerability to HIV by reducing the likelihood that they will use condoms should they engage in sexual activity.

Another way in which religion was found to reduce condom use in the current study was through the association of condom use with sexual wrong doing.

...in the Muslim religion according to those people who don't marry sex is illegal. So the Pakistani people who are doing this, who are Muslim will think that they are doing wrong and because of this person will stop themselves and save their life at the same time and their religion also (Participant 1)

If someone is here and what they are doing is wrong, I will say that to them because they are doing wrong, they will think bad (Participant 1)

...they still protect themselves but they know that they are doing wrong and they are feeling bad (Participant 1)

The above quotes clearly illustrate the moral judgement which a Pakistani migrant who engages in sex outside of marriage might experience. Such moral judgement is likely to make it difficult for those Pakistani migrants who do engage in sex outside of marriage to take steps to protect themselves against HIV. The literature reviewed suggests that a significant determinant of condom use is the approval or disapproval of sex by significant others (MacPhail & Campbell, 2001). Hence, the belief that by engaging in sex outside of marriage one is doing wrong may discourage one from accessing services related to HIV protection for fear of chastisement and discrimination (Volk & Koopman, 2001). The quotes below illustrate this point by providing insight into how the view that sex outside of marriage is 'illegal' and wrong might impact HIV protective behaviour such as condom use.

No. they might get embarrassed about what they are doing wrong...(Participant 1)

When they are having a female in their mind then they are even shy to ask for the condom unless they are a married person...So the, all the youngs, at school and who are unmarried, however old he is mostly they wont say I need that condom... he must be shy, he must be. Ya, they must be (Participant 2)

He must have in mind someone can look at me and he gonna think, I am a Muslim, I am a Pakistani and what I'm doing, his eyes was down, when he was talking his eyes was down, you understand? So the thing is I don't think he will get involved such a big big problem (Participant 2)

He had a fear in his mind, in his heart, someone looking at him, someone thinking one of the days when my father, my sister, my brothers they heard about this (Participant 2)

Participant 1 and 2 state that because sex outside of marriage is constructed as wrong, Pakistani migrants may be embarrassed to be seen buying condoms, as this would be evidence of being seen to be doing wrong. This is similar to the finding of Ortiz-Torres et al (2000) that access to condoms is mediated by cultural beliefs that sex before marriage is wrong. Having said this however, it must be noted that there was some indication that despite perhaps feeling embarrassed about buying condoms some Pakistani migrants do use condoms to protect themselves. This is illustrated by the following quotes:

What I have seen here in South Africa is that when people sleep with people they don't know, with girls, then they use condoms (Participant 1)

They use the protection, ah... according to my knowledge (Participant 2)

The fact that some Pakistani migrants do use condoms is encouraging with regards concerns about HIV vulnerability among Pakistani migrants, however it must be remembered that condom use is nonetheless constructed as being associated with wrong, immoral behaviour. In the area of HIV protection, condom use is unfortunately not as common as it should be, added to this the idea that condom use is associated with wrong doing further reduces the likelihood of condom use. One might add that the association of condom use with wrong doing may mean that condoms are not spoken about among Pakistani men, however information gathered from the participants seem to contradict



this assumption, since a few participants spoke about warning new Pakistani migrants about the dangers of HIV, as well as recommending condom use.

We warning each other, yes. Especially the new guys, we have to tell them (Participant 3)

You tell them there's this HIV, this thing you don't want it. So you tell them protect yourself, you have a girlfriend, you don't have sex. When you meet somebody, you can get married here but you have to go yourself to check. You don't go the wrong road like a club. Because we speak like this, when you come here you don't know, you don't watch TV or read newspaper so you don't know (Participant 3)

Some of my friends was joking and saying if you want to sleep with women, use a condom (Participant 5)

The above is once again encouraging in terms of mediating HIV vulnerability among Pakistani migrants however there are a number of things which may be cause for concern. For instance, it seems that whenever condom use is discussed it is in the form of a joke, for example the comment by participant 5 above. The implication of this is that HIV protection is not commonly a topic for discussion, except when it is the butt of jokes. To illustrate that HIV is not commonly spoken about, participant 5 who had been in South Africa for less than a month and had very limited knowledge about HIV said that he had not heard about HIV from fellow Pakistani migrants but from television. Research indicates that HIV knowledge is impacted by the amount of discussion that takes place around the subject (Agadjanian & Menjivar, 2008). Here it seems that the danger is that HIV knowledge may be impacted by the lack of open communication around condom use. As pointed out by participant 3 above, new Pakistani migrants to South Africa do not

know very much about HIV. For many the first time they have even heard about the disease, is in South Africa.

13 years then we came here and we heard that name HIV and Aids in South Africa, there's none of that in Pakistan (Participant 4)

You see the most, the thing about Pakistani people, most of them don't know about this like we don't have knowledge about this. Sometimes you will see an advertisement but most people don't have education. These things we don't have any of these things in Pakistan (Participant 3)

In summary, the association of condoms with wrongdoing has two concerning consequences. Firstly, by directly impacting access to condoms and secondly by possibly impacting HIV knowledge.

As mentioned above, it seems that for the participants Islam provides protection against HIV via the prescriptions which it places on the behaviour of its members. In this regard, the religious prescriptions which were overwhelmingly identified by participants as providing protection against HIV were those relating to marriage and the restriction of sex outside of marriage.

You can secure by the HIV if he goes the perfect ways, you must be limited by your family, only husband and wife...we have to thankful to our almighty that we are not able to do anything (Participant 2)

...you don't have sex until the real lady, like your wife. Like the Muslim people, part of you must be used to your wife, that's the right and simple way (Participant 3)

You see, our religion, I think even the other religion, I don't think they're allowed to go with other women to have sex, even the other religion also I don't think they allow it. Our religion is very, very strict (Participant 4)

Before marriage, you can't have sex...with any girl, any lady. When you finished get married you can sleep with your wife (Participant 8)

The above quotes illustrate that it is through prohibiting sex before marriage that Islam is perceived as providing protection against HIV. Also evident in the above abstracts is the idea that once married, Islam ensures that partners will remain faithful to each other, hence protecting them from HIV. The idea that marriage provides protection against HIV is contested. In fact, it is widely recognised that marriage may even be a risk factor for contraction of the disease. For a growing number of people, many of them women, marital sex represents their single greatest risk for HIV infection (Hirsch et al., 2007; Parikh, 2007). As much as marriage is often synonymous with discourses of love, trust and monogamy, infidelity is also a possibility which is often realised within marriage (Parikh, 2007). It is this tension between the ideals of marriage and the reality that infidelity within marriage does frequently occur which creates a space for HIV risk. Discourses of trust and fidelity in marriage, limits the ability of a spouse to negotiate safe sex within marriage (Parikh, 2007). This is because for many, to request safer sex practices, such as use of a condom, within marriage is to admit to extramarital sexual activity or accuse one's partner of the same (Parikh, 2007). Therefore, even someone who is having extramarital sex may not use a condom during sex with his/her spouse because to do so would be to jeopardise his/her marriage (Parikh, 2007).

An interesting aspect with regards to marriage within the Islamic faith is that a Muslim man is allowed to have more than one wife, as pointed about by participants 3 and 7 below.

You can control about yourself, you do no wrong. You can have four wives, you can get first time married, if you can afford and your wife can give you her permission, you can get another wife, you can get another wife and if you don't get a child, you don't get nothing, she can agree and you can get another wife. You need her permission. This thing is very important, that's why if you get this you can protect yourself. So especially the Muslim people, they can protect themselves very easily (Participant 3)

The wife... Islam is one man is three...five wife. If business is right, if man is right, make three, four wife one time (Participant 7)

The above mention of polygamous marriage within the Islamic religion is interesting because, it means that in effect men are allowed to have more than one sexual partner, but within the confines of marriage. This contradicts participants' views about HIV being transmitted primarily through sex with multiple partners. It seems that participants' do not construct polygamous marriage as sex with multiple partners. This illustrates the degree of protective power that marriage is perceived as having, since simply by virtue of marriage what is seen as the primary mode of HIV transmission, i.e. sex with multiple partners, comes to be seen as safe.

### ***Culture***

As with religion, participants presented culture as being a significant factor which protects them from HIV. For example, participant 6 makes the statement that culture can stop HIV, adding that HIV can be prevented in South Africa if only the culture in South Africa were changed.

If you change your culture, by the culture you can stop Aids (Participant 6)

A dominant theme in the discourses of participants is the perception that HIV in South African is a consequence of the culture of morally degenerative behaviour which participants link South Africans to. The most commonly mentioned vice which South African's were linked to was sexual promiscuity. This is illustrated in the following captions:

...in this country, it is a sex free country so they are scared to bring the wife and girls (Participant 1)

...here in South Africa, the atmosphere is entirely change, here and there. Here there is a relation with girl, a lot of them, you can do what you want to do, anywhere, whenever (Participant 2)

... in South Africa they are having a culture where men must have a girlfriend (Participant 4)

This other nation, the Hindu and Christian have two to four... four boyfriend, girlfriend... AIDS too much (Participant 7)

Sometimes I see one girl got maybe 10 boyfriend. One boy got maybe 10 girlfriends (Participant 9)

All participants quoted above clearly view South Africa as a country in which sexual freedom and indeed promiscuity predominates. There is a clear moral distinction drawn between Pakistan and Pakistanis who are seen as being free of promiscuity and South Africans who are depicted as sexual deviants who have many sexual partners. As discussed before, for participants the main mode of HIV transmission is sexual promiscuity. Of interest in this regard is the exaggeration of the sexual promiscuity among South Africans. For example, participant 9 goes so far as to say that some South African girls have 10 boyfriends. It might be hypothesised that these exaggerated accounts of the rampant sexual promiscuity of South Africans is used in order to further

strengthen Pakistani migrants' denial of their own risk of contracting HIV. Participants seemed to want no doubt that firstly Pakistani migrants, unlike South African's, are not sexually promiscuous and secondly that Pakistani migrants therefore have very low risk of contracting HIV. The above abstracts clearly show that Pakistani migrants construct the risk of HIV in ethical and moral terms, projecting immorality and danger onto the other, in this case South Africans (Smith, 2003). In this way they are able to deny their own risk of contracting HIV and therefore unlikely to engage in HIV protective behaviour.

As stated before, health behaviour models, commonly used to inform HIV prevention strategies, such as the health belief model and the theory of reasoned action acknowledge the centrality of perceived risk in behaviour change (Akwara, Madise & Hinde, 2003). These models posit that HIV preventative behaviour is more likely among those who feel vulnerable to a disease (Simbayi et al., 2005). This is supported by a number of research studies which show that while not sufficient, the perception that one is at risk of contracting HIV is crucial in order to engage in HIV protective behaviour (Akwara, et al., 2003; Barden-O'Fallon, et al., 2004; Macintyre, Rustenburg, Brown & Karim, 2004). In light of this it is clear that poor perception of HIV risk limits the likelihood that participants will engage in HIV protective behaviour. Given that the participants believe that South Africans are at risk of contracting HIV because of sexual promiscuity it is not inconceivable that a Pakistani migrant who is engaged in a sexual relationship with only one partner, who is not believed to be sexually promiscuous, will feel that it is not necessary to take steps to protect against HIV. However, as experience

has shown this assumption is false and extremely dangerous. Someone who has only had one sexual partner can contract HIV if that partner has the disease.

Interestingly, given the denial of HIV vulnerability, participants also pointed out that the perceived culture of sexual freedom in South Africa has not left Pakistani migrants unscathed. The majority of participants indicated that at least some Pakistani migrants do have sex before marriage in South Africa, giving up the protection that religion may provide. In light of this, concerns about protection and HIV vulnerability among Pakistani migrant become extremely important.

When I came here I can have plenty of fellows around me, being a Pakistani he is, he will see me and he will talk to me; I did sleep last night with three girls, he did tell me, he's gonna tell me I did sleep and I was having 3 bottles of whisky and that and that and this and that I did, even like orgies, right, right? (Participant 2)

Not all of the people but some of the people are getting sex, maybe they've got a girlfriend, maybe they do it (Participant 1)

He will come here 1 month, 6 months, 1 year, 2 years and he might meet someone and propose and go to bed (Participant 6)

Mostly the (Pakistani) guys is sleeping around (Participant 8)

The above quotes illustrate that not only do at least some Pakistani migrants engage in premarital sex, but as pointed out by participant 2 and 8, some Pakistani migrants engage in risky sex with multiple partners. This is interesting in light of the fact that many participants were determined to point out that Pakistani migrants are at low risk of contracting HIV because they are not sexually promiscuous. In this regard there appears to be a degree of tension with some participants more reluctant than others to admit that some Pakistani men in South Africa engage in sex before marriage.

Other boys come from Pakistan and they check is nice she, is the marriage, no sex before. Nothing sex. I am coming from Pakistan two years, no is sex this country...wife is Pakistan, sex with wife no other. My wife is nice one (Participant 7)

Participant 7 contradicts the statements made by other participants that some Pakistani migrants do engage in sex before marriage. Willingness to concede that sex before marriage does occur among Pakistani migrants may be related to factors such as age and marital status, since participant 7 was an older married migrant and may therefore have been more reluctant to admit that sex before marriage does take place among Pakistani migrants.

While a few of the participants were willing to admit that some Pakistani migrants do engage in sex before marriage, it is worth noting that this was blamed on the temptation which Pakistani migrants are believed to be confronted with in South Africa. Hence, not only are South Africans constructed as being sexually promiscuous, but they are seen as threatening to the chastity of Pakistani migrants.

The following quotes illustrate that while it may be conceded that some Pakistani migrants do engage in sex before marriage this is blamed on the temptation which is put before them by South African women.

Yes, so you have to control yourself, maybe the girl asks you for sex, the girls forcing you – you don't have to do all of these things, you have to cover in your mind to stop yourself (Participant 1)

Freedom. In Pakistan you can't even look at a female, it will be a big problem. So the thing is for me, I'm just looking after myself; I can have plenty of girlfriends around here. But I haven't gone to anyone, I don't want to (Participant 2)

...when they come here, they may cheat, before they come here every female is covered, you can't even see their faces as well, here you can see their body, every



part. So off they go and after a few times it's just a frustration for themselves (Participant 2)

...there's a lot of woman around so you can get everything (Participant 4)

South Africa you are open, you can use a mini skirt or something like that, this force a man to want women sex (Participant 6)

...if you put butter by the fire, its gonna melt. Same like us, we do mistakes but we still, we ask forgiveness each and every second what we, God please give us, please give us (Participant 6)

Even if a woman come, he's not going to change, in his mind, he is always chained to his culture (Participant 6)

By blaming the sexual behaviour of some Pakistani migrants on the temptation of South Africa women, participants are able to deny their own and other Pakistani migrants' HIV risk. In other words, they are able to maintain that they and others who are able to withstand the temptation which South African women pose, are not vulnerable to contracting HIV. Hence it may be said that the discourses which blame South African women for the sexual deviance of some Pakistani migrants, serves to maintain participants view that they are not personally at risk of contracting HIV.

One of the most salient aspects of Pakistani culture, as revealed by this study is arranged marriage. That the majority of participants made mention of arranged marriage, is evidence of the fact that this is an important aspect of Pakistani life and culture. Related to previous discussion of Islamic marriage being seen as providing protection from HIV, arranged marriage was similarly viewed as an important aspect of Pakistani culture which provides protection from HIV. For example,

Actually in our country, no boyfriend no girlfriend. Also mostly arranged marriage. Patience in my country. Maybe I like you, so nice, beautiful but I have patience. I don't know you, maybe you have got lot sickness and that things (Participant 9)

Pakistan is a Muslim country so no sex free. You see? Then you get married and that woman has to be a virgin to get married, if she is not a virgin, the marriage wont work. Its not going to last (Participant 6)

You see the men, they mustn't get involved with the people here, they don't know the people here. They can see anybody in the road or wherever they walk, they can have sex and all these things (Participant 4)

The sentiment expressed by participant 9 above is that having an arranged marriage means that the history and background of one's marriage partner is known and hence one's family can ensure that one's marriage partner is not infected with illnesses such as HIV. In addition, the theme of arranged marriage is linked to the idea that in the Pakistani community, personal desires and wants are secondary to considerations of duty and responsibility.

Participants expressed the view that it is wrong to make one's decision to marry merely based on love or one's personal desires. This is illustrated by the following:

They (people who do not have arranged marriage) are lost...the basic this was first they didn't understand the situation...they're just going according to the heart, they didn't try to go with the mind (Participant 2)

Like the girls are nice, maybe they can marry her. I told my mother, agree maybe she agree. But not like freeness, lets go straight to I love you, I like you, lets go out for supper, go see a movie (Participant 3)

Marriage is not an individual thing but rather recognised as having repercussions for one's family, as is shown in the following quotes.

Nice, it's fine. Decide my family also. My brother, sister, mother, father also decide. They like, you like. All family is together in the marriage. She and he, family is marriage (Participant 7)

The 5%, 2% people who say we are going to get married so I don't care about my father, my sister, my mother – I don't care what they think, what they want, what they do, we are going to get married. They getting married after that, they lost their family support (Participant 2)

### ***Gender***

Concerning issues of gender, themes relating to constructions of masculinity and femininity as well as the role of sexuality in these constructions of gender emerged. The picture which the participants paint of Pakistani masculinity in some ways epitomises traditional hegemonic constructions of men, especially in relation to the treatment of women. However, in other ways, particularly as it relates to expectations regarding sexual behaviour, Pakistani constructions of masculinity seem to depart from dominant constructions of masculinity.

Synonymous with notions of being a man in Pakistani culture are expectations of duty and responsibility to family. The following quotes provide insight into this central feature in Pakistani constructions of masculinity.

A man is someone who do something for his wife and for his parents. And if the man is not making something then the man deny his responsibilities. So we say he's not a right man, if he deny his duties and his responsibilities that he is running away. So we say in our world, you are not a man if you deny your responsibilities (Participant 1)

You know about being a man, in our culture, a man, the man who is the father, being a father, he has responsibilities so that it goes according to responsibilities; his behaviour is going to his responsibilities (Participant 2)

The one thing I know is that they know they know their responsibility, you know? You see the people around here, every month they send the money home, every month (Participant 4)

First of all, he have to remain for the only, for the God. What he signed for, to pray five time a day, second he must look after his mother, his father. While in Pakistan he must look after his wife, his children. He must look after his brother; his whole family is depending on him. If he come to overseas then he has good family in Pakistan that is a man (Participant 6)

The above quotes illustrate the centrality of respect, duty and responsibility towards ones family in Pakistani constructions of masculinity. Here it is interesting to note that duty and responsibility towards one's parents play a big part of what it means to be a good man, even after marriage.

Important, ja. First parents then wife (Participant 8)

Participant 8 points to the fact that duty, responsibility and obedience to ones parents come before one's duty towards one's wife. Furthermore duty and respect towards parents, in addition to religion, is an important influence on sexual behaviour.

In Pakistan they don't sell the drink or anything. So they come here and they get freeness, no mother, brother (Participant 3)

He had a fear in his mind, in his heart, someone looking at him, someone thinking one of the days when my father, my sister, my brothers they heard about this (Participant 2)

It has happened here, because you know there are no people to stop you here, nobody to say that it's not right what you do. If it was Pakistan I gonna say eh, this is my fathers friend, he gonna see me drinking, he's gonna tell my father and he gonna hit me (Participant 6)

The thing is, when we come here, nobody can tell us, nobody can stop us whereas in Pakistan, if we do something wrong there is a mother, father, you have a family (Participant 3)

Both participant 2 and 6 allude to the fact that consideration about the reaction of one's parents appears to act as a deterrent to what is considered immoral behaviour such as sex before marriage and drinking. The fact then that the majority of Pakistani migrants in South Africa do not migrate with their parents means that in South Africa there are no parents who can act to deter sexual behaviour, which may put migrants at risk of contracting HIV. Participant 3 raises this point when he states that on arrival in South Africa Pakistani men experience an unprecedented a level of freedom. They now have no one to answer to, it is this freedom which may place Pakistani migrants at risk of contracting HIV. In other words, participants make the claim that Pakistani migrants are vulnerable in South Africa without the protection of their families.

Another important aspect of Pakistani masculinity relates to the duty to provide financially for one's family. In fact all participants mentioned financial responsibility when asked about Pakistani masculinity.

When he has children, he has to provide for his family, his wife, children and parents and possibly even his sister so we will have to look from his father to his grandchildren, that is what we try to do in Pakistan (Participant 1)

Muslim men's responsibility is to provide the food for the children and for the ladies, for the house like a sister or a mother, they don't have to go around. He has to provide their necessities. He is responsible for his family, for his children, for his parents, he is a man. If he bring the food at home and his children respect him, if he bring the necessities, what they like, what they desire, they must respect him then he can be a man, he can say I am a man (Participant 2)

Ahh..i'm happy, I make the money. My sister, my wife nothing job. Man is also family, make sure everything is right (Participant 7)

From the above discussion one might conclude that sex does not play as big a part in the construction of Pakistani masculinity. Rather notions of duty, responsibility and financial support are important aspects of Pakistani masculinity. It is widely accepted that dominant construction of masculinity construct successful masculinity in terms of sexual prowess and performance as well as the ability to satisfy multiple partners (MacPhail & Campbell, 2001; Makahye, 2008; Noland, 2008). Pakistani constructions of masculinity seem to contradict this view. From the responses of participants it seems that the pressure which is thought to exist among men of western cultural backgrounds to prove their sexual prowess does not occur among Pakistani men. Hence, in contrast to some of the literature regarding masculinity and HIV vulnerability which contends that men may feel pressured in risky sexual behaviour by dominant constructions of masculinity which may hold that men must be sexually active and even promiscuous to be considered men, this does not appear to be the case among Pakistani migrants. Having said this however, it is perhaps worth noting that just because sex does not seem to feature strongly in Pakistani constructions of masculinity is not to say that Pakistani men do not engage in behaviour that in some ways epitomises dominant constructions of masculinity. For example, as mentioned before, during interviewing a number of participants made overtures of a romantic nature towards the female interviewer. This shows that though Pakistani men may not consider sex as a crucial aspect of being a man, their behaviour in matters sexual may not necessarily depart drastically from men who consider sexual prowess to be an essential part of being a man.

Related to the above, it is worth noting that participants did allude to another common assumption about masculinity suggesting that Pakistani constructions of masculinity do have some things in common with dominant constructions of masculinity. As mentioned before, popular construction of male sexuality includes notions of male sexual drive as being overwhelmingly strong, urgent, and difficult to control (Shefer, 2004). For example,

Yes, you have to control yourself, you know you have to control yourself. It is difficult to control it (Participant 1)

If you put butter by the fire, its gonna melt (Participant 6)

Participant 1 and 6, above allude to the idea that Pakistani men have a strong sexual desire, which is difficult to control. The only difference, compared to dominant ideas about masculinity, is that among Pakistani men this desire must be controlled whereas within dominant western cultures this desire is indulged. So while Pakistani men may not feel coerced into sexual activity by other Pakistani men, the notion of men as having a strong sexual drive may mean that as seen above, in the South African context they feel coerced and forced into sex by South African women. Pakistani migrants' constructions of themselves as victims in face of their strong sexual nature on one hand and the temptation found in South Africa on the other hand may mean that they in fact do not see themselves as responsible for worrying about HIV and protection from HIV. This may be gleaned from the following statements.

What I have seen here in South Africa is that when people sleep with people they don't know, with girls, then they use condoms, the girls they know what is the

condoms. Pakistani people don't have use for the condoms, the girls; females can arrange their own things (Participant 1)

So there is no problem, even the female of the South Africans is stronger than the mans (Participant 2)

The statement above suggests that in seeing themselves as victims at the mercy of the temptation of South African women, who are constructed as being more worldly and sexually knowledgeable, Pakistani male migrants who do engage in sexual activity in South Africa may rely on their partners to initiate condom use. The danger then is of placing responsibility for one's sexual wellbeing in the hands of another. Research shows that women may be reluctant to ask a sexual partner to use a condom (Shefer, 2004). Hence, it is not inconceivable that a situation may arise where neither the Pakistani migrant nor his South African partner broach the subject of condom use, because they each hold expectations that the other should be the one to raise the subject of condom use. As mentioned above participants' construction of masculinity is closely connected with treatment of women. The participants all mentioned traditional patriarchal ideas about the role of women.

Basically the men are at work and the women at home but things are changing and more women are going to work and more girls are getting educated (Participant 1)

The difference is that in other places people believe that women can do whatever they want to do in this life, Muslim people believe that the women as a daughter she must obey her father, as a wife she has to obey her husband, as a mother she has to obey her children and look after them also so these people are controlling these things in the Pakistani community, the Muslim community, these people limit these things. If the girl go and study then, if her parents allowed her to study then she can go for it (Participant 1)

Well, you see compared to other countries, Pakistan is very different to other countries. In Pakistan, the women, we don't send women to work. They are not



allowed to go to work, he, the man can go to work. One man can work in every house but he won't let his wife go to work (Participant 4)

Pakistani community women, for example you are a Pakistani woman. I will come from the work, you will bring, she will bring my food, she will stay at home, if she not working she will stay at home and cook everyday, she clean the house. Before I get up, my shoes will be by the bed. And she will respect a man more than a God, for Pakistani women's man is a second God. But South African women they will say fuck you. Not insulting South African women's because the Western culture is too much in South Africa. ... I will prove you Pakistani women's, South African man, Pakistani man come to South Africa for 10 years and yes she will stay without the sex even. 10 years, you won't believe, I will prove it and if I don't prove it, you can throw me there (Participant 6)

No. Man is give Talak (Islamic Divorce), wife can't give Talak, in Islam (Participant 7)

Ahh..i'm happy, I make the money. My sister, my wife nothing job (Participant 7)

The above descriptions of Pakistani women are consistent with literature that suggests that within Pakistan, women have very little independence and are expected to be reliant upon men for support and protection (Baobaid, 2006). A number of participants' make reference to resistance to Pakistani women working. The above constructions of femininity seem to be in stark contrast to the women which participants encounter in South Africa. A result of this contrast women in South Africa are implicated in the spread of HIV/AIDS.

I told you that it comes from girls, all the sickness come together and different disease, come here something (Participant 6)

Womens have got HIV (Participant 5)

Like a women, a prostitute who has HIV, that is how it can be spread, there are a few things, sexually main things (Participant 2)

The implication of women in the spread of HIV is not unique to this study. As pointed out by Skinners and Mfecane (2004) the attachment of gender discrimination to HIV stigma has led to women being blamed for the spread of the HIV epidemic. In traditional patriarchal discourses, women are contradictorily expected to provide sexual services to men generally, be chaste and pure, and take on the responsibility of preventing pregnancy and disease (Skinners and Mfecane, 2004). Hence, we see that the strongly patriarchal norms of Pakistani men in the study are at the root of the construction of South African women as being responsible for the spread of HIV.

***Marginalisation, xenophobia and access to health care services***

Contrary to the literature that suggests that access to HIV protection services may be impacted by xenophobia and discrimination against migrants (Landau, 2005), xenophobia does not appear to play a significant role in the accessing of HIV protection services among Pakistani migrants. For instance, none of the participants cited xenophobia or discrimination as a reason for not making use of HIV or other health related services. In fact as illustrated by the quotes below, many participants reported that they were generally happy in South Africa.

It is nice here, no problems (Participant 8)

It is difficult but you have to work hard for this. In this country, in this situation, really you can ask for help anytime, anywhere (Participant 1)

The above quotes suggest that Pakistani migrants do not experience high levels of xenophobia in South Africa. This is in keeping with the literature which suggests that not

all migrants in South Africa are uniformly victimised (Harris, 2002). Rather, black foreigners, particularly those from Africa, comprise the majority of victims of xenophobia in South Africa, with migrants from Europe and Asia being at lower risk for violence, relative to African migrants (Harris, 2002; Kiguwa, 2006).

Despite the fact that participants did not report experiencing xenophobia or discrimination within the South African health care system they nonetheless stated that they tended not to use the public health care system. Participants stated that the main reasons for this were concerns around the time it takes to wait in line at public health care centres. Since Pakistani migrants are generally self employed, they are not able to afford to spend time waiting in long lines. In interpreting this finding one must bear in mind the extreme suspiciousness which the researcher was met with during interviewing Pakistani migrants for this study. This indicates that while participants may not experience as much overt incidents of xenophobia, feelings of marginalisation and isolation do exist. It might be hypothesised that perhaps these feeling of marginalisation and exclusion from South African society may in fact play a role in participants' reluctance to make use of public health care services.

In this chapter three broad emerging themes i.e. 1) HIV knowledge; 2) Perception of HIV risk and 3) Social factors and HIV protection, were discussed. Various valuable insights were gained regarding possible areas of vulnerability for HIV among Pakistani migrants. Discussion regarding these factors will be continued in the following chapter.

## CHAPTER 5: CONCLUSION

### **Introduction**

This chapter begins with a continuation of the discussion of findings presented in the preceding chapter. In this chapter the researcher also reflects on the limitations of the study, as well as makes recommendations for future research. Finally it is argued that despite the limitations of the study, it nonetheless provided valuable information which has a broad range of implications spanning from research to practice.

### **Discussion and Summary**

From the previous chapter, it is clear that a number of themes which emerged from the interview data give valuable insight into various factors that may affect HIV protective behaviour among Pakistani migrants. These will now be discussed. Firstly, findings suggest that while participants have a basic awareness of HIV, their HIV knowledge is rudimentary and therefore not adequate in order to protect them from HIV. For example, knowledge about modes of HIV transmission is limited to the belief that HIV is transmitted through promiscuous heterosexual sex, with some vague knowledge about the blood transmission of HIV. In addition, a number of inaccurate beliefs about HIV transmission, such as that HIV is caused by not washing after sex, were also found.

A lack of adequate HIV knowledge has significant implications for HIV protective behaviour since it is well established that HIV knowledge is a necessary condition for behaviour change (Bhattacharya, 2005; Gregson et al., 1998; Lindan et al., 1991; Simbayi et al., 2005). Knowledge about how the disease is transmitted and

prevented is necessary so that people know what steps to take in order to protect themselves. Knowledge is also an important determinant of perception of HIV risk. Inadequate or inaccurate knowledge about HIV transmission may lead people to the mistaken belief that they are not at risk of contracting the disease and therefore do not need to concern themselves with protecting themselves from HIV. In summary, an important finding of this study is that Pakistani migrants may be at risk for contracting HIV due to a lack of adequate HIV related knowledge.

Low perception of HIV risk was arguably the most dominant of all the themes which emerged from interview data. In fact, low perception of risk seemed to permeate many, if not all, of the emerging themes in this study. Stigmatising attitudes which construct HIV as a punishment for sexual promiscuity and wrong doing serve to maintain participants' sense of invulnerability to the disease. Stigma makes it possible to characterise HIV as a disease of "others" (Skinners & Mfecane, 2004). In this study it is abundantly clear that the "other" which HIV is identified with is South Africans. It was argued earlier that this "othering" by participants serves as a psychological defence which protects them from anxiety about HIV, a disease which they see as being equivalent to a death sentence. The threat of HIV is thus externalised on to South Africans, with South Africans perceived as being vulnerable to the disease while Pakistani people are not.

The low perception of HIV risk which participants' hold is particularly relevant to one of the primary concerns of this study, HIV protective behaviour. Research suggests that perception of HIV risk is related to HIV protective behaviour, in that HIV preventative behaviour is more likely among those who feel vulnerable to the disease (Akwara, Madise & Hinde, 2003; Simbayi et al., 2005). Hence in addition to lack of

adequate HIV knowledge, another area of HIV vulnerability for participants is their low perception of HIV risk. By constructing HIV in moral terms as relating to immoral promiscuous behaviour, participants were able to deny their own vulnerability to HIV, projecting immorality and thus HIV risk onto South Africans.

Social factors such as religion and culture play an important role in participants' denial of their vulnerability to HIV through the externalisation of HIV threat onto South Africans. Participants' sense of invulnerability to HIV, by and large, arose from social differences relating to religion and culture which participants' perceive between South Africa and Pakistan. It is because of these perceived differences that participants are able to construct HIV as a South African disease. For example, participants' strongly associate South African with sexual freedom and construct South Africans', particularly South African women, as promiscuous.

In this study, low perception of risk among the participants was found to be related closely to the idea that the Islamic faith through its regulation of behaviour serves as a protector against HIV. The religious prescriptions which were most often identified as providing protection against HIV were those relating to marriage. It was felt that by prohibiting sex outside of marriage, Islam protected one from HIV infection. As mentioned above however, the assumption that marriage protects against HIV is highly problematic. This is because there is growing support from literature that for many people, being married represents their single greatest risk for HIV infection, due to the occurrence of extra marital sex (Hirsch et al., 2007; Parikh, 2007).

Though participants seem reluctant to admit it, sex outside of marriage does occur even in Pakistan. For example, Bhurgri (2006) reports a booming commercial sex

industry and widespread indulgence in commercial sex with low levels of condom use and Khan (1998) concluded that a percentage of HIV infections were related to extramarital contacts. Hence from this it can be concluded that the belief that marriage within the Islamic tradition protects one from HIV is misleading and may significantly contribute to the HIV vulnerability of Pakistani migrants.

The belief that religion protects Pakistani migrants from HIV through restrictions regarding sex before marriage is further undermined by the fact that some of the participants report that at least some Pakistani migrants engage in sex outside of marriage. Furthermore, a small number of the participants' reported that some Pakistani migrants even engage in sex with multiple partners. This shows that there is incongruence between Pakistani migrant's perceived and actual risk of contracting HIV/AIDS.

More concerning than the denial of HIV risk in light of risky sexual behaviour is the finding that participants may be too embarrassed or ashamed to take measures such as buying condoms to protect themselves from HIV. The construction of sex outside of marriage as wrong and the association of condom use with wrongdoing may impact Pakistani migrants' ability to protect themselves from HIV because they fear that other Pakistani migrants will judge them for their wrong doing.

Literature suggests that men may be victims of traditional gender patriarchal norms which may encourage them to engage in risky sexual behaviour, such as having multiple partners (van der Walt et al., 2007). However, findings from this study suggest that this may not be the case among Pakistani migrants, since sexual prowess does not appear to be an important characteristic of the Pakistani construction of masculinity.

However, having said this, Pakistani constructions of masculinity nonetheless still seem to ascribe to the view that male sexuality is strong and urgent.

Respect, duty and responsibility towards one's family constitute an important aspect of Pakistani constructions of masculinity. It is this sense of responsibility to parents which plays an important part in deterring Pakistani men from engaging in behaviour which may constitute an HIV risk, such as promiscuous sex and drinking. However, an implication of this is that Pakistani migrants in South Africa may engage in behaviour that they otherwise would not have in Pakistan, since their parents are not in South Africa to regulate their behaviour.

A particularly interesting finding was the fact that participants' perceive women in Pakistan and in South Africa in completely opposite terms. Pakistani women are depicted as chaste and pious while on the other hand South African women are constructed as being responsible for the spread of HIV through their rampant promiscuity.

Finally consistent with literature which suggests that Asian and European migrants experience lower levels of xenophobia than African migrants, participants in the current study did not report xenophobia as a factor which prevented them from accessing health services, including HIV related services. However, in interpreting this finding one must bear in mind the extreme suspiciousness which the research met with while interviewing Pakistani migrants for this study. This indicates that while participants may not experience as much overt incidents of xenophobia, feelings of marginalisation and isolation do exist. It might be hypothesised that perhaps these feelings of marginalisation



and exclusion from South African society may in fact play a role in participants' reluctance to make use of public health care services.

### **Limitations**

This is an exploratory study intended as a first step to describing the relatively unexplored area of HIV protective behavior among Pakistani migrants and the factors which may affect such behaviour. The study only begins to examine issues relating to HIV risk and protection among Pakistani migrants. Hence, the findings of the study are modest and tentative and conclusions made on the basis of these finding must also be carefully tempered by consideration of some of the important limitations of the study.

Firstly, this study covers only a small convenience sample of nine Pakistani migrants. Hence, the generalisability of the findings to the general population of Pakistani migrants in South Africa or even the general population of Pakistani migrants living in greater Johannesburg is limited. However, having stated this, it must be noted that this study was not as concerned with the generalisability of its findings as it was with obtaining rich descriptive and anecdotal data which will form the basis for possible patterns, variables and hypotheses for further studies in the area of HIV prevention among Pakistani migrants (Neuman, 1997).

While the study did attempt to examine the level of HIV knowledge among the participants, this aim may have been better served by using quantitative methods, instead of the qualitative methods which were utilized. Hence, while this study was able to discover that participants possess basic awareness of HIV, it is unable to conclusively say

how low the overall level of HIV knowledge among the participants is, relative to other populations.

The sample for the current study consisted of only male Pakistani migrants, however as pointed by one of the participants it appears that there is a growing number of females Pakistani migrants entering South Africa. Hence it is of importance that a study be conducted to ascertain the perceptions of female Pakistani migrants regarding factors that influence HIV protective behaviour.

Another aspect of this study which might be considered a limitation by some, is the fact that as with all qualitative research, the data produced is not an objective report of a phenomenon under enquiry. Rather the researcher and participants together have contributed toward generating and creating knowledge on the subject of HIV protective behaviour among Pakistani migrants. Hence, as mentioned previously both the personal and demographic characteristics of the researcher and the participants have had an affect on the knowledge produced (Eagle, Hayes & Sibanda, 2006). However, since this study is based on the interpretive paradigm of research, this is not considered by the researcher to be a limitation of this study.

Finally, while participants' were able to communicate in English, difficulties in communication were experienced due to language differences. Hence, participants' may not have fully understood the questions put to them because of language barriers and conversely the research may not have fully understood the subtleties of participants' communications.

## **Recommendations**

In response to some of the methodological limitations of the study mentioned above the following recommendations are made for future research. It is recommended that a study utilising a larger sample should be undertaken, in order to determine whether themes similar to those in the current study emerge. Given the finding of strongly patriarchal ideas, about the role of women, among male Pakistani, it is recommended that a study employing a mixed sample of both male and female Pakistani migrants be undertaken. Further studies, will benefit by employing an interpreter. This might ensure that subtle but important information, which may have been lost as a result of language difference in the current study, is captured. Finally with regards to research design, it is recommended that quantitative instruments, such as an HIV knowledge questionnaire, be utilised in order to make definitive conclusions regarding the level of HIV knowledge of Pakistani migrants relative to other populations within South Africa.

This study highlights the fact that there is an urgent need to increase HIV knowledge among Pakistani migrants. It is therefore recommended that HIV education programmes be developed that specifically target the Pakistani migrant community in South Africa. Such HIV education programmes should focus on communicating to Pakistani migrants the fact that while promiscuous sex is a risk factor for HIV, one may contract the disease during sex with just one person, if that person is HIV positive. Inaccurate beliefs about the transmission of HIV, such as that it is caused by not washing after sex, must also be challenged. In addition, education initiatives should also stress the fact that though not a 100% effective in preventing HIV, condoms do provide a high degree of protection against HIV, if properly used.

While this study cannot be generalised to all migrants in South Africa, in light of the findings of this study regarding the rudimentary nature of HIV knowledge among Pakistani migrants, there is a probability that HIV knowledge is similarly poor among other migrant populations. Hence, as mentioned above, it is important to undertake research to establish the level of HIV knowledge among other migrant populations.

Given participants' low perception of HIV risk and the proven negative effect of this on HIV protective behaviour, it follows that intervention is necessary in order to ensure that participants gain a more realistic perception of their own risk of contracting HIV. In this regard, it would be necessary to actively challenge the view that that religion and culture protects one from HIV.

The stigmatising beliefs around HIV must be challenged so that it is made explicit that HIV is not a disease which only affects sinners. Rather many good and righteous people can and do contract the disease. Islamic religious leaders have a crucial role to play in this regard. Likewise, religious leaders may have a role to play in debunking the notion that condoms are associated with wrong doing.

The overly ominous and pessimistic view that HIV means imminent death must likewise be challenged. This view contributes to fear of the disease making it more likely that people will employ psychological defences such as denial of vulnerability in order to cope with their exaggerated fear of the disease.

The current study only begins to explore some of the ways in which social factors such as religion, culture, gender, migration and xenophobia may influence HIV protective behaviour. As argued through out this report, further research in this regard is of the utmost importance in the fight against HIV.

Finally, on a more practical level, it is necessary to ensure that condoms are easily and discreetly available. In this way participants will not be discouraged from accessing condoms due to fear of being judged or reprimanded by other Pakistani migrants.

### **Conclusion**

In final conclusion, it can be said that despite its limitations this study provides valuable information regarding the factors, particularly social factors, which affect Pakistani migrants' ability to protect themselves from HIV. This information has a number of implications not only for HIV prevention efforts but also for research both among Pakistani migrants and migrants of other nationalities.

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**APPENDICES**

**Appendix A: Participant Information Sheet**



**Appendix B: Interview Consent Form**



**Appendix C: Audio Recording Consent Form**

**Appendix D: Semi Structured Interview Schedule**

