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MA Sociology by Course Work

**WHITE FEMALE SCHOOLTEACHERS
PERCEPTIONS AND EXPERIENCES WITH
HIV/AIDS**

**This research report was submitted as partial fulfilment
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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
BBC	British Broadcasting Corporation
GDE	Gauteng Department of Education
HIV	Human Immunodeficiency Virus
HSRC	Human Science Research Council
NP	Nationalist Party
PWA	People Living With AIDS
SARPPCO	Southern African Regional Police Chiefs Cooperation Organisation
STD	Sexually Transmitted Disease
UNFPA	United Nations Population Fund
WHO	World Health Organization

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INTRODUCTION

HIV/AIDS is not a cliché that appears in thousands of newspapers, magazines, state policies and addresses throughout the world on a daily basis. Rather, it is a tumultuous epidemic with terminal outcomes for the individuals concerned, as well as for society in general. According to UNAIDS (2002) “...more than 60 million people worldwide have lived with HIV/AIDS since the beginning of the epidemic and 20 million of these have died. There is not a country in the world that is not affected by this fatal disease”. As South Africans, the most sobering thought is that our country is part of the region that is most severely affected. In the only national study of HIV/AIDS prevalence rates in South Africa, using racial groups as categories of analysis, it was found that 12.9% of Black, 6.1% Coloured, 1.6% Indian and 6.2% of White South Africans are HIV positive (Nelson Mandela/HSRC, 2002)¹. Based on the above, although the population mostly at risk is Black, cognisance needs to be taken of the fact that 6.2% of the White population is infected. This prevalence is higher than in ‘White’ populations in other countries (Nelson Mandela/HSRC, 2002). For this reason, combined with the widely spread perceptions that it is a ‘Black disease’ it is of importance to explore the experiences and perceptions of Whites in SA with regard to HIV/AIDS, of which, to the best of my knowledge, there is no substantial literature so far.

Aim

The focus of my research, however, will centre primarily on White female schoolteachers. I do not propose that my relatively limited exploratory research report will have any significant impact on the prevalence or incidence of this frightening epidemic within South Africa. However, I do aim to perform a thorough analysis of White female schoolteachers experiences and perceptions of HIV/AIDS; with the intent that it will awaken White women’s consciousness to an understanding that Whiteness is

¹ The ‘racial’ classification used in this research, is of historical origin. The use of the terms ‘Black’, ‘White’, ‘Asian’ and ‘Coloured’ indicates a statutory stratification of the South African population in terms of the now abolished Population Registration Act, 1950. The fact that the terms are used in this paper does not imply the legitimacy of this racist terminology, but it is necessary due to its sociological significance.

not a protective coat that encapsulates and protects one from the epidemic. White women are at risk, but they may not necessarily presume themselves to be so. For this reason then, my main **research question** is:

What are the perceptions and experiences of White women schoolteachers with regard to HIV/AIDS.

Rationale of the Study

Historically, HIV/AIDS has been perceived as a minority epidemic. Initially the gay population was held responsible for its conception and spread. Much of this emphasis has now been directed towards Blacks. In Africa specifically, HIV/AIDS has been adopted as a Black disease. Not surprisingly, the obvious reason would be because there are millions more Black Africans than there are White. However, if that were the only reason, then there would be no need for the vast and comprehensive interdisciplinary literature dissecting this social phenomenon. Although many academics such as Bradshaw (2002), Crewe (2001), Gilbert and Walker (2002), Nettleton (1995) and Pelser (2002) have focussed on the effects and repercussions of social inequality on HIV/AIDS, this theme will not be fully investigated in this study. My attention will, however, turn more toward the crisis associated with attaching labels to HIV/AIDS, specifically that of a Black label. The limitations of this label are that it tends to exclude millions of White South Africans from affiliating with this epidemic. The most alarming results emanating from the South African national prevalence study, as indicated earlier, were that of White South Africans, having a higher prevalence rate of both Coloureds as well as Indians. This prevalence rate of 6.2% is high in comparison to other countries such as Australia, France and the USA, where the prevalence among Whites is 1% percent or less (Nelson Mandela/HSRC 2002). According to these statistics, it would be grossly inaccurate to consider the HIV/AIDS epidemic in South Africa as a Black one.

This realization that White South Africans are six times more likely to be infected with HIV/AIDS than White Americans, White Australians and White Frenchmen, is reason enough to question the perceptions of White South Africans regarding HIV/AIDS. What makes White South Africans so vulnerable to this disease? More importantly, I

wonder if White South Africans realize just how vulnerable they are? It is not my intention to downplay the seriousness of the prevalence rates amongst Black South Africans, or any other group for that matter. It is my objective, however, to highlight the situation amongst White South Africans, as I have come to realize that this is a tremendously under researched and unacknowledged catastrophe. What I aim to investigate is that not only do government and local NGO's ignore these statistics and seem unaffected by it, but so too, do White South Africans themselves. In an article published by e-health, entitled 'The Silent Killer', the author comments that "It's exactly this "unaffectedness" on the part of the South Africans, especially White South Africans, that has fed into the vicious cycle of stigma, denial, ignorance and silence" (2003). A baseline study of 2 500 people nationwide, was commissioned by the Department of Health to inform its new communication campaign, Khomanani. Reporting the campaigns findings in an article published by e-health, 'Whites feel less at risk of AIDS', they state, "White respondents were less likely to perceive themselves, their peers or partners as being at risk of contracting HIV/AIDS, and therefore may take less interest in the issue"(2002). The lack of interest being paid to HIV/AIDS by White South Africans does not stop the pandemic from spreading. This White silence must be broken by awareness and acknowledgement that all are susceptible to HIV/AIDS, as well as its social implications.

In a survey carried out by Soul City (2002), and reported by e-health (2002), it was found that 67% of African and Coloured respondents believed they were at risk, while 63% believed their partners to be at risk. In contrast, only 35% of White respondents believed they were at risk and 30% believed their partners were at risk. With such a low HIV/AIDS risk perception percentage, I feel it imperative to research who White woman perceive to be at risk and what their actual experiences of HIV/AIDS are. The importance of this research is that it will specifically focus on Whiteness as it relates to HIV/AIDS; an area that has received little attention, but which I hope to explore as a significant contributing factor to HIV/AIDS risk denial and lack of association by White South Africans. I will investigate the meaning that White South African female schoolteachers attach to Whiteness, and how this Whiteness is used, most times

unconsciously, as a divider, and protector that keeps one from various social conditions, in this case, HIV/AIDS.

Objectives

The main objectives of the study are to explore the following:

- what experiences white school teachers encounter
- who White female schoolteachers perceive to be at risk
- what these respondents perceptions of HIV/AIDS are
- contributing factors which aid in this perception formation
- how these perceptions are maintained
- how these perceptions contribute to personal risk identification
- how often unconscious, yet normative thoughts of whiteness, influence white schoolteachers perceptions and experiences with HIV/AIDS.

LITERATURE REVIEW & CONCEPTUAL FRAMEWORK

This chapter is organised around the various themes guiding this study. The literature presented, therefore, focuses on these themes in an attempt to provide the conceptual framework within which the findings of the study will be analysed and discussed.

Whiteness

An understanding of what is meant by the term Whiteness is imperative to a conclusive comprehension of this research. However, before elaborating on this subject, it is vital that cognisance be taken of the fact that race is a social construct. This construct is explained by Roediger when he states “Race is given meaning through the agency of human beings in concrete historical and social contexts, and is not a biological or natural category”(Walker, 1999:47). Hence, as stated by Walker, “...race is a category which is constantly being made and remade” (1999:47), depending on the social circumstances and people involved. This same categorization can be applied to the studies of Whiteness. Steyn describes Whiteness as “...socially powerful, privileged positionality, not a naturally bounded group of people” (2001:6). Here Steyn emphasises that Whiteness is more of a social position. Frankenberg suggests that Whiteness has three linked dimensions. “First, Whiteness is a location of structural advantage, of race privilege. Second, it is a standpoint, a place from which White people look at ourselves, at others and at society. Third, Whiteness refers to a set of cultural practices that are usually unmarked and un-named” (1993:1). Frankenberg clearly explains that Whiteness is used as a position of power, a frame of reference and a behavioural guide. These definitions indicate that as Whites, much of what we do and say originates from our social construction of Whiteness. The most publicised and documented attribute that is associated with Whiteness is that of privilege and power. Solomos and Back (1996, 2000), Steyn (2001) and Frankenburg (1993) adequately expound on White privilege and how it fosters an air of superiority and breeds discrimination. Most authors on the subject tend to group White and Whiteness as the same category, in the sense that the

characteristics of Whiteness are most often, if not always, attached to White people. A distinction needs to be made between White and Whiteness, even though both are socially constructed. Being White primarily refers to one's race, where Whiteness on the other hand refers more to a position of power and superiority, an attitude which often accompanies being White. Not enough distinction has been made in this regard.

Whiteness studies seem to be divided amongst two schools of thought. Walker describes this distinction; "On the one hand scholars in the field are concerned that studying Whiteness will simply lead to or be seen as a reassertion of White power and privilege and therefore such scholars are at pains to preface their work with avowedly anti-racist disclaimers. On the other hand, it has been greeted as the need for White academics to rid themselves of guilt associated with their race, in part resulting in the 'new abolitionist racial project'" (1993: 48). Often these academics from both schools of thought, claim not to homogenise Whites as a whole, however, I find that the underlying assumptions to be quite contradictory. Being White tends to mean that you consider yourself to be superior and that most of what you have attained to in this life has come because of your ability to manipulate your White power. While this is most certainly true for many Whites, it is most certainly false for others. I fully comprehend that as a White South African growing up in the apartheid era, I was afforded tremendous privilege, most of which continues to advantage my life today. I am aware too of the atrocities that have befallen millions of so called 'marginalized' human beings throughout the world and throughout time. However, for the purposes of this research, attention must be placed on the reality that not all Whites intentionally and overtly use their position of Whiteness as a tool to discriminate and to gain advantage. Many White South Africans are guilty of practising Whiteness, but I would argue that, much like any other 'socially constructed' phenomena, this is often performed unconsciously.

"Newitz (1997) in a study entitled "On the Whiteness of the police" points to the normative notion of Whiteness, where Whiteness and its associated entitlement is presumed natural, it is seen as tantamount to having 'no colour', as invisible" (Walker, 1999:48). White South Africans were historically taught to be superior, and this behaviour became normative and 'invisible' as the White skin colour. While many White

South Africans continue to use their skin colour as a justification for dissonance, gain and privilege, I would hypothesize that much of this behaviour occurs because it is associated with White normative behaviour, which is not fully comprehended and realized by many White South Africans. This has particular relevance to my research as Whiteness not only affords one privilege, but this superior position, allows Whites to distance ourselves from social dilemmas that are predominantly set aside for the marginalized. Whiteness would have you believe that crises such as HIV/AIDS do not frequent with positions of advantage. Therefore, for many White South Africans who often unconsciously embrace whiteness, the notion of being infected with HIV/AIDS appears quite foreign, as it does not seem to fit into the whiteness frame of reference.

This study will demonstrate how often unconscious, yet normative thoughts of whiteness, influence white schoolteachers perceptions and experiences with HIV/AIDS. This report will explore the type of experiences that the schoolteachers have, as well as how these encounters take place. These encounters have a direct influence over the perceptions of schoolteachers. Their exposures can either lead to the adoption of risk perception or denial. It would appear that the majority of schoolteachers do not associate themselves with HIV/AIDS in anyway. Not associating oneself with specific social disorders could be as a result of denial. This attitude may be adopted due to an overt decision, or as a process of unconscious social learning. For this reason I feel compelled to explore the perceptions of White South African women in order to discover a possible cause/s for this denial. By analysing the perceptions of White women, it will shed light on some of the sociological reasons as to why this denial occurs.

In a study performed by the Institute for Justice and Reconciliation, respondents were asked to state their level of agreement with regards to the following statement, “In the past, Whites profited greatly from Apartheid, and most continue to profit today from the legacy of Apartheid” (2003). The report states that less than one quarter of Whites (22%), compared to just short of three quarter of Blacks (74%), agreed with the statement. The report indicates that almost 50% of all White respondents felt that they had not profited from apartheid and do not continue to profit from it today. In my opinion, it is quite obvious that White South Africans profited from apartheid. We were

allotted superior schooling, public facilities, freedom to vote, luxury housing with a flushing toilet and running water and perhaps one of our greatest advantages was the fact that we were validated and respected as intelligent human beings. It seems unthinkable that White South Africans could deny this advantage. This study will indicate how denying this advantage is closely linked to the fact that most White South Africans deny that they are at risk of contracting HIV/AIDS, on the basis of their whiteness. This denial of advantage indicates that Whites in South Africa under the apartheid rule, were raised to believe that we were the superior race.

This ideology was not only presented and subscribed to by government, but religiosity was also used as a form of validation. According to Boonzaier (1988) “Religion has the ability to create moods in the minds of humans and to provide justification for action”. The government used the Dutch Reformed Church (NGK) in the apartheid era, to validate and justify these notions. The colonial pioneers also used religion as a means to authenticate racist ideologies. According to the Journal of Social History, “Black South Africans had not forgotten the insidious accusations of white supremacists—from nineteenth-century missionaries condemning libidinous “heathen” to twentieth-century segregationists persecuting so-called dirty and unfit Bantus—who attributed promiscuous sex and reckless death to tribal appetites” (2003). Religion helped to formulate horrendous ideas of Black people being innately inferior and promiscuous. Whites often fell into the trap of believing that as the superior race, wealth, prestige, employment, superior public facilities and good fortune, to name but a few, were ours for the taking. This superior standard of living, with all its rights, privilege and divine destiny, became somewhat normative. Just as customary as it was to view Black South Africans as somewhat less important and not quite as intelligent as our White selves. Being White meant/means that there were certain standards that we were afforded, conversely, there were also certain conditions that we were not affiliated with.

This report will indicate, that HIV/AIDS is one of those conditions that in general, White South Africans do not associate themselves with. This inability for White South Africans to associate themselves with HIV/AIDS risk, will be suggested as stemming from a position of Whiteness. In Elizabeth Walkers thesis on The South African Society

of Medical Women, she explores how the society constructed themselves as White, thereby ‘inadvertently’ and what seemed to be quite naturally, excluding all Black female doctors. She comments that apartheid was able to construct a separate society, “If one of the aims of apartheid was to construct a divided society in which people existed in their own worlds, unaware of, and unconcerned with, the lives of others, then the SASMW is one example of this achievement. Black people generally were not part of its frame of reference, socially, politically and importantly, professionally”(1999). She further explains that many of the White doctors lived in a world where “...Whiteness was all that there was. This is perhaps best summed up by the following statement made by the current president of the South African Medical Association, “We were White and privileged but never recognised it”(1999). Not taking cognisance of this privilege forms part of the social denial. The SASMW is a good example of a group that were able to almost completely remove Black South African women from their organization as well as their “frame of reference” (Walker, 1999). Black medical doctors were then seen as the ‘other’, subject to other experiences and conditions. As indicated, the SASMW did not recognize their social privilege and were able to formulate their organization and their ideologies around Whiteness; which I would hypothesize that the majority of White South Africans embraced. Hence the ease with which White South Africans adopted the acceptance of privilege and being able to disassociate themselves with that, which was not, considered White. Today that denial is manifest in the lack of HIV/AIDS risk perception amongst the majority of White South Africans.

Stigma

If termination of life is not enough consequence for being HIV positive, stigmatisation is surely a dreaded bi-product. The Stigma that people with HIV/AIDS face are unusually multiple and complex. This bias is not experienced only because of a persons HIV status, but also because of all that this status connotes. Many of these overtones cause inequalities to arise, affording its bearer a devalued social order. According to the WHO (2001), “HIV/AIDS-related stigmatisation is not something that simply springs from the minds of individuals, it is instead linked to power and domination in the community as a whole, playing a key role in producing and

reproducing relations of power and control”. This chapter will deal with some of the specific stigmatised ideas fostered by the researched teachers.

Ndivhuwo Masindi states that “Stigma is thus an attribute used to set affected persons aside from the normalized social order, and the separation involves an implicit devaluation” (2003). This result of stigmatisation as described by Masindi I feel has specific relevance to the White population and their perceptions of HIV/AIDS, as it removes Whites from their social order of Whiteness and privilege, rendering them with what Goffman calls a “spoiled identity” (Aggelton & Parker, 2003:14). Williams elaborates on Goffmans work by stating that “...today the term is applied more widely to any condition, attribute, trait, or behaviour that symbolically marks the bearer off as ‘culturally unacceptable’ or ‘inferior’ and has as its subjective referent the notion of shame or disgrace” (Williams, 1987: 136). According to Goffman, stigma is “...an attribute that is significantly discrediting” (Aggelton et al 2003:14). Aggelton and Parker elaborate on this discrediting attribute by stating that it “...serves to reduce the person who possesses it” (2003:14). By being stigmatised through the diagnosis of HIV/AIDS, Whites stand the chance of losing their position at the top of the social hierarchy, ‘as HIV/AIDS is not something that Whites have’, thereby ‘reducing’ Whites as ‘culturally unacceptable’ which is accompanied with ‘shame and disgrace’. This position of Whiteness as described by Frankenburg, “...signals the production and reproduction of dominance rather than subordination, normatively rather than marginality, and privilege rather than disadvantage” (1993:237).

In order to maintain this ‘normative’ position in society, it is easy to associate ‘others’ with the disease. “The tendency to view HIV and AIDS as something which happens to other people, and particularly to people who are ‘different’ either in their behaviour or their sexual orientation, can lead to a stigmatising response by society” (Carlisle, 2001: 119). This perception that ‘AIDS is what happens to others’, needs additional attention urgently with regards to White South African women. In a statement made by the UNFPA executive director (2003), she declared that “Among the main reasons, in addition to the shameful shortage of resources to fight HIV/AIDS, is the persistence of stigma and discrimination against those infected. This outrageous violation of basic human rights drives the disease underground, crippling efforts for

prevention, treatment and care”. White South Africans are not as affected by the lack of treatment and care, as a large majority of those registered with medical aids are White. However, the stigma attached to being infected with HIV/AIDS, is seriously “...crippling efforts for prevention”(UNFPA, 2003) amongst White South Africans, as HIV/AIDS is seen as a Black disease. Schoepf joined with colleagues to form an organization known as CONNAISSIDA. They performed research in various areas in Africa, including Kinshasa and Lubumbashi. Amongst their results, they found that “...racism, poverty, inequality, and gendered discourses about AIDS hamper prevention” (2004). If the ‘crippling’ effects of stigma are not addressed within the White community, prevention efforts will go unnoticed, steadily increasing prevalence levels of HIV/AIDS. The statistics show that this is obviously not an ‘others’ problem, but one involving ‘us’. The social construction of stigma will offer some understanding as to reasons why White South African women do not associate themselves with HIV/AIDS.

Historically, this is not the first time that Blacks have been associated/accused with sexual promiscuity. Along with the colonisation came racism. The White Europeans perceived themselves to be superior to all Blacks. “Africans were primarily migrants whose health was only important insofar as it determined their fitness to labor and suitability for contact with the White population” (Jochelson, 1991). As long as the Africans could perform their duty with as little contact as possible, then the Whites had little concern. Adding to the dilemma for Black Africans is that “...medical services were concentrated in urban areas to ensure that the current workforce was healthy” (Jochelson, 1993). This was of little help to the thousands of women in the rural areas who were infected by their partners before returning to the urban areas. Obviously, this lack of medical provision by colonial rule meant that people were not receiving adequate medical attention, treatment or diagnosis, which lead to the further spread of STDs. It is no wonder that sexually transmitted diseases have historically been pinned on the Black population. Medical facilities were scarce and in many cases, nonexistent, which affords little resistance to the rapid spread of any infection. Unfortunately, this dilemma continues to exist today. So too does the stereotype that Blacks are synonymous with sexually transmitted diseases, more commonly known today as HIV/AIDS. I am not

debating the fact that more Black South Africans are HIV positive than White South Africans.

Risk Perception

In order for risk perception to be realized, for what ever condition (e.g. lung cancer or HIV/AIDS etc), one has to be open to the fact that belonging to a risk group is a possibility. I would hypothesize that the majority of White South African women do not perceive themselves to be at risk as far as HIV/AIDS is concerned. They are content in their perceptions that it is 'others' that are at risk. Due to the fact that this 'Black' HIV/AIDS stigma exists, I feel that it has significant influence on White women's perceptions today. A significance that causes separation from those suffering with HIV/AIDS, a separation from responsibility, a separation from blame, as well as formulating distance between oneself and the epidemic. It would appear that the fear of risk and the blame for it spreading rests solely with the 'Blacks' or the 'other's'. Carol Goldin comments on this 'blaming behaviour by stating, "One consequence of such identification is that it allows the rest of society to simultaneously assign blame, and through contrast, define their own innocence. The contrast of innocence/guilt poses a serious health threat because it allows individuals to disassociate themselves from the disease by disavowing membership in identified risk groups. The identification of risk groups has a potentially stigmatising result, as risk groups are identified through prevalence statistics. Naming these groups can have a catch 22 effect. Bringing attention to their risk, labels are often attached to this particular group, which carries unintentional social connotations.

Persons with AIDS who are not members of perceived risk groups may be described as 'innocent victims' (Goldin, 1994: 1360). As White South Africans this feeling of innocence persists with HIV/AIDS, as most Whites feel blameless for its spread. Not only do most Whites feel innocent, but they too feel like victims. Not victims of HIV/AIDS, but victims of its numerous social effects, such as struggling economy and crime. Being White, allows one to have a false sense of security by not associating oneself with risk, which results in this feeling of what Goldin suggested as

‘innocent victims’(1994: 1360). Discussing the influence of race on perceptions, Emile Boonzaier suggests, “...even when ‘race’ is not explicitly used, it is clear that ideas and assumptions about innate racial differences permeate much of our thinking” (1988: 59). Race then becomes the determining variable with regards HIV/AIDS perceptions. Boonzaier elaborates on this race paradigm by stating, “Like religion, it has the ability to create moods in the minds of humans and to provide justification for action” (1988: 65).

Simply being White may be reason enough for ‘justification’ that HIV/AIDS is not your risk. I wish to present the fact that this isolation from catastrophe is not a new phenomenon associated with White women. The effects of an apartheid government continue to filter into our perceptions and therefore our actions, on a daily basis; allowing White South African women to feel as previously indicated, ‘innocent victims’. Apartheid no longer exists, however, its consequences still linger. In describing the apartheid vision, Posel (1987) states that it embodied “...a set of [Christian Nationalist] principles and standards according to which the moral and social meaning of apartheid policies was interpreted and justified, and the identity of White subjects was constituted. Political, economic, social, cultural and sexual segregation were cast as divinely ordained, historically vindicated and the foundation of a just and harmonious society. ‘Being White’ meant being socially and culturally distinct, politically and economically privileged and physically segregated from those who were not” (Sharp, 1988:82). It is irrational to believe that with the emergence of a new democracy that society would automatically give birth to a new paradigm and bury the ideologies that governed our suppressive and discriminatory past. Sharp maintains that many of these ideologies became ‘common sense’. He states, “Many White South Africans would have denied, and will still deny, the representational nature of this vision. But this illustrates no more than the success with which the apartheid ideology has spun a web of meaning around the interests, aspirations and fears of White South Africans to the extent that this vision of society appears as part of their ‘common sense’” (1988:82).

Changing what was once ‘common sense’ requires time and a transformation of vision. Not all White South African women have had this paradigm shift. Therefore, many of them still foster the ‘innate’ ideologies that were presented as normative,

through the apartheid era. I would conjecture that these ‘normalized apartheid’ thoughts is one of the reasons as to why HIV/AIDS has been dismissed as belonging to the ‘others’, and why many White women do not perceive themselves to be at risk.

History has contributed much to the stigmatising of HIV/AIDS as a Black Disease. Blacks were perceived to be “potentially diseased” (Jochelson, 1993), hence the desire for segregation and discrimination. “The STDs were perceived to be so rampant in sub-Saharan populations which led to the direct inference that Africans were by nature promiscuous, hence constitutionally predisposed to immorality” (Setel, 1999:7). In fact, Blacks were alleged to be so contagious and diseased that “...handling of cutlery, crockery, or even sheets by domestic servants was sufficient to infect an entire White household” (McCulloch, 1999:198). This aura of superiority, lead to the marginalisation of Blacks in almost every social, political and economic sector. When seeking employment, which meant migration from rural to urban areas, Blacks were “...vaccinated, obliged to have baths, wash their clothes etc and undergo a medical examination” (McCulloch, 1999:203). It was automatically assumed by the colonial settlers, that Blacks were dirty and “a walking reservoir of disease” (McCulloch, 1999:202). These ‘diseased’ human beings were denied proper medical attention and facilities. “Segregated facilities” (Jochelson, 1993) appeared throughout South Africa and Zimbabwe, which were supported by the local governments. The spread of sexually transmitted diseases was a huge threat to the European settlers. However, they were not prepared to provide the facilities necessary to manage the disease or care adequately for its victims.

A ‘Black’ Disease

The media and others have done an incredible job of portraying the disease amid Black people. This depiction has in some instances lead to the disease being categorized as a ‘Black’ disease. Nancy Coulsons (2002) research amidst HIV/AIDS campaigns, namely Soul City, loveLife and Beyond Awareness I and II, serves as a foundation in exploring the impact of the media on HIV/AIDS. She highlights the success of the campaigns, identifies their target audiences, as well as offers suggestions for future

implementation. According to Coulson (2002), these campaigns focus almost entirely on Black Youths. This racial portrayal by the media, gives light to a possible reason as to why White Female schoolteachers do not perceive themselves to be at risk, and place the emphasis on Black South Africans.

Accusations that HIV/AIDS is a 'Black' disease, have even entered into politics. When our then minister of health, Dr Zuma, while debating Virodene, suggested that the Democratic Party (DP) does not care about Blacks, and would be happy if they all died (Crewe, 2000: 22). Not only was Dr Zuma making a huge generalization about the entire Democratic Party and its members' views, but she was also indicating that Virodene was only something to be used by Blacks, being the only race living with HIV/AIDS. This type of debate issues the HIV/AIDS epidemic with a face, a Black face. Mary Crewe comments on this racial classification by stating "There are also the conclusions arising out of a racial categorization of the epidemic, fuelling White perceptions that this is a Black epidemic and evoking a response from the Blacks that AIDS is a White-created ploy to halt population growth among Africans. While these may now seem less important and less obvious than they were a few years ago, they still surface and are still obstacles to AIDS education" (2000:34). This whispered, mistaken message is loud and clear; it is Blacks that have HIV/AIDS; some even go so far as to say that Whites invented it. It is communication such as this that has contributed to the stereotyping of the disease. I believe that this is one of the reasons why many Whites have become complacent in their perceptions of HIV/AIDS. Complacent in the thought that they are not at risk, because they are not Black.

When we turn on our televisions, flip through the pages of popular magazines, and walk through the halls of government hospitals, it is not sickly White faces that have been depicted as dying of AIDS, but those of Blacks. Little to no attention has been given or focused on White South Africans as a risk group. Somehow Whites seem to have removed themselves or been removed, from the HIV/AIDS risk groups. The media is not the only institution responsible for excluding the White population from their scrutiny; academia is equally as responsible. It is almost impossible to find statistics, messages or theory directly relating to White South Africans involvement with

HIV/AIDS. It is my experience as a White South African woman, that Whites themselves, have little personal association of risk in connection with HIV/AIDS; even though relatively speaking, we are 6 times more likely than White Americans to be HIV positive. In 2003 the Nelson Mandela fund commissioned the HSRC to carry out an extensive research, in order to obtain reliable information about the prevalence of HIV/AIDS and the scope of its influence. My immediate reaction to the statistics was that of shock, due to the high prevalence rate amongst White South Africans. I am not sure whether I was more shocked by the statistics or by the fact that I was so shocked by my reaction to the statistics. Numerous Professors were approached on the subject. Surprisingly, they too were just as astonished by the statistic as I was. I realized then, that I too had labelled HIV/AIDS as a 'Black' disease. Our President, Thabo Mbeki, has also gotten involved in this race categorization, "President Thabo Mbeki of South Africa has caused a race row by making a scathing attack on whites who link HIV/AIDS to the alleged promiscuous and predatory behaviour of black Africans. Mr Mbeki turned a parliamentary debate on HIV and rape into a broadside against "bigots" who he said regarded blacks as "sub-human disease-carriers". (The Guardian, 2004). While the appropriateness of such a accusatory statement made by the President of South Africa, is not under scrutiny here, it is clear that he and many more do believe that a racial categorization has occurred with regards HIV/AIDS.

Dressler "concludes that skin colour is a kind of 'master status', which serves as a criterion of social class in colour-conscious societies" (Bartley, 2004:155). Classing HIV/AIDS as a 'Black' disease is incorrect, however, this study will indicate how such a classification is not done at random. Therefore, the experiences that the teachers are subject to, become of paramount importance, in not only dispelling HIV/AIDS as a 'Black' disease, but also in the perception of personal risk. I am fully aware that the majority of Black South Africans bare the brunt of this devastating epidemic. What I will argue is that common premise that HIV/AIDS is a 'Black' disease, is in the South African context, an altogether false and a dangerous notion for White South Africans to foster.

The concepts explored within this chapter, will form as a guide in the analysis of the findings outlined in this study.

METHODOLOGY

Neuman states, “when dealing with exploratory research that is new or researchers had written little about, you begin at the beginning” (1997:19). This is truly indicative of this study. With little known about White South Africans and HIV/AIDS in general, this study will serve as a foundation to additional, much needed research. Neuman continues by stating that “Exploratory research rarely yields definitive answers. It addresses the “what” question” (1997). Hence this report, will be focusing on what White schoolteachers’ experiences and perceptions of HIV/AIDS are. Though some suggestions are presented as possible reasons for the ‘what’, ‘definitive’ explanations were not explicitly explored in their entirety. Each of the explanations offered, need intentional research in order to offer a comprehensive explanation. All of the respondents offered some sort of personal experience as a form of retort. These experiences shed light on the ‘what’, enabling the study to take a more inclusive, yet still limited look at possible reasons for the ‘what’.

Analysing White women as a holistic group is far too generalized and adventurous a project to undertake. For this reason a concentrated effort was placed on White female schoolteachers. This was done for a number of reasons. Firstly, by using schoolteachers, it allows a concentrated access into a specific group. It divides the vastly diverse group of white women, into a specific target category, easily accessed. Secondly, I feel that schoolteachers have a powerful voice, with the ability of transferring overt as well as latent messages to the youth of South Africa.

Even though the teachers interviewed are all White Female South Africans, generalized perceptions cannot be transferred onto all White South African Females. “Usually the results of such qualitative research cannot be generalised beyond the respondents who contributed to the study. However, we may be able to identify *one* reason for silence on the topic and explore it further” (Greenstein, 2003: 4). More than one topic has been identified as a possible reason for the HIV/AIDS silence/denial. This was only made possible because of the personalized approach adopted with each

interviewee, allowing the responses to come from a more casual conversation rather than a fully structured question-answer session.

No other criterion was adhered to, besides that of race, sex and occupation. Due to the nature of the study, these criteria were imperative.

Respondents

All respondents were accessed through the relevant schools. Due to the fact that I did not have much control as to who was interviewed within each school, race and occupation remained the only criteria. The average age of the participants was forty six (46). I was not able to influence this age structure in any way, as each school drew up their own interview roster, keeping only those two classifications in mind.

Although the respondents were gathered from two different locations, all of them appeared to be from middle income groups, living in predominantly white, middle to upper class suburbs. All of the participants were fully qualified teachers, who had obtained at least a higher diploma in Education. The total number of participants was twenty four (24). Ten teachers were obtained from one school and fourteen were obtained from the other.

Nature of Schools

Two schools were utilized in order to obtain the required amount of respondents. Both schools were extremely different in their composition. The one, being occupied by predominantly Black students, and the other, by predominately White. They were both however, Government Primary schools, concentrating their efforts on children from grades one to seven. One of the schools had a pre-primary attached to it. These schools were also situated in vastly different areas. The school with a majority of white students enrolled was situated in the Northern Suburbs of Johannesburg, while the other was located in the South, in close proximity to Soweto. While both were Model C, government schools, the school situated close to Soweto, predominately occupied by

Black children, was one considered a ‘White School’ under the old NP government. Due to the fact that this was not a comparative study, emphasis has not been placed on any differences. When conceptualising this research, it was thought that this would be a significant factor. However, difference was only evidenced in the types and frequency of experiences the teachers encountered with the students. All other perceptions and experiences remained alike. For this reason, no comparison has been made in order to differentiate between the schools. This however, could generate significant findings if a more exhaustive study were conducted.

Data Collection Methods

In exploring a sensitive issue such as people’s perceptions of HIV/AIDS, it is essential that this be done in an open and responsive environment. For this reason a qualitative approach to the methodology was adopted, in order for a more thorough understanding of the subjected matter to be developed, as “Qualitative research usually involves the collection and analysis of in-depth information on a smaller group of respondents” (Greenstein, 2003:4). For this reason, in-depth interviews were chosen as the preferred method of gathering information. Greenstein states that “in-depth interviews have the potential to yield great flexibility, to secure personal comfort/feeling of ease, allow for the preservation of anonymity, as well as allowing the time and space for participants to share in shaping the interview in the direction to which they are most concerned or interested in” (Greenstein, 2003:57). Fontana and Frey, and Atkinson suggest too, that a flexible, adaptable, non-imposing and negotiated approach is the best method to employ in order to facilitate the emergence of the ‘truly’ particular and individualistic understanding of participants (Fontana & Frey, 2000: 654 & Atkinson, 2002: 131). This approach was imperative. In-depth interviews, using open-ended questions, allowed participants to share personal experiences, which highlighted the ‘individualistic understandings’. This method also permitted me to distinguishing “...between what people ‘say’ and what they ‘do’. Sometimes we say one thing but our actions are exactly the opposite” (Greenstein, 2003: 4).

This approach allowed for semi-structured interviews. By so doing I was able to attach greater insight into the experiences and thoughts shared. An interview schedule was used, which allowed the participants flexibility to structure the process, as they felt comfortable. Each of the respondents was asked the same questions. However, these questions were structured very differently, in order for a personalized approach to govern the procedure. This method also allowed the respondents to feel at ease, by dispelling traditional power relationships that can be experienced between interviewer and interviewee.

Interviews were the predominant form of information gathering. The only other process used was that of examining the official document adopted by each school, with regards to their HIV/AIDS policies.

Analysis

This process took on a continuous nature. Due to the fact that each interview was individual by nature, initial analysis after each interview was imperative. This was not comprehensive, but rather constituted of notes and impressions gathered during the interview process. This type of timely analysis allowed for the early recognition and exploration of themes. Most of the analysis, however, was undertaken upon the completion and transcription of the interviews.

All interviews were recorded, with the permission of the participants. They were then transcribed verbatim, in order to minimise personal interpretation. Initial notes were documented and attached to each interview, recording themes and sub-themes. The bulk of the conceptualisation took place upon the division of the interviews into the dominant themes. It is important to note that each interview was thoroughly read through at least five times, in order to crystallize the topics. A self-created word programme was produced which allowed for the clear division of themes with accompanying quotes from the respondents, in order to substantiate the findings. Once the division into the various categories was accomplished, quotes from academia were added to the respondents responses, to add insights and explanation. These tailored notes, formed the basis of my

analysis, and allowed for a congruent argument to develop, in a structured, precise manner.

Being able to study the information in an organized, logical manner, gave rise to the emergence of additional sub-themes. These sub-themes often formed as a partial explanation for a predominant theme, thereby allowing for a broader understanding of the topic.

Personal Experience with Research

Neuman states that exploratory research can be “...difficult to conduct because there are few guidelines to follow. Everything about a topic is potentially important” (1997: 19). For this reason, it was imperative that my own personal bias did not influence what the interviewee expressed. While such dialogue is imperative for the free flowing of thought, it did however, present a certain amount of discomfort. Due to the fact that all the respondents were white females, I was often submitted to the ‘group’ through sheer racial and sexual categorization. Terms such as ‘us’ and ‘them’, often included me in their presumed shared perceptions. This dilemma often left me feeling quite uncomfortable, as I was faced with the choice of dispelling preconceptions at the cost of rich research. This is an extremely difficult dilemma to deal with. Thankfully I had a few gracious friends who allowed me to practice interviewing skills on them. Through these experiences, I quickly learned that almost any expressed opinion on my part, severely affected the respondents answers and honesty. There were times that I felt quite uncomfortable belonging to the ‘group’, but realized the discomfort would yield far more beneficial results.

On a few occasions, once the interviews had ‘ceased’, I was able to engage on a more personal level with a few of the respondents. Many questions that were not able to be answered during the interview, were discussed by some later. I found these encounters to be stimulating and thought provoking, often leaving with a feeling of gratitude that attitudes and perceptions about HIV/AIDS had been questioned.

Ethical Issues

There are a number of ethical issues that have relevance to this particular study. The following issues have been adapted from Neuman (1997) as well as Punch (2000):

Consent

This was obtained from both the respondents and the schools involved. Communication with the school principals was of substantial benefit. With their endorsement, access to the teachers became freely available. Although explicit permission was not required by the various school authorities, respect for their jurisdiction yielded a relationship of trust and helpfulness. My encounters with the principal, or vice-principal, proved to be hugely beneficial, as they served as my primary contact with the teachers. In both cases, it was the principals who arranged for all of the interviews. Express permission was not required from the principals, as the school was not being used in the study. However, because many of the interview were conducted in school time and on the school property, this authorization was imperative. Due to the fact that I was welcomed with such support, this did not present any sort of problem.

At the commencement of each interview, every respondents was briefed as to the reason and purpose of the research, how it will be used, as well as the expected duration of the study. They were also instructed that their identities would be kept private. Each respondent was reminded of their voluntary status and informed that they could withdraw at any time without penalty. They also agreed to the taping of the interview. These disclaimers were presented on an official document, and signed by each teacher.

Privacy, Anonymity and confidentiality

In all cases, the respondents have been kept as nameless individuals, unless consent has been given. None of the respondents gave permission to use their names, therefore, all remain anonymous. This includes not naming the schools involved. As the researcher, I feel that this is imperative for this particular study, especially due to the fact

that the Principals organized the interviews, and that most of them took place on the school premises. It was imperative that the respondents be reassured that their responses would not be scrutinised by their superiors, thereby jeopardizing their employment or reputation. Therefore all forms of privacy, anonymity and confidentiality have been upheld. As the sole researcher, all information has only been accessed by me, and I am the only one with access to the tape containing the recorded interviews.

Excerpts from the transcripts have been included in the report so as to allow for participants' 'voices' to be present in the report. Atkinson affirms that the 'giving (and sharing) of voice' increases the validity of research through aiding internal consistency (Atkinson, 2002: 133). Despite the fact that these 'voices' have been used, much effort has been utilized in order to maintain the anonymity of each respondent quoted.

Ownership of Data

Respondents, including the schools they are employed by, will not have ownership rights to the data obtained. Several of the respondents have requested to read the findings. No commitment was made, however, to distribute any copies. If contacted by any of the respondents, access will not be denied.

Harm and Risk

None of the respondents have encountered any form of harm or risk, due to their participation in this study. All physical environments were secure and safe. The greater concern was that teachers would not encounter any emotional or mental harm or risk because of their involvement. I believe this too has been accomplished. While many of the experiences shared were very personal by nature, at times accompanied by tears, they could not be considered as harmful. These experiences were shared out of personal desire and not under duress.

Limitations Of The Study

The information presented in this study has encountered several limitations. These will be discussed below:

Scope of Study

For the purposes of this study, twenty-four respondents was a sufficient amount, enabling sound findings to be revealed. However, in order for the study to have relevance to the more general population of White South African Females, a far more extensive study needs to take place.

As the sole researcher, my funds and capabilities are limited. This topic requires the concerted effort of numerous researchers with financial backing.

Recalling Personal Experiences

The experiences quoted in this study have been directly quoted by the respondents themselves. Cognisance must be taken of the fact that when recalling facts and feelings from history, events are open to current persuasion. Inconsistencies have not expressly been sorted out, except if opinions expressed contradict an experience previously shared. This incongruence of opinion has then been pointed out.

Age of Respondents

The mean age of 46, is substantially older than what I had originally planned for. Unfortunately, I did not have too much control over this fact. There was a large scope of ages represented, ranging from 25 to 63. This difference is not ideal, as it introduces substantial variation into the group. Those at twenty-five, would have encountered far different experiences to those of sixty-three. Future studies need to scale down on the generation gap in order to obtain relevant information for a specific group.

ANALYSIS OF FINDINGS

Experiences

Of consequential influence to the varied perceptions that white schoolteachers foster about HIV/AIDS, are the experiences that they encounter. In most cases, these experiences directly impact on the respondents risk perceptions, whether that be of self or others, on their desire and actual commitment to render community service, as well as aid in the nurturing of stigmatised attitudes. The type of experiences these teachers have with HIV/AIDS, appears to directly influence a host of attitudes connected with HIV/AIDS. As will be elaborated on later, the experiences they have, often contribute to their perceptions of who constitutes a risk group, whether they perceive themselves to be at risk, and in determining whether an HIV test is necessary or not. These experiences often explain why these teachers foster certain perceptions about HIV/AIDS, and those who have contracted the virus. An array of these experiences will be briefly discussed, in order to display a short synopsis of the types of incidents that the teachers encounter. Many of these occurrences will be discussed in greater detail later, describing their relevance and influence, under the appropriate themes. These experiences will be analysed in detail, clearly indicating how their influence has contributed to a specific image or stigma attached to their perceptions.

Of the twenty-four respondents that were interviewed, only two personally knew of a friend or relative that was HIV positive. One of these teachers had a co-worker, a white homosexual male, who was diagnosed with HIV, and died of AIDS over 25 years² previously. “I knew about it 25 years ago, because a very good friend of mine died from AIDS. It was a he, and he was gay and I have since discovered that he was the 65th person to die of AIDS in SA.” Although this experience took place over 25 years ago, it continues to influence her life today, as well as her perceptions of HIV/AIDS, as will be discussed later. The other teacher was far more illusive about her ‘friend’. She was unable to tell me in what circumstance she knew this person, and that she only found out

² Research indicates that HIV/AIDS was not identified in South Africa before about 1983. This respondent however, was fervent in her belief that it was 25 years ago.

about her friend's HIV status by coincidence, from another friend. Upon further probing, it would appear that they are no longer 'close' friends. "I would say we are friends, I wouldn't class her in my close circle of friends; she was, now I would say that we are just friendly, we chat." She guaranteed me that it was not because of her HIV status; rather it was because of 'the secret thing'. When requesting what she meant by the 'secret thing', she told me that she was hurt that her friends HIV status was kept from her as a secret. Without further intensive investigation, it is difficult to determine whether the distance between these previously close friends was truly because a secret was kept, or because that secret had to do with HIV/AIDS. The remainder of the experiences were what can be considered second hand experiences, as the respondents themselves did not consider them to be of a personal nature; meaning that they were not directly involved and the encounter took place outside of their close circle of friends and/or relatives.

A large majority of those interviewed, had never met or known anybody with HIV or AIDS. Their experiences predominantly came due to their employment at the various schools. These encounters took place principally in three ways:

Learners

These experiences took place with the students they taught in their respective classrooms. None of the teachers reported any incidents of actually getting personally involved with a family member of one of their students. Their interaction, however, was chiefly that of story telling (learners relaying stories of actual occurrences from their own lives). Many of the respondents stated that their school experience, was their only experience; "You know here at school you hear a lot of it, you see a lot of it. You know never in my life have I heard of so many people dying. At first it was very naive thinking, and I would ask if it was a grandfather or a father, but then I hear it is a cousin or a brother, and then you get to the ages, and it happens all the time. You know as white people we are confronted with it here at school, but otherwise we are really not confronted with it". This statement clearly indicates two things. Firstly, the students seem to entrust high levels of confidence in their teachers. They are able to share extremely intimate and personal details about their home life, personal life and their

experiences of being directly involved and witnessing many of their family members pass away from what would appear to be AIDS. Secondly, this statement and many like it, confirm that this group of teachers really have little to no personal experience with HIV/AIDS. Their experiences come vicariously through the students they tutor. Reporting on the frequency of these encounters with students, another teacher stated, “I got to a stage a little while ago when almost everyday someone would say their sister died or the uncle or whatever. There is a child in my class, who told me quite openly, she did not hide it, that her sister died of AIDS. These children are actually living in Nkosi’s Haven. Then she told me that her other sister’s child died at 2.” Clearly, these teachers are faced with very traumatic situations. Having learners come on an almost daily basis, reporting on recent family deaths, must not only be a harrowing experience, but one requiring great skill and sensitivity. One teacher reports about having taught children who had died of AIDS, “I got to Kwazulu Natal and there is probably a funeral every 2 weeks. If I think of the amount of children that I taught who died of HIV.”

What is illuminating from these responses is the fact that the teachers do not consider these experiences as personal ones, nor do they seem to affect them personally. They are clearly able to differentiate between their personal lives and their professional ones. Even though these encounters are traumatic by description, the affects thereof seem to be annulled in their personal lives. It would appear that they are able to compartmentalize these experiences, thereby creating a distance between themselves and the experiences they encounter at school with their learners. This is clearly indicated when asking the teachers to describe how HIV affects their lives. Although this will be examined later, it is crucial to note at this point, that the vast majority of the teachers felt completely unaffected by HIV/AIDS. Further indicating their ability to separate their school experiences from their personal lives. Many of the teachers recalled incidents of having to answer sexual questions that arose due to HIV/AIDS discussions. “We answer very basic questions. We have had a lot of questions about whether they can get it through oral sex or whatever.” Many of the teachers recalled incidences of having to describe oral sex, answer questions about it, as well as discussing the implications for HIV/AIDS transmission. From this research, it would appear that the teachers are not just academic educators, but amongst a host of duties, they are also sexual advisors.

Policy³ (Gauteng Department of Education)

Due to various policies adopted by the GDE (Gauteng Department of Education), many of the teachers have had to change their behaviour in the school environment. These policies can supposedly be obtained from each teacher, who is required to keep these policies in a holder, in the classroom. These policies include intolerance toward any person portraying discrimination toward someone with HIV/AIDS; this is to be accomplished by ‘observed Equality at all times’. Testing for employment is prohibited and no student or educator is compelled to make his or her HIV status known. All are to be treated as if they are HIV positive. If an employee is diagnosed with HIV/AIDS, they should continue to be employed until they are certified by an appropriate medical review board as being unfit to work. All employees are to be trained on how to give guidance as well as to be involved in educational programmes. A safe environment for all is meant to be maintained, by not playing sport with an open wound, as well as the requirement to wear gloves at all times.

Only 54% of the respondents mentioned having to wear gloves however. Some of the other teachers mentioned that gloves were not at the top of their priority list when dealing with an injured student. Two of the teachers felt that they would treat the learner first without looking for the protection of a glove. Of those who did wear gloves, they implied that this was a new habit that they had to acquire. “I suppose with handling children, compared with even eight years ago, I never wore gloves then when working with blood, now I am more aware and always wear gloves.” Another teacher states, “The policy regarding the kids in school is that you treat everybody as if they have it – you use your gloves and take all normal precautions, because you don’t know who has and who hasn’t.” Part of this policy change demands that each classroom is equipped with the afore mentioned file, outlining the GDE HIV/AIDS policy. Most teachers did not even mention this file. In fact only 3 out of the 24 teachers interviewed even made mention of it. Of the three that eluded to its existence, one openly indicated that the file was really there in case someone from the department came around to check; “We do actually have a file – an HIV/AIDS file in every classroom, each of us teachers, on our policy, if we

³ See appendix for a copy of the entire policy document

have an HIV child in our classes and I must admit I have glanced at it, but it's there if anyone comes around from the Department and says 'what is your policy'." It seems that the policy files are not something the teachers refer to often or even pay much attention to. The reason might be that they have the policy well internalised, that physically referring to the file would be a tedious and worthless task, as the information is already memorized. From the percentage of teachers who appear to wear gloves, I would venture to say, without having fully researched the topic, that this hypothesis would be void. Based on this study, however, I would propose that a more likely assumption would be that the teachers are not concerned about HIV/AIDS, hence their apathy toward the file and the wearing of gloves. Many of the interviewed teachers validated this point by saying "To me it's this huge, big unbelievably uncomfortable fatal disease and I don't think I will ever come into contact with it." This unaffectedness and feeling of immunity will be further elaborated on under the Perception of Risk Section. Interesting to note however, is the close link between perceptions and experiences. This particular teacher feels that she will probably never be in contact with HIV, which might explain her indifference to the wearing of gloves, as well as in referring to the HIV policy in her classroom.

In addition to having HIV/AIDS policy files, the teachers also receive mandatory instruction, usually in the form of a course or seminar. The teachers themselves drew attention to the validity of these courses when only half of the respondents reported ever having attended a course or listed the course as worthwhile and an informative source of erudition. Noteworthy is the fact that one teacher could not even remember having attended a course, after the principal of the school informed me that it was mandatory that every teacher attend a course each new year. This particular teacher had been employed for 10 years. "You know I actually don't know if we have at school, we may have, I have been here for 10 years, so I can't actually remember. I think we may have been on some seminar that was specifically for AIDS, but I don't know. So, no, there has been no formal teaching." One of the teachers matter-of-factly confessed that there was a significant gap between the learning that takes place on the courses, and the subsequent application that is meant to take place; "Its like learning something, you have to practice it to remember it. I'll attend lectures about it. Then I move on with my life and forget

about it. I don't know anyone with it, haven't seen anyone with it, except in pictures – like children.”

Staff Members

Some of the respondents reported having interacted with other members of staff who were living with AIDS. “One of the black ladies at (name withheld) who did the photostating, she just passed away and she definitely passed away from AIDS. At the time we all suspected she had AIDS, but we weren't quite sure.” Another teacher, when asked about an image that came to mind when mentioning HIV/AIDS, responded by saying, “A black person very thin and ill looking. I think I get that because when I worked at (name withheld), one of the staff at school with us, she was a big lady and the last year or two that I was there, she just faded literally to a skeleton.”

Based on the findings, it seems that for a large percentage of the teachers interviewed, the school becomes the primary and oft times the only reported source of contact with people living with HIV and AIDS or the affects thereof. It seems that the school offers firsthand experiences with HIV/AIDS. Some teachers recall experiences with learners whose parents or siblings have passed away because of AIDS, and others have explained that they watched members of staff ‘literally fade away’. The somewhat sobering experiences encountered via the school seem to remain there - at school. It was surprising to note that the stories rattled off as if they were just simply a story. What is significant to note, however, is that these experiences perpetuate the colour that has been attached to the HIV/AIDS epidemic. Most of the teachers continue to associate HIV/AIDS with black people. Due to the experiences that the teachers are having at school, it would appear that these contribute to the cementing of the alliance between race and disease.

Media

Many of the teachers reported not having any experiences with HIV/AIDS at all. None at school and ‘most definitely’ none at home. In fact, for them their only

experiences with HIV or AIDS, are those they encounter through the media and its portrayals. There they are able to gain knowledge about the disease, have experiences via the airwaves, as well as become involved in the sensationalistic stories that get published. One teacher when asked to describe an image that she has of HIV/AIDS, said, “To me it is the image I have seen on TV, where someone is dying and they are very thin, a malnourished person. Then of the little babies, the little AIDS babies, most the images I have seen on TV, because I have not in my own life met someone, or I might have met someone with AIDS, but not in the end part of AIDS where they are very sick.” Many of those teachers who did not indicate experiences at school with students or members of staff explained that the media was their only source of experience. However, others while not directly indicating that they relied on the media, described images or perceptions of HIV/AIDS, and made statements which clearly indicated that the media was the main source of their experience, rendering the media with substantial influence over these schoolteachers perception formation. This will be discussed in more detail under the Whiteness Section. When asked if she knew anybody with HIV/AIDS, one teacher answered, “Nobody personally, other than knowing of Nkosi Johnson.” Not ever having personally met Nkosi Johnson, it was clear that this ‘connection’ must have been formulated via the mass media. This was not an isolated occurrence. In fact, four other respondents also mentioned Nkosi Johnson as the one person they ‘knew’ as being HIV positive. Other respondents spoke of images of babies and abandoned children that they had seen through the mass media, as their experiences with HIV/AIDS.

Employees

In addition to friends, school and the media being a basis of experience, three of the respondents indicated that they had either a ‘Gardener’ or a ‘Maid’, employed by them, who was HIV positive. Interestingly enough, none of these respondents classified their encounters with their maids and gardeners, who probably worked in their homes on a daily basis, as a ‘personal experience’. One of the teachers had employed her gardener for 28 years before he died. Another teacher discussed the plight of her Maid, as she had to support 6 children who were not all her own, due to the fact that her family was dying rapidly from AIDS; “I know that my maid’s family is dying at a rapid rate, cousins,

aunties and uncles, people in their village, but I don't think it has touched us personally.” Another respondent reports how she had two gardeners who have died of AIDS, “We've actually had a couple of gardeners as well, who we have just watched getting more and more ill, then just died. No one actually said anything about being HIV positive, but you know the signs”. It would appear that a similar pattern that appeared in their handling of the learners, is also apparent when dealing with their ‘maids and gardeners’. Even though these schoolteachers may be involved in their employee's lives on a daily basis, the teachers seemed to take on the role of bystander, being able to distance the trauma from their own lives.

Social Clubs and Organizations

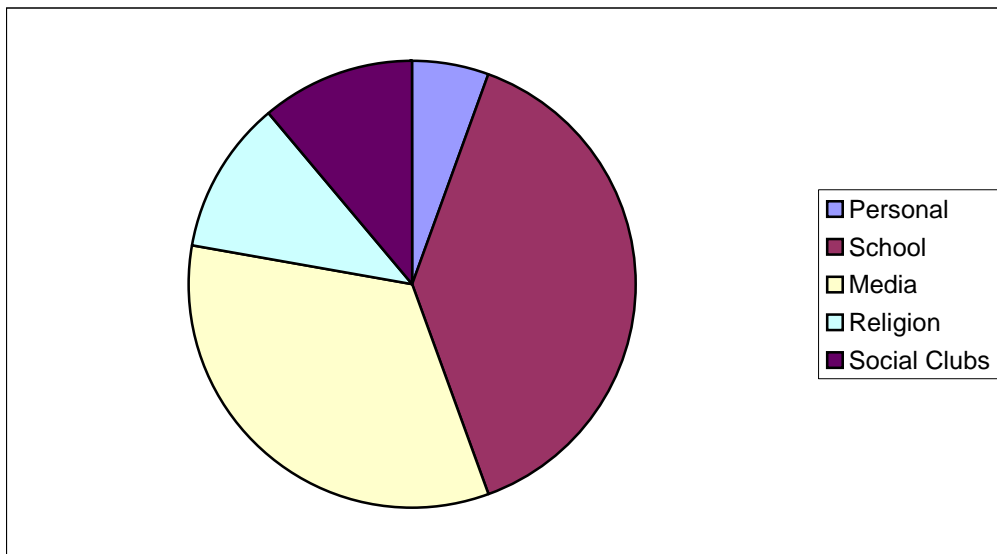
Societal institutions appear to be another way that these schoolteachers were able to gain experiences with HIV/AIDS. One of the organizations being a religious association of some sort. Of the six respondents that spoke boldly of their religious affiliations, five of them used their organizations as means to render community service, and thereby gain experiences with HIV/AIDS. The full impact of these experiences will be discussed in more detail under the section entitled Whiteness Section. While one teacher contributed significant financial means to a specific AIDS Church Fund, two of the other teachers were quite heavily involved with extra lessons for homeless children on Saturday mornings, also organized by their religious leaders. The other two teachers spoke of “...going to drop off clothes and that at the homes. They like you to go in and just hold the babies.” From the responses offered by the teachers, it would appear that going to homes to hold babies, is quite a common practice amongst the various religious organizations. Religion has the power to be used for good as well as the ability to instil prejudice. This capability will be discussed in more depth later, revealing how religion has been used by the teachers to both perpetuate discrimination, as well as abolish it.

In addition to religious social groupings, another respondent described her book club as a means of experience. It is in the book club that HIV/AIDS stories and/or folktales are shared and where additional information about the topic is gained. Another teacher spoke of two former schoolmates who had become “absolute druggies”. She was

able to find out about their HIV status via the ‘alumni’ club, as old friends sit around and chat about the good old days, and bad old teachers. These types of reunions, whether it be with old friends or new, are also an influential social ‘club’. These social gatherings, whether religious or recreational in intent, have tremendous ability to shape the perceptions of its members. Here you gather with peers, whose influence is often vital and necessary to your own perception formation. Most often you gather because of a common belief or bond. When sharing stories and information, this influence can have a potent impact on whether that communication is believed or discarded.

The pie chart below offers an exact visual breakdown of a summary of the answers given by the teachers, indicating the means by which their experiences with HIV/AIDS are obtained. Clearly, it is the media and the school environment that offers the greatest amount of experience.

Experiences with HIV/AIDS



From the information presented throughout this chapter, it is evident that the majority of the schoolteachers interviewed, have not had any ‘personal’ experiences with HIV/AIDS. Only 3 of the respondents mentioned that they had a friend or relative who was living with HIV/AIDS. Of those three, two did not consider their friend as close; in fact, the one had not had any contact with this friend for years. Her experience can be boiled down to scandal, as old school friends sat around and discussed what had

happened to whom. The other has very little contact with her friend since hearing about her HIV status. Three other respondents spoke of their experiences with their employees who were either living with HIV or had already died of AIDS.

As illustrated the majority of experiences take place in the classroom or via the media. Each experience plays a pivotal role in either adding to or changing the perceptions of HIV related ideologies. Therefore the type of experiences and exposure these schoolteachers have with HIV/AIDS, appears to be central in grasping why these perceptions and often discriminations toward HIV/AIDS, continues to exist and flourish.

The White Perspective

An attempt to focus on the relatively high HIV/AIDS statistics amongst white South Africans is by no means a ploy to draw attention away from any other racial groups in South Africa. By contrast, as significant attention is given to all people living with HIV/AIDS, a more accurate, better-equipped and superior HIV prevention program will be able to address all South Africans, as none are without risk. As indicated earlier, very little, if any, attention is addressed to white South Africans as a risk group. This neglect has no justification. As previously indicated, “Although many white South Africans feel “insulated” from the HIV/AIDS epidemic, the population's HIV prevalence is higher than the prevalence among “any other white population in the world” (kaisernetwork, 2005).

As mentioned, the statistics released by the HSRC and the Nelson Mandela Foundation, white South Africans have no justification for feeling ‘insulated’. My findings confirm that this cohesive feeling of unawareness or ignorance strongly exists amongst this group. The majority of respondents did not feel that they were at risk, and the bulk of teachers, 96%, did not feel that HIV/AIDS affected their lives personally. In fact a large portion of the teachers felt quite immune and far removed from HIV/AIDS. The one teacher, who did feel that HIV/AIDS affected her life personally, was a teacher who had had an HIV/AIDS test due to sexual choices she had made during a kibbutz experience. She also believed that her ‘maid’ might be HIV positive, and was taking drastic measures around the house to avoid infection. Her responses will be analyzed under the Risk Section. The other responses followed a similar pattern; “I am removed from it I could say. I am over here and the AIDS issues are over there. It is not that I don’t know about them or care about them, it is just that they are not a part of my life”. This distance from HIV/AIDS appeared to be a common consensus amongst the teachers. For them personally, their lives had not been affected nor had it changed their lives in any way. After restructuring the question slightly, I found out that respondents did feel affected in various ways, none of which were considered personal.

The ‘economy’ was a factor of concern for a large portion of the respondents. One respondent openly admitted, “as whites we discuss more the effect it has on the

economy”. Some drew attention to the fact that the economy will affect all South Africans, making a problem for the entire South Africa. Three of the teachers displayed contempt about the money that was being spent on HIV/AIDS. One stated, “It really bothers me that there is so much money being ploughed into this”. Obviously this respondent felt that the millions spent on HIV/AIDS, was money misspent. Another respondent felt that the government has purposefully delayed the rollout of retrovirals in the hopes that it would eliminate those who are HIV positive. She felt that “...the babies that come from them are going to be huge millstones around our necks, because we are bringing up a nation of orphans and it is also not going to be economically good for us, as it is going to be hard to keep the economy going. That’s how I feel, I honestly do”. This teacher felt that those who are HIV positive not only contribute to a nation of orphans, but that these orphans will become a millstone around the necks of the South African economy. It is evident that a large portion of the respondents feel that HIV/AIDS is going to have a devastating effect on the economy, which will then indirectly affect them. Although awareness is drawn to the fact that there are thousands of homeless children in South Africa, the focus of the concern, however, lies in the fact that the economy is going to be affected, and thus, they will be personally disadvantaged by it.

Other ways in which the teachers felt affected was through their career choice as teachers. Due to the fact that a large portion of the teachers’ experiences with HIV/AIDS takes place in the school grounds, it is no wonder that they feel that the one way that HIV/AIDS affects them is at school. Although, a significantly lower amount of individuals who had expressed the view that the school was their only source of contact, stated that they felt effected by HIV/AIDS at school. Only 20% of the respondents felt that school was a place of affect. This influence was felt mainly because of the ways in which the teachers had to deal with the learners i.e. the wearing of gloves for fear of infection. Two other teachers felt that they needed to keep an eye on those they knew where infected, in order to make sure that they were ok, thereby drawing their attention to concerns that had previously not existed.

The only other ways that the teachers felt affected by HIV/AIDS, was through the contact they had with their maids or gardeners. The one respondent felt that she was indirectly affected because she felt an obligation to help her maid, “I just know from my

maid who has two children of her own. She has never married, so she is responsible for her own children. The fathers don't seem to take responsibility for their children or he doesn't. Then the cousin died and she took on her daughter, who has since had two children with somebody. Then a while ago, another cousin died and she had to take one of those children. So now she is supporting 6 people. This indirectly affects us, because I can't bear to see her battling to support and educate and feed those babies, so now indirectly it is my problem too". As her employer, she feels that she cannot watch her employee suffer, because 'the fathers don't take responsibility'. Hence her involvement in trying to help her maid cope with the load that has become hers, due to the HIV/AIDS deaths in her family. Another respondent, replied when asked if HIV/AIDS affected her life in any way, "It doesn't really when I come to think of it. The only time it affected me was when my gardener was ill. But you know it was not like a family member or a dear friend that you have to watch". Notice that even though her gardener had worked for her for 28 years, this experience did not seem to be considered a 'personal affect', and could not be classed on the same level as that of a friend or family member.

It seems that the only time respondents feel personally affected by HIV/AIDS, is if they themselves have done something to cause doubt over their HIV status, or if a 'dear friend or family member' is suffering. Other ways indicated by the teachers as areas of affect, are within the economy, as well as concern when dealing with the learners at school.

This remoteness that the majority of respondents felt toward HIV/AIDS, was evident in the types of conversations that the teachers would have with family and friends. Many of the teachers commented that the longest discussion they have ever had about HIV, was with me in the process of conducting the interviews. One teacher stated that if she did ever have a conversation about HIV/AIDS, it "...would be like 0.0005%" of the time. Some admitted to not ever having a conversation about HIV/AIDS that they could recall. In fact, it would appear that crime and the economy were far more topical; "we chat far more about crime than we do about HIV and AIDS". 'Topical' conversations that appeared via the media, seemed to be the one time that respondents would engage in a conversation about HIV/AIDS, "Just when Mbeki was on that huge

stance about HIV does not cause Aids, that was quite topical. I chatted with my husband about it and my parents, but that was the last time we really chatted about it. Other than that time, we haven't really discussed it". This point further illustrates the influence of the media over the lives of its subscribers. Those 'topical' issues that the media portray, are the ones that are given that '0.0005%' of attention. The lack of conversation about the personal effects of HIV/AIDS, as well as what can be seen as of the total neglect of the subject generally, seem to add evidence to the fact that white South African school teachers interviewed in this study, do not feel affected by HIV/AIDS.

This point gains scope when evaluating whether the respondents offer any sort of community service directly for the purpose of alleviating the effects of HIV/AIDS. Of the 24 respondents, only 6 of them had ever donated their time or means, to any sort of NGO, charity or religious organization. Of those six who had offered a contribution within the community, one of them had done it outside of a religious organization. She was affiliated with the 'People Against AIDS in South Africa' association. This membership was due to her involvement with 'First Aid'. She was the First Aid teacher at the school and had received training on assistance and care of those with HIV/AIDS. None of the other teachers reported having been involved in any sort of fundraising for prevention of HIV/AIDS or having been affiliated with any group that campaigned for assistance of those suffering with the many aspects and consequences of HIV/AIDS.

It is quite clear from the evidence that the affect that HIV/AIDS has had on the lives of those interviewed is minimal. Only 20% of them felt affected at school and a further 35% felt that the economy was the main source of concern. Of particular interest, none of the respondents felt an immediate economical affect, but felt that it would be in the future. An article entitled 'HIV in Society' was posted on 'iafrica.com' and discussed how we are all affected. They state, "The economic and social effects of HIV in a country like South Africa, where the disease is so prevalent, are so profound that at the end of the day, every one of us will be affected in some way or another"(2000). The analysis of the teachers' responses could not be considered as indicating a 'profound' affect. In fact, there is often a sense of apathy and lack of responsibility. One respondent declared, "It worries me because I know we are going to have all these children who

don't have parents. I know our economy will be affected, but I still feel like there is nothing that I can do". Another respondent boldly announced that because the HIV epidemic was due to no fault of hers, she had no responsibility to ease the situation, "I just think it is not my responsibility. This leads me to ask myself whose fault it really is that those babies have AIDS - is it because the mother was raped by a man with AIDS, is it because the mother was promiscuous or because she was a drug addict? I don't know, but what happens when those children don't have any parents left, then I think it is probably the governments responsibility to look after the children". It is noteworthy that the two respondents quoted above, have never participated in any sort of community service. While there may not be a direct link between community service and a sense of responsibility, I do believe the relationship is worth further exploration, which is beyond the scope of this study.

Not only do white South Africans need to be made aware of their relative high risk status, but a sense of urgency needs to be felt in the community, making all white South Africans aware that the effects of HIV/AIDS, do not only lie in the future, but they are blatantly apparent today. According to iafrica, those enjoying the benefits of a medical aid, will find that "As the costs associated with caring for those with HIV and AIDS increase, so too will your medical aid premiums and the costs of private care"(2000). All South Africans will be profoundly affected, whether it is through the cost of a medical aid, the loss of gross domestic product or the loss of a loved one. This urgent message must be released, so that the most affluent sector of our society do not sit back awaiting the government to ease the burdens of millions.

The 'White' Lens

Knowing that white South African schoolteachers do not associate themselves with HIV/AIDS, and for the most part, do not feel affected by it, must lead to the next logical step of asking 'why'. Especially keeping in mind the previously discussed prevalence statistics offered by the HSRC (2002). What is it that surrounds these respondents with such security, which allows them to remove themselves, and many just like them, from the risk of contracting HIV/AIDS? It would appear that the social-

psychological theory of ‘groupthink’, bears some relevance to the subject. According to Janis (1971), groupthink is described as “The mode of thinking that persons engage in when concurrence-seeking becomes so dominant in a cohesive in-group that it tends to override realistic appraisal of alternative courses of action” (Myers, 1999). This theory, though not comprehensive in its scope, does shed some light as to the reason why it would appear that there are some polarized racial perceptions. Realizing that in-groups are prone to a dominant and cohesive way of thinking helps in analysing why racial stigmatisation has been adopted and maintained for decades. Those who belong to the same in-group, tend to adopt a similar train of thought, often overriding realistic and accurate information. What this theory does not cover, however, is how group formation takes place. Because this is a study of white schoolteachers, it becomes imperative to analyse why these white schoolteachers perceive Black South Africans as promiscuous, thereby affiliating them with the spread of HIV. Those who associate themselves with each other, whether that is for religious, race or political reasons, often seek to maintain congruence by adopting a dominant mode of thinking. While this is not an in-depth study of white racial identity, also known as whiteness, it is relevant, however, to briefly explore how the ideology of associating oneself with whiteness, the in-group, impacts on your perceptions, as well as experiences with HIV/AIDS.

In order to comprehend how being white might impact on the perceptions and experiences of these schoolteachers, it is vital that a nuanced description of whiteness be offered. In explaining the white experience, Hitchcock offers the following explanation, “Behaviour can be viewed as a culturally-influenced repertoire of experiences available to each cultural member. By culturally-influenced, we intend to say that people who share common characteristics, (in this case, race) will have common experiences, whether or not these experiences are known or felt to be common by other cultural members. In terms of race, if we posit that white culture exists, we should also expect that white people will share similar, hence common, experiences based on their racial membership” (Alfonso Association). According to Hitchcock, as a socially racialized group of white people, we will experience many of the same occurrences, whether we are aware of it or not, based on the fact that a common racial group is shared; bringing us back to the groupthink theory. The study of whiteness then, is an exploration of culture, experiences,

thoughts and other commonly held phenomenon that frame being white. While this is rather a new and somewhat topical area of study, there is enough evidence to warrant it as a legitimate theory.

At the centre of this theory, is the notion that white people share an identity, often unknown to its bearer. As previously identified, this identity, however, is one of power and superiority. This attitude of whiteness is almost second nature to those who possess it. It is a normal thought, hence encouraging the notion that whites in and of themselves, are normal. Those differing with them, in this case those belonging to a different racial group, appear to be classified as 'not normal', because of difference. Solomos and Back comment on this normalized notion, by stating "Dyer contends that white ethnicity in the cinema is implicitly present but explicitly absent and as a result it has 'an everything and nothing quality'. In these representations whiteness is equated with normality and as such it is not in need of a definition. Thus 'being normal' is colonized by the idea of 'being white'"(1996). The study of whiteness brings obvious attention to being white, and discovering what being white means. However, many theorists, believe that this attention has been lost by many whites, who consider themselves non-racialized, or in other words, normal. Howard Winant, a professor of sociology at the University of California states that "Historically, it has been common to see whites as a people who don't have a race, to see racial identity as something others have" (Fears, Washington Post, 2003). He goes on further to state that "It's a great advance to start looking at whiteness as a group"(Fears, 2003).

While it is imperative to explore ways that being white could contribute to the total cultural experience of being white, it is also a mistake in my opinion to view white people as a homogenous group. This expectation that all white people are racists, oppressors and those who only consider life through their own 'white' lens, is a grave mistake to make. David Horowitz, a social critic, states "...whiteness studies is leftist philosophy spiralling out of control. Black studies celebrates blackness, Chicano studies celebrates Chicanos, women's studies celebrates women, and white studies attacks white people as evil" (Fears, 2003). It is not my intent to adopt either side of the theory in its entirety, what I will portray, due to the research undertaken, is how normalized ideas of

whiteness can often enter our consciousness through social learning. This social learning, although adopted and practiced, is oft times not fully realized, but adhered to because of ideologies of groupthink and learned cultural practices connected with being white.

Apartheid and HIV/AIDS

In trying to understand the impact of whiteness on the schoolteachers, it is imperative to turn back the pages of history, in order to understand the foundation of whiteness that was laid by our forefathers, and continues into the present day. All of the respondents interviewed were old enough to have experienced apartheid. While the laws protecting and enforcing this ideology have been abolished, the affects thereof continue to permeate today. According to the University of Wisconsin, laws instilling racism have long been abolished in the USA. However, racism still abounds, “Once the crude legal structures of discrimination were torn down, Americans faced the fact that changing the laws did not change the feelings and beliefs of individuals, black or white. Beyond the abstract words of law and legislation, real people continued to carry with them the history of racism, whether as victims of its horrors or as beneficiaries of its privileges” (1998). This same emotion has been expressed about the apartheid influence in South Africa. According to Swartz, “Although South Africa has undergone a dramatic political transition in the last decade, many of the distortions and dynamics introduced by apartheid continue to reproduce poverty and perpetuate inequality” (2003). The birth of a democracy in South Africa, officially demolished all previous apartheid laws, restricting and dehumanising other races. The unmasked truths of the affects of apartheid will never quite be fully comprehended, especially if you are a white South African. The majority of teachers interviewed expressed this heartfelt notion.

Although the concept of whiteness was never expressly discussed as a theory, the majority of the respondents shared experiences of living through the apartheid era as white women. They, too, expressed sad and oft times intense thoughts about their shock in coming to realize that their notion of whiteness, was based on a lie. One respondent stated, “My anger in this whole thing was finding out how little we knew”. The majority of the respondents confessed that they never quite knew what was going on. They were

content in their notion of being protected, educated, validated and served, under what appeared to be a normal and justifiable South African ideology. In evaluating the responses of the teachers, one word kept emerging – “unaware”. Over and over, the respondents relayed the fact that they were so unaware, “but I think as with so many people in South Africa, we were very protected from it, we were very blissfully unaware of the realities of apartheid”. Another teacher felt totally oblivious to the situation; “I didn’t really even know that it was happening. When you are younger you don’t really think of it, but when you are older you start to ask yourself why”. Along with being oblivious and content, some of the respondents felt that they had been indoctrinated; “I went to Pretoria University, which was very much an NP strong hold. So I was basically indoctrinated, and it did work, but I don’t feel guilty, because I know myself and my family were never nasty or horrible, we never did anything about it, we just accepted it”. Many of the teachers felt that the apartheid persuasions were so normative, that you did not know that you were being taught something wrong. “When we talk about apartheid we talk how bad it was for the blacks, but I think we forget how bad it was for the whites, because we were falsely taught to think of ourselves as being superior”. Some acknowledge the fact that because they were white, they received differential treatment, “If you were a white person in the 60’s you were very privileged, you had the nice education and the nice ‘whites only’ toilets”. Another teacher in comparing her life now to what it was then, stated, “It was not my doing that I was in the privileged position, it was my colour that put me in that position”. According to the respondents, this position of power and privilege was not fully realized until after apartheid was dropped, and in some cases, not until they were exposed to a different environment.

Environment

According to the experiences encountered by the respondents, it would appear that the environment is crucial. Many of the respondents spoke of being raised in a ‘liberal’ home. Upon further investigation, it seems that the term liberal would need further investigation, identifying some clear-cut boundaries and explanation, as ‘liberal’, can be used as a relative term, with vastly different interpretations for each user. Three of the teachers, who claimed to come from ‘liberal’ homes, not only spoke of this outlook,

but lived it. Their parents were crucial in supplying these experiences. They spoke of how, from a young age, they were taught to question, and were told explicitly that the ideologies of the apartheid government were indeed incorrect. One of the respondents mother was ‘a big shot in the Red Cross’. She had many friends of colour, who often frequented their home. She was not only taught by her parents that apartheid was wrong, but by their actions, this knowledge was solidified, as she was able to distinguish between the ‘truth’ that society presented, to that of what her family displayed. Another teacher, whose life also clearly indicated the importance of circumstantial experiences in the acquisition of social learning, spoke of how her convent boarding school brought attention to the inequalities and injustices of apartheid. Religion, serving here, as a vital component in combating racialized thought. Many spoke of growing up in a ‘protective environment’. This environment was, of course, specifically created by the government, allotting each racial group with a separate area of residence; “we did not have a domestic or a gardener, my only contact really was with people that worked at the local store. Other than that, I really was very protected. If someone had asked me, I would have said that South Africa is predominantly white, at that stage of my life, because the numbers of black people who were allowed into the white areas was so controlled”. This segregation was well-planned by the government, ensuring as little contact and crossover as possible.

It was not until the respondents left their familiar environments surrounded only by those also reaping the benefits of apartheid, that they came to realize that there were civilized, black human beings, who were intelligent and suffering under the auspices of racial superiority. For most, this different environment took place at the Johannesburg College of Education, where they obtained their teaching diplomas. There, for what appeared to be the first time for most, they were exposed to people of colour of the ‘same intellectual level’, not as a maid or gardener. One respondent spoke of the time she remembers becoming ‘aware’, “Only when I was at JCE and we went on the campus. I actually liked that element where people stood up and said things against apartheid, because I’m not one to really be that outspoken. They made you aware of things that you were not reading in the paper”. The college experience offered the various teachers a firsthand opportunity of mingling with people of colour, as well as exposing them to alternate views. One teacher shares an encounter with ‘the other side of the story’, “Then

when I went to college, history was my major, I got exposed to the other side of the story, and it was so exciting to be able to argue in an essay and to put points of view across and you were not marked on giving their opinion, you were marked on how good you were with backing up your argument, whichever side you took”. At college it would seem that they were also encouraged to think beyond the limited bounds previously established in their high school careers. Here they were urged to question. Associated with this questioning environment was the fact that they were in surroundings with other racial groups. This exposure automatically put strain on previously fostered racialistic views.

Ironically, just as education is used as a perspective enhancer, it can be the vehicle used in forming and fostering superior, racialistic and oppressive normative thought. According to the respondents, education played a central role in dispersing the apartheid philosophy. Through a standardized, government controlled curriculum, history was presented with the purpose of solidifying the white man’s place as master. Emile Boonzaier states that “... the same basic set of assumptions and premises about race could be found in local newspapers, in school textbooks, and in popular thinking”(1988:61). The teachers experienced this phenomenon that Boonzair speaks of, “And a lot of it came from the education system, the history that we learnt. And they were excluded. We only learnt about the Voortrekkers and the Whites and how they came to South Africa, we were never exposed to the Koi San. We were told about Shaka, but it was always a very prejudiced view, this little Black tribe and all that kind of thing. But the way history was presented was terribly one sided”. This presentation of knowledge, by a trusted source, did much to anchor stereotyped beliefs about people of colour, as well as white people’s position in society. P.W. Botha, who was president of South Africa during apartheid rule, stated in his controversial ‘Rubicon’ speech in 1985, “Destroy white South Africa and our influence, and this country will drift into factional strife, chaos and poverty” (Leach, 1989:10). This type of philosophy governed our laws, interactions, as well as dictated what was to be taught in our classrooms.

Today, teachers are still endowed with the ability and capacity of moulding, shaping and influencing students’ perceptions. Although the present curriculum offered by the Gauteng Department of Education is not anything as one-sided as previously

experienced, the teachers still hold the power of deciding how a message will be presented and how much emphasis will be allotted to each subject. This personalized approach to teaching which each teacher is encouraged to have, can often include negative influences on the students they teach. This is particularly important when considering that teachers confront a melting pot of cultures within one classroom - each culture, cherishing vastly different behaviours, norms, and customs. It is vital then that the teachers maintain an unbiased approach to their teaching. In analysing the teachers' responses, the need for a dispassionate approach became very apparent.

Cognisance of the fact that the majority of the white school teachers interviewed, believe that the spread of HIV/AIDS is due to promiscuity and immoral living, mostly practised by Black South Africans, is vital in considering how these schoolteachers present information about HIV/AIDS, as well as answer questions pertaining to it. Many of the teachers spoke of having to answer questions around various sexual activities, some of which cross cultural boundaries of acceptance. It became quite evident that most times the teachers were using their 'white' normative beliefs to set a standard and teach a principle. "We sit with kids who are not taught what's right and what's wrong, what's good and bad and I'm not just talking in a religious sense. I don't care what your sexual orientation is or your religious orientation, but you should have morals in your life. And that's where AIDS comes in, how do they know what's good for them". This particular teacher felt that the learners were not taught what was 'right and wrong' in the home. It, therefore, became her responsibility to set this precedent in the classroom.

Many of the teachers spoke of the difficulties in teaching children who spoke a different language and had a different culture. Oft times I was taken down memory lane, being asked to recall my school days in comparison to the situations that teachers now face. The teachers often expressed views on how the morals have deteriorated and how the learners were just not the same. Another teacher spoke of her frustration in having to teach too much 'HIV', "As I said the HSS book is HIV, HIV, HIV. If we had to teach everything we were supposed to, then we would teach nothing else the whole year. To me the teenage mind, once they have heard it they have formulated their ideas and you are wasting your time".

What is disconcerting about this approach, is firstly that we cannot be forcing one opinion and train of thought on a host of people who practice different cultures. By enforcing this code of conduct, we continue to drive a wedge between the races, making a moral judgement that your custom is wrong and mine is right. Such cultural and often religious messages should consciously be struck from our vocabulary. Of course prevention messages such as that of the A (abstinence), B (be faithful) and C (condomise) are a vital approach, but they must be presented in a culturally sensitive manner, void of judgement and bias.

Morrell, Unterhalter, Moletsane and Epstein (2001), are the authors of an article entitled 'Missing the Message: HIV/AIDS Interventions and learners in South African Schools', state that gender sensitivity is also vital in presenting an HIV/AIDS message, "In order to be successful, it is vital that school HIV/AIDS interventions take gender seriously. This means taking account the lived realities of boys and girls and moulding the interventions to speak to these realities. Only in this way, will the intended message of the interventions be "heard". Whether that lived reality is of gender, culture or race, these realities must be taken into consideration when presenting information to the learners, if erudition is the desired outcome. This could be a reason why the previously quoted respondent felt that she was wasting her time teaching HIV, as the 'teenage mind' does what it wants anyway. Liontos, quoting McCormick, states, "Many educators agree that HIV education is more easily accepted, when the curriculum, materials and activities are developed locally, with the community's needs and values in mind"(ERIC). A local flavour must be incorporated into the HIV/AIDS messages being presented at the schools. A culturally sensitive presentation has a better chance of being understood and therefore, a more positive chance of being incorporated.

In comparing how the education system was used to instil the ideas of apartheid, to identifying how this same system is used to present messages of HIV/AIDS, there are a few lessons that can be learned. Firstly, it is evident that the education system is a powerful means of relaying knowledge, developing culture and acquiring norms. The apartheid regime did this with excellence, incorporating many social structures to

accomplish their task, one being the educational system. Many of the respondents spoke of how furtively the apartheid aims were accomplished. None of the respondents can remember a teacher overtly relaying racial prejudice. However, this notion was well taught through separation, segregation and latent attitudes constantly flowing through conversation. This bears relevance to HIV/AIDS in the sense that many pupils are being taught by teachers, who foster the notion that HIV/AIDS is a black, promiscuous man's disease. Perhaps these messages are not explicitly expressed, as with apartheid, however, they are relayed in a number of underlying ways. This concealed message not only harms many Black children through stereotypical labels, but by not wanting to discuss the subject, because you feel it is either not heard or not necessary, will have a profound influence on the White children, who need to comprehend the realities of HIV/AIDS. They, too, need to be associated with the disease, realizing that they are at risk.

Teachers must take heed not to allow their biases and cultural norms, to influence their pupils. From this study, it is apparent that the environment can play a vital role in social learning. For this reason, it is vital that each teacher create an atmosphere within every classroom that is void of personal prejudice and stereotyping, and focuses rather on an atmosphere of questioning and acceptance in the face of difference.

Religion

Another social institution that has tremendous power over the perceptions of its members, is that of religious denominations. This topic was not expressly explored with the teachers, neither was it planned for. However, 21% of the respondents made specific reference to their religious beliefs. Others, though not implicitly stating their religious affiliation, portrayed attitudes and viewpoints conducive to Christianity. Even though the apartheid government used religion, more specifically the Nederduitser Gereformeerde Kerk (NGK) to justify many of their hideous laws, other religious affiliations persisted in drawing attention to the atrocities falsely practiced in the name of deity. One respondent spoke of how her perceptions about apartheid, were influenced by spending her school years under the tutelage of Catholic Sisters in a convent. "We were made aware of it, and once you are aware of it, you are uncomfortable with it. You know that it is not right.

The sisters would explain that you are in a segregated society and you shouldn't be, you are in a segregated school and you shouldn't be, there are privileges that the white people have that should not be their privileges alone, and once you are aware of that, that is how you see the country". Thankfully, for this teacher, the wisdom of the Sisters, has helped shape her attitudes, affecting her life forever. Religion, and its teachings, guided this respondents attitudes, enabling her to discard the intolerance widely practiced by most of society in that day. While this was a positive experience for her, other respondents spoke of how religion was used to stifle their opinions, in order to embrace and feel comfortable with the falsehoods of apartheid. Many of these values, though religious by nature, were also fostered and used by the apartheid regime as a means to accomplish dominance. In fact, Christianity and the church was a vital ingredient used to justify racism and segregation.

By infusing apartheid in the name of God, confessing that this was something ordained of Him, people would not be as likely to question the phenomenon. One of the respondents expressed disdain for the church by stating "Because once again the people that told you are the people you went to church with and you trusted them implicitly and that is why I am so fed up with the whole church thing, our church, the Dutch reformed church are the ones who gave their blessing to apartheid; they actually found verses in the Bible to say that God said this is what should be". Leach states that "...church theology on race became enshrined in a document adopted by the 1974 general synod called *Ras, Volk en Nasie* (Race, People and Nation), the result of many years of scriptural study. Its conclusion was that separate nations had been ordained by God; the individual lived out his religious, social and political life within this context" (1989:116).

Knowing that God wanted this separation made it easier to accept. Society was divided on all sides, a teacher commented "My mom never sat me down and said you are better than a black person, but I was kept in schools for whites and went to a church attended only by whites and I mixed with white people. It's just that society kept me away from the rest of our society - from other race groups, and this was the society I lived in, and by basically not saying anything, they gave the approval to us". Even though the respondent may not remember specific things that were said, the NGK

explicitly denied interracial marriages, when they gave their approval to the Immorality Act, banning sex across the colour line (Leach, 1989). This ban made sex illegal with people of colour. Sex was only to be had in your own racial group. This intolerance is still evidenced today. One of the respondents stated how she felt that HIV/AIDS can be contributed to the mixing of marriages, she states “You know also with the cross race relationships that are not frowned upon any more, they don’t have to be hidden anymore, so my perception would be that this has also spread HIV. You know a black guy could now be with a white girl, or a black girl with a white guy - my stepson could walk in with a black girlfriend. This is how it is and these are the times that we are living in”. Having mixed marriages outlawed, taught this respondent that it was wrong. This same perception continues to cloud her perceptions of Black people and sexual activity today.

By endorsing such an outlandish law, the church was in essence saying that having sexual relations with someone of colour was a sin, not to be partaken of and certainly to be repented of. They were also fundamentally reinforcing the bigotry projected toward all those of colour. Although the NGK thrived amongst Coloureds and Blacks, it did so on their own turf. The church reserved the right for people to reverence God separately, in their own places of worship.

In evaluating the responses that the teachers gave concerning HIV/AIDS, it would appear that the majority of the teachers still foster the same ideas presented by government and the NGK. As discussed under ‘Stigma’, most of the respondents felt that promiscuity was responsible for the spread of HIV/AIDS. Throughout the apartheid era, stemming from colonial times, Black people have been accused of being promiscuous. With the church outlawing sexual contact with any persons of colour, it continued to fuel such racialistic notions. Setel states “The STDs were perceived to be so rampant in sub-Saharan populations, which led to the direct inference that Africans were by nature promiscuous, hence constitutionally predisposed to immorality” (1999:7). This word ‘immoral’ appeared to be one of the main reasons why respondents felt HIV/AIDS was such a tremendous problem in South Africa. Most of the respondents attached the word immoral to Black South Africans, especially because they had different cultural practices to ‘us’. This moral judgement has its roots in Christianity, and although people are not

encouraged to view Black South Africans as immoral and promiscuous, this message continues to linger as we attach it to the HIV/AIDS epidemic. One of the respondents who was very outspoken about her religious affiliation, spoke boldly about the fact that Blacks have very different attitudes toward sex than what we do. She described how she lives in a religious community, where promiscuity is not permitted. She admitted to being reared in a religious environment, where she was taught that sex was only to be had after marriage. She states, “I move in a group that is very religious, not religious but committed to God, which means we live according to high moral standards. That does not mean that nobody ever slips up, but it makes sexual promiscuity not really an option”. Notice how the respondent attached a very different label to her and her community if they do have sexual relations with more than one person. She states that ‘it does not mean that nobody ever slips’. Seeing a sexual act as merely a ‘slip’, carries a very different connotation than that of being promiscuous. Later in the interview, it was also discovered that this respondent lived with her boyfriend, outside of marriage.

Since government and religion were so successful in the apartheid implementation, many of the ideologies conceived in that time, still bear fruit today. This was seen in many of the respondents, “You know you can’t just do away with decades of error and a certain way of thinking. You can’t just wipe it clean. Even our way of thinking, we know we are prejudiced and as much as we try not to be, we just can’t help it”.

From the responses given, I would propose that the idea that Blacks are sexually immoral in their practices, is one of those ideologies envisaged in white dominant thought, reinforced by religion and continues to flourish amongst many of those influenced by this regime. According to the respondents, while Christianity offers its millions of followers messages of hope, peace, love and equality, it can be used, however, to stigmatise and judge others.

Many Black people living with HIV/AIDS, are being judged as immoral, by the same people who confess to be ‘religious’. This judgement it would seem, stems from white, racist ideologies, formed during apartheid and reinforced by religion. Such moral judgments, will keep those living with HIV, from being honest about their status. This

dishonesty can have a tremendous impact on society as a whole. Those affiliated with any religious organization need to do more to ‘love thy neighbour’, instead of prescribing judgement without knowing and trying to comprehend all the necessary cultural and social implications.

Media

Internationally, the media is recognized as an extremely powerful means of conveying information. The apartheid government also successfully utilized this method. Boonzaier states, “Indeed, it was the legislation that ossified these populations and rigidified the boundaries between them, so that the statutory groupings and the resultant very real differences in income and status, simply served to reinforce basic assumptions about the existence of racial groups and innate differences. School textbooks and the media equally helped to spread these underlying notions” (1988:64). Many of the respondents identified the media as culprits in their ‘brainwashing’, “I think we must have been hoodwinked. I think the Press must have been paid off. There was no freedom of speech and I think everything must have been completely veiled and edited and we probably didn’t hear the whole truth”. Certainly the media has the capacity to cement ideas, as well as to create suspicion. According to the respondents, the media were used by the government in order to convey their agenda. “Only now sometimes you look back and you think gee I did know that. I look at a book with all old newspaper headlines and I was reading things that at that stage I never even knew about, so I think we were kept away from what was going on”. This exclusion from truth helped maintain the values of apartheid, by not giving their readers any reason to question the government’s judgement.

Just as the media were a powerful tool in relaying messages that maintained normative apartheid thought, according to the respondents, it continues to have a significant influence over the perceptions of HIV/AIDS. The majority of times when asked what source has been most useful in their HIV/AIDS education, the response followed a similar pattern; “I know what I hear in the media, what I read in the newspaper, the stories I read in various magazines, or what I see on TV.” Oft times, the

media was the only form of contact or experience that the teachers would have with anybody who as HIV positive or living with AIDS. Besides the mandatory courses the teachers would have to attend as a result of their employment in the Gauteng Education Department, the media was the other main source of influence. There they receive their facts, images and experiences with HIV and AIDS. This media influence was measured amongst nursing home staff by Selbest and Alves (1994). They too found that “Most respondents - 92.5% got information about HIV/AIDS from newspapers and magazines, followed by radio and TV sources - 82.5%. In descending order, other sources reported were professional journals - 58.3%, professional seminars -35.8%, and churches -1.6%.”

To further indicate the power that the media possesses, at the 6th International AIDS Conference in 1990, Macdonald and Smith indicated that HIV/AIDS had received less media coverage and attention over the last 18 months. This hush by the media, they believe, “might have led to complacency and low risk perception of HIV infection.” As research has shown, millions of people utilise the mass media as an information gathering source, and as seen, oft times become their primary educational tool. However, as indicated by Macdonald et al, this didactic source employed by millions can easily lull its followers into complacency if the media cease or slacken off on their emphasis given to a particular subject; more specifically, HIV and AIDS. A sobering thought is that these teachers, and thousands of other professionals, turn to the media, where the primary objective is to sell papers, as an exclusively trusted source of information. Judith Soal, a Health Reporter for the Cape Times comments on this dynamic of having to sell papers and present educational pieces “... I'm a journalist so perhaps I see things slightly differently from most of your respondents. I know that you can't expect the media to simply play the role of AIDS educators. We are all hard pressed to get our stories into print or onto air. There's no way the commercial media can devote heaps of space to AIDS intervention. A typical editor's quote will be: "I don't want worthy, give me sexy." That's what so many NGOs don't seem to understand. They think that just because the issues are so important we should be running educational stories every day.” A concern that arises from this commentary is that if the HIV/AIDS pieces they are running are not always ‘educational’, then thousands of viewers, readers and listeners, are basing their HIV/AIDS facts on sensationalism and ‘sexy’.

However, as revealed in this research, the mass media can also be used to bring about awareness and positivity. One of the teachers mentioned, “it takes someone like Princess Di who is kissing them and hugging those people with AIDS, and she is a princess or whatever and if she is doing it and she is fine, that really opened my eyes. It needs to be ongoing.” This image of Princess Di was conveyed via the media. This picture brought about change and dispelled fear, enabling the respondent to view those living with HIV in a different paradigm. This positive shift took place because of the persuasion of the media. Responses such as these reinforce the power that the media has, not only to convey information, but also to mould perceptions, whether that is overtly or covertly.

According to loveLife (2001) “In South Africa it is estimated that 99% of people have access to the radio, 75% have access to television and 7% readership of newspapers”. It would appear that only 1% of our nation is excluded from one or other means of media coverage. With the media being afforded the opportunity of addressing an entire nation, one that has devastatingly high HIV prevalence statistics, it becomes imperative to view the types of messages our media in South Africa are conveying. This information is vital for this study, as a majority of the respondents indicated that it was the media they trusted to be their informant, ‘sexy’ or not. However, such an in-depth and exclusive analysis of the media, go way beyond the bounds of this study.

Coulson (2002), in her previously mentioned research, indicates, “Prior to the development of Soul City, the Beyond Awareness campaigns and loveLife, the use of the national mass media for HIV/AIDS prevention was very underdeveloped. Unlike in other resource-rich countries where the earliest signs of an HIV/AIDS epidemic triggered an outburst of national media advertising, South Africa was slow to respond.” According to Coulson (2002), it is the fore mentioned Soul City, Beyond Awareness I and II as well as loveLife, that have been the main prevention campaigns. Upon scrutiny, it would appear that all three of these campaigns have very similar target audiences. Soul City’s “...target audience is black and coloured South Africans between the ages of 16-65”, and loveLife, “who combines high-powered media awareness and education with

development of adolescent-friendly reproductive health services and other outreach and support programmes for hard to reach youth in poor communities.” (Coulson, 2002). Beyond awareness no longer exists, however, their target group was much the same as that of lovelife and Soul City.

While I am not disputing the urgent need for prevention campaigns to focus on young black and coloured youths “in hard to reach poor communities”, I am suggesting that in light of the emphasis given the mass media by the teachers interviewed, the question must be asked, ‘What about the white sector of the population, who is targeting them?’ This is of particular importance when one considers the former mentioned HIV/AIDS prevalence statistics amongst white South Africans, released by HSRC (2002). The HSRC themselves, when reporting on this statistic, recommended that “...white South Africans be made aware that it is not only mostly black women and children who are at risk” (health-e, 2003). In order for this recommendation to have any significance whatsoever, prevention campaigns must with urgency, expand their target audiences. The need to feature white South Africans takes on particular urgency when evaluating who the researched white schoolteachers perceive to be at risk; which is considered in the Risk section. For the purpose of this position, however, I will indicate that in the majority of cases, the schoolteachers did not perceive themselves to be at risk. Using the media as their main guide, it is difficult to dispute their stance or wonder why it exists.

In Coulson’s article, she states that in evaluating the success of the lovelife campaigns, it is reported that “black respondents were more receptive to the campaign than whites, and over 60% of blacks rated the campaign “very effective” while almost 60% of whites rated it “fairly effective” (2002). This is of course no shock or surprise to anybody, as indicated earlier; lovelife’s target audience is young black and coloured youths. According to the research undertaken with the white schoolteachers, it would appear that a ‘60% fairly effective’ rating would be a generous helping. Only two of the teachers could mention the name of any campaign, advertisement or slogan they felt to be effective. In fact of the two who were able to recall a campaign, the one was not able to recall the exact name of the campaign, referring to lovelife as ‘trust love’. The other,

being able to recall lovelife's name, spoke of the campaign with disdain, "I also have my doubts about that whole campaign. Its very vague and what is it actually teaching – have sex, but just make sure its safe."

With the white population not being part of what would appear as any target audience of any prevention campaign, it is quite understandable that only 8% of the respondents could recall any campaign at all. There appeared to be consensus among many of the schoolteachers that little attention, if any is paid by them, to the advertisements or billboards that might appear in their relevant neighbourhoods or magazines. When asked, the respondents gave an array of answers, with similar context; "No, not that I'm aware of. I don't know if it would catch my eyeball. I might see it and take no notice", or "If I do I just pass them over, but I have never really seen anything that specifically relates to my community". These responses clearly indicate that the respondents do not feel that the advertising is relevant or note worthy, in fact it does not even warrant a second glance. No one knew of any or could recall any advertising in their specific areas of residence, and those who could recollect any advertising at all, said they had seen 'things' on the side of a taxi, or on the side of the highway when going to Johannesburg. However, none of them could recall the contents of the advertisement.

It would appear that white South Africans are not the only ones being neglected by the various prevention campaigns. According to Coulson (2002) "...the loveLife survey of youth shows that youth who live in rural areas are more likely to be sexually experienced than those who live in a metropolitan area (34% v. 26%). Beyond Awareness found in their sentinel site research that poor and rural communities are lower on most prevention indices. Soul City 4 is reported to have reached 16,2 million youth and adult South Africans. This represents 79% of its target audience. However, the reach into rural populations of the TV series and the print media is not as great as into urban communities." Even though rural youths are more likely to be sexually active than their metropolitan counterparts, they too are not treated with the necessary urgency.

Not only are the campaigns such as lovelife not inclusive in their coverage, but they have been accused of promoting stereotypes and having confusing advertisements.

Quoting Stadler, Coulson states, “As their billboard campaign has unfolded, loveLife has come under increasing criticism. “The fun loving, partying and carefree young people seemed to suggest that such a lifestyle places one at risk of acquiring HIV, directly contradicting the overall strategy of the loveLife campaign. It was also Developments in the use of mass media at the national level for HIV/AIDS prevention in South Africa seem to imply that people who are HIV positive couldn’t have a good time. As with previous phases, the imagery that was of black people and suggested that HIV is a ‘Black’ disease. The characters portrayed in the advert were also seen to suggest promiscuity and prostitution”(2002). By lovelife only using black people in their campaigns, they do stealthily depict HIV/AIDS as a ‘Black’ disease. This has dangerous implications for all the other content racial groups in South Africa, as they do not associate themselves with the advertisement and remain happy in their assertion of unaffectedness.

Taher, the media Director for the Gay and Lesbian Alliance Against Defamation in Los Angeles, claims that it is vital to be able to ‘see’ yourself in advertising, as “If you don’t see yourself reflected, that’s what comes to your mind: This doesn’t really affect us”(Coulson, 2002). Perhaps some of the teachers had seen a billboard in their neighbourhoods, or even a relevant advertisement in one of the magazines they read, the point however remains, that it was so insignificant to them, that none of the teachers could recall even one noteworthy slogan of any importance. Perhaps this would have been different if the campaigns themselves would have been more geared toward the white community. Halperin and Williams, writing for the Washington Post, indicated that the youth they informally spoke to in the North West Province found the lovelife billboards “confusingly vague” (Coulson, 2002). From the above statement, it would appear that not only does the lovelife campaign need to focus of becoming more inclusive, thereby allotting all risk groups relevant attention, but they too need to improve on their advertising for them to have a significant impact on all population and/or risk groups.

Although this report is not meant to be an evaluation of the lovelife or any other campaign, analysis of their operational strategies is imperative, however, as it affects the

perceptions of respondents covered by this study. It is a vital argument that lovelife and other such campaigns as well as commercial media, need to focus on making their advertising less 'sexy', but on being relevant, understood and applicable to their target audiences. Commenting on culturally sensitive advertising in communities of color, Talvi states "Prevention specialists have learned through trial and error over the course of a sixteen-year epidemic that programs which work for one population may not be effective for other populations. The challenge, according to these experts, is to develop interventions tailored to the specific needs of each community." South Africa is an extremely culturally diverse country, encompassing the traditions and beliefs of many cultures, religions and races. Such 'tailored' interventions are therefore not only vital, but essential. This does issue the reporters and campaign executives with a challenge of ensuring that their advertising is well researched. This will enable a culturally sensitive, appropriate, meaningful and clearly understood message to be grasped by desired target group. Messages such as 'zero grazing' that have been highly successful in Uganda will not have the same level of understanding or meaning to white business men living in Sandton. Applying that selfsame motto in suburbia would be meaningless and void of significance.

In order to 'see yourself', the advertisers need to portray 'you'. Advertisements need to be created, depicting white individuals, not just people of colour. This is not an attempt to create segregation and difference, rather a plea for integration. All are at risk and must therefore be included in the campaign efforts. One of Soul City's prevention messages from their series 2, 3, and 4, states that 'Anyone can get HIV/AIDS' (Coulson, 2002). If Soul City truly believes this slogan to be true, then more needs to be done to inform 'Anyone' that they actually are at risk. They need to expand their TV coverage to not only focus on black youth, but also on the white youth. All materials need to make use of symbols and characters that they can relate to, such as music, movie and sport stars. Presentations need to be executed by members of the community whom they can identify with. This type of messaging will drive home the point that people just like me can get HIV; it is not just 'reserved' for the 'others'.

Talvi comments on community involvement by stating “...the creation of effective prevention strategies tends to require the participation of members of the target population”. This involvement has the potential to breakdown walls of denial, realizing that you and those just like you are also susceptible to the HIV virus. By being able to associate yourself with the message and the messenger, you stand a better chance of internalising the message and coming to a realization that you too belong to a risk group. Productions like ‘Serafina’ and ‘Yesterday’ have done well to draw attention to the plight of those who live with HIV/AIDS. Their portrayals were stark and heart wrenching, leaving one with grater awareness of the realities of the disease. However, as a white South African, the content was not as easily relatable. Most of the characters were black, and the settings were that of a rural nature. The vast majority of white South Africans have absolutely no idea what it would be like to live in a rural town or a township.

Another method that the media could endorse in order to put forth a more heterogeneous representation of HIV/AIDS, would be to create a production that dealt with white characters; not white homosexual men, thereby portraying yet another stereotype.

It would be foolish to think that simply extending their current advertising into predominantly white residents would be measure enough to capture the forgotten white market. What commercial media and prevention campaigns must centre their approach around, is appropriate advertising. Advertising that has been researched, suitable and culturally understood by each specific risk group. E-health, quoting the previously mentioned HSRC report, state, “This highlights the dangers of HIV/AIDS being labelled as a problem affecting particular groups of people and the imperative need to develop a range of messages which appeal to different audiences, says the report” (2002).

By the media continuously portraying stereotypical images across our TV screens, in our newsprint and along our airwaves, white South Africans will never begin to realize that they are not immune from HIV/AIDS. This disease is not a ‘Black’ disease, a gay disease or a poor, promiscuous man’s disease. It is, however, a disease that affects all mankind, across all nations, tongues and creeds and social classes. Some are more

susceptible to the disease than others due to an array of social conditions. Being white is certainly not a criterion for disqualification from a HIV risk group. However, in order for this message to be heard and comprehended, it must be depicted first of all, and secondly it must be done in a culturally appropriate way. White South Africans are at risk, already over 300 000 white South Africans live with HIV/AIDS. The media themselves need to take cognisance of this fact, and stop portraying misguided stereotypical messages about HIV/AIDS risk groups. As discovered, the media is a vital tool in educational disposal for the respondents interviewed. With this in mind, the media must take responsibility for portraying accurate and unbiased images of HIV/AIDS across all racial groups. Until this happens, thousands of white South Africans will continue in their attitude of complacency, being prepared to accept the images that they are currently receiving, indicating that HIV/AIDS does not affect them. No emphasis must be taken away from the current efforts of dispelling incorrect ideas of risk perception amongst all the racial groups, none is more important than another. However, it would appear that white South Africans are currently receiving no attention. This must change as according to this study and other research undertaken by the HSRC (2002), the majority of white South Africans do not perceive themselves to be at risk. With whites being the second highest racial group at risk of HIV infection in South Africa, they cannot afford to be 'lulled' into feelings of contentment that come via the media, that HIV/AIDS is reserved for the 'others'. The media, in taking its place as a watchtower, must do more to awaken white South Africans to the fact that they are at risk, and do more to offer a holistic view of the HIV/AIDS epidemic in South Africa.

The education system, religion as well as the media, are all social institutions, mentioned by the respondents as having a significant influence in creating and maintaining apartheid philosophy or white supremacy. These same institutions were also discovered to have a similar influence over the respondents' perceptions and experiences with HIV/AIDS. This is of particular concern for White South Africans, who rely on these mediums as trusted sources. Religion seems to offer a message that being HIV positive equates with being promiscuous. The media depict stereotypical images of those living with HIV/AIDS, paying little attention to the other groups that fall out of this range. These images cement the already existing stereotypes, creating no necessary

awareness for white schoolteachers. Education has the potential of broadening horizons and developing greater cultural sensitivity. Unfortunately, according to this study, the majority of the respondents attached their own understanding and discrimination about HIV/AIDS to the messages they transmit to their students.

It is imperative that teachers become aware of their socially constructed racial biases, so that they will educate their learners in a culturally sensitive environment, void of white superiority and power. Education can be an authoritative tool in overcoming these intolerances. In order for this to take place, the media need to convey the message that white South Africans are not exempt from HIV/AIDS. According to the respondents, being exposed to Black people, either through education or other means, helped change their perspectives and question the ideologies they had been taught by the apartheid regime. This, too, is possible and crucial with regard to HIV/AIDS. White South Africans must be given exposure to the fact that it is not only Black South Africans who are HIV positive. As white South Africans come to realize that they are at risk, it will help in the abolishing of stereotyped views of Black people, developed by white dominant thought, as well as create greater HIV/AIDS awareness.

Stigma

Academia offers volumes of articulate and well-researched journals of knowledge about stigma and its debilitating affects upon people of all races, sexes and cultures around the world. It was not until the interviews for this research report were conducted, that I truly came to realize how tangible and encapsulating stigma really is. It no longer was this body of knowledge merely understood, it now has taken on a new dimension. By interviewing the teachers, I have come to a realization that stigma has far reaching affects, which are not merely thought up at random, but have their roots firmly planted in the history of society. Stigma is a multifaceted phenomenon, which can be affixed to the same person numerous times, for vastly different reasons. This chapter will cover the many facets that the schoolteachers feel encompass HIV/AIDS stigma. It will also draw attention to some of the reasons why this stigma exists, and how this stigma is associated with prior experiences.

According to SARPCCO's Training Module dealing specifically with Stigma and Discrimination (2003), they describe stigma as "...holding negative attitudes towards others on the basis of what one believes about them or the group they belong to". Clearly stigma is associated with beliefs, a value system, what individuals hold to be true. When these attitudes are given an action, it is understood then that discrimination is taking place. SARPCCO continues by stating that these attitudes cause "...the display of hostile or discriminatory behaviour towards members of a group on account of their membership in that group". According to this definition, discrimination will not take place unless it is preceded by a stigma; hostile thoughts, attitudes and beliefs. I believe that the comprehension of this point is vital as it pertains to this research.

Most of the respondents shared what are clearly stigmatised thoughts about HIV/AIDS. Some of them, perhaps unconsciously, divulged discriminatory behaviours. In scrutinizing these words, I became aware of a pattern; most times the respondents attached a discrediting value to a person. This belief then became that person. And most often, that same conviction was then attached to the group that person belonged to. The International Center for Research on Women (2003), conducted a study in Ethiopia,

Tanzania and Zamiba, entitled ‘Disentangling HIV and AIDS STIGMA’. In this article, they quote Link and Phelan (2001), who use a four-step programme in displaying how stigma occurs within the context of power. They state, “The first three steps seek to divide the “tainted” from the “usual” people by distinguishing and labelling differences; associating negative attributes with those differences; and separating “us” from “them”. These steps culminate in the forth and final step in Link and Phelan’s process - status loss and discrimination for the stigmatised”. This process can be applied to this study, as can be seen by the following quote, “The black people don’t seem to have the same cultural standards that we do – you know like only having sex after marriage. Now I know these days it isn’t so much like that, but then usually you have sex with your future husband, but for them it seems so indiscriminate and secondly, they don’t seem to have the same reverence for life – all the killings and the violence and pregnancies. They don’t seem to have the same cost, ideals, appropriation of life that we do and I think that’s how it spreads. They are so much more spontaneous to their basic instincts, whereas we think, think, think. I don’t really know the facts, but that’s how it seems to me”. Applying Link’s and Phelan’s four step process to this quote, we are able to see that all four steps are realized here.

The first step is ‘distinguishing and labelling differences’. This is realized throughout the statement and begins in the very first line. The teacher indicates that ‘blacks do not have the same cultural standards that we do’. Unmistakably drawing attention to the difference in standards, labelled as cultural standards.

The second step is ‘associating negative attributes with those differences’. One of the ‘cultural’ differences that the teacher points out is that of sexual behaviour. For her, sex is an act that is only to be partaken of after marriage. For this respondent, and a large portion of other respondents, sex is accompanied with much reverence and respect, reserved for the sanctity of marriage. According to her, ‘blacks’ on the other hand have no reverence for this act. In fact for ‘blacks’ sex is such a ‘spontaneous’ deed involving ‘their basic instincts’. Sex now takes on a new element, first it was something ‘you do with your future husband’, indicating an action accompanied with much love and affection. Now, when compared to ‘blacks’, it almost takes on an animal instinct;

something that happens because you are simply 'spontaneous and basic in your instincts'. 'Negative attitudes' have most certainly been attached to the previously indicated difference in step one.

The third step involves 'separating "us" from "them"'. I believe this step has already been made quite obvious in the comparison between "us" and the "blacks". Word usage such as 'they, us, them and we' clearly signify the divide. This division polarizes groups of people, thereby proving the innocence of one and the guilt and wrong doing of another, leading us to our fourth and final step.

'Status loss and discrimination for the stigmatised' is the forth step, also evidenced in this statement. Noticeably, the 'blacks' are not viewed with the same standard as the 'us'. The 'us' seem, according to the respondent, to be more intellectual beings, as the 'us' 'think, think, think'. The 'blacks' on the other hand, are not on the same intellectual level, as they 'are so much more spontaneous to their basic instincts'. According to 'us', 'blacks' are also responsible for the killings and violence, indicating a different reverence for life. The example clearly indicates a 'loss of status and discrimination for the stigmatised', thereby coming full circle with the four-step process.

This four step process also indicates what I referred to earlier; many of the respondents attached a value to a person, and then ultimately were not able distinguish between the deed and the person, seeing the person as their conviction. This is evident as one of the teacher's explains her encounter with her gardener; "Like with my Gardener when he got sores all around his mouth and that sort of thing, he was not a nice sort of person to be near and then you did feel like - stay back a little, don't get too close". With the gardener going through what would appear to be the last stages of AIDS, this teacher felt almost repulsed by his appearance. This outward manifestation of HIV/AIDS, had such an effect on her that she now classed him as 'not a nice sort of person to near', thereby asserting a judgement upon his character, making him 'not a nice person'. This is an example of how stigmatised labelling takes place. Often one tends to attach a label like this to all people who are HIV positive.

This labelling went on further to be attached to a group. Two of the groups that were specifically stigmatised by many of the teachers were Blacks South Africans and teenagers. A closer look at both of these groups will be done under the headings of Risk Perception. However, because these groups were also stigmatised by the respondents, I wish to draw attention to them here.

Teenagers were without exception, referred to as being 'promiscuous' and 'care-free'. These attitudes are what many respondents feel are responsible for the rapid spread of HIV/AIDS in South Africa. Sometimes this group was broken down in sub-groups, such as 'the poor'. However, most times the respondents categorized all teenagers in the same group. The following teacher indicates this point when asked who she felt were the main risk groups in South Africa; "I would say our young people from about 14 to 30". Notice there was no sub-grouping or disclaimer; she simply thought that young people between the ages of 14 and 30 are a risk group. When asked why she thought this way, she responded by saying, "Because they are the group that are most sexually active, young having fun". According to this respondent, it would appear that all young people are out there having sex and having fun while they do it. Indicating that their behaviour is a choice and planned. This type of reflection, groups all teenagers into the same category, stigmatising them as people who have a lot of sex and spread the HIV/AIDS virus.

The second group that was stigmatised and almost always attached to an image of HIV/AIDS by the respondents, were Black South Africans. This image was usually accompanied with other adjectives, such as 'ill, thin, skeleton, suffering, malnourished, poor or uneducated'. This type of terminology used by the respondents, further stigmatises them. As will be discussed later, most of the respondents felt that Black people were the main risk group in South Africa. Several times, this group was broken down into, 'uneducated or poor' Blacks. One respondent spoke of the first image she receives when thinking of HIV/AIDS, "I guess the first image that comes to me is really black people, which is quite sad. A black person very thin and ill looking". I found many times that people became quite apologetic as they mentioned their images of Black people. Perhaps realizing at times the bias with which some of the respondents spoke. It

was imperative that I made them feel comfortable and realize that I desperately needed their true perceptions and experiences, whether they seemed discriminatory or not. Many of the respondents automatically attached race, being black, with HIV/AIDS. “To me straight away you start thinking about race and those kinds of things. You know you always perceive AIDS to be a black person’s problem”.

Analysing these statements in the South African context, it is imperative to acknowledge the influence of our historical apartheid past, on her current perceptions. This subject as already been discussed in the White Perception section and will be given attention in the Risk Perception section. According to the Encyclopaedia of AIDS, “...a stigma has been attached to AIDS as a result of both fears surrounding contagion and pre-existing prejudice against the social groups most seriously affected by the epidemic” (Herek and Cogan, 1998). Black South Africans are the ones most affected by the AIDS epidemic, and without dispute, it can be argued that a tremendous amount of pre-existing prejudice accompanies this group of people. A large portion of this tainted slander originated and was given birth by colonial and apartheid leaders. As previously discussed, throughout the colonial era and all through apartheid, Black South Africans were generally known as being far more promiscuous, and “... perceived to be “potentially diseased” (Jochelson, 1993). This viewpoint perpetuates the stigma that HIV/AIDS is a Black promiscuous man’s disease.

Seeing HIV/AIDS as a ‘Black’ disease does not seem to be isolated to South Africa. According to the World Health Organization (2001), “All over the world, HIV/AIDS is largely associated with Black people and with Africa”. Keeping in mind that stigma is the focus of discussion, there are three problems that arise due to the nature of this thought. One is that by attributing a colour to the disease, all those that do not fall into this colour category, are immediately dismissed as a risk group. Herek et al comment on this denial; “Because of the stigma of AIDS, many people may distance themselves from the disease and deny their potential risk. Such behavior serves as a serious obstacle to prevention efforts” (1998). This can be considered as a suicidal thought for all those who adopt this frame of thinking. If there is no fear of HIV infection, people might feel at ease in participating in high-risk behaviours.

Secondly, those belonging to this group will not want to admit to having HIV/AIDS, for fear of rejection and scorn. Keeping their status a secret will distance the person from medication, support and care. This fear also keeps people from being tested; “The AIDS stigma also deters people at risk of HIV from being tested and seeking information and assistance for risk reduction; indeed, entire communities have been reluctant to acknowledge their collective risk” (Herek, 1998). From the interviews conducted with the teachers, it was apparent that many times they were not simply stressing their own opinions, but that of their family and friends. According to this information, it would appear that they, too, could fall into the category of what Herek et al categorise as ‘communities reluctant to acknowledge their collective risk’, thereby placing themselves at greater risk. The majority are content with the stigma that HIV/AIDS is a ‘Black’ disease.

Thirdly the perception that HIV/AIDS is a ‘Black’ disease, does not simply stop there as a race classification. This philosophy usually goes one step further by associating a negative connotation with being ‘black’. Most times being Black is also accompanied with being promiscuous.

Based on the findings, promiscuity is synonymous with HIV/AIDS. The problem with promiscuity is that it is difficult to define. What may seem as promiscuous behaviour to me may not necessarily be so for another. The respondents put forth an assortment of ideas. For some, having sex outside of marriage was promiscuous, others thought that sex before marriage was licentious, while others thought promiscuity had to do with ‘looseness’. In trying to verify a definition for promiscuity, the Reuse Guidelines state (2004), “...promiscuity in discussions on HIV/AIDS refers to situations where there is more than one, usually many sexual partners. Bolton, in a seminal work on the topic, has criticized the concept as too vague and ill-defined, confused especially with marital infidelity and a product of the general hypocritical taboo in western societies on fornication and the strict insistence on sexual relations within monogamy”. According to this study, the schoolteachers perceive having sexual intercourse with more than one person at a time, outside of a committed relationship, as promiscuous. According to Herek and Capitanio, in their piece entitled AIDS Stigma and Sexual Prejudice, they

quote Weiner by stating "...people who contract AIDS through behavior that is perceived as controllable (e.g., sex, sharing needles) are assigned more blame, receive less sympathy and more anger, and are less likely to receive assistance than are PWA's who were infected through circumstances such as receiving a blood transfusion"(1999). One respondent commented, "I think the perception is that if you have AIDS, you are a loose woman or a loose man". Notice that the person bears the stigma of being 'loose'. Other comments display frustration with promiscuous behaviour, "These people sleeping around, can't they sort themselves out, like condoms don't just do everything". Others feel that sleeping around is a decision made out of desperation, anyone will do. Not much thought is given to their decision as to who they will sleep with or when, as long as it is now; "I think that people don't think. What they do think, is 'I want sex and I want it now' and they don't really care who it is with, they don't realize it could do them harm". Often sex is deemed as a thoughtless act, bad and immoral with the potential to do harm. This, however, does change when the respondents refer to their own sexual lives with their 'monogamous' partners. "Most of those who are HIV positive are sleeping around, and they don't care with whom". This type of message is not only hideously false, but also dangerous. If people living with HIV are so severely stigmatised, all efforts in providing adequate care and medication will be of little worth, as nobody will want to divulge their HIV status.

There is a level of sympathy for those living with HIV, but it depends on how you contracted it. Many respondents, when asked if they would disclose their HIV status if they were positive, gave responses that focused around a similar point; 'it would depend how I got it'. One teacher responded that the problem did not lie with the disease, but where you got the disease from; "Its not the so called illness, it is the whole 'where did she get it from' and the blame. It's a whole psychological thing. You can take your medicine and eat properly, but it's what it does to you psychologically. Where did they get it, what was happening?". Being responsible to society for your status appears to be a very stressful thing. For this respondent, the disease would be easier to live with than the stigma. She is, of course, in the fortunate position of being able to afford the necessary health care to provide for her needs as her body begins to succumb to the virus. Millions of others in this position would not have that option. Not only do they not have

access to adequate treatment, but they can also not afford it. Being able to eat properly would be an aspiration, not a necessity. Releasing your HIV status would be a difficult task for this teacher, “Because people start to think ah ha, you’ve been screwing around. People will wonder how you got it”. This type of imagery is that of being blasé, care free, irresponsible and sex crazed; all attitudes accompanying promiscuity and often attached to those being HIV positive. According to Herek et al, this type of blaming behaviour is quite customary; “People with AIDS are routinely blamed for their condition, especially if they contracted HIV through sexual behavior or injecting drug use. In our 1991 survey, for example, 20.5% of respondents agreed that “people with AIDS have gotten what they deserve”. Approximately six years later, in the 1997 survey, 28.8% agreed with that statement, an increase of roughly 40%”(1999).

Although each teacher was not directly asked to respond to the question of blame, often this thought arose simply by the language the teachers would use whilst responding to other questions. One respondent spoke of people with HIV/AIDS as feeling “ashamed”. Another stated that if she contracted HIV/AIDS in a hospital having a blood transfusion, or any other “innocent” way like that, that she would have no problem in disclosing her HIV status. Both of these statements illustrate the moral judgment being made by these respondents, on all those who have contracted HIV; except the “poor little children of course”. This disclaimer distinctly separates the guilty from the innocent.

Young adults and teenagers were also issued with the guilty, promiscuous label. For some, their perceptions of this group were based merely on hearsay; for others, however, it is interesting to note how their experiences coincide with their perceptions. This teacher, who having taught in Kwazulu Natal, feels that the young rural teenager is incredibly promiscuous, “The Zulu girls are asked to remain virgins, but they do a hell of a lot of foreplay, that’s the thing that really worries me. When I got there I realized that HIV is horrible. Before that I actually did not want to know about it. Who understands the teenage mind? They are told about AIDS, told about condoms, yet the teenage mind can’t comprehend all that it has been told and stop having sex”. She too, feels that the HIV/AIDS epidemic amongst teenagers is unquestionably a choice, ‘they have been told, and still they don’t stop having sex’. Of fascinating interest is that this same respondent,

who blames sexual promiscuity amongst teenagers as a huge contributor to the spread of HIV, appears to have different standards for her own children, which is not labelled as promiscuity. She is not the only respondent displaying this double standard.

Another teacher, when asked if she had spoken to her children about HIV/AIDS, responded "...I definitely did make sure that they had fresh condoms regularly, look boys will be boys you don't want them to get into a situation where they go ahead without anything, and we have spoken about STD's." While this same respondent emphatically stated that it was sexual promiscuity that is largely responsible for the spread of HIV, she believes that her sons' behaviour is not classified as promiscuous, merely 'boys being boys'. She also spoke much about the fact that society has degenerated, as when she got married, she was a virgin, and that was the norm of the day. On the one hand this respondent seems to condemn society for lowering the moral code by encouraging sex before marriage, yet on the other, it would appear that she encouraged it herself by providing 'fresh condoms' for her sons who were merely behaving 'as boys being boys'. Clearly, one behavioural label is being attached to those living with HIV/AIDS, while the same behaviour, practised by her children, is allocated another more diluted and socially acceptable label. This same irrational thought takes place when giving this same promiscuous label to Black persons. While those we know and love are purely being 'boys', Black people on the other hand are promiscuous.

Similarly, it was enlightening to see how many of the respondents felt that those living with HIV/AIDS, had made a bad choice, and in the process, contracted HIV/AIDS. Many felt that this was a behavioural choice that could have been avoided by most, if they had just controlled their sexual urges. When one respondent was asked if your husband was at risk of contracting HIV/AIDS, she responded by stating that "it was not her lifestyle" - delineating HIV/AIDS as merely a lifestyle disease, negating any social implications. One teacher called the intelligence of those living with HIV, into question, by stating, "To me it's a bit of a 'look how clever I am', but if you were that clever you would not have gotten HIV. It started off being a stupid move". This type of statement attaches two stigmatised labels to those with HIV. Firstly, she implies that it is a disease of choice, one where the person decided they were going to have sex, out of their own

free will without giving any heed to the consequences, a carnal act. Studying the HIV/AIDS epidemic from an African perspective, and more specifically, South African, it is clear that the HIV/AIDS epidemic can never be demarcated as a purely lifestyle disease. As will be discussed in the 'Black Disease' section, there are many social implications fuelling the spread of the disease, which is why HIV/AIDS is often referred to as a social disease. Another teacher felt "... you know, for their little bit of pleasure is it worth that?". This indicates that HIV/AIDS is a by-product of a very pleasurable choice. Another teacher felt that many living with HIV/AIDS have chosen against their better judgement; "If you know about it and you still choose to do the wrong thing, then it's your tough luck". This teacher felt that most of the people living with AIDS are those who have been given adequate information, yet have chosen otherwise and gone against their better judgement. The consequences for such a decision are rightfully yours, HIV/AIDS. Oft times, HIV/AIDS was compared to other illnesses, such as cancer or even chickenpox.

One respondent stated that if you get chickenpox, no one would wonder what you have been doing. It would merely be a case of 'oh shame, somebody sneezed on you'. This is, of course, vastly different to the assumption people make when you are HIV positive. You are firstly considered to have been sleeping around, and secondly, some feel that the punishment fits the choice; "So we have known for a long time that people thought, 'well AIDS? What have you been doing, why have you been sleeping around? Whereas with cancer, people feel sorry for you, you didn't deserve to get it, it just happened".

It would appear that contracting cancer is something you have little control over, unlike HIV/AIDS, where you made the choice, you received pleasure, and now you deserve the consequences. In an article published by health-e, entitled, Condoms – a simple choice? They discuss that a new brand of condoms, has been put into circulation, "...called 'Choice'. It has entered the market to replace the old condom with its plain packaging and AIDS ribbons stamped on the wrapping. The re-launch was necessary after the old government unbranded condoms, but failed to strike the right cord with the public. As Health-e discovered, there's much more to condom usage than merely

providing protection”. While transmitting a public message that sex is a choice, is essential and helpful in some cases, it certainly is horrendously false in others. According to UNAIDS and the WHO (2001), “Gender norms are frequently linked to attitudes and behaviours that contribute to risk of and vulnerability to HIV. For example, the high value placed on virginity in some cultures, may encourage older men to seek out younger women, or it may encourage unmarried women to practice anal sex so as to protect their ‘virginity’. HIV-related risks are often greater in situations where women are socialized to please men, not to say ‘no’ to unwanted sex, and to defer to male authority”. Such cultural practices are encouraged in South Africa, and must be taken into account when sending out public broadcasts that HIV/AIDS is a choice.

Millions of women and children around the world do not have a voice. They are subject to cultural practices that deem them as inferior and privileged servants to the more socialized dominant male figure. While there is merit for the perceptions held by many of these teachers concerning promiscuity and HIV/AIDS, such a blanket statement, however, should not be attached to all of those living with HIV/AIDS.

Much of the silence that encapsulates HIV/AIDS can be attributed to the already discussed topic of promiscuity. Many do not want to reveal their HIV status for fear that people will think that they would be considered a ‘slut’. One respondent acknowledged, “...if I got it, it certainly would not be from any fault of mine, so why should I be punished. It could have been from a ‘vrot’(dirty) needle when I was giving blood, it can happen anywhere. Unless I am some ‘skom gat’ (loose slut), a promiscuous thing, then I would not want to say anything, because then everybody would think, ‘ya you bloody slut’. If I got it through no fault of my own, and God has deemed that I should have it, then why should I hide it”. This respondent indicates that silence should be adopted by those who contracted it through sexual intercourse, because you would immediately be regarded as a slut and a person who sleeps around.

While discussing this same topic with other respondents, who have had actual experiences with people who are HIV positive, they expressed similar views. None of them had actually been personally told by the respective persons about their HIV status,

but somehow they all knew; “No one actually said anything about being HIV positive, but you know the signs”. Although it is a very silent epidemic, it would appear that most who encounter it, do not need to be informed, it is common knowledge; “To this day, no one had said to us that she had AIDS, but we all put it together that she must have it”. So even though “...nobody says a word”, somehow through the deafening silence, the stigma attached to HIV/AIDS, continues on its destructive mission all through society. Of interest is the fact that none of the respondents, who had contact with someone who was HIV positive, ever discussed this condition with them; it continued to remain a secret.

Recently former President Nelson Mandela’s oldest son died of AIDS, he was quoted by BBC as saying, “...the only way to break down the barriers surrounding the virus is to speak about it publicly, and doing so in such a personal way can only help raise awareness further”. Perhaps if some of the respondents had spoken with the respective persons, they might have had the opportunity of seeing the disease through the eyes of a human being, one with feelings, emotions and aspirations. Adopting this personal approach may have an influence in breaking down walls of discrimination and cleansing the lens of stigmatisation.

Another teacher felt that silence was necessary because “...you feel you might be targeted for various reasons. I think it comes down to it that people don’t talk about it because they are scared, they are scared how it might impact on their lives, and they don’t want people to know, they would rather keep it to themselves”. This fear of how it might impact on your life, was displayed by many of the teachers. Most of them felt that the biggest impact would be on their employment. When asked if she would talk about her HIV status, this teacher replied “Well, I’d be nervous about it, to be honest. If parents, found out that their children are being taught by someone who is HIV positive and they didn’t know much about it, they could become quite nasty. So I’d get nervous about it, but I would tell my own family. I know they wouldn’t have made an issue of it, but I think my main concern would be work.” According to Avert, in an article entitled HIV & AIDS Stigma and Discrimination, they state that “While HIV is not transmitted in the majority of workplace settings, the supposed risk of transmission has been used by

numerous employers to terminate or refuse employment. There is also evidence that if people living with HIV/AIDS are open about their infection status at work, they may well experience stigmatisation and discrimination by others". It would appear that as corrupt as your employer would be to dismiss you from your job because of your HIV status, it is still a valid concern amongst those who suffer. Many of the respondents not only felt this fear for themselves, but felt that this is one of the reasons why so many people feel the need to keep their HIV status a secret.

Fear of losing your job, is not the only fear that surrounds being HIV positive. Even though none of the respondents displayed any signs of having incorrect knowledge about HIV and how it is transmitted, many of them felt fearful of the actual disease, as well as the person with the virus; "I know you should not be scared of people with HIV, but people don't like to be in the company of people with HIV. I know you can still drink out of the same cup, and hug or whatever, but there is still something in the back of my mind saying that I don't really want to be a huge friend with that person. I know I won't get it having a friend like that, but there is just something about it that makes you uneasy". Although this respondent recalled several experiences with people living with HIV/AIDS, she still found herself afraid of the disease, as well as people possessing the virus. This type of behaviour most definitely stimulates the stigma that HIV is something to be feared, as those people living with well person who possesses it. Another respondent whose gardener had died of AIDS, expressed a similar notion, "I still sort of feel a bit afraid of HIV, even if I know that it can't be transmitted. I have to think that there is no fear or getting this disease by being with this person. My emotions say this is not a healthy situation to be in, but my mind tells me that I am safe". Both of the respondents knew perfectly well that being in somebody's presence was not going to spread the virus, yet this was not reason enough to settle the fears of the teachers. It would appear that there is a gap between what the respondents know and how they comprehend that knowledge. Even though they appeared to believe that HIV/AIDS could not be transmitted via oxygen, the fear of infection still existed.

The fear of HIV/AIDS is a significant contributing factor to the silence. Silence from those not infected, so they don't discuss it and leave all interpretation open to

speculation. This silence can lead to denial of one's own risk, as well as fuel emotions of fear toward those with HIV. More importantly, I would suggest that by continuing in this vicious, silent cycle, those who do not have HIV or are never personally exposed to it, never come to a more realistic idea of what it truly feels like, both in an emotional and physical sense, to be HIV positive. By not getting personally involved and asking questions, stigmatised labels will continue to cloud the perceptions of those seemingly unaffected by HIV, and cause those living with HIV, to disguise their status so that they are not shunned and ridiculed by our society.

According to Leithead of the BBC, reporting on Nelson Mandela's announcement about his son's HIV/AIDS status, she states, "Surrounded by close friends and family, he made it clear that the best way to fight stigma and denial is to be open and honest about the virus". An environment of 'openness' to the understanding and alleviation of another's plight, acceptance of difference, as well as change and 'honesty' about the virus with yourself and others, has the potential of pacifying fear and bringing scope to the narrow minded. All these attitudes are vital in the disintegration of stigma.

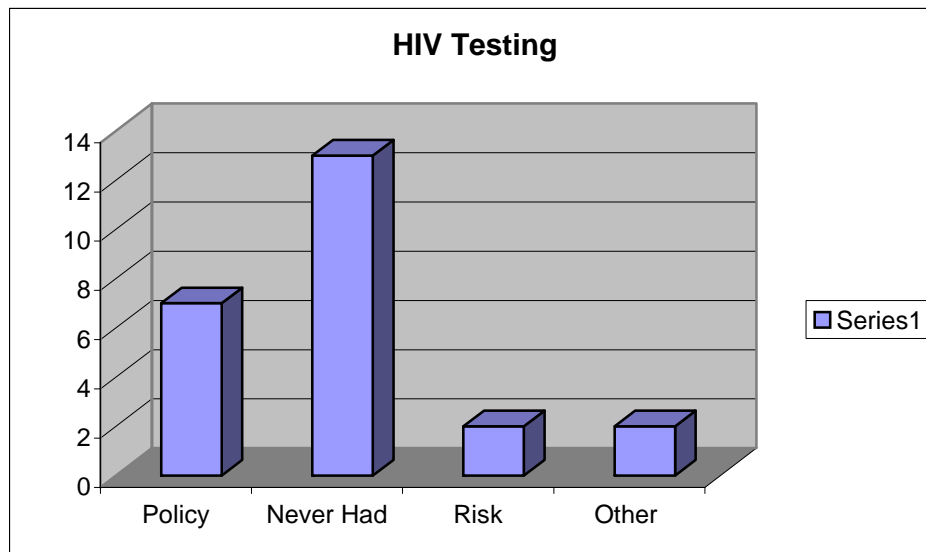
Perception of Risk

In determining the teachers perceptions of risk, it was imperative to be able to establish who they perceived to be at risk, and why. Experiences personally encountered, appeared to play a significant role in risk determination.

This Section can be divided up into two sub-sections. The first would be to explore the respondents' personal views on risk. Secondly, to identify other groups the respondents feel are at high risk.

Personal Risk

A large majority of respondents did not perceive themselves to be at any personal risk of being infected with HIV. Note how this train of thought adds substance to the notion that HIV/AIDS is a lifestyle disease. This statement also indicates blame and judgement. Many of them stated that if they were to be infected, it would be through no fault of their own. Some of these 'no fault' risk situations mentioned were blood transfusions or being injected with a dirty needle at a hospital or when donating blood. Infection from sexual contact was not an option. The majority of the respondents felt this would never happen. One way to determine this risk perception, is to find out if the respondents have ever had an HIV/AIDS test and why they had it, if they had. Most of the respondents had never had an HIV/AIDS test - there was no reason to do so. Those who had had a test, the majority of them had done so for insurance or medical aid purposes. There were only 4 respondents out of the 24 who stated that they had a test for other reasons besides insurance requirements. One of the teachers had to have a test in order to adopt a child. Both her and her husband were required to take the test. This test was also not taken for fear of HIV infection, rather as a government regulation. Another teacher spoke about how she had to have an HIV/AIDS test when she had given birth to her children. This too was not a test she chose to have, but one that was mandated by the hospital. The other two had tests because of engaging in sex with multiple partners. The husband of one of the respondents had an affair, while the other respondent caused the doubt in her own HIV status herself.



The main reason given for the confidence in their HIV status was the fact that most of the teachers were married. Marriage appeared to be a protective coat, keeping one from ‘immoral’ and ‘promiscuous’ behaviour. Some of the respondents answered that they were not at risk because they were married’ “I am a bit immune to it – I’m married and I don’t sleep around”. Marriage is certainly not a 100% protection from HIV/AIDS infection, and should not be viewed as such. It was apparent that many of the respondents felt like I was bringing into question their own, as well as their partner’s fidelity - this was not my intent. This line of questioning was adopted in order to estimate levels of risk perception. Discussing HIV/AIDS with a person who is married, can sometimes bring up issues of trust. Many of the teachers tried to stop this line of questioning by expressing their explicit trust in their husbands. Trust became the issue, not HIV/AIDS; “I trust him implicitly”.

Associated with the marriage protection, was that many of the respondents had not had sexual intercourse before their marriages. This was considered the right thing to do, as well as a show of morality, “marriage is not as holy as it used to be and no sex before marriage was the prevalent thing, and it’s not anymore”. Many of the respondents spoke of how they were virgins when getting married because it was the correct thing to do. Some felt that society no longer had the same regard for this restraint, as well as for marriage as an institution. This disregard was also felt to exist among other races, “The

racist side of me comes through. The black people don't seem to have the same cultural standards that we do – you know like only having sex after marriage. Now I know these days it isn't so much like that, but then usually you have sex with your future husband, but for them it seems so indiscriminate”.

One respondent, who was not married, spoke of an uncomfortable time when she discussed HIV/AIDS with someone before entering into a sexual relationship, “It actually took a long time to discuss it before we got involved. As enlightened as we are, it is not an easy thing to do, because you don't want them to think that you don't trust them, but at the same time, you don't want to put yourself at risk. It actually makes things very difficult”. It would appear that discussing HIV/AIDS is embedded with other latent messages of distrust and unfaithfulness. None of the teachers had discussed HIV/AIDS with their partners before getting married. This too indicates a lack of risk perception.

While absolute trust appeared to accompany marriage, this was called into question on a few occasions. Despite the affairs, two of the respondents still did not consider themselves at risk. According to The African Women of Faith Network, the Chairperson states, “In spite of existing data highlighting the danger women face with respect to HIV/AIDS, many still believe that their risk is low as long as they remain faithful to their husbands or partners” (Karam, 2003). The other teacher, who was now single, although not admitting that she was at risk, did state that she would ensure that any future partners have an HIV/AIDS test before engaging in a sexual relationship. In fact, all three of the respondents stated that they would want any future partners, if they were to have any, to have an HIV/AIDS test before engaging in a sexual relationship. After further probing, it turned out that only one out of the three respondents had gone for an HIV/AIDS test, as she felt the woman her husband had been with was very ‘loose’. The other two had never gone for a test, as they were both too scared to. The one admitted that at the back of her mind she does have doubts. This expression of doubt is somewhat of a different attitude to the one previously expressed, where there was absolute certainty of no HIV/AIDS risk. Now it would appear that there was an element of doubt. The interesting thing about these situations is the fact that neither of the husbands went for HIV/AIDS tests after being unfaithful. Both of the respondents stated

most fervently that having a test was part of the condition of the husbands return to the marriage, but this threat was never carried out. The one teacher said that she thinks her husband went for a test when he applied for a new insurance policy, so she would assume that HIV/AIDS would have come up. These experiences indicate a definite gap between the knowledge possessed by the respondents and their actions. It would appear that marriage alone was not fidelity enough. This knowledge did not appear to change the respondents' view of personal risk. However, it would appear that this risk perception was more a matter of denial than belief.

There were respondents who stated that everybody was at risk. While this thought was convincing at first, it did lose some of its impact. In determining if the respondents truly felt that everybody was at risk, this 'everybody' had to include their family, friends and community. Only two of the respondents followed a consistent pattern of risk perception, where they perceive themselves, their family, friends and community at equal risk. I will illustrate this pattern by quoting from a respondent. When asked whether she perceived herself to be at risk, she stated "Ya. I know that my lifestyle is maybe not a high-risk lifestyle. I am married and I have a faithful partner, but even then you don't know". Notice how she mentioned marriage, but was realistic in her view that there was still risk. Later she stated that even though she trusted her husband, 'we all make mistakes'. She was not bringing her husband's fidelity into question; she was merely stating that the chance was there. Of interest, this respondent was extremely religious. She donated time and substantial financial assistance to the relief of those with HIV/AIDS. This conviction, however, did not appear to be accompanied with intolerant moral judgements, as had been the case with other respondents. This became quite evident in her response about whether she felt her children were at risk; "I think we have been quite open and been able to say that this is something that your generation has got that we did not have. Our parents used to say, now don't sleep around because you will get pregnant. Now they say, don't sleep around because you will become pregnant and contract HIV". While she stated that she had frank discussions with her children about the dangers of contracting HIV, she did appeal to their moral conviction to keep them from infection. This moral plea was not one of judgement. It was more an appeal to the moral standard that they lived as a family, due to their religious decision. This is better

understood in analysing her words, “We know that our children have morals, but we also know that other people who have morals have contracted AIDS”. This type of statement clearly indicates that she does not judge all who have HIV/AIDS as promiscuous and immoral, it also demonstrates the consistency in her risk perception. Her perceptions of risk did not start outside of herself, her family or her community. She did have a moral standard by which she lived and hoped her children would live by. This standard however, was not a moral yardstick used to judge the rest of society with.

According to this study, it seems that if one truly believes that you are at risk, this perception will be realized in all areas of your life. If this perception is not truly innate, then inconsistencies will appear. Some who professed that ‘everybody’ was at risk demonstrated levels of discrepancy. One respondent when asked about her risk perception stated, “I think everybody is at risk”. I later asked whether she felt that people like her, in her community, were at risk. Her answer proves the inconsistency; “No. I definitely don’t see that, I would like to know if I am wrong, but I don’t see it”. Another teacher was also fervent in her conviction that “I think everybody is at risk”. However she later shared a story, which painted a slightly different picture. In her book club, one of the ladies shared an experience of how she had heard that there were a group of kids at a private school who were being treated for HIV/AIDS. When asked how they all reacted to this information, she stated, “...everyone was really shocked. I don’t think anybody thought you can’t get it, but I think everybody was shocked that these supposed to be well educated children from good homes”. One has to wonder why when you perceive ‘everyone’ to be at risk, why the information about a group of White teenagers, living with HIV/AIDS would accompany such huge ‘shock’.

This feeling of surprise or shock is not isolated to this group, commenting on the HRSRC and Nelson Mandela Foundation study, which revealed high prevalence statistics amongst white South Africans, Dr Webber states, “These figures came as a surprise to everyone except medical professionals working with patients. We see wealthy, middle-class white people every day who are infected. However, many white people continue to feel that the epidemic is “restricted” to South Africa’s black population” (Kaisernetwork.org, 2005). If one truly believes that all are at risk, then shock should not

be the reaction associated with the news of HIV. This 'shock' indicates that although some people may say that white South Africans are at risk, they truly do not believe it.

It seems that unless respondents truly believe that they are at risk, they would not perceive those like them, to be at risk. They seem to foster the understanding that others unlike them are at risk, while those in their communities, family and friends are immune to this disease.

Those perceived to be at risk are mostly Black South Africans. The respondents' perceptions of high risk groups, are reflected below:

Other Groups at Risk

A 'Black' Disease

HIV/AIDS, has been conceptualised as "a distinctly racialised disease" within people's minds and public discourse (Crothers, 2001:13). This is particularly evident among the white schoolteachers interviewed. Most often, the image of a 'Black person' represented the picture that the teachers fostered about HIV/AIDS. Occasionally the word 'black' was not unequivocally used. However, words such as 'tribal' or 'rural' gave the same perception. In analysing why the respondents attached a colour to the disease, two explanations became evident.

The first justification would be that of experience. As indicated earlier, the majority of the respondents have not had what they would call personal experiences with HIV/AIDS. The majority of the respondents have never known or met anybody with HIV/AIDS. Their experiences are drawn from stories from school, the media and encounters with their employees. Two of the teachers each had a friend that was HIV positive. The one was a gay man, who had died 25 years previously and the other no longer kept contact with her friend. It is evident, in analysing these experiences, that they play a large part in the conceptualisation of perceptions. This is illustrated by the following comment, "We kind of think that it won't affect us because we work at an

affluent school. I think that is the reality – how many of the little children in our school would be HIV? I don't think there are any. Maybe there might have been one in the whole history of the school. But if I were working in a rural area, I would feel more at risk. I think I would be a lot more cautious". This respondent does not perceive herself to be at risk, and feels that Black South Africans are the main risk group. Since she has had no experience with any White people with HIV, she tends to make the exaggeration that in a school of hundreds of learners, in a white affluent area, there would not be any learners with HIV. For most of the teachers, this was their reality and their experience. They knew no White person with HIV/AIDS, they had never known any White people who had died of HIV/AIDS. This is not to say that there are no White people with HIV/AIDS of course. The Nelson Mandela Foundation study put an end to that notion; it was just that they had never had contact with any white people with HIV/AIDS. However, in all actuality, the respondents felt quite justified by their perceptions. Just as one respondent felt that when growing up in South Africa she thought it was a predominantly white country, because that was her experience. The teachers, who did have experiences at school, experienced them with Black students. None of them had ever had a White learner speak of a sibling or friend who had HIV/AIDS. For these White schoolteachers, their experiences told them that HIV/AIDS was a black disease.

Similarly, many people in the United States of America and Europe see AIDS as a 'homosexual' disease. While HIV/AIDS started out being represented as such, it has most definitely evolved into a disease that has the potential of affecting all heterosexual people who practice unsafe sex. It is difficult to associate risk with something you have never experienced or ever hear much about. The respondents' experiences relay the message that this is a 'Black' disease. If all their experiences had been with White learners, then perhaps their perceptions would take on a different 'colour'.

Another motivating factor adding substance to this train of thought is the fact that the media themselves portray HIV/AIDS as a Black disease. As discussed previously, not only are Black South Africans the target group for prevention campaigns, they are also guilty of constantly portraying stereotypical images. None of the prevention campaigns such as loveLife and Soul City, target White South Africans as a risk group.

Their main target audiences are young Black youths. While this emphasis is imperative because of the high rate of infection in this group, it does, however, have one devastating consequence, the disregard of White South Africans. Cromie, writing for the Harvard University Gazette (1998), reports on a study conducted by the Kaiser Family Foundation, which stipulates "...most blacks get their information about AIDS from the media, particularly television". This media coverage appears to have had a significant impact on how Black Americans view HIV/AIDS. The Kaiser Family Foundation states that "...more than half of blacks believe (wrongly) that AIDS is the nation's leading health problem. However, that idea has helped shape an increased concern about the problem and has spurred more people to take action" (Cromie, 1998). This survey indicates that Black Americans perceive the HIV/AIDS problem to be the most pressing health problem in the USA. While this perception is incorrect, it does however prove the influence the media has over its viewers. As I do not have access to their survey, or a comprehensive analysis of its findings, I would propose that a correlation exists between the amount of culturally sensitive media viewed about HIV/AIDS, and one's perception of personal risk.

Black people are able to see images of other Black people with HIV/AIDS on just about every billboard or advertisement about the subject. This extended coverage could contribute to the reason why Black Americans have a heightened perception of the risks around HIV/AIDS. Many of the respondents admitted to only ever having viewed 'Black' images in the media. Not one of them had ever seen an advert or campaign that they felt related to them or their community. This colour perception portrayed by our media is significantly contributing to the continued "racialized disease" (Crothers, 2001:13). With all the emphasis placed on Black South Africans, as well as the obvious fact that Black South Africans form the majority of people in South Africa, it cannot be considered as a surprise that White South Africans do not consider themselves to be at risk, thereby placing that risk on Black South Africans.

The second explanation identified as to why White South Africans view HIV/AIDS as a Black disease, can be viewed as social learning adopted due to history, which will be explored in this section.

An explanation as to why the respondents viewed HIV/AIDS as a black disease, often followed the declared statement. This explanation was “I think amongst the black population, culturally they have different attitudes towards sex”. All the respondents who felt the HIV/AIDS was a Black disease mentioned a cultural practice that they either found “horrificing” or “strange”. Many of these revolved around Black peoples sexual practices.

One such practice is polygamy, “So if you have two wives, it just becomes problematic. Whereas you look at us, my group that I move in, that is not acceptable, it is totally frowned upon to have an affair”. Notice that the respondent classes a second wife in the same category as having an affair. The respondent is comparing an act of deception and betrayal, to one that is lawful, culturally sanctioned and often accompanied with much pride and love. This clearly indicates that the respondent is using her set of cultural norms to place judgement on another vastly different culture. Another respondent spoke of the importance of reproduction, “You know for a Black person to reproduce it is a huge thing. In the Black community I believe that the more children you have, the better your standing is”. Another expressed a similar thought in that sex before marriage was encouraged because “...in their culture the woman have to prove that they can have a child before anybody will marry them”. This was compared to ‘our’ culture where “our mothers would be happy if we were still virgins”. Other practices such as virginity testing and visits to a witch doctor, was also classified as ‘strange cultural practices’. Additional attitudes, which the respondents mentioned as contributing to the ‘colour’ factor of HIV/AIDS, were those of “the breakdown of the family”. Some of the respondents felt that Black people did not value the nuclear family as much as their extended family. A Black man’s attitude toward women and sex, were additional reasons for the ‘Black Spread’.

It is true that many of the practices mentioned by the respondents do contribute quite significantly to the spread of HIV/AIDS. Many of these practices have been researched and documented as such. However, the problem with the labelling, entered into by the teachers, is that these practices were not merely spoken about as a matter of

fact, they were discussed as a matter of judgment. While many thought the practices were 'strange' and 'horrificing', none of them came up with any sort of significant explanation as to why these customs exist or even hinted at as some sort of significance behind some of the conduct. The impression was that Blacks were promiscuous by nature. It is something that is part of 'them', something 'they' do. Comments of a similar nature, such as "They have nothing else in their lives" or "they have got nothing else to do", clearly illustrate that many of the respondents felt that Black people are sexual people, it is their recreation and the thing that fills up the space in their day. Interestingly though, this same judgment was not placed on their own children, who also entered into behaviour that could be considered 'promiscuous'. One of the religious respondents spoke of a conversation she had with her son about having sex with his girlfriend; "I didn't want my son to hurt the woman he loved by getting her pregnant when she did not want to be pregnant, step no.1. And step no. 2 if you want to have sex with your lady I would much rather you told me about it and I will vacate my home, so that you can bring her here and do it here in safety and treat her like a lady, I don't want you to f--- her in the back of a car". On the one hand, this respondent was condemning sex before marriage, stating that this was a reason for the spread of HIV/AIDS by promiscuous Blacks. On the other hand, however, her son, who appeared to also be having sex outside of marriage, could do so in the comfort of her home. This same act would be considered promiscuous if performed by a Black person also wanting sexual intercourse.

What then makes the difference? Why does it appear that one set of standards is applied to one racial group and a very different set is applied to another? I believe that part of the answer lies in what I alluded to earlier as the second justification why the respondents attached a colour to the disease.

This answer lies in history. In order to understand this justification, one needs to comprehend history, the history of South Africa. While this is not a history report, some reflection on the past can bring understanding to the present. This type of understanding was significantly lacking in the answers obtained by the respondents. While a few of them spoke of how many of the men had to leave their homes in search of employment, this thought was never entertained for any length of time. While many of the respondents

felt sincere sympathy for the atrocities of the past, it was apparent that an adequate understanding of them, as well as their repercussions, were lacking. According to Thornton, "...there is a period before HIV, a period in which the society will already have developed and entrenched multiple factors - ideas and ideologies, values and practices, social forms and cultural norms, demographic densities and distributions – that will influence the vulnerability of the society to HIV infection and that will influence the rate of transmission, as well as the rate of progression from HIV infections to full-blown AIDS and death. These are the social and pre-conditions for the epidemic"(2004). The social and pre-conditions of the epidemic in South Africa made Black South Africans extremely susceptible to contracting HIV/AIDS.

According to the WHO (2001), "In many countries, numerous health problems derive from the legacies of colonialism, racism and apartheid. They include migrant labour, the rural-urban drift, lack of housing, informal settlements and lack of educational opportunity". As evidenced by the teachers, we as White South Africans, often underestimate the full impact of these inequalities, and fail to realize their far-reaching affects. While some acknowledgement is given to the fact that the men were forced to leave their homes, the only consequence ever mentioned by the respondents was the fact that men had to quench their sexual appetites. Little recognition is given to the fact that these men were taken from their families, homes, familiar environments, where they were head of a patriarchal society. Living in the compounds was not only an extremely unhygienic experience, but a very lonely and suppressed one. Most men were not able to keep in touch with their families. Visits home were infrequent, due to the exorbitant cost relative to their salaries, as well as due to the lack of public transport. Jochelson states that "engaging in relationships with many partners" quenched this loneliness. Campbell states, "...drinking and sex appeared to be two of the few diversionary activities easily available on a day-to-day basis" (1997:276). Activities that they had control over, a privilege they no longer had since leaving their homes. It would appear that men resorted to drink and easily accessible women, perhaps even as therapy to numb the distress of their putrid situations.

Women were severely affected by this neglect. They were now breadwinners, mother, father and in many cases destitute. Jochelson states, “For women abandoned by their husbands or lovers, brewing and selling beer and sexual relationships with returned migrants were the means to survival” (1999). Instead of living on the farmlands, providing and caring for their children and husbands, many women were now prostitutes. Once valued for their fertility and reproductive powers, women were now lusted after for their sexuality.

Traditionally, the children of the village were taught by their parents and cohorts within the community, about gender roles and sexuality. Now left on their own, many children sought refuge and companionship from gangs. This meant that cultural values and norms were no longer being taught and therefore not being upheld. A new culture was being formulated, a gang culture. Grandparents were also traditionally a source of cultural enlightenment and support. However, with migration, it “...disrupted the relationship between city born children and their grandparents, who might have played a supportive role in sexual guidance” (Delius 2002:15). Many children found themselves in the precarious position of having no mother or father around as a stable guide. The gangs were their homes, their schools and their place to express their total frustration; “Aside from worries about their criminality, these gangs were associated with high levels of promiscuity and sexual coercion” (Delius, 2002:14).

In a racially divided country, skin colour determines your status, class and standard of living. Dressler “concludes that skin colour is a kind of ‘master status’, which serves as a criterion of social class in colour-conscious societies” (Bartley, 2004:155). Black people were not afforded the privilege of medical attention, which accelerated the spread of STD’s. Catholic missionaries, who did much to convert the Black Africans to Christianity, and abandon many of their heathen customs, offered some education. Black people became conceived as ignorant, “...a walking reservoir of disease”(McCulloch, 1999:202), and “...constitutionally predisposed to immorality” (Setel, 1999:7).

Apartheid has been abolished, but many of the stigmas and prejudices created in that time, continue to flourish today, perpetuating the thought that Black South Africans are predisposed to HIV/AIDS because of the ideology that was created in the apartheid era. Commenting on the lingering affects of apartheid, Swartz states, “Although South Africa has undergone a dramatic political transition in the last decade, many of the distortions and dynamics introduced by apartheid continue to reproduce poverty and perpetuate inequality”(2003).

History plays an important role in coming to understand why many White South Africans attach a colour and promiscuity to HIV/AIDS. It would seem from this study, that a natural connection has been made, automatically linking the two to HIV/AIDS. The White schoolteachers have been socialized to accept that Black Africans ‘are predisposed to immorality’. This makes the association with HIV/AIDS, a disease known to spread by promiscuity, a logical conclusion for the respondents to make.

Being poor and undedicated were two other groups identified by the respondents, as being responsible for the rapid spread of HIV/AIDS in South Africa.

Poverty

Poverty was mentioned by the majority of respondents as a factor that significantly contributes to the spread of HIV. Most often, this classification was also attached to being a ‘Black ‘disease. A few of the respondents felt that it was more of a socio-economic disease than a Black one, “On the odd occasion that I have gone into town (Johannesburg) and I see people that are obviously poor, helpless, unkempt and desperate, then I do think, I wonder if they are HIV positive. For me it’s more a socio-economic issue than a race issue, because if I think of the black kids in my class, their parents are wealthy and educated. I would never think of them as being HIV positive. Whereas if I had children who looked poor and neglected, I might think they are at risk”. Most of the respondents felt that being poor would not allow you access to treatment and that the living conditions you would be forced to live in, would promote the spread of HIV/AIDS. Today, the income differential amongst the South African population is vast:

so much so that the poorest 52% of the population (which comprise 40% of all households) receive less than 10% of the total income, meanwhile the richest 6% of the population (10% of the households) amass over 40% of the total income available (Seekings & Nattrass, 2001: 143). While it is clear that the majority of Black South Africans continue to bare the brunt of inequality in South Africa, it cannot be hypothesized that HIV/AIDS is a disease caused by poverty. There are many countries around the world, and in Africa, who do not have as high a prevalence rate as we do in South Africa. It is true that those living in poverty will not be able to manipulate the necessary resources and social services to guarantee a prolonged and healthier existence, thereby rendering the impact of HIV/AIDS less devastating (Farmer, 1998: 265-7). It is incorrect, therefore, to suggest that because a person is poor and seems neglected, that he/she is HIV positive. A direct correlation between poverty and HIV/AIDS cannot and must not be made.

A concern that arose from the answers received, was the fact that many of the respondents associated 'low class' with poverty and HIV/AIDS. One respondent when justifying her answer as to why she did not feel that those in her neighbourhood were at risk of HIV/AIDS, stated " I believe that any person who could afford to live in my area, cannot be a low class type of person, not just any Joe Bloggs and come and live in the area. There are even Whites who can't afford to live in the area that I am living in. So I guess what I am trying to say is, if you can afford to live there, then you can't be a low class - I guess you could be a drug dealer for all I know". This distinction of being low class, attaches additional stigma on those already bearing this burden. This stigma becomes even heavier to carry when it would appear that the respondents add 'uneducated' to the list of categories attached to being HIV positive.

Uneducated

The majority of the respondents felt that being uneducated meant that you were unable to read or understand the warnings given about HIV/AIDS risk. Many felt the rural areas were of particular risk, as they felt that this was the most uneducated sector of South Africa, "I think we take for granted being here in a city. You see adverts, it's on

the news, you hear about it all the time. In rural areas, I don't think they get newspapers, never mind TV or radio. I don't even think that they know that it exists. I think we take for granted that if we know about it that they know about it. And I don't think they do. So I would say your rural areas, and they are largely uneducated, so even if it did get into a newspaper or whatever, they would not be able to read it". This train of thought leads one to believe, that if you know about HIV, then you are less likely to be affected. Many felt that this lack of education leads to ignorance and lack of understanding. According to the Health and Human Services Department in the USA, they state "The AIDS death rate for people with less than a high school education is five times the rate for people with a college education" (2003). It would appear that the respondents' perceptions are in alignment with research. However, caution must be taken that uneducated does not become confused with stupidity. One teacher states, "If they had to cut themselves or whatever, they don't have plasters and that kind of set up. How do they keep it clean and covered, latex gloves and all those sorts of luxuries that we take for granted. I don't think that those people even know that these things exist". It is probably a reality that the majority of South Africans do not have access to latex gloves and plasters, however, stating that 'these people probably don't even know that these things exist', smacks of condescension.

By narrowing the spread of HIV/AIDS down to being 'uneducated', it negates all the other cultural and social dilemmas associated with the spread of HIV/AIDS. The respondents attached a similar expectation of applied knowledge to their own children. Many stated that their children had the knowledge, unlike thousands of others, which would not put them at risk. Confusion arose, however, when the respondents justified their conclusions by stating that White South Africans were just as much at risk as Black South Africans, "I think probably the less educated part of our population is most affected and because of our history, that would mean more black people. But I also think the white population is running a close second, I don't think there is a huge discrepancy". If lack of education is going to be labelled as a major cause for the spread of HIV/AIDS, it seems illogical to state then that White as well as Black South Africans carry similar risk. Without question, Whites in South Africa have been afforded a far more superior education. We have had full access to all schools and universities for decades. A large

portion of the Black community has never even received primary school education, let alone a graduate degree. A social epidemic such as HIV/AIDS, that spans across the world, affecting millions of people, cannot solely be blamed on the lack of education. If this were the case, a book would be the answer to the world's social complexities.

Teenagers

Youth of all races were attached with high risk for HIV/AIDS infection. Although this risk was not equally distributed among the races, it was interesting to note that the respondents were able to assign 'blame' to all the races, instead of just one. According to Lynn-Balster, "Adolescents are considered a high risk group because (1) they're exploring their sexual identities and often are experimenting not only with sex, but with drugs; (2) their behaviour tends to be impulsive and greatly influenced by peer pressure; and (3) they often feel invulnerable and have trouble seeing long-term consequences" (ERIC). Many of the teachers shared this same sentiment, "They are the group that are most sexually active, young having fun, carefree". This type of carefree attitude was expressed many times by the teachers. Some discrepancy was apparent with three of the respondents, who spoke of providing their teenagers with condoms. These same teachers spoke of the problem with promiscuity amongst teenagers, and how they felt it was a huge problem. Yet, when asked about their own children, these same respondents tended to class their children's behaviour quite differently. When asking this teacher if she had spoken to her own children about HIV/AIDS, she responded by saying, "Oh yes. I got into a lot of trouble because I put a whole lot of condoms in my cupboard at home, in my medicine cupboard, when my kids got to about 17, 18, and a friend of mine said that I was promoting them sleeping around. I definitely didn't. When the pile disappeared, I did not ask questions, I just put some more there. Where they went I don't know, I don't care, I did my bit". Clearly she sees the need for condoms for her children and rural youth. However, her attitude changes when considering that her children and the rural youth were probably participating in very similar behaviours. While with her children she 'did her bit' by providing the protection, the rural youth, however, are blamed for the spread of HIV.

There is definite link between the respondents' experiences and their perceptions of risk. Those who unequivocally perceive themselves to be at risk, have the same perception about their children and their community. For most, this perception is that HIV/AIDS is a Black disease. This is generally accompanied with being poor and uneducated. This relationship is not straight forward, as evidenced by the category of white people, who have the lowest unemployment and poverty rates, received relatively more education, yet exhibit the second highest HIV prevalence (HSRC/Nelson Mandela Foundation, 2002). Promiscuity is the number one reason for the spread of HIV/AIDS. This perception was most often attached to Black people, as well as teenagers. According to the respondents, both groups tend to display attributes of unregimented sexual control.

CONCLUSION

This study set out to explore the perceptions fostered and experiences encountered by White Female schoolteachers with regards to HIV and AIDS. An understanding of the respondents' perceptions was gained through the experiences they shared. These encounters, which shaped their perceptions, are imperative in evaluating personal risk awareness, establishing perceived risk groups, as well as identifying stigmatized views.

The data was collected by means of semi-structured, in-depth interviews. While all the same information was covered with each respondent, an individualistic approach was utilized. This fostered an atmosphere of ease between interviewer and interviewee, and issued the teachers with a safe space to relay their personal thoughts and experiences.

Most of the respondents' experiences occurred through their association at school, via an employee or through the media. While all three of these sources offer a different type of experience, they portray a very similar message to the respondents; HIV/AIDS is a Black disease. All of these connections are explored throughout the study. Only 8% of the teachers knew a personal friend or relative with HIV/AIDS. All their experiences have been with Black South Africans, with the exception of one teacher, who had a homosexual friend pass away from AIDS. Many had not had any experience at all with HIV/AIDS, in fact the only encounter they had ever had, was through the media. Through this study, the media has been identified as a vital source, not only in issuing the respondents with experiences, but also in forming perceptions. As indicated, the media target young Black South Africans. While this is vital, it does exclude millions of other people who are also at risk of HIV infection.

This knowledge makes a more holistic approach in HIV/AIDS prevention campaigns of utmost importance. Due to the fact that respondents seem to make a natural connection between HIV/AIDS and race, emphasis must be placed on White South Africans, in order to aid in the dispelling of false and potentially fatal misconceptions. A false sense of security does exist amongst the white schoolteachers interviewed. A large majority did not perceive themselves, their family or friends, as

being at risk of HIV/AIDS infection. However, cognizance must be taken of the fact that this perception has not merely been thought up at random. It seems that it stems from the personal experiences that the teachers have had, the social encounters experienced, as well as the prejudices created about Black people throughout colonial and apartheid times. These perceptions are that Black people are promiscuous by nature and culture.

Promiscuity is considered as the number one reason why the spread of HIV/AIDS has been so rampant in South Africa. Therefore, Black people are not only perceived as being promiscuous, but HIV positive.

Those considered poor and uneducated, were also classed as high-risk groups. This perception is considered as an additional reason for the respective White schoolteachers to disassociate themselves from risk. Our unequal apartheid past has afforded the majority of White South Africans a sound and accredited education. However, in viewing the previously discussed prevalence statistics, the lack of education is not reason enough to be blamed for the spread of HIV/AIDS. White South Africans, who have historically received the greatest amount of education, have the second highest prevalence statistics.

Although exploratory studies are not required to offer explanations for what has been perceived, this study has identified some possible contributors to the perceptions cultivated by the respondents. Of significant influence is that of history. Most of the teachers spoke of the false realities of their past. The White supremacist regime that governed South Africa for decades, was highly successful in implementing their discriminatory ideologies. The respondents, and millions more, perceived these ideas, as truth. These supposed facts were endorsed by religion, education and the government, making these details attractively believable. Unfortunately, these ideas are not easily replaced or abolished, which is why they continue to influence perceptions of Black South Africans today and their association with HIV/AIDS.

A revolution of truth regarding HIV/AIDS, needs to take place in South Africa. This movement must involve all racial groups, as none are exempt from infection. In

order for the population to be receptive to this message, it must be relayed in a culturally sensitive environment, one involving the media, education, the government, as well as religiosity. Greater effort must be made to reach those who are not currently being addressed. People need to identify with the campaigns, drawing attention to their own beliefs and perceptions. This can only be accomplished through a campaign that is well researched, implemented in a culturally sensitive manner and which represents the target audience.

This suggestion is not solely applicable to all those involved in publicly portraying this message to white South Africans, this proposal must be adhered to by the White schoolteachers themselves. All HIV/AIDS campaigns, whether adopted via the media or in the classroom, must be void of discrimination, prejudice and stereotyping. It is imperative that these messages are relayed in a way in which the target audience will be able to comprehend, as well as be able to relate to them. White schoolteachers need to beware of their biases and personal beliefs, so that they may be able to set them aside in order to convey an HIV/AIDS message absent of all bigotry and relevant to their target audience. This will require a greater understanding and tolerance for other cultures, acquired outside of the 'white lens'.

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