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The impact of culturalism in the translation of STDs and HIV/Aids materials

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CHAPTER 4: ANALYSIS AND INTERPRETATION OF RESULTS

4.1 INTRODUCTION

To complete this study properly, it is necessary to analyse the data collected in order to test the hypothesis and answer the research questions. As already indicated in the preceding chapter, data is interpreted in a descriptive form.

This chapter comprises the analysis, presentation and interpretation of the findings resulting from this study. The analysis and interpretation of data is carried out in two phases. The first part, which is based on the results of the questionnaire, deals with a quantitative analysis of data. The second, which is based on the results of the interview and focus group discussions, is a qualitative interpretation.

4.2 PHASE ONE: QUANTITATIVE INTERPRETATION OF RESULTS

Analysis of Questionnaires

Of a total of 400 questionnaires distributed, only 380 completed questionnaires were the base for computing the results. Four (4) questionnaires completed by those who never had the chance to attend workshops, three (3) non-responses and thirteen (13) with a lot of missing data were subtracted from the total sample size. This means that 20 questionnaires, out of 400 questionnaires distributed, were completely discarded from the analysis. The rest, (380 questionnaires) were used to interpret the results.

Data gathered through the questionnaire was subjected to frequency counts. In other words, the subjects' responses for each individual question were added together to find the highest frequency of occurrence (i.e. the number of times that a particular response occurs). These responses to the questions, which are quantified, are then presented in percentage forms. This analysis is presented in tabular form. The researcher uses tables containing a variable and in some cases, combines two or more variables in a single table.

This first section of the questionnaire sought to identify the subjects who had the opportunity to attend workshops on HIV/AIDS campaigns. It enabled the researcher to identify the responses of those subjects who had never attended such workshops and exclude them from the analysis. It is the researcher's conviction that to obtain reliable results, only the responses of subjects who had the chance to attend workshops should be analysed since most of the questions are based on what transpired in such workshops. The responses to the questions are summarised in the tables below, of which some consist of a maximum of 380 responses and others depended on the responses subjects gave in the preceding question. For example, subjects who chose, for instance, (C) in a particular question may not be required to answer the next question. This made the total number of responses for each individual question different.

4.2.1 How many times did you attend workshops on AIDS education? (Excluding this one)

VARIABLE	FREQ.	PERC.
A = Never attended	4	1,0
B = Once only	156	40,6
C = More than once but less than 5 times	207	53,9
D = More than 5 but less than 10 times	14	3,6
E = More than 10 times	3	0,7
Total	384	100

TABLE 1: NO. OF TIMES OF ATTENDANCE OF AIDS WORKSHOPS

This table shows that only 4 (1,0%) of the subjects had not attended any workshop on AIDS education campaigns. The rest (i.e. 380 or 98,9%) of the population had the opportunity to attend such workshops although there is a vast difference in the number of times of their attendance. The total number of those who attended workshops will be used as a total sample size. The results are based on the subjects' experiences and not on speculation or what they believe or think, and should therefore be reliable. It is also interesting to note the high number of subjects who attended these workshops more than once.

4.2.2 Please indicate your age category.

AGE	TOTAL	PERCENTAGE
A = 15 – 17 yrs	109	28,7
B = 18 – 20 yrs	92	24,2
C = 21 – 23 yrs	47	12,4
D = 24 – 26 yrs	58	15,2
E = 27 – 29 yrs	74	19,5
Total	380	100

TABLE 2: AGE GROUP BREAKDOWN

This table shows the age categories of subjects who took part in the completion of the questionnaires. The percentage in this table shows that the allocation of questionnaires to various groups was in no way influenced by bias. It is a true reflection of the researcher's impartiality in the distribution of questionnaires.

4.2.3 Have you had an HIV blood test? Yes or No

VARIABLE	FREQUENCY	PERCENTAGE
Yes	116	30,5
No	264	69,5
Total	380	100

TABLE 3: BLOOD TEST HIV

This table shows that of the total sample size, only 116 subjects had undergone a blood test. This number amounts to only 30,5% of subjects. The rest indicated that they had not had a blood test.

(i) If the answer was "Yes" then answer this question. Why?

VARIABLE	FREQUENCY	PERCENTAGE
A = Voluntary	14	12
B = Employment obligations	2	1,8
C = Insurance obligations	8	6,9
D = Advice from health centre	85	73,3
E = Other	7	6
Total	116	100

TABLE 4: REASON FOR UNDERGOING HIV BLOOD TEST

This table shows that, out of 116 subjects who underwent HIV test, nearly three quarters of them, i.e. 73,3% did so on the advice of health workers. 12% of the subjects were tested out of free will, while employment and insurance obligations recommended 8,7% of subjects to have their blood tested. Only 6% of subjects and did not disclose the reason for undergoing such treatment. Evidence from this table clearly shows that the 73,3% of subjects who opted for a blood test on advice from health centres is too high a figure. It is also a known fact that patients are advised to undergo a blood test if found to be affected by diseases transmitted through sexual intercourse. These people are often found to be HIV positive.

The following questions were investigated in the second section of the questionnaire. These questions are based on the observations and experiences of counselling workshops and presentations that subjects attended.

4.2.4 In which language was the workshop on AIDS education presented?

VARIABLE	FREQ.	%
A = Mainly Sepedi	253	66,6
B = Mainly Sepedi but sometimes English	95	25
C = Mainly English	22	5,8
D = Mainly English but sometimes Sepedi	7	1,9
E = English and Sepedi used interchangeably	3	0,7
Total	380	100

TABLE 5: MEDIUM OF COMMUNICATION

From this table one realises that the AIDS workshops that the majority of subjects attended were conducted mainly in Sepedi. The figure amounts to 253 (66,6%). In addition to this number, another 95 (25%) subjects attended workshops that were presented predominantly in Sepedi with English used but to a very limited extent. Only 29 (7,6%) subjects indicated that the workshops they attended were conducted in English, whereas 3 (0,7%) said that both languages were used equitably. This table reveals that the majority population (more than 90% of subjects) was addressed in Sepedi (their language of habitual use).

4.2.5 Answer this question if you have chosen (A= Mainly Sepedi) in 4.2.4 above. Indicate whether the language used was figurative or literal?

VARIABLE	FREQUENCY	PERCENTAGE
A = Figurative	148	58,4
B = Literal	101	40
C = Uncertain	4	1,6
Total	253	100

TABLE 6: TYPE OF LANGUAGE

The figures and percentages in table 6 show the type of language that was used in AIDS workshops that subjects attended. As can be seen from this table, 58,4% of subjects indicated that the language used at workshops was figurative while 40% of them showed that it was literal. Only 1,6% of subjects showed that they were not sure of the type of language used. The first two figures (i.e. those representing figurative and literal languages) will be used to calculate and analyse table 8 underneath.

4.2.6 Answer this question if you answered (B) in 4.2.4 above. Why did counsellors in certain instances have to code-switch to English during the presentation?

VARIABLE	FREQ.	PERC.
A = Sepedi lacks medical and health terms	11	11,6
B = Impress audience that they are bilingual	26	27,4
C = Avoid offence	58	61
Total	95	100

TABLE 7: REASON FOR CODE-SWITCHING

58 (61%) out of a total of 95 subjects observed the employment of Sepedi with an occasional interference of English in workshops they attended. They indicated that they suspected that counsellors did not want to insult their audience by using offensive language. The only alternative was to seek refuge in the English language. This confirms our earlier postulation that in order to evade Sepedi linguistic taboos, English loanwords are often preferred. 27,4% of subjects believes that it is neither because people avoid offence nor is it because of the language's lack of advanced health terminology. It is because sometimes campaigners want to showcase their bilingual competence. 11,6% of the subjects indicated that there is a need-filling motive. They believe that almost all other historically disadvantaged African languages still lag far behind in terms of linguistic development especially in the technical and scientific fields. As a temporary measure to address this backlog, people prefer to use loanwords.

4.2.7 Subjects who have answered "Uncertain" in 4.2.5 should not answer this question.

What are your feelings about the type of language you have chosen in table 6?

VARIABLES/TOPICS		No. RESPONDENTS			
		YES	%	NO	%
(i) Are you satisfied with the presentation?	FIG[7]=	53	35,8	95	64,1
	LIT[8]=	68	67,3	33	32,6
(ii) Do you condone the usage of this type	FIG =	57	38,5	91	61,5
of language?	LIT =	63	62,4	38	37,6
(iii) Did you experience difficulty in	FIG =	84	56,8	64	43,2
understanding this language.	LIT =	27	26,7	74	73,3
(iv) Language facilitated accurate and	FIG =	64	43,2	84	56,8
appropriate information.	LIT =	63	62,4	38	37,6
(v) Language provided insight into and enriched					
better understanding of the disease.	FIG=	62	41,9	86	58,1
	LIT=	58	57,4	43	42,6
(vi) Language reflected the audience's needs.	FIG=	49	33,1	99	66,9
	LIT=	53	52,5	48	47,5

TABLE 8: SUBJECTS' FEELINGS ABOUT LANGUAGE USAGE

The observations below are deduced from this table:

[7] It is an abbreviated version for figurative language.

- Item 4.2.7 (i): Only 53 (i.e. 35,8%) out of 148 subjects indicated that they were satisfied with the presentation while 95 (64,1%) of subjects recorded their dissatisfaction with the presentation. If these figures are compared to that of subjects, who attended workshops that were presented in literal language, it seems that the majority of the latter group was content with the presentation. The results show 67,3% satisfaction with literal language and only 32,6% dissatisfaction. These overall figures could be interpreted to mean that more than half of the subjects (i.e. 66%) are in favour of literal language while only 34% favour figurative language.
- Item 4.2.7 (ii): Although there are a few, i.e. 38,5% who showed an appreciation for complex figurative language most of the subjects, (i.e. 61,5%) indicated their disapproval of this type of discourse. This therefore implies that attempts should be made to "demetaphorise" language so that it could be more accessible. This is clearly reflected by the 62,4% of subjects who indicated that they approve of literal language compared with only 37,6% of subjects who do not condone it. This resembles the preceding findings in 4.2.6 (i) above.
- Item 4.2.7 (iii): This table shows that 56,8% of the total respondents experience difficulty in understanding figurative language whereas only 43,2% do not encounter any difficulty of comprehension. In contrast, responses in the literal language group show that the number of those who experienced difficulty is far less than that of those who are content. The percentage reflects 26,7% for those who experience difficulty and 73,3% for those who encounter no problem at all. This could be interpreted to mean that figurative language is more likely to be misunderstood than literal language. This

[8] It is an abbreviated version for literal language. The figures and percentages opposite these abbreviations represent the total number of subjects who chose this type of language.

conclusion is based on the high average of responses, which prefer literal language at the expense of figurative language.

- Item 4.2.7 (iv): We see from this table that a higher number/percentage 84 (56,8%) of subjects answered that figurative language does not facilitate accurate and appropriate communication while only 64 (43,2%) of the subjects agree that it does. In contrast, 62,4% of subjects indicated that literal language provides accurate and appropriate information while only 37,6% indicated that literal language did not play any significant role.
- Item 4.2.7 (v): The above table again shows that 58,1% of subjects mentioned that figurative language does not provide insight into the understanding of the disease while only 41,9% agree with the statement. On the other side, 57,4% of the respondents indicated that literal language played a significant role in assisting the audience towards understanding the disease while 42,6% said its role is of least importance.
- Item 4.2.7 (vi): Asked whether the subjects' needs and interests are taken into consideration, the majority of respondents, i.e. 66,9% showed that figurative language does not seem to reflect specific needs of audience while only 33,1% agreed with the statement. Interestingly, 52,5% of subjects indicated that literal language does reflect the needs of audience while only 47,5% of subjects disagree. The results show that there is therefore a need to address this problem by ensuring that counsellors are aware of the specific demands of their target audience. To overcome this oversight, counsellors should at all times remember that the objective of these workshops is to educate people so that they could live happy and satisfactory lives.

From this table, one could say that the overall results seem to be in favour of literal language. In all the six questions surveyed, the number of subjects preferring literal language is always higher than that of subjects in favour of figurative language.

4.2.8 Answer this question if you have answered (A) or (B) in question 4.2.5.

How would you rate the counselling in terms of comprehension?

	FREQUENCY		PERCENTAGE	
VARIABLE	FIGURATIVE		LITERAL	
	%	No.	%	No.
A = Excellent (Faultless)	8,1	12	48,5	49
B = Good (Generally well presented)	15,6	23	28,7	28
C = Fair (Acceptable but with minor flaws)	33,1	49	17,8	18
D = Bad (Not well-presented/unacceptable)	49,3	73	3,9	4
E = Not sure	2	3	0,9	1
Total	100	148	100	100

TABLE 9: RATINGS OF COMPREHENSIBILITY OF COUNSELLING

- As can be seen from Table 9, of the 148 subjects who chose figurative language in 4.2.5 above, only 12 (8,1%) indicated that the presentation was faultless (i.e. they understood the intent of the message clearly). 23 (15,6%) of them indicated that it was generally well presented, while 49 (33,1%) showed that it was acceptable but with minor flaws in presentation. 73 (49,3%) showed that it was generally unacceptable because of major faults and only 3 (2%) subjects said that they are ‘Not sure’. These figures shows that the majority (nearly half) of the subjects (i.e. 49,3%) did not benefit from these workshops. For the subjects who chose literal language, the figures show that

approximately half of the population (48,5%) benefited a lot because the counselling was excellently presented. In addition to this figure, another 28,7% indicated that the counselling was well presented, 17,8% partially benefited because of some minor flaws in presentation, while less than 5% seems to have not benefited from the counselling at all. Since one of the aims of the study is to find out whether figurative language impacts on comprehensibility, a conclusion could be reached based on these results that figurative language does contribute towards incomprehensibility. That is why it is unfavourable to the majority of subjects.

4.2.9 How often do you listen to radio programmes such as *Ngaka Nkalafe*?

VARIABLE	FREQUENCY	PERCENTAGE
A = Always	80	21,5
B = Sometimes	113	29,7
C = Seldom	142	37,3
D = Never	37	9,7
E = Not sure	8	2,1
Total	380	100

TABLE 10: REGULARITY OF LISTENING TO *NGAKA NKALAFE* (RADIO PROGRAMME).

The responses to this question as reflected in Table 10 reveals that, out of the total of 380 subjects, only 80 (21,5%) indicated that they cannot afford to miss this radio programme. 255 gave B and C (i.e. 113 responses for 'Sometimes' and 142 for 'Seldom') as answers, which means that they do not always have time to listen to such programmes. 37 subjects

showed that they never listen to these programmes, while only 8 answered that they are not sure whether they listen to this programme or not.

(i) Answer this question if your answer above is (A), (B) or (C) by saying 'Yes' or 'No'.

VARIABLES	No. RESPONSES			
	YES	%	NO	%
The medical practitioner:				
A. Communicates his thoughts and feelings effectively through language;	217	64,8	118	35,2
B. Uses language indiscriminately;	202	60,3	133	39,7
C. Often avoids using sensitive language;	106	31,6	229	68,4
B. Answers questions posed to him frankly.	185	55,2	150	44,8

TABLE 11: MEDICAL PRACTITIONERS' COMMAND OF LANGUAGE

The following observations can be drawn from this table, which comprises a total of 335 subjects.

- The figures 217 (64,8%) show that the language used by the medical practitioner conveys effective thoughts and feelings whilst only 118 subjects (35,2%) disagree.
- This table again shows that 60,3% of subjects perceive the medical practitioner's language to be indiscriminately used as against 39,7% who counter this perception. The former percentage suggests that the language is not elusive.

- Less than half (31,6%) of subjects indicated that the medical practitioner often avoids using sensitive language while 68,4% showed that he does not. The figures parallel the results of the preceding response, which portrays the medical practitioner as non-selective in the choice of words.
- 55,2% of subjects indicate that the medical practitioner tries to explain and answer as frankly as possible the questions posed to him by listeners while 44,8% perceive that in another way.

One may safely conclude that the overall results of this table reveal that the medical practitioner achieves something, (in terms of communicating meaning) no matter how little and insignificant it might be.

(ii) Answer this question if you have answered (A), (B) or (C) in 4.2.9 above. What motivates you to listen to this programme?

VARIABLE	FREQUENCY	PERCENTAGE
A = Educative	244	72,8
B = Entertaining	54	16,1
C = Fun	23	6,8
D = No compulsion	14	4,1
Total	335	100

TABLE 12: MOTIVATION TO LISTEN TO RADIO PROGRAMMES

72,8% of the subjects said that they listen to this programme because it educates them about health problems and diseases. It is clear from the above table that the highest frequency is for the variable educative, while the remainder is shared amongst the other three variables.

The results in the table are a clear indication that HIV/AIDS workshops could be helpful to most people. Therefore, educators should not lose sight of this objective by using ambiguously worded statements.

The subjects were requested in the next table, which consists of a number of variables, to choose whether they agree or disagree with the under-mentioned statements.

4.2.10 Choose whether you Agree or Disagree with the following statements.

VARIABLES	AGREE		DISAGREE	
	No.	%	No.	%
(i) Campaigners should use simple and straightforward language when they hold HIV/AIDS workshops.	298	78,4	82	21,6
(ii) Sensitive terms should be made explicit.	288	75,8	92	24,2
(iii) Parents should sit with their children and discuss their sexual experiences.	259	68,1	121	31,9
(iv) There should be more open discussions and exposure to sexuality.	294	77,3	86	22,7
(v) Young people should be taught about AIDS and other STDs before they become sexually active.	323	85	57	15
(vi) Talking about sex encourages the youth to indulge in sexual activities.	73	19,3	307	80,7
(vii) Sexuality issues that people are exposed to in print and electronic media should be supplemented by being preached at community gatherings such as funeral and religious services.	204	53,6	176	46,4
(viii) HIV/AIDS education should be included in the school curriculum.	236	62,1	144	37,9
(ix) Young people should delay starting a relationship until they are ready to marry.	96	25,3	284	74,7

TABLE 14: AGREE/DISAGREE TYPE OF QUESTIONS

On the basis of the quantitative findings expounded in the preceding table, it can be observed that:

- Item (i): The majority of subjects, 78,4% agree in the usage of simplified language drawn from everyday speech repertoire when conducting HIV/AIDS workshops while only 21,6% opposes this statement. It may be inferred from the above finding that figurative language, as currently employed by counsellors and translators respectively, needs to be transformed. This confirms the postulation that figurative language negatively affects the understanding of messages.
- Item (ii): 75,8% of subjects agrees that sensitive terms should be made explicit so that these HIV/AIDS materials could be accessible to the overwhelming rural masses they strive to serve. They must be written in a language that is immediately comprehensible to the readership. Otherwise they would not be in a position to eliminate misunderstandings as observed by Newmark. It is not only young people who hardly comprehend language full of idiomatic expressions; even older people find it difficult to handle, for instance, technical and unfamiliar phrases.
- Item (iii): The majority of subjects, 68,1% agree that it is best for parents to give information and life-skills rather than being silent so that young people would not run the risk of venturing into sexual relationships without knowledge of the repercussions. Parents are faced with the challenge of not knowing the time at which their children start relationships. It is best for the parents to alert their children about these dangers and pleasures of making relationships while the children are still young. It is the parents who will carry the burden of having to look after their children and grandchildren.

- Item (iv): 77,3 % of subjects agree that people should engage in sexuality issues in the form of discussions and debates while only 22,7% indicate that such topics should be discouraged.
- Item (v): A high percentage of respondents (85%) agree with the statement that it is good to teach young people about AIDS and STDs at an early stage so that by the time they are grown up, they already know how to deal with them. Only 15% of subjects see experience as the best teacher. According to the latter young people should learn about these diseases by experiencing them on their own rather than being warned by their parents.
- Item (vi): Only 19,3% of the subjects agrees with the statement that sex education encourages the youth to indulge in premarital sexual relationships. The majority of subjects - 80,7% - indicate that young people would be better able to make informed decisions if they have been taught about this disease.
- Item (vii): Respondents showed mixed reactions when it came to this question of whether AIDS campaigns should be included even at funerals and places of worship. The figures clearly show that a consensus has not yet been reached. This issue is still hotly debated and no definite answer could be given at this juncture.
- Item (viii): 62,1% seems to agree with the introduction of AIDS issues in the school curriculum, while only 37,9% do not agree. This large number of subjects agreeing with this statement seems to suggest that sex education in schools, which currently consists of only a few basic lessons in anatomy and reproduction, should be substituted by more comprehensive programmes oriented towards educating pupils about AIDS and other sexually transmitted diseases.

- Item (ix): The majority of responses disputes the fact that young people should postpone sexual encounters until they feel ready to have responsible sex. The figures reflect 74,7% of opposition as against only 25,3% in concurrence. Many subjects argue that it is very difficult nowadays to encourage people to obey the biblical philosophies of abstinence and premarital sex. Young people are exposed to sexual issues at a very early age. To discourage and scare them from indulging in sexual relationships will result in teenage pregnancies, back-street abortions and sex-related diseases. Instead of advising them to abstain, young people should be given the resources to protect themselves against AIDS and other STDs. They could be advised and encouraged to use condoms and contraceptives until they are ready to marry.

On the basis of all statistical information reflected in this table, it is evident that the majority of subjects, who took part in this study, confirms the need to popularise sexuality. They tended to rank highest the need for a layperson's language – a transparent and non-symbolic type of language. The results are in agreement with the study by Ratzan (1993) whose results indicated that topics of public health should be in ordinary speech rather than in poetic language. Poetic language, which is characterised by abstract and uncommon expressions, creates trouble by complicating issues. This study again revealed that only a few parents could easily talk to their children about sex and sexuality, while the majority feels embarrassed or uncomfortable discussing these sensitive but important issues with their children.

It is traumatising that whilst campaigns are launched to engage in the process of overcoming the spread of AIDS and transform our cultural perceptions, there is still an

evident escalation of criticism levelled against these programmes. Societies must wake up to the reality that whether we like it or not, teenagers engage in sex very early in life. This is captured in one of the health posters published by the Department of Health, which rightly states that "we don't talk about sex but we perform sex". It is unreasonable for the elderly to regard sex education as sinful and atrocious, while hypocritically and overtly; youth perform a kind of sexual practice, which is detrimental to human life. Campaigners should not be silenced by the mere fact that this subject raises ethical and moral considerations. It is better for them to prevent the spread of STDs than seek for a cure. Whatever the motive, it is obvious that most young people are in dire need of counselling and advice in the field of sex education, which is so sadly neglected.

4.3 PHASE TWO: QUALITATIVE INTERPRETATION OF RESULTS

Analysis of Interviews and Focus Group Discussions

To supplement the results and to fill the gaps left in the questionnaire, the qualitative approach was used. This kind of technique looks more likely to give more substance and to reveal detailed information. Qualitative research is concerned with trying to achieve a clear understanding of the problem under review in a more complex way than in the generalised way that is the outcome of questionnaires. This methodology is used to get information about how people think, feel and act and what they know. This section of the research was conducted in two ways, through individual interviews and focus group discussions consisting of 10 people at each workshop. The information collected was presented in a narrative form that includes the description and analysis of data.

This section reflects on the results of the interviews and focus group discussions conducted with interviewees. It presents the analysis of their verbal responses during the interviews and focus group discussions.

Long and informal interviews were carried out with subjects regarding their perceptions of figurative language in HIV/AIDS texts. The purpose was to find out how subjects feel about the use of this type of language during AIDS awareness presentations. Topics discussed during the interviews and focus group discussions included the following questions.

4.3.1 TOPICS DISCUSSED DURING INTERVIEWS AND FOCUS GROUP DISCUSSIONS

a) Cultural manifestations vs. Human life: which one should be emphasised at the expense of the other?

Most, if not all, of the groups the researcher had discussions with, indicated unanimously that cultural influences should not be preserved at the expense of human life. The latter, according to them, is so important such that no one can run the risk of losing it at the expense of preserving cultural manifestations. They all agreed that it is better to be punished for violating cultural dictates than to lose the life of the individual.

b) Should there be more open discussions and exposure to sexuality issues?

It is necessary that these topics, irrespective of their sensitivity, should be spoken about openly. This will provide teenagers opportunities to know more about the repercussions of

premature and premarital relationships. Previous research shows that teenagers who are exposed to sexuality issues at an early stage often delay indulging in sexual encounters until they are grown up.

c) Should young people be taught about AIDS and other STDs before they become sexually active?

HIV/AIDS knows no age limit. It affects all people - young and old. It is therefore imperative that young people should be informed about these diseases before they are sexually active hence prevention is better than cure.

d) Should parents sit with children and discuss sexual experiences?

Many subjects did not perceive any problem with parents discussing sexual issues with their children. They said that it is good that parents should discuss such issues with their children. The only problem is that parents do not know how to discharge this prime responsibility. Through no fault of their own, many parents are not in a position to give frank answers to their children. Some do not even have the necessary vocabulary to do the job while others are tongue-tied with inhibitions or overcome with shame or embarrassment.

e) Opinions about sex education/AIDS campaigns

From the discussions, the researcher observed that there are divergent opinions especially in African culture about whether the masses should be taught about, for instance, AIDS and other sexually related diseases such as gonorrhoea, syphilis, herpes, trichomoniasis, chlamydia, etc. This is because AIDS awareness campaigns involve within themselves sex education; and talking about AIDS much the same as school-based sex education is

perceived as immoral. Certain people argue that talking about sex encourages the youth to indulge in sexual activities. They therefore suggest that instead of discussing such issues in public, we rather exercise our patience until a cure is found. In contrast, others argue that counsellors are not doing justice by withholding this factual information from the children in an attempt to preserve 'innocence' when they need to know. To them denial of knowledge or inadequate communication will result in children seeking answers elsewhere, usually from peers and places (such as shebeens) ill-equipped to provide a foundation for healthy sexuality. The latter (those in support of AIDS education campaigns) therefore move that cultural barriers that hinder these education efforts should be violated for the sake of rescuing the Rainbow Nation from this disaster.

f) Opinions about effectiveness of workshops

Asked about the effectiveness of AIDS workshops, only 4 out of 20 groups expressed their satisfaction. The rest felt that the messages they received were inefficient, ineffective and non-educative. They realised that counsellors are often afraid to say things directly. Certain terms, especially sensitive ones, are not elusively stated. Language used in AIDS workshops is neither simple nor straightforward. Translators invent symbolic and metaphorical language to conceal the real nature of messages that is being verbalised. This renders such workshops fruitless and insufficient. This contradicts table 12 wherein nearly three-quarters of the subjects indicated that they benefit from radio talk-shows such as *Ngaka Nkalafe*. Perhaps if AIDS campaigners could begin to minimise the use of figurative expressions, as is the case in this talk-show, their workshops will be a success.

From the discussions and interviews held with the subjects, the researcher is able to deduce that the negotiation of meaning is vitally important. This therefore necessitates the transformation of language in such a manner that it is readily accessible to the audience. This can be achieved when more literal phrases are preferred than obscurely constructed ones. The results reveal that the present approach employed by campaigners is ineffective because it leaves most of the young people in the confused.

There seems to be an urgent need for an alternative method to answer this burning question. Communicative translation seems undoubtedly the answer. Effective communication can help people to change their self- image so that they cannot look at the world differently. In all AIDS awareness campaigns and workshops held to rally against the spread of this disease, uninhibited communication, if used adequately and effectively, can assist in controlling infection. Instead of allocating funds to assist in the search for a cure, effective communication could be used at no cost to the government to stop the disease's deadly march. Campaigners and translators need to adopt this approach.

4.3.2 FURTHER TASKS

During focus group discussions subjects were also asked to perform two tasks which provided data for analysis. These tasks are described below.

4.3.2.1 Listen to the counsellor's tape-recorded address and narrate it in alternative ways.

The following paragraph is an excerpt of a verbatim transcription of the counsellor addressing the public about the mode of AIDS transmission.

Verbatim Transcript

Malwetši a thobalano a ka phatlalatšwa ka ditsela tša go fapana. Mohlala:

- Go reipa, gagolo banna bao ba lomilwego ke mmutla.
- Banna, bo nka-ja-mo-nka-nona, ba eta ba phelea basadi ka maleme ba re ba a ba rata, eupša go se bjalo, se segolo e le go ntšha bohloko fela. Taba ya go re monna ke thaka o a naba ga se yona. Banna, itshwareng, le tlogele go ba le mahlo a mantši. Tshephagalelang basadi ba lena. Moano wa rena a e be "One round, one condom", e sego fao "No condom, no sex".
- Tlala ka lapeng le yona e ka fetola basadi go ba botlhephišantepa. Basadi ba ka ikhwetša ba gapeletšega go alela banna ba lefase le ka moka gore ba kgone go iphediša.

A ke a mangwe a mabaka ao a ka oketšago phatlalalo ya malwetši.

My own translation

(Sexually transmitted diseases can be spread in a variety of ways. Example:

- *Through rape, especially men who are afraid to court girls.*
- *Men who are lecherous will go around telling women that they love them whilst they are interested in satisfying their sexual urge. We should demystify the belief that justifies men to have as many wives as they desire. Men, please behave and be faithful to your partners. Let our motto be "One round, one condom", otherwise "No condom, no sex".*
- *The economic vulnerability in the family can also force women to become prostitutes. These poor women find themselves dictated by circumstances to have sex with different partners to sustain themselves.*

These are some of the reasons that could contribute to the spread of sexually transmitted diseases).

After listening to the presentation, the researcher went out to interview some of the attendees to detect how far they understood. The researcher asked the attendees to narrate the counsellor's presentation in alternative ways. Most of them were unable to relate what the counsellor's speech because of the use of euphemisms and evasions of popular discourse during the presentation. Phrases such as 'a eta a alela' were interpreted as 'to prepare a bed' (instead of 'to sleep around') and 'bonka-ja-mo-nka-nona' as 'people who eat a lot' (instead of 'those who want to have sex with different people'). The compound noun 'tlhephišantepa' also generated controversial debates. This is a culture-bound concept which comprises of two words: 'hlephiša' (to loosen) and 'ntepa' (a loin-skirt). This literally translates as loosening one's underwear. Loose women or prostitutes are often called by this title. Hotly debated was the ambiguous phrase 'banna bao ba lomilwego ke mmutla'. This comes from the Sepedi idiom 'go longwa ke mmutla' – which is loosely translated as 'to be bitten by a hare'. This phrase comprises of two interpretations. It refers to 'feint-hearted men' (i.e. men who are afraid to court girls). It could also be interpreted as 'men who are impotent'. Only a handful of attendees confessed that they had understood this address.

Interviewees observed a lot of figurative language used in the presentation. To complicate the presentation even further, words that were too sensitive were said only in English instead of their target equivalents. A practical example in the excerpt is "reipa" (from English word "rape"). Speakers prefer this loanword instead of the existing target word

‘kata’ (to force a woman to have sex against her will). Others who do not feel comfortable with this target word, prefer the humorous phrases ‘go ikabela’ and ‘go tšea ka kgang’ (literally translates ‘to take by force’). The use of these phrases depicts the scene of how this activity takes place without the consent of the female partner. The man uses his strength to satisfy his sexual urges.

This tendency of using loanwords even in cases where Sepedi phrases would do as well was observed at several workshops that the researcher attended. It is believed that when taboo words in Sepedi are said in another language, particularly English, they do not invoke the same derogatory appeal as when they are pronounced in Sepedi. For instance, it is strongly prohibited to call a prostitute in black and white terms in Sepedi. To lessen the degree of offensiveness, speakers opt for the loanword ‘phorostitšhute’ instead of the word ‘segwebakamarago’ (a commercial sex worker), its existing target equivalent. It is because there are no emotional connotations attached to the loan concepts. Other examples include concepts such as ‘menstrueita’ (to menstruate) and ‘telibara’ (deliver) instead of ‘go belega’ (to give birth). These words are becoming popular substitutes for the more offensive Sepedi words. This means that people believe that one of the ways of dealing with linguistic taboos is to pronounce them in another language (which has a parallel, of course, with English, which has original Anglo-Saxon/Germanic words existing alongside Latin and Greek loanwords. The former tends to be offensive and the latter “respectable”).

Although the majority of the target audience indicated that they had understood the gist of the matter, others said that they did not grasp the real message. They believe the presentation had not been specifically adapted to suit them. As long as there is a fraction of

the audience who has not entirely understood the information, it means that there is a communication fault. This oversight should be addressed as a matter of urgency. Educators should develop alternative channels in order to foster understanding, thus making workshops more efficient and profitable. It is hoped that if the above concepts are understood properly by not using loanwords or colloquial language, the incidence of sexual misdemeanours among the young people will be minimised.

4.3.2.2 Study extracts

Besides listening to the recorded-tapes, subjects were also requested to study three extracts in their respective groups. The first two are taken from a publication "Talking about AIDS" drafted by Gauteng Health Department. The last one is taken from the publication "Sexually Transmitted Diseases" published by National HIV/AIDS and STD Programme. These are originally written in English and then translated into other official languages (in this context Sepedi) by provincial language services. These extracts were distributed to the groups first in the target language and then in the source language.

(i) EXTRACT 1

Translated Text

Ye ke tsela yeo khondomo e ka go šomišwa.

1. Ntšha khondomo ka pakaneng.
2. Ge bonna bo le bothata, tsenya khondomo ntlheng ya bonna.
3. Swara mafelelo a a tswaletšwego a khondomo ka monwana wa mogogorupa le wo monnyane.
4. Tatollela khondomo bonneng ka letsogo le lengwe.

5. Robalana le molekani wa gago.
6. Swara khondomo gomme o ntšhe bonna sethong sa molekani wa gago morago ga thobalano.

Morago ga go robalana, ntšha khondomo ka tlhokomelo bonneng.

Source Text

This is how a condom is used correctly:

1. Take the condom out of the packet.
2. When the penis is hard, place the condom on the tip of the penis.
3. Hold the closed end of the condom with the thumb and finger.
4. Roll the condom down over the penis with the other hand.
5. Have sex with your partner.
6. Hold on to the condom and remove the penis from your partner's body after having sex.

After you have had sex, carefully remove the condom from the penis.

(ii) EXTRACT 2

Translated Text

O ka hwetša bjang HIV?

Ke tsela tše tharo feela tšeo o ka go hwetša HIV:

1. Ka thobalano. Thobalano ke tsela ye e tlwaelegilego yeo batho ba hwetšago HIV. Malwetši a mangwe a thobalano a akaretša tšhofela le thosola. O ka hwetša HIV ge o robala le motho yo a nago le HIV. Thobalano e šupa thobalano ya go tsenya bonna sethong sa mosadi goba thobalano ya go latswana mapele. Ge batho ba robalana,

twatši ya HIV e ka fetela go tloga go motho o tee go ya go yo mongwe ka matšhedi, seela sa bosadi goba madi. Le motho yo a lebelegago a phelegile a ka ba le HIV.

HIV e ka dula mo matšheding a monna. Matšhedi ke seela seo se tšwago bonneng pele ga goba nakong ya thobalano goba ka tsela ya kgobošo ya mapele.

HIV e ka hwetšwa gape dieleng tša bosadi.

Source Text

How do you get HIV?

There are only three ways to get HIV:

1. From sexual intercourse. Sexual intercourse is the most common way that people get HIV. Some other sexual diseases include gonorrhoea, herpes and syphilis. You can get HIV if you have sex with a person who has HIV. Sex means penetrative sex or oral-penile sex. When people have sex, the HIV virus can pass from one person to another in the semen, vaginal fluid, or blood. Even a person who looks healthy can have HIV.

   HIV can live in a man's semen. Semen is the liquid that comes from the penis before or during sex or through masturbation.

   HIV can also live in a woman's vaginal fluids.

(iii) EXTRACT 3

Translated Text

Dintlha tše dingwe ka STDs (malwetši a go fetela ka tsela ya thobalano)

- STDs di fetela go tloga go motho o tee go ya go yo mongwe nakong ya thobalano. STD gantši e hlola dišo goba diela go tšwa dithong tša thobalano.
- Monna le mosadi bobedi ba ka hwetša STD le gona a mangwe a ka fetetšwa lesea nakong ya go ima goba ge le belegwa.
- STDs a ka fetela go tloga go motho o tee go ya go yo mongwe ka tsela ya thobalano ye e tlwaelegilego, go kgoma ditho tša thobalano goba matanyola.

Source Text

Some facts about STDs (sexually transmitted diseases)

- STDs are passed from one person to person during sex. The STD usually causes sores or a discharge from the genitals.
- Both men and women can get STDs and some can be passed on to a baby during pregnancy and childbirth.
- STDs can be passed from one person to another through vaginal, oral (mouth) or anal sex.

Most groups, even if they agreed that the first two extracts of the target texts are offensive and unchristian, indicated that they are very instrumental in enabling the readership to access and understand information with ease and less difficulty. They therefore agree to the use of direct words such as ‘robalana’ (for ‘have sex’) instead elusive phrase such as ‘tsena dikobong’. They believe that these direct words are aimed at, nothing else, but

communication of information. To others especially the elderly, these direct translations are an insult to human dignity. Phrases such as ‘go latswana mapele’ (for ‘oral-penile sex’) and ‘kgobošo ya mapele’ (for ‘masturbation’) are regarded as verbal taboos. The elderly people prefer simplified forms of language such as ‘go kgoma ditho tša bonna le bosadi ka leleme’ (for ‘oral-penile sex’) and ‘go kgotsofala ka go swara ditho tša thobalano’ (for ‘masturbation’) which are likely to be understood by the young people as well.

One sees in the last translated text the avoidance of offensive terms by substituting them with less offensive concepts such as ‘dithong tša thobalano’ (for genitals instead of ‘mapeleng’), ‘thobalano ye e tlwaelegilego’ (for vaginal sex instead of ‘go nyobana’), ‘go kgomana ditho tša thobalano’ (for oral sex instead of ‘go latswana mapele’) and ‘matanyola’ (for anal sex instead of ‘thobalano ya ka mogweteng). The results in both cases, (i.e. interviews and focus group discussions) showed that such words are often misunderstood. It therefore means that we need to pronounce these verbal taboos until they become an integral part of our daily communication. If they continue to be prohibited and discouraged, they will remain foreign to our tongues.

Although avoidance of sexual taboos might be seen as a strategic move by the translator to comply with moral convictions and ethical considerations, it does not help the targeted readership. The problem is that when one compares the target text with the source text, one discovers that the former does not communicate what is contained in the source text.

This was proved by the tasks that were performed by all these groups. Before they were provided with the source text, each group was asked to find the source text equivalents of

certain key words from the extracts. No single group was able to arrive at those English equivalents. Subjects suggested concepts such as ‘sex organs’ (for ‘ditho tša thobalano’), ‘true sex’ (for ‘thobalano ya nnete’), ‘to kiss’ (for ‘go atlana’). Upon receipt of the source text, subjects confessed that they had misunderstood some of the concepts.

4.4 FINDINGS OF OVERALL RESULTS

The following observations were drawn from the results of the questionnaires, the interview and focus group discussions held with subjects.

- The results reveal that only a relatively small number of subjects benefit from this traditional culturally oriented type of counselling. Failure to understand messages could be the result of the translators’ and campaigners’ inability to verbalise their message adequately.

- The responses further revealed that the workshops achieve very little because they are characterised by the use of rhetoric which is heavily laden with rich Sepedi metaphor and jargon - here used in the sense of overblown and pretentious groups of words, used to replace simple words - not in its usual sense of ‘technical and specialised language’. The reasons for the failure of these workshops may be that the majority of staff employed to translate these texts did not specialise in scientific or technical translation. Others did not even pursue a career in the field of translation or a language related field. Their appointment was based mainly on whether they majored in one or two languages

> at undergraduate level. Some were appointed because they were either bilingual or experienced language teachers. These people therefore cannot be regarded as qualified professional translators. They should have had in-service training in the field of translation to supplement their current qualifications thus broadening their theoretical knowledge in this profession. Employers, particularly government institutions, should henceforth begin to realise that bilingualism does not guarantee that a person is a good language practitioner. Translation is a profession, which requires that translators possess certain professional qualities that distinguish them from people who can merely read or speak several languages.

Subjects also observed a general reluctance to break linguistic taboos and this continues to impact on the dissemination of information in a sober and realistic manner. AIDS campaigners should begin to realise that a language can only flourish if it is used with pride and without any feelings of guilt, censorship or embarrassment. Now that we are living in a time of rapid and radical change, we seek to encourage a change of attitude and perceptions towards sex education rather than resist it. We should realise that what was inherited from the past no longer seems to fit the reality experienced by the new generation. Words that were tabooed in one era may become commonplace in another. Linguistic taboos and euphemisms are merely relics of an earlier time and do not serve any useful social function. If the findings of this research are valid, it might well be concluded that cultural translation does little, if anything, to remove language barriers. Instead of facilitating direct communication by rolling back figurative language, it condones the latter thus making it far more difficult for campaigners to tackle sexual issues.

4.5 LIMITATIONS OF THE STUDY

This research, as it is often the case with social research, also encountered certain challenges such as public criticism. Many people argued that it is not proper to inquire into human sexual behaviour. Most of the subjects were reluctant to volunteer information despite the assurance that they would remain anonymous. These subjects indicated after the interview that the questions asked were not culturally attuned to communities that are still traditionally conservative. Some indicated after the interview that the study was controversial because it involved ethical issues. The researcher also discovered that others were unwilling or unable to give details of their sexual experiences in public. Notwithstanding these problems, the responses obtained are genuine.