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MA Sociology by Coursework

Factors affecting the social responses of a group of white South Africans to HIV/AIDS

This research report was submitted as partial fulfillment of the requirement towards the completion of an MA by coursework.

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ABBREVIATIONS

ABC	Abstain, Be faithful, Condomise
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
HIV	Human Immunodeficiency Virus
PMTCT	Prevention of Mother-To-Child Transmission
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UN	United Nations

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INTRODUCTION

Sub-Saharan Africa is home to almost 65% of all people living with HIV, despite having less than 10% of the world's population and, of those sub-Saharan Africans who are infected, almost 60% are women. With sub-Saharan Africa being one of the poorest regions in the world, these figures crudely show how the global pattern of HIV infection reflects existing fault lines of inequality, such that the bulk of those who are infected are poor, black and female (UNAIDS, 2004).

Within sub-Saharan Africa, South Africa is the country with the highest number of people living with HIV, and the pattern of infection in the country mirrors the global pattern, with vulnerability to the disease being shaped along the lines of class, race and gender (Gilbert & Walker, 2002).

The class dimension of vulnerability to the illness is demonstrated in the 2005 *National Household Survey on HIV Prevalence, Incidence, Behaviour and Communication*, which shows stark differences in HIV prevalence between rural and urban, and formal and informal areas. For example, prevalence in urban formal areas stands at 9,1%, while it measures 17,6% in urban informal areas. Similarly, a provincial breakdown shows HIV prevalence to be higher in provinces that are poorer (Shisana *et al*., 2005).

The survey illustrates the racialised nature of the disease by showing prevalence in South Africa's African population to be 13,3%, while prevalence in the country's white population stands at 0,6%. Prevalence in the coloured population stands at 1,9%, and the country's Indian population has a prevalence of 1,6% (Shisana *et al*., 2005).

The gendered dimension of the disease is evident in the survey's indication that prevalence among women in South Africa is 13,3%, while prevalence among men is significantly lower, at 8,2% (Shisana *et al*., 2005).

South Africa's pattern of HIV infection, as well as the country's extremely high prevalence levels, can be seen as a consequence of a number of social factors, many of which have their roots in the system of racially-determined social exclusion that was established during the country's colonial and apartheid past, but which has persisted under democratic governance (Gilbert & Walker, 2002).

This ongoing social exclusion in South Africa has meant that access to resources that could assist in HIV prevention – such as education, healthcare and the power to resist unsafe sexual encounters – remains limited in those sectors of the population that are unempowered, notably, poor African people, particularly women.

Worldwide, social responses to the HIV/AIDS epidemic have been largely negative, with widespread revulsion to the illness manifesting in hatred, discrimination, rejection, exclusion, marginalisation and fear of those infected, such that witch-hunts, harsh criminal legislation, seclusion camps and other extreme reactions to the illness have been seen (Cameron, 2005).

South Africa, despite having enacted a number of laws and policies to protect the rights of people living with HIV/AIDS, has not been immune from the negative social response to the disease, with many HIV-positive South Africans having recounted stories of how being HIV-positive has led to alienation from family and friends, difficulties in accessing education and healthcare services, job loss, emotional and verbal abuse, and even physical violence (Campbell, 2003; Preston-Whyte, 2004; Stadler, 2004; Stein, 2004).

Research question and rationale

Negative social responses to HIV/AIDS can be seen as having a detrimental effect on the ability of affected communities to deal with the challenges posed by

the disease. For example, fear of the shame and disgrace attached to HIV/AIDS is often at the root of the failure of people to undergo testing, to reveal their HIV-positive status, to seek out treatment and routinely take medication. Cases have been cited of HIV-positive women who continue to breastfeed, despite the knowledge that this may endanger their child, in order to avoid being identified as having HIV, and of HIV-positive people who continue to engage in unprotected sex, for the same reason (Campbell, 2003; Preston-Whyte, 2004).

Thus, it is important to tackle the challenge represented by negative social responses to people infected with HIV/AIDS. In order to do so, it is necessary to understand the nature, causes and consequences of responses to the disease. Towards this, this research study has attempted to examine the factors shaping negative social responses to HIV/AIDS among a selected group of white South Africans.

The decision to locate this study in the white population was based on the assumption that, with HIV prevalence in South Africa's African population far surpassing prevalence in the country's white population, and with a history of systematic racism and social exclusion being a key contributor to this situation, responses to people infected with HIV/AIDS are likely to have a racial dimension.

Certainly the literature shows this to be true. For example, Deacon *et al*. (2005) indicate that HIV/AIDS has been stigmatised by many white South Africans as a disease that affects only African people. Further, the literature indicates that social responses to people infected with HIV/AIDS often perpetuate existing prejudices (Parker & Aggleton, 2003), and South Africa, with its long history of systematic prejudice and discrimination along racial lines, is likely to be a case in point.

Bharat (2002) indicates, however, that 'the relationship between racism, racial discrimination and HIV/AIDS has not been explored sufficiently well' (p. 8), leaving an opening for this study to provide new insight into such a relationship.

The approach to understanding negative social responses to HIV/AIDS as a reflection of relations of power and control, and how they serve to maintain the existing social order (Parker & Aggleton, 2003) is one of two approaches that the literature generally uses in explaining negative social responses to HIV/AIDS and those infected with it. The other, based on Goffman's (1963) conceptualisation of stigma, frames responses to the disease in more individualistic terms, looking at the influence of factors such as blame, fear and morality. However, the role that such factors play in shaping responses to HIV/AIDS does not necessarily have to be considered in solely individualistic terms, as such factors can also be seen as a reflection of broader social processes and influences.

This research study has attempted to marry the two approaches that the literature uses to explain negative social responses to HIV/AIDS in an effort to produce a contextually sensitive and nuanced account of responses to the disease among a selected group of white South Africans.

While the study has attempted to uncover the role of racially-biased ideas in shaping these responses, this was done in the knowledge that the country's history of racial discrimination has been tempered by 12 years of democratic governance, and that the influence of racial prejudices on the responses of white South Africans to people infected with HIV/AIDS are likely to be subtle rather than overt. Further, the country's colonial and apartheid past is certainly unlikely to be the only factor influencing social responses to HIV/AIDS and, thus, this study has attempted to explore a range of factors shaping responses to the disease among the study population.

LITERATURE REVIEW

Within the literature, a number of factors have been identified as contributing to negative social responses to HIV/AIDS. Many of these factors are linked to the notion of stigma; in particular, the notion of stigma as conceptualised by Goffman (1963). Indeed, many discussions about attitudes, perceptions and responses to HIV/AIDS use Goffman as their starting point.

Stigma, as conceptualised by Goffman (1963), is the possession of an attribute, or undesirable difference, deemed so discrediting by society that the person possessing it is considered to have a spoiled identity as a result of that attribute. Stigma carries negative moral and cultural connotations, such that the stigmatised person is considered morally inferior and culturally unacceptable, and the labels that accompany stigma are essentialising, in that the implications that they carry about the stigmatised person extend to all areas of that person's identity, and there is a tendency to impute a wide range of imperfections based on the original one.

HIV/AIDS seems to represent a clear example of Goffman's (1963) description of the manner in which stigma can be attached on three levels – to the body, to the character and to social collectivities – with HIV/AIDS being considered to have devastating physical consequences, to be a sign of moral weakness, and to be closely correlated with particular social groups (Goldin, 1994).

Negative social responses to HIV/AIDS fit well into Goffman's (1963) conceptualisation of stigma, particularly with regard to notions of blame, deviance and morality. Other factors that the literature identifies as playing a role in shaping responses to HIV/AIDS include fear and levels of knowledge about the disease.

Blame

According to Goffman (1963), stigma seems to mark most severely those conditions where the affected person is seen as being responsible for contracting the disease.

This can be seen in responses to HIV/AIDS, with many of those who are infected considered to be victims of their own behaviour (Walker *et al*, 2004). The degree of blame is seemingly determined by the means through which the disease was contracted. Jennings *et al*. (2002) explain that those who contract HIV through consensual sexual relations, are seemingly blamed for their 'self-induced' illness, and are often deemed to 'deserve' it. This group of 'guilty' sufferers, constitutes the majority of those who are infected with HIV/AIDS. Cameron (2005) concurs with Jennings *et al.* (2002), and goes on to explain that there is also considered to be a group of so-called innocent victims of HIV/AIDS, such as hemophiliacs, children of HIV-infected mothers, and wives of bisexual or promiscuous partners. The more people are blamed for their HIV-positive status, the more likely responses to such people are to be negative. The 'innocent victims', however, are not immune to negative responses (Cameron, 2005).

The notion that people who are 'responsible' for their HIV-positive status are likely to experience a higher degree of prejudice and discrimination than those who are considered to be 'innocent victims' guided the questions put to respondents in this research study. Further, the study explored the observation by Paicheler (1992) that additional distinctions are drawn between the guilty.

Deacon *et al.* (2005) explain that blame, as a response to HIV/AIDS, may arise, unconsciously, in light of perceived danger, and may serve to allow the uninfected to distance themselves from the behaviour that causes the disease. Such distancing often takes the form of 'othering', which allows a distinction to be drawn between the observer and the source of fear. The result is that HIV/AIDS,

and the behaviour that leads to its contraction, are commonly attributed to groups other than those with which the observer identifies. Representations of the 'other' frequently reflect key social divisions (Deacon *et al*., 2005).

This study will show how race, as a social division, exerts particular influence on responses to HIV/AIDS, and how 'othering' along racial lines is strongly accompanied by negative stereotypes, which also shape responses to the disease.

In its examination of how blame, and the resultant 'othering', affects social responses to HIV/AIDS, this study will show that the association of the disease with certain social groups may lead to a shift from the demonisation of the illness to the demonisation, not only of those infected with it, but to the demonisation of particular social groups.

Morality and Deviance

Goffman (1963) also indicates that stigma is most likely to be attached to conditions that fail to conform to social norms. In other words, stigma is most likely to be attached to conditions that are considered to be socially deviant.

The notion of deviance can be seen as shaping negative social responses to HIV/AIDS, with the pandemic often being considered to represent a transgression from socially-acceptable sexual behaviour, originally having been a 'gay' disease, and now being seen as a consequence of promiscuity which, while this may not represent a transgression of norms in some societies, does in others (Williams, 1987). Beyond being a consequence of deviant behaviour, HIV/AIDS may also be considered to produce deviant behaviour, in the form of illness and death, which is in contrast to the social norm of being healthy (Jennings *et al*., 2002). Other examples of 'deviant' behaviour caused by HIV/AIDS include unemployment and poverty (Williams, 1987).

Numerous pieces of literature identify the notion of deviance as being significant in evaluating social responses to the HIV/AIDS. For example, a study conducted for the South African Department of Health in 2002, found that people who considered HIV/AIDS to be a consequence of deviant behaviour were significantly more likely to behave in a discriminatory manner and to hold discriminatory attitudes towards HIV-infected people (Jennings *et al*., 2002). According to Mills (2004), the conception that HIV/AIDS is related to social deviance has, to a large extent, characterised the global response to the disease.

At the root of the tendency to attach stigma to conditions that represent a transgression from social norms, and to those conditions in which the affected person is seen as being responsible for contracting the disease, lies the moral- or value-based component of stigma, also known as symbolic stigma (Pierret, 2000).

In the case of HIV/AIDS, society's moralistic construction of sexuality has ensured that the disease is imbued with moral undertones, linked to the fact that the primary mode of HIV transmission is sexual (Mills, 2004). The result is that those so-called deviant behaviours that give rise to HIV/AIDS are, in many instances, considered by society to be immoral (Jennings *et al*, 2002).

According to Sontag (1988), the behaviour that produces AIDS is not simply considered to be a weakness; it is considered to demonstrate indulgence and delinquency, with the result that AIDS is seen as not only a disease of sexual excess, but one of perversity as well.

The influence of morality on social responses to HIV/AIDS may be due to the disease's early association with already-discriminated against groups, such as homosexual men and drug users (Carlisle, 2001).

This notion that HIV/AIDS is a consequence of sexual deviance, and that it represents the outcome of immorality, illustrates the attachment of stigma at the level of character, one of three levels on which Goffman (1963) indicates stigma can be attached.

The issues outlines above were explored with the participants in this study, and informed the study design.

Fear

Another factor that the literature shows to be influential in shaping responses to HIV/AIDS is fear. In fact, Richter (2001), through a study of the client files of the AIDS Law Project, indicates fear, together with ignorance, to be the main contributors to the formation of prejudice and discrimination against people with HIV/AIDS.

The study conducted by Jennings *et al* (2002) for the Department of Health also highlights the importance of fear in shaping responses to HIV/AIDS. The participants in this particular study showed high levels of fear of contracting the disease and, generally, those with higher levels of fear showed higher levels of discrimination against those infected. However, the study also showed that about 14% of the participants with low levels of fear still demonstrated high levels of discrimination.

Much HIV/AIDS-related fear is related to the nature of the disease as incurable, deadly and transmissible, and the literature shows that fear related to these characteristics of HIV/AIDS is likely to arise out of utilitarian self interest, with those who are infected representing a real material threat to those who are uninfected. Stein (2004) refers to such stigma as being instrumental, in that it is designed to protect the uninfected from infection.

This fear of contracting a disease that will lead to physical decline and, ultimately, death reflects the attachment of stigma at the level of the body, with the physical consequences of the disease, or at least the fear of these consequences, being the cause of the negative response.

The literature indicates that fear causes people to exaggerate the risk of infection from casual contact. For example, according to Sontag (1988), infectious diseases that are sexually transmitted often inspire fears of easy contagion and bizarre fantasies of transmission by nonvenereal means in public places. Similarly, Deacon *et al*. (2005) indicate that much stigma is based on an over-estimation of potential risk.

The role of fear in shaping social responses to HIV/AIDS was explored in this study through questions aimed at assessing the extent of fear, as well as the nature of such fear and how it impacts behaviour towards people infected with the disease.

Levels of knowledge about the disease

Another factor that has been identified as shaping responses to HIV/AIDS is a lack of knowledge about the disease. Several studies have shown that increased levels of knowledge about HIV/AIDS reduce the levels of discrimination towards those infected with it. In fact, some have gone so far as to suggest that increasing knowledge about HIV/AIDS will be the most effective means of decreasing discrimination (Jennings *et al*., 2002).

Other literature suggests, however, that education campaigns are not necessarily an effective means of altering negative responses towards HIV/AIDS. Instead of altering responses, education campaigns may simply make people aware that it is unacceptable to hold negative attitudes about the disease. The result is that

education campaigns may only seemingly reduce HIV/AIDS-related stigma and discrimination (Stein, 2004).

In South Africa, education campaigns about the pandemic have been extensive and have permeated most communities. And, indeed, some South African studies, such as the Nelson Mandela/HSRC Study of HIV/AIDS, suggest that the majority of South Africans express attitudes of acceptance towards people living with HIV/AIDS (Shisana & Simbayi, 2002).

However, anecdotal evidence continues to support the notion that people with HIV/AIDS in South Africa experience discrimination, with the condition continuing to be stigmatised and reviled by many. This suggests that knowledge does not necessarily shape attitudes towards HIV/AIDS by reducing stigma, but rather that knowledge has pushed HIV/AIDS-related stigma and discrimination underground (Stein, 2004). This study attempted to be sensitive to this dynamic.

A social-control understanding of responses to HIV/AIDS

While factors such as blame, deviance, morality, fear and knowledge are certainly a useful starting point in understanding social responses to HIV/AIDS, explanations that make use of such factors have often been disparaged as providing an individualistic rather than a social understanding. In response to such critiques, Parker & Aggleton (2003) have developed a new framework in which to understand social responses to HIV/AIDS. This framework suggests that negative responses to HIV/AIDS are better understood as being part of complex social processes that serve to maintain the existing social order and bolster the interests of those in possession of power. As such, negative responses to HIV/AIDS come to be seen as being closely allied with existing mechanisms of exclusion and dominance (Deacon *et al*., 2005).

As power often has a racial, class and gendered dimension, negative responses to HIV/AIDS often reproduce existing structural inequalities along these lines (Masindi, 2003).

In fact, according to Parker & Aggleton (2003), much HIV/AIDS-related stigma can be seen as being layered upon pre-existing stigma. Mills (2004) says much the same thing, when she explains that HIV/AIDS-related stigma is established upon discriminatory discourses and practices, such as racism.

According to Deacon *et al*. (2005), people living with HIV/AIDS are often stigmatised more for their existing membership of a group that is defined negatively than for gaining a new negative identity, in the form of being HIV-positive. This reflects the attachment of stigma on the third level identified by Goffman (1963) – social collectivities.

Jennings *et al.* (2002) explain how this has operated in South Africa, where two independent HIV epidemics have been identified. The first emerged in the early 1980s among white gay men. The second, emerging in the mid-1980s, was found among heterosexual adults, primarily in the African population. Thus, HIV in South Africa has, since its emergence, been concentrated in already marginalised and stigmatised groups in the population, groups that were subjected to intolerance, prejudice and moral condemnation long before HIV/AIDS emerged. The concentration of the disease in these groups reflects the social causation of HIV, and the fact that social exclusion is a key contributor to infection.

Thus, negative responses to HIV/AIDS in South Africa have interacted with existing prejudices and vulnerabilities to shape the response to the epidemic, and to further entrench existing prejudices.

This knowledge informed the design of this study by allowing for questions probing the role of pre-existing prejudices in shaping responses to HIV/AIDS.

Beyond the dichotomy of individualism vs. social control

The literature on social responses to HIV/AIDS reveals an ongoing tension between individual and social explanations (Deacon et al., 2005). However, the establishment of such a dichotomy is false, and a more complex reading of the so-called individualistic explanations reveals that the influence of factors that, on the surface, appear individualistic is, to a degree, a reflection of social processes directed at maintaining the existing social order.

For example, the identification of deviance and morality as factors shaping social responses to HIV/AIDS should be mediated by the knowledge that it is the power held by certain sectors of society that enables the definition of deviance and morality in the first place. As such, it can be said that negative social responses to HIV/AIDS are shaped by the ability of the powerful to marginalise and exclude individuals and groups displaying certain traits or behaviours (Parker & Aggleton, 2003).

Similarly, the role of blame and fear in shaping social responses to HIV/AIDS can be seen as part of complex social mechanisms directed at maintaining relations of exclusion and dominance rather than being merely individualistic influences. Through attributing blame for their HIV-positive status to those who are infected, the uninfected are able to gain an illusion of control by assigning risk-enhancing behaviour to the 'other'. In the case of HIV/AIDS, which has, since the first cases of the disease were diagnosed, been associated with particular social groups – initially gay men, and now African people – 'othering' has been especially easy (Deacon et al., 2005).

According to Joffe (1999), the process of 'othering' is a defensive mechanism used in response to anxiety, such that "people are motivated to represent the risks which they face in a way that protects them, and the groups with which they identify, from threat" (p.10).

The projection of risk onto the 'other' is particularly prevalent in society today, where high levels of risk awareness force people to depend on their own resources (Deacon et al., 2005).

In the case of HIV/AIDS, much of the anxiety felt can be attributed to the media's coverage of the illness, although, in a sense, the media has contributed to the process of 'othering' not only through generating fear, but through the use of stereotyped images to depict HIV/AIDS. For example, images of the disease used in the press generally show visibly ill black people. Such images make it only too easy for white people to believe that HIV/AIDS belongs to the 'other'.

In the process of 'othering', responses to HIV/AIDS are shaped by existing forms of prejudice and existing patterns of inequality. Thus, following existing social cleavages, the attribution of blame for HIV/AIDS is often directed at already excluded groups, and so serves to maintain existing power relations (Deacon et al., 2005). In South Africa, 'othering' may have served an additional function, through allowing white people to maintain identities that are untainted by the polluting elements associated with HIV/AIDS.

History

The layering of negative responses to HIV/AIDS on top of existing prejudices seems to suggest that negative responses to HIV/AIDS have deeper and older roots than the epidemic itself (Jennings *et al*., 2002).

Indeed, the literature seems to suggest that social responses to HIV/AIDS are, in many ways, similar to responses to earlier epidemics of sexually-transmitted diseases (STDs), and that these earlier responses reflect the influence of similar factors to those that are shaping the response to HIV/AIDS. Deacon *et al*. (2005) go so far as to suggest that there are striking similarities in how different diseases have been stigmatised over time.

Certainly an examination of historical responses to STDs reveals the influence of factors such as morality and deviance, fear, blame and pre-existing prejudice – all factors which have also been identified as shaping the response to the HIV/AIDS epidemic.

The historical role of morality in shaping responses to STDs can be seen in the manner in which STDs in Africa in colonial times were frequently explained in terms of an uncontrolled African sexuality and African sexual immorality (Vaughan, 1992). This led to the stereotyping of African people as promiscuous and highly sexed, and the conception of Africans as reservoirs of disease (Lyons, 1999).

In addition to showing the historical role of notions of morality in shaping responses to STDs, such conceptions also illustrate the historical operation of pre-existing prejudice, in the form of racism.

Gender-based prejudice is also evident historically, with many explanations of STDs specifically focusing on African female sexuality, which was often deemed to be rampant (Vaughan, 1992). Jochelson (1993) indicates how African women were believed to have caused a general decline in moral standards, and such a decline in morality was thought to inevitably lead to the spread of STDs.

The role of fear in shaping responses to STDs is also evident historically, with such fears frequently focusing on African domestic servants and their potential to

infect sexually-innocent white women and children. McCulloch (1999) explains how colonial settlers in southern Rhodesia believed syphilis to be so contagious and so common among Africans that the handling of cutlery, crockery or even sheets by domestic servants could lead to infection. This ties in with Sontag's (1998) description of bizarre fears of easy contagion, even by non-venereal means.

Notions of blame can also be seen in historical responses to STDs. For example, Vaughan (1992) explains how the 'otherness' of Africans was emphasised in explaining STDs in colonial Africa. This ties in with Goffman's description of the attachment of stigma at the level of social collectivities.

Beyond the individualised analysis of historical responses to STDs, the role of power can be seen in the manner in which the sexuality of African people became very much a focus of European concern, and came to represent the problems of maintaining social order in a rapidly changing society (Vaughan, 1992).

Similar fears regarding problems of maintaining social order can be seen as having shaped social responses to HIV/AIDS in South Africa. With the escalation of the AIDS epidemic in the country coinciding roughly with dramatic political and social changes linked to the onset of democracy, white responses to the disease may be a reflection of fears regarding the position of whites as a social group in the new dispensation, and fears regarding the compromising of white identities.

This study explores the notion that similar factors that shaped historical responses to STDs are currently shaping responses to HIV/Aids, and highlights similarities in actual responses to epidemics of STDs and HIV/AIDS.

The ongoing influence of historical stereotypes

Many of the historical stereotypes of African people, established as part of the colonial response to STDs, can be seen as persisting in the response to HIV/AIDS. The sexual transmission of HIV/AIDS has seen the disease cast as a marker of rampant sexuality, and the concentration of the disease in the African population has seen the perpetuation of colonial stereotypes of African people as hypersexualised and promiscuous carriers of disease (Dodds *et al*., 2004).

Many of these stereotypes are based on notions of morality and deviance, established by those sectors of society in possession of the power needed to define such categories.

Also operating in responses to HIV/AIDS are stereotypes that are linked to the attribution of blame, and the media plays a significant role in the generation of such stereotypes. For example, images of 'helpless', 'blameless' babies infected with HIV abound in the popular press, with the counterpoint being that those who contracted the virus through their own (immoral) behaviour are deserving of their suffering (Jennings *et al*., 2002).

According to Jennings *et al*. (2002), to some extent, the press coverage of the plight of Nkosi Johnson – an HIV-positive child who contracted the illness from his black biological mother, but went on to survive until he was almost a teenager under the care of his white foster mother – went a long way towards reinforcing harmful stereotypes attached to notions of blame. As a symbol, Nkosi Johnson also reinforced damaging racial stereotypes attached to the disease, as well as stereotypes of helplessness.

Indeed, the media has been instrumental in stereotyping people living with HIV/AIDS as helpless, thereby creating the perception that such people are a drain on society and, further, the perception that the contraction of HIV/AIDS is

necessarily a death sentence. Such stereotypes feed into negative responses to people living with HIV/AIDS (Jennings *et al*., 2002).

According to Stroebe & Insko (1989), the process of stereotyping allows those in the 'ingroup' to positively differentiate themselves from those in the 'outgroup', with membership of the outgroup often being defined by the ingroup. As such, the attachment of stereotypes to people living with HIV/AIDS assists those who are uninfected in attributing the disease to the 'other'. The uninfected are thereby offered the comfort of knowing that they will be spared from harm and responsibility (Schoeneman *et al*., 2002).

This study examines the role of stereotypes in shaping responses to HIV/AIDS.

Mbeki's rejection of the stereotypes

Through his rejection of the orthodox scientific view of HIV/AIDS – which holds, among other things, that HIV causes AIDS, that sex is a primary transmitter of the disease, and that antiretroviral (ARV) therapy is an appropriate medical means of treatment, although not cure – South Africa's president, Thabo Mbeki, has been at the forefront of politicising HIV/AIDS in the country.

Although never insisting outright that sex is not a vector of AIDS, Mbeki has attributed the disease, rather, to poverty, and his efforts to de-link AIDS from sex are believed to be part of an effort to dispel the stereotyped images of African sexuality and to avoid the possibility that discourses around HIV/AIDS could undermine African identities (Posel, 2005).

According to Posel (2005), Mbeki's efforts, instead of achieving his aim, have served to spark insistent publicising of the sexual nature of the disease, the dangers of 'unsafe' sex and the enormity of the sexual problem.

As such, Mbeki's stance may have done more to entrench the stereotypes of rapacious African sexuality than to dispel them. Certainly, Mbeki's stance served to politicise the disease, and an unfortunate outcome of this politicisation has been that it has played into the racial polarisation of HIV/AIDS discourse (Stein, 2002).

Perceptions of government's response to HIV/AIDS

Mbeki's stance has formed part of what, on the whole, has been a very confusing HIV/AIDS message from the South African government, whose response to the pandemic has largely been characterised by controversy and contradiction (Schneider & Stein, 2001).

Other senior political figures who have contributed to what is generally perceived as an inadequate HIV/AIDS response by government include the Minister of Health, Manto Tshabalala-Msimang, who has received criticism both locally and internationally for her insistent publicising of nutrition-based remedies and her failure to provide adequate leadership in the rollout of ARVs; and the country's former deputy president, Jacob Zuma, whose trial for the rape of an HIV-positive woman has likely perpetuated stereotypes of African masculinity and sexuality, and the strong link between the two.

The involvement of these high-profile figures in scandals relating to HIV/AIDS has served to undermine the credibility of government's response to the disease, and has reinforced stereotypes relating to the inadequacy of African leaders (Stein, 2002).

While not directly indicated by the literature as shaping responses to HIV/AIDS, this study explored the role of perceptions government's response to the disease in shaping social responses to it.

Theoretical framework

As reflected by the above literature review, this research project was located within a broad theoretical framework on stigma. The classic sociological work of Goffman (1963) served as a starting point for the study, with the influence of factors such as blame, morality, notions of deviance, fear and levels of knowledge being assessed in relation to the responses of white South Africans to people infected with HIV/AIDS.

The study was also informed by critiques of Goffman's work, such as the one provided by Parker & Aggleton (2003), which commonly indicate Goffman's analysis of stigma to be individualistic. Through the use of alternative frameworks of understanding, the study has attempted to reflect not only the influence of individualistic factors on the social response to HIV/AIDS, but also the influence of broader social processes, such as power, pre-existing prejudice, stereotyped images of Africans and African sexuality, and processes that operate to maintain the existing social order.

Further, this study has attempted to move beyond the dichotomy created in the literature between individualistic and social-control understandings of the response to HIV/AIDS to demonstrate that many of the so-called individualistic influences are, in fact, shaped by social processes, and operate to maintain the *status quo*.

METHODOLOGY

This study was conducted using a combination of quantitative and qualitative research methods.

The quantitative component of the study enabled an assessment of the extent to which factors identified in existing literature as shaping social responses to HIV/AIDS – such as blame, morality, fear, knowledge, pre-existing prejudices – were in operation in the sample being studied. The qualitative component of the study allowed for a more in-depth examination of the factors at play, and enabled the study to probe the context and history of these factors, allowing for an analysis that is social rather than individual, and sensitive to issues of power and control (Neuman, 1997).

Sampling

The sample was drawn from the staff of a Johannesburg-based publishing company, and was supplemented with people from outside the company in order to secure sufficient participants to make the study meaningful, as well as to broaden the demographic base of the sample, as the company employs mainly young women.

All white staff members at the company were approached to participate in the survey component of the project and were invited to distribute surveys to family members as well. Those who agreed to participate in the survey were also asked if they would be willing to be interviewed.

In all, close to 80 questionnaires were distributed, and 47 returned. Sixteen in-depth interviews were conducted.

Of the 47 survey participants, 32 were female and 15 male, 29 were english-speaking, and 18 Afrikaans-speaking. Twenty-six were between the ages of 20 and 30, although a range of ages from under 20 to between 61 and 70 were represented. Twenty-one of the participants indicated matric to be their highest level of educational attainment, while 3 had not matriculated, 12 had qualifications from either university or technikon, and 11 had post-graduate qualifications.

The mean age of the interviewees was 32 years, with the oldest interviewee being 60, and the youngest 19. Six were male, and 10 female. All had a minimum educational level of matric, and all, except for one, were employed.

While the participants' demographic characteristics did not form the foundation for the project's analysis, such information was requested in order to reflect that the study included a range of people with regard to gender, age and educational attainment.

Clearly the sample is not representative of the population being studied, and does not allow for generalisations to be made on the basis of the study's findings (Greenstein *et al*., 2003). However, the study has enabled a greater understanding of some of the factors shaping responses to HIV/AIDS in South Africa, and provides insight into the operation of these factors within the population being studied.

Data collection

The quantitative component of this research study, which took place first, was conducted through a survey that entailed the application of a structured questionnaire. All of the questions in the questionnaire had a list of pre-determined answers from which the respondents could make a selection. Questions aimed to determine the nature of responses towards HIV/AIDS, as

well as to explore the extent to which factors identified in the literature as influencing such responses were in operation.

Subjects who agreed to participate in the study were given a week in which to complete the questionnaire, and were requested to place the completed questionnaire in a sealed envelope before returning it to the researcher.

On completion of the data collection for the quantitative component of the research, the qualitative portion of the study was conducted, using in-depth semi-structured interviews. These were designed to allow the subjects to discuss their feelings about HIV/AIDS and their responses to the disease, and through this discussion the researcher attempted to uncover the reasons underlying the responses mentioned. This portion of the study made use of open-ended questions intended to allow the respondents to provide in-depth information about their opinions. The questions were flexible, and the researcher used sub-questions to probe further where necessary, and to pursue topics raised by the subjects that were, perhaps, not anticipated.

With the permission of the subjects, the interviews were all taped for later transcription, and notes were taken by hand if any non-verbal information was communicated. Interviews were transcribed by the interviewer shortly after being conducted.

Challenges faced in the data collection process

Stein (2004) suggests that there is a growing awareness that it is considered unacceptable to hold prejudiced attitudes towards people infected with HIV/AIDS.

Bearing in mind the potential impact that this could have on the findings of this research project, the questionnaires requested no information that would enable the identification of the respondent, and all questionnaires were issued with an

envelope in which the subjects were requested to return the completed document. Subjects were requested to seal the envelope and were assured by the researcher that the envelopes would only be opened once all anticipated questionnaires had been received. It was hoped that by reassuring the subjects that there would be no way in which the researcher or anyone else would be able to identify them, subjects would be encouraged to respond honestly.

In the interview section of the data collection process, a technique that was used to address the difficulty of self-censorship was to present the subjects with a statement, and to ask them for their opinion on it. For example, 'The media should publicise names of people who are HIV-positive so that others within the community can know who they are', or 'HIV-positive children should be educated in separate schools or classrooms to those who are not infected' or 'Black people are more likely to be infected with HIV/AIDS because they are promiscuous'. It was expected that such a technique would be useful in that subjects may have been more likely to agree with a statement reflecting prejudice proposed to them by the interviewer than if they had to articulate such a sentiment themselves.

To further address the challenge that self-censorship posed to the findings of this study, the researcher made every effort to ensure that the interviews were conducted in an environment in which the subjects felt comfortable to discuss their attitudes openly and honestly. In addition, in an effort to put the subjects at ease, the interview began with questions that were general and not too sensitive in nature (Greenstein *et al*., 2003).

Another potential difficulty faced by the study was the fact that the subjects to be included in the interview portion of the study had, by the time of the interview, already been included in the questionnaire phase of the study (Punch, 2000). By participating in the questionnaire, the subjects may have been conditioned to the topic of the research, with the result that their responses in the interview section of the study were possibly shaped by an awareness of the topic that they would

otherwise not have had. However, as the qualitative interviews were conducted very shortly after the quantitative survey was administered, any conditioning effect is likely to have been small.

Piloting of data collection tool

Once the questionnaire had been designed, it was tested on four people to ensure that its content and structure were adequate to secure the desired information. Three pilot interviews were also conducted to ascertain whether the interview design would elicit pertinent information. Fine-tuning of the data-collection tools was undertaken as indicated by the piloting process.

Data analysis

Data analysis on the quantitative component of the study made use of an excel programme designed to organise the information obtained. All survey responses were entered into this programme. Descriptive statistics were used to systematise and describe the information obtained.

In the qualitative component of the study, a certain degree of superficial data analysis was conducted congruently with the data collection process, to identify patterns and relationships between ideas as the interviews unfolded (Neuman, 1997). However, in-depth analysis only began once data collection was completed. Initially, the transcripts of the interviews and any notes made by the researcher were be examined, and themes identified. Following this the data was coded according to these themes.

Together, the quantitative and qualitative components of the study enabled an analysis that is both detailed and sensitive to the context in which the data was gathered.

Limitations of the methodology

As qualitative research usually requires that the data collected be rich in description rather than representative, the results of this study are not generalisable beyond the respondents who participated in it (Schurink, 1998). However, the research has aimed to reveal interesting information, and could form the foundation for further research into factors shaping the attitudes of South Africans towards HIV/AIDS.

Ethical considerations

This research study operated on the principle of informed, voluntary consent, by clearly informing all participants of what the study is about, and what was required of them. In the case of the interviews, this was done prior to finalising an appointment for an interview, in order to give the prospective subjects the opportunity to decline to participate in the study without undue inconvenience to either the researcher or the prospective subject (Neuman, 1997).

The study protects the privacy of participants by keeping the participants anonymous. No names or identifiable characteristics are used in this report.

ANALYSIS OF FINDINGS

Social responses to HIV/AIDS

With the aim of this research study being to explore the factors affecting the social responses of white South Africans to HIV/AIDS, it is important to have an understanding of the nature of such responses. While covered quite extensively by other surveys, this study, nonetheless, elected to include, in its survey component, a number of questions in this regard and, owing to the indication by Shisana *et al* (2005) that the complex nature of attitudes makes them difficult to measure using a questionairre-based approach, explored the attitudes further in the interview context.

Largely, the responses were characterised by a complete lack of uniformity. While some respondents showed themselves to be very prejudiced towards people infected with HIV/AIDS, and others showed themselves as very tolerant, most fell between the two ends of the spectrum. Frequently respondents who appeared prejudiced towards people infected with HIV/AIDS in certain areas, showed a surprising lack of prejudice in others, while other respondents who, on the whole seemed accepting of people infected with the disease, occasionally demonstrated significant prejudice and hostility.

Participants in the survey generally showed less prejudice when responding to abstract questions than when answering questions relating to their own lives. For example, while 55% of respondents strongly disagreed with the statement 'HIV-positive children should not be allowed to attend government schools', only 21% of respondents indicated that they would definitely allow their own children to be in the same class as an HIV-positive child. Similarly, while 8% of respondents agreed with the statement 'Businesses should have the right to dismiss HIV-positive employees', 19% indicated that they would dismiss their domestic worker if they found out that he/she was HIV-positive.

Similar findings emerged in the interview component of the project, indicating that while people may, in theory, feel quite tolerant towards those infected with HIV/AIDS, they feel significantly less tolerant regarding the disease on a personal level.

A significant portion of the seemingly prejudiced responses to HIV/AIDS evident in this study can be seen as stemming from fear of contracting HIV and the knowledge that the virus is primarily transmitted through intimate contact. For example 98% of respondents indicated that they would definitely not have a sexual encounter with someone who is HIV-positive. Respondents were seemingly more willing to engage in less intimate contact with HIV-positive people, such as being friends or working with an infected person, while behaviours such as sharing a meal, a house, a bathroom or a bed seemingly fell in the middle of a hierarchy of perceived risk, as is illustrated by Table 1.

However, to describe responses to HIV/AIDS as being solely determined by knowledge of how the disease is transmitted, and fear of its contraction, is overly simplistic.

Rather, the findings of this study reveal the responses of white South Africans to HIV/AIDS as being affected by a range and interplay of complex factors, including blame, notions of deviance and morality, fear, levels of knowledge about the disease, perceptions of government's response to the disease, pre-existing prejudice and stereotypes, and efforts to maintain the existing social order. The role of each of these factors is discussed below and, finally, the similarities between responses to HIV/AIDS and historical responses to other STDs are highlighted.

Table 1: Willingness to be involved with an HIV-positive person

Question posed	% answering definitely yes	% answering probably yes	% answering probably not	% answering definitely not
Would you be friends with someone who is HIV-positive?	43%	49%	9%	0%
Would you be happy working with someone who is HIV-positive?	38%	43%	19%	0%
Would you share a meal with someone who is HIV-positive?	34%	21%	34%	11%
Would you share a house with someone who is HIV-positive?	32%	36%	26%	6%
Would you share a bathroom with someone who is HIV-positive?	23%	36%	30%	11%
Would you share a bed with someone who is HIV-positive?	6%	15%	36%	43%
Would you date someone who is HIV-positive?	0%	9%	38%	53%
Would you have a sexual encounter with someone who is HIV-positive?	0%	0%	2%	98%

Note: Any differences are due to rounding

Blame

With the literature indicating blame as one of the key factors shaping responses to HIV, a decision was taken to use the survey component of this research project to ascertain the extent to which HIV-positive people are perceived as being to blame for their infected status, and to use the interview component of the project to gain a deeper understanding of the role that blame plays in shaping responses to HIV/AIDS.

To fulfill this mandate, the survey component of the research included the following two statements, which respondents were asked to indicate as being either true or false:

- People who get HIV/AIDS have only themselves to blame; and
- An HIV-positive person brought it upon himself/herself.

Twenty-six per cent of respondents indicated the first statement to be true, while 19% indicated the second statement as such.

Table 2: Survey statements assessing levels of blame

Statement posed	**Percentage of respondents indicating the statement to be true**
People who get HIV/AIDS have only themselves to blame	26%
An HIV-positive person brought it upon himself/herself	19%
Men who have lots of sexual partners and don't use condoms deserve to become infected with HIV	55%

It is believed, however, that the levels of blame indicated by these figures may have been suppressed by the fact that the statements are very broad. Indeed,

as reflected in Table 2, in response to the following more specific statement, a far higher percentage of respondents, 55%, indicated the statement to be true:

- Men who have lots of sexual partners and don't use condoms deserve to become infected with HIV.

Certainly, in the interview component of the research, blame emerged strongly as a factor shaping social responses to HIV/AIDS, with most of the interviewees attributing some degree of blame for their infected status to those who are HIV-positive. For example, Interviewee 10 said, "It is definitely their own fault. Definitely", and Interviewee 7 said, "They're to blame. And, it's very harsh to say, but they deserve it".

While other interviewees were rather more circumspect in their judgement, indicating discomfort at the use of the word 'deserve', the general feeling seemed to be, that if people are aware of how HIV is spread, and still behave in a manner that puts themselves at risk, then they are, at the very least, responsible if they become infected. For example, Interviewee 4 said, "I don't think anybody deserves to contract HIV. However, there is some blame to go around. If you know about AIDS and you still act in certain ways, then you are being really stupid". Similarly, Interviewee 6 said, "I don't think they deserve it, but I think they're to blame. They should be more aware. And they should use a condom or abstain".

The above statements are indicative of how HIV/AIDS prevention programmes based on the ABC (Abstain, Be Faithful, Condomise) model can, in fact, lead to negative sentiment and blame towards those who are infected (Stein, 2003). This occurs through the manner in which ABC programmes create the impression that people simply need to follow the principles of the programme in order to avoid contracting the disease, with the implication being that people who choose not to follow the principles of the programme, *choose* to put themselves at risk (Doherty & Colvin, 2005).

Campbell (2003) explains, however, that 'the forces shaping sexual behaviour and sexual health are far more complex than individual rational decisions based on simple factual knowledge about health risks' (p. 7). The result is that ABC programmes fall short of their mandate by ignoring the social dynamics and context that prevent many people from implementing lifestyle decisions that would protect them, and the fact that for many people, especially women sub-Saharan Africa, the scope to make any sort of choice regarding sexual behaviour is limited (Doherty & Colvin, 2005).

One of the factors limiting the ability to make real choices regarding sexual behaviour is poverty, which is widely acknowledged to exacerbate vulnerability to HIV infection for a number of reasons, including that people living in poverty have less access to education and information about the illness. Even when people are aware of HIV and how it is contracted, conditions of poverty reduce the capacity to negotiate safe sexual practices, thus making people living in such conditions more likely to engage in high-risk behaviour, including commercial and transactional sex as a means of survival (Doherty & Colvin, 2005).

African women are further limited in their ability to make any sort of choice regarding sexual behaviour by social norms, such as gender inequality and the subordination of women, which often result in women being in a position of economic and emotional dependency on their partner, and therefore being unlikely to have the necessary power to refuse sex or negotiate terms of sexual interaction, including condom use (Jewkes *et al*., 2003).

Linked to prevailing gender inequalities is a social norm whereby violence, including sexual violence, against women is widespread (Walker *et* al, 2004) widely accepted. This increases the vulnerability of women to HIV infection in three ways. Firstly, a forced sexual encounter increases the risk of HIV infection due to bleeding and tearing. Secondly, women involved in violent relationships

are less likely to ask their partner to use a condom, as such a request may lead to violence (Jewkes *et al*., 2003). Thirdly, Africa has high rates of abuse and violence against children, and women who were abused as children are more likely to engage in risky sexual behaviours as adults (Msimang & Ekambaram, 2004). The December 2005 *AIDS Epidemic Update*, published by the United Nations Development Programme*,* explains that, "choosing to abstain or have safer sex is not an option for the millions of women around the world who endure rape and sexual violence" (p. 13).

Other social norms, such as the practice of *lobola*, make it difficult for women to raise the topic of HIV and condom use, or to leave risky relationships (Mane & Aggleton, 2001).

With this context in mind, it becomes clear that it is problematic to say that people who ignore HIV/AIDS messages are to blame if they become infected, as realistically, the ability to apply ABC principles is grossly constrained for a large portion of the South African population.

In this research project, the extent of the blame attributed to those who are HIV-positive was seemingly determined by the means through which HIV was contracted, and a clear distinction was drawn between 'innocent' and 'guilty' victims of the disease.

In accordance with Goffman's (1963) notion that stigma seems to mark most severely those conditions where the affected person is seen as being responsible for contracting the disease, the interviews conducted as part of this research project found that those people considered to be 'guilty' victims of HIV/AIDS – ie. those thought to be to blame for their HIV-positive status – were generally subjected to a higher degree of prejudice and discrimination. For example, when asked about whether government should provide antiretroviral (ARV) therapy to people who are infected with HIV/AIDS, Interviewee 7 said, "Maybe people who

were victims of a blood transfusion or an accident and got it, maybe government should provide treatment for them. But if it was your own fault, then no". Similarly, Interviewee 11, when asked if she would make friends with someone who is infected with HIV/AIDS, said, "Well, it depends on how they got it. If it was innocent, from a blood transfusion, then yes. But people who got it in other ways, I wouldn't make friends with them".

Such observations could be linked to notions that the so-called 'bad' means by which HIV is contracted constitute 'deviant' or 'immoral' behaviour, with respondents wishing to distance themselves from such labels, as is discussed further under the heading Morality and Deviance. In addition, the respondents seemingly also wished to distance themselves from people engaging in such behaviours.

The so-called 'innocent' victims of HIV/AIDS are seen to have contracted the disease through actions that are considered to be 'normal', and even nurturing, such as child-birth or breastfeeding, or even sexual relations within the context of a marriage (Paicheler, 1992).

In line with the observation by Paicheler (1992), that additional distinctions are drawn between the guilty, some interviewees established a hierarchy of blame among those they considered to be responsible for their HIV-positive status. For example, Interviewee 6 said, "Government should definitely provide treatment for people who got it from a cheating spouse, or were raped, or had a bad blood transfusion. They should be first priority. But for a man who got AIDS from sleeping with prostitutes, or a promiscuous gay man, or a man who cheats on his wife, treatment for them should be a last priority. People who got it in other ways, like a young single guy who had a one-night stand or something, they should be somewhere in the middle of the list for receiving treatment ".

Again, it seems that, within the context in which people are blamed for their infected status, notions of 'deviance' and 'immorality' are key in shaping the degree of blame attributed to the infected, with those who contracted the disease via means that the interviewees consider to be 'deviant' or 'immoral' being subject to higher levels of discrimination and prejudice.

Perhaps this notion of what is deviant or immoral was also responsible for the survey findings indicated in Table 2, with a high percentage of respondents felt that men who have lots of sexual partners and don't use condoms deserve to become infected with HIV.

Further, the demographic characteristics of the sample included in this study are also likely to have contributed to the structuring of a hierarchy of blame. Within the context of white, middle-class South Africa, issues such as homosexuality and prostitution remain, to a certain degree, taboo, with the result that people who contract HIV as a result of engaging in such behaviours are likely to receive more 'blame' than people who contract the disease through less contentious means.

Jennings *et al* (2002) suggest that the media has played a role in shaping notions of 'innocence' and 'guilt' with regard to the contraction of HIV, marginalising those who have contracted the disease through taboo sexual practices, or using intravenous drugs, while depicting those who contract the disease through 'innocent' means, such as mother-to-child transmission, as deserving of compassion.

Through the attribution of blame, especially when the blame is linked to behaviours considered to be 'immoral' or 'deviant', there is a shift from viewing the disease in a negative light to viewing those who are infected with it in a negative light. Thus, the attribution of blame is one of the means through which people infected with HIV/AIDS have become stigmatised – to use Goffman's

(1963) terminology, the person with the undesirable difference (ie. the person with HIV/AIDS) is considered to have a spoiled identity as a result of that difference.

Deacon *et al*. (2005) explain that blame is often an unconscious response to perceived danger, and helps people to feel that they are less at risk as, through the attribution of blame to those who are infected, the uninfected gain an illusion of control and are able to distance themselves from the behaviour that causes the disease.

Certainly efforts to distance themselves from behaviours that lead to the contraction of HIV/AIDS were evident in the interview component of the research, with several interviewees indicating that, while they may be at risk of contracting HIV, it would be unlikely to be through one of the 'bad' means by which the disease is spread. For example, Interviewee 15 said, "If I ever contracted HIV it would most likely be from a blood transfusion". Similarly, Interviewee 10 said, "There is less than a one per cent chance that I would ever contract AIDS. And if I did, it would only be from a needle. I would never sleep around". Interviewee 2 said, "Maybe I could contract AIDS. In the country we live, there's such a high incidence of rape, so maybe I could get it through something like that. Other than that, my lifestyle is such that I shouldn't get AIDS".

Such findings are similar to those reported by Shisana *et al* (2005), with 45,3% of respondents in their study indicating that, if they were to contract HIV, it would most likely be through an accident or a cut, and a further 29% of respondents indicating blood transfusions to be the means through which they would contract the disease, if they were to become infected.

References similar to the comment by Interviewee 2 on lifestyle were fairly common in the interviews conducted for this study, with a number of participants indicating lifestyle to be a factor that determines risk of HIV contraction.

Frequently, however, the term lifestyle was used interchangably with ‘culture’, and, as is indicated under the heading Pre-existing Prejudice and Stereotypes, ‘culture’ was frequently used in this study as a mask behind which to express racially-biased opinions and stereotypes.

Further, in highlighting an appropriate lifestyle as a factor that serves a protective function with regard to the contraction of HIV, the participants in this study implied a level of choice that is not an option for most of those infected with HIV/AIDS in South Africa (refer to the above discussion on ‘real’ choices). Peterson & Lupton (1996) explain that lifestyle-based explanations of health and ill-health fail to acknowledge the impact of factors such as race, class and gender, and contribute to the tendency to blame those who are ill for the position in which they find themselves, which is the case in this study.

In addition to interviewees distancing themselves from the ‘bad’ means through which HIV is contracted, most also distanced themselves from the possibility of becoming infected at all. This desire to distance themselves from the possibility of contracting HIV was confirmed by the survey component of this research project, with 68% of respondents indicating themselves to be unlikely to ever contract HIV. This finding echoes that of the 2005 *National Household Survey on HIV Prevalence, Incidence, Behaviour and Communication*, where 66% of participants believed that they would never get infected with HIV/AIDS, although among white participants in that study, an even higher 84,7% believed they would not become infected (Shisana *et al*., 2005). Further, the survey component of this research project showed 62% of respondents believing it to be unlikely that any of their family members would ever contract HIV, although, interestingly, a fairly high number of respondents – 64% – agreed that, at some point, they are likely to have friends who contract HIV/AIDS.

Table 3: Survey statements assessing the extent to which respondents feel themselves, their family and their friends to be at risk of contracting HIV/AIDS

Statement posed	Percentage of respondents indicating themselves to agree with the statement	Percentage of respondents indicating themselves to disagree with the statement
It is unlikely I will ever be infected with HIV/AIDS	68%	32%
It is likely that some members of my family will, at some stage, contract HIV/AIDS	38%	62%
At some point, I will have friends who die of HIV/AIDS	64%	36%

On the whole, however, there was a tendency among the participants in this study to consider HIV to be a disease affecting the 'other', with Price (1989) explaining that, through 'othering', the process of blaming the infected for their status, serves as a means of distinguishing the observer from the source of fear. Thus, 'othering' enables the uninfected to consider themselves to be less at risk (Deacon *et al*., 2005), and thereby enables them to manage their fears regarding contraction of the disease (Schoeneman *et al*., 2002). (Fear as a factor shaping social responses to HIV/AIDS is discussed in a later section of this report.)

The interview component of this research project confirmed that the projection of HIV/AIDS onto the 'other' is a common response to the disease, with interviewees generally attributing HIV, and the behaviour that leads to the contraction of it, to groups other than those with which they identify. For example, Interviewee 8, when asked about who is primarily responsible for the spread of HIV/AIDS in South Africa, said, "People who sleep around, African people". Similarly, Interviewee 3, when asked about the types of people most likely to contract HIV/AIDS, said, "Drug-users, people involved in high-risk behaviours, prostitutes".

Deacon *et al*. (2005) explain that representations of the 'other' often reflect key social divisions, such that the 'other' is likely to be distinct from the person doing the othering along the lines of race, class, gender and sexual-orientation.

Certainly in this research project, most of the interviewees, at some stage, identified HIV/AIDS as being a problem of the 'other' in terms of race, linking the disease to the country's African population. Of course race, as a key axis of structural inequality, is an important contributor to the global pattern of HIV infection, with the result that HIV *is* more prevalent in the African population, and 'othering' statements linking HIV to the African population are not necessarily incorrect.

However, the literature indicates that the process of 'othering' usually includes ideas linked to a variety of other forms of prejudice, and follows existing patterns of inequality and bias (Deacon *et al*., 2005). This was evident in the responses of participants in this study who, along with indicating HIV/AIDS to be a disease of African people, also linked HIV/AIDS in the African population to a variety of negative stereotypes.

Few of the 'othering' statements made in the interviews indicated an understanding of the social epidemiology of HIV/AIDS. Rather, these statements were used by the interviewees as a means of differentiating their own group identities, in key risk-reducing ways, from the groups being blamed for the spread of the disease (Deacon *et al*., 2005). For example, Interviewee 9, who identified homosexuals and African people as being primarily responsible for the spread of HIV/AIDS in South Africa, said, "When HIV/AIDS hit the black communities is when the boom happened. Because they think it's fine to have 30 women or whatever the case may be". This statement serves not only to distance the observer from behaviours that might lead to HIV infection, but to imply that those who are infected are responsible for their HIV-positive status, owing to the fact

that they engage in such behaviours. The statement also contains a stereotype of African sexual behaviour that, for the most part, was common among participants in this study.

In identifying certain groups of people as being responsible for the spread of HIV, little space is left for the possibility that people outside these groups are at risk of contracting the disease. This could create a false sense of immunity from HIV/AIDS among those who are not members of the identified risk-groups (Gilmore & Somerville, 1994).

Goldin (1994) explains that the concept of risk groups first emerged in epidemiological studies in reference to categories of people with statistically higher rates of a particular disease, but that the concept has been broadened to the point where all people in particular groups are considered, owing to their membership of such groups, to be contaminated and dangerous. Certainly such labelling was evident in this study, and generally took place along racial lines, with several participants in the study holding the perception that all African people, while not necessarily HIV-positive, are 'potential carriers of the virus' (Interviewee 12).

Further, the association of HIV/AIDS with certain groups could lead to a shift from the demonistation of the illness to the demonisation, not only of the individuals infected with it, but to the demonisation of the groups identified as being most likely to contract the illness (Sontag, 1988). Therein lies the link between blame, disease stigma on an individual level, and disease stigma at the level of social collectivities, one of the three levels at which Goffman (1963) believes stigma to be attached (Mills, 2004).

The fact that the social collectivity in which HIV/AIDS is particularly prevalent – the African population – is already stigmatised has led to a situation of double stigma, with HIV/AIDS-related prejudice playing into, and reinforcing, already

existing racial prejudice (Bharat, 2005). Other stigmatising content, in the form of sexism and homophobia, may also be deployed in disease stigma, leading to multiple stigmatisation (Deacon *et al*., 2005).

Williams (1987) makes use of the term 'stigma symbols' to describe markers that draw attention to a 'debasing identity discrepancy'. For example, wrist scars may be a symbol of an attempted suicide, and pock-marks from needles may be a symbol of drug addiction. In the case of HIV infection which, at least in the early stages, does not have any visible markers, people are often stigmatised on the basis of secondary markers, such as their membership of a group in which the disease is particularly prevalent (Deacon *et al*., 2005). This is a form of courtesy stigma, with non-infected people being stigmatised because of their association with people who are infected (Williams, 1987). HIV/AIDS' strong association with particular social groups has meant that courtesy stigma is fairly common and the process of attributing blame takes place without any foundation of evidence (Sabatier, 1988).

In the context of this study, courtesy stigma can be seen as being closely tied with the concept of risk-groups, and the attachment of such stigma had a starkly racial character, with many participants demonstrating prejudice and discrimination towards African people in general, owing to the 'possibility' that they may be infected. Such attitudes highlight how HIV/AIDS-related prejudice is, to some extent, a new manifestation of pre-existing racial prejudices, although this study attempts to show, in the section on Pre-existing Prejudice and Stereotypes, that HIV/AIDS-related prejudice also has a unique character that makes it more than just a mask for old discrimination.

While the literature generally indicates the identification of blame as having limited ability to provide a social explanation for responses to HIV/AIDS, the findings of this study show that blame, in fact, contributes to the maintenance of the existing social order and is thereby central to a social explanation of

responses to the disease. Blame reinforces key barriers that determine social, economic and political opportunity, through the attribution of responsibility not only to those who are infected but, as a result of 'othering' and stereotyping along the lines of race, class and gender, to particular social groups. Such social groups are generally those that are already disadvantaged and disempowered, and negative responses to HIV/AIDS reinforce this position, thus reinforcing the existing social order. Further, blame interacts with existing prejudice towards such groups, increasing its power to maintain social difference (Deacon *et al*., 2005).

Morality and deviance

With the primary mode of HIV transmission being sexual intercourse, and in a society in which there exists a strongly moralistic construction of sexuality, it is unsurprising that HIV/AIDS is a disease imbued with moral undertones (Mills, 2004). Further, with HIV/AIDS first emerging in the gay population, and later coming to be seen as an epidemic tied to 'promiscuity', much of the moralising about the disease has focused on the so-called deviant nature of the sexuality that gives rise to infection.

Of course, definitions of what constitutes deviant and immoral behaviour are contested. However, for the most part, those definitions that have the greatest influence are those espoused by the powerful who, owing to their possession of power, are able to marginalise and exclude individuals and groups displaying traits and behaviours that fall outside of what the powerful define as 'normal' and 'moral' (Parker & Aggleton, 2003). The powerful perpetuate their values through institutions such as the family, the church and the education system and, as a result, such values come to be widely accepted as natural and correct rather than socially constructed (Mills, 2004). Notions of deviance and morality interact with existing racial prejudice and stereotypes to cast African people as inherently immoral and deviant, thus compounding the 'need' to marginalise such groups. The fact that such groups are already marginalised enhances the role that notions of deviance play in reinforcing the existing social order.

The population studied for this research project, being white and middle-class, undoubtedly represents a powerful grouping in the South African social order. Thus, the definitions of deviance and immorality employed by this group are likely to be a significant influence on social responses to HIV/AIDS in the country.

Certainly, the influence of such factors was made evident in this research study, with the construction of blame regarding the contraction of HIV/AIDS being

influenced by the extent to which the infected are considered to have engaged in deviant or immoral behaviour.

Findings of the survey indicate that people engaging in certain types of behaviour are thought to be particularly likely to contract HIV. For example:

- 87% of respondents felt that people who have lots of sexual partners will most probably become infected with HIV;
- 72% of respondents felt that sexually-active homosexual men will most probably become infected with HIV; and
- 83% of respondents felt that men who make use of prostitutes will most probably become infected with HIV.

Such behaviours were also strongly indicated as being either immoral or deviant. For example:

- 77% of respondents felt that having multiple sexual partners is immoral;
- 45% of respondents felt that homosexuals contract HIV/AIDS because their sexual behaviour is unnatural;
- 68% of respondents felt that gay sex is disgusting;
- 83% of respondents felt it is immoral for a man to make use of prostitutes; and
- 77% of respondents felt it is immoral for a woman to earn money by having sex with men.

Thus, the survey shows that certain behaviours commonly thought of as contributing to the spread of HIV – promiscuity, homosexuality and prostitution – are also commonly thought of as either deviant or immoral.

In the interview component of the research, the relationship between these behaviours and notions of deviance and morality was elaborated on, and it became clear that, through the labelling of such behaviours as deviant and

immoral, the behaviours, and the people engaging in them, have been stigmatised. Further, the links between such behaviours and HIV/AIDS has contributed to the stigmatisation of the disease, and those infected with it.

Prostitution was cast as being highly deviant, with several interviewees indicating it to be only slightly better than rape. For example, Interviewee 4 said, “I think its better to pay for sex than to rape somebody”. Similarly, Interviewee 2 said, “I don’t agree with prostitution, but I would rather somebody go to a prostitute than go out and rape an innocent woman”. Prostitution was also strongly indicated as being immoral. While some of the interviewees acknowledged that poverty may force women into prostitution, others insisted that there are always other options. For example, Interviewee 12 said, “You can sweep the streets, you can scrub toilets. There is always something else you can do. Prostitution is wrong”. Interviewees felt that people that are prostitutes, and people that make use of prostitutes, are particularly at risk of contracting HIV/AIDS.

Homosexuality was also referred to in the interviews as being sexually deviant and immoral. For example, Interviewee 11 said, “It’s very likely that gay men will get HIV, because their behaviour is so unnatural. Within the bible it is a sin to be gay”. Along similar lines, Interviewee 10 said, “Gay men, they are bad. They don’t believe in the bible, and the devil just comes and takes over. Gay men just sleep with each other. It is definitely a sin, because it’s not the way it’s supposed to be”.

The above statements reveal the influence of the Christian church on definitions of deviance and morality. Indeed, according to Gilmore & Somerville (1994), the use of concepts such as sin, guilt, evil and damnation has made religious institutions a powerful force in shaping responses to HIV/AIDS.

As an institution, the Christian church has been involved in shaping social responses to disease in Africa since the first missionary organisations sent

representatives to the continent over a hundred years ago and, as is revealed by this study, the church continues to be powerful influence in the current era of HIV/AIDS.

South Africa's apartheid past may have magnified the role of the church in shaping notions of deviance and morality, as this system of government, to a certain extent, employed its own interpretation of Christian teachings to justify policies aimed at undermining and controlling the non-white population. This version of Christianity was disseminated through a wide range of channels, including the education system.

The influence of the apartheid state on the church is evident in the manner in which Christian-based definitions of deviance and morality frequently imply racially-biased stereotypes of African people as inherently predisposed to immorality and deviance.

One such stereotype evident in this study was that of African people as promiscuous, and the value-judgements attached to this stereotype by the participants in this study revealed the influence of notions of morality on responses to HIV/AIDS. Further discussion on this is included under the heading Pre-existing Prejudice and Stereotypes. According to Lyons (1999), 'the stereotype, so widely expressed in the European subconscious, of the promiscuous, highly-sexed African [has] contributed greatly to the perception shared by many African observers, that the real cause of the AIDS epidemic in Africa was immorality and promiscuity" (p. 97).

In this research study, efforts to explore what is meant by 'promiscuous' revealed the contested nature of the term, with some participants indicating that it is promiscuous to have more than one sexual partner in a lifetime, and that such a relationship must be conducted within a marriage, while others were less proscriptive and indicated it to be acceptable to have a number of sexual

partners in a lifetime. What was consistent in the conceptualisations of 'promiscuity', however, was the feeling that casual sex – ie. sex outside of a relationship – is not acceptable.

Promiscuity, while not overtly referred to in the interviews as deviant, in the sense of being a failure to conform to social norms, was strongly indicated as being immoral. In fact, many interviewees indicated that it is increasingly the norm to be 'promiscuous', but that this is tied to the increasing immorality of society.

Promiscuity was readily attached to the 'other', such that the stereotype of African people as promiscuous was expressed by a number of interviewees. The 'promiscuous' nature of African people was attributed to their having a different, and lesser, set of morals. For example, Interviewee 13 said, "There is so much AIDS among the black people because of their morals. Sex before marriage to them is an everyday thing. And to have more than one sexual partner is also normal to them".

Deacon *et al*. (2005) explain that the long association of disease and sexuality with the 'other' is what has allowed sexually transmitted infections (STIs), and HIV/AIDS in particular, to form a potent moral vehicle. Further, the long tradition of equating disease with punishment from God for sinful deeds, especially sexual sins, has given rise to a belief, held by many, that AIDS is a punishment for deviant and immoral lifestyles (Jennings *et al*., 2002). Certainly, in this research project, several of the interviewees indicated HIV/AIDS to be a punishment from God. For example, Interviewee 16 said, "AIDS might have been created by God. God gives us a choice. We can choose whether we want to be sexually deviant or not". Interviewee 13 said, "HIV/AIDS might be a punishment from God. He's punishing people for not behaving like they're supposed to behave. You're not meant to have more than one sexual partner, and you're not meant to have sex before marriage". Sontag (1988) maintains that since the primary mode of HIV

transmission is sexual, people who are more sexually active are necessarily more at risk. Unfortunately, in such circumstances, it becomes easy to view the disease as punishment for sexual activity, especially when such activity has been cast as deviant and immoral by those in possession of the power to define such terms.

Some interviewees implied that not only is HIV/AIDS a consequence of deviance and immorality, but that it is closely tied to criminal activities. This was made evident through several interviewees who indicated that a significant factor facilitating the spread of HIV/AIDS in South Africa is ineffective law enforcement. Perhaps this link between HIV/AIDS and criminal behaviour was tied in with ideas about sexual violence, with a number of interviewees indicating that HIV/AIDS is primarily transmitted through rape. Certainly, rape has become a site of mounting public awareness and controversy, possibly on the back of rising public awareness about HIV/AIDS (Posel, 2005).

Even beyond fears of rape and sexual violence, sex was indicated in the interviews to be something dangerous, with several interviewees indicating a link between *sex* and criminal behaviours, such as taking drugs. Posel (2005) explains that HIV/AIDS has come to signify 'bad' sexuality and, within the context of a society with high HIV prevalence, sex has become cast as dangerous – even murderous – rather than pleasurable. In a sense, then, sex is beginning to be cast as deviant, and possibly immoral. HIV/AIDS, as a sexually-transmitted disease, becomes cast as immoral and deviant, enhancing the influence of such factors on responses to the disease.

Other studies, such as the one by Jennings *et al* (2002), have shown that people who consider HIV/AIDS to be a consequence of deviant or immoral behaviour are more likely to behave in a discriminatory manner and to hold discriminatory attitudes towards people infected with the disease. While this relationship was not overtly established in this research project, it was clear from the interviews

that people who were thought to have engaged in deviant or immoral sexual behaviour were more likely to be blamed if they contracted HIV and, as indicated in the previous section, the more people are blamed for their infected status, the more likely they are to be subject to prejudice and discrimination.

The fact that HIV/AIDS is considered to be a disease related to deviance and immorality reflects the attachment of stigma at the level of character, one of the three levels on which Goffman (1963) indicates stigma can be attached. The close association drawn between HIV/AIDS and deviance and immorality also reflects the description by Goffman (1963) that stigma has negative moral connotations, such that the stigmatised person is considered to be morally inferior. The articulation of stigma takes place in a language of relationships, whereby the labelling of one person as deviant or immoral reaffirms the normalcy of the person doing the labelling (Deacon *at al*., 2005).

Fear

Fear regarding HIV/AIDS was strongly evident in both the survey and interview components of this research project. The fear manifested differently, however, to other studies which have shown this factor to be influential in shaping responses to the disease.

For example, contrary to other studies, such as the one conducted by Jennings *et al* (2002) for the Department of Health, the subjects in this study made little overt reference to being fearful regarding the contraction of HIV/AIDS, and the subjects generally did not feel themselves, or the members of their families, to be particularly at risk of contracting the disease.

The disparity between such findings and the findings of other studies is likely to be related to the population being studied in this research project which, being white and middle-class, is unlikely to have much personal experience of HIV/AIDS. This is largely due to the fact that personal interaction in South Africa continues to reflect the racial boundaries established during apartheid, with the result that white South Africans largely interact and socialise with other members of this population group, and HIV prevalence in this group stands at only 0,6% (Shisana *et al*., 2005).

Indeed, the survey showed the respondents to be largely unfamiliar, on a personal level, with people infected with the disease, as indicated by Table 4.

This contrasts with findings of studies conducted in the general population which show a large portion of South Africans to have experienced some form of personal loss to the AIDS epidemic. A March 2005 *Afrobarometer Briefing* showed 31% of South Africans to know of a family member, relative or friend who has died of AIDS-related illnesses, and these figures are expected to be understated owing to the stigma attached to the disease.

Table 4: Survey questions assessing levels of personal experience with HIV/AIDS

Survey question	Percentage of respondents answering 'yes' to the question
Do you personally know anyone infected with HIV?	25%
Do you personally know anyone who has died of HIV/AIDS?	23%
Is any member of your family HIV-positive?	2%
Has any member of your family died of HIV/AIDS?	0%
Are any of your friends HIV-positive?	11%
Have you had any friends die of HIV/AIDS?	9%

Most of the participants in this study indicated that the bulk of their knowledge on HIV/AIDS has come from media sources, such as reading the newspaper or watching the news. Interestingly, an *HIV and AIDS and Gender Baseline Study*, compiled by nongovernmental organisation Gender Links, indicates that the bulk of media stories on HIV/AIDS in South Africa use officials, UN agencies and experts as their sources, while only 6% of stories use people living with the disease as their source (Gender Links, 2006). This tendency is likely to have contributed to the absence of familiarity with the disease evident among the participants in the study.

This lack of familiarity could be the reason behind the absence of overt expressions of fear regarding the contraction of HIV. Despite the absence of such expressions, however, many of the subjects included in this research project nonetheless demonstrated fear of the disease and, in some cases, indicated how such fears would impact their behaviour towards infected people. For example, Interviewee 13 said, "I would hate to be infected with AIDS. And to

make sure I never become infected, I will make sure that I'm not around infected people". Similarly, Interviewee 8 said, "Anyone with HIV has the potential to infect others. So it's better to avoid such people. I wouldn't want to have the same death sentence as they have hanging over their heads".

The survey component of the research included seven statements relating to the consequences of HIV/AIDS and, the extent to which the respondents agreed with these statements, together with comments made during the interview component of the project, indicate a high level of fear related to the nature of HIV/AIDS as a disease that is incurable, fatal and transmissible.

HIV/AIDS as a disease without cure

Seventy-two per cent of the survey respondents indicated that science is unlikely to find a cure for HIV/AIDS in the near future, and many of the interviewees indicated this absence of any hope for a cure as being what makes HIV/AIDS the worst disease a person can contract. Further, a number of the interviewees felt that even if a cure is found, it will be too late to rectify the 'damage' that has already been done.

HIV/AIDS as fatal

Fears regarding the deadly nature of HIV/AIDS generally related to the physical consequences of being infected with the disease. For example, many of the interviewees described the physical impact HIV/AIDS has on an infected person, and such descriptions generally indicated rapid physical decline to the point of death. Of course, many such descriptions were based on stereotyped ideas which cast people with HIV/AIDS as being in contrast to the norm of being healthy, and thus contribute to the establishment of the notion that people with HIV/AIDS are in some way deviant. Such stereotypes are often perpetuated by the media, which seldom depicts images of HIV-positive people living productive

lives (Jennings *et al*., 2002). Further discussion on the role of stereotypes in shaping responses to HIV/AIDS is included in the section of this report entitled Pre-existing Prejudice and Stereotypes.

Mak *et al*. (2006), in a study comparing the stigma attached to HIV/AIDS, tuberculosis (TB) and severe acute respiratory syndrome (SARS), indicate HIV/AIDS to be more stigmatised than the other two conditions, and one of the factors they identify as contributing to this situation is the fact that TB and SARS are easily curable with antibiotic medications, while HIV/AIDS, untreated, is deadly.

Treatment for HIV/AIDS, in the form of ARVs, while unable to cure the disease, is capable of significantly prolonging the length and quality of the lives of those infected. Even among those participants in the study who were aware of such medications, however, HIV/AIDS continued to be perceived as a death sentence. As is indicated under the heading Perceptions of Government's Response, part of this ongoing perception could be linked to the lack of availability of such medications in South Africa, and government's vacillations in rolling out an appropriate treatment programme.

Further, participants in the study raised doubts about whether being constantly medicated offers people quality of life. Interviewee 7, for example, said, "What kind of life is that, when you can only live on medications".

Such a statement raises the question of whether people with other chronic conditions that require constant medication, such as diabetes or hypertension, are subject to similar prejudices as people infected with HIV/AIDS. Bearing in mind, however, that the notion of requiring medication in order to stay alive is only one of a range of factors shaping responses to HIV/AIDS, it seems likely that HIV/AIDS-related prejudice and discrimination differs from that associated

with other conditions, which are likely to have their own unique set of causal factors.

Other fears relating to the deadly nature of HIV/AIDS that were raised in this study commonly made reference to dying of HIV/AIDS as being undignified, lonely and lacking in any sort of peace.

HIV/AIDS as transmissible

The fact that HIV is transmitted from one person to another, rather than being related to genetic predisposition, means, essentially, that anyone can contract the disease. While the subjects showed an acute awareness that certain people are more at risk than others, the fact remains that no-one can declare that they are completely safe. Such knowledge about the transmissible nature of HIV contributes to fears about the disease which, in turn, impact behaviour towards those infected. For example, Interviewee 12 said, "I wouldn't mind working with someone who is HIV-positive, but I'd keep my distance, just for extra precaution. I don't want to get infected, and if they're infected, I don't want it around me".

Instrumental stigma

The fact that there is currently no cure for HIV/AIDS, together with its deadly and transmissible qualities, makes fear about the contraction of the disease a not unreasonable response. In fact, Stein (2004) indicates that owing to the nature of HIV/AIDS, some of the negative responses to the disease arise out of utilitarian self interest, with those who are infected representing a threat to the lives of those who are uninfected. She refers to such stigma as being instrumental, in that it protects the uninfected from infection. For example, the refusal of an uninfected person to have a sexual encounter with an infected person can be construed as stigma if this decision is based on the fact that the other person is HIV-positive. However, while stigmatised, the response can be

seen as serving an instrumental function, in that it is protecting the uninfected person from being placed in a situation where they could potentially become infected.

In the context of this study, much of the negative sentiment towards people infected with HIV/AIDS was justified by those holding the sentiment as being related to their need to protect themselves from risk on either a physical, emotional or financial level.

On a physical level, one of the primary means through which instrumental stigma manifested itself was in an unwillingness to be involved in a relationship with an HIV-positive person. Fifty-three per cent of the questionnaire respondents indicated that they would 'definitely not' date an HIV-positive person, and 38% indicated they would 'probably not' date an HIV-positive person. The remaining 9% indicated they would 'probably' date an HIV-positive person, but none of the respondents indicated they would 'definitely' date someone who is infected.

While an unwillingness to date an infected person may be construed as prejudiced, this issue was further probed in the interviews, which found that the unwillingness was more related to a fear of infection than to negative attitudes towards infected people. For example, Interviewee 7 said, "I wouldn't have a relationship with someone who is HIV-positive because I wouldn't want to become infected".

In ignoring that condoms offer an effective means of protection from infection, this statement reveals some of the complexities involved in understanding social responses to HIV/AIDS. One possible explanation for disregarding condoms as a means of protection is that there is doubt regarding their effectiveness. An alternative explanation is that the casting of a stigmatised attitude as instrumental is merely an effort to put a socially-acceptable mask on a position that is actually based on symbolic judgements.

Fear of physical infection was also shown in the interviews to be at the root of the high levels of prejudice expressed towards HIV-positive medical professionals in the survey, which showed that 57% of respondents were likely to change to another doctor if they found out that their doctor was HIV-positive, and 62% of respondents were likely to change to another dentist under the same circumstances. Further, 48% of respondents agreed that HIV-positive doctors should not be allowed to treat patients, 53% felt that HIV-positive nurses should not be allowed to treat patients and 49% felt that HIV-positive dentists should not be allowed to treat patients.

These seemingly prejudiced attitudes were explained in the interviews as being a means of protection from infection. For example, Interviewee 2 said, “If you go to a doctor and you have an open wound, then you could be at risk. So HIV-positive doctors shouldn’t be allowed to work hands-on with patients”. Similarly, Interviewee 9 said, “I don’t think I would go to a doctor who was infected. Purely for the reason of injections and stuff like that. I’ve heard too many stories of people who have become infected from needles”.

Beyond offering protection on a physical level, certain stigmatised responses to HIV/AIDS were explained as being instrumental in that they offer protection on an emotional level. For example, a number of respondents indicated that their unwillingness to be involved in a relationship with an HIV-positive person was due to the fact that the relationship would not have a future, as the infected partner would, ultimately, die of their disease. Bearing in mind the other factors that have been revealed as shaping social responses to HIV/AIDS, it seems likely that such a position is not solely based on its instrumentality, however, and that it reflects the symbolic aspects of stigma as well. Thus, it seems unlikely that a similar response would be indicated regarding a person infected with a disease that does not have the same moral attachments as HIV/AIDS.

Stigma that is instrumental on an emotional level was also cited by several of the interviewees as the reason why they believe HIV-positive people should not have children. For example, Interviewee 14 said, in reference to a recent newspaper article on a judge who awarded custody of a child to its father rather than its HIV-positive mother, "I think it's a pretty fair decision. The mother will most likely die at some point in the future, and the child would have grown very attached to her if they were living with her. So it's better for the child to be with the father".

Beliefs that HIV-positive people should not have children were also indicated in this research project as being instrumental on a physical level, with several of the interviewees stating that it is wrong to bring children into the world if there is a possibility that they will be sick.

Further, some subjects indicated that HIV-positive people should not have children due to the fact that such children are likely to become orphans, and therefore a burden on the state. This is an example of how stigma can be seen as being instrumental at a financial level. Other indications of instrumental stigma at a financial level include that a number of subjects felt that government should limit the funds being spent on HIV/AIDS in order to tackle the range of other problems facing the country, with several interviewees specifically highlighting the ARV rollout as hampering government's ability to channel funds into other areas.

Such attitudes can be linked to the lack of personal experience of HIV/AIDS found among the survey respondents, and among white South Africans in general. The result of this lack of experience is that white South Africans, while generally acknowledging that HIV/AIDS will have a significant impact on the country, have not yet experienced the impact of the disease on a personal level.

Further, owing to the role that notions of morality and deviance play in shaping social responses to HIV/AIDS, the idea that HIV-positive people are to blame for

their infected status contributes to the impression that government should not be responsible for providing treatment.

In addition, the perception, held by many, that HIV/AIDS is a 'black' disease (De Kock, 2005) creates the impression that it is a problem of a specific sector of the population rather than a national problem that requires government intervention.

Resentment towards people with HIV/AIDS, stemming from the resources they require within the public health and welfare system, is increasingly shaping responses to the disease in resource-poor countries with high prevalence levels, such as South Africa. While not necessarily pertinent to this research project, owing to the sample's lack of personal experience with HIV/AIDS, resentment is also increasingly manifesting at a household level, with the uninfected begrudging the infected the money spent on medications, with such expenditure being considered a drain on household finances (Stein, 2004).

Overestimation of risk of infection

While, in the context of this research project, much of the stigma towards people infected with HIV/AIDS was explained as being instrumental – especially with regard to being in a relationship with an HIV-positive person, HIV-positive medical professionals and HIV-positive people having children – it is clear from the above discussion that many of these so-called instrumental beliefs are based on fears of easy contagion, which stand in contrast to the perception by most participants in the study that they are not at risk of contracting the disease.

Fears of easy contagion were illustrated by the survey findings, with 72% of respondents agreeing that it is easy to get infected with HIV. The interviews confirmed the above by showing how such fears align with a tendency to overestimate the risk of infection, with many of the interviewees exaggerating the risk involved in casual contact with an infected person. For example, Interviewee

11 said, “I know you can’t get HIV/AIDS from touching, but I wouldn’t be comfortable touching someone who has it. A handshake here or there would be OK, but I would avoid physical contact, just to be safe”.

Despite the participants in this study showing generally high levels of knowledge about HIV/AIDS, most of the fears of easy contagion expressed in this project seemingly stemmed from ignorance. For example, 60% of the survey respondents indicated that unprotected sex with an HIV-positive person will definitely result in the contraction of HIV/AIDS. Factually, this is incorrect, with the risk of being infected from a single sexual encounter, in the absence of other factors, being relatively small at 1 in 500 for women and 1 in 1 000 for men (Foreman, 1999).

Other misinformation that was cited in defence of so-called instrumental stigma included the belief that medication for the prevention of mother-to-child transmission (PMTCT) is largely ineffective. This misinformation saw interviewees indicating that HIV-positive people should not have children because the children will most likely be born infected and sick. In fact, PMTCT medication, if taken correctly, is very effective, and babies born to mothers on such medication stand a good chance of being born healthy.

As is discussed in the following section on Levels of Knowledge About the Disease, expressions of ignorance could be related to a desire on the part of the respondents to establish their stigmatised ideas as being instrumental rather than admitting to holding stigmatised ideas based purely on moral judgement, and if this requires the expression of ignorance about how the disease is transmitted, then they will choose to do this to enable the justification of their opinions and behaviour (Deacon *et al*., 2005).

Another reason for expressions of ignorance that reflect an overestimation of risk could be the sense of panic that has surrounded the HIV/AIDS epidemic, which

has contributed not only to the perception that infection is easily possible, but the overestimation of levels of infection, as indicated in the section of this report entitled Responses to HIV/AIDS as Reminiscent of Historical Responses to STDs (Jennings *et al*., 2002).

Parker & Aggleton (2003) argue that stigma arises in specific contexts of culture and power. In a sense, HIV/AIDS in South Africa is a disease associated with shifting power relations, having emerged at roughly the same time as the country was experiencing a dramatic political transition. In this context, HIV/AIDS may have emerged as a target for fears related to the dissipation of the political power formerly held by white South Africans. Certainly, historical evidence shows responses to STDs in colonial Africa as being representative of problems related to the maintenance of social order in a rapidly changing society (Vaughn, 1992).

Further, in casting certain responses to HIV/AIDS as instrumental, fear, in a sense, provides justification for attitudes that perpetuate existing patterns of inequality and exclusion. As Parker & Aggleton (2003) explain, negative responses to HIV/AIDS serve as a means of legitimising the dominant status of certain social actors within existing structures of inequality.

Is instrumental stigma acceptable?

With the findings of this research project showing that attitudes towards certain HIV/AIDS-related matters are more stigmatised than general attitudes towards the disease, with the reason being that, in certain circumstances, stigma serves a protective function, the question is raised whether stigma that serves a purpose is an acceptable response to HIV/AIDS.

With this research project also showing, however, that many stigmatised beliefs that can be construed as being instrumental are based on exaggeration and misinformation, meaning that such beliefs actually offer very little ‘protection’

against infection, and actually serve very little purpose at all, then the answer would have to be no.

Further, attitudes based on instrumental stigma may cause as much harm to efforts aimed at tackling HIV/AIDS as stigmatised attitudes that serve no purpose at all.

In this research project, it was strongly evident that many of the respondents were using the instrumentality of their attitudes as an excuse for opinions and behaviours that are, in fact, unacceptable. It seems likely, therefore, that the role of fear, based on ignorance, in shaping social responses to HIV/AIDS, may be tied to the growing awareness that HIV/AIDS-related stigma is not an acceptable response to the disease.

In casting certain responses to HIV/AIDS as instrumental, fear, in a sense, provides justification for attitudes that perpetuate existing patterns of inequality and exclusion.

Levels of knowledge about the disease

The literature offers two possible explanations of how levels of knowledge about HIV/AIDS affect responses to the disease. On the one hand, it describes an inverse relationship between knowledge about HIV/AIDS and levels of prejudice and discrimination towards people infected with the disease, such that higher levels of knowledge are associated with lower levels of prejudice and discrimination, and *vice versa*. On the other hand, the literature suggests that higher levels of knowledge may only seemingly reduce prejudice and discrimination towards the infected, with education campaigns creating an awareness that stigmatised responses to the disease are unacceptable (Stein, 2004).

Through sets of questions aimed at assessing levels of knowledge about the contraction of HIV/AIDS, and more general levels of knowledge about the disease, the survey component of this research project found most of the respondents to have a comprehensive understanding of the disease, which is similar to the findings of Shisana *et al* (2005). Further, the correlation proposed in the literature was evident, with higher levels of knowledge being associated with lower levels of prejudice and discrimination.

However, in the interview component of the project, it became apparent that despite generally high levels of knowledge about HIV/AIDS, responses to the disease continue to be shaped by ignorance, suggesting a more complex interpretation of the role of knowledge in shaping responses to HIV/AIDS than is usually depicted in the literature.

Expressions of ignorance in this research project generally took one of two forms. The first form saw respondents with high levels of general knowledge about HIV/AIDS expressing ignorance regarding the subtleties of the pandemic, such as the social epidemiology of the disease. For example, few of the

interviewees identified poverty as a contributor to high prevalence levels in South Africa. Further, few of the interviewees were aware that women are more vulnerable to contracting HIV than men, and even among those who were aware of the increased biological vulnerability faced by women, few acknowledged the increased social vulnerability they face in a society in which poverty has been feminised (Tallis, 2000; Doherty & Colvin, 2005), and cultural and social norms perpetuate gender inequality, violence and values that lead to unsafe sexual encounters (Jewkes *et al.*, 2003; Gilbert & Walker, 2002). Such ignorance seemingly shaped responses to the disease by increasing levels of blame and limiting levels of sympathy towards those infected.

The second form of ignorance expressed in the interviews, as described earlier, saw ignorance playing a role in the construction of responses to the disease as instrumental. While some such ignorance may have been real, the high levels of knowledge shown in the survey component of the project make it seem more likely that the ignorance was false. One explanation for false expressions of ignorance could relate, as suggested by the literature, to a growing awareness that it is considered unacceptable to hold stigmatised ideas towards people infected with HIV/AIDS. The result, then, is that false expressions of ignorance allow the respondent to establish their opinions and behaviours as protective, and therefore more acceptable, than opinions based solely on moral judgement.

A second explanation for false expressions of ignorance could be that such expressions reflect a lack of trust in the source of the information (Deacon *et al*., 2005). Certainly, in this study, a number of the interviewees mentioned that too little is known about the disease, and that we shouldn't trust everything we hear about it. For example, Interviewee 14, said, "They say there's no risk of getting AIDS from normal physical contact, but I think they don't know all the ins and outs of AIDS at the moment. So it's better not to take a chance". Similarly, Interviewee 16 said, "Not enough is known about AIDS to say that certain things don't put people at risk".

Deacon *et al* (2005) explain that the historical, political and cultural context of information shapes the extent to which people view such information as accurate. In the context of the South African government's response to HIV/AIDS, which has been characterised by controversial messages and a lack of political will and decisive action, it is likely that HIV/AIDS-related information disseminated by government, or organisations perceived as being associated with government, is seen as suspect. Perceptions of government's response to HIV/AIDS as a factor shaping social responses to the disease is discussed further in the following section.

Further, the country's apartheid history may be a source of doubt on the part of white South Africans, owing to racist notions about African leadership and intelligence. This is discussed further under the heading Pre-existing Prejudice and Stereotypes.

Beyond the influence that levels of knowledge have on individual responses to HIV/AIDS, they can also be seen as contributing to the maintenance of the social order. Information disseminated about the disease is determined by the powerful, and many education campaigns, through an emphasis on abstinence, faithfulness and the use of condoms, have perpetuated powerful notions of appropriate sexual behaviour, and the idea that those who are infected are to blame. Some education campaigns have also contributed to the idea of 'risk' groups, a notion that has the ability to stigmatise those groups that are already disadvantaged and disempowered.

Perceptions of government's response to HIV/AIDS

HIV/AIDS emerged in South Africa in the early 1980s. Politically, this was a time of turmoil and unrest, with the apartheid government attempting to maintain its hold on power in the face of rising opposition.

The nature of the apartheid government, as well as the seemingly insignificant magnitude of the HIV/AIDS epidemic at that stage, saw the first government responses to the disease in the country being weak and repressive. Initially, coercive legislation, including the labelling of AIDS a communicable disease, and the declaration of immigrants with HIV/AIDS to be prohibited and subject to deportation, was enacted, although later repealed. The apartheid government then began to consider the development of a national AIDS strategy, and established an AIDS unit within the Department of Health (Pelser *et al*., 2004).

While certain successes were achieved during this period, including the establishment of HIV surveillance systems and the initiation of the distribution of free condoms, on the whole, the response of the apartheid government to HIV/AIDS can be seen as having failed to develop and implement a comprehensive national strategy to tackle the disease (Ngwena & Van Rensburg, 2002).

Under democratic governance, South Africa's response to HIV/AIDS has continued to be weak, with intense contestation within the state, and between state and non-state actors, hampering the development of appropriate policy. Further, policy implementation has failed to progress significantly towards tackling the epidemic. Pelser *et al*. (2004) describe the South African government's response to HIV/AIDS as having, "suffered from a number of important flaws … chiefly tardiness, minimalism, fragmentation, inconsistency and inefficient or incomplete implementation" (p 302).

Based on the survey and interview components of this research study, perceptions of how government is dealing with HIV/AIDS have emerged as significant in shaping social responses to the disease.

As indicated earlier, one of the means through which perceptions of government's response to HIV/AIDS can be seen as shaping social responses is through the creation of doubt regarding information about the disease. This contributes to ignorance, be it actual or just expressed, which has the potential to increase levels of blame, and thus increase levels of stigma.

It was clear from the survey that government is perceived as having mounted a poor response to the challenge posed by HIV/AIDS, with only 3 of the 47 respondents (6%) indicating themselves to be satisfied with government's response to the disease. The interview component of the project showed similar results, with Interviewee 16 succinctly puttting into words what was implied by all the rest of the interviewees: "I think, as we all know, government's response to HIV/AIDS has been pathetic".

Several of the interviewees highlighted inadequate political attention as having hampered the response to HIV/AIDS in South Africa. For example, Interviewee 7 said, "The government has behaved like an ostrich putting its head in the sand. They think if they don't acknowledge it, then they won't have to do anything about it". Similarly, Interviewee 15 said, "They're trying to pretend it doesn't exist". Certainly, a lack of political attention characterised the South African government's response to HIV/AIDS in the early years of the pandemic (Schneider & Stein, 2001).

This lack of attention was initiated when HIV/AIDS first emerged in the country under the apartheid government which, being based on racialised notions often justified in relation to Christian morality, was unlikely to have mounted a significant response to a disease that emerged among homosexual and bisexual

men and once evident in the general population, was clearly concentrated among African people. The struggle against apartheid limited the scope to develop meaningful partnerships between government and civil society that could tackle the disease, while the seemingly insignificant magnitude of the disease at that point in its trajectory limited the levels of attention directed towards it (Ngwena & Van Rensburg, 2002).

So too in the early years of democracy, when the epidemic was growing but was still largely invisible, government focused its attention on more immediate priorities and, despite being accorded the status of Presidential Lead Project, HIV/AIDS continued to receive little political attention or leadership (Schneider & Stein, 2001). This was possibly also a result of the new democracy relying on politics of consensus and inclusion, with issues that could threaten the delicate balances of power being sidelined (Parkhurst & Lush, 2004).

Following these early years of lack of attention, HIV/AIDS became, and remains, one of the most attended to issues in government. However, much of this attention has sparked controversy and scandal, and the problem of political commitment to HIV/AIDS no longer seems to stem from a lack of political concern but from the inappropriate nature of such concern (Schneider & Stein, 2001).

Probably the first HIV/AIDS-related controversy the South African government was involved in was the 1995 debacle of *Sarafina II*, which was closely followed by the uproar surrounding the Virodene 'cure' for AIDS (Ngwena & Van Rensburg, 2002). These served to undermine the credibility of government's response to the disease, and doubt surrounding government's response has since been consolidated by the involvement of three very prominent political leaders – the President, the Minister of Health and the former Deputy President – in controversies related to HIV/AIDS.

The first of these began with President Mbeki questioning, if not completely denying, the link between HIV and AIDS (Ngwena & Van Rensburg, 2002). Posel (2005) argues that this stance, adopted through an association with so-called AIDS denialists, has contributed to the sense of catastrophe surrounding HIV/AIDS in South Africa.

Certainly Mbeki's involvement with the denialists was repeatedly highlighted by participants in this study, who were generally disdainful in this regard, and perceived it as having harmed the country's ability to tackle the disease. The survey component of the study revealed 53% of respondents as feeling that Mbeki's stance on the disease has caused much confusion in South Africa. Interviewee 2 said, "Mbeki has wasted so much time going on stupid wild goose chases trying to prove that AIDS doesn't exist, when clearly it does". Similarly, Interviewee 5 said, "After having his ear pulled by a bunch of rather odd dissidents, Mbeki came up with these ludicrous claims that HIV doesn't cause AIDS, and that poverty is what causes it".

Mbeki's questionable stance on HIV/AIDS has also seen him indicating that AIDS is a consequence of poverty and malnutrition. While never completely denying that sex plays a role, his position sparked insistent publicising of the sexual nature of the disease. This may have served to entrench stereotypes of rampant and uncontrolled African sexuality (Posel, 2005). Indeed, as is illustrated under the heading Pre-existing Prejudice and Stereotypes, this study reveals that stereotypical views of African people are exerting an ongoing influence on responses to HIV/AIDS.

The second prominent South African political leader to be involved in HIV/AIDS-related controversy is the Minister of Health, Manto Thabalala-Msimang, whose stance on HIV/AIDS is seen by many as further hampering South Africa's response to the disease. Her regular promotion of the benefits of lemon, garlic, beetroot and the African potato in tackling HIV/AIDS, despite the absence of

scientific evidence to back this up, was described by various participants in this study as 'laughable', 'embarrassing', 'shameful', 'stupid' and 'ridiculous'. Generally attitudes towards her were completely disdainful.

Perceptions of Tshabalala-Msimang's stance as untenable were confirmed in September 2006, when more than 80 scientists, including leading international academics, in a letter to President Mbeki, called for the health minister's immediate dismissal, in order to bring an end to the "disastrous, pseudo-scientific policies that have characterised the South African government's response to HIV/AIDS" (*Mail & Guardian*, 2006).

In the letter, the academics echoed the words of Stephen Lewis, United Nations envoy on AIDS in Africa, who, at the close of the International AIDS Conference, held in Toronto, Canada, in August 2006, said, "South Africa is the unkindest cut of all. It is the only country in Africa, amongst all the countries I have traversed in the last five years, whose government is still obtuse, dilatory and negligent about rolling out treatment. It is the only country in Africa whose government continues to propound theories more worthy of a lunatic fringe than of a concerned and compassionate state … The government has a lot to atone for. I'm of the opinion that they can never achieve redemption" (Lewis, 2006).

The third prominent political leader that has been involved in an HIV/AIDS-related scandal in South Africa, although this involvement took place in his personal rather than professional capacity, is the country's former deputy president, Jacob Zuma, who was, in the first half of 2006, on trial for the rape of an HIV-positive woman. During the course of the trial, Zuma claimed that unprotected consensual sexual intercourse had taken place between him and the woman who made the rape allegation. He also indicated that, having known her HIV-positive status beforehand, he had taken a shower after the encounter in order to prevent himself from being infected.

Aside from the hype surrounding the rape allegation, Zuma's obvious ignorance of, or perhaps disregard for, conventional knowledge about the means by which HIV is contracted and prevented, caused an uproar in the South African media and among HIV/AIDS organisations.

This study, conducted shortly after Zuma was acquitted of the rape charge, saw some 92% of the respondents in the survey indicating that Jacob Zuma's trial has seriously damaged South Africa's efforts to fight HIV/AIDS and, in the interview component of the project, almost all participants made unfavourable mention of Zuma. For example, Interviewee 5 said, "The man is an idiot. Hasn't he ever heard about how AIDS is spread? Of course he's heard, he just thinks he's above listening". Similarly, when asked about whether condoms represent an effective means of targeting HIV/AIDS, Interviewee 10 said, "No, not when you think of that stupid Jacob Zuma. If he doesn't bother to wear one, why will anyone else?"

A number of the interviewees surmised that Zuma was willing to engage in unprotected sexual relations with an HIV-positive woman because he himself is HIV-positive, and so not concerned about contracting the disease. Zuma has certainly never publicly indicated himself to be HIV-positive, and such opinions could be related to the finding in this study that white South Africans significantly overestimate HIV prevalence levels among African people. (This is discussed further under the heading Responses to HIV/Aids as Reminiscent of Historical Responses to STDs.)

Several of the participants in the study indicated Zuma's involvement in a rape and HIV/AIDS-related scandal to be 'typical' of African men, African sexuality and African immorality, pointing to the role of stereotypes in shaping responses to HIV/AIDS. (This is discussed further under the heading Pre-existing Prejudice and Stereotypes.)

The involvement of Mbeki, Tshabalala-Msimang and Zuma in controversies regarding HIV/AIDS has created the impression that government's message about the disease has served more to confuse than to educate. According to Interviewee 15, "Government is not dealing with HIV/AIDS. Things come from the top down. And if your leader at the top does not believe it, and his next one down in the health ministry doesn't believe it, why should the guy half way down the scale, still working in government, believe it. And if he doesn't believe it, then why must the man at the bottom, or the poor guy who comes to them for assistance, why must he believe it, if they don't at the top".

This serves to indicate that a weak political message on HIV/AIDS is perceived as having harmed South Africa's response to the disease. The literature confirms this perception, frequently contrasting the vacillations, contradictions and denials of South Africa's political leadership on the matter with the direct unequivocal message about the disease delivered in countries that have been more successful in efforts to tackle the epidemic, most notably Uganda, where that country's president, Yoweri Museveni, has been credited with speaking openly and plainly on the disease, and thereby leading a campaign that has seen an ongoing improvement in HIV prevalence and incidence levels since the early 1990s (Parkhurst & Lush, 2004).

The unclear message on HIV/AIDS provided by South Africa's political leadership indicates a lack of political will to deal with the issue, and this lack of political will is also evident in the lack of decisive action in rolling out appropriate medications. The Minister of Health resisted the introduction of ARVs for the prevention of mother-to-child transmission until a Constitutional Court ruling forced her to do so, and she resisted the introduction of ARVs for AIDS-sick people until 2003 when, following prolonged campaigning by civil society organisations, the South African Cabinet committed government to rolling out such treatments (Nattrass, 2006).

Since then, the public sector rollout of ARVs has begun, although not without further delays owing to the Minister's procrastination in awarding tenders for the supply of the drugs, and not without the creation of further confusion, with the Minister continuing to warn about the dangers of taking such medications (Nattrass, 2006).

In addition to the delays in initiating the ARV rollout, this programme is now progressing at a far slower rate than envisaged by government's plan (Nattrass, 2006). The interviewees in this research study made frequent mention of this, as well as a not inaccurate observation that government's delayed response to HIV/AIDS has caused many unnecessary deaths.

What also emerged strongly in the study was the perception that the contraction of HIV/AIDS continues to be tantamount to a death sentence, and this is likely to be at the root of much of the fear that can be seen shaping social responses to the disease. As mentioned earlier, much of the HIV/AIDS-related fear expressed in this research study was based on a perception of the disease as incurable and deadly, and government's delays in providing the necessary medications have done little to alter this idea.

Perhaps once ARVs are widely available, South Africa can begin to move towards the perception of HIV/AIDS that is increasingly being grasped in the developed world, a perception that regards the disease as a chronic condition that can be controlled through appropriate treatment regimens rather than an automatic death sentence (Berger, 2001; Preston-Whyte, 2004). Owing to ARVs, a growing proportion of HIV-infected people remain without any clinical symptoms, and people with AIDS are living longer and staying in better physical condition (Pierret, 2000).

A number of the interviewees indicated that they felt the 'old' government – ie. the pre-democratic government, led by the National Party – would have provided

better leadership on the matter of HIV/AIDS. Considering the nature of the apartheid state, however, and the legislated inequality on which that state was based, it is unlikely that any response to HIV/AIDS led by the apartheid government would have benefited the bulk of the population. Indeed, the apartheid government's response to HIV/AIDS has been reported as largely repressive and inadequate (Ngwena & Van Rensburg, 2002). Thus, perceptions indicating that the 'old' government would have responded better to HIV/AIDS than the current government seem improbable. Nonetheless, they reflect the racial polarisation of HIV/AIDS discourse, much of which is a consequence of the politicisation of the disease brought about through the high-level government controversies surrounding it. Such perceptions also reflect white stereotypes about the inadequacy of African leadership (Stein, 2002).

Further, perceptions that the 'old' government would have mounted a more effective response to HIV/AIDS could reflect the influence of the biomedical model on the respondents, with a number of interviewees indicating that the 'old' government would have been more inclined towards Western medical thought, which would have facilitated the more effective rollout of appropriate medications. Certainly Western medicine, in the form of ARVs, had it been timeously rolled out, could have saved the lives of many South Africans who have died of AIDS-related illnesses. However, as long as the psychosocial and environmental aspects of the disease are ignored, responses will continue to be inadequate. Participants in this study, however, largely failed to consider such possibilities.

Walker *et al* (2004) indicate that broad acceptance of biomedical explanations of HIV/AIDS has seen other understandings of the disease being subdued and, certainly in this study, respondents dismissed the possibility that traditional African healthcare practitioners could play a role in tackling the disease. Further, participants failed to indicate any possibilities for collaboration on HIV/AIDS between western biomedical and traditional African healers. Perhaps this is related to strong objections to the Minister of Health's promotion of diet as a

response to the disease and the significant amount of attention that has been directed towards highlighting her stance as unscientific. This is another unfortunate spinoff of the Minister's position on HIV/AIDS as, for a large portion of South Africa's population, the traditional healthcare sector carries significant legitimacy, with as much as 80% of the country's population consulting with such practitioners. Thus, the potential for the traditional healthcare sector to promote HIV/AIDS education and treatment programmes is significant, and the involvement of traditional healers in such a strategy could reach a portion of the population that is mistrustful of western medical thought (Ndaki, 2004; Walker *et al*, 2004).

Some interviewees went so far as to indicate that HIV/AIDS is a problem that has only surfaced under the new government. For example, Interviewee 14 said, "When the old government was in power, AIDS hardly existed. Now it's everywhere, and it's all you hear about". This observation could represent a shift that has taken place with regard to anxiety among white South Africans. As indicated later in the report, during apartheid, the primary focus for anxiety among white South Africans was the 'danger' represented by the African population and, while some anxiety continues to be framed in such terms, a rising source of anxiety among white South Africans is HIV/AIDS, which, interestingly, relies on much of the same imagery of pollution, morality and deviance as earlier fears relating to the African population.

While the scale of the epidemic during the apartheid years was certainly less significant than now, few respondents attributed this to the fact that the epidemic, at that point in time, was in its early stages. In fact, far from having limited the progression of HIV/AIDS, the apartheid government set in place the social and economic conditions that have served as such a significant contributor to the pattern and magnitude of the epidemic in South Africa today. For example, the apartheid government's strategies of forced removals, migrant labour and single-sex hostels contributed significantly to family and community breakdown, which

have aided to the spread of HIV/AIDS. Further, the creation of rural and urban slums, as well as the struggle against apartheid and the violence that accompanied this struggle, can also be seen as having served as catalysts in the progression of HIV/AIDS (Ngwena & Van Rensburg, 2002).

In contributing to racialised stereotypes and pre-existing prejudice, perceptions of government's response to HIV/AIDS act to preserve social difference, thereby maintaining a situation in which certain groups are held to be inferior and, thus, deserving of their lack of power and privilege.

Pre-existing prejudice and stereotypes

The global pattern of HIV infection reflects key axes of structural inequality, such that those most severely disadvantaged in terms of race, class and gender, are also those most vulnerable to HIV infection (Bharat, 2002). Indeed, the bulk of those infected are poor, African and female.

The same fault lines of inequality that seem to serve as markers of vulnerability with regard to HIV infection also commonly form the foundation for prejudice, such as racism, elitism (broadly defined as prejudice based on class) and sexism. As such, HIV seems to be concentrated in groups that have long been subject to prejudice and discrimination, and the literature indicates that responses to the disease have been shaped, strengthened and reinforced by existing prejudices (Jennings *et al*, 2002). Further, responses to HIV/AIDS can be seen as entrenching existing inequalities and relations of power and control (Parker & Aggleton, 2003).

In South Africa, the country's colonial and apartheid past has determined that the most significant fault line of social inequality, the most significant determinant of vulnerability, and the most significant foundation for prejudice, is race. As such, HIV in the country is particularly prevalent among African people who, for hundreds of years, have been subject to racial prejudice on an unprecedented scale (Jennings *et al*, 2002).

Early responses to HIV/AIDS in the country, during the apartheid era, reflected openly racist interpretations of the disease on the part of white South Africans (Schneider & Fassin, 2002). Jochelson (1991) explains that HIV was not understood simply as a disease, but rather through a lens of racist fears. Based on the findings of this research study, racial prejudice can be seen as a factor that continues to shape the responses of white South Africans to HIV/AIDS, although expressions of prejudice have, perhaps, become more subtle.

Franchi (2003) indicates post-apartheid South Africa to be an environment in which it has become relatively unfashionable to make reference to race and, in line with this, just as the sample in this study showed the effects of a growing awareness that it is considered unacceptable to hold negative attitudes towards people infected with HIV/AIDS, the sample showed a strong awareness that it is also considered unacceptable to hold, or at least express, negative ideas towards people of other races. Thus, when trying to assess the extent to which social responses to HIV/AIDS are affected by pre-existing prejudice, the study was confronted with subjects who were reluctant to overtly express racist ideas. Upon probing, such ideas were, nonetheless, made apparent, and their influence on responses to HIV/AIDS made evident.

In situations in which it is considered unacceptable to make racially-based comments, reference to race is often replaced with phrases such as 'ethnic group' or 'language group' (Franchi, 2003). In this study, the primary mask behind which the subjects attempted to hide their racially-biased opinions was the phrase 'African culture'. For example, when asked to explain the different HIV prevalence levels found in the country's African and white populations, most subjects made use of the phrase. While this in itself does not reveal racial prejudice, the attachment of a number of negative values to African culture made evident the fact that the use of the term has a racially-biased foundation. This ties in with Goffman's (1963) description of stigma, which is indicated as having negative cultural connotations, such that those who are stigmatised are considered to be culturally unacceptable.

Most of the subjects appeared to believe that it is more acceptable to attribute negative traits to a culture than to a racial group. For example, Interviewee 7 said, "I wouldn't say that black people are more promiscuous than white people, but in terms of African culture it's okay to have a whole lot of sleeping partners". Interviewee 2 said, "African culture is generally very relaxed regarding things like

work ethic. So what we perceive as laziness is really just a part of their culture. But I wouldn't generally say black people are lazy".

In line with Schneider & Fassin's (2002) indication that, since the demise of apartheid, racist interpretations of the AIDS epidemic are reflected in deeply-held stereotypes about African people, most of the prejudices expressed in this research study under the banner of 'culture' were based on stereotypical views of the nature of African people.

One of the most common stereotypes of African culture expressed by the participants in this study is that of African people as promiscuous and highly-sexualised. For example, Interviewee 8 said, "They just sleep around a lot … In their culture it's easy for them to have more than one sleeping partner". Interviewee 10 said, "One man has ten children by ten women. Because they just think they can sleep around, and they don't use condoms". A number of interviewees indicated that promiscuity is common in African culture due to polygamy. For example, Interviewee 9 said, "To have five wives, ten wives even, that is part of African culture". Similarly, Interviewee 15 said, "I don't think promoting abstinence will ever stop AIDS, because of the culture of African people. It might work in the white population, but among black people, multiple partners don't mean a thing. That's the culture unfortunately. For them, it's nothing to have five or ten wives. They marry one, but then they've still got a whole lot of mistresses hanging around". In fact, polygamy is not particularly common, with only 3,4% of participants in the 2002 Nelson Mandela HSRC survey on HIV/AIDS indicating themselves to be in polygamous relationships (Shisana & Simbayi, 2002).

Marshall (2005) indicates that much of the discourse surrounding HIV/AIDS emphasises the sexuality of 'black bodies', and that Western writing on HIV/AIDS frequently employs images that have long been used to depict African people, including darkness, danger and deep primordial nature.

The literature makes mention of how stereotypes of African sexuality contribute to shaping social responses to HIV/AIDS. For example, Deacon *et al* (2005) indicate that the process of 'othering' in response to HIV/AIDS frequently includes notions of oversexed African people. Similarly, Paicheler (1992) explains that when AIDS is described as a disease of the 'promiscuous', African people are generally included in this category.

According to Lyons (1999), "The stereotype, so widely expressed in the European subconscious, of the promiscuous, highly-sexed African [has] contributed greatly to the perception, shared by many African observers, that the real cause of the AIDS epidemic was immorality and promiscuity" (p. 97).

A number of subjects also indicated that African culture is very relaxed about sex. For example, Interviewee 11 said, "Sex is a way of life for black people. They have sex to be social". Similarly, Interviewee 2 said, "You see them with those little scanty skirts and bare breasts from a young age. That's how they've grown up. Sex is natural to them".

Another stereotype of African people commonly indicated is that African people are lacking in intelligence. While most of the subjects attempted to soften their use of this stereotype by citing the fact that, due to the country's apartheid history, many African people have been denied the opportunity of a good education, the deductions that the subjects attached to this fact blatantly demonstrated the use of stereotyped images. For example, Interviewee 6 said, "Most blacks are only semi-educated, so their thought patterns are different. They don't think rationally and they don't listen to facts. This is why AIDS education isn't working with them". In indicating that a lack of education necessarily implies an inability to think rationally and to assimilate knowledge based on facts, this statement shows the use of faulty logic, and is likely to illustrate racial prejudice. Similar faulty logic was demonstrated by several other

subjects, such as Interviewee 8, who said, “Africans are uneducated, and they just believe superstitious nonsense and old-wives tales. They don’t have the common sense to know that they’re killing themselves by sleeping around”.

Linked to the stereotype of African people as unintelligent, a number of the subjects also stereotyped African people as apathetic and lazy. For example, Interviewee 8 said, “Black people are always causing trouble through the unions, because they don’t want to do this or that. I suppose some of them work hard, but most of them have no initiative”. Similarly, Interviewee 14 said, “They work slower. You only have to go to Pick ‘n Pay [supermarket] to see it. They would rather chat with their friends than serve the customers”. Several of the interviewees indicated that, owing to the fact that African people are apathetic and lazy, they are more likely to become infected with HIV. For example, Interviewee 6 said, “Lots of them know that you need to use condoms, but they just couldn’t be bothered. It’s too much of a hassle for them”.

Another stereotype frequently invoked was that African people are poor leaders. A study by the Media Monitoring Project shows stereotypes of African leadership as inadequate to be quite strongly perpetuated by the media, including implications that, under African leadership, South Africa will slip into poverty, anarchy, disaster, disease and violence (Media Monitoring Project, 1999). In this research project, stereotypes of African leadership were used to contrast how South Africa’s current African-led government is responding to HIV/AIDS with ideas of how the previous white-led government would have acted. For example, Interviewee 6 said, “Our government doesn’t know what they’re doing. They just confuse people and make things up … And not just relating to AIDS. In all areas, they’re making a mess of the country … You can see it all over Africa, these guys don’t know how to run a country”. Similarly, Interviewee 4 said, “The old government would have responded better to HIV/AIDS because their thinking would have been more Western. African thinking isn’t going to solve the problem of AIDS”.

The apartheid government's response to HIV/AIDS, far from being the panacea participants in this study indicate it would have been had that government remained in power, was, in fact, weak and ineffective. One of the reasons for this was that the disease, at that time, was in its early stages, and still seemingly insignificant. More importantly, perceptions of HIV/AIDS as a 'black' disease meant that it was given little importance on the agenda of a government that actively disregarded the welfare of African people. This shows how early responses to the disease, even at the level of government, were informed by pre-existing prejudices.

The use of stereotypes depicting African people as promiscuous and highly-sexualised, stupid, apathetic and lazy, and poor leaders reflects not only pre-existing racial prejduce, but a confluence of such prejudice and other factors that this research study has identified as shaping social responses to HIV/AIDS, such as blame, notions of deviance and morality, fear, knowledge and perceptions of government's response.

The stereotyping of African people as promiscuous and highly-sexualised was linked to another stereotype, that of African people as immoral. Interviewee 12 said, "Blacks think its okay to have sex with lots of different people because they have different set of morals to white people – they're immoral". Similarly, Interviewee 8 said, "Their morals are very different, so they don't think it's wrong to sleep around".

The stereotype of African people as promiscuous and highly-sexualised was also linked to a stereotype of African people as engaging in deviant sexual behaviour, with some subjects going so far as to indicate that African people are nothing more than animals who breed indiscriminately.

Earlier discussion on morality and deviance showed such notions to play a central role in shaping responses to HIV/AIDS. By indicating African people to be immoral and deviant, through the use of stereotypes of promiscuity and hypersexuality, notions of morality and deviance interact with pre-existing racial prejudice to exacerbate negative responses to people infected with HIV/AIDS.

The confluence of pre-existing racial prejudice and other factors identified in this research study as shaping social responses to HIV/AIDS is also seen in the stereotyping of African people as unintelligent, apathetic and lazy, with such stereotypes implying that people who are infected with HIV/AIDS are to blame, or at the very least responsible, for their status. Further, the stereotyping of African people as poor leaders reflects the obvious confluence of racial prejudice and perceptions of government's response to HIV/AIDS, as well as the confluence of racial prejudice and fear. Fear of the contraction of HIV/AIDS, as well as fear regarding the uncertain position of white South Africans in the country's social order since the end of apartheid, contributes to, and is affected by, stereotypical views of the inadequacy of African leaders.

In showing how racial prejudice contributes to the role that factors such as morality, deviance, blame, fear and perceptions of government's response play in shaping responses to HIV/AIDS, this study lends some credence to the observation by Jennings *et al*. (2002) that, in some cases, hostility towards people with HIV/AIDS may be no more than a mask for pre-existing prejudices. However, the findings of this study also show that the influence of racial prejudice on factors such as morality, deviance, blame, fear and perceptions of government's response is not one-way and that, in fact, racial prejudice and other factors shaping social responses to HIV/AIDS are mutually reinforcing.

Further, the contribution of pre-existing racial prejudice to negative social responses to HIV/AIDS, is also not one-way, with HIV/AIDS, and the prejudice associated with it, also contributing to the maintenance of racial prejudice.

Indeed, Parker & Aggleton (2003) argue that stigmatised responses to HIV/AIDS can serve to produce and reproduce social inequality and exclusion. For many of the study participants, HIV/AIDS seemingly provides support for their racially-biased stereotypes, particularly those relating to the sexual behaviour of African people. For example, Interviewee 13 said, “You can see from the way that AIDS is found mainly in black people that they just sleep around with everybody”.

Another reason why negative responses to HIV/AIDS are more than a mask for pre-existing racial prejudice is that responses to HIV/AIDS emerge in the knowledge that HIV represents a real material disadvantage, directly reducing the life chances of those infected. It is this that Stein (2003) indicates as being the primary difference between HIV/AIDS-related prejudice and other forms of bigotry, with other the bases of other prejudices, such as race, class and gender, not directly reducing a persons life chances, although, of course, they do indirectly.

HIV/AIDS-related prejudice also differs from other forms of prejudice in that, for HIV/AIDS, the line dividing the ingroup and outgroup is porous, while in racism or sexism, that line is fixed. Of course, as already indicated, the invisibility of HIV infection enhances the attachment of stigma based on secondary markers, leading to what Goffman (1963) refers to as courtesy stigma. This involves the attribution of stigma to the close connections of the stigmatised person through symbolic contagion (Williams, 1987). Based on the findings of this study, it seems that among white South Africans, courtesy stigma is commonly attached based on race, with the result that, at least for some of the participants in this study, all African people are stigmatised for being HIV-positive, despite the fact that only a portion are actually infected. This again points to the importance of existing racial prejudice in shaping social responses to HIV/AIDS.

When discussing the role of pre-existing prejudice in shaping social responses to HIV/AIDS, the literature not only examines racism, but also looks at elitism and

sexism. In this study, the role of elitism in shaping social responses to HIV/AIDS was broadly tied to racism, with race and class in the South African social order broadly corresponding with one another. Interestingly, however, in cases where race and class did not correspond, race appeared to be over-riding influential factor shaping social responses to the disease.

The influence of pre-existing gender-based prejudice on responses to HIV/AIDS was largely absent in this study. For those participants in the study that *did* show gender-based prejudice, it was in the unusual direction of being towards men, and had a very strong racial element, with *African* men being the subject of the prejudice. While 83% of participants in the survey component of the research project indicated that African men do not treat women well, little evidence of gender-based prejudice emerged in the interviews, and it seems likely that the high percentage of respondents who indicated African men as treating women badly were basing such ideas on a stereotype. Among those who showed gender-based prejudice in the interviews, their views were reminiscent of historical fears relating about African men infecting sexually-innocent white women. For example, Interviewee 10 said, “Most cases of AIDS are found among black men. And then they infect the white people, by raping white women”. Similarities between responses to HIV/AIDS and historical responses to other STDs are discussed further under the heading History.

Dissenting views

It is important to note that, while most participants in this study did demonstrate a significant degree of pre-existing prejudice, most of which was racially-based, there were some participants who showed very little racial prejudice. Interestingly, those subjects who showed less racial prejudice, also showed less prejudice towards people infected with HIV/AIDS, reinforcing the theory that pre-existing racial prejudice is exacerbating negative responses to HIV/AIDS.

Responses to HIV/AIDS as reminiscent of historical responses to STDs

Marks (2002) explains that HIV/AIDS is at once a modern, or even postmodern, disease, and a profoundly traditional one. Its modern/postmodern nature can be seen, for example, in the speed with which it has spread globally, the extent of the medical research it has given rise to, and the range of interests that have been involved in mounting a response to the disease. On the other hand, however, the disease, and responses to it, bear a striking similarity to epidemics of the past, and provide a sad reminder of mankind's continuing vulnerability to infectious disease.

The literature suggests that social responses to HIV/AIDS in Africa are, in many ways, similar to historical responses to epidemics of STDs. Indeed, this study has revealed the responses of white South Africans to HIV/AIDS as being largely reflective of historical responses to STDs in colonial Africa, confirming the suggestion by Jennings *et al*. (2002) that negative responses to HIV/AIDS have deeper and older roots than the epidemic itself.

One of the most striking similarities in contemporary responses to HIV/AIDS and historical responses to STDs is the attribution of disease to the 'other'. Joffe (1999) explains that 'othering' is a common response to fear, enabling people to represent the risks they face in a way that protects them, and the groups with which they identify, from threat. 'Othering' frequently entails moral judgement, and secures the identity of the person doing the labelling by reinforcing their normalcy and establishing the difference of the 'other' as a point of deviance (Grove & Zwi, 2006). 'Othering' ties in with Goffman's (1963) discussion on stigma, whereby he indicates that stigma is constructed by society on the basis of perceived difference or deviance (Bharat, 2002).

In colonial Africa, the 'other' was strongly defined by white settlers as being African and African customs, family life and sexuality became the focus of much attention (Vaughn, 1992). So too, this study has shown that in the context of the AIDS epidemic, white South Africans commonly perceive the disease as being almost exclusive to the African population, and continue to mark African people as 'other'. Further, the participants in this study frequently called attention to the distinct nature of African culture, sexual behaviour and morality.

In the attribution of disease to the 'other', both historically and in contemporary responses to HIV/AIDS, those doing the 'othering' have been able to cast as deviant not only those infected with the disease, but the entire group to which it has been attributed.

A difference between the 'othering' that took place historically, however, and that which was evident in this research study on responses to HIV/AIDS, can be seen in the manner in which historical 'othering' not only located disease among African people, but specifically among African women (Vaughn, 1992). The tendency to use gender as a marker for 'othering' has been seen in responses to HIV/AIDS in South Africa, with Stadler (2004) indicating that local discourses blame women for the spread of HIV/AIDS, but was not evident among the white participants in this study. It is thought that 'othering' on a gendered basis may be found more among African than white people. If anything, the responses of the participants in this study show a bias against African men, linked to stereotypes of African men as sexually promiscuous and violent, and fears that whites, particularly white women, may become the target of such promiscuity and violence.

Nonetheless, in the process of 'othering', blame emerges as a factor shaping attitudes to disease, both historically and in contemporary society. Another commonality in contemporary responses to HIV/AIDS and historical responses to STDs is the manner in which blame is attributed to the infected on the basis of

their being perceived as immoral and deviant. Their immoral and deviant status, however, is not primarily determined by the fact of their infection, but by their membership of a group – the 'other' – which is perceived as such. Infection, with either an STD or HIV/AIDS, is seen to provide support to the belief that the 'other' is a group that is immoral and deviant. In this way, disease provides an opportunity for the powerful to reaffirm their social values, and to perpetuate pre-existing prejudices.

Historically, notions of African people as immoral and deviant, and connections between such notions and the contraction of STDs, are evident in descriptions of African people as inherently promiscuous and highly-sexed (Vaughn, 1992). Very similar notions can be seen as shaping responses to HIV/AIDS, with many participants in this research study attributing the disease to the uncontrolled sexuality of African people. This is discussed in more detail in the section on Pre-existing Prejudice and Stereotypes.

Some participants in this study felt African sexuality to be so rampant that they drew a likeness between African people and animals. As despicable as this comparison may seem, it is one that has an historical precedent, with Vaughn (1992) noting how *The Lancet*, in 1908, described African women as, 'in effect, merely female animals with strong passions' (p. 270).

Historically African people were not only cast as sexually immoral, but immoral in all areas of life. For example, in work on historical epidemics of STDs in Malawi, Chijere Chirwa (1999) indicates that African people were believed to have no morals at all, as evidenced by frequent marital breakdown, polygamy and disintegration of family life, and Vaughn (1992) describes how African people were thought to be living in a 'kind of moral limbo'. This reveals what Goffman (1963) refers to as the essentialising nature of stigma, in that the labels that accompany stigma extend to all areas of that persons life. Similar implications

can be seen in responses to HIV/AIDS, with participants in this research project making numerous references to a general lack of morality among African people.

Several participants in this study indicated African sexual behaviour to be not only immoral and deviant, but sinful, and drew a connection between sin and disease which is remarkably similar to historical connections drawn between the two. During colonial times, medical missionary morality emphasised the 'sinfulness' of traditional African society, and highlighted a connection between suffering and sin. Such morality placed specific emphasis on the 'evils' of polygyny and paganism (Vaughn, 1992), with paganism being linked to notions of superstition and 'witchcraft' (Vaughn, 1991). Similarly, despite the fact that polygamy is not the norm in South Africa, a number of participants in this research study indicated that the 'sinful' polygynous relationships encouraged in African society have been a significant contributor to the spread of HIV/AIDS. Mention was also made of the 'evil' of paganism, through reference to African people going to 'witch' doctors and using the 'magic potions' such practitioners prescribe.

In colonial times, the superiority of western medicine over traditional medicine was frequently emphasised by white settlers and Vaughn (1991) indicates that medical missionaries represented African healing systems as ineffective, unscientific and manifestations of evil. Similarly, in this study, participants highlighted traditional medicine as being ineffective when compared to allopathic medicine, and indicated that the use of traditional medicine to be a marker of the cultural inferiority of African people. As described by Bharat (2002), superstition seemingly stands as an affront to so-called modern notions of health and medicine.

In historical responses to STDs and contemporary responses to HIV/AIDS, the primary target for the labels 'immoral' and 'deviant', and the notions that accompany such labels, are African people. When non-African people are found

to be infected, they are also commonly cast as immoral and deviant, although such labels frequently refer back to the inherent immorality of African people. In this study, this was evident in the manner in which a number of participants indicated that, aside from African people, the only people who contract HIV/AIDS are those who behave in a way similar to the 'immoral Africans'. For example, Interviewee 8 said, "In South Africa, it is mostly only blacks who have AIDS. When whites get AIDS, it is because they behave like blacks, and sleep around with lots of people". Historically, this notion was evident regarding venereal disease in white South Africans, with Jochelson (1993) explaining that poor white South Africans with venereal disease in the 1920s and 1930s were seen as similar to 'naturally licentious' Africans. This is an example of courtesy stigma, whereby those associating with the stigmatised are often subject to similar stigmatisation. In this case, 'poor whites' lived and worked in close proximity to African people, who were stigmatised because of their race and their so-called hypersexuality and lack of morality.

The above discussion shows how notions of morality and deviance, pre-existing prejudice, stereotypes and the attribution of blame for their infected status to those who have contracted the disease, have operated in shaping responses to historical epidemics of STDs as well as in shaping responses to the contemporary HIV/AIDS epidemic. Another influential factor evident both historically and in the current HIV/AIDS context is fear which, in part, arises due to the incurable nature of the epidemics under discussion, with no cure being currently available for HIV/AIDS, and a cure for syphilis having only emerged in the 1950s when penicillin was introduced. Of course, as discussed earlier, HIV/AIDS, while incurable, is, under appropriate medical treatment, manageable, and, in the South African context, fear linked to the disease's incurability is likely to be related to the controversies and complexities that have surrounded the rollout of ARVs, and the fact that, by the end of 2005, only 25,2% of those who needed the medication had access to it (Nattrass, 2006).

Another factor affecting the likelihood that fear will shape responses to disease is the tendency of the general public to overestimate levels of infection.

Historical responses to STDs commonly involved the over-estimation of levels of infection among African people. For example, Jochelson (1991) describes how, in the 1880s, the district surgeon in the Carnavon region of South Africa concluded that syphilis was so extensive that all Africans fell into one of three groups – those who have had it, those who have it and those who will get it. Vaughn (1992) describes a similar overestimation of infection when she explains how, in the early 1900s, levels of syphilis in the Uganda Protectorate were described by an officer of the Royal Army Medical Corps as being in the region of 80%. These figures were later disputed, with more realistic estimations putting prevalence closer to 15%.

In this study on responses to HIV/AIDS, a similar tendency is seen. The 2005 *National Household Survey on HIV Prevalence, Incidence, Behaviour and Communication*, shows HIV prevalence among South Africa's African population to be 13,3%. However, over 90% of the participants in the survey component of this research study estimated HIV prevalence levels among African people to be over 20%. In fact, as indicated in the table below, over 60% of respondents estimated that more than half of South Africa's African population is infected with HIV/AIDS, almost 50% estimated over 60% of the African population to be infected, and almost 30% of respondents indicated HIV prevalence among African people to be above 70%.

Interestingly, survey respondents also overestimated prevalence in the other racial groups, although not to the same extent as was evident in estimations regarding African people. Further, overestimations were greater for the coloured and indian population groups than for the white population.

Table 5: Estimates of HIV prevalence among African people

	Percentage of respondents indicating HIV prevalence at each level
Under 10%	0
10% - 20%	8,5
20% - 30%	4,3
30% - 40%	12,8
40% - 50%	12,8
50% - 60%	14,9
60% - 70%	17
70% - 80%	17
80% - 90%	10,6
90% - 100%	2,1

The tendency to overestimate prevalence levels reveals that responses to HIV/AIDS may, to a certain extent, be based on a sense of panic and hype regarding the disease, which may be related to the sexual nature of transmission of the HI-virus, as well as the ravages the disease can inflict on the body (McCulloch, 1999).

Similar observations have been made regarding historical responses to STDs. For example, Chijere Chirwa (1999) indicates how, in Malawi, colonial reporting on STDs and African sexuality reflected a moral panic, and Vaughn (1992) describes responses to STDs in colonial East and Central Africa as having been shaped by a sense of panic.

McCulloch (1999) notes that colonial settlers in Southern Rhodesia believed syphilis to be so contagious and common among African people, that the handling of everyday objects by domestic servants was thought to be sufficient to infect an entire household. The participants in this study showed similar fears, with a several indicating that they would be unwilling to employ an HIV-positive domestic worker because, as Interviewee 12 said, “You don’t know what they do when you’re not around. She could cut herself while she’s washing the dishes.

She could bleed on your clothes or your towels. Those are your personal things. You don't want to put yourself at risk". This ties in with Sontag's (1998) description of bizarre fears of easy contagion, even by non-venereal means, whereby estimations of the ease with which the disease can be contracted are so over-inflated that people suppose themselves to be at risk of contracting a virus that is primarily sexually-transmitted through means that are not sexual.

Regarding infection by sexual means, several participants in this research study showed a fear similar to historical notions that African men would infect sexually-innocent white women (Vaughn,1992). Interviewee 10 said, "AIDS has come into the white population because black men rape white women. And they're going to keep on doing it until there is as much AIDS among the whites as there is among the blacks". This statement echoes historical fears of white colonial settlers, who believed themselves to be on the brink of invasion (Vaughn, 1992).

Lyons (1999) explains how expressions of fear regarding STDs in colonised territories have included reference to 'the ravages of diseases which, it was feared, would exterminate whole populations of potential laborers and taxpayers' (p. 98). Similarly, McCulloch (1999) comments on how white settlers in colonial Zimbabwe believed venereal disease to be so common that it would threaten the supply of labour. Interestingly, fears regarding HIV/AIDS expressed in this study on responses to HIV/AIDS were frequently been framed in similar terms. For example, Interviewee 16 said, "The impact of AIDS is going to be terrible in this country. Already its wiping out whole communities, and the economy is going to feel this. What are we going to do when we don't have any miners left to go underground, what are we going to do when we don't have any workers left in the manufacturing industry?"

In overestimating the risk of infection, historical responses to STDs demonstrate not only the role of fear in shaping those responses, but also the role of levels of knowledge, which have also been identified as shaping responses to HIV/AIDS.

Amat-Roze (1999) describes how, in Cote D'Ivoire, up until the 1950s, yaws, an endemic disease, was frequently misdiagnosed as syphilis. Similar misdiagnoses took place in a number of other countries, including South Africa. A lack of knowledge, can also be seen as having contributed to the role that notions of deviance and morality played in shaping responses to STDs in colonial times, with opinions regarding such matters being more often based on pre-existing racial prejudice and stereotypes of African sexuality (Lyons, 1999). Similarly, notions of deviance and morality that shape responses to HIV/AIDS are seldom based on knowledge.

McCulloch (1999), writing of colonial settlers in Southern Rhodesia, indicates that although fears regarding syphilis were present from the beginning of colonisation, during the 1920s there was a shift in fear from the 'Black Peril' to syphilis as the principle focus for anxiety, and as fears of the 'Black Peril' subsided, the fear of venereal infection rose.

A similar shift can be seen as having taken place in South Africa where, during the apartheid years, the primary focus for the anxiety of white South Africans was the 'danger' represented by the African population. The apartheid government characterised HIV/AIDS as the new 'swart gevaar' (black peril) (Jochelson, 1991) and since the advent of democracy, with the transition having taken place relatively peacefully, especially in the eyes of white South Africa, the fear shifted easily to a new target, such that HIV/AIDS has come to be the focus of much of the fear previously directed towards Africans as a group. The fact that, as argued in this study, much of this fear reflects pre-existing racial prejudice, anxiety regarding HIV/AIDS can be seen as relying on much of the same imagery of pollution that was employed when fears were of African people rather than the 'disease of African people'. This compares with what McCulloch (1999) observes in regard to colonial settlers in Southern Rhodesia. He indicates that their fears, regarding both the 'Black Peril' and STDs, were based on perceptions of the sexuality of African people as being rampant and deviant.

GENERAL DISCUSSION AND CONCLUSION

In 1987, Jonathan Mann, the founding director of the World Health Organisation's Global Programme on AIDS, described negative social, cultural and political responses to HIV/AIDS as being potentially the most explosive dimension of the epidemic (Stein, 2003). Now, almost 20 years later, the truth of his observation is evident, with some degree of negative sentiment towards those infected having manifested in almost all countries and contexts.

The findings of this study go some way towards explaining why social responses to HIV/AIDS have been so strongly negative and persistent, in revealing that responses to the disease operate not only at the level of the individual, but also at a social level, where they serve to reinforce and justify the existing social order and its associated patterns of inequality, exclusion, power, control and dominance.

As indicated in the analysis of the findings, each of the factors identified by this study as shaping social responses to HIV/AIDS can, on close examination, be seen as reflecting and perpetuating existing relations of power and control, and contributing to the maintenance of the existing social order (Parker & Aggleton, 2003) through affecting, and being affected by, pre-existing racial prejudice, and its accompanying stereotypes, which also exert a direct influence on responses to HIV/AIDS.

Further, beyond the ability of responses to HIV/AIDS to reinforce the existing social order, such responses also serve as a 'justification' for the social order, through establishing HIV/AIDS as symbolic of a host of meanings about society, its structure, and attitudes towards matters of race and sexual behaviour (Mills, 2004).

Parker & Aggleton (2003) indicate that negative responses to HIV/AIDS enable some groups to be devalued and others to feel that they are superior. In this study, it emerged that HIV/AIDS, through providing 'evidence' for stereotypical and prejudicial notions about African people, enables white South Africans to maintain feelings of superiority. It also emerged that HIV/AIDS allows white South Africans to justify their positions of privilege, through casting African people as immoral and deviant, and so unworthy of social advantage. Such justification is perhaps reflective of the justification offered over the years in which institutionalised and legalised racism dominated the country, and perhaps reflects that racism, to all intents and purposes, is not dead, but now manifests in a new form of prejudice.

In addition to the role that negative responses to HIV/AIDS play in perpetuating the existing social order, the strength and persistence of such responses may also be related the fact that HIV/AIDS-related stigma is capable, as revealed by this study, of attaching at all three of the levels identified by Goffman (1963) – to the body, the character and to social collectivities. While the stigma associated with other diseases may attach at one or two of the levels, HIV/AIDS-related stigma often simultaneously attaches to all three levels, being considered to have devastating physical consequences, to be a sign of moral weakness and to be closely correlated with particular social groups (Goldin, 1994).

The persistence of negative social responses to HIV/AIDS is hampering the ability of affected communities to deal with the challenges posed by the disease. If the difficulties represented by negative responses are to be effectively addressed, however, a thorough understanding of the nature, causes and consequences of such responses is necessary.

Towards this, this study has attempted to examine the factors affecting the social responses of white South Africans to HIV/AIDS.

The link between responses to HIV/AIDS and the maintenance of the existing social order highlights that the alteration of such responses is unlikely to be easily achieved. Strong motivation for change exists, however, if the epidemic is to be halted, and this motivation needs to be directed towards programmes and policies that can remove the stigma attached to the disease and bring about greater acceptance of those infected with it.

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