

**The University of the Western Cape**



**Faculty of Arts**

**Department of Anthropology and Sociology**

**The impact of religious belief and stigma on people living with HIV/AIDS: A study in  
Cravenby, Cape Town**

**A mini thesis submitted in partial fulfilment of the requirements for the degree of  
Magister Artium in the Department of Anthropology and Sociology, University of the  
Western Cape.**

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**Plagiarism Declaration**

I declare that *The impact of religious belief and stigma on people living with HIV/AIDS: A study in Cravenby, Cape Town* is my own work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Name and Surname \_\_\_\_\_

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## **Abstract**

This study is a descriptive study and describes the effects of religious beliefs and stigma toward people living with HIV/AIDS. The religions looked at were Islam, Christianity and Hinduism and it was conducted in the community of Cravenby, situated in Cape Town. Its objectives were to investigate; how religion affected people's attitudes to HIV/AIDS within Cravenby; to investigate how religious beliefs may lead to stigma; does religion allow an individual to disclose his or her HIV status if they are HIV positive; how religion may affect one's sexual behaviour and how much is known about HIV by people living in Cravenby. The study employed qualitative research methods and the method of data collection was implemented through the use of in depth interviews with community residents. Content analysis was used to analyse the data, with findings showing that those living with HIV/AIDS deserved to be treated with respect and empathy. Respondent's knowledge and awareness of HIV/AIDS was very good and showed that few people have not heard about HIV/AIDS. Stigma is defined as an attribute that is significantly discrediting and is used to set an affected person or group apart from a normalized social order and the use of such separation implies devaluation. Religiously based stigma towards those living with HIV/AIDS arose from people's personal beliefs and justification because they did not adhere to religious teachings and injunctions. Respondents saw religion as serving to promote cleanliness, marital harmony and respecting one's self and towards others. Biographical disruption implies that a person's stock of knowledge of their selves and social world are disrupted by the experience of illness and suggests that explanatory frameworks normally used to understand daily life are disrupted. The study recommends having a joint forum which is attended by Muslims, Christians and Hindus discussing HIV/AIDS would help to address incorrect and or incomplete knowledge and beliefs around HIV/AIDS in the community.

## Keywords

HIV/AIDS

Stigma

Cravenby

Cape Town

Biographical disruption

Islam

Hinduism

Christianity

South Africa

People living with HIV/AIDS (PLWHA)

Voluntary counselling and testing (VCT)

Faith Based organisation (FBO)



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## CHAPTER 1

### INTRODUCTION

#### 1.1 Introduction

South Africa's population of 50 million people are of diverse linguistic, cultural and religious backgrounds. The country is well known for its struggle against apartheid and all its ethnic groups are represented in its parliament (Cochrane and Nawab, 2012:877). A predominantly Christian country, Muslims comprise only about one and a half percent of its total population (Cochrane and Nawab, 2012:877). According to the 2001 census, the population of Hindus living in South Africa was 551 669 people (<http://www.gcis.gov.za/sites/default/files/docs/resourcecentre/pocketguide/004saspeople.pdf>). For the 2011 census, religion was not asked, because the question on religion was low on the list of priorities as informed by the users of census data and therefore it did not make it onto the final list of data items ([http://www.statssa.gov.za/census\\_2011/documents/censusfaq.pdf](http://www.statssa.gov.za/census_2011/documents/censusfaq.pdf)). An estimated 5.6 million people are living with HIV in South Africa, nearly 18% of the adult population, while the HIV prevalence rate among pregnant women is 29% (Cochrane and Nawab, 2012:877). UNAIDS data showed that this trend stabilized and the incidence of HIV infection amongst some groups is decreasing (Cochrane and Nawab, 2012). Annually, there are still over half a million new infections and fewer than a third of young people aged 15-24 were able to correctly identify the ways to prevent sexually transmitting HIV (Cochrane and Nawab, 2012:877).

HIV/AIDS is a debilitating disease caused by the Human Immunodeficiency Virus. AIDS is the condition that is caused by HIV and is an acronym for Acquired Immune Deficiency Syndrome. People can delay the onset of AIDS by taking their medication and anti retrovirals (ARV). One cannot get AIDS without having been diagnosed with HIV. The virus is transmitted through bodily fluids, through sexual intercourse, mother to child transmission, needle stick injuries and contaminated blood transfusions. This implies that HIV infection is mainly a sexually transmitted disease. Contracting HIV may be prevented by condom use and engaging in responsible sexual behaviour or abstinence and is not transmitted by casual or intimate non-sexual contact (Amod, 2006:9-11).

### **1.1.1 HIV/AIDS and Christianity**

At its onset, the response of the Catholic Church to HIV/AIDS was slow in starting off in South Africa, however, presently they do provide care and support to people infected and affected by HIV/AIDS which includes providing material support, health supervision, spiritual encouragement and educational and moral guidance to the struggle against HIV/AIDS (Toefy, 2009:248). A theme in Christianity is the idea of sin which originates from the story of Adam and Eve, in which they both disobeyed God by eating from ‘the tree of knowledge of good and evil’ (Lala, 2007:48). The Bible has identified greed, pride, lust and excessive sexual activity as sins. The idea of lust being a sin, coupled with associating HIV/AIDS with sex, constituted a major drive of HIV/AIDS related stigma (Lala, 2007:48). The Bible is clear about topics such as pre-marital sex and adultery, stating ‘you should be faithful to your wife...save yourself for your wife and do not have sex with other women’ (43 Isaiah 57:5; cited from Lala, 2007:48). Direct phrases such as ‘do not commit adultery’ are used (Matthew 5: 27-30, 32; Matthew 19:9, 18, 19; Mark 10:11, 12, 19; Luke 18:20; John 8:1-11; cited from Lala, 2007:48). Based upon associations between HIV/AIDS and pre-marital sex, stigma toward people living with HIV/AIDS (PLWHA) may be fuelled by religious ideology (Lala, 2007:48).

Homosexuality has been associated with HIV/AIDS and scriptural verses do identify its practice as sinful, among them; ‘you shall not lie with a male as with a woman, it is an abomination’ (Leviticus, 18:22; cited from: Lala, 2007:49). Biblical verses describe how God uses disease as punishment for sin: ‘if you do not carefully observe all the words of this law that are written in this book, that you may fear this glorious and awesome name, The Lord Your God, then the Lord will bring upon you and your descendants extraordinary plagues-great and prolonged plagues-and serious and prolonged sicknesses. Moreover, he will bring back on you all the diseases of Egypt, of which you were afraid, and they shall cling to you. Also every sickness and every plague, which is not written in this Book of the Law, will the Lord bring upon you until you are destroyed’ (Deuteronomy 28:58-61; cited from: Lala, 2007:50).

### **1.1.2 HIV/AIDS and Hinduism**

Strong parallels exist between Hinduism, Christianity and Islam in how it describes its ideal way to God through love and compassion for others. In the first decade of the spread of HIV/AIDS, Hinduism did not feature strongly in international discussion on the work of faith

based organizations in fighting against HIV. This was due to a perceived lower HIV prevalence rate amongst Hindus in the 1980's and 1990's (Toefy, 2009:246). This situation has changed as there were 2.5 million HIV infections in India alone with the prevalence rate likely to exceed 1% of the total population by 2010 (Toefy, 2009:246). In South Africa, Hindu groups have played a role in the response to AIDS since the early 1990's and mobilized against HIV/AIDS in their communities (UNAIDS, 2008) by providing supplemental health care to impoverished areas in Kwa-Zulu Natal through Sai Baba medical camps and the Ramakrishna Clinic (Schmid *et al.*, 2004).

Hindus also associated acquiring HIV/AIDS with pre-marital sex and with abandonment of a value system called the '*brachmacharya ashram*' (Lala, 2007: 68-69). Vedic philosophy states that the human lifespan is divided into four consecutive stages or 'ashrams'. The Brachmarya (pre-married), Grahasta (married), Vanaprastha and Sanyasa stages, these latter two involve dedication to spiritual pursuits (Lala, 2007:69). The Vedas (Hindu holy scripture), states that fulfilling each ashram's rules is important because they facilitate union with God (Lala, 2007:69). In the Brachmacharya stage, priority is given to celibacy and having premarital sex results in a decreased marital sanctity. Because HIV/AIDS in unmarried people indicate a broken celibacy, they are considered 'impure' and are oblivious of their duty or '*dharma*'. This is a negative stigmatizing attitude that discredits an unmarried person living with HIV/AIDS (Lala, 2007:69).

Marriage is the basis of the Grahasta stage but if it is undermined through unfaithfulness, it is seen as a sign of disrespect to the faith. The practice of burning widows (*sati*), among 19<sup>th</sup> century Hindus was based on a religious story in which a queen who was accused of unfaithfulness proved her loyalty by burning herself. Through such ideology, married Hindus living with HIV/AIDS have not adhered to Hindu values and are without a sense of *dharma* (Lala, 2007:69-70). *Dharma* is derived from the Sanskrit root *dhri* (which means to hold) and stands for that which holds up the existence of a thing (Nirvedananda, 1944:17). Mankind has an essential nature that upholds its existence as something distinct from the rest of creation, this is the dharma of man, this is called '*manava dharma*' (Nirvedananda, 1944:17).

Hinduism sees abstinence as a way of harnessing the energy of body and mind, and converting base energy into subtle energy, with the ultimate goal of spiritual realization. Sex is a practice of base instincts fostering preoccupation with worldly pleasure and hinders the pursuit of spiritual realization and self-awareness (Lala, 2007:70). All desires which centre on

ego satisfaction, including sex, are considered to have their basis in ignorance because the true Self is all-pervading and fulfilling (Lala, 2007). The Bhagavad Gita states: 'restricted, unattached sex life is also a divine practice because the restricted householder sacrifices his general tendency toward sense gratification for higher transcendental life.' (Bhagavad Gita 4:26 Purport; cited from: Lala, 2007:70). This means that other than for purposes of procreation, sex is regarded by traditional Hindus as unclean. Noting that HIV/AIDS is transmitted mainly through having sex, many Hindus view PLWHA as people who cannot control their basic instincts, as impure and enslaved by carnal desires and with no capacity for spiritual progress, this discrediting attitude constitutes a stigma (Lala, 2007:70). An English translation used for the Tamil language phrase for pre and extra marital relationships is called *tahaata udaluravu* which means 'illegal intercourse' and assumes that someone with HIV has engaged in illegal sex and is therefore blamed for having the disease (Van Hollen, 2010:636). HIV positive women may face a greater stigma and discrimination than men because women are expected to uphold social norms of morality and to have HIV is viewed as a symbol of transgression of morality (Van Hollen, 2010:646).

Some Hindus may see PLWHA as being responsible for it and such ideas originate from the Hindu law of Karma. Karma means 'act' or 'deed' and encompasses the principle of cause and effect that Hindus believe rule all life (Lala, 2007:71). It abides by the principle that humans act with free will and are able to create their own destiny, when they suffer; it is because of evil deeds done in their present or previous life (Lala, 2007:71). Karma offers an explanation as to why suffering is distributed unevenly through humanity, it is used to explain social inequality and is also intertwined with the philosophy behind the caste system, through which many Hindus perceive a person's status and positive or negative fortune as reflected in individual worthiness. Based on ideas associated with karma, PLWHA are assumed to create their misery wilfully and are seen as societal burdens (Lala, 2007:71).

### **1.1.3 HIV/AIDS and Islam**

The first reported case of a Muslim who died of AIDS was in Cape Town, in 1986 (Amod, 2006:71). In 1993, the first Muslim infant died of AIDS and this indicated that HIV/AIDS was already prevalent in the Muslim heterosexual community (Amod, 2006:71). Dating back to 1985, Islamic ethical literature notes that AIDS is an illness that pertained to European and American homosexuals (Amod, 2006:71). In this early period, it was first stated that HIV/AIDS was the consequence of living an improper lifestyle and engaging in immoral

sexual behaviour and second, that it was viewed as a punishment from God. Throughout such discourse, ideas of sin as a punishment for homosexuality continued to be present in the background (Manda, 2011:202). This literature engaged in moralizing the epidemic with blame accorded to HIV infected people, creating a 'punishment theory of disease' as Loretta Kopelman argued (Manda, 2011:202) in which an illness is regarded as a divine punishment inflicted on human beings for their offences, providing them with a chance to rehabilitate themselves, warning them to become more virtuous or to demonstrate that the bad perishes and the good thrives, or to show that some cosmic order requires the punishment of sin (Manda, 2011:202). HIV/AIDS is primarily spread through multiple partner heterosexual activity and due to this Muslim community leaders tended to avoid discussing the topic because of religious taboos regarding sex (Kagee *et al.*, 2005). Muslims made up an estimated 1.45% of South Africa's population (Kagee *et al.*, 2005) and among a community sample, an HIV prevalence rate of 2.56% was found (Kagee *et al.*, 2005), this was lower than the national prevalence for the over 15 age group which was 22.8% (Paruk *et al.*, 2006:511).

Islam stresses sexual abstinence before marriage (Rademakers *et al.*, 2005). It is attributed that HIV/AIDS is brought about by disobeying God's orders and this necessitates a punishment according to the Islamic view (Al-Islam, 2001; Manda, 2011). Homosexuality is disapproved of, Surah (7:80-82), described the community of Prophet Lot (peace be upon him), in which men who engaged in homosexual relationships with other men were punished by God (Lala, 2007:59-60). Other Qur'anic verses state that 'the believers must (eventually) win through, those who humble themselves in their prayers; who avoid vain talk; who are active in deeds of charity; who abstain from sex, except with those joined to them in the marriage bond, or whom their right hands possess,-for they are free from blame' (Surah 23:1-6; Lala, 2007:58). Marital faithfulness is important in Islam and the behaviour of married PLWHA was considered unfaithful towards their partners and was negatively viewed by some Muslims. A Cape Town study found that Muslim women were almost four times more likely to report infidelity as a reason for divorce than men and more than half of the sample of 600 divorced couples got married in order to legitimize a pre-marital pregnancy (Toefy, 2002). Two Qur'anic verses defending the stigma toward adultery and unfaithfulness are; 'nor come nigh to adultery, for it is a shameful deed and an evil, opening the road to other evils' (Surah 17:32) and 'the woman and the man guilty of adultery or fornication,-flog each of them with a hundred stripes: let compassion not move you in their case, in a matter

prescribed by Allah, if ye believe in Allah and the last day, and let a party of believers witness their punishment' (Surah 24:2; Lala, 2007:59).

A recent development regarding AIDS in the Muslim community was that Moulana Rafeek Shah, a South African Muslim, recommended that people be amenable to HIV tests prior to marriage (Chabillal, 2010:56). This initiative's purpose was to create more awareness and not promote stigma. He asserted that HIV posed a far more serious threat to the security of South Africa and South African society as a whole than any other normal or conventional threat (Chabillal, 2010:56). It was placed before the United Ulama Council of South Africa, but AIDS activists rejected it as undemocratic as it served to further isolate people (Chabillal, 2010:56). Associating ethical and moral issues with HIV risk behaviour pronounces the social stigma attached to HIV/AIDS in a Muslim society (Hasnain, 2005). The Qur'an states: 'and say to the believing men that they should lower their gaze and guard their sexual organs; that will make for greater purity for them...And say to the believing women that they should lower their gaze and guard their sexual organs' (Surah 24:30-31; Lala, 2007:59).

Justice, as ensured by Allah, is an integral philosophical point of the Muslim faith. Muslims explain that societal calamities are characterized as a 'punishment from Allah' (Lala, 2007:60) and are accompanied with reference to a Qur'anic verse (Surah 30:41) 'Evil has spread on the land and on the sea because of what humankind has done.' Lala (2007:60) reported that a South African Muslim legal authority, in its efforts to reveal Allah's justice argued that patients should be asked and admit how they got their HIV infection before receiving aid from the Muslim community. This constituted a tangible resistance to intervention and such scriptural interpretation motivates a discrediting attitude to PLWHA because they 'earned' their ill fortune (Lala, 2007:60). Justice and blame make up one of the key roots of social stigma, because they foster ideas that the people suffering from a disease are responsible for it and are guilty of misconduct (Lala, 2007:76). Stigma generated by such ideas are community based as well as internalized, and may lead to an entire religious community holding a common negative attitude toward PLWHA and to the internalizing of such negative attitudes among infected or at risk groups (Lala, 2007:74). Muslim religious groups also emphasize Islam's tolerance, including toward PLWHA (Francesca, 2002).

## **1.2 Study rationale**

The literature is replete with the intersection of HIV/AIDS and religion which focused attention on Islam and Christianity within an international, African and South African context. Very little has been written on the role of Hinduism within the South African and specifically within a Cape Town context and its intersection with HIV/AIDS. The literature on HIV/AIDS within Muslim communities in Cape Town is not particularly sufficient. Not much has been written with regard to HIV/AIDS and Islam, Christianity and Hinduism, collectively within a Cape Town context and extending to its many communities. No study of such nature has been done in Cravenby that the researcher is aware of and it is for this reason that the researcher attempts to fill this gap by conducting such research in this community. It seeks to make a contribution to the literature on the interface between religion and HIV/AIDS. The researcher also seeks to draw comparisons between the three religions of Hinduism, Christianity and Islam in the study and specifically within the Cravenby community.

## **1.3 Aims and objectives of the study**

The main aim of the study was to explore the effects of religious beliefs and stigma towards people living with HIV/AIDS. This study was conducted in Cravenby, Cape Town.

### **1.3.1 Specific Aims and Objectives**

**The specific aims and objectives were to investigate the following:**

- a) How religion affects people's attitudes to those living with HIV within Cravenby?
- b) If religious beliefs lead to stigma?
- c) Whether religion allowed one to disclose one's HIV status if one is HIV positive?
- d) How religion affects one's sexual behaviour?
- e) How much is known about HIV by people living in Cravenby?

## **1.4 Overview of the thesis**

Chapter 1 introduces the study, its main research question, its study rationale, aims and objectives and chapter overview. Chapter 2 focuses on the literature review which looks at literature incorporating international, African and South African studies. The theoretical framework consisting of stigma and biographical disruption is also outlined. Chapter 3 outlines the research methodology; including its methodological framework, research

methods used and participant selection. Ethical considerations of the study are also discussed. Chapter 4 presents the findings and analysis of the study. Chapter 5 discusses the conclusions, recommendations and uniqueness of the study and also looks at the contributions of the study.

### **1.5 Limitations of the study**

This study has limitations in that it only used interviews (an interview schedule is provided in Appendix C). Other methods which could have been used, but were not, include the use of observations and focus group discussions. These methods were not practical and it was difficult to get participants together for a group discussion. The number of respondents (30) was not equal in that there were ten Christians, eleven Muslims and nine Hindus. Because of the nature of the research topic people were not generally willing to participate. A Majority of the respondents may have given their own interpretations and opinions or were unwilling to express themselves freely owing to the nature and sensitivity of the questions asked, the topics which have been discussed and the possibility that certain questions were thought of as being of a personal nature or that the answer to the question was subject to personal opinion. The study can in no way be generalised to the larger population because only a small part of the population was interviewed. It is for this reason that the research is exploratory. The study sample was not equally representative in terms of gender, with there being 14 males and 16 females participating in the study. The study did not look at those living with HIV/AIDS, because there were difficulties in obtaining people living with HIV/AIDS in the community, the probability also exists that they may be unwilling to disclose their HIV status, and this makes it difficult to identify them.

### **1.6 Chapter Summary**

In this Chapter, I discussed the introductory background to the thesis; HIV/AIDS and the response to it by Christianity, Hinduism and Islam. A study rationale was discussed, its aims and objectives outlined and specified and it ended with an overview of the discussion and contents of the following chapters of the thesis. The next chapter deals with the literature review and theoretical framework of the study.

## CHAPTER 2

### LITERATURE REVIEW AND THEORETICAL FRAMEWORK

#### **2.1 Introduction**

Since the beginning of the HIV/AIDS epidemic, almost 70 million people have been infected with HIV and about 35 million people died of AIDS (<http://www.who.int/gho/HIV/en/>). Globally, 34.0 million (31.4 to 35.9 million) people were living with HIV at the end of 2011. An estimated 0.8% of adults worldwide aged 15-49 were living with HIV. Areas such as Sub-Saharan Africa remain the most severely affected, with nearly 1 in every 20 adults (4.9%) living with HIV, this statistic accounted for 69% of the people living with HIV worldwide (<http://www.who.int/gho/HIV/en/>).

The transmission of HIV occurs through the exchange of bodily fluids, which occurs generally through intimate physical contact. Other than through breastfeeding and pregnancy, its transmission in most instances is associated with 'sinful' activity (Clarke, Charnley and Lumbers, 2011:6). This includes having sex with multiple partners or commercial sex workers, through sexual practices such as anal intercourse, which may include homosexual sex or injecting illegal drugs (Clarke *et al.*, 2011:6). Reducing the likelihood of its transmission requires behavioural changes or abstinence, the former is regarded as unlikely and the latter involves undertaking a harm reductionist approach (Hasnain, 2005). Such an approach involves the usage of condoms during sexual intercourse and to use sterile and clean equipment for injecting (Clarke *et al.*, 2011:6).

#### **2.2 International, African and South African contexts**

##### **2.2.1 Christianity**

Given the stigma attached to HIV/AIDS, in the past, many religious leaders and faith based organizations denied this was a relevant issue for their own communities and this further added to the stigma felt by those affected, including the family of infected persons (Clarke *et al.*, 2011: 6). There was a widely held view that in sections of evangelical Churches, conservative attitudes toward sex and women were more entrenched than in the society as a whole (Marshall and Taylor, 2006: 366). Church members and their leaders believed, that in some cases, sex was to be endured rather than enjoyed as a gift from God, that it was viewed

as inappropriate, within culture, to speak about sex and that the Bible required women to be submissive (Marshall and Taylor, 2006:366). Such mutually reinforcing views and a reluctance to speak about issues of sex meant that the Church was perceived to agree with traditional values and this made it difficult for female Church members to challenge their husband's extra-marital affairs (Marshall and Taylor, 2006:366).

The Roman Catholic Church has made statements on HIV in general and on its African context in particular. As early as 1987, Pope John Paul II spoke the words: 'God loves all of you without distinction, without limits. He loves those of you who are sick, those suffering from AIDS...He loves all with an unconditional and everlasting love' (Frederiks, 2011:117). However, in 1988, a journalist asked him whether HIV was a punishment for homosexuals; he gave an evasive response and said that it was not easy to know God's intentions. This was viewed as a missed opportunity for him to clearly reject links between HIV and retribution theology (Frederiks, 2011:117-118).

Statements made by Kenyan, Ghanaian and Zimbabwean Roman Catholic bishops on HIV/AIDS were expressive of a strong moral discourse, linking HIV to sexual promiscuity and emphasizing fidelity and self-discipline. Statements considered condemnatory were made by Kenyan bishops in 1987 (Frederiks, 2011:118): 'AIDS has cast a baleful shadow across, what was fancied to be, the beautiful lives of men and women emancipated after the sexual revolution...it would be wrong, theologically unsound, to think that this calamity is the work of an avenging God, punishing mankind for individual and collective sins. Certain actions will have certain consequences. Nature has its own law of retribution. When we misuse tobacco, drinks or drugs, the consequences are inevitable. So also AIDS is the necessary consequence of certain abuses. Promiscuity, it would seem, is at the bottom of the whole problem, the root cause of the rapid spread of the disease in epidemic proportions' (Frederiks, 2011:118). Later statements reiterate eroding Christian values, but avoid direct connections between HIV and promiscuity and instead focus on the need for fidelity and abstinence. Rejecting condom use as a means to prevent HIV infection has formed a recurrent theme in statements made over the years (Frederiks, 2011:118).

In Latin America, although Churches have officially condemned contraceptives, abortion and homosexuality, many Catholics and clergy quietly dissented from official Church policy (Replogle, 2005). Latin American experts have said that religious beliefs were not usually people's first concern when it came to decisions made about family planning and the reason

for most women not using birth control was because they did not know about them, could not access them or were concerned about their side-effects (Replogle, 2005). Some HIV/AIDS activists have said that the official stance of the Catholic Church against condoms and homosexuality was hurting AIDS prevention efforts. At the beginning, the Church was slow in responding because talking about sex was taboo. Intellectual energy wasted on debate over condoms and the Church should have instead been used to fight the epidemic. Making everything controversial did not help in the fight against AIDS (Replogle, 2005:623).

In Latin culture, *machismo* and *marianismo* are dominant cultural values that prescribe the social roles and sexual behaviours of men and women (Valencia-Garcia *et al.*, 2008:741). Women are good *marianas* when they remain sexually naïve and passive in relationships with male partners and do not question them when they suspect infidelity (Valencia-Garcia *et al.*, 2008:741). *Machismo* grants men the sexual freedom to engage in behaviour that women are forced to accept. However, at the same time, homophobia in Latin America blinded women to men's sexual relations with other men or to openly acknowledging such arrangements even when apparent (Paternostro, 1998). Leading women to believe that infidelity by male partners involved only women (Valencia-Garcia *et al.*, 2008:742). Notions of *machismo* and resulting beliefs about male sexuality partly explain why Latin women perceive themselves to be at little or no risk for HIV infection. *Marianismo*, the female counterpart to *machismo* further explains this perception (Valencia-Garcia *et al.*, 2008:742).

*Marianismo* can be traced to the Roman Catholic Church in reference to the religious practice in which followers idolized the icon of the Virgin Mary (Stevens, 1973) and is associated with aspects in which women's self-esteem is manifested in their ability to be giving and generous and promoting cultural ideals such as familism, personalism, respect and the ability to create friendly and smooth relationships which avoid conflict (Comas-Diaz, 1989; Falicov, 1998). Paradoxically, enacting a *mariana* role may place married women at a high risk for HIV infection than other women such as sex workers (Paternostro, 1998; Miller *et al.*, 2004). Because they abandoned their *mariana* identity and resist its discourse, sex workers can enact other identities which allow them a degree of sexual freedom, the power to negotiate sex with men, and for protection against HIV infection (Valencia-Garcia *et al.*, 2008:743).

In Peru, monogamy is the norm for married women (Cohen, 2006:490). Married women who are at risk of HIV remain invisible and silent because *machismo* and *marianismo* expect and

require it (Valencia-Garcia *et al.*, 2008:750). Peruvian HIV prevention campaigns primarily target men (Cohen, 2006), when women are included, the focus is mostly placed on female sex workers or HIV-positive pregnant women with the *mariana* remaining outside prevention efforts (Valencia-Garcia *et al.*, 2008:750). For men, HIV prevention efforts can highlight aspects of *machismo* which focus on them as the protectors of their wives' *mariana* roles. Prevention messages focusing on family safety can acknowledge the reality of men's greater sexual freedom under *machismo* but also support safer sexual practice by promoting condom use during relationships with extramarital partners (Valencia-Garcia *et al.*, 2008:750). For women, definitions of who may be eligible for recognition and respect should include HIV positive *mariana*. Interventions for prevention and treatment should be sensitive and not marginalize and stigmatize people living with HIV/AIDS. Because HIV is stigmatized, women cannot be asked to speak out about HIV until it is safe for them to do so nor can it be expected that cultural and attitudinal changes should happen in isolation (Valencia-Garcia *et al.*, 2008).

Churches have associated condom use with promiscuity and have spoken against it, even if it be for sexual intercourse within a marriage (Marshall and Taylor, 2006:366-367). Evangelical beliefs may compound this situation when incomplete knowledge or a biased selection of Biblical text leads to an unbalanced view (Marshall and Taylor, 2006:367). Christians may be familiar with selected Biblical texts referring to women's submission and neglect to balance this view with other texts speaking of the need for equal submission to one another in love and that men and women are created in the image of God (Marshall and Taylor, 2006:367). African Christians suggest that, in Africa, many Christians operate in two worlds at the same time: 'Christian western civilization' and 'traditional African culture' and often, traditional values define beliefs around gender and sex for Christian men and women (Marshall and Taylor, 2006:367). Some Church-going people were indoctrinated by their religious leaders and have felt ashamed to talk about their status or that of their family and this further hinders proper health intervention efforts (Marshall and Taylor, 2006:367).

In Croatia, because of a history of low HIV incidence and prevalence, the HIV/AIDS epidemic received relatively little attention in Croatian media since the end of the 1980s (Štulhofer *et al.*, 2007:64). It was given low priority in public health discussion and resulted in an absence of nationwide preventative efforts, and was probably one of the main reasons for a slight but significant decline in HIV knowledge among young adults (Štulhofer *et al.*,

2007:64). A fairly high prevalence of potentially risky sexual behaviour in a nationally representative sample of young adults was found (Štulhofer *et al.*, 2007:64). Introducing school-based health education which included modules on sexuality was considered controversial. At the centre of the debate were proponents of an abstinence-only programme, which received support from the Croatian Roman Catholic Church and the backers of a comprehensive approach to sex education. Implementing a pragmatic and comprehensive sex education curriculum was no easy task (Štulhofer *et al.*, 2007:64). In 2005, the only existing HIV prevention programme, a peer-based intervention, designed for high schools was criticized by the Croatian Bishops' Congregation as promoting condom use which led schools to drop it. Abstinence-only programmes were not effective and Croatian HIV and sexually transmitted illness prevention programmes needed an approach which promoted sexual responsibility and improved young people's understanding of sexual health risk and also to provide them with behavioural and communication skills (Štulhofer *et al.*, 2007:64).

Ridge *et al.* (2008:424) offer insight into the way that prayer and meditation feature as narrative devices in spiritual stories about successfully coping with HIV. One of the key narratives in coping with HIV concerned spirituality and religion for most Black Africans and many gay male interviewees (Ridge *et al.*, 2008:424). Narratives deployed about Jesus accepting all people regardless of illness or social status were powerful in combating HIV stigmatizing discourse within organized Christianity (Ridge *et al.*, 2008:425). Compared to the gay White male interviewees, Black African PLWHA described less room to move in order to avoid a discredited identity associated with HIV (Dodds, 2006). Silence surrounding HIV in Black African migrant communities and a lack of social support for Black Africans living with HIV in the United Kingdom meant that it was difficult for them to pass off as normal and avoid a spoiled identity in a religious setting (Ridge *et al.* 2008:425). People may attribute specific subjective changes in wellbeing, for example, reduced anxiety and increased strength, to prayer and meditation. Religion and spirituality can at times undermine wellbeing, such as when sexuality and HIV are viewed as sinful (King *et al.*, 1999). However, the skilful ways in which spiritual beliefs and devices are constructed and deployed are important to gain positive health benefits (Ellison and Levin, 1998). Given the importance of prayer as a narrative tool, and places of worship as a source of social support for many PLWHA, bringing spiritual and religious narratives back into the mainstream (Ridge *et al.*, 2008; Fakoya *et al.*, 2012).

Studies done in the United States found that PLWHA used religion to cope with their illness, an HIV diagnosis strengthened people's faith, an increase in spirituality or religiousness after being diagnosed with HIV was correlated with slower disease progression and spiritual beliefs about HIV influenced end of life decisions (Zou *et al.*, 2009). Religious beliefs about HIV can contribute to a fatalistic attitude and passive resignation, which may hinder treatment participation. In rural Mali, people who believed that AIDS was a punishment from God had more fatalistic attitudes than those who did not (Zou *et al.*, 2009). Beliefs that prayer can cure HIV may challenge adherence to antiretroviral (ARV) treatment programmes. A Ugandan study found that 6 out of 558 (1.2%) patients discontinued treatment because they believed that prayers from their pastor cured them of HIV (Zou *et al.*, 2009).

A majority of Ugandan adolescents, particularly females, have believed that contracting HIV was more or less an inescapable reality (Kibombo *et al.*, 2007:179-180). High proportions of male adolescents reported engaging in risky behaviour while the females had perceived themselves as more at risk and also had a higher HIV prevalence, pointed to a need for a more holistic approach in dealing with adolescent sexual and reproductive health (SRH) needs (Kibombo *et al.*, 2007:179-180). Many HIV and SRH programmes have tended to focus on female adolescents and children because of their supposed vulnerabilities and paid less attention to males (Kibombo *et al.*, 2007:179-180). Many traditional practices spread across Uganda increased risky sexual behaviour among adolescents (Asiimwe *et al.*, 2003). In Eastern Uganda, certain ethnic groups practiced circumcision and during such occasions, casual sex among adolescents was common and traditionally encouraged. In Northern Uganda, male adolescents, aged 15 and older were considered adults, lived in their own hut and received less parental monitoring, which increased their vulnerability. In Western Uganda, some sections of the population were reluctant to adopt condom use because of its incompatibility with their sexual styles (Kibombo *et al.*, 2007:179-180). Cultural functions that traditionally provide environments for adolescents to engage in risky sexual behaviour could be used as platforms to provide HIV/AIDS prevention information (Kibombo *et al.*, 2007:180).

In Tanzania, religious beliefs strongly influenced the way many people have thought about HIV/AIDS (Zou *et al.*, 2009). A significant percentage of those surveyed believed that people infected with HIV did not follow the Word of God, that it was a punishment from God and that it could be cured through prayer (Zou *et al.*, 2009). Shame related HIV stigma was

strongly correlated with religious beliefs about punishment from God and following the Word of God, this view was held even after adjusting for demographic and HIV belief or knowledge factors (Zou *et al.*, 2009). Respondent intention to disclose to the religious community (to the pastor or congregation) if they became HIV positive was primarily associated with non-religious factors in a multivariate analysis (Zou *et al.*, 2009). Gaining an understanding of how church members look to their religious community for guidance and support in matters related to HIV can help to direct collaborative efforts between Church leaders and clinicians or HIV educators (Zou *et al.*, 2009). Religious beliefs should be incorporated and addressed by intervention to reduce shame related HIV stigma, policies should be designed to improve ARV treatment and adherence and should focus primarily on addressing socio-demographic factors. Enhanced educational initiatives that are focused within faith communities may help to reduce stigma and enhance disclosure, contributing to improved social support for coping with HIV and may have the potential to increase HIV adherence (Zou *et al.*, 2009).

The key to successful HIV/AIDS intervention by faith based organizations is managing the tension between the ability of and limitations on faith based organizations in achieving behavioural change within a community (Clarke *et al.*, 2011:13). The authority of faith based organizations are attributed to their relationship to a religious belief system, which warns against risky behaviour, for example, using illegal drugs and non-monogamous sexual intercourse (Clarke *et al.*, 2011:13). However, such teachings may not necessarily prevent people from engaging in such risky behaviour (Clarke *et al.*, 2011:13-14). If the authority of a religious body cannot hold sway over personal behaviour, faith based organizations cannot dictate the appropriate behaviour and should acknowledge their limitations when seeking to change risk behaviour in working with communities (Clarke *et al.*, 2011:14). Religious organizations are influential networks that have the power to stigmatize or support PLWHA. At a community level, they can promote or impede HIV education and endorse or reject the medical treatment of HIV (Zou *et al.*, 2009). The shame about having HIV is closely linked to internalized self-directed stigmatization, which can lead PLWHA to withdraw from their religious community, fear of stigma and blame are closely linked to intentions of disclosure (Zou *et al.*, 2009). Religious beliefs may shape individual outlook on living with HIV. Faith practices can provide peace, hope and help people to prepare for and accept their death (Zou *et al.*, 2009).

Agadjanian (2005:1536) argued that HIV/AIDS related issues may permeate a Church member's world view and daily life directly and more often, indirectly. His informants saw their faith as an important factor in dealing with HIV/AIDS because it taught them virtuous behaviour, especially in matters such as family life and instilled fear and reason to help them better heed prevention messages (Agadjanian, 2005:1536). He also stressed the importance of advice and psychosocial support which was offered by other congregation members in making the right choices in order to reduce infection risk (Agadjanian, 2005:1536).

Trevino *et al.* (2010:387) acknowledge that while positive religious coping consists of methods which reflect a secure relationship with God, a belief in life's larger meaning and a sense of spiritual connectedness with others, it includes strategies such as seeking spiritual support, benevolent religious appraisal (finding a lesson from God in the event) and purification rituals (Pargament *et al.*, 1998). Spiritual struggle is defined as an expression of conflict, question and doubt regarding matters of faith, God and religious relationships that represent an effort to conserve or transform a spirituality that has been threatened or harmed (Pargament *et al.*, 2005). Assessing positive religious coping and spiritual struggle in patients living with HIV/AIDS may help health professionals identify and support patients using positive religious coping methods while at the same time target those individuals whose spiritual struggle may adversely affect their well-being (Trevino *et al.*, 2010).

Cotton *et al.* (2006) found that each year since an HIV/AIDS diagnosis appeared to be associated with an increase in spirituality, a possible increase in religiosity and an increase in beliefs that religiosity or spirituality was helping to lengthen one's life, indicated a positive feedback mechanism whereby the longer someone was living with HIV/AIDS, the more likely it was that they became more religious or spiritual and that it may have led to a greater likelihood that along life was attributable to changes in religiosity or spirituality. The state of religiosity and spirituality in PLWHA is dynamic and highlights the understanding that the religious and spiritual beliefs of PLWHA are not just of peripheral interest, but are a necessary part of culturally competent holistic care (Cotton *et al.*, 2006; Ehsanzadeh-Cheemeh *et al.*, 2009).

Plattner and Meiring (2006) found that self-blame and personal deservedness was combined with beliefs that their respondents HIV contraction was seen as a test or punishment by God. Even though self-blame (internal causal attribution) and attribution to God (external causal attribution) seem contradictory, combining the two beliefs helps participants to accept and

reconcile with the virus. Attributing HIV infection to God made the HIV status more meaningful and such attribution brought purpose and hope to their infection (Plattner and Meiring, 2006:244). Believing in something greater than oneself is a means to making reality understandable and meaningful (Wayfarer, 1995; Jenkins, 1995; Kubler-Ross, 1969). Hope helps people to maintain a future orientation and is essential in order not to give up on life. More research is needed to determine how people who do not turn to religion maintain hope and make meaning out of their HIV infection (Plattner and Meiring, 2006:244).

Christian churches have received criticism for a perceived male dominant and hierarchical culture and a practice of preaching down to their congregations, especially towards younger people (Chikwendu, 2004: 313). To reach these young people with effective AIDS prevention messages, Churches needed to review their educational culture to reflect the concern and aspirations of men and women who sought their help and aid, however, such education was conducted by a male clergy, with secrecy about sexual matters and a high level of stigma of people with AIDS (Chikwendu, 2004: 313). In light of such critique, many Church organizations have reviewed their positions on prevention and remain willing to accommodate HIV prevention strategies such as abstinence, voluntary counselling and testing (VCT), mutual faithfulness in marriage and condom use (Chikwendu, 2004:314).

The resurgence and revival of Christianity in many African countries (Bediako, 1995; Gifford, 1994; Jenkins, 2002; Ojo, 2000; Munro, 2002; Smith, 2004; Maman *et al.*, 2009) suggests that Africa and other Southern African regions have become the centre of worldwide Christianity. The relationship between the African Church and its community has been close. The Church was the main focal point of much of what would happen in the congregation and in the community (Toefy, 2009: 243). Faith based organizations (FBO) are important in communities facing desperate situations as a result of HIV/AIDS or other calamities (Weaver, 2004) and offer combinations of practical, emotional and spiritual support to households affected by AIDS, or with orphans and vulnerable children in the community (Toefy, 2009: 243).

The Kathleen Voysey Clinic, run by the Musgrave Methodist Outreach Project in Durban, provided healthcare service to homeless and indigent people, used the services of voluntary registered doctors and nurses, dispensed medication and operated in conjunction with a soup kitchen supported by Churches in Berea, Durban (Toefy, 2009: 243). The Moravian Masangane ARV programme in the Eastern Cape incorporated 'new' methodologies into

existing infrastructure (Toefy, 2009: 243) and provided care and support to infected and affected people and children, with a specific focus on providing ARV treatment to those needing it (Toefy, 2009:243). Health workers gained access to the congregation and infrastructure allowing them to reach often remote communities with ease (Toefy, 2009:243).

The Anglican Church of Southern Africa (ACSA) covers six countries and is divided into 26 dioceses with a membership of 4 million baptized people. Nineteen of these dioceses fall in South Africa, this represents approximately 2.5 million Anglicans in over 815 parishes (Council of Anglican Province of Africa; cited from Toefy, 2009:243). The first public commitment from the Anglican Church addressing HIV/AIDS was made during the 'All Africa Conference' of August 2001 in Boksburg, South Africa (Toefy, 2009:243). Christian doctrine encourages that one should be of service to others or engage in works of mercy which may lead to a stronger emphasis on care and support in a context of HIV/AIDS (Olivier and Clifford, 2011:370). In April 2003, ACSA launched the Isiseko Sokomoleza (Building the Foundation) HIV/AIDS Programme (Toefy, 2009:243), its main purpose was to reduce the stigma and impact of HIV/AIDS in Southern Africa (Deacon and Simbayi, 2006) and looked at strengthening the capacity of the Church to advocate for and provide effective and expanded community-based responses to HIV/AIDS in partnership with other regional stakeholders (Toefy, 2009:243-244). It addressed HIV vulnerability through increasing knowledge, encouraging responsible behaviour and promoting positive attitudes toward PLWHA and their families (Toefy, 2009:243-244). Through this programme, over 600 projects were managed in partnership with other denominations, NGO's and government departments (Toefy, 2009:243-244). Such projects included the care of orphaned and vulnerable children, care for care-givers, home-based care, wellness management, skills training, food security, promoting VCT, support groups, pastoral care, retreats for Christians living with HIV, counselling and capacity building, raising awareness and HIV education programmes, including peer education and empowerment projects (Toefy, 2009:243-244).

Other programmes coordinated by ACSA and funded by the President's emergency plan for AIDS relief (PEPFAR) through USAID was a youth programme called Siyafundisa (teaching our children) and the Anglican care for orphaned and vulnerable children (OVC) project (Toefy, 2009:243-244). Siyafundisa targeted people aged between ten and 24 with the aim of reducing HIV incidence by promoting abstinence before marriage and faithfulness within marriage (Toefy, 2009:243-244). The OVC project mobilized Church communities to provide

care and support to orphaned children or made vulnerable by HIV and to those under their care (Toefy, 2009:243-244). Nazareth House, situated in Cape Town, provides paediatric antiretroviral therapy to HIV-positive orphans living under their care (Toefy, 2009:243-244).

The proliferation of AIDS projects in the Catholic Church in South Africa impacted upon how it was perceived by the public, how it had engaged in conducting its business and its internal organization (Joshua, 2012). The influence of AIDS-related money has made it appear more as a nongovernmental organization (NGO) and less as a faith based organization FBO (Joshua, 2012). What he called the NGO-isation of church projects who were involved in responding to HIV/AIDS has had a lot to do with the place of religion in contemporary South African society. Whereas South Africa was still religious, religious institutions were losing social control (Joshua, 2012).

South Africa is predominantly Protestant; however, Catholicism's role in fighting apartheid and in responding to HIV/AIDS has increased the Catholic Church's visibility in the public arena. Catholicism in South Africa is becoming individualized (Joshua, 2012). Its hierarchy is not only less in a position to influence behaviour but its members' conceptualization of religion has changed from a system of public beliefs and practices enforced from a central and organizational point of view to a private and experiential reality judged by individuals. Such reform may be seen as an effect of secularism and other social forces on modern South African society (Joshua, 2012).

### **2.2.2 Hinduism**

In a historic initiative, Hindu religious groups, including over 70 prominent faith leaders from across India came together to commit to incorporate HIV information into their religious education and training of future faith leaders and included AIDS in their discourses, rituals and festival celebrations (UNAIDS, 2008). Senior Hindu religious leaders agreed to join the national effort to reverse the spread of HIV at the first meeting of 'Faith in Action: Hindu Leaders Caucus on HIV/AIDS' which took place at the Art of Living International Centre in Bangalore, India (UNAIDS, 2008). They came together to sign a joint declaration and expressed commitment to work with UNAIDS and the National AIDS Control Programme to increase HIV awareness among youth and to end stigma and discrimination against PLWHA (UNAIDS, 2008). Ravi Shankar, founder of the Art of Living Foundation, said that stigma

around the disease can only be overcome if religious leaders speak about it openly (UNAIDS, 2008). In 2008, there were approximately 920 million Hindus living around the world. After Christianity and Islam, it is the third largest religion in the world (UNAIDS, 2008).

There is no one view of sexuality in Hinduism, for every view revealed in traditional texts, there is an equally valid counterview (Mehta and Pramanik, 2010; Krishnamurthy, 1994). Traditional Hindu culture largely celebrates sexual openness and this is evident in texts discussing sexuality such as *Kama Sutra* (Mehta and Pramanik, 2010). This ideal came under pressure during the colonial period when sexuality was oppressed and repressed. Section 377 of the Indian penal code outlawed homosexuality and any 'unnatural sexual activity' (Mehta and Pramanik, 2010). Enacted in 1867, it lasted until 2009 when it was overturned in a historic judgment by the New Delhi High Court. Many of Victorian Britain's missionary values codified what kind of sex and between whom was permissible in law and this made for an environment of sexual hypocrisy and repression. Against such a backdrop, HIV entered into India (Mehta and Pramanik, 2010; Paterson, 2011). At its first detection, it was met with intolerance and considered a 'foreigner's disease' with early responses accompanied with appeals for the country to return to its 'pristine values' (Mehta and Pramanik, 2010).

India runs one of the largest AIDS programmes in the world (Mehta and Pramanik, 2010). This existed uneasily with laws such as section 377, the Hindu leader's caucus attempted to open the boundary of the social discourse on AIDS, the idea being not only to tap into latent influences of the religious community, but to open it to new ideas and to reform. Such efforts exist on the junction of modernity, tradition, HIV and the state apparatus (Mehta and Pramanik, 2010). The Hindu leader's caucus on HIV began as an exercise to bind together and negotiate the heterogeneity of Hinduism in order to mobilize a united 'Hindu' response to HIV (Mehta and Pramanik, 2010). However, this ended up reinforcing the heterogeneity even further and this is the great challenge of the Hindu response (Mehta and Pramanik, 2010). As such, plans for a district-wide mapping exercise of Hindu groups were meant to provide new insights into this and was accompanied with opportunity-mapping exercises as to which of these groups were open to talking about sexuality and health (Mehta and Pramanik, 2010).

Solat *et al.* (2012) interviewed a total of 724 individuals with 202 males and 522 females, 615 were aged 15-40 and 710 were Hindus. In the study, 626 participants heard of HIV/AIDS. The level of awareness about HIV/AIDS in males was 96.04% and in females 82.76%. Social values and customs restrained people from knowing and discussing about HIV/AIDS since it

is mainly a sexually transmitted disease (Solat *et al.*, 2012:42). Misconceptions about HIV transmission include mentioning: mosquito bites (29), kissing (27), sharing food (22) and clothes (16), coughing (11), through urine (8), through water (2), attending the funeral of a person who died of AIDS (2) and familial or hereditary (2) as ways of transmitting HIV/AIDS (Solat *et al.*, 2012:43-44).

Such misconceptions were low but should be addressed as they increase the fear and stigma of HIV/AIDS in the community and people caring for those with HIV may face stigma. In villages, HIV infected persons and their families could be seen as outcasts and it may result in neglecting individuals with HIV and increase social difference (Solat *et al.*, 2012:44). Only 397 participants were aware about condoms and this is attributed to low levels of exposure to information about condoms and being shy to talk about them as most study participants were female (Solat *et al.*, 2012:44). There was a lack of awareness about HIV/AIDS, different sexually transmitted illnesses as well as condoms, especially among females, adolescents, illiterates, unemployed and the poor and this indicates a need for awareness programmes in these groups. Rural people's knowledge about HIV/AIDS transmission and prevention should be improved with the help of campaigns, training workshops and HIV/AIDS education sessions with a special focus on migrant workers and their families. Awareness campaigns should increase at the time of religious festivals and fairs as migrant workers visit their native villages during this period. Proper counselling and testing facilities should be made available to those willing to go for HIV testing (Solat *et al.*, 2012:44).

In Hindu cultural and religious scripture, abstinence is considered a virtue (Nag, 1995:302). Although Hindu epics enjoin husbands and wives to have sex for procreation, over-indulging in sexual relations is considered a sin and is believed to cause serious illness (Nag, 1995:302). In religions such as, Christianity, the virtue of sexual abstinence is recognized but Western psychologists and sexologists generally consider prolonged abstinence from sex as detrimental to mental and physical health (Nag, 1995:303). Sigmund Freud thought of sexual abstinence as the source of various illnesses and believed that 'abstinence' was 'hardly thinkable for young artists because sexual experience acted as a stimulant to artistic activity' (Nag, 1995:303). Emphasizing abstinence from sex as a protection from HIV/AIDS and other sexually transmitted diseases in sex education programmes was seen as a more viable option in India than in Western countries (Nag, 1995:303). Sublimating sexuality into spirituality through sexual abstinence has influenced Hindu thought and action. Contemporary Indians,

rural and urban, believe in the theory of sublimation in some form or other (Nag, 1995:302). Advocating sublimation theory and the virtues of sexual abstinence by Indian national leaders such as Mahatma Gandhi reinforced existing folk traditions and religious beliefs in such respects (Nag, 1995:302). (Kakar, 1989, von Stietencron, 1986; Porter, 1993; Vicziany, 2001; Patnaik and Mehrotra, 2005; Rogers *et al.*, 2006; Steward *et al.*, 2008; Bharat, 2011; Bluthenthal *et al.*, 2012).

The contents of Hindu faith regarding God, nature and soul came down to them through *shastras* (scriptures) from the days of the Rig-Veda (sacred text), and were amplified and explained by later *shastras* and verified by seers called *rishis* (Nirvedananda, 1944: 221). The findings of *rishis* revealed certain unalterable, eternal truths about life and existence, such as the immanence of God in nature and the divinity of the soul. These may be called the fundamentals of the Hindu faith, for this reason, it is also called the ‘eternal religion’ or *sanatana dharma* (Nirvedananda, 1944: 221). The essential divinity of man is one of the fundamentals of the Hindu faith (Nirvedananda, 1944: 223). His soul being none other than God, man has the potential of becoming divine in all his bearings and cannot be damned forever for any act of his, however outrageous it may be (Nirvedananda, 1944: 223).

Sin is viewed as no more than a mistake committed through ignorance but one must pay for it in this world or in the hereafter. He grows wise through such suffering and proceeds through repeated births until the Divinity within him is completely manifested; this goal is for everyone to reach (Nirvedananda, 1944:223). Sinners should be treated with sympathy and helped out of their ignorance, but not condemned (Nirvedananda, 1944:223). As long as man does not realize his oneness with the Universal Spirit and remains attached to his physical body and the physical universe, he is in a continuous state of bondage and is almost seen as a brute in human form (Nirvedananda, 1944:223). Hinduism helps him in a step by step process until the brute is gone and yields its place to God (Nirvedananda, 1944:223). Religion is practical and is intended to govern one’s entire life; to regulate life and conduct in a way that it enables mankind to advance as far as possible towards Divinity from where he or she started (Nirvedananda, 1944:226). We should stick to the principle of unity in diversity while dealing with human problems, individual or social, and accommodate diversity but without overlooking underlying unity. Harmony, not rigid uniformity is the Divine law of nature (Nirvedananda, 1944:228).

Genrich and Brathwaite (2005) reported that Hindu representatives felt that HIV/AIDS occurred primarily among homosexuals and did not pose a significant problem for their organization. It was assumed that Hindus were less likely to acquire HIV due to high social and spiritual obligations to obey religious doctrine (Genrich and Brathwaite, 2005:4). According to one representative, HIV/AIDS was seen as a medical problem, although prayers and mantras are seen as effective treatments and cure for disease, his organization was less concerned about body ailments than it was about eternal life (Genrich and Brathwaite, 2005:4-5). He felt that PLWHA in the Hindu community may feel discriminated because disease is an 'unhygienic situation.' PLWHA are seen as unclean and are therefore expected to stay away from organized worship (Genrich and Brathwaite, 2005:4-5). Compassion is inherent in Hinduism, but did not provide opportunity for confession and reconciliation (Genrich and Brathwaite, 2005:5).

In Hindu literature, explanations that HIV/AIDS is a punishment from God are not apparent and emphasis is placed on individual behaviour. Raman (2003) suggested that according to Hinduism, not all diseases afflicting humankind are a result of some higher power but the result of human weakness and follows that HIV infection was quite clearly a direct consequence of human excess and transgression (Manda, 2011:204). It did not attribute HIV/AIDS directly to God as with early Islamic and Christian responses, it did understand the epidemic as a direct consequence of improper sexual behaviour (Manda, 2011:204).

The Ramakrishna Centre of South Africa, a social, religious and humanitarian organization founded in Durban in 1942 provides social welfare services among the poor and needy (Amod, 2006:45). It began its AIDS awareness programme in 1985 by printing charts and booklets discussing HIV/AIDS in English and Zulu, such information was obtained from the Department of Health and was distributed in rural clinics, doctors rooms, African schools and handed to chiefs in the areas of Inanda, Kwa Mashu and from Verulam to Ngoma in the north coast of Kwa Zulu Natal (Amod, 2006:45). Talks on HIV/AIDS awareness and prevention from a Hindu perspective are conducted at various branches of the centre over the year, delivered by teams of medical personnel using audio-visual material. Such talks are based on Swami Saradananda's book, 'AIDS-Hindu perspectives' published by the centre in 1992, dealing with scriptural injunctions relating to moral, ethical and social values that foster a healthy lifestyle (Amod, 2006:47). They look at aspects such as facts on HIV/AIDS; its mode of transmission, abstinence, sexual morality, attitudes of PLWHA, the care and support for

PLWHA and prevention (Amod, 2006:47). Hinduism, like Christianity and Islam, opposes homosexuality and promotes marriage (Amod, 2006:48).

### **2.2.3 Islam**

Islam is the final message revealed by Allah (subhana wa ta'ala) to the Prophet Mohammed (Sallallahu alayhi wasalam). It promotes a belief in one God and continues the message brought by earlier prophets such as Noah, Abraham, Moses and Jesus (peace be upon them) (Cochrane and Nawab, 2012:876). Islam integrates all aspects of the human personality, be it spiritual, physical, moral, aesthetical and intellectual, into a balanced and coherent, practical way of life (Amod, 2006:57). It balances the spiritual with the mundane by integrating both, everything that is physical also has a spiritual dimension to it so that there exists no conflict between the two (Amod, 2006:57). Muslims live all over the world and constitute a vast majority in regions stretching from Morocco to Pakistan and many parts of South East Asia, but are a minority, sometimes very small, elsewhere (Cochrane and Nawab, 2012:876). All aspects of an Islamic way of life, be it prayer (Salaah), fasting during Ramadan and the Hajj pilgrimage, serve to develop the human personality in all its dimensions toward the perfection of the individual on the one hand and developing a harmonious society on the other (Amod, 2006:58). Islam has made it the mission of Muslims to purify society of evil by enjoining what is right and forbidding evil (Amod, 2006:58). It prescribes dress codes for men and women to prevent unnecessary sexual excitement, discourages flirtatious behaviour and provocative attire and condemns pornography and prostitution (Amod, 2006; Ebrahim, 2007; Ebrahim and Nawab, 2007; Cochrane and Nawab, 2012).

Islam's solution is to go to the root of the problem of HIV/AIDS and it advocates; (a) the promotion of chastity before marriage, (b) the upholding of sexual fidelity during marriage, (c) to screen blood donors (d) to collaborate among social and cultural organizations to encourage people to uphold sexual morality and to create a drug free society (Ebrahim, 2007:13). Individuals should be made aware that in most cases it could be due to irresponsible behaviour that could lead to acquiring HIV/AIDS (Ebrahim, 2007:13). The Holy Qur'an warns: 'and do not destroy yourselves, for indeed Allah has been to you Most Merciful' (Ebrahim, 2007:13). The Prophet Muhammad (Sallallahu alayhi wasalam), reminding us not to voluntarily expose our body to any injury or harm, stated: 'Your body has a right over you' (Ebrahim, 2007:13-14). A majority of people actively involved in the

fight against HIV/AIDS overlooked the fact that it is a moral and ethical problem. Given the fact that the main mode of spreading HIV/AIDS is through sexual intercourse, they consider that focus should be placed on regulating sexual activity (Ebrahim, 2007:13-14).

The Holy Qur'an prohibits '*khamr*' (alcoholic drinks and drugs) and this may close the avenue for transmitting HIV, such as, by sharing contaminated needles (Ebrahim, 2007: 14). It may be considered true that an HIV positive pregnant woman who is on anti-retroviral therapy lessens the risk of her transmitting the disease to her baby and some Muslim jurists are of the view that it is allowed for her to have an abortion during the very early stages of pregnancy, during the first forty day period of having fallen pregnant (Ebrahim, 2007: 14). Two reasons justify this; firstly, to consider the health of the mother and secondly, to avert the risk of transmitting HIV to the foetus (Ebrahim, 2007:14). It is considered plausible for HIV-positive women to make use of contraceptive devices or undergo sterilization in order to safeguard themselves from falling pregnant altogether (Ebrahim, 2007:14). Muslims should not discriminate against PLWHA, they are duty bound to visit, pray for or assist them financially to receive antiretroviral treatment. The person should be reminded that Allah is Most Forgiving and should be encouraged to strengthen his or her bond with their Creator and to seek inner peace through sincere repentance (Ebrahim, 2007:14).

Islamic law mandates that individuals should care for others and that 'there is a strong current of mercy in Islam, which applies to anyone in distress, even sinners and criminals' (Olivier and Clifford, 2011:371). The Holy Qur'an enjoins believers to visit the sick or to give charity to the poor (Zakah) (Olivier and Clifford, 2011:371). At community levels, this literature describes fewer institutionalized care responses to HIV/AIDS in Muslim communities. Some authors indicate that there are few formal Muslim healthcare institutions or support groups for PLWHA and suggest that most Muslim activities, even those concerned with care for PLWHA, mostly concern influencing behaviour (Olivier and Clifford, 2011:371). Such statements are based upon particular definitions of community care, it is acknowledged that fewer care-focused entities do not necessarily equal less care at a community level; it does indicate that there are different kinds of care (Olivier and Clifford, 2011:371).

Religious constraints on sexuality may have consequences for transmitting sexually transmitted diseases. Among 38 Sub Saharan African countries, the percentage of Muslims within countries negatively predicted HIV prevalence (Gray, 2004:1751). Surveys of

published journal articles containing data on HIV prevalence and religious affiliation showed that six of seven such studies indicated negative relationships between HIV prevalence and being Muslim (Gray, 2004:1751). Additional studies on the relationship of risk factors to HIV prevalence gave mixed evidence with respect to following Islamic sexual codes but benefits arising from circumcision may help in accounting for a lower HIV prevalence among Muslims (Gray, 2004:1751). Six of seven studies that enabled within-population comparisons revealed a lower HIV prevalence among Muslims. Islamic religious affiliation sometimes appeared to, but at other times, not to, be associated with a reduction in sex outside marriage, for example, with commercial sex workers or in extramarital affairs. However, in no study was Islamic affiliation positively associated with such sexual behaviour (Gray, 2004:1751).

Muslims consume less alcohol, which may partly underlie any differences in risky sexual behaviour and higher rates of circumcision compared with non-Muslims, but Islam's allowance for polygyny and discouragement of condom use will work against a reduced sexual transmission of HIV (Gray, 2004:1755). The hypothesis that Islamic religious affiliation is negatively associated with HIV sero-positivity is generally supported. The percentage of Muslims negatively and significantly predicted the prevalence of HIV among Sub Saharan countries (Gray, 2004:1755). Future discussion of the predicted course of the global HIV epidemic may consider Islamic religious affiliation as a socio-demographic factor associated with a reduced risk of HIV transmission (Gray, 2004:1755).

When a high proportion of people within a country are Muslim, all its residents may be subject to Islamic-inspired public discourse, norms and customs (Adamczyk and Hayes (2012:729). To preserve relationships with Muslims and maintain a self-image based on reference group expectations, residents of Muslim countries may adopt attitudes that support sex within marriage. Kelman's (2006) work on attitude change, has argued that individuals may adopt the attitude of others without accepting the rationale to maintain their sense of self and increase the likelihood of desirable relationships, a process called identification. Through this process, people living in countries with high Muslim populations may adopt their more conservative sexual attitudes. Informal cultural norms which limit the interactions between members of the opposite sex could result in a decrease in access to potential romantic partners (Adamczyk and Hayes, 2012:729).

When support exists for advocating certain cultural values, individual preference may lead to macro-level changes and could manifest in laws, policies and restrictions (Coleman, 1986). Once created, such formal restrictions can become active and may shape the behaviour of all residents. Because formal restrictions may remain even after the saliency of cultural norms subside, it is difficult to discern whether formal restriction or culture per se shape individual action (Adamczyk and Hayes, 2012:740). At a macro level, a high proportion of Muslims in a country may limit the spread of HIV/AIDS by reducing the odds of all residents having premarital sex (Adamczyk and Hayes, 2012:741). Across the developing world, where HIV/AIDS is primarily spread through heterosexual sex (Piot *et al.*, 2001), married Muslims report more conservative sex-related behaviour than adherents of other religions, which supports the idea that differences in religious affiliates sexual behaviour could provide an explanation of lower rates of HIV/AIDS for Muslims (Adamczyk and Hayes, 2012:741). However, the authors have noted that while all major world religions do engage in discouraging premarital sex, none of them have been equally effective in shaping behaviour (Adamczyk and Hayes, 2012:742).

In Senegal, Islamic taboos and tradition play into traditional African hierarchies to produce powerful effects on youth behaviour (Gilbert, 2008:406). Low drug and alcohol use and the effect of religiosity on abstinence, suggests that Islam plays an important role in promoting low risk behaviour among Muslim university students (Gilbert, 2008:406). However, growing numbers of infections among married populations suggests that engaging in sexual activity may provoke conflicted feelings about adhering to preventive measures when making decisions about sexual behaviour. Both AIDS prevention and the Muslim community would benefit from reducing this internal conflict and may find a way for sexually active students to practice safe sex without compromising religious beliefs (Gilbert, 2008:406).

In Taiwan, Tung *et al.*, (2008:406) recommend that: (1) accurate information about HIV must be emphasized for students on the country's university campuses, because of general cultural expectations that Taiwanese women remain virgins until marriage and are subject to male domination, strategies should be developed to encourage women to actively engage in HIV prevention strategies, for example, negotiating condom use; (2) most participants held positive attitudes toward PLWHA, but HIV stigma must be reduced; (3) sexually active students have not routinely practiced safe sex, and have reported multiple sexual partners and inconsistent condom use. HIV education and prevention programmes should emphasize the

importance of minimizing the number of sexual partners as well as addressing other risky behaviours; (4) Formal sources of information should be strengthened; teachers and health care providers should be involved in developing strategies informing Taiwanese students about HIV. Internet websites may prove useful for providing culturally specific, properly reviewed, and accurate information; (5) teachers should teach and direct students to accurate and current sources of information about HIV transmission, prevention and treatment; and (6) although small numbers of participants have reported ever having sex, HIV prevention education efforts should begin at an early age because it is likely that rates of sexual activity among Taiwanese youth would increase over time and therefore must receive early, frequent and accurate information about HIV transmission and prevention. Young Taiwanese adult's lack a sufficient knowledge base upon which to build understandings of HIV. While knowledge alone is not enough to prevent HIV, it is needed to make an informed decision (Tung *et al.*, 2008:407).

Peltzer, Nzewi and Mohan's (2004:105) study found some country differences regarding HIV testing and attitudes. They found that American students held significantly more positive attitudes towards HIV testing and stronger intentions to test than South African and Indian students and have related it to the presence of educational and HIV prevention programmes on many American universities and have indicated the positive outcomes of such programmes (Peltzer *et al.*, 2004:105). There were country differences with regard to emotional reaction toward PLWHA, contact readiness with PLWHA and attitudes toward homosexuals. South African students scored higher on two emotional reactions, fear and irritation, than students from the United States and India. One explanation is that South Africa has a high prevalence rate of HIV infection among the three countries, which could arouse a higher emotional reaction toward PLWHA. American and South African students showed more positive attitudes toward willingness to engage in personal contact with PLWHA than Indian students. The least sympathetic attitudes toward homosexuals were held by Indian students (Peltzer *et al.*, 2004:105).

Intention to avoid risky behaviour and knowledge of factors that increase the risk of being infected did not translate into practices reducing HIV infection risk. The three groups of students had high intentions for condom use but were inconsistent in actual condom use. This was the case with South African and American students, indicating a need to incorporate behavioural components into prevention programmes at the universities in these three

countries (Peltzer *et al.*, 2004:105). The findings were important for mapping psychosocial factors associated with HIV risk in the three populations and likely influences on student participation in HIV risk reduction counselling. Efforts to promote voluntary counselling and testing (VCT) require education about the benefits of testing and reducing stigmatizing attitudes toward PLWHA. Structural and social marketing interventions aiming to reduce the stigma of AIDS would probably decrease resistance to seek VCT (Peltzer *et al.*, 2004:106).

University students represent a particularly vulnerable group in terms of HIV related sexual risk behaviour because of opportunities offered by university environments that engender sexual risk taking. Adefuye *et al.* (2011:25) found low perceptions of HIV risk among American and Turkish university students. The percentage of South African male and female students perceiving themselves to be at risk for HIV infection was higher than American and Turkish students. There was no agreement between engaging in risky sexual behaviour and self-perception of HIV risk among South African female students, while agreement was poor for American male and female students, Turkish male and female students, and South African male students. Not only did higher proportions of South African female students have higher HIV risk profiles, there was no agreement between their behaviour and perceptions of HIV risk, a situation connoting disaster (Adefuye *et al.*, 2011:25).

Tendencies to systematically underestimate personal risk, termed optimistic bias (Eiser, 1986) and treating HIV infection as a distant possibility (Macintyre *et al.*, 2004) meant that students might not be motivated to adopt HIV preventive behaviour (Adefuye *et al.*, 2011:25). American, Turkish and South African students displayed high levels of HIV high risk behaviour (Adefuye *et al.*, 2011:26). The HIV risk behaviour of Turkish students was lower than those of American and South African students and indicates eroding socio-cultural and moral norms. There was poor agreement between engaging in HIV high-risk sexual behaviour and HIV risk perception among students (Adefuye *et al.*, 2011:26). Perceived threat was a strong motivating factor for behavioural change, particularly if individuals perceive control over the risk behaviour. Recognizing poor HIV risk perceptions among university students is an important consideration in planning and implementing prevention programmes targeting this population in these three countries (Adefuye *et al.*, 2011:26).

In a 2011 study conducted with 62 University of the Western Cape (UWC) students, respondents mention that going for an HIV test: (1) presented them with a desire to lead a healthier lifestyle; (2) to protect themselves and to prevent spreading HIV; (3) it will affect

their job opportunity prospects if they should test HIV positive; (4) engaging in risky or promiscuous sexual behaviour present a greater chance of HIV infection and (5) knowing their status by testing gave them a chance to change their behaviour (Parker, 2011:56). HIV/AIDS risky behaviour remains a critical health concern for adolescents, specifically if they are at university (Peltzer, Nzewi and Mohan, 2004; Adefuye *et al.*, 2011; Mwaba and Naidoo, 2005, Tung *et al.*, 2008; Korhonen *et al.*, 2012; Meena *et al.*, 2013).

Adolescents who delay first sexual experience of sexual debut have a better chance of not having their lives at risk with HIV/AIDS infection than those with earlier sexual debut (Fennie, 2011). Fennie's (2011) study was conducted to explore the levels of sexual knowledge and attitudes about risky sexual behaviour and to identify trends in misinformation among young adults about HIV/AIDS at UWC, focusing on the area of HIV/AIDS and sexual reproductive health in order to better understand young adolescent's knowledge, attitudes, beliefs and risky sexual behaviour around HIV/AIDS (Fennie, 2011). First-year psychology undergraduate students (56 males and 164 females) aged between 18 and 24, with an average age of 19.7 years, partook in the study. Over 80% of students had high levels of knowledge and attitudes with regard to HIV/AIDS. However, they mention that they would refuse to have sex without using a condom. Over 80% chose to abstain from sex until marriage, 48% felt that more educational and awareness programmes with regard to HIV/AIDS were necessary. Behavioural change proved to be the key variable which could impact on the spread and prevention of HIV (Fennie, 2011:3).

In Saudi Arabia, an extremely staunch Islamic country, recent data on HIV/AIDS spanning 19 years (1984-2003) indicate that 7,807 HIV/AIDS cases were reported to the Saudi Ministry of Health (Badahdah, 2010:386). Most of the infected cases (6064) were expatriates and 1743 were of Saudi nationality, with 77% of males being diagnosed HIV-positive (Badahdah, 2010:386). The citizens resided in three Saudi cities: Jeddah (40%); Riyadh (15%) and Dammam (12%) (Badahdah, 2010:386-387). The main mode of infection was through heterosexual sex, with almost all Saudi women contracting it from their husbands, whereas men had contracted it from commercial sex workers (Badahdah, 2010: 386-387; DeJong *et al.*, 2007; Ehsanzadeh-Cheemeh *et al.*, 2009; Rostosky *et al.*, 2004).

Yemen is a conservative and tribal state of 23 million people with a median age of 16.7 years and a high rate of illiteracy, poverty and unemployment and is considered one of the poorest and least developed countries in the Arab world (Badahdah and Sayem, 2010: 902). The

World Health Organization estimated that there were approximately 24000 HIV-infected individuals in Yemen. During the 1990's, a majority of HIV infected people were males. In 1995, for every four HIV-infected males there was one HIV-infected female (Badahdah and Sayem, 2010:902). HIV infection risk among Yemeni women has increased. In 2005, it was reported that as many women as men were infected. Yemen lacks basic tools to halt HIV spread. To illustrate, only 107 patients were receiving antiretroviral therapy with limited testing and counselling facilities available (Badahdah and Sayem, 2010: 902).

In the Arab world, women are at heightened risk for HIV infection because of their socially disadvantaged societal position. A lack of independent income and low literacy curtails their ability to access HIV information, to ward off unwanted sexual advances and to negotiate safer sexual practice (Badahdah and Foote, 2010:983). Arab women represent half the total number of people carrying HIV in the region and nearly 80% of affected women contract it from their spouse (Badahdah and Foote, 2010:983). Genuine but comparatively meagre attempts were made to raise AIDS awareness by Arab regional authorities but they failed to address the population's continued lack of access to good HIV information (Badahdah and Foote, 2010:983). Young adults are likely to be negatively affected because they are at the life stage where risky behaviour such as engaging in unprotected sex or abusing drugs is more likely to take place (Badahdah and Foote, 2010:983). Studies of Jordanian and United Arab Emirates (UAE) college students found alarming gaps in HIV/AIDS knowledge and negative attitudes towards PLWHA (Badahdah and Foote, 2010:983).

In Jordan, the perception of Jordanian Muslim religious leader's relating to PLWHA was positive and tolerant as they felt that PLWHA should not be discriminated against or punished. (Abu-Moghli *et al.*, 2010:662). They considered it a responsibility toward the prevention and control of HIV/AIDS by giving spiritual counselling to PLWHA and their families. Their general belief was that health education programmes should address HIV/AIDS using culturally sensitive approaches based on Islamic values and teachings. Islamic and cultural values should be strengthened, especially amongst adolescents, to prevent the further spread of HIV/AIDS (Abu-Moghli *et al.*, 2010; Hasnain, 2005; Ehsanzadeh-Cheemeh *et al.*, 2009; Barmania, 2013).

Even though Iran has been a leading country in HIV prevention and treatment in the Middle East, its healthcare system had yet to combat stigma in both HIV and other health facilities (Rahmati-Najarkolaei *et al.*, 2010). As long as those infected with HIV remain hidden and do

not seek care timeously, efforts to stop the spread of HIV are inadequate (Ghabili *et al.*, 2008; Rahmati-Najarkolaei *et al.*, 2010). Integrated approaches to healthcare based on a human rights framework, grounded in community realities and delivered in partnership with PLWHA offer a viable approach to overcoming the deficiencies of HIV/AIDS care in the healthcare system (Rahmati-Najarkolaei *et al.*, 2010). Solutions to this may be found in Islamic law, to investigate Islamic literature and the instructing and requesting of official public statements from spiritual leaders (called Ayatollahs) regarding stigma and discrimination in healthcare settings, should be used in educational intervention programmes targeting health care providers (Rahmati-Najarkolaei *et al.*, 2010).

The population of the UAE grew from 180 000 in 1968 to 4.1 million in 2005; 22% were citizens of the UAE and the remainder were mainly foreign workers with about half residing in cities such as Dubai, Abu Dhabi and Al Ain (Ganczak *et al.*, 2007). Until recently, HIV prevention in the UAE was mainly by screening blood, organs and tissues before transplantation and early detection for population groups such as foreign workers, government employees, university students and couples who were about to marry (Ganczak *et al.*, 2007). Local culture, politics, religion, and social surrounding are helpful in understanding why young people in the UAE receive insufficient HIV/AIDS information. Where religion is dominant in a culture, sexuality is dealt with not only in terms of reproductive, sexual, family, and psychological health, but also in terms of religion (Ganczak *et al.*, 2007). Because of fears that HIV and sexual education may promote high-risk forbidden behaviour, it is inappropriate to introduce HIV/AIDS prevention that specifically target young people and health providers find it difficult to fill the void because of their own cultural, political, and religious views about youth sexuality (Ganczak *et al.*, 2007). Most lack the training and necessary skills to understand their own beliefs and discuss sensitive topics with adolescents. Although some health providers can provide facts, few were trained in workshops that were effective to modify attitudes, such as those developed by the World Health Organization (Ganczak *et al.*, 2007).

Middle East emigrants are one of the fastest growing immigrant populations to the United States (Ehsanzadeh-Cheemeh *et al.*, 2009:232). The lack of valid, reliable information is a major barrier to providing effective HIV/AIDS prevention and treatment for this population group, both in their homeland and within the United States. Sex and injection drug use which are the main HIV transmission routes, are culturally and religiously stigmatized (Ehsanzadeh-Cheemeh *et al.*, 2009:232). Due to cultural and language barriers, such immigrant

populations might be less able to seek HIV education information and access proper care (Ehsanzadeh-Cheemeh *et al.*, 2009:232). HIV/AIDS risk factors, such as unprotected sex and injection drug use are sinful or illegal in most Middle Eastern countries. Consequently, they may not be willing to disclose their HIV risk behaviour (Ehsanzadeh-Cheemeh *et al.*, 2009:232). Existing American HIV/AIDS intervention programmes and sexual orientation messages might not be culturally or religiously appropriate for Middle Easterners and it is recommended that Middle Easterners be involved in preparing culturally sensitive curricula for these populations (Ehsanzadeh-Cheemeh *et al.*, 2009:232).

There is a multitude of conditions and factors that encourage the spread of HIV among migrant populations, since in most cases migration implies a dramatic change in cultural environment (Ramsden and Hopkins, 2012:145). This may challenge norms and behaviours prevalent at the place of origin (Parrado *et al.*, 2004). Family separation, social isolation and depression, coupled with perceived anonymity have often rendered migrants more likely to engage in risky sexual behaviour with multiple partners or commercial sex workers (Duckett, 2001). It is argued that, to effectively deal with the HIV/AIDS epidemic, it is important to understand its socio-cultural risk predictors and that it should be addressed through culturally competent programmes (Ehsanzadeh-Cheemeh *et al.*, 2009:232).

Vlassoff and Ali (2011:39) found that second generation South Asian immigrants to Canada are more open to discussing matters of sexual health, including HIV, than first generation immigrants. Younger South Asians could offer an entry point for change in this area. Participant preparedness to overcome discomforts and talking to children about HIV was a positive step. HIV represents an opportunity for challenging acceptance and endorsement of HIV related stigma in the community (Vlassoff and Ali, 2011:39). If the youth are able to find ways to talk about HIV and sexual health with their family, such information shared could have a considerable impact (Vlassoff and Ali, 2011:40).

In many Muslim countries, strong moral views on HIV prevail including those within the medical profession; give rise to stigma and discrimination against PLWHA and those perceived to be infection risks (Kamarulzaman, 2013). Such prejudice forces those in need of HIV prevention and treatment programmes away from such services and that many countries and policymakers are unable to separate public health imperatives of sound HIV prevention programmes based on evidence from people's private behaviour which is at odds with

religious teaching (Kamarulzaman, 2013). Muslim majority countries do address the HIV epidemic and parts of the Islamic world are undergoing socio-cultural transitions leading to an increased tolerance and acceptance of practices such as premarital and extramarital sex (Kamarulzaman, 2013). However, what is forgotten is that in the Islamic world's response to the HIV epidemic is that central in Islamic teachings is the concept of compassion and justice. Muslims are encouraged to recite the phrase *Bismillah ir rahman ir rahim* (in the name of Allah, most beneficent, most merciful) before engaging in any action, large or small (Kamarulzaman, 2013).

Malaysia's first case of HIV/AIDS was documented more than 25 years ago and there are more than 81000 PLWHA in the country (Barmania, 2013: 2070). In the past, some Malaysian religious leaders were unhelpful with regard to discussing HIV/AIDS, many now engage in HIV prevention. Arrahman Awang, a religious leader, explains that Muslim leaders initially focused attention on reducing stigma and discrimination against PLWHA and counselled them by way of Islamic principles. Presently, the approach uses 'khutbahs' (religious sermon done in mosques) and 'halaqahs' (Islamic values) to raise HIV awareness (Barmania, 2013: 2070). Religious leaders can use Islamic principles to 'inspire hope of the mercy of Allah and use of the rule of necessity', the concept that 'one harm should be removed by a lesser harm'. Needle exchange programmes were accepted by Islamic leaders as being a necessity in order to avoid further spreading HIV/AIDS (Barmania, 2013: 2070-2071).

Condom use is a sensitive area pertaining to HIV prevention and harm reduction. Ilias Yee, a clinical coordinator at the Centre of Excellence for Research in AIDS, has proposed that harm reduction is compatible with Islam. He explains that the lesser of two evils concept is available in Islam but notes that it is not readily applied and results in an all or nothing approach that marginalizes people, which is the antithesis of central Islamic tenets (Barmania, 2013:2070-2071). Homosexuality is also frowned upon culturally, it is often hidden, and it is argued that a majority of homosexuals may be married and to design HIV interventions for men who have sex with men does present challenges (Barmania, 2013:2070-2071). Malaysia's transgender community is also an issue as attempts to educate the public and religious leaders not to discriminate against transgender people have only resulted in shoes being thrown at them when they enter a mosque to pray. In a nation where HIV is a sensitive

issue, collaborating and engaging with religious leaders is a positive step and requires a continued and concerted effort by all involved (Barmania, 2013:2070-2071).

A form of denying HIV/AIDS is to engage in 'othering' the disease (Abrahams, 2006: 22). Muslims engage in 'othering' HIV/AIDS because they believe they are not at risk of contracting HIV but contend that 'others' are (Abrahams, 2006: 22). Such forms of 'othering' may be based upon perceptions of 'self' as religious, good or obedient and the 'other' as irreligious, bad or deviant (Abrahams, 2006: 22). Such dichotomous thinking has been explained in a study done by Petros *et al.* (2006) which looked at themes of 'othering' that emerged from research preceding a national population-based HIV/AIDS study in South Africa. They sought to examine the cultural and racial context of behaviour relevant to HIV infection risk among South Africans (Abrahams, 2006:22) and showed that PLWHA were 'othered' in South Africa by using religious, race, gender, health systems, homophobia and xenophobic forms of 'othering' (Abrahams, 2006:22).

Religious 'othering' was perceived as a safe space to deny and distance HIV/AIDS and could sometimes be used as a mask for racial 'othering' (Abrahams, 2006: 22). Cultural and racial positioning also mediate perceptions of those considered responsible and vulnerable to HIV infection and AIDS (Abrahams, 2006: 22). Central to such positioning was the 'othering' of blame (Petros *et al.*, 2006). Black women were seen to be carrying the heaviest burden of HIV/AIDS, including stigma (Abrahams, 2006: 22). HIV/AIDS was connected to the practice of 'anal sex' and blame was also placed upon foreigners for bringing the virus to South Africa (Abrahams, 2006: 22). Their study raised questions concerning social life in South Africa and exposed the limitations of approaches which did not take into account critical contextual factors in HIV prevention and care for PLWHA, sensitizing people to the problem of 'othering' and its complex social dynamics (Abrahams, 2006: 22). Anyone is at risk of HIV infection regardless of a safely perceived social space (Abrahams, 2006; Guma, Henda and Petros, 2007).

In the case of Muslims, Muslim women may also be vulnerable to HIV infection (Ahmed, 2003a:229). A women's 'muslimness' has little to do with her experience of living with HIV/AIDS. Poverty, sexual violence and socioeconomic conditions also have an impact on their vulnerability to HIV infection and their ability to subsequently cope with it (Ahmed, 2003a: 229). Poorer women were likely to be forced or coerced into engaging in sexual

practices making them a risk for HIV infection (Ahmed, 2003a:230). A lack of food or money may have immediate consequences; however, to be infected with HIV/AIDS may take months or years in order for it to present itself as a problem (Ahmed, 2003a; Ahmed, 2003b).

It is estimated that South Africa has 6.4 million PLWHA and it is seen as an ongoing scourge in the country (Mukadam, 2013: 9). Ashraf Kagee, chairperson of Stellenbosch University's psychology department states that 'HIV/AIDS does exist in the Muslim community' and one of the greatest challenges is the stigma attached to being HIV positive and as a result, sufferers tend not to disclose their status (Mukadam, 2013: 9). Such sentiments are echoed by Faghmeeda Miller, the first South African Muslim to disclose her HIV-positive status in 1996. She says that 'there is still a strong stigma attached to being HIV-positive in the broader community, not just among the Muslim community.' While not many other Muslims disclosed their HIV status, she believes that there is an increased awareness of HIV and more empathy for PLWHA, however, there is a need to talk about AIDS and she remarks that 'Muslims do not talk enough about AIDS' (Mukadam, 2013:9). She adds that 'because of the means of contracting HIV, people shy away, but we must face reality, Muslims have sex outside of and before marriage' (Mukadam, 2013:9).



Miller was a co-founder of Positive Muslims, a support group committed to addressing HIV/AIDS in a Muslim context (Westh and Noordien, 2008:7; Ahmed, 2003a; Positive Muslims, 2007). It strived to create an enabling environment for Muslims infected and affected by HIV/AIDS based on a theology of compassion, a theology neither silent nor judgmental about HIV issues (Westh and Noordien, 2008:7). Its mission statement defined the theology of compassion as a way of reading the Qur'an and understanding the Sunnah, the path of the Prophet Mohammed (Sallallahu alayhi wasalam) that focuses on Allah as a God who cares deeply about all of His creation and who, according to Hadith (Prophetic saying), said at the time of creation, 'indeed, My mercy overcomes My anger.' (Westh and Noordien, 2008:7). Such compassion, the organization believed, must be accompanied by a critique of and a challenge to a society that marginalizes people (Westh and Noordien, 2008). The theology of compassion is ascribed to Professor Farid Esack, described as a key figure within progressive Islam, which shares much with liberation theology in its emphasis on social justice and an insistence of keeping a close link between text and context (Westh and Noordien, 2008:8). Progressive Islam relies on the norms and values articulated in religious

texts which support the transformation of society from an unjust one in which HIV positive Muslims are marginalized to one that is just and compassionate (Ahmed, 2003a:226). The theology of compassion has underpinned all of Positive Muslims activities, non-judgmentalism was a core value of their practice as they did not ask anyone who approached them how they got infected (Westh and Noordien, 2008:8).

From a personal interview conducted with Faghmeeda Miller in September 2012, she revealed that when she started Positive Muslims, at its inception, Muslim religious leaders were not supporting her, but with time she continued to talk about HIV and started Positive Muslims. These leaders began to accept that Muslims could also become infected and they began sending people looking for help and support to her. She advises that there is life after HIV and that those infected can live a normal life if they take their medicine (antiretrovirals) and presently, she said that people seemed to be more accepting of those living with HIV/AIDS, as opposed to ten or 15 years ago.

Moulana Zakariyah Philander, director of the Discover Islam centre notes that more religious leaders need to get on the bandwagon and demystify misconceptions around AIDS. There are two main views of AIDS, retributive and compassionate. The former assumes that AIDS is a punishment from God and the latter explains that Islam is a religion of compassion and mercy (Mukadam, 2013:9). The latter view recognizes that we have a pandemic and focuses on our responsibility toward those in need, regardless of their lifestyle choice (Mukadam, 2013). By highlighting God's merciful and compassionate attributes, religious organizations may encourage people to reflect on these attributes and to be critical of followers that do not have a positive attitude towards PLWHA (Lala, 2007:80). Statistics have shown that women bear the brunt of the HIV/AIDS pandemic, with a 2012 household survey finding that in the age 15-49 group, a 23% prevalence rate among females and 13% among males was found (Mukadam, 2013:9). Muslims realize that Islam needs to respond and Islamic scholars began looking at issues that affect those living with HIV and asked if the fiqh (Islamic jurisprudence) speaks to them. Moulana Philander notes that HIV/AIDS sufferers can still lead normal lives as Muslims, but notes that there is a need for AIDS education and to raise awareness (Mukadam, 2013:9).

Bavikatte (2009:194) has argued that merely being a Muslim was insufficient security against a pandemic that breeds in conditions of misery and affects the people who live there,

regardless of religious affiliation. To be a Muslim who understands something about the Qur'anic imperative to be just and to uphold justice is to appreciate and oppose the structural causes for the crisis of HIV/AIDS and to know we are complicit in them (Bavikatte, 2009:194). Blaming individuals and shifting blame is easy and convenient than asking 'how have I supported these structures of capitalism, racism and patriarchy that have caused this untold misery' (Bavikatte, 2009:194), in doing so we emulate the justice of the Prophet Mohammed (Sallallahu alayhi wasalam). We should move away from blaming the victim and fight against the root of oppression (Bavikatte, 2009:194). The Prophet Mohammed (Sallallahu alayhi wasalam) has told us 'the best jihad is to speak a word of truth to an unjust ruler' (Khan, 2008:9).

South Africa's health education policy should be in keeping with Islamic moral values and the customs and culture of society, but must avoid turning such policies into chapters on moral education (Kamali, 2009:85). The Prophet Mohammed (Sallallahu alayhi wasalam) taught that 'religion is sound advice, *al-din al-nasihah*' (Kamali, 2009:86). Sound advice and religion tell us that in combating calamity and *darar* (harm), the priority is try to be as relevant and effective as possible. We should take affirmative action and address issues on their own ground, being realistic and affirmative while acting in harmony with society's moral and cultural values (Kamali, 2009:86). In the event of conflict between the two and in places where fighting a lethal *darar* entails an unavoidable sacrifice of moral and religious values, fighting *darar* takes priority over conformity to religious rules (Kamali, 2009:86). This is the essence of the realism in Islam which favours efficiency and rational advice and should be reflected in health education and disease prevention strategies (Kamali, 2009:86).

Reflection that moves beyond care and compassion to focus on justice is an important task for religious scholars. The move away from compassion as an area of theo-ethical reflection was partly motivated by associated negative connotations such as pity (Manda, 2011:208). Those who exercise compassion do so from positions of superiority which, according to Farid Esack and Sarah Chiddy, ignore the heart of what makes us human: agency, the ability to take charge of and control our own lives (Manda, 2011:208). Compassion should construct a discourse of agency and of the right of HIV positive persons (Manda, 2011:208). Care and compassion are two recurring themes in Islamic theo-ethical literature. In an HIV/AIDS context, Islamic caring perspectives require Muslims not to discriminate or judge PLWHA and should exercise mercy and compassion toward them despite their beliefs, race, ethnic affiliation, social status and wealth (Manda, 2011:208). Ethical reflection in Islamic studies

publications is taking place as Muslim scholars critically appraise sacred and legal sources in light of the challenge HIV/AIDS presents (Manda, 2011: 208-209), with more contextual approaches to Islam being adopted in regard to how the Sharia law and Holy Qur'an can contribute to developing Islamic ethical principles, guidelines and approaches to issues such as access to healthcare and treatment, gender and poverty in a HIV/AIDS context (Manda, 2011: 209).

### **2.3 Summary of the section**

From the above literature review it is evident that, in the past, the stigma attached to HIV/AIDS was met with denial by Christian religious leaders as well as Christian faith based organisations and it was argued that this further added to the stigma felt by those who were affected, including the family of infected persons (Clarke *et al.*, 2011:6). At the time of the onset of HIV/AIDS, similar responses towards HIV/AIDS were met with denial by Muslim and Hindu religious leaders. Attitudes and statements on HIV/AIDS expressed strong moral discourses which sought to link HIV to sexual promiscuity, with religious leaders emphasizing fidelity and self-discipline, to their congregation (Frederiks, 2011:118). If an individual is living with HIV/AIDS, it is argued that his or her religion (be it Islam, Christianity or Hinduism) or religious beliefs may shape his or her outlook on living with HIV/AIDS and in doing so, their faith practices can or may provide peace, hope and to help them prepare for and accept their death (Zou *et al.*, 2009).

In Hinduism, there is no one view of sexuality and for every view revealed in the traditional texts, there were equally valid counterviews (Mehta and Pramanik, 2010; Krishnamurthy, 1994). Traditional Hindu culture largely celebrated sexual openness and this is evident in texts which discussed sexuality such as *Kama Sutra* (Mehta and Pramanik, 2010). In India, where Hinduism originated, the emergence of HIV/AIDS was met with intolerance and it was considered a 'foreigner's disease' and early responses to HIV/AIDS were accompanied by appeals for the country to return to its pristine values (Mehta and Pramanik, 2010). Abstinence is considered a virtue in Hindu cultural and religious scripture (Nag, 1995:302). In Hindu literature, explanations which argue that HIV/AIDS is considered a punishment from God is not apparent and such literature instead emphasized individual behaviour as an explanation. Raman (2003) has suggested that according to Hinduism, not all diseases which afflict humankind are the result of some higher power but instead explains that they are the result of human weakness and it followed that HIV infection was clearly a direct consequence

of human excess and transgression (Manda, 2011:204). Hinduism did not attribute HIV/AIDS directly to God as was the initial response by the religious leaders and literature of Islam and Christianity; it did understand that the epidemic was the result of a direct consequence of improper sexual behaviour (Manda, 2011:204).

Like Christianity and Hinduism, all aspects of adhering to an Islamic way of life serve to develop the human personality in all its dimensions towards the perfection of the individual on one hand and to encourage the development of a harmonious society on the other (Amod, 2006:58). Muslims should not discriminate against PLWHA, but are duty bound to visit, pray for or assist them financially to receive antiretroviral treatment (Amod, 2006; Ebrahim, 2007). Islamic caring perspectives require that Muslims should not discriminate against or judge PLWHA and instead, they should exercise mercy and compassion towards them despite their beliefs, race, ethnic affiliation, social status or wealth (Manda, 2011:208).

Retributive and compassionate were the two main views of AIDS, the former assumed that AIDS was a punishment from God and the latter explained that Islam is a religion of compassion and mercy (Mukadam, 2013:9). This latter view recognizes that we have a pandemic and emphasizes the focus on our responsibility towards those in need, regardless of their lifestyle choice (Mukadam, 2013). By highlighting the merciful and compassionate attributes of God, Islamic, Hindu and Christian religious organizations and individuals may encourage their congregants to reflect on these attributes and to be critical of followers that do not have a positive attitude towards PLWHA (Lala, 2007:80). There are similarities between the three religions of Christianity, Hinduism and Islam; in that it is regarded as a pandemic by all three religions, and that the focus should be on our responsibility toward those living with HIV/AIDS, by helping, aiding and not condemning them. The difference was that, at its onset, Hinduism saw HIV/AIDS as a direct consequence of human behaviour, in that it did not view HIV/AIDS as a divine retribution, as was the response by Islam and Christianity as an explanation for the origin of HIV/AIDS in their respective communities.

The section looked at the literature review of the thesis with focus on Christianity, Hinduism and Islam. It also looked at the response of these three religions to HIV/AIDS.

## **2.4 Theoretical Framework**

### **2.4.1 Stigma**

In saying that someone has a disease or is diseased, implies that they are less whole, functioning, or worthy than 'normal' people. Consequently, all chronically ill persons must struggle against stigma (Weitz, 1990:37). No other physical illness in American society carried a stigma as severe as AIDS (Weitz, 1990:37). People may believe that diseases such as herpes or leprosy were considered a divine punishment for sin; far more believed and viewed AIDS as a divine punishment (Weitz, 1990: 37). The stigma of AIDS is reflected in the fact that it was considered contagious, deforming, fatal, imperfectly understood, and associated with already stigmatized groups (Weitz, 1990; Weitz, 1989). To avoid stigma, PLWHA do not disclose their illness if it is invisible or would mask signs of the illness if they are seen, may lie about signs if they could not be masked and would seek to minimize contact with those who may reject them should their illness become known. PLWHA may reveal their illness and either challenge their detractor's theological and biological assumptions or ask forgiveness for former deviant conduct. In doing so, PLWHA can limit the impact of illness on their social lives (Weitz, 1990:37).

Stigma is defined as an 'attribute that is significantly discrediting' (Goffman, 1963) and an attribute used to set the affected person or group apart from a normalized social order, and such separation implies devaluation (Gilmore and Somerville, 1994). Goffman (1963) identified three types of stigma; (1) there are abominations of the body, the various physical deformities; (2) blemishes of individual character perceived as weak will, domineering or unnatural passions, treacherous and rigid beliefs, and dishonesty inferred from a known record of examples such as mental disorder, imprisonment, addiction, alcoholism, homosexuality, unemployment, attempting suicide and radical political behaviour and (3) tribal stigmas of race, nation and religion, stigmas that could be transmitted through lineage and may equally contaminate all members of a family (Goffman, 1963:14). Stigma creates 'difference' and social hierarchy and then in turn legitimizes and perpetuates social inequality (Skinner and Mfecane, 2004:158).

Rintamaki *et al.* (2006:360) argued that the anxiety or fear of being stigmatized defines a person's concern for HIV stigma (Rintamaki *et al.*, 2006; Gilbert and Walker, 2010). Stigma concerns are informed by (1) understandings of and attitudes towards both HIV and PLWHA;

(2) perceptions of other people's attitudes towards HIV and (3) experiences with expressions of fear, bias or discrimination directed at one's self or other PLWHA (Rintamaki *et al.*, 2006). Consequently, stigma concerns may affect behaviour (Rintamaki *et al.*, 2006:360). The fear of discrimination has been shown to create problems for disclosure, since disclosure has the common reaction of rejection and leaves the person with HIV feeling lonely (Skinner and Mfecane, 2004:162). Discrimination and stigma have implications for implementing preventative efforts and reduces the possible impact of such interventions (Skinner and Mfecane, 2004:162). Behaviour such as condom use came to signify the epidemic and led to the possible rejection of those who used them. Many South African youth were scared to use a condom due to its felt implications. Options of being faithful could be stigmatized. In communities where having many partners is viewed as a sign of success, a person with one partner may feel marginalized (Skinner and Mfecane, 2004:162).

Stigma that is based on the fear of infectivity and the potentially terminal nature of HIV has been called 'instrumental' stigma by authors such as Herek and Capitano (Stein, 2003:97-98) who argued for a distinction between 'instrumental stigma', which arises from utilitarian self-interest and 'symbolic stigma' which arises from value based ideology (Stein, 2003:98). Distinguishing between instrumental and symbolic stigma suggests that stigma which results from the concerns of the uninfected regarding their own material wellbeing is related to a different set of causal factors from stigma that is based on adverse social or moral judgments (Stein, 2003:98).

Symbolic stigma (stigma based on moral condemnation regarding sexual behaviour) can be instrumental, albeit only psychologically (Stein, 2003:98). It is instrumental because it serves to distance the individual or group from the fear of infection by facilitating the denial of one's own risk; seeking to give a sense of invulnerability and is a response to an imminent threat which is designed to control anxiety (Stein, 2003:98). Stigma is a psychological defence mechanism which serves to control anxiety in the face of danger (Stein, 2003:98), serving the functional need of what Finchilescu (2002) called the 'observer at risk' by allowing the minimization of anxiety but without the discomfort of changing behaviour. Stein (2003) argued that if HIV/AIDS stigma did not diminish, but became another 'dirty secret', the question arises, for researchers and campaigners is how to measure a hidden truth (Gilbert and Walker, 2010:145).

Stigma has theological and ethical implications and theological thinking may be a subconscious driver of discriminatory structures, attitudes or actions (Paterson, 2011: 351). People tend to be blind to the stigmatizing beliefs and attitudes they hold or are common to their social, cultural or institutional context. It is easy to perceive other people's beliefs and attitudes as stigmatizing, one's own may tend to look self-evidently true, for example, beliefs about gender roles or sexual orientation (Paterson, 2011: 351). Because HIV is an infectious virus, societies found it necessary to place the blame for it on others (Paterson, 2011: 359). The virus comes into society externally and we hear stories about HIV entering from outside into a culture and the need to document the foreign source of its origin (Paterson, 2011: 359).

Susan Sontag and Peter Allen (cited from Paterson, 2011: 359) describe this scenario; those who are economically or socially marginalized in any society are often those most at risk of acquiring HIV infection, such as, drug abusers and needle sharers, prostitutes, having homosexual sex, heads of families forced to move to seek employment and those at home waiting for them and women and girls engaging in sex with older or richer men to support their children, family or school fees (Paterson, 2011: 359-360). Associating HIV with such groups reinforces links between disease and sin and in making such associations, one who suffers from an illness such as leprosy; syphilis or HIV/AIDS, deserves it (Paterson, 2011: 360). Since the condition in most cases is presumed to be one's own fault, it may not merit a sympathetic response (Paterson, 2011: 360).

Alonzo and Reynolds (1995) and De Bruyn (1999) identified four factors related to HIV stigma (Visser *et al.*, 2006:44): (1) HIV/AIDS is a life-threatening disease, perceived as contagious and threatening to the community. The disease is not well understood, which results in the fear of contracting HIV; (2) PLWHA are responsible for contracting the disease, which increases attribution of guilt; (3) HIV/AIDS is related to behaviour unsanctioned by religious and moral beliefs, which result in perception that it is the result of deviant behaviour and deserves punishment, and (4) HIV/AIDS is associated with pre-existing social prejudices such as sexual promiscuity, homosexuality and drug abuse, behaviours considered 'less worthy' in many societies, it also adds to existing societal judgment (Visser *et al.*, 2006:44); (Parker and Aggleton, 2003; Paterson, 2011; Scambler, 2009).

Stigma is a social process, experienced or anticipated, characterized by exclusion, rejection, blame or devaluation that result from experience, perception or reasonable anticipation of an

adverse social judgment about a person or group (Weiss, Ramakrishna and Somma, 2006:280). Such judgment is based on enduring features of identity conferred by a health problem or health related condition and is medically unwarranted. In addition to application to a person or group, discriminatory social judgments may be applied to the disease or designated health problem itself with repercussions in social and health policy (Weiss, Ramakrishna and Somma, 2006:280). Other forms of stigma which result from adverse social judgment about the enduring features of identity apart from health related conditions (race, ethnicity and sexual preference) may also affect health. These are matters of interest that concern questions of health related stigma (Weiss, Ramakrishna and Somma, 2006:280).

Discussions of stigma, particularly its relationship to HIV/AIDS took Goffman's (1963) work as its point of departure, who defined stigma as an attribute that is 'significantly discrediting' which in the eyes of society serve to reduce the person possessing it (Parker and Aggleton, 2003:14). Goffman argued that stigmatized individuals possessed an 'undesirable difference' (Goffman, 1963). Society conceptualizes the basis of what constitutes this 'difference' and 'deviance' is applied by society through its rules and sanctions which results in a 'spoiled identity' for the person concerned (Parker and Aggleton, 2003:14). While reference to stigma and stigmatization in work on HIV/AIDS acknowledge Goffman and his work as intellectual precursors, discussing discrimination is rarely framed in reference to any theoretical tradition (Parker and Aggleton, 2003:16). The *Oxford Dictionary of Sociology* stipulates that the concept meant 'treating unfairly' and its use occurred commonly in sociology in the context of theories of ethnic and race relations (Parker and Aggleton, 2003:16).

Early sociologists viewed discrimination as an expression of ethnocentrism, in other words, it meant a cultural phenomenon of 'dislike of the unlike' (Marshall, 1998). Parker and Aggleton (2003: 17) argue that stigma and stigmatization take shape and come about in specific contexts of culture and power. Stigma has a history which influences its appearance and form (Parker and Aggleton, 2003: 17). Understanding this history and its consequences for affected individuals and communities can help us develop better measures for addressing and reducing its effects. It is important to better understand how individuals, communities and states use stigma to produce and reproduce social inequality (Parker and Aggleton, 2003: 17). To recognize how understandings of stigma and discrimination in such terms encourage a focus on the political economy of stigmatization and its link to social exclusion (Parker and Aggleton, 2003: 17). For HIV/AIDS stigma to exist, a person is identified as having HIV/AIDS, negative stereotypes are then associated with this label which might lead to some

form of social distancing, status reduction and discrimination (Maughan-Brown, 2004: 2). Forming such negative stereotypes occurs when dominant cultural beliefs link labelled persons to undesirable characteristics (Link and Phelan, 2001).

AIDS is socially constructed to happen to those who 'do not behave', and is passed on to innocent wives and children (Rutledge *et al.*, 2009:29). PLWHA suffer status loss and individual and institutional discrimination perpetuated by multiple levels of power holders, including religious leaders, neighbours, and health service providers (Link and Phelan, 2001). Religion seemed to be a central force behind stigma, at least in their experiences in Grenada and Trinidad and Tobago (Rutledge *et al.*, 2009: 30). Providers were neighbours, relatives, and Church members rather than simply detached medical professionals. It was social constructions of HIV/AIDS as a punishment from God and reference to homosexuality as immoral that may give licence to providers to act badly toward PLWHA. AIDS stigma may be a response to a professional obligation to uphold the moral order and defend 'what is most at stake... in a local social world' (Yang *et al.*, 2007: 1525).

HIV/AIDS carries a high level of stigmatization (Herek, 1999; Yang *et al.*, 2007; Liamputtong *et al.*, 2009). Firstly, those who are infected are assigned blame for their condition and many believe that HIV can be avoided if individuals considered making better moral decisions. Secondly, although AIDS is treatable, it is progressive and incurable, this is more so in countries such as South Africa where 28% of those needing treatment have access to it (WHO, 2008). Thirdly, HIV transmission is poorly understood by some people in the general population, causing them to feel threatened by the mere presence of the disease (Moller and Erstad, 2007) and fourthly, HIV infection is asymptomatic and can be concealed. The symptoms of an AIDS-related illness cannot and may be considered repulsive or disruptive to social interaction (Herek, 2002). Drawing a conclusion, Gilbert and Walker (2010:140) argue that the HIV/AIDS body is one that is highly stigmatized.

Rohleder and Gibson (2006:40) found that once receiving an HIV-positive diagnosis, their participants incorporated into their sense of self, social discourses of HIV as dangerous, dirty and contagious. Positive and empowering social discourses around HIV/AIDS do exist. However, individuals drew on negative, more damning, social discourses when first diagnosed. Such discourses spoil an HIV-positive individual's identity and it is difficult for respondents to manage this 'spoiled identity' in a lived social context (Rohleder and Gibson,

2006:40). Despite attempts to fend off stigma and stigmatization, their narrative reveal social discourses around HIV as dirty, deviant, dangerous and as a punishment. They drew upon and internalized these discourses to create a 'spoiled identity' (Rohleder and Gibson, 2006:40). Many struggled with these notions and defended against the anxiety it caused by splitting off such bad representations and projecting them onto 'others' who were then represented as 'bad' (Rohleder and Gibson, 2006:40). Those who did not test nor knew their status represented the 'bad', deviant 'other' (Rohleder and Gibson, 2006:40).

Other means of defence was to split experiences of themselves into a 'bad' and 'sick' past self and a 'good' and 'healthy' present self on anti-retrovirals. The deviant 'other' are those who have not cared for their health. In this way, the undesirable aspects of illness and being 'unhealthy' were located in 'others' who did not care for their health, enabling respondents to hold on to a sense of a 'good', 'healthy' self (Rohleder and Gibson, 2006:40). On the surface, respondents felt that there was little stigma in their community, but an analysis of narrative experiences, however, reveal highly stigmatized individuals, struggling to defend against the negative notions they constructed of themselves. Those who receive stigma cannot be held responsible for protecting themselves. The real challenge is to alter powerful and negative social discourses that surround HIV/AIDS (Rohleder and Gibson, 2006:42).

Defining stigma as something resulting in discrimination reduces the analytical clarity about the relationship between stigma and its effects and there are reasons for this (Deacon, 2006:421): (1) anybody can stigmatize, regardless of social position. Poor and marginalized groups can stigmatize wealthier and powerful groups, both within and between societies (Joffe, 1999). Stigma can remain a problem because it may result in people feeling protected from the risk of contracting a specific illness through membership of their in-group, and therefore may not practice preventive measures, such as, condom use as in the case of HIV/AIDS (Deacon, 2006:421); (2) even if active discrimination is absent, stigma can still negatively impact the self-concept and actions of those stigmatized. Expecting to be stigmatized or discriminated against may change people's behaviour, causing social withdrawal and consequent disadvantage (Deacon, 2006:421) and (3) stigmatization does not always lead to disadvantage for the stigmatized and can be challenged. Activist groups such as the Treatment Action Campaign, with its 'HIV-Positive' slogan, directly challenged stigma around HIV and the consequent lack of attention to issues of treatment. Under certain

contexts, people may gain a status if they decide to ‘come out’ about a stigmatized characteristic and become legitimate spokespeople for minority or marginalized groups (Deacon, 2006:422). A stigmatized status may form the basis for a minority group identity and establish their legitimacy in lobbying for state recognition (Berbrier, 2002).

Treating HIV/AIDS as a medical condition, which includes providing anti retrovirals (ARV) may reduce the stigma ascribed to PLWHA (Simbayi *et al.*, 2007:1830). Reducing AIDS stigma at a societal level will impact internalized stigma which are magnified in PLWHA (Simbayi *et al.*, 2007:1830). For Deacon (2006:422) stigma always results in blaming, shaming and status loss for the stigmatized person or group, at least for the stigmatizer, but need not result in discrimination in order to have a negative effect. She argues that such effects may include (a) status loss, (b) discrimination and (c) the internalization and failure to take advantage of social, economic and healthcare opportunities because of expected discrimination and stigma (Deacon, 2006:424). Indirect effects of stigma such as internalization and fear of stigmatization are important in reducing PLWHA access to health services and receiving a better quality of life (Deacon, 2006:424).

Associating AIDS with death has implications at the level of theory and practice. Deacon pointed to a serious imbalance in the HIV/AIDS literature. While researchers did examine ways in which people view and speak about sex and sexuality, very few explored the construction of AIDS related sicknesses (Niehaus, 2007:860). They remained silent about disturbing aspects of AIDS, which is where the stigma presides. Constructing AIDS as an incurable, untreatable condition accounted for people’s inclination not to get a HIV test or use ARV (Niehaus, 2007:860). Constructing it as an infectious but manageable chronic disease akin to high blood pressure and diabetes than to illnesses such as leprosy is essential to destigmatize it. Hope can be an important incentive for practicing safer sex, going for HIV tests and using ARV’s (Niehaus, 2007:860). Career patients can play an important role. In Bushbuckridge, he found that campaigns in which healthy PLWHA addressed teachers unions were more successful than fire and brimstone sermons about sexual abstinence during AIDS awareness classes at school (Niehaus, 2007:860).

#### **2.4.2 Biographical disruption**

Biographical disruption has been a leading framework for the study of the experience of chronic illness (Bury, 1982). It first implies that a person’s stock of knowledge of self and social world is disrupted by the experience of the illness (Felde, 2011:102). Second, it

suggests that explanatory frameworks normally used for understanding daily living are disrupted and requires a rethinking of biographical particulars (Felde, 2011: 102). Third, implication is related to the mobilization of resources in face of the altered circumstances of chronic illness. Mobilizing cognitive, material and practical resources to repair the biography and maintain everyday life is the adaptive response to the disruption (Felde, 2011: 102). Bury contended that illness and especially chronic illness is precisely that kind of experience where the structure of daily life and the form of knowledge underpinning it is disrupted (1982: 169).

Chronic illness involves recognizing pain, suffering and possibly death, normally seen as distant possibilities or the plight of other people. It might bring individuals, their family and wider social network face to face with the character of their relationships in stark form; this disrupts the normal rules of reciprocity and mutual support (Bury, 1982:169). While reviewing 'research and prospects' Bury (1991:453) tried to work out the concept of biographical disruption by taking into account the context, a notion missing till then: 'the notion of biography suggests that meaning and context in chronic illness cannot be easily separated' (Bury, 1991:453). By placing chronic illness in a social context, attention can be turned to factors such as social policy, patient's associations, charitable organizations, consumerism and the mass media (Bury, 1991).

Disruptions in biography were, at one and the same time, disruptions of social relationships and the ability to mobilize material resources (Bury, 1982:180). Medical and lay knowledge about disease and illness do enter these fields, but the warrantability of a person's changed behaviour, through chronic illness is also determined by other factors (Bury, 1982:180). Little is known about the 'limits of tolerance' within the family and workplace and how they may vary between different settings and social groups. Disrupting reciprocity, problems in legitimating changed behaviour and the overall effects of stigma associated with chronic illness may affect the individual's ability to mobilize resources to their advantage (Bury, 1982:180). Conversely, he stated that the variability in resources between different social groups affect these processes (Bury, 1982:180). Illsley (1980) pointed out that processes involved in the interaction between wider social structures and the experience of ill health, within specific cultural and familial contexts were poorly understood. Biographical disruption and the interplay of lay and professional modes of thought are contributions to tackling that problem (Bury, 1982:180).

Pierret (1992: 72) argued that being HIV positive placed much of one's life under a sign of uncertainty. It leads a person to think that they are experiencing a state with which others could not empathise. Such uncertainty as well as difficulties of understanding what it meant to be an HIV positive person, was reflected in talking about the condition and saying things such as 'I am HIV positive', 'I am infected', 'I am a healthy carrier', 'I am carrying the virus', 'I am biologically concerned' and 'it' (Pierret, 1992: 72). Being infected with HIV is not the same as having AIDS; however, it does mean that those infected will eventually come down with a fatal disease. No medical prognosis can predict when they will fall ill (Carricaburu and Pierret, 1995: 66). Consequently, asymptomatic HIV-positive persons must manage an apparently healthy life in conditions of uncertainty (Carricaburu and Pierret, 1995:66).

Life as an HIV-positive person means that a person's private experience as an infected individual becomes a part of the collective experience of an infectious illness associated with ideas of contagious diseases and epidemics (Carricaburu and Pierret, 1995). Given how HIV is transmitted, such individuals may come from groups with their own collective history, such as haemophilia and homosexuality (Carricaburu and Pierret, 1995). The way in which people are able to cope with chronic illness conditions and how they manage daily life is bound up with interpretations they develop about the meaning of their illness condition, this holds more in the case of HIV-positive individuals, whether they are asymptomatic carriers or stricken with AIDS (Carricaburu and Pierret, 1995).

AIDS and its consequences for daily life raise problems that are faced by the chronically ill generally: that is, dealing with uncertainty, coping with stigmatization, managing the illness trajectory, doing biographical work and recomposing a sense of identity (Carricaburu and Pierret, 1995:86). Such research helps us better understand what it means to live with uncertain prognoses and handling its consequences for daily life (Carricaburu and Pierret, 1995:86). To be HIV positive is not just a matter of being infected individually, it is a question of being affected as part of a group which has its own history and one that has been affected and decimated by AIDS (Carricaburu and Pierret, 1995: 86). By observing the evolution of AIDS and its collective impact, we can advance our understanding, on one hand, of relationships between micro and macro levels of social analysis and of feedbacks between individual experience, cultural factors and macro-social structures on the other (Carricaburu and Pierret, 1995:86-87).

Disclosing to family and friends, and joining a group of people infected by HIV, are acts or processes that follow the biographical disruption caused by the knowledge of infection, when the structures of daily life become disjointed by the awareness of the chronic condition (Seeley *et al.*, 2012:335). Knowledge of infection is ‘a critical event that may entail extensive and all-pervading changes in a person’s life’ (Asbring, 2001:313). Such changes may take time and may not be welcomed. Renegotiating an identity or identities requires what Corbin and Strauss (1985) termed ‘biographical work’: the reconstruction of the affected person’s narrative of their life. Through the experience of people who have faced HIV-related biographical disruption at least twice, once when they acquired the identity of someone living with HIV and later when they found that they were HIV negative. These authors explored how individuals may manage such experience and their reworking of the private and social dimension of their identity (Seeley *et al.*, 2012:335).

People who rebuilt their lives while on antiretroviral therapy (ARV) or after learning their HIV-negative status may face similar challenges of re-establishing their self-worth in the face of public scrutiny of their behaviour (Seeley *et al.*, 2012:341). Reconstructing an HIV negative identity may be undertaken amidst a real uncertainty about whether that new status was really true. Joining the AIDS Support Organization (TASO), an ‘illness community’ of people living with HIV, signalled a confirmation of their HIV-positive identity (Roth and Nelson, 1997); the public acknowledgement of what, for some, might have been a long-standing personal belief that they were HIV positive. The strain of managing the transition to living with HIV was considerable, with worries surrounding what might happen to children and other family members after their death, compounded by the way they were treated by some people because of their status (Seeley *et al.*, 2012:341). TASO provided a setting for publicly managing this new identity, the social biographical work as they remoulded their self-image as someone who is HIV positive. After gradual incorporation into TASO and the safety and reassurance gained from attending clinics and receiving food and medication and their exit when they were told that they were HIV negative seemed abrupt, was seen as a form of dismissal (Seeley *et al.*, 2012:341-342).

Those who had their HIV status reversed knew that their HIV-negative status could be temporary if they contracted an infection from a new sexual partner (Seeley *et al.*, 2012:342). However, in the face of such uncertainty embarking on a new, transformed life, constructing a new identity, would demand considerable work in the personal dimension unsupported by

public scrutiny and a discourse which may continue to consider them as HIV positive (Seeley *et al.*, 2012:342). It was ironic that in some ways such transformations were easier to accomplish for people taking ARV, supported by TASO, than for people who tested unexpectedly HIV-negative and found themselves alone with their new status, sometimes fearful to disclose because of disbelief in their test result or fear that people may not believe that they are HIV-negative (Seeley *et al.*, 2012:342).

Respondents found disclosing themselves as HIV-negative was difficult to do. Special counselling and support is needed to help such people cope with their situation (Seeley *et al.*, 2012:342). Managing the disruptive event and learning of a negative test result is borne privately. Not only may such people feel unable to confide in family and friends but may face the loss of social relationships formed out of their former HIV-positive identity (Seeley *et al.*, 2012:342). Consequently, their ability to mobilize social resources was limited. This was in contrast to the social resources they could access through TASO, during their period of biographical revision when they thought they were HIV-positive (Seeley *et al.*, 2012:342). Therefore, this identity 'reversal' was handled by the individual as part of a continuing human struggle associated with having lived with a socially fatal illness experience (Alonzo and Reynolds, 1995). Being HIV positive is not just a matter of being infected individually, it is a question of being affected as part of a group with its own history and decimated by AIDS (Carricaburu and Pierret, 1995:86). Managing the loss of self, identity and sense of belonging to a stigmatized group requires considerable biographical work to manage the new identity in the face of self and public doubt (Seeley *et al.*, 2012:342).

Initial formulations of biographical disruption emphasized the assault of illness on a previously held and often cherished conception of self and life course, prompting a fundamental re-thinking of a person's biography and self-concept (Bury, 1982:169) in light of the illness (Wilson, 2007:622). Biographical disruption emphasizes a fundamental re-formulation of a key identity in the light of illness, and focuses greater attention on the critical nature of identities threatened by illness (Wilson, 2007:623). The experience or fear of HIV-related stigma has previously been analysed as a form of biographical disruption (Doyal and Anderson, 2005; Green and Sobo, 2000). The conceptualization of biographical disruption as employed by Wilson (2007) suggests that the importance of greater focus on relationships between identity and illness, rather than only effects of illness on identity,

which has implications for recent critique of Bury's concept and for research into the experience of illness more generally (Wilson, 2007:623).

Recent work on biographical disruption called for greater attention to be paid to the timing and context of chronic illness, and notably the age (Pound *et al.*,1998) and previous experiences of hardship (Ciambrone, 2001), including the illness (Faircloth *et al.*,2004), of the person affected (Wilson, 2007:623). Respondents did not see their condition and its implications in individualistic terms. However, in contrast, illness effects were explored with respect to aspects of life which reflected the concern and priority of single individuals (Wilson, 2007:624). Biographical disruption was based on interviews with recently diagnosed young women living with rheumatoid arthritis, of which many of whom were mothers (Bury, 1982). His analysis took an individual approach with focus on the effects of illness on work-related, rather than on caring, responsibilities (Wilson, 2007:624).

Wilson's (2007) study was similar to that of Young *et al.* (2002) which examined the effects on mothers of a potentially terminal illness (HIV) in a child, and suggested the limitations of using such individualistic approaches. It pointed to the importance of incorporating 'cognitive and emotional significance' (Bendelow and Williams 1995:150) of motherhood and of caring responsibilities more generally into sensitive explorations of the effects of illness and interest in identifying further key identities through which illness experience may be refracted (Wilson, 2007:624).

Ciambrone (2001:535) found that upon diagnosis, women experienced feelings of despair. They described threats of premature death and barriers to intimacy as among the disruptive effects of HIV/AIDS. As they recounted living with HIV/AIDS, many concluded that the illness was not the most disruptive event in their lives thus far. When the lives of women were contextually situated, we are afforded insight into how women living with HIV/AIDS interpreted their illness (Ciambrone, 2001:535). Professionals treating women with HIV/AIDS could not adequately address the health and social needs of this population without giving attention to their social milieu and needs. There are commonalities across their experiences but to treat them as homogenous interferes with optimal carer and service provision (Ciambrone, 2001:535). She found that the theory of biographical disruption may be less applicable to many women with HIV infection since it implicitly assumes that illness enters lives untouched by crisis (2001:536). The disruption framework appeared to be time

bound and was more useful for certain points along an illness trajectory. However, we can adapt the elements of biographical disruption, for example, changes in meaning systems and identities to investigate how women with HIV/AIDS interpret their life circumstances, especially in the illness's early stages. Knowledge of these processes further our understanding of women with HIV but also highlights the illness experience of other illness populations. Paying attention to the social milieu in which disruption and repair occur is critical to developing effective treatment protocol and preventative efforts optimally suited to the needs of women (Ciambone, 2001:536).

Biographical disruption due to illness extends beyond the affected individual, because the experience of illness is not bound by the bodies or consciousness of those who are ill. It reaches to encompass a household, family or a social network (Chisaka and Coetzee, 2009:111). Their study aimed to show the disruptive effects of chronic illness on concepts of the self and social relationships. Using the concept of 'biographical disruption' (Bury, 1982) and 'loss of self' (Charmaz, 1983), which were applied to relatively well-off individuals living in Western communities, it attempted to show that such concepts may be useful in understanding the lived experience of chronic illness among non-Westerners living in poverty (Chisaka and Coetzee, 2009).

Deplorable living conditions make the suffering worse for the chronically ill and the poor, but at the same time cushion the existential or ontological assault on selfhood brought on by chronic illness (Chisaka and Coetzee, 2009:125). It is for this reason that many individuals on the margin of society, especially in rural Sub-Saharan Africa defined poverty as their primary concern above all others, including HIV risk (Chisaka and Coetzee, 2009:125). How does one tease out 'biographical disruption' that results from chronic illness suffered among the chronically poor? The answer is multifaceted because it involves a complex interplay of illness and poverty narratives (Chisaka and Coetzee, 2009:125).

Using the concepts of 'biographical disruption' and 'loss of self' (Charmaz, 1983) can be powerful interpretational tools for understanding individuals, specifically women, infected and affected by AIDS, whose voices are often drowned in poverty and whose illness narratives are sidelined in social research (Chisaka and Coetzee, 2009). An unintended consequence of focusing on 'biographical disruption' due to illness among the poor, instead of the disruptive effects of chronic poverty, offer a critique of Western understanding of the

experience of chronic illness (Chisaka and Coetzee, 2009). Studies show that chronic poverty and chronic illness are intricately linked (Baylies and Bujra, 2000; Chisaka, 2007; Ciambrone, 2001). By contrast, wealth and chronic illness are not necessarily experienced or interrogated in a similar manner. For the wealthy, making sense of their chronic illness experience, was centred on issues of ill health and not on other living conditions (Chisaka and Coetzee, 2009:126). For them, previously held notions of an ontologically secure self-identity were reconstructed or reconceptualised mainly in light of the illness (Chisaka and Coetzee, 2009:126). Although studies show that ‘narrative reconstruction’ (Williams, 1984) or ‘narrative reconfiguration’ (Kleinman, 1988), involve an interrogation of a wealthy individual’s broader life, focus is mainly centred on self-concepts or identity. Therefore, ‘loss of self’ (Charmaz, 1983) due to a chronic illness compounded the suffering inherent in illness experiences. It is argued that an individual’s wealth and Western worldview do not cushion the devastating impact of chronic illness on selfhood in a similar way that poverty and an African or Indian worldview do (Chisaka and Coetzee, 2009:127).

Williams (2000:49) argued that as a concept, biographical disruption was predicated on an adult-centred mode of illness. The bulk of chronic illness fell in the middle to later years of life and most sociological studies tended to reproduce this picture. Biographical disruption, in such contexts, became an apposite term, denoting the shift, gradual or imperceptible, from a ‘normal’ state of health to one of illness (Williams, 2000:49). In so doing, the question of conditions which one may have from birth or early childhood, such as congenital abnormalities or deformities, were neglected; conditions, from the inception of life, integral to the individual’s biographically embodied sense of self (Williams, 2000:49-50).

Struggles may occur and whenever the condition may emerge; this is compared to the socially set standards and cultural prescriptions of ‘normality’, in such a stance, these individuals’ lives may appear as being profoundly disrupted (Williams, 2000:50). He further argued that phenomenologically and existentially speaking, it remained the case that these biographies have not, in any real or significant manner, shifted (Williams, 2000:50). Continuity remained the guiding principle rather than change, with the inclusion of the important elements of ‘biographical confirmation or reinforcement’ (Williams, 2000:50); the adult centric transition from health to illness remained a problematic assumption on which much biographically-oriented research was based on (Williams, 2000:50).

## **2.5 Chapter Summary**

This chapter focused on the literature review and theoretical framework section of the thesis. It focused on studies done in an international, African and South African context and placed focus on the response of Christianity, Hinduism and Islam towards HIV/AIDS. It expanded on the theoretical framework used in the study and discussed stigma and biographical disruption. The next chapter looks at the research methodology of the study.



## CHAPTER 3

### RESEARCH METHODOLOGY

#### **3.1 Introduction**

This chapter focuses on the methodological framework of the study, the research design used in the study, the process of the selection of participants. It gives a detailed account of the research site and interview questions posed to participants. It addresses the ethical considerations of the study and ends by giving a summary of whole data collection process.

#### **3.2 Methodological Framework**

In the study I have employed qualitative methods to address the understanding, opinions and perceptions of participants about PLWHA. The research design indicates the overall framework for the empirical research which is to be undertaken (Babbie and Mouton, 2008:74). The nature of approach to this study is exploratory. Exploratory research is an attempt to determine whether or not a phenomenon exists (Dane, 2011: 81). Any question about the existence or nature of human behaviour, or lack thereof, is an appropriate question for exploratory research (Dane, 2011: 81). A qualitative research paradigm is relevant to social research which 'takes its departure point as the insider perspective on social action' (Babbie and Mouton, 2008:53). Qualitative researchers tend to collect data in the field at the site where participants experience the issue or problem under study; the information that is gathered, by actually directly talking to people and seeing them behave and act within their context is a major characteristic of qualitative research (Creswell, 2009:175). I choose to employ this methodology, because in the qualitative research process, the researcher keeps a focus on learning the meaning that the participants hold about the problem or issue, and not the meaning that the researchers bring to the research or writers express in the literature (Creswell, 2009:175).

The key idea behind qualitative research is to learn about the problem or issue from participants and to address the research to obtain that information (Creswell, 2009:176). Qualitative research is a form of interpretive inquiry, in which the researcher makes an interpretation of what they see, hear and understand. Their interpretation cannot be separated from their own backgrounds, history, context and prior understanding (Creswell, 2009:176). Such researchers also try to develop a complex picture of the problem or issue under study. This may involve reporting multiple perspectives, identifying the many factors involved in a

situation, and generally sketching the larger picture that emerges (Creswell, 2009: 176). A qualitative mode of enquiry has been undertaken because the aims of the research are to understand and describe rather than predict social action. The core of qualitative data enquiry is gathering information through observation, interviewing and analysing documents as well as material culture (Marshall and Rossman, 2006). Qualitative research uses a naturalistic approach which seeks to understand phenomena in context-specific settings such as in the real world, where the researcher does not attempt to manipulate the phenomenon of interest in any way (Golafshani, 2003:600). It is a type of research which produces findings which cannot be arrived at by means of statistical procedures or other means of quantification (Strauss and Corbin, 1990:17); it produces its findings from real-world settings where the phenomenon of interest naturally unfolds (Patton, 2002:39). Unlike quantitative researchers who seek causal determination, prediction, and generalization of findings, qualitative researchers seek instead illumination, understanding, and extrapolation to similar situations (Hoepfl, 1997).

### **3.3 Selection of the Participants**

In selecting the participants, I approached the Sheikh of the local mosque, the priest of the Hindu temple and two Christian Church pastors. I began by introducing them to the topic and nature of my research, explaining to them that I am a master's student at the University of the Western Cape. They informed their congregations of my study and this was how I had managed to obtain participants for my study. Participants were all residents of the Cravenby community and were from diverse backgrounds and varied in terms of age, the oldest being aged 70 and the youngest aged 15. A table is provided:

Name of Religion	Age of respondents	Gender of respondents	Total
Islam	18 – 56	4 males and 7 females	11
Christianity	15 – 70	6 males and 4 females	10
Hinduism	22 – 40	4 males and 5 females	9

The population of Cravenby amounts to 4185, according to the 2011 census (Frith, 2011). The total number of participants involved in the study amounted to 30 individuals. A purposive sample is one where people from a specified group are purposely sought out and sampled (Gerrish and Lacey, 2010: 149). Purposive samples have an over – representation of people or events of interest to the researcher. This means that they are not usually

representative of the whole population under study (Gerrish and Lacey, 2010: 149). Purposive sampling is used to justify the inclusion of rich sources of data that can be used to generate or test out explanatory frameworks (Gerrish and Lacey, 2010: 149). The sampling procedure used, was purposive sampling, it is a sampling technique which falls under non probability sampling. Non probability sampling is any technique in which samples are selected in some way not suggested by probability theory (Babbie, 2013: 199). Participants were chosen with regard to their religious adherence, namely, Christianity, Hinduism or Islam. Their occupations included teaching, pharmacists, university and school students, Church pastors, and committee members of the mosque, domestic workers, cobblers, shop assistants and financial services. Participants asked about the purpose of the research and what I was planning to do with the information they provided, this information was conveyed to them on information sheets and informed consent forms (Appendix A and B).

Interview locations were in a variety of places which included the two churches located within the community, which were done mostly at night, on Wednesdays just after 7pm as the Churches would hold sermons and there would be many Church congregants present with whom I would be able to conduct interviews with, prior to this, they were informed of my intentions. Muslim respondents were met at the mosque and upon presenting them with information about the study, a time was scheduled with them as to when to go to their homes to conduct interviews, a similar process was undertaken for Hindu respondents, who were also mainly interviewed at their homes. It was a new experience for me in that I have never entered the worshipping spaces of people of other faiths, upon entering the Church there were chairs in rows for the congregation to be seated and facing the pastor. Religious material such as Bibles placed on tables, pamphlets explaining various Biblical stories, a cross on the outer facade of the building and there were some differences from the mosque in terms of layout, such as minarets and carpets upon which worshippers pray. The Hindu temple was different in that it had five resident deities; it has an 'aum' symbol on the wall at the entrance into the temple. Worshippers must remove their shoes upon entering the temple and there is an aroma of burnt incense sticks. Muslims also remove their shoes upon entering the mosque, but I did not notice this at the Church.

I chose Cravenby because it is an area of which I am familiar with and I sought to ask respondents how much they knew about HIV/AIDS?; e.g. what their interactions with PLWHA would look like to them?; should PLWHA be treated with respect or face stigma?; do they regard HIV/AIDS as a problem that the community is facing?; is HIV/AIDS a subject

that they would discuss with their community, family or friends or to a wider public?; what are their views on their religion and its relationship with the disclosure of their HIV status?; is HIV testing something that is promoted by their religions?; these are questions of which I also thought about and I also asked personal questions such as are the religious beliefs which people may hold on to be responsible for stigmatizing PLWHA?; and lastly, I sought to ask if such religious beliefs would have an influence on their sexual behaviour?

### **3.4 Research area**

The research area, Cravenby, forms part of the northern suburbs of Cape Town and is surrounded by areas such as Parow, Goodwood, Elsies River, Ravensmead and Uitsig. It was classified as a formerly Indian area under the Group Areas act of the Apartheid regime (<http://www.wctf.co.za/cravenbycontacts.htm>). Presently, the community is a multicultural one with a population of around 4000 people. While Indians form the majority racial group within the community, there is a presence of foreign nationals from neighbouring countries as well as from Pakistan and India. The majority of Cravenby residents adhere to Islam and Christianity; a small percentage makes up Tamil, Gujarati, Hindi and Telegu speaking Hindus. It has a primary and high school, a community civic centre, a Mosque, two Churches and a temple called the Divine Cultural Centre or Shree Paraasakthie Aalayam which has five resident deities, they are Ganesha, Paraasakthie (Mother), Shiva (Lingam), Vishnu, and Muruga (<http://www.wctf.co.za/cravenbycontacts.htm>).

### **3.5 Method of data collection**

#### **3.5.1 Interviews**

In-depth interviews were used to gather information on resident's religious beliefs towards those who are living with HIV/AIDS (an interview schedule is provided on Appendix C). Questions were open-ended, however, they were not audio recorded, as most respondents were not willing to be recorded because of the nature and sensitivity of the topic. Notes and transcripts were recorded on A4 sheets of paper which were later typed. This allowed for all the information to be recorded, as it was dictated verbally, with pauses, for the researcher to write down and then allow the respondent to continue. The positives of the method, was that, as I was writing, the respondent was observing me writing their responses which ensured that the perspective is from their point of view and not of the researcher. The negatives of the method are that the respondents may give their own opinions and may not necessarily answer

the question at hand, owing to the sensitivity of the topic and the issues dealt with. I chose this method because, the interviews were conducted face to face as it is useful when the participant cannot be directly observed, and it allows the researcher, to have control over the line of questioning, with the respondent having the ability to provide the researcher with a response. Interviews were accompanied with an information sheet and an informed consent form which was provided to respondents informing them about the nature of the study, permission was first sought and then consent forms were signed by participants signalling their approval to be a part of the study (Parental consent forms, were also provided, for respondents younger than 18). Time limits for interviews ranged from 30 minutes to 60 minutes. The questions posed to participants were: What did they know about HIV/AIDS? Have they personally known PLWHA? How would they interact with PLWHA? Should those PLWHA be treated with respect, indignation or scorn because of how they have acquired the virus? Do the participants believe that HIV/AIDS is a problem in the Cravenby community? Do they discuss the issues of HIV/AIDS with other community members, amongst their family and friends or to the general or wider public? Supposing that they are diagnosed as being HIV positive, does their religion allow them to disclose their status? Does their religion promote HIV testing? Does their religion stigmatize PLWHA? And do their religious beliefs affect their sexual behaviour?

Content analysis is a research method that uses a set of procedures to make valid inferences from text. These inferences are about the sender(s) of the message, the message itself, or the audience of the message (Weber, 1990:9). Content analysis has several advantages which include: communication is a central aspect of social interaction. Content analytic procedures operate directly on text or transcripts of human communications and content analysis usually yields unobtrusive measures in which neither the sender nor the receiver of the messages is aware that it is being analysed. Therefore, there is little danger that the act of measurement itself will act as a force for change that confounds the data (Webb, Campbell, Schwartz and Sechrist, 1981; cited from Weber, 1990:10). A coding process was also used to analyse the data. Coding is the process of organizing material into chunks or segments of text before bringing meaning to information (Rossman and Rallis, 1998: 171; cited from; Creswell, 2009: 186). It involves taking text data gathered during data collection, segmenting sentences or paragraphs into categories, and labelling those categories with a term, which is often a term based in the actual language of the participants (called an *in vivo* term).

### **3.5.2 Trustworthiness of the study**

For Lincoln and Guba (1985), the principle of good qualitative research is found in the notion of trustworthiness: the neutrality of its findings or decisions (Babbie and Mouton, 2001:276). Credibility refers to the compatibility between constructed realities which exist in the mind of respondents and those that are attributable to them. Transferability refers to the extent to which the findings can be applied in other contexts or with other respondents. Qualitative researchers do not maintain or claim that knowledge gained from one context will necessarily have relevance for other contexts or for the same context in another time frame (Babbie and Mouton, 2001:277). In a qualitative study (such as this one), the obligation for demonstrating transferability rests on those who wish to apply it to the receiving context (that is, the reader of the study). Strategies for transferability include: *thick description*; because transferability in qualitative studies depend on similarities between sending and receiving contexts, the researcher collects sufficiently detailed descriptions of data in context and reports them, with sufficient detail and precision, to allow judgments about transferability to be made by the reader. In contrast to random sampling that is used in quantitative studies, qualitative research seeks to maximize the range of specific information that can be obtained from and about that context, by purposely selecting locations and informants that differ from one another. The location of the study was purposely selected, in that it is the community where the study sample was to be found. The informants differed from one another, in that they adhered to three different faiths and were of differing ages and gender (Babbie and Mouton, 2001:277). Dependability refers to providing the audience with evidence that if the study were to be repeated with the same or similar respondents in the same or a similar context, then its findings would be similar. Confirmability is the degree to which the findings are the product of the focus of the inquiry and not of the bias of the researcher (Babbie and Mouton, 2001:278).

### **3. 6 Ethical considerations**

The research has been based on moral and ethically sound principles in terms of its execution as the nature of such research is highly sensitive, personal and potentially controversial and it is of utmost importance that at every step, ethical procedures have been adhered to. Ethical approval was sought from the Postgraduate Board of Study and Senate Higher Degrees Committee of the University of the Western Cape. The anonymity of respondents has been guaranteed as false names have been used throughout the research. Participants were not

coerced or forced to participate in the research process and could withdraw from the study at any time. Interviews were completely voluntary and all information is treated as confidential. Individual privacy has been respected and no harm has been inflicted on them. Respondents were given informed consent forms clearly stating the nature of the research. In the case of minors, consent was obtained from their parents or guardians. Interviews only commenced once they were signed. These interviews were not audio recorded, as a majority of the participants had declined to be audio recorded. An information sheet, a research consent form, an interview schedule and a parental consent form have been attached as Appendix A, B, C and D. These measures of scientific integrity were respected by the researcher as stipulated by Babbie and Mouton (2001: 526-528); (a) that he did not forge the data and reported on something which did not exist or did not reflect what has been done; (b) the researcher avoided plagiarism by presenting his own work and ideas; (c) the relevant literature sources were consulted and referenced and all respondents who made a contribution to the study have been acknowledged; (d) he did not distort the findings in order to support a preconceived view, and (e) the research participants were not influenced in their responses to support views held by the researcher (Babbie and Mouton, 2001:526-528; cited from <http://uir.unisa.ac.za/bitstream/handle/10500/1799/03chapter3.pdf>).

### **3. 7 Chapter summary**

The chapter discussed the research design of the study, selection of participants and their demographic information, a delineation of the research area, use of in depth interviews. The research questions asked of respondents was included and the ethical considerations of the research were also discussed. The next chapter looks at the data findings and analysis of the study.

## CHAPTER 4

### DATA FINDINGS AND ANALYSIS

#### 4.1 Introduction

This chapter discusses the findings and analysis of the study. The method of analysing the data is by means of content analysis.

#### 4.2 Findings of the study

##### 4.2.1 How much do you know about HIV/AIDS?

**Muslims:** Most respondents (ten out of eleven) have a good understanding about HIV/AIDS and its dangers and are aware of how it can be contracted, prevented, it is incurable but treatable. Responses include: *'HIV/AIDS is currently incurable; however, there are treatments that exist to counteract the symptoms'* (Eesa, 19). *'About 80%, the basics, like how it is contracted and how it can be prevented'* (Mishkah, 18). *'My knowledge is extensive. I spent 12 years at school learning about HIV/AIDS at life orientation classes. Thereafter, during my first year at university, I had a module which comprised of a unit that focused on HIV/AIDS and law. Furthermore, I did a first aid level 3 course which taught us about the importance of protecting oneself from HIV/AIDS when dealing with patients'* (Zakkiyah, 22); *'I am a pharmacist and therefore I have a broad knowledge on HIV/AIDS'* (Bashiera, 26).

Some respondents mentioned that they knew *'about 50% about HIV/AIDS'* (Habieba, 46). *'I know enough about HIV/AIDS to protect myself'* (Rashieda, 24); *'not a lot, only the basics'* (Irfaan, 21); *'not much, I know it is a sexually transmitted disease, I know it can be transmitted through infected blood, sharing needles or syringes and that there is no cure for it'* (Ahmed, 27). Or, as one respondent said: *'I do not know very much'* (Ashieq, 54). They express awareness of the consequences posed by HIV/AIDS such as realizing that PLWHA may die from opportunistic infections or might transmit the virus to others. *'HIV/AIDS is blood contaminated with a virus, which if transmitted into people, can result in that person contracting HIV/AIDS. It can be contracted through sexual relationships with an infected partner. Used contaminated needles can infect people. HIV/AIDS can be transmitted from a mother to her child through childbirth in which case the baby has to be treated with antiretrovirals'* (Naseema, 56).

**Christians:** All respondents (ten respondents) knew about HIV/AIDS. They were aware that it is a big problem, it is preventable, and can be treated by antiretroviral drugs. It is spread by coming into contact with the bodily fluids of an infected person and it is also a sexually transmitted disease. Responses include: *'HIV is a sickness transmission, it is a sexually transmitted disease, it is a sickness transmitted to another person'* (John, 44); *'it is a virus that enters the body's immune system and destroys it through unprotected or unsafe sex'* (Damien, 15). Other responses indicate that: *'somebody came to church to educate us; I learnt that you need to be aware of HIV/AIDS and what it does to people'* (Maria, 70). Respondents gauged their knowledge levels, such as: *'the basics, I know the cause, its prevention and how it is spread and I know how it is for someone to live with HIV/AIDS'* (Michelle, 37); *'I know how it is transmitted, I know of antiretroviral drugs which are used to slow the progress of the virus and it cannot be spread by physical touching'* (Linley, 45).

**Hindus:** All respondents (nine in total) were aware about HIV/AIDS, with most learning about it through lessons at school. Responses include: *'I think that I know about AIDS and HIV, a safe amount of knowledge. I was taught about what it was through schooling. The media has educated everyone'* (Priya, 24). Most respondents have been exposed to HIV/AIDS through media such as television, newspaper, advertisements, pamphlets and public speakers who had disclosed their HIV status at places such as schools and sought to raise awareness about HIV/AIDS.

#### **4.2.2 Do you personally know of people living with HIV/AIDS?**

**Muslims:** Nine respondents said no with two saying yes. The majority of respondents did not know of anyone living with HIV/AIDS in their immediate personal lives.

**Christians:** Seven respondents (seven out of ten) personally knew people to be infected with HIV/AIDS; three indicate that they did not personally know of someone living with HIV/AIDS.

**Hindus:** Six respondents affirm that they did not personally know any person living with HIV/AIDS; three respond that they did know of someone living with HIV/AIDS.

#### **4.2.3. How would you interact with people living with HIV/AIDS?**

**Muslims:** Respondents regard interacting with them as normal (eight respondents). They would respect the person *'yes, most definitely, they are normal humans like ourselves and*

*have feelings and emotions too*’ (Irfaan, 21). Three respondents suggest that they would be careful in matters of personal hygiene, they would be nervous as a finger prick, needle stick injury or contact with blood may cause them to get infected and another suggested that we approach them with caution, but not so much to the level that they may feel alienated.

**Christians:** Nine out of ten respondents would treat PLWHA normally. Responses include: *‘the first thing I will do is encourage them, the person living with HIV/AIDS. Another person is an innocent person. When you go for an HIV test and you found out that you already have this sickness, by another women and she was abused by another man, and she found out that she was getting this sickness after a long time, after this we encourage them to make a greater focus on their life. Do not get a lot of stress, do not use alcohol and do not use cigarettes. In the cigarette is nicotine, it does not make the blood strong, it makes it fail. If she stops smoking cigarettes and drinking alcohol and follows the instructions of the doctor and takes her medicine as prescribed at its appropriate times he will live a long time and it will stop her from having sex all the time. I had an uncle about twelve years ago, he was diagnosed HIV positive. He had HIV because he did not follow the doctor’s instructions to refrain or stay away from alcohol, sex and cigarettes.’* (John, 44); *‘the same way I would interact with everybody else, but I just treat them with empathy, but because of their sickness they are to be treated a bit different, but with sympathy and empathy. If you are okay, if today or tomorrow you feel better, I will understand.’* (Michelle, 37). Other responses encourage PLWHA to take their antiretroviral medication and to *‘be careful with wounds and blood’* (Brian, 24).

**Hindus:** All respondents would treat PLWHA normally; *‘I would be normal with them, you do not know in today’s world, who knows who has it anyway’* (Priya, 24); *‘treat them with respect and be aware of the sickness, so that you can take simple precautions if necessary’* (Katrina, 35). Others said to treat them as normal; *‘you cannot get HIV/AIDS by just interacting, talking or just sitting next to them. But, you are more aware of the things you do with and around that person’* (Shilpa, 22).

#### **4.2.4 Should those living with HIV/AIDS be treated with respect, with indignation or scorn, owing to the manner in which they have acquired the virus?**

**Muslims:** All respondents (eleven) acknowledge that PLWHA should be treated with respect. They should be accorded the same rights as anyone else; people may be infected unknowingly and are to be absolved of blame. People may not be condemned for their sins by

others, as God is the only judge. However, people may face scorn if they contract it by forbidden means (Eesa, 19), such as by having premarital sex and injecting drugs from contaminated needles.

**Christians:** All ten respondents agree that PLWHA should be treated with respect and dignity. *'Nothing is physically wrong with them'* (Linley, 45). For John, the HIV virus carries a meaning: *'if someone gets that infection, we can respect them. We can respect him, because he is sick, he is still the same, if it is not his or her fault for becoming infected with HIV. Indignation and scorn are faced by PLWHA. We may respect them, but they may also face scorn and indignation. Because the virus means something, it is supposed to give them scorn and indignation.'* (John, 44).

**Hindus:** All respondents would treat PLWHA with respect; *'after all, it is a disease, irrespective of what'* (Rajesh, 37); *'any human has rights'* (Priya, 24) and *'should be treated in a normal manner, there are numerous ways of contracting the virus and even if it was through sexual intercourse, it does not mean that person is a 'slut.' That one time that someone decided to have sex could have led them to contracting HIV'* (Shilpa, 22).

#### **4.2.5. Do you believe that HIV/AIDS is a problem in the community?**

**Muslims:** Seven respondents said yes and four said no. However, responses suggest that HIV/AIDS is not viewed as a problem in the community but remains a problem in a wider sense. It is not discussed openly or freely as the Cravenby community is conservative. To live a life according to Islamic teachings has the effect of safeguarding one from getting HIV/AIDS and prevent him or her from 'going astray'; some responses suggest that because it is a predominantly Muslim community there is doubt that HIV/AIDS poses much of a problem. The majority of Cravenby residents are Indian and Muslim, it is for this reason that HIV/AIDS is not a frequently discussed topic as no one really spoke about it.

**Christians:** Eight of ten respondents believe that HIV/AIDS is a problem in the community, one says no and the other was unsure. For those who say it is a problem, they mentioned the community needs *'more awareness on a continuous basis and not only at the hospitals and we should do it every day to outline its seriousness'*(Melvin, 39). Others respond that *'except drugs and alcohol, it can become a problem in the community, as younger generations are sexually active. Ten years ago, children aged twelve were not necessarily sexually active and a lot of them do not believe in the condom, do not see the big picture and do not foresee things going wrong.'* (Michelle, 37). HIV/AIDS is a problem in the community because

*'people are educated, but they do not adhere or listen to HIV/AIDS messages' (Mary, 45); 'it could be a problem, if we are not careful, or the community is careless with it' (Brian, 24). We should also be aware and realistic and 'practice safe precautions' (Lauren, 53).*

**Hindus:** Six respondents say that HIV/AIDS is a problem in the community; one said that it is not a problem and two were ambivalent. *'People (need) to be more aware of their surroundings, especially with regard to young children and teenagers' (Katrina, 35). HIV/AIDS is 'not curable as yet and it is killing people' (Shilpa, 22). They also acknowledge that 'rapists who know that they have HIV/AIDS may pass it. People should get tested more often and more tests should be available' (Priya, 24). For those who respond ambivalently, they say that 'you cannot look at someone and say that they have or do not have HIV; the only way to be sure is to go for an HIV test' (Avisha, 40). The 'number of people in the community diagnosed as being HIV positive is minimal or unspoken of, due to those infected not speaking openly on their status, the myths around the subject causes a stigma among people. The fact that people are not encouraged to speak openly on their status means that educating people on this is a problem' (Sachin, 29).*

#### **4.2.6. Do you discuss HIV/AIDS with your community, among your family and friends or to the general public?**

**Muslims:** Four said yes and seven said no. HIV/AIDS was not openly discussed, but there is willingness to make people aware of it, so that they are educated and are informed about it. In an Indian cultural community context it is not widely spoken of. Within the community context, HIV/AIDS is not widely discussed and talked about; but in South Africa and internationally it receives a great amount of attention.

**Christians:** Six out of ten respondents said yes that they discuss HIV/AIDS with their community, among their family and friends and to the general public and four said no. *'Yes, we discuss it amongst our families because we know that malady exists, the television and the newspapers know about it; by means of propaganda, so we discuss it' (John, 44). Others said that they would discuss it 'first with their family, then go to the public and disclose if they are ready and if not then they should not disclose' (Mary, 45). They discuss it so that they may 'not look down on other PLWHA and treat them with respect and be good to them' (Maria, 70). Education and educating people was very important in such discussions.*

**Hindus:** Seven respondents discussed HIV/AIDS amongst their community, family and friends or the general public. HIV *'affects the daily lives of everyone'* (Sachin, 29) and is *'discussed by health professionals such as doctors and nurses'* (Priya, 24). For those who say no (2 respondents), it meant that it was not discussed, or was under discussion but discontinued. Respondents were more likely to discuss HIV/AIDS with immediate family and friends but not so much to the public.

#### **4.2.7. If you are HIV positive, does your religion allow you to disclose your status?**

**Muslims:** Seven respondents regard it as allowed, three said no and one was unsure. Respondents saw this as a personal matter, but within marriage, it is important that spouses know each other's HIV status. Religion is not a big factor in accounting for HIV disclosure, because most people would not want to test for a fear of being treated differently. Because of the stigma attached to being HIV positive, respondents note that they would not like to disclose their HIV positive status.

**Christians:** Five respondents affirm that religion allows one to disclose ones status; three replied in the negative and two were ambivalent because *'at the end of the day, it is a personal choice'* (Michelle, 37). For those who said yes: *'In our religion, Christianity, you must disclose, tell the preacher that you have HIV/AIDS, so that he can pray for you'* (Mary, 45). Religion, for some respondents is used as a support structure where it is needed in terms of disclosure (Lauren, 53). Others respond that *'if you are a Christian, it is kept secret, because you are human being, we keep your secret, we are supposed to teach you the right thing, the Church warns you not to transmit HIV to other people and to believe in God and to prepare your way. Because the Church is a clean place, we represent God; God is in the Heaven, to respect, to believe, to follow all the commandments, that is God. If you say, I am son of God, everything you do is nice in the face of God and you should not be living like the son of Satan, because if I believe in Jesus, it change all my life'* (John, 44).

**Hindus:** Eight respondents said that religion does allow disclosing your HIV status, one respondent was unsure, viewing it as a personal matter, *'my religion would respect whatever I decide to do but I emphasize that there are rules or regulations'* (Avisha, 40).

#### **4.2.8. Does your religion promote going for HIV tests?**

**Muslims:** Religion does promote going for HIV tests, with seven respondents affirming so; one such response was: *'my religion promotes the idea of prevention is better than cure, if*

*you get married, you can have sexual intercourse. My religion does not encourage sex before marriage, nor does it promote it, but before you get married, it is good to go for an HIV test'* (Ahmed, 27). Islam promotes good health and encourages its followers to take care of their body and immune system: *'Yes, as one should know your status in today's day and age, as sometimes you might need to donate blood.'* (Irfaan, 21). Three respondents disagree, with one being unsure; for them, Islam prohibited sexual behaviour before marriage, which may protect one from getting HIV/AIDS, they believed that: *'Even if my religion did promote HIV testing, most people would not be open to this idea'* (Saffiyah, 20). Islam did not promote HIV tests, but may limit one's sexual behaviour to one's spouse, because this in itself: *'Helps one to safeguard oneself and his or her spouse from contracting HIV, compared to if one had multiple partners'* (Rashieda, 24). For some respondents, HIV testing was not promoted by Islam, nor discouraged.

**Christians:** Seven of ten respondents affirm that religion does promote going for HIV tests; three said no. For them, they believe that Christianity did not really *'promote going for an HIV test'* (Melvin, 39) and *'because our religion; Christianity does not promote sex before marriage, it will not promote HIV tests'* (Linley, 45). For those who affirm; they reason that: *'Yes, you are supposed to go, to know your identity all the time, give testimony to God, supposed to go every time to know what is going on all the time; it is an infection. If you get a headache, go to the hospital, your body is sore; the first thing you need to know is your status.'* (John, 44). HIV lessons are *'conducted and discussed at this Church during the last lesson of the year and it is beneficial to know your status'* (Michelle, 37). Knowing your status is beneficial from a health perspective. Some respondents ascribe a personal choice to HIV testing and note that it is not actively encouraged by Christianity.

**Hindus:** Seven respondents said yes that Hinduism does promote going for HIV tests; two respondents noted that *'we do not really discuss HIV in our religion'* (Avisha, 40); Hindus mention that it is not specifically addressed or could not say whether it was approved or not (Shilpa, 22); but responses seem to agree that Hinduism does promote going for HIV tests.

#### **4.2.9. Does religion stigmatize people living with HIV/AIDS?**

**Muslims:** Eight respondents said that religion did not stigmatize PLWHA: *'it is people who choose to stigmatize PLWHA'* (Saffiyah, 20). For those who say yes: they mentioned that: *'homosexuality is taboo in Islam. Muslims are forbidden to practice it. If the source of HIV infection is through these means, the Muslims would frown upon the person. Should the*

person die, he must be washed cautiously to prevent AIDS contamination' (Naseema, 56). Religious ideology may cause people to stigmatize PLWHA based on how they contracted the illness; another respondent was ambivalent, she said: Religions have evolved from the 'old days' where people were scorned for committing 'sin' be it major or minor. 'Most religious leaders now focus on keeping youth occupied so as to stay out of trouble rather than punish them after already getting themselves into trouble. On the other side, working in an environment where I see patients who are both HIV positive and negative, stigmatism is still rife even though people try and pretend like HIV/AIDS does not have an effect on their attitude toward others' (Bashiera, 26).

**Christians:** Nine out of ten respondents felt that Christianity did not stigmatize PLWHA. One respondent felt that those who do have HIV/AIDS, but did not disclose it may face gossip, 'uninfected people may gossip about you because you have HIV' (Mary, 45). Other responses said that: 'not really, it does not say it directly, one of the main things the Bible teaches us is not to have sex before marriage' (Adrian, 34); 'no, in our Church, because we do not know, we cannot really say that we stigmatize PLWHA' (Linley, 45). 'No, the Church cannot stigmatize PLWHA, the Church must receive everybody, you have HIV or you do not have HIV, you are son of God, because the Church, it can change and it can help people with HIV' (John, 44); 'no, because we are an open religion, Jesus died for our sins, there is no thing as big or small sin, everybody sins and God sees that you sin. Anybody can join our religion and it does not discriminate' (Michelle, 37). Responses have mostly indicated that Christianity did not stigmatize PLWHA; rather, stigmas arise from individual personal beliefs and are not messages which religion may inculcate.

**Hindus:** Religion does not stigmatize PLWHA according to most Hindu respondents: 'it is rather the people doing it' (Priya, 24). Those who say yes reason that most people see HIV/AIDS as a sexually transmitted disease.

#### **4.2.10. Do your religious beliefs have an effect on your sexual behaviour?**

**Muslims:** All respondents affirm that their religious beliefs has affected their sexual behaviour: 'yes, my religion forbids premarital sex' (Eesa, 19); 'yes, you are allowed to practice sexual behaviour if you are married and only with your wife' (Irfaan, 21); 'religious beliefs have an impact upon sexual behaviour. Allah (God) says in the Qur'an that he created mankind in pairs, to complement each other; males and female). We must not deviate from these laws. If we do, then a great punishment will be in store for us' (Naseema, 56). Religion

*'promotes purity, sanctity of marriage and respect for other people as well as your own self-respect'* (Zakkiyah, 22).

**Christians:** Six out of ten respondents said that religious beliefs did have an effect on their sexual behaviour; four said that it does not. For those who say no, their religion did not affect their sexual behaviour because their behaviour is governed by their own personal choices and are private. For those saying yes: the Bible said *'it is one man, one wife and you can only have sex once you are married, it is totally against Biblical laws.'* (Melvin, 39) or they said *'Yes, because one of the commandments says, you shall not lust after women in your mind'* (Adrian, 34). John mentioned: *'I can say yes it exists; we can generalize because we believe that and it is a difference if you are a Christian. You cannot do that, something is going on. Yes, we believe that, if you engage in bad sexual behaviour, ask forgiveness. Forgiveness is like someone changing, he could do that again. If someone asks forgiveness, God will forgive him, you come from darkness into light and when you are in the light, everyone sees you. You cannot make light in the club, if you switch off the light, nobody sees them. If you are married, you are in Jesus Christ and then you are free to do that. Because it is something we do in the community, I am not doing that, but others are doing that, it is an impact, it is in the community and we believe it has an impact. We follow our Bible, our light to follow, go inside the Bible, that is the light, the Bible says. If you think it is not wrong, do it and if you think it is wrong, then stop doing that.'* (John, 44).

Other respondents said that: *'in the Bible, we are taught not to have sex before marriage, in some cases, I will have sex if we are married, but in other cases we live together and it is regarded as okay to have sex and there is the possibility that Christians do engage in sexual behaviour before they are married'* (Michelle, 37). Some responses were realistic; *'yes, they do tell you, you must use a condom and be aware, there is a virus out there'* (Mary, 45) or *'wait until you are married, at this moment, I am not abiding by the Bible, religion allows me to have a conscience. Your conscience sinks into your head. For example, Sunday morning I was not in the Church, it is in your conscience, that you did not go to Church. Religion, tells you to be careful, but I am not willing to wait to get married, but it does not mean that I will not be careful.'* (Brian, 24). Religion has the power to guide, respondents acknowledge that people do make mistakes and there is forgiveness if they ask for it, sexual behaviour is a personal and private matter but respondents admit that religious beliefs and ideology have an influence on decisions and consequences that people make in their personal and private lives.

**Hindus:** Religious beliefs do influence the sexual behaviour of Hindus, with seven saying yes and two saying no. Such beliefs helped them so that they would not *'do things in the open or dress openly, by wearing provocative or revealing outfits'* (Shilpa, 22); *'they are not allowed to have several or multiple sexual partners at the same time'* (Katrina, 35). *'You need to stay faithful'* (Rajesh, 37) and *'yes, have good moral values, in Hinduism; our belief is that when you marry, your partner is your partner for life and when he passes on, you should not remarry. But in reality this does not happen. Women are having more partners before marriage and even divorcing and remarrying'* (Avisha, 40). Their religious beliefs affected their sexual behaviour because it prescribed a moral code to live by and therefore should be followed by its adherents (Hindu's). Responses also indicate that people have moral choices which they are free to make and also showed how traditions, ideas and cultural practices could change over time which included how they were adopted, understood, interpreted and practiced.

### **4.3 Analysis of the data**

#### **4.3.1 Knowing about HIV/AIDS**

Muslim respondents acknowledge HIV/AIDS to be a sexually transmitted disease. They indicated that they knew only the basics when it comes to HIV/AIDS, which meant that they believed that they possessed the necessary knowledge to protect themselves from acquiring HIV. Muslims always saw themselves as protected against the AIDS epidemic because of the social value system prescribed by their religion (Toefy, 2009:245). Such a social value system is prevalent in this community with a few respondents mentioning that the community has conservative attitudes and values and has very minimal PLWHA.

A high level of education lends itself to a better conceptual understanding of HIV transmission and to more awareness of human rights issues (Paruk *et al.*, 2006:514). Statistics also indicate that South Africa has high rates of PLWHA than most other countries in the world and it is noted that few people have not heard about HIV/AIDS (Paruk *et al.*, 2006:514). Community Muslim youth may face the same dilemmas as youth in any other racial or cultural group (Maqsood, 2001:6-7). Young Muslims do experience frustration of being trapped between developmental stages and do tend to question all that is placed before them (Maqsood, 2001:6-7). During this complex stage, if adolescents find it difficult to explain to their parents what the conflicts and confusions are, they may resort to unethical religious behaviour without the adult being aware of such behaviour (Beshir and Beshir,

2002:10). Young adults staying longer under the tutelage and guardianship of both parents stand to benefit from emotional, financial and social support rendered by their parents. This is important in warding off 'deviant' peers whose influence upon them could be enormous during adolescence (Tenkorang *et al.*, 2009:242).

Other studies found that to live with both parents may delay sexual intercourse (Ekundayo *et al.*, 2007; Ramirez-Valles *et al.*, 2002; Tenkorang, 2004; Upchurch *et al.*, 1998). Adolescents may make life changing decisions and such decisions may only be made if their parents groom them to handle this aspect of their life and if their school culture can complement this development (Beshir and Beshir, 2002:54-55). Muslim adults can act as role models in their child's life according to Beshir and Beshir (2002:143), who assert that they can meet social challenges by showing these attributes to understand their child: (1) never resort to force; (2) express feelings and share in happiness and pain; (3) be clear in communication; (4) be an active listener; (5) assist in skills development; (6) use examples from the environment and (7) use holistic approaches. The social actions of the individual within the Muslim family are directed by the social control being exerted by that society and its ability to act in a unified manner (Barnett and Whiteside, 2006:93). Social control in terms of HIV/AIDS and sexuality are dependent upon factors such as family culture and religious control (Chabillal, 2010:58).

Frank *et al.* (2008) argues that South African youth are trapped in risky sexual behaviour which is piled on top of each other in a morass of dictating gender norms and coercive sex (2008: 398). Religious groups and parents need to take a more aggressive role in such issues. Inadequate protection and care for children is a violation of basic human rights as well as a foremost factor in the AIDS epidemic in South Africa. As a democratic society, we must give priority to the human rights of our children; of paramount importance is the maintenance of norms and values which are the foundation of society. It is argued that risky sexual behaviour is symptomatic of a society that is in crisis (Frank *et al.*, 2008: 398).

All Christian respondents regarded HIV/AIDS as being a big problem. In the past, HIV/AIDS was met with denial by Christian religious leaders and faith based organizations and this added to the stigma of those infected and affected PLWHA including their families (Clarke *et al.*, 2011). Respondents saw PLWHA as being no different than the uninfected. Responses provided by Christians were of a similar nature to those of Muslim respondents concerning

their knowledge of HIV/AIDS. That is, they believe that it is transmitted by having unprotected sex or sharing needles and that there is no cure for it.

A study by Genberg *et al.* (2009:2286) showed that negative attitudes and perceived discrimination towards PLWHA were related to a lack of knowledge of ARV, a lack of prior history of HIV testing and not having discussed HIV/AIDS with anyone. High negative attitudes toward PLWHA were in sites with a low HIV prevalence, namely Tanzania and Thailand, and the highest perceived discrimination of PLWHA were in sites with the least support and care available to PLWHA, Tanzania and Zimbabwe (Genberg *et al.*, 2009:2286). Universal access to HIV treatment and widespread educational and prevention efforts which promote the understanding of ARV, adopting HIV testing and discussing HIV/AIDS may reduce instances of HIV/AIDS related stigma and discrimination (Genberg *et al.*, 2009:2286).

All Hindu respondents indicate that they had a very good knowledge about HIV/AIDS. Hinduism is a practical religion and intends to govern and regulate an individual's life in such a way that it enables them to advance as far as possible toward divinity from where they started (Nirvedananda, 1944:226). It views the human soul as infinitely pure and that all impurities can be washed away (Lala, 2007:73). It advocates that, Hindu PLWHA may partake in a ritual known as 'homa' fire, a ceremony performed that is thought to purify the mind and heart of the people performing it. Its attendees are offered 'ritualistic food' intended to purify and create a nurturing, care oriented environment (Lala, 2007:73). Another programme offered to Hindu PLWHA in response to stigma associated with sex is a meditation exercise which guides the attendee to 'picture Ganges water, pure and crystal clear, pouring over your whole body and mind, washing away guilt and anguish. The Ganges in Hinduism is a holy river that can purify people of all their sins, and such exercises are meant to emphasize and manifest internal purity (Lala, 2007:73).

#### **4.3.2 Personally knowing people living with HIV/AIDS**

A majority of Muslim respondents did not know of many PLWHA in a personal capacity with nine saying no and two saying yes. For Christian respondents, three said no and seven said yes. Three Hindu participants said yes and six said no. Due to a paucity of individuals willing to disclose their HIV status, many Muslim and Hindu participants did not personally know PLWHA. A very small amount of Hindu (3) and Muslim (2) respondents knew someone personally living with HIV/AIDS. Christian participants (7) were more likely to personally know someone living with HIV/AIDS.

### **4.3.3 Interacting with people living with HIV/AIDS**

Muslims respond that PLWHA are normal humans with feelings and emotions, with the only difference being that they have HIV/AIDS. Despite low infection rates among Muslims, the disease is not unknown amongst them (Paruk *et al.*, 2006:514). People do witness ill health and the death of families and friends due to HIV infection (Crewe, 2002; Demmer and Rothschild, 2011). Bowman *et al.*, (1994) found that personally knowing someone with AIDS significantly affected student's attitudes toward AIDS. Guth *et al.*, (2000) found that education campaigns which include input from infected people resulted in an increase in positive attitudes toward HIV/AIDS and those living with the disease. Exposing infected people has the effect of personalizing the disease and forces one to confront one's own issues about a disease that does not discriminate against race, class, culture or religion (Paruk *et al.*, 2006).

In asking what could be done to reduce HIV stigma, education is often the first step in stigma reduction and should be combined with other strategies (Jacobi *et al.*, 2013:179). Educational influence is limited because many stereotypes as a whole were resilient to change. An educational approach can be effective if it is combined with other approaches, such as non-infected individuals having contact with PLWHA and skill building (Jacobi *et al.*, 2013:179). Studies showed that combining education, counselling and contact were promising to reduce HIV/AIDS stigma (Brown *et al.*, 2003; Heijnders and van der Meij, 2006; Bos *et al.*, 2008).

Christian respondents believe that PLWHA deserve sympathy and empathy. Ideas of inclusion and hospitality are emphasized by respondents. Comparing PLWHA to different types of people met by Jesus, of whom he welcomed and forgave, despite them sinning. Such people included, the unclean, Gentiles, women, tax collectors and persons with physical and emotional challenges and those in need of food, drink, clothing, shelter and respect (Lala, 2007:53). The intentions of using Biblical references was to encourage a more welcoming and hospitable attitude toward PLWHA. Some respondents, mentioned to go inside the Bible, as that is the light to follow. When congregations reach out and embrace all people, including those affected by HIV/AIDS and are infected with HIV/AIDS, then healing happens not only amongst individuals but to the Church community as a whole (Lala, 2007:54; Ridge *et al.*, 2008).

If Churches are to be successful in including, understanding and helping sufferers with HIV/AIDS, these approaches need to be embedded (Nalini, 2012:144): (1) to rethink the essence, purpose and meaning of the Church. The Church must truly be Catholic, universal and ecumenical. Galatians (3:28) graphically captured this vision, ‘neither Jew nor Greek, neither slave nor free, neither male nor female, all are one in Christ Jesus.’ Church discrimination against people of lower castes, women, or any perceived marginalized group, from knowledge, positions, powers, appointments, promotions or even theological education must be addressed in order to improve its potential to positively affect the lives of PLWHA; (2) to revise the liturgy of the Church from the perspective of HIV/AIDS sufferers and that it should not be content with one special liturgy prepared for celebrating World AIDS Day; (3)

Christian teachings should include in-depth discussion of topics such as human sexuality, condom use, safe sex, abstinence, fidelity, sexual behaviour, lifestyle and ethics; (4) the Church should invest in promoting treatment, usage of related drugs, routine clinical approaches and relevant treatment guidelines; (5) Churches should promote changes in attitude toward PLWHA. Persons infected with HIV continue to live in a secret world, hoping to shield themselves from stigma, scorn, and discrimination of community members by not speaking about their infection. To them, even governmental support of antiretroviral drugs may be of little relevance and (6) to avoid the duplication of work; network and negotiate with others in order to get better involved in prevention and intervention (Nalini, 2012:144).

Hindus respond that there is awareness that you should be careful with and around PLWHA even though you cannot get infected with HIV/AIDS by talking or interacting with them generally. In response to arguments that PLWHA are responsible for their condition because of Karma and are not deserving of support, have been refocused to appeal to Hindu ideas of *dharma* or duty (Lala, 2007:74). We should not focus on the karma of PLWHA, but should focus on our own *dharma* toward them. Islam teaches that we should care for and help PLWHA and the response expected of Christianity is likewise, that Christians should accept and not discriminate against them. The Hindu idea is that only when one acts in accordance with *dharma* is one’s karma ‘good’. By stigmatizing and ignoring the duty to offer support to PLWHA, one is not sowing good karma and will have to face its consequences. It is asked: ‘ask yourself what your own karma should be toward PLWHA, not what their karma should

have been' (Lala, 2007:74). Regardless of the manner in which people may become infected with HIV/AIDS, all Hindu respondents regarded PLWHA as deserving of respect and not stigma.

#### **4.3.4 Should people living with HIV/AIDS be respected or be unfairly treated because they have HIV/AIDS**

According to respondents, people living with HIV/AIDS should be treated with respect and should not be unfairly treated and may be absolved from blame if getting HIV/AIDS was not their fault, but attitudes persist, that they should be scorned if they became infected by doing something 'sinful'. Islamic principles such as 'akhaf al-dararayn' or choosing the lesser of two evils can be used to derive a new solution, because even though unfaithfulness and premarital sex are 'evil', helping PLWHA is considered 'the lesser of two evils' (Lala, 2007:61; Ebrahim; 2007; Barmania, 2013).

Most Christian and Hindu respondents express the view that PLWHA should be treated with respect. Regardless of people having HIV/AIDS or not, it is a disease and they are still the same. Using compassion based messages to counteract stigma has positive implications (Lala, 2007:83). The frequency with which compassion is encouraged and the extensive scriptural evidence on which it is based makes its positive aspects valuable. However, anti-stigma messages can implicitly validate a stereotype that PLWHA are guilty of misconduct. Such an acknowledgement may perpetuate negative attitudes towards PLWHA, even if they were less harmful when coupled with compassion (Lala, 2007:86). While compassionate attitudes do negate hateful attitudes, resentment, exclusion and apathy, they do not necessarily or directly counteract the perception that PLWHA were promiscuous, responsible for their condition or were sinful. Although drawing such parallels might intend to influence people to adopt a more compassionate and destigmatized attitude, they may reinforce the negative labels which are attached to PLWHA and create a morally superior label for those in a position to help them (Lala, 2007:87).

#### **4.3.5 Is HIV/AIDS believed to be a problem in the Cravenby community?**

Most Muslim respondents have not actively discussed much about HIV/AIDS in a community context and this aspect agrees with statements drawn from Ashraf Kagee, Faghmeeda Miller and Moulana Zakariyah Philander (Mukadam, 2013), with regard to HIV/AIDS being present in the Muslim community, it is possible that despite an awareness

of HIV/AIDS, it is still not much spoken of. If adherents follow Islamic teachings, then they will not be made vulnerable to HIV infection. Abrahams (2006:87) found that Muslims in the Mitchell's Plain community in Cape Town were engaging in 'othering the disease' and passed moral judgment on PLWHA. For her it seemed that Muslims perceived a decrease in the prevalence of HIV/AIDS stigma in their community, similarly to those found in South Africa by Shisana *et al.* (2005; cited from Abrahams, 2006:87). The most salient factor which had an influence on almost all forms of stigma was religious positioning. However, supportive attitudes and behaviour are also expressed (Abrahams, 2006:87). The findings outlined here have somewhat agreed with what these authors have found.

Speaking at the 20<sup>th</sup> International AIDS Conference in Australia, Shisana argued that stigma and discrimination continued to 'hinder the implementation of science on the ground' in countries facing the HIV/AIDS epidemic (Sapa-dpa, 2014:6). In recent years, much has been made of punitive anti-homosexuality laws existing in some 35 African countries and more recent severe amendments made to them in countries such as Uganda and Nigeria. The past three decades of HIV/AIDS taught that it was not the disease that discriminated, but people and governments, a sentiment shared by Muslim, Christian and Hindu respondents. Less than half of the 28 million people eligible for anti-retroviral therapy were receiving them. UN data showed that 35 million people were living with HIV, the vast majority in Sub-Saharan Africa (Sapa-dpa, 2014:6). Internationally, HIV infections are rising in countries such as Russia and Ukraine, especially among intravenous drug users, sex workers and prisoners (Sapa-dpa, 2014:6).

Christian respondents do see HIV/AIDS as a community problem because people may unknowingly infect others and more awareness is needed to outline its seriousness. Respondents mention that drugs and alcohol may worsen this problem. Respondents contend that young people are viewed as being sexually active, that they may not believe in the effectiveness of condoms and could not foretell that they could infect other people with HIV/AIDS. Levels of education did not necessarily mean that they will heed HIV/AIDS messages. People should have realistic expectations and that if they do engage in sexual intercourse, then they should take precautions and practice safe sex, but this might not always be the case, as the literature has shown (MacPhail and Campbell, 2001; Gennrich and Gill, 2004; Peltzer *et al.*, 2004; Mwaba and Naidoo, 2005; Kibombo *et al.*, 2007; Štulhofer *et al.*, 2007; Frank *et al.*, 2008; Tung *et al.*, 2008; Valencia-Garcia *et al.*, 2008; Fennie, 2011; Frederiks, 2011; Mfecane, 2011; Nalini, 2012; Barmania, 2013).

MacPhail and Campbell (2001:1625) argue that young people's sexuality is contested and complex. For intervention programmes, young people who challenge stereotypical norms and beliefs provide a starting point for debate about the possibility of developing new behavioural norms. New norms and values negotiated by peer groups in this way may provide a health enhancing environment in which healthy sexual behaviour is likely to be maintained (MacPhail and Campbell, 2001; Becker and Joseph, 1988; Lambert and Wood, 2005; Pettifor *et al.*, 2005; Zambuko and Mturi, 2005; Rehle *et al.*, 2010; McGrath *et al.*, 2009).

Eaton, Flisher and Aarø (2003:150) note that if we wish to understand sexual risk behaviour in Southern Africa, including South Africa, then we need to consider the interactive effects of factors at three levels: within the person and within his or her proximal and distal contexts. Personal factors include cognitions and feelings relating to sexual behaviour and HIV/AIDS and thoughts about one's self (such as, self-efficacy and self-esteem). The proximal context comprises interpersonal relationships and the physical and organizational environment. The distal context includes the culture and structural factors. Culture comprises factors such as tradition, societal norms, social discourses within a society, shared beliefs and values and variations in such factors across subgroups and population segments. Structural factors include the legal, political, economic or organizational elements of society (Eaton *et al.*, 2003:150).

Respondents mention issues such as drug and alcohol abuse, which are very prevalent in the community; alcohol use may often be associated with behaviour which places an individual at a high risk for sexually transmitted infections, including HIV. Factors which may contribute to alcohol use in a sexual context are differences in individual personality characteristics and beliefs about alcohol's influence on sexual behaviour (Kalichman *et al.*, 2006:298). Efforts aimed at individuals at great risk for HIV infection should address alcohol use in sexual contexts and risk reduction interventions can be delivered in settings where alcohol is served and sexual relationships formed (Kalichman *et al.*, 2006:298). Informal establishments are common places where people may meet sexual partners and such networks have been closely associated with HIV transmission risk (Weir *et al.*, 2003). In such contexts, intervention can deliver targeted prevention messages and condom distribution to men and women involved in using alcohol to barter sex (Kalichman *et al.*, 2006:303). Other intervention modalities are to embed brief alcohol counselling within HIV counselling and testing programmes and sexually transmitted infection treatment services. Addressing alcohol

use in proximity to sexual relations offer one viable avenue for breaking connections between alcohol use and HIV risk, including among people classified as risk takers (Kalichman *et al.*, 2006:303).

Changing sexual risk behaviour in the long term among people at great risk for HIV infection might require multilevel intervention strategies which address individual behavioural change and changes to the behavioural context and social milieu (Kalichman *et al.*, 2007:600). Potential community level interventions that can change risk levels in drinking establishments are the popular opinion leader intervention model developed by (Kelly *et al.*, 1992; cited from Kalichman *et al.*, 2007). To train opinion leaders in social conversational skills for advocating HIV prevention in the community may result in a significant reduction in unprotected sexual intercourse over a sustained period of time. Community level interventions for supporting risk reduction in drinking places can be applied to alcohol serving establishments in parallel to risk reduction counselling for high risk drinkers in Southern Africa. Such multi-level HIV risk reduction interventions are needed for this group in Southern Africa (Kalichman *et al.*, 2007:600). Mfecane (2011) argued that HIV positive men could be empowered to resist dominant images of masculinity that threaten their health and that changes in beliefs about masculinity at a community level can create environments for HIV positive men to adhere to a 'disciplined' and 'responsible' lifestyle demanded by their condition but without feeling pressure to take risks (Mfecane, 2011).

Hindus view HIV/AIDS as a community problem as having HIV may affect job retention. From a criminal perspective, rapists who have HIV may unknowingly infect their victims. Going for an HIV test may give people the peace of mind that they are not infected. If they are infected then they can receive counselling and advice on how to live with and manage it. Hindus, like the Muslim respondents, believed that the amount of PLWHA living in the community is small or that these individuals have not disclosed their HIV status, were not encouraged to speak out and publicly disclose their HIV status and this meant that educating people about it is a problem.

#### **4.3.6 Is HIV/AIDS discussed amongst the community, family and friends or the general public?**

Because Cravenby is a small community, discussing HIV/AIDS is not widespread but some Muslims expressed willingness to engage in discussion about it. Christian respondents were more open and would engage in discussion with family, friends and to the general public.

Hindu respondents showed a preference to discuss HIV/AIDS among their family and friends but were not keen to discuss it among the general public.

Alubo *et al.* (2002:124) study showed generally high levels of rejection and a low acceptance of PLWHA, both of which were extended to their families. There were consistently stronger reactions and a lower acceptance by the general community than from family members. This is expected because family members are to take care of their own family members. As part of the general other, community members do not perceive themselves to have personal stakes and could more easily reject and isolate PLWHA (Alubo *et al.*, 2002:124). From differing reactions displayed from family and community members, acceptance of PLWHA could be likened to three concentric circles where the innermost circle is the family, followed by neighbours and general community members. Acceptance is highest in the family circle and rapidly decreases thereafter (Alubo *et al.*, 2002:124). If the youth and people more generally can find ways to talk about HIV/AIDS and sexual health with their family, the information shared could have a considerable impact (Vlassoff and Ali, 2011). In this study, Christian, Hindu and Muslim respondents mostly agree that PLWHA should be treated with acceptance, tolerance and respect.

Zhou (2007:294) examined constructions of HIV/AIDS and its impact in a Chinese context through the lens of the daily encounters of PLWHA. Actual interactions between PLWHA and other people revealed that the sociocultural meanings of HIV/AIDS were not fixed but were co-constructed by various participants (PLWHA, their family, friends and health workers) in such interactions (Zhou, 2007:294). Despite possessing knowledge, prejudice toward HIV/AIDS and PLWHA can be generated, spread, and worsened through interpersonal interaction. Social and interpersonal interactions are a part of the process of HIV/AIDS construction; therefore, AIDS education should not be limited to disseminating only biomedical knowledge; non-biomedical and interactive dimensions of stigma and discrimination should also be considered. To have critical conversations with PLWHA family, friends, and health workers about discrimination may facilitate such social ties or networks transforming into anti discriminatory forces within communities which can positively shape PLWHA self-perception and bring about a change in the larger society. Such an intervention would be appropriate for the community of Cravenby. Creating this supportive social environment is determined by achieving social justice for various groups disproportionately affected by HIV/AIDS due to gender, socio-economic status, sexual preference, and lifestyle (Zhou, 2007:294).

#### **4.3.7 Does religion allow one to disclose an HIV positive status?**

Muslim, Christian and Hindu respondents viewed this as personal matter; but consider it allowed. For marriage, it is important that spouses know each other's HIV status (Toefy, 2002; Kalichman and Simbayi, 2003; Lala, 2007; Chabillal, 2010; Gilbert and Walker, 2010; Mukadam, 2013). Religion is not a big factor in accounting for disclosure. However, if the individual is infected with HIV/AIDS, then it is commendable to visit and pray for them (Ebrahim, 2007). PLWHA should not transmit HIV to others and should strive to lead a more religious life.

Disclosure can have beneficial consequences including, reducing anxiety and increasing social support within the household and community (Almaleh, 2006). It increases access to treatment, care and support programmes, contributes to adherence, benefits those on ARV, expands risk of awareness to significant others, increases opportunity for risk reduction within sexual relationship and enable couples to make informed reproductive decisions (Almaleh, 2006). Gilbert and Walker's (2010) study has indicated that respondents were reluctant to disclose their HIV positive status because despite public assurance and encouragement, there was little guarantee of support and understanding. To remedy this, high profile HIV/AIDS education campaigns and individuals disclosing their HIV status (which may be implemented in the community of Cravenby) may have a positive effect on the experience of living with a HIV positive diagnosis (Gilbert and Walker, 2010:144).

Baumgartner (2007:926) explored how people incorporated HIV/AIDS into their identity over time, the longer people had lived with HIV/AIDS, the more incorporated their HIV/AIDS identity and the lesser the attention was paid to it. At the onset of diagnosis, it consumed the thought of participants, but after seven to 16 years of living with HIV/AIDS, they adapted and began to integrate the infection into their lives. This general truism is mediated by health. When participants feel well, a daily reminder that they have HIV/AIDS is their medicine and when their health deteriorates then their HIV/AIDS identity is more prominent (Baumgartner, 2007:928).

Disclosure is stressful because it may make one vulnerable to the perceived stigma of friends, family or community and to lead a double life may be psychologically disturbing (Paxton, 2002). The author found that while disclosing a stigmatizing condition is difficult and frightening, it alleviated stress and improved health (Paxton, 2002), supporting the theory that

it is physically beneficial for people to disclose secrets, even when it is presented with a high personal cost. Respondents mention that disclosing one's HIV status is a personal choice. It may be hard to do it at first, but with time, they could learn to live with and accept it. The paradox of public HIV disclosure is that the thing that may seem dangerous to do, that is, confronting stigma and facing discrimination, ultimately can be liberating (Paxton, 2002).

In light of benefit gained from disclosure, HIV-positive people should be encouraged to gain the confidence and support needed to come out and publicly discuss what it is like to live with HIV/AIDS. A prerequisite to public disclosure is to address not only fears of rejection but to facilitate the process of disclosure to the family and to develop autonomous peer support groups. Counselling can help people deal with the secrecy, stigma and loss related to being diagnosed with HIV (Gewirtz and Gossart-Walker, 2000). Care should be taken with regard to the timing of media exposure. Those wanting to disclose need good support as well as a sustainable income (Paxton, 2002). The death of Gugu Dlamini who went public in South Africa on World AIDS Day in 1998 and was killed three weeks later by her neighbours, provides a solemn warning to those daring to break down the wall of silence surrounding AIDS (McNeil Jr., 1998). To increase the number of those willing to disclose is possible in an environment which is conducive to doing so, the government can play a role to ensure that those living with HIV/AIDS can disclose their HIV status safely (Paxton, 2002).

#### **4.3.8 Do their religions promote or advocate HIV testing**

Islam promotes HIV testing and the idea that prevention is better than cure. Islam promotes good health and to take care of the body and immune system (Amod, 2006; Ebrahim, 2007). Going for an HIV test should not be frowned upon, nor discouraged. Some Christians respond that Christianity does not really 'promote' HIV testing, because it does not promote behaviour which leads to HIV infection, such as unprotected sex and sharing needles. For them, HIV testing should be encouraged because if people get sick and suspect that they have HIV, then they should get tested for HIV. Hindus respond that Hinduism does promote HIV testing. It is neither condemned nor promoted. Hinduism, Christianity and Islam, promotes cleanliness and the caring of the body, mind and soul (Nirvedananda, 1944; Krishnamurthy, 1994; Lala, 2007).

Kalichman and Simbayi (2003:446) have shown that 53% of their participants did not test for HIV and two out of three indicate at least one behavioural risk factor placing them at a high risk for HIV infection. More than one in three people who did test were unaware of their HIV

test results. Those who did not know their test results were more likely to have a history of exchanging sex for money or food. They found that participants who did not know their test results may have held more negative HIV testing attitudes and saw fewer benefits to testing than those who knew (Kalichman and Simbayi, 2003:446). Although people who did not test held more negative attitudes towards testing than those who did, two thirds of untested people believed that HIV testing helped them, more than half stated that HIV testing helped to prevent an HIV infection and more than half of those who did not test would have liked to know their HIV status (Kalichman and Simbayi, 2003:446). Not seeking voluntary counselling and testing (VCT) was more a function of social barriers to getting tested, particularly AIDS stigma, rather than a lack of perceived value of getting tested (Kalichman and Simbayi, 2003:446).

Individuals in the community can undergo voluntary counselling and testing (VCT) as it is an individual intervention that consists of two counselling sessions performed before and after a usually rapid HIV test. By combining personalized counselling with knowledge of one's status, VCT is an opportunity to motivate people to change their behaviour and prevent transmitting HIV (Denison *et al.*, 2008; Swanepoel, 2004). HIV associated stigma can be reduced over time in a community burdened with a high HIV prevalence and such a reduction is associated with an increase in reported HIV testing (Mall *et al.*, 2013). Since HIV testing is the entry point to all HIV prevention and treatment interventions, initiatives to reduce stigma in communities affected by the disease should be encouraged (Mall *et al.*, 2013:200).

#### **4.3.9 Have religions stigmatized people living with HIV/AIDS**

Religions do not stigmatize PLWHA, but rather, stigma emanates from the interpretations derived at by followers. Sexual orientations such as homosexuality, committing adultery, having multiple partner sexual intercourse and sharing injecting drugs are considered disliked or forbidden. A respondent (Bashiera) mentions that, at first, religious leaders frowned upon PLWHA, but eventually came to understand that people needed to keep themselves occupied and away from trouble rather than being scorned and punished after getting infected. She mentions that stigmatism towards PLWHA is prevalent even though people may try and pretend that issues such as HIV/AIDS may not affect their attitude or outlook towards others. While HIV/AIDS related stigma associated with homosexuality could not be argued against, there must be a refocus by Muslims to take care of people (Lala, 2007:63). Visiting and

caring for the sick is recommended by the Prophet Mohammed (Sallallahu alayhi wasalam) and verses from the Holy Qur'an affirm this; 'and if anyone saved a life, it would be as if he or she saved the life of the whole people' (surah:5, verse:32); and 'so compete with each other in doing good. Every one of you will return to Allah about that with which you differed' (surah al Kahf, verse: 7) (Lala, 2007:64).

A majority of Christian respondents felt that Christianity did not stigmatize PLWHA, but rather it was gossip and hasty judgments levelled at people because they knowingly or unknowingly had HIV. In a Christian sermon reported by Lala (2007:51), on the topic of judgment, it said; 'do not judge or you too will be judged. For in the same way you judge others, you will be judged, and with the measure you use, it will be measured to you. Why do you look at the speck of sawdust in someone else's eye and pay no attention to the plank in your own eye.' If Christians had applied their teachings into practice, the history of the first two decades of the AIDS epidemic would look different. Christians have been doing what Jesus has condemned, that HIV infection and AIDS are stigmatized, has been the case primarily because of hasty judgment and unloving rejection by people (Lala, 2007:51).

West (2011:159) argued that for the dominant religions in Africa, Christianity and Islam, sacred texts may take on different forms in their appropriation. For ordinary believers, their sacred material is a resource. For those representing institutional religion, sacred texts affirm and uphold orthodox teachings and offer some capacity to reach out beyond the constraint of orthodoxy in order to address the reality of HIV/AIDS. For socially engaged scholars, sacred texts did not have a fixed single meaning or dominant trajectory, so their meaning in the context of HIV/AIDS should be contested (West, 2011:159). Sacred texts have the capacity to become idols of death and the landscape of HIV/AIDS strewn with its corpses. We must be overt not only about what we interpret them to say to an HIV/AIDS context, but, more importantly, how they are interpreted (West, 2011:160).

Ackermann (2005:391) suggests that Christians are charged with living out the values of the reign of God, meaning that they should confront the sinful nature of stigma squarely and then find hope in scripture and tradition for communicating God's grace, mercy and compassion in our actions in the present time (Ackermann, 2005:391). (1) Stigma is sin and is alien to the nature of God. Love, mercy and compassion as divine attributes are the opposite of stigma which is unloving and intolerant. Our hope is vested in the very nature of our God to whom

stigma is foreign and contrary to His universal all-inclusive intentions for humankind. (2) God is forgiving, merciful, loving and compassionate. Stigma may breed judgmental attitudes that are a denial of the very nature of God. (3) Stigma denies the reality that we are created equally in the image of God (Genesis, 1:27), that we are loved equally and unconditionally by God and have equal worth as bearers of the godly image. (4) It destroys human communities by affecting human relationships negatively. (5) Stigma is sin because it deals in lies. Scriptures have a great deal to say about living in truth (Ackermann, 2005).

The Psalmist asks (15:1-2): ‘our Lord, who may abide in your tent? Who may dwell on your holy hill?’ the answer: ‘those who walk blamelessly, and do what is right and speak the truth from their heart.’ (6) Stigma acts covertly, cannot bear light and thrives in darkness. The light beckons us as Jesus has promised: ‘I am the light of the world. Whoever follows me will never walk in darkness but will have the light of life’ (John, 8:12). (7) Love is a distinguishing characteristic of the reign of God; it is ethically compelling for all of its members and can never be qualified by double standards. (8) Humility is a Christian virtue of inestimable value. Jesus Christ cautioned his followers that ‘...those who exalt themselves will be humbled, and those who humble themselves will be exalted’ (Luke, 14:11) (Ackermann, 2005).

Stigma breeds attitudes of superiority and arrogance (Ackermann, 2005:392). In Proverbs (15:33), it is mentioned: “humility goes before honour”. A life worthy of our calling is characterized by attributes such as humility, gentleness and patience, ‘...bearing one another in love, making every effort to maintain the unity of the Spirit in the bond of peace’ (Ephesians, 4: 2, 3). (9) Stigmatizing human sexuality is sinful as God created us as sexual beings. Our sexual nature is God’s gift to us and should be enjoyed responsibly. The general stigmatizing of human sexuality that has been so much a part of HIV/AIDS-related stigma is a denial of the goodness of one of God’s gifts to humanity. HIV/AIDS offers the Church an opportunity to reclaim and celebrate our sexual human nature in a life giving and responsible manner. (10) Stigma closes the door on individual and communal healing.

Communities which are enmeshed in the falsehood of stigma cease to exercise a ministry of healing. Stigma cuts off individuals from the potential for healing in their community. All humans seek healing of some kind and are all potential healers. The present pandemic presents an opportune moment to the Church to be God’s agent for healing in new and in life-changing ways. (11) Stigma prevents the proper functioning of the Church as the Body of

Christ. Our hope for the Church is founded on the fact that God has given us all of the means to accomplish the task of 'building up' the Body of Christ. Stigmatizing members of the Body and rendering their gifts as unacceptable is to cripple the Body and render it ineffective. Equipped with such gifts, we can affirm and celebrate our God-given diversity, protect the weak, care for the sick and live out the Gospel of love and redemption. (12) Scripture gives us a language which can express the truth of the present suffering and our hope in God; it is the language of lament (Ackermann, 2003).

The question is: Why are we not lamenting? Recovering individual and communal lament in the Church has three effects (1) effective pastoral care responds to present needs. Lament spells out the present condition unequivocally by naming the painful effects of stigma and shifts suffering from the private inner world to the outer reality of the community of faith. Lament allows tears to flow and bodies to rock in grief so that it provides a counter to the numbness of human suffering. (2) The public witness of a lamenting Church calls attention to the suffering of the voiceless and despair of the hopeless that challenge conditions of silence and denial. (3) HIV/AIDS raises questions about God's power and presence in a suffering world. We may ask where God is in this pandemic. If we stifle questions about suffering in the world, we are tempted to settle for a God whom we dare not approach with our grief and with whom our relationship is less than truthful (Ackermann, 2005).

The Psalms showed that God can be addressed directly with our questions, doubts and fears and at the same time, God can be praised. Such is the power of lament that comes 'out of the depths' (Psalms, 130:1) and shows us an authentic and truthful way of grappling with suffering (Ackermann, 2005). (13) Stigma is a sin to which the Christian Church has contributed significantly. It had a history of stigmatizing people of the Jewish faith. It stigmatized women, their calling and their gifts as not of the same value as those of men, it is a small wonder that women's second class status in society was a powerful contributing factor to feminizing the HIV/AIDS pandemic. It stigmatized the human body in a hierarchy of values by relegating it to an inferior position to the mind and the spirit, forgetting that the incarnation is central to our faith. It has not dealt well with race, gender and class stigma. Potential 'polluters' of the social order have been made into scapegoats who must be punished, such as unmarried mothers who violate ideals of female sexual purity or persons infected with HIV who are refused the communion cup because they were 'ritually unclean', for which it read 'sexually active' (Ackermann, 2005:394).

Ackermann (2005) argued that the Church cooperated in perpetuating stigma by underpinning social stigma clothed in dubious moral judgment, such as giving judgment on those with AIDS. However, what we have made, we can unmake. God's Spirit has drawn the Church to renewal in order to conform to what God has desired for it, a community of hope and compassion, actively practising mutual relationships that are of a loving and just nature. We bring this about by actively shaping moral communities that nurture the moral capacity of their members by story-telling and involving ourselves in the work of justice and charity (Ackermann, 2005:394). (14) Jesus Christ is the model of what it means to live a life that demonstrated the sinfulness of stigma. He himself was stigmatized. He bore the wounds of stigma on his body. Yet his entire life, his ministry, death and resurrection offer us a great resource for countering stigma. The Gospels show us a person with a particular concern for the suffering, the sick and marginalized, who moves easily across social barriers, whose compassion is so profound that it touches, heals and gives new life to those experiencing stigma, disease and exclusion. His teachings bring hope to those in despair and are burdensome to those who know power. His death and resurrection hold the promise of new life for the world (Ackermann, 2005:394).

Most Hindu respondents respond that Hinduism does not stigmatize PLWHA and that such sentiments arose from personal beliefs, which in certain cases are explicitly attributable to religious beliefs, such as condemning homosexuality or having sex with multiple partners and spreading HIV. Respondents, who believe that religion may stigmatize PLWHA, reason that HIV/AIDS is regarded as a sexually transmitted disease. Moral judgments may form the basis for frustration (Likalimba, 2001:30) and there is a tendency to believe that in order to stop the spread of a disease people must live according to the moral values proposed by their religion (Likalimba, 2001:30). The difficulty of dealing with the disease is conceptualized around this judgment. It is perceived that the sexual drive has dominated human consciousness to the extent that people are oblivious of the fact that the disease is a serious problem of our society (Likalimba, 2001:30). Efforts were aimed more at changing behaviour, but were not addressing the fact that people were becoming infected with HIV/AIDS and that they needed help and assistance and not scorn and rejection.

Lala (2007:72) reports that the Hindu organization as part of his study actively acknowledged that concerns about chastity and celibacy are important. However, based on the teachings of the organizations international founder, its leadership argued that priority is to be given to 'alleviate human suffering' noting that the founder prioritized 'the service of God in man'

above all else. Addressing international leaders sceptical of HIV/AIDS efforts, the senior leadership of the organization respond by arguing that ‘you have not seen death, misery and suffering the way we see it with AIDS in South Africa.’ Such language was reminiscent of the international founder’s language when conveying to his fellow monks that service to mankind was more important than their personal spiritual concerns (Lala, 2007:72).

Reference of prioritization is made to reduce HIV/AIDS related stigma by referring to the founder’s ‘pyramid of needs’ in which he explained that spirituality was impossible before the basic needs of food, shelter, health and wellness was achieved. Using such a model, the organization argued that not to serve PLWHA and to stigmatize them, degraded the prospect that people suffering from the disease could eventually rise in the pyramid and live a spiritual life (Lala, 2007:72-73). Additionally, the organization argued that celibacy and purity could not be expected of the general population and they elaborated by arguing that celibacy and purity was crucial for spiritual aspirants but that this is not for everyone (Lala, 2007:73).

Similar to remarks made by my respondents, Lala (2007:77) found that Christian and Islamic references was made to either committing or not committing sins, while similarly, Hindu references were made to ‘good’ or ‘bad’ Karma. In all three cases, a religious framework is presented in which people are either obedient or disobedient, sinner or saint, spiritual or not spiritual, pure or impure, clean or unclean. Such dichotomies make it easy to generalize an attitude over entire groups of people, not taking into consideration, the nuances of obedience, the fine line between sin and virtue, or unique individual circumstances (Lala, 2007:77). Because stigma is just generalized and oversimplified belief sets inaccurately directed to a unique group of individuals, such as PLWHA, such dichotomies that generalize to identify people as guilty or innocent make an ideal framework for generating stigma (Lala, 2007:77).

Religiously based anti-stigma messages could have the positive effect of encouraging a nuanced and independent religious thinking. By engaging in debate with the religious ideas that fuel stigma, religious organizations may demonstrate that there are many ways to interpret religious ideology and that there is often not a set of judgments which can be conclusively applied to a complex social and public health phenomenon such as HIV/AIDS (Lala, 2007: 84). Such strategies demonstrate that equally legitimate religious ideas can be in tension with one another and labelling things as good and evil is not always ‘black and white.’ By undermining the clarity of religious dichotomies and labels, the potential of religion to encourage blanket generalizations on moral character is reduced (Lala, 2007:84).

Anti-stigma messages also encourage people to critically examine the religious premise of stigma; this weakens the power of religion to subvert independent reasoning and logic (Lala, 2007:84).

There are negative implications of making inaccurate assumptions about an anti-stigma messages audience (Lala, 2007:88). (1) Messages which are intended for those not at risk convey ideas that HIV/AIDS is an external community issue, reinforcing conceptions that HIV/AIDS is 'out there' and 'not among us.' If a person in the community has HIV/AIDS, they have a disincentive to disclose their HIV positive status because to do so may place them outside of community norms. Ideas that HIV/AIDS is not in the community are usually associated with attitudes that the community is 'above' HIV/AIDS perpetuating the moral superiority which is at the root of stigma. (2) The practice of initially acknowledging religious ideas that fuel stigma have a stronger negative impact because such acknowledgement is communicated to the stigmatizer and to the stigmatized. Such acknowledgment may legitimize a religious premise for stigma and is likely to cause internalized stigma among infected or at-risk individuals (Lala, 2007:88). (3) Communicating anti-stigma messages on the assumption of a homogeneous audience makes the practice of drawing parallels to examples of religious figures and those whom they have aided have a strong negative impact (Lala, 2007:89).

If anti-stigma messages targets a community that does not have infected or at-risk individuals, such parallels, may encourage compassion, while also invoking a moral superiority and characterizing PLWHA as having negative attributes similar to those of negatively depicted groups described in scripture (Lala, 2007:89). In such situations, infected or at-risk people may not receive such messages or feel stigma by being actively compared with such negatively depicted groups. The reality is that infected and at-risk individuals are part of the same congregations to which these anti-stigma messages target. To draw parallels between PLWHA to negatively depicted groups described in scripture has a strong effect because, firstly, because of the social capital and credibility which religious messages give and, secondly, because issues of self-respect and morality draw far greater passion when within one social community (Lala, 2007:89). Therefore, there is pressure on infected or at-risk individuals to prove personal morality and self-respect because the opinion and esteem of community members are at stake (Lala,2007:89) and, thirdly, the negative aspects of anti-

stigma messages are that they are only able to reduce or affect stigma within the confines of obedience to a religious ideology (Lala,2007:91).

While credibility and social capital can be used in religiously based anti-stigma strategies. To maintain credibility, obedience to religious doctrine is necessary even if such doctrines fosters some degree of stigma or impose restrictions on the way in which anti stigma strategies are applied. To completely remove a stigma may entail disassociating sexuality with sin or wrongdoing but to do so is outside the confine of authoritative religious doctrine (Lala, 2007: 91). Additionally, to communicate anti-stigma messages that are exclusively in a context of religious ideology run the risk of making religion the ultimate currency by which a decision can be made or an attitude justified, even if the complex nature of a phenomenon such as HIV/AIDS makes religion inadequate to make such a decision (Lala, 2007:91). Therefore, religious organizations may use minimal hard evidence regarding HIV/AIDS and place most discussion of it only in a context of religion. All religious traditions and sects may not have the same tools to counteract religiously based stigma (the religions of Islam, Christianity and Hinduism all have sects, and various denominations) and therefore, to acknowledge religion as a lens through which HIV/AIDS should be viewed may open the possibility of less liberal religions fostering even greater stigma towards HIV/AIDS (Lala, 2007:91).

#### **4.3.10 Did respondents religious beliefs affect their sexual behaviour**

All Muslim respondents believed that sex should be performed only while married. Islam does not condone actions which allow people to harm themselves or others, it promotes cleanliness, marital harmony and to respect others and have self-respect.

In South Africa, polygynous Muslim marriages demonstrate that while polygyny may be a contributing factor, it did not cause AIDS to spread any more than monogamy guaranteed a reduced spread (Moosa, 2009). Islamic tenets governing sexual conduct and the practice of polygyny, if followed, pave the way to prevent its spread. In South Africa, Muslims are fully integrated in society and are susceptible to its temptations, such tenets need to be supplemented with additional safeguards to both promote and sustain change in sexual behaviour (Moosa, 2009:88). Educational and awareness campaigns about the epidemic in the community, coupled with interventions, encouraging informed sexual choices and enabling parties to positively and responsibly influence each other's sexual choices and

behaviour both before and during marriage regardless of its monogamous or polygynous nature (Moosa, 2009:88-89).

For many of Hoel and Shaikh's (2013:90) respondents, sex was discussed in terms of women being available to satisfy their husband's needs and sex as an act of worship (*ibadah*) and a charity. In the lives of Muslim women respondents, seemingly positive ideas of sexuality did not exist in isolation, but functioned as part of a complex systemic configuration of gender power relations that were often asymmetrical and hierarchical (Hoel and Shaikh, 2013:90). Purportedly positive views of sex as an act of worship or charity function in a coercive way into pressuring women to participate in 'virtuous' acts while being enmeshed in hierarchical and sometimes abusive relationships (Hoel and Shaikh, 2013:90). In the context of HIV/AIDS, women with promiscuous husbands were physically endangered by religious beliefs that wives should be constantly sexually available. Viewing Islam as a 'sex-positive' religion is not neutral (Hoel and Shaikh, 2013:90). This construction of sex is not positive for men and women because the primary subject that generally constitutes the centre of this discourse is male. Ideas of women being constantly available for sex, as developed by premodern male jurists are antithetical to most contemporary Islamic feminist ideals of mutuality and reciprocity in sexual relationships (Hoel and Shaikh, 2013:90).

Traditional utilitarian approaches to women's sexuality may invite contemporary Muslims to a 'conscientious-pause', a concept introduced by Muslim ethicist Khaled Abou El Fadl, who advises contemporary Muslims to adopt a critical approach to religious texts and normative traditions that may cause them to feel an 'unsettling or disturbing of the conscience' (Hoel and Shaikh, 2013:90). Women with abusive or promiscuous husbands resisted their husbands' sexual advances on the basis that God's mercy and justice will support their refusal to have sex. They contested dominant religious narratives of the wife's constant sexual availability on the basis of their individual moral conscience dictating their self-preservation and well-being (Hoel and Shaikh, 2013:90). The issue for Islamic feminist ethics is, in part to recover parts of tradition that do not primarily frame women's sexuality in relation to men's needs but rather to facilitate the well-being of men and women. Contemporary feminist scholar Kecia Ali suggests that 'an egalitarian sexual ethics cannot be constructed through pastiche...we need, instead, a serious consideration of what makes sex lawful in the sight of God' (Hoel and Shaikh, 2013:91). Continuing validations of androcentric sexual mores developed by pre-modern jurists has detrimental consequences for contemporary Muslim

women. Ali argues that a contemporary sexual ethics based on principles of justice is unattainable if it is founded on the gendered assumptions of pre-modern legal canon (Hoel and Shaikh, 2013:91). These arcane and gendered assumptions are taught by religious clerics in *madressas* (Islamic school) and marriage classes have continued to inform contemporary Muslim subjectivities in gender biased ways. Hoel and Shaikh's data sought to make the call by Islamic feminists for a need to reconfigure the religious imagination on intimacy so that women are considered as equal subjects of sexual desire and needs (2013:91).

While Christian respondents mention that they can only have sex while married, they acknowledge that we do not live in a black and white world anymore and we cannot make the claim that it is only the sinners or unbelievers who get HIV/AIDS and die while the true children of God retained their good health (Lala, 2007:52). Ideas of lust being a sin and associating HIV/AIDS with sex were mentioned by respondents as having influenced their sexual behaviour (Lala, 2007:48). For Muslims, Christians and Hindus, it is argued that adhering to its religious precepts and teachings is not enough to guarantee that its followers would strictly adhere to it (Adamczyk and Hayes, 2012).

Eriksson *et al.* (2010:111) found that with respect to intangible assets, Church leaders demonstrate the Churches' unique position in communities in relation to natural events in people's lives, such as, weddings, sickness and death. The work of Church leaders related to these events motivated them to deal with conflicting values related to HIV. However, they expressed ambivalence about their HIV prevention messages to young people, especially concerning condom use (Gennrich and Gill, 2004), although some Church leaders tried to talk about condoms in terms of 'taking precautions' (Eriksson *et al.*, 2010:111). Gender inequalities were also related to the HIV epidemic. Church leaders were inconsistent when articulating a conviction to adhere to government gender policy and their messages were shaped by patriarchal norms (Eriksson *et al.*, 2010:111). Women were excluded from leadership in patriarchal hierarchies and leaders in Christian Churches often reinforced this inequality between men and women (Oduyoye, 1995; Paterson, 2007). There is a need to involve women in positions of leadership as a way of addressing gender inequality (Dube, 2007; KwaZulu-Natal Christian Council, 2005).

Christian Churches are changing and there is a need for developing theology to correspond to the HIV epidemic (Haddad, 2006; Messer, 2004; Ryan, 2007; Speicher and Wilson, 2007; UNAIDS, 2005). However, it takes time for a new approach to reach individual Church

leaders who work daily with the people affected by HIV. Even when leaders may change their view related to HIV, they have to negotiate with their congregation on the action to take (Eriksson *et al.*, 2010:111). Addressing stigma and gender inequality will be the main challenge for faith based organizations and Churches in order for them to play an active role in the HIV epidemic among young people in KwaZulu-Natal and in other parts of the country, and within the study community. Increased understandings of gender differences in HIV prevention may have appeared to be a burden on girls and research is needed to explore the effects of Church teachings on the development of gender identities and sexual behaviour in youth (Eriksson *et al.*, 2010:111).

Simbayi, Chauveau and Shisana (2004:605) investigated the behavioural response of South African youth to the HIV/AIDS epidemic. They found that the median age of sexual debut for both sexes was 16.5 years. The rate of sexual frequency amongst sexually active youth was relatively low, secondary abstinence during the past 12 months was 24%. Condom use at last sexual intercourse encounter was high, being 52.8% for males and 47.6% for females especially among Africans living in urban informal settings (Simbayi *et al.*, 2004: 605). A majority of youth (74%) indicated that they discussed HIV prevention with their partners during the past 12 months. The study's results suggest that South African youth were heeding messages of abstinence, being faithful and using condoms; messages which are at the core of South Africa's HIV/AIDS prevention programme (Simbayi *et al.*, 2004:605).

Hindu respondents mostly agreed that their religious beliefs did affect their sexual behaviour. Hindus should stay faithful to one partner and have good moral values. Hindu respondents also acknowledge that other Hindus may have multiple sexual partners and do marry, obtain a divorce and remarry with other Hindu partners. Responses serve to indicate that Hindu traditions, ideas and cultural practices have changed over time and this includes how they are understood, adopted and practiced. In response to ideas that women infected with HIV are described as sexually impure or unfaithful, Hindu religious organizations use scriptural references attesting to the inherent purity of all women and argue that a majority of Hindu women were infected with HIV by their husbands (Lala, 2007:73). In ancient India, women occupied a superior position to men. The Hindu word '*shakti*' means 'power' and 'strength' and it is emphasized that all male power comes from the feminine (Lala, 2007:73). The Hindu epic, Ramayana, taught that Ravana, the epic's villain and his clan were wiped out because he abducted Sita, who was a respected queen (Lala, 2007:74). In responding to the perception that PLWHA are unclean because of their sexual acts or that they possess a

decreased worthiness in accordance to karma, the organization appealed to an example of a saint and the teacher of the international organization's founder. Pamphlets recount an incident in which the saint washed the bathroom of an untouchable as an exercise in humility. In doing so, parallels were drawn to identify stigma as an attitude contrary to humility (Lala, 2007:74)

#### **4.4 Summary of the section**

Muslims experience frustration in terms of being trapped between developmental stages and tend to question all that is placed before them (Maqsood, 2001:6-7). Young adults who remained longer under the guardianship of both parents stood to benefit from the emotional, financial and social support rendered by their parents. Muslim adults (as well as Christian and Hindu adults) should show these attributes to better understand their children; (1) that they should never resort to force; (2) to express feelings and to share in happiness and in pain; (3) to communicate effectively; (4) be an active listener; (5) to assist in skills development; (6) to use examples from the environment and (7) to use a holistic approach (Beshir and Beshir, 2002:143). It is argued that social control in terms of HIV/AIDS and sexuality are dependent upon factors such as family culture and religious control (Chabillal, 2010:58). Islam, Christianity and Hinduism all encourage the idea that prevention is better than cure while also encouraging the promotion of good health and taking care of the body (Amod, 2006; Ebrahim, 2007). Hinduism holds the view that the human soul is infinitely pure and that all impurities can be washed away (Lala, 2007:73). Such beliefs are evident in Christianity and Islam, in that, if people commit sin, but with sincere repentance and the vow to never to return to that sin, they would be forgiven. Using religion as a framework in which people are seen as either obedient or disobedient, sinner or saint, spiritual or not spiritual, pure or impure, clean or unclean, makes it easy to generalize attitudes over entire groups of people, without considering, the nuances of obedience, the fine line between sin and virtue, or unique individual circumstances (Lala, 2007:77). Adamczyk and Hayes (2012) argue that for Muslims, Christians and Hindus, adherence to religion was not enough to guarantee that its followers would strictly adhere to their religion (Adamczyk and Hayes, 2012).

This chapter presented a discussion of the data findings of the study and an analysis of its findings. The next chapter is the final chapter and it looks at the conclusion and recommendations.

## CHAPTER 5

### CONCLUSION AND RECOMMENDATIONS

#### 5.1 Introduction

In this final chapter, the conclusion of this study is presented and it also focuses upon the study's conclusions and recommendations. It will explain what was unique about the study and how has it helped to increase the knowledge on the discourse of religion and HIV/AIDS.

#### 5.2 Conclusions of the study

The study's main aim was to assess the impact of religious beliefs and stigma on people living with HIV/AIDS, which was conducted in the community of Cravenby, situated in Cape Town. Its specific aims and objectives were to investigate: (a) how religion affects people's attitudes to those living with HIV within Cravenby? (b) If religious beliefs lead to stigma? (c) whether religion allowed one to disclose one's HIV status if one is HIV positive?; (d) how religion affects one's sexual behaviour?; and (e) how much is known about HIV by people living in Cravenby?

Muslims possess good knowledge understandings about HIV/AIDS and its dangers, with a few individuals holding an incorrect or incomplete knowledge about HIV/AIDS. Some respondents seemed to regard Cravenby as a conservative community. The amount of PLWHA living in Cravenby is believed to be very small and because of this some Muslim respondents believed that they may have felt protected from becoming infected with HIV. A majority of Muslim respondents did not know many PLWHA in a personal capacity. Muslims would treat PLWHA as normal but some have expressed the view that they would be cautious and careful around them. Muslim respondents regard PLWHA to be deserving of respect, empathy and sympathy and Muslims should employ the lesser of two evils concept, because even though a person may be labelled as unfaithful or shared needles for drugs, to help someone living with HIV/AIDS is considered the lesser of two evils as authors such as (Lala, 2007; Ebrahim, 2007; Amod, 2006 and Barmania, 2013) have noted.

Muslims express awareness that they do talk about and discuss HIV/AIDS but, the reality is that they do not talk enough about it and this is corroborated by statements expressed in Mukadam (2013). There was some silence regarding HIV/AIDS, however, Muslim respondents express sympathetic and supportive attitudes toward PLWHA akin to those

expressed by respondents in Abrahams (2006) study. Muslims regard disclosing an HIV status as a personal choice, but if people test HIV positive, then there is a stigma. Islam allows Muslims to go for an HIV test, but ideally it seeks to promote the idea that prevention is better than cure and instead emphasizes healthy lifestyle choices and to care for the body as it is a trust from God. Such tenets are also endorsed by Christianity and Hinduism. HIV tests have not been frowned upon nor discouraged. However, initiatives which have proposed to implement this have faced resistance, as reported in (Lala, 2007; and Chabillal, 2010). Islam does not stigmatize PLWHA as stigma emanates from people's own beliefs. However, sexual orientations such as homosexuality are discouraged and the use of substances (drugs and alcohol) are disliked or forbidden (Ebrahim, 2007). Muslims should care for people if they do get sick, even if they suffer from HIV/AIDS (Lala, 2007). The Prophet Mohammed (Sallallahu alayhi wasalam) used to visit the sick and it is commendable for Muslims to do so. All Muslim respondents affirm that their religious beliefs have affected their sexual behaviour. Muslims should not commit adultery nor go near it because it is shameful and evil. However, evidence has shown that Muslims have decided to get married in order to legitimize a premarital pregnancy (Toefy, 2002).

All Christian respondents express awareness that HIV/AIDS is a sexually transmitted disease. In the past, early Christian responses toward HIV/AIDS were met with denial by Christian religious leaders, as noted by authors such as Clarke *et al.* (2011). Christian Church congregations should reach out and embrace all people, including PLWHA and those affected by HIV/AIDS, such an initiative would promote healing, both to single individuals and to the Church as a whole (Lala, 2007). However, although, compassionate attitudes do negate feelings or attitudes of hate, resentment, exclusion and apathy, they have not necessarily or directly counteracted perceptions that PLWHA were seen as promiscuous, as being responsible for them having HIV or that they were sinful (Lala, 2007). It is also noted that parallels which may be drawn from religious stories may have intentions to influence people to adopt a compassionate and de-stigmatized attitude, at the same time, such stories reinforced negative labels attached to PLWHA and created morally superior labels for those who were in positions to help them, as noted by authors such as (Ridge *et al.*; 2008 and Lala, 2007).

HIV/AIDS is seen as a problem in the Cravenby community and needs more awareness. Having an education does not mean that people will listen to HIV prevention messages. For

example, if individuals do decide to have sex, they should take precautions. However, the literature has shown that this may not always be the case (Becker and Joseph, 1988; MacPhail and Campbell, 2001; Eaton *et al.*, 2003; Lambert and Wood, 2005; Pettifor *et al.*, 2005; Zambuko and Mturi, 2005; Frank *et al.*, 2008; McGrath *et al.*, 2009; Eriksson *et al.*, 2010; Rehle *et al.*, 2010). Christian respondents are more likely to speak to and discuss HIV/AIDS with and amongst their family, friends and to the general public. They also see it as commendable to visit the sick and would encourage PLWHA to lead a more religious life and that they should not infect others with HIV.

Christianity, according to some Christian respondents did not 'promote' HIV testing, because it does not promote high risk behaviour or having sex before marriage. However, engaging in high risk behaviour does exist (Adefuye, *et al.*, 2011). HIV testing is encouraged and is accompanied with counselling before and after the test (Kalichman and Simbayi, 2003; Peltzer *et al.*, 2004; Swanepoel, 2004; Denison *et al.*, 2008; Toefy, 2009; Mall *et al.*, 2013). Churches do assist PLWHA and Christianity as some respondents noted, does not discriminate against anyone, as anybody could convert to Christianity. Christianity allows for one man and one wife and sex is only allowed once you have married. In contrast, Muslims are allowed to have polygynous marriages (up to four wives), but the husband should treat all his wives equally (Moosa, 2009).

Sin was not regarded as being in a major or minor category for Christians, with respondents noting that everyone is capable of sinning. In Islam, sins do have a major or minor category. Major sins are polytheism and adultery and minor sins could be engaging in gossip or swearing. Lusting after other women is seen as a sin by respondents and associating HIV/AIDS with sex was mentioned by respondents as having effects on their sexual behaviour. Respondent attitudes were realistic in that adhering to religion and religious beliefs is not enough as a guarantee to ensure that followers would strictly adhere to it (Adamczyk and Hayes, 2012), because people can make beneficial or harmful choices.

Hindu respondent's knowledge about HIV/AIDS was very good as information about HIV/AIDS is very widespread. Hindus should focus on their dharma or duty toward PLWHA and should not ignore or stigmatize them so that they would not face the consequences of bad karma (Lala, 2007). Hindus see HIV/AIDS as a problem in the Cravenby community but note that not a lot of PLWHA have come forward to disclose their status. The most effective way

to know your status is to go for a HIV test. Hindus did not discuss HIV/AIDS so much at a public level; but they do discuss it amongst their family and friends. Hindu groups have mobilized against HIV/AIDS in countries such as India, South Africa and Trinidad (Genrich and Brathwaite, 2005; Goldman, 2008; Toefy, 2009). To disclose one's HIV status may have benefits and drawbacks as authors such as (McNeil Jr., 1998; Gewirtz and Gossart-Walker, 2000; Paxton, 2002; Maman *et al.*, 2009 and Zou *et al.*, 2009) have noted. Hinduism allows for HIV testing, but some respondents indicated that there was a lack of certainty about it. Hindu, Christian and Islamic literatures have all expressed the belief that it is essential to take care of your body, mind and soul (Nirvedananda, 1944; Krishnamurthy, 1994; Amod, 2006; Lala, 2007; Toefy, 2009).

Hinduism did not stigmatize PLWHA according to Hindu respondents, but rather it comes from people. Personal beliefs may in some cases be explicitly attributed to religious beliefs, such as religions which condemn or speak out against homosexuality, premarital sex and adultery. Moral judgments may form a basis for frustration (Likalimba, 2001), as there are tendencies to believe that in order to stop the spread of disease, people must live according to the moral values proposed by their religion (Likalimba, 2001). Hindu respondents believe that their religious beliefs do have an effect on their sexual behaviour. Hindus should remain faithful to their marital partner and have good moral values. However, Hindus do dress provocatively, especially in the entertainment and television media (Mehta and Pramanik, 2010). Sexual abstinence is considered a virtue for Hindus (Nag, 1995). Unlike Islam and Christianity, Hindu literature did not view HIV/AIDS as a punishment from God, but instead more emphasis is laid on individual behaviour (Raman, 2003) and improper sexual behaviour (Manda, 2011).

The stigma of AIDS is reflected in the fact that it was considered contagious, deforming, fatal, imperfectly understood, and was associated with already stigmatized groups (Weitz, 1989; Weitz, 1990). Therefore, to avoid stigma, PLWHA do not disclose their illness if it is invisible to others or may mask illness symptoms if they are seen. Sufferers of HIV/AIDS may lie about their symptoms if it could not be masked and would seek minimal contact with those who may reject them should their illness become known. Stigma is a psychological defence mechanism which serves to control anxiety in the face of danger (Stein, 2003).

For HIV/AIDS stigma to exist, individuals must be identified as having HIV/AIDS, negative stereotypes are then associated with this label which may lead to some form of social distancing, status reduction and discrimination (Maughan-Brown, 2004). Forming such negative stereotypes occurs when dominant cultural beliefs link such individuals to undesirable characteristics, as noted by Link and Phelan (2001). To reduce the stigma associated with HIV/AIDS, educational approaches should be combined with other approaches, such as having contact with PLWHA and skill building (Jacobi *et al.*, 2013). Respondents mention more education is needed and awareness needs to be raised as measures to reduce HIV/AIDS stigma. Studies by (Brown *et al.*, 2003; Heijnders and van der Meij, 2006; and Bos *et al.*, 2008) have shown that combining education, counselling and contact were most promising in reducing HIV/AIDS stigma. HIV-positive individuals should be encouraged to gain confidence and support to come out and publicly discuss what it is like to live with HIV/AIDS; to counsel individuals living with HIV/AIDS may help them to deal with the secrecy, stigma and loss related to an HIV positive diagnosis (Gewirtz and Gossart-Walker, 2000).

Religiously based anti-stigma messages may have the positive effect of encouraging nuanced and independent religious thinking. In debating with religious ideas which may fuel stigma (in this case, Christian, Hindu and Muslim) religious organizations could demonstrate that there are many ways to interpret religious ideology and that it is often not a set of judgments which can be conclusively applied to a complex social and public health phenomenon such as HIV/AIDS (Lala, 2007). Anti-stigma messages can encourage people to critically examine stigma's religious premise and in doing so, may weaken the power of religion to subvert independent reasoning and logic (Lala, 2007).

Drawing parallels between PLWHA to negatively depicted groups in scripture has strong effects because: (a) of the social capital and credibility that religious messages give and (b) because issues of self-respect and morality draw far greater passion when within one social community. Therefore, there is a great pressure placed upon infected or at-risk individuals to prove their personal morality and self-respect, because the opinion and esteem of community members is at stake (Lala, 2007). To communicate anti-stigma messages exclusively in a context of religious ideology may run the risk of making religion the ultimate currency by which a decision can be made or attitudes justified, even if the complex nature of HIV/AIDS may render religion inadequate to make such decisions (Ganczak *et al.*, 2007; Lala, 2007). Religious organization may use minimal hard evidence regarding HIV/AIDS and place most

of its discussion in a religious context. It is argued that, all religious traditions and sects do not have the same tools to counteract religiously based stigma and to acknowledge religion as a lens through which to view HIV/AIDS, opens the possibility of less liberal religions fostering even greater stigma toward HIV/AIDS (Lala, 2007).

Biographical disruption firstly implies that people's stock of knowledge of self and social world is disrupted by the experience of illness (Felde, 2011). Secondly, it suggested that explanatory frameworks that were normally used to understand daily life have been disrupted and may require a rethinking of biographical particulars (Felde, 2011) and thirdly, implication is related to mobilizing resources in face of the altered circumstances of chronic illness. Mobilizing cognitive, material and practical resources to repair the biography and to maintain everyday life is the adaptive response to the disruption (Felde, 2011:102).

Biographical disruption's initial formulation placed an emphasis of an assault of illness on a previously held and often cherished conception of self and life course, prompting a fundamental re-thinking of an individual's biography and self-concept (Bury, 1982) in light of the illness (Wilson, 2007). Biographical disruption was based on interviews with young women, recently diagnosed with rheumatoid arthritis, a chronic illness condition (Bury, 1982). However, it is argued that Bury's analysis took an individual approach with a focus on the effect of illness on work-related rather than on caring responsibilities (Wilson, 2007).

Being HIV positive places much of one's life under a sign of uncertainty (Pierret, 1992:72). As such, a medical prognosis is not able to predict when such an individual may fall ill (Carricaburu and Pierret, 1995: 66). Seeing that HIV/AIDS is mainly considered as transmitted by sexual intercourse and because HIV may be viewed as a chronic illness, the way in which people are able to cope with living with this chronic illness condition and how they manage their daily life is bound up with the interpretation that they may develop about the meaning of their illness condition (Carricaburu and Pierret, 1995). Respondents mention that HIV is a virus that enters the body's immune system and destroys it through unsafe sex. HIV/AIDS and its consequences for daily life raise problems that are faced by the chronically ill: they deal with uncertainty (the possible reaction by family, friends or the public because of their HIV status), having to cope with stigma (people who are HIV positive may face scorn if they have unprotected sex or infect themselves with HIV through contaminated needles), manage the trajectory of the illness (antiretroviral drugs treat HIV/AIDS and it cannot be

spread by physical touching), do biographical work and also have to recompose a sense of identity (Carricaburu and Pierret, 1995). Managing the loss of self, identity and sense of belonging to a group that is stigmatized requires considerable biographical work in order to manage the new identity in the face of self and public doubt (Seeley et al., 2012: 342). Christian, Hindu and Muslim respondents mention that they would like to interact with PLWHA in a manner they would with everybody else. This means that PLWHA still have the same external identity, it is just that they are infected with HIV/AIDS internally, and this internal difference is regarded by Christian, Hindu and Muslim respondents as salient.

Elements of biographical disruption can be adapted to, find changes in meaning systems and identities to investigate how women or PLWHA may interpret their life circumstances, especially in the early stages of an illness, for example (Ciambrone, 2001). Knowing such processes may further our understandings of women or PLWHA and also highlight the illness experience of other illness populations. To address the social milieu in which disruption and repair occur is critical to developing effective treatment protocols and preventative efforts which are optimally suited to the needs of women or PLWHA (Ciambrone, 2001:536).

An illness experience is not only bound by the body or consciousness of an ill individual, it may encompass a household, family or a social network and in this way biographical disruption due to illness may extend beyond the affected individual (Chisaka and Coetzee, 2009). A majority of respondents are open to the idea of treating PLWHA with empathy and sympathy and to view PLWHA as normal. To live in deplorable living conditions may make the suffering worse for chronically ill individuals living in poverty, such conditions may also cushion the existential or ontological assault on selfhood brought on by chronic illness (Chisaka and Coetzee, 2009). Because of this, many individuals living on the margin of society, especially in regions such as Sub-Saharan Africa and in South Africa, define the poverty that they live in as a primary concern above all others, which includes the risk or reality of contracting HIV (Chisaka and Coetzee, 2009).

This section looked at conclusions that could be drawn from religion and HIV. Conclusions which could be drawn from stigma and biographical disruption have also been discussed.

In answering as to whether the research question (as outlined in 1.3) has been answered. For Muslims, all respondents affirm that Islam forbids premarital sex (which is also discouraged

by Christianity and Hinduism). Islam regards actions such as adultery to be a major sin. Any sin, major or minor and apart from polytheism (*Shirk*), can be forgiven with sincere repentance and vowing not to return to it. Religious beliefs do have an effect on sexual behaviour. Allah (God) has said in the Holy Qur'an that He created mankind in pairs, to complement each other; males and females and that to deviate from this, invites wrath and punishment from God. For Christian respondents, like Muslim and Hindu respondents, most respondents believed that their religious beliefs did have an influence upon their sexual behaviour. Religion and religious beliefs have the power to guide. For some Christian respondents, sexual behaviour was considered to be a personal and private matter and if people make irresponsible decisions then they should face the consequences. For Hindus, most respondents agree that their religious beliefs did influence their sexual behaviour. Hindus should remain faithful to one marital partner and should have good moral values. (These beliefs are shared by Islam and Christianity). However, some mention that in Hinduism, the belief is that when they marry, their partner is theirs for life and when he dies, the widow should not remarry. But the reality today is that this does not happen. Women have more partners before marriage and may even divorce and remarry. In Christianity, there is divorce and one can remarry, thereafter. In Islam, if the husband dies or divorces his wife, then there is a waiting period (called *Iddah*), before the woman is allowed to remarry. If the wife dies before the husband, then it is allowed that he can marry someone else, and there is no waiting period prescribed for him.

### **5.3 Recommendations and uniqueness of the study**

Recommendations which could be gathered from the study are that although Muslims possess good understandings about HIV/AIDS and the danger it poses, their accounts also portray an incomplete or incorrect knowledge about HIV/AIDS. Possible reasons include the age of the individuals, especially, of those who had lived prior to the prominence of the epidemic, because HIV/AIDS is not discussed widely in the Muslim community and that they attribute it to deviance and a shift in attitude towards religious scripture and teachings (that is, that those who are infected with HIV/AIDS were not adhering to its scripture and teachings). Muslims express an awareness that they do talk about HIV/AIDS, the reality of the situation, is that they do not talk enough about it. Islam does not stigmatize PLWHA; rather, the stigma comes from incorrect personal beliefs held by individual groups or people. If Muslims, like Christians can reach out and embrace all kinds of people, including those who are infected

and affected by HIV/AIDS, then such initiatives promote healing, as it is not only the individual person who gets healed, but the entire community. HIV/AIDS is seen as a problem in the community and needs more awareness. Christians were more likely to speak about and discuss HIV/AIDS with and amongst their families, friends and the general public. However, such initiatives are not so keenly accepted by some Muslims and Hindus. People's moral judgments may form the basis for frustrations and there are tendencies to believe that in order to stop the spread of a disease, in this case, such as HIV/AIDS, then people must live according to the values proposed by their religions. A difficulty in dealing with a disease such as HIV/AIDS is conceptualized around this judgment. People may perceive that the sexual drive has dominated human consciousness to the extent that people are oblivious to the fact that a disease such as HIV/AIDS is a serious problem of our society (Likalimba, 2001). Having a joint forum attended by Muslims, Christians and Hindus discussing HIV/AIDS would help to address incorrect and or incomplete knowledge and beliefs around HIV/AIDS in the community.

More can be done to study the actual nature of people's interaction of those living with HIV/AIDS to reduce stigma, as even though people may speak of HIV/AIDS, the reality is that people were not talking enough about it. Although respondents indicate that PLWHA should be treated with respect and compassion, people are still clinging to ideas of the 'other.' Rendering HIV/AIDS as a chronic disease akin to less stigmatized chronic diseases could be helpful in de-stigmatizing the stigma surrounding HIV/AIDS. More positive discourses should be inculcated to those infected with HIV, as a newly infected person is exposed to negative discourses around HIV/AIDS and such a discourse may affect their identity, livelihood and well-being. A larger study should focus on the intersection of Christianity, Hinduism and Islam, with the inclusion of those living with HIV/AIDS and those who are not living with HIV/AIDS. Further research can also look at the lived reality and religious practices of people adhering to religion and how such practices may lead to a reduced risk of infection of HIV, as well as to discouraging less risky behaviour, so the chance of HIV infection transmission is minimized. Such research could look at the lived reality and practices of other religions practiced in South Africa, other than those of monotheistic ones, for example, among people who follow religious traditions such as Buddhism or who are atheistic and how they may view and respond to HIV/AIDS.

What has made the study unique is that little has been written on the role of Hinduism within a South African and specifically within its Cape Town context and its intersection with

HIV/AIDS. Not much has been written with regard to HIV/AIDS and the religions of Islam, Christianity and Hinduism, collectively within a Cape Town context and in relation to its various communities. No study of such nature has been done in the community of Cravenby that the researcher is aware of and it is for this reason that the researcher attempts to fill this gap by conducting such research in this community. This research also sought to draw comparisons between the three religions of Hinduism, Christianity and Islam in the study and specifically within the Cravenby community.

#### **5.4 Contributions of the study**

A majority of the respondents from the community have a good grasp of HIV/AIDS. However, during the course of the study, many Christians, but not many Muslim and Hindu respondents personally knew those living with HIV/AIDS. This is because, those who are living with HIV/AIDS in the community of Cravenby have not spoken about or disclosed their status, or that those individuals had moved out of the area or were living with HIV/AIDS, but have since passed on. Attitudes towards those living with HIV/AIDS indicate that most respondents viewed those living with HIV/AIDS in a positive light, with the main belief being that they should be treated with respect and empathy and not with scorn or indignation. Negative social behaviours should be discouraged, the use of alcohol and drugs is also prevalent in the community and such anti-social behaviour, is believed to contribute to the problem of HIV/AIDS increasing in the community. More awareness is needed with regards to the danger that HIV/AIDS may pose. HIV testing is encouraged among Muslims, Christians and Hindus, as all three religions exhort and encourage their followers to take care of their bodies and it is believed that going for an HIV test provides an ideal opportunity for people to make better choices and lifestyle changes as this is an ideal outlet for disseminating knowledge about HIV/AIDS. Respondents did not believe that their religions stigmatize those living with HIV/AIDS, but that not adhering to religious teachings or rulings may contribute towards people stigmatizing those living with HIV/AIDS and this is mainly due to the factors which surround the contraction of HIV/AIDS. The religious scripture and tenets of the three religions did affect the sexual behaviour of a majority of respondents. This was agreed upon by all Muslim respondents; however, some Christian and Hindu respondents have voiced the view that religious beliefs did not affect their sexual behaviour.

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**Appendix A**  
**UNIVERSITY OF THE WESTERN CAPE**

***DEPARTMENT OF ANTHROPOLOGY AND SOCIOLOGY***

Private Bag X17  
BELLVILLE  
7535  
CAPE TOWN  
SOUTH AFRICA  
Tel: (021) 959 2336  
Fax: (021) 959 2830

**INFORMATION SHEET:**

**Research on:** The impact of religious belief and stigma on people living with HIV/AIDS: A study in Cravenby, Cape Town

The study seeks to explore the religious beliefs and stigma towards those living with HIV/AIDS. Research questions include:

- The impact of religion on people's attitudes to HIV.
- Do religious beliefs lead to stigma?
- Does your religion allow one to disclose one's HIV status if one is HIV positive?
- How do your religious beliefs affect your sexual behaviour?
- How much do they know about HIV?

The study is under the Department of Anthropology and Sociology and is undertaken by Wajeed Parker, supervised by Professor Nadasen, at the University of the Western Cape. To participate in the research is voluntary and you may do so if you understand the aims of the research and if you would like to participate. If you agree to participate in the interview, you must sign a consent form which will protect you and inform you of your rights as a participant in the research. I look forward to your participation in the interview should you agree to participate.

Contact details:

Student researcher: W. Parker, [wajiedparker@gmail.com](mailto:wajiedparker@gmail.com); cell phone: 074 971 4444

Supervisor: K. Nadasen, telephone: 0219592831

**Appendix B**

**UNIVERSITY OF THE WESTERN CAPE**

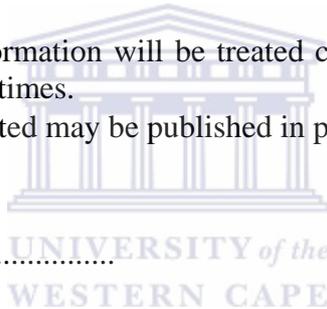
**DEPARTMENT OF ANTHROPOLOGY AND SOCIOLOGY**

The impact of religious belief and stigma on people living with HIV/AIDS: A study in Cravenby, Cape Town

**RESEARCH CONSENT FORM**

I,.....Hereby give my consent to participate in this research project which is an exploration of people’s religious beliefs towards people living with HIV/AIDS.

- I understand that the study is being undertaken by Wajeed Parker (supervised by Professor Nadasen) under the auspices of the Department of Anthropology and Sociology, at the University of the Western Cape.
- I have been informed fully of the study’s aims and I participate in it voluntarily.
- I have not been coerced or pressurised unduly to participate in the interview, and I understand that I may withdraw from the study at any time and without consequence.
- I understand that I am free to withdraw from the study even after the interview is complete.
- I understand that any information will be treated confidentially and that my identity remains anonymous at all times.
- I agree that the data collected may be published in publications or in reports.



Respondent signature:.....

Date:.....

Place:.....

Facilitator:.....

Witness/es:.....

Contact details:

Student researcher: Wajeed Parker

Cellphone Number: 074 971 4444

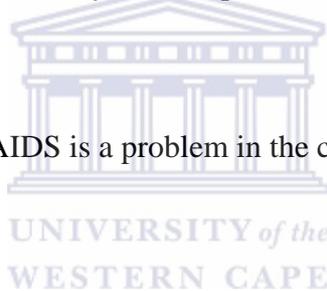
Supervisor: K. Nadasen

Telephone Number: 021 959 2831

## Appendix C

### Interview Schedule

1. How much do you know about HIV/AIDS?
2. Do you personally know of people living with HIV/AIDS?
3. How would you interact with people living with HIV/AIDS?
4. Should those living with HIV/AIDS be treated with respect, with indignation or scorn, owing to the manner in which they have acquired the virus?
5. Do you believe that HIV/AIDS is a problem in the community?
6. Do you discuss HIV/AIDS with your community, amongst your family and friends or to the general public?
7. If you are HIV positive, does your religion allow you to disclose your status?
8. Does your religion promote going for HIV tests?
9. Does religion stigmatise people living with HIV/AIDS?
10. Do your religious beliefs have an effect on your sexual behaviour?



## Appendix D

UNIVERSITY OF THE WESTERN CAPE

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SOUTH AFRICA

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### Parental Consent Form

This study seeks to explore the religious beliefs and stigma towards those living with HIV/AIDS. The research questions of the study include; (a) the impact of religion on people's attitudes to HIV; (b) do religious beliefs lead to stigma?; (c) does your religion allow one to disclose one's HIV status if one is HIV positive? (d) How do your religious beliefs affect your sexual behaviour? And (e) how much do they know about HIV?

I,..... (Parent's name) hereby give my consent for my son or daughter to participate in this research project which is an exploration of people's religious beliefs towards people living with HIV/AIDS.

- I understand that the study is being undertaken by Wajeed Parker (supervised by Professor Nadasen) under the auspices of the Department of Anthropology and Sociology, at the University of the Western Cape.
- I have been informed fully of the study's aims and I participate in it voluntarily.
- I have not been coerced or pressurised unduly to participate in the interview, and I understand that I may withdraw from the study at any time and without consequence.
- I understand that I am free to withdraw from the study even after the interview is complete.
- I understand that any information will be treated confidentially and that my identity remains anonymous at all times.
- I agree that the data collected may be published in publications or in reports.

Respondent signature:.....

Date:.....

Place:.....

Facilitator:.....

Witness/es:.....

#### Contact details:

Student researcher: Wajeed Parker

Cellphone Number: 074 971 4444

Supervisor: K. Nadasen

Telephone Number: 021 959 2831