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PERCEPTIONS OF AND ATTITUDES TO HIV/AIDS AMONG YOUNG ADULTS AT THE UNIVERSITY OF CAPE TOWN

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Abstract

Given the exponential rate of growth of HIV/AIDS in the Western Cape in recent years, and university concerns about the health of students and others, knowledge about young peoples' ideas and social constructs of the virus and syndrome is important. Medical anthropology lecturers Fiona Ross and Susan Levine present here their preliminary findings about University of Cape Town student perceptions regarding HIV/AIDS. This paper shows that young adults tend to imagine that they have an immunity to HIV infection and so continue to practice unsafe sex, irrespective of their educational background and specific knowledge about HIV/AIDS. The data suggest a critical need to reassess the efficacy of education as a means of disease prevention, and to examine more closely the knowledge, attitudes and practices of young adults.

Introduction

In the light of the HIV/AIDS pandemic in South Africa, the exponential rate of increase in the Western Cape in recent years, and the current public debates on cause and treatment (see TAC website 2002), the dearth of information on the attitudes, beliefs and practices of young adults is a matter of concern (Skinner 2001). Context specific and detailed ethnographic material can shed light on popular attitudes towards, and conceptions of, the disease. The data reported here, drawn from interviews with young adults conducted by their peers, indicate that they imagine they have an immunity to HIV infection, irrespective of their educational background and specific knowledge about HIV/AIDS. There is some evidence to suggest that they continue to practice unsafe sex. The data indicate a critical need to reassess the efficacy of education as a means of disease prevention, and to examine more closely the knowledge, attitudes and practices of young adults.

Background

Since 1997, the Social Anthropology Department at UCT has offered, as part of its SAN226F (Medical Anthropology) course, a two-week intensive focus on the social contexts of and responses to HIV/AIDS.

Lecturers have invited advisors from Student Health Services to give seminars and/or lectures to students[1]: the course's focus is envisaged as critical and interventionist. As part of the submission requirements for the course, students have been obliged to conduct small, interview-based research projects on HIV/AIDS, designed to develop their interviewing skills and to enable students to apply knowledge derived from the course. Student responses in previous years suggested the importance of a sustained focus on young *educated* adults, especially in the light of the limited local literature on the educated elite.

[1] Current estimates are that approximately 22% of students at undergraduate level are HIV positive, a rate that is predicted to rise to 33% by 2005 (www.uct.ac.za/depts/hivaids. (Accessed 15th February 2002.) Note that throughout the paper, we use 'students' to refer to the SAN226F students conducting interviews, and 'interviewees'/'respondents' to refer to the students who were interviewed.

Methodological Approach and Limitations of the Study

Accordingly, students interviewed five peers regarding their knowledge of HIV/AIDS. The research topic, centred on the effects of education regarding knowledge of HIV and its and transmission, was broad, to enable students to pursue enquiries of interest to them. It is cited in full below.

> **PROJECT 1: HIV/AIDS**
> Education is often posed as being the 'solution' to HIV/AIDS transmission by sexual interaction. Such 'solutions' fail to take into account cultural and social explanations for sexual behaviours.[2] Interview at least five friends or acquaintances of your age about their knowledge of HIV/AIDS, about their understandings of the disease, its causation and prevention. Use a semi-structured questionnaire as a guide for your interviews. Write a 1 500 word report in which you describe your sample, and discuss your research findings and conclusions. Your discussions should also include literature on the subject (at least four readings) and also reflect your own opinions and views on the matter. Include as an appendix to your report some interview notes and the questionnaire.

In addition to the topic, students were given two weeks of lectures on HIV-related themes, additional reading material, and the projects and their ethical implications were discussed in detail in class.

Approximately 480 young adults, ranging in age from 19 to approximately 30 years, were interviewed.[3] No specific sample was designated. As the project was a training exercise, students were required to devise their own interview schedules. (It is worth noting that notwithstanding widespread public campaigns, some respondents felt that asking questions about HIV, even when carefully posed by peers, remains a sensitive issue, and some felt that discussions about HIV and sex were inappropriate.) The data reported here are drawn from both student reports on their interviews and from their raw material. Respondents' names were not recorded and their confidentiality was guaranteed. While not uniform, the questions posed by student researchers and the interview material they generated address a broad range of attitudes, perceptions and reported behaviours. The findings reported here, then, represent the *scope* of responses to a variety of issues in relation to HIV/AIDS.

The paper, drawing on the rich material offered in student reports concerning their interviews, gives information on trends and themes rather than on statistically reliable data. Owing to the non-standardised research designs, findings should not be more broadly generalised. However, although not necessarily reliable or valid in relation to a larger population, the data do offer significant insight into the knowledge, attitudes, practices and beliefs of young adults in Cape Town, especially those based on UCT campus. Despite the limitations of the sample and interview schedules, the material is important in exploring student perceptions and identifying general patterns in the responses of young, educated adults to the disease. The material reflects a wide array of opinions, which in some instances can be linked with differing religious affiliations, gendered perspectives, and ideas about racial, ethnic, and cultural differences.

In general, the data indicate that:

- General knowledge of HIV/AIDS transmission is good, with the exception of knowledge about vertical transmission, which was seldom mentioned by students or their respondents.

[2] The education model informs much of the public intervention in South Africa. It is explored in Karen Boswell's film 'Dancing on the Edge' (2001).

[3] Ninety-six students were registered for the course, and each student was asked to interview five respondents. In some cases, students chose to interview family members and/or younger school students. We did not include these interviews in the sample, and therefore our figure of 480 interviews is approximate.

- Students and their interviewees are familiar with principles of the South African 'ABC' campaign, yet many students report that they and their interviewees are 'bored with AIDS education'; and 'sick and tired' of hearing about AIDS.
- Discourse about the disease is usually couched in terms of debate around 'safe' and 'unsafe' sex, where sex is defined as heterosexual, vaginally penetrative intercourse, where 'safe sex' = 'protected sex' and where 'protection' = use of condom. Condom-use is negatively associated with trust in relationships.
- Few of the respondents had discussed HIV/AIDS with their partners, and few reported having had HIV tests. Few know people with HIV/AIDS.
- Despite the fact that the HIV/AIDS public campaign has specifically been constructed around awareness/prevention of 'risk *behaviours*', respondents are consistent in their reference to risk *groups*. Respondents consistently stereotype those at risk and, in so doing, distance the possibility of personal risk.

In the remainder of the paper we explore these and other dimensions emergent from the study by focusing on reported ideas about safer sex practices; respondents' knowledge of HIV/AIDS, and young peoples' constructions of safety and stigma.

Protected and Unprotected Sex

For the most part, students and interviewees define 'real sex' as vaginally penetrative heterosexual intercourse. No interviews on homosexual practices were mentioned, although homosexuals were consistently reported as being at great risk of getting and transmitting the disease. 'Homosexuals are the key transmitters of disease', said one, in a comment that was widely echoed. Homosexuals are defined as male – only one respondent expressly referred to lesbians.

'Safe sex' was construed by respondents as 'protected sex', where 'protection' is equated with condom use during vaginally penetrative intercourse.[4] Reports on HIV testing were uncommon.[5] Where students asked about sexual practice, many respondents mentioned having had unprotected sex, despite their knowledge about HIV transmission. Reasons given included the following: 'having gone too far without thinking'; 'did not have condoms handy'; 'being drunk'; 'being in a long-term relationship and thinking it must be all right'; and 'the condom broke'. In addition, several respondents reported that their primary concern was with pregnancy and not HIV, and were making use of contraceptive pills rather than condoms. One man reported that he had unprotected sex both because he knew his partner's HIV status and because she was using contraception. A woman reported that she used the pill and so did not feel it necessary to use condoms, even as she acknowledged that her behaviour put her at risk of sexually transmitted infections. One student study specifically evaluated fears in relation to sexual conduct: four out of five (female) respondents reported that they feared pregnancy more than HIV infection, and the sole male respondent in the study reported that he feared 'performance failure' more than HIV infection. Many respondents stated that women have little negotiation power in relation to condom-use (see below), but the women did not always attribute powerlessness to themselves; it was usually attributed instead to 'poor' and 'rural' women, always defined as black.

[4] All respondents recognise a link between 'unsafe sex' and HIV transmission. Unsafe sex here is defined in terms of 'unprotected sex'; intercourse without condom-use. Most students and respondents felt strongly that there is a link between HIV and AIDS. They use the terms interchangeably and many seem unaware of the differences between a virus and a syndrome.

[5] Students' papers do not discuss HIV testing in any detail. Some students asked respondents whether they had or would consider having HIV tests: most replied that they had not had tests and that they had not asked their partners about testing. A few replied that they had considered being tested but were too afraid of the results to go through with tests. This fear is widely held, as material collected by Mapolisa confirms (personal communication).

Respondents consistently viewed condom use in a negative and stereotypical light. Sayings such as, 'You can't eat a banana without removing its cover', and 'Having sex with a condom is like having a sucker with a wrapper on it', were reported in a number of the studies. One respondent commented that condoms are 'uncomfortable and impersonal', and another, a Catholic, reported that condoms 'kill the moment'. The same respondent felt it important to obey strictures on contraception even though he disobeyed Catholic teachings on premarital and extra-marital sex. A young woman responded that use of condoms is '…detached from love. Clinical, sterile. Kinda takes the passion out of sex…My man doesn't like the feel so I have to agree or he will find someone that will satisfy him'. A student researcher concluded that there is '…a prevailing belief [among respondents] that condoms make sex uncomfortable or inauthentic'.

A prevailing notion among respondents seems to be one of 'authenticity', where love and passion are linked in ways that, to them, make condom use inappropriate. In part, this has to do with the ways in which 'primary relationships', passion, and trust are envisaged. These relationships are described in terms of trust; this is predicated by not asking questions of an intimate nature - including prior relationships and HIV status – as well as by having 'naked' penetrative sex and by not asking for or using condoms. Physical intimacy is an act set against silences and silencing of particular kinds. States one respondent: 'In a relationship you should trust your partner and you should know them well before sleeping with them so using a condom is not necessary'. In evaluating such claims, the student reporting on the study noted that 80% of all HIV+ women contracted HIV from long-term partners (no reference cited), pointing out the extent to which fallacies about morality and monogamy endure[6]. Another respondent said that asking someone to go for an HIV test is 'rude and shows lack of trust'. Trust is defined not only as the core of relationships but also as being central to notions of propriety. One respondent, a white woman, felt that in asking her partner to use a condom she was 'insulting him by implying that he had a disease'. Another female respondent reported having had unprotected sex because 'in demanding a condom it would look like I had a disease'.

From student reports, it seems that young adults use a tacit social taxonomy that relates trust and protection negatively. This finding is confirmed in other (as yet unpublished) research undertaken elsewhere in the Western Cape. Research conducted by the Triangle Project (personal communication and Boxford 2001) suggests that non-use of condoms is a way of demonstrating and expressing trust between primary partners while condoms are used with sexual encounters that are considered less meaningful or permanent. Recent research conducted with patients attending an STD clinic by Siphelo Mapolisa (2002) clarifies an elaborate local taxonomy that codes forms of sexual conduct, including assessments of availability and condom-use. In addition, unpublished research conducted by Tara Vajayan (2001) with sex workers in the Western Cape indicates that they are more likely to contract HIV from their partners in primary relationships based on trust than with their clients. They report higher rates of condom use with latter.[7]

Two clear conclusions can be drawn from the data relating to condom use: (i) sexual intercourse in relationships that are socially constructed as 'trusting' is reported as being 'unprotected', suggesting that the ways that 'trust' is construed mitigates against condom-use; and (ii) students and respondents report what one student describes as an 'it won't happen to me mentality'. We return to this later in the paper.

[6] Paul Farmer notes that a 1992 UN report identified marriage as the single greatest risk factor for HIV infection (Farmer 1999: 51). Farmer counters this, arguing that,'It is not marriage per se, however, that places young women at risk. Throughout the world, most women with HIV infection, married nor not, are living in poverty' (*ibid*).

[7] There is evidence to suggest that sex workers operating from escort agencies or private property are better able to negotiate condom use than sex workers on the streets (Leggitt 2001 cited in Skinner 2002: 2).

Knowledge and Constructions of Safety and Stigma

The South African campaign against HIV infection explicitly characterises risk as a product of behaviour, and prevention in terms of behaviour modification (the ABC campaign). This differs from campaigns expressed in terms of risk groups, as was the early tendency in the USA and Europe (see Bolton, 1987; Farmer, 1992, 1999; Shilts 1987; Sontag 1988). This feature is important to bear in mind in relation to the discussion below, for while acknowledging the central place of 'risk behaviours' in transmission, research respondents consistently categorise risk in relation to 'risk groups'.

The ABC campaign contains a set of moral ideas about risk and, while it encourages abstinence, it also explicitly spells out safer sex options. Notwithstanding this, however, respondents stereotype and stigmatise those who have the disease. Where informants report being afraid of contracting it, their greatest fears seem to be associated with stigma,and not the actual pain and suffering of AIDS-related illnesses. Informants almost always state that everyone is at equal risk of getting the disease, but then go on to differentiate, frequently in terms of stereotypes of 'the other'. These include homosexuals, the promiscuous (heterosexual and homosexual), prostitutes, drug addicts, the poor, and those lacking in formal education. Black people in particular, especially women living in rural areas, are stereotyped as vulnerable, both because people in rural areas are believed not to know about HIV/AIDS and because rural areas lack medical and other resources. For example, one respondent stated: 'HIV happens to most rural people as they have the least resources. When they come to the urban areas they bring the disease with them'. The respondent's argument is the opposite of findings of research conducted both in South Africa and abroad (see Farmer, 1992 and 1999), but is congruous with conservative ideas of disorderly urbanisation, in which rural migrants are seen as the cause of urban poverty, urban sprawl, and urban overpopulation.

Both students and interviewees report what we call 'HIV information fatigue'. Said one respondent: 'Why this again?' Another: 'We are sick and tired of hearing about AIDS, AIDS, AIDS'. Many respondents felt that HIV/AIDS campaigns carried in the media and schools were desensitising the issue of HIV. One student suggested that rather than focusing on the disease and its transmission, sex education should stress the issue of 'how to keep your wits about you in the heat of the moment'. Another felt that, 'It is not enough to address the issue of AIDS by pumping education into people. We need to reinstall values into people and thus change their sexual practices'. In many responses, ideas about disease transmission were closely linked with ideas about morality (we return to this below).

In general, student interviewers were more knowledgeable about the technical aspects of the disease than their interviewees. Young people appear to share common knowledge of the *sexual* transmission of the HI virus. Even where student interviewers display good knowledge of transmission, however, an alarming finding is embedded in a comment made by one interviewer: 'I still have difficulty connecting unprotected sex to the reality of the disease'. Students report that many of the people they interviewed did not have good technical knowledge of the disease but were aware of ways to prevent transmission, citing variations of the 'ABC' campaign. The respondents with the greatest reported technical knowledge were two black people, living in a poor urban area. Both said that they belonged to an organisation of people living with AIDS. Some respondents commented on other means of transmission, such as intravenous drug use. Few commented on haemophiliac infection, and vertical transmission was seldom mentioned in their interviews (or in the questions posed), despite the recent attention in the South African media to the question of mother-child transmission and the rights of access of pregnant women to anti-retrovirals.

The latter finding is interesting given that most respondents report the media as having been instrumental in their knowledge of the disease. Most interviewees received information about HIV/AIDS at school, through radio, television and the newspapers. Very few reported having learned about the disease from or discussed it with their parents. One respondent commented that 'Parents are still embarrassed to talk to their kids about

sex education'.[8] Several respondents commented on the media coverage of Mbeki's stance on the links between HIV and AIDS. Some were scathing, but most were confused about the relationship between poverty and illness. Some students asked about/reported on drug treatments, using 'AZT' as the descriptor. No other names were mentioned. These findings suggest that students and respondents absorb selectively from the media (e.g. drug names, the general contours of key debates), but appear not to have a larger framework within which to situate their (partial) knowledge, and do not absorb information that they consider to be presently irrelevant to them (e.g. vertical transmission).

Student and respondent understandings of the impact of education on HIV/AIDS transmission are variable and contradictory. Respondents argue that it is the lack of education that leads to unsafe sex/increased risk. Many argue that knowledge, couched as education, is central to inhibiting transmission – 'Education is the solution' – even as they recognise the limitations of the 'knowledge-attitudes-practices' (KAP) model. Students and their respondents believe that AIDS is spreading rapidly in poor townships, and attribute this to poor peoples' lack of education. One respondent stated that 'lower-class people with little education, and mis-education' cause AIDS. Others argue that individuals are responsible for their own health, particularly in relation to sexual practices. Phrasing sexual activity as a simple personal choice, they argued that education regarding HIV transmission and protection is therefore useless, and that learning to make appropriate choices is more important than knowledge about HIV. Such ideas of causation and personal responsibility give rise to victim-blaming attitudes. One student reported that respondents argued that the illness is caused by carelessness, particularly when women are infected. The underlying message of such assumptions is that, given the HIV/AIDS awareness campaigns, people should know better than to become infected. Such arguments fail to take into account complex social issues, such as those around gender and power. Interestingly, as we discuss below, most respondents are aware of these, but their emphasis on personal choice in sexual behaviour erases the effects of this power in shaping the ways that the disease is both transmitted and represented.

The disease is not seen as neutral. Most interviewees who were asked about origins and explanations for HIV/AIDS argued that it was either a natural selection mechanism (such as the crude Malthusian demographics contained in one statement, 'nature keeps its population down') or sent by God as punishment. 'Aids is like the great plague during the times of the Bible. When people were disobedient, they received retribution for their sins. The sins are promiscuity, sex outside of marriage, unfaithful sex, and the glamorisation of sex', commented one respondent. Another stated that the disease restores the 'equilibrium' of the population and that it is 'controlled by God', adding 'There's got to be something that cuts down the world's population' (white male aged 22, who self-reported that he had unprotected sex and had had three HIV tests).

The mechanisms of spread are unclear to respondents, many of whom stated that AIDS originated in Africa and was spread by monkeys. Only one respondent pointed out the racist assumptions implicit in the 'monkey' argument. Some argued that HIV entered South Africa with immigrants from Northern and Central Africa, another assumption underwritten with racist stereotypes and xenophobia. One respondent stated that HIV may have originated with 'the polio vaccine', indicating that he was aware of recent debates regarding the testing of polio vaccines by the Belgians in the Congo, as reported by Hooper (2000).

Many respondents argued that there is a cultural basis for the risk of HIV infection. Some arguments were sensitive, such as that offered by one student who stated that culture shapes both gender relations and the ideal forms of trust and intimacy. Some students contested the arguments of those respondents who stated, with regard to condom use, that 'it goes against my culture' by pointing out that culture is flexible and

[8] There do not appear to be differences in rates of reporting between black and white students, contrary to a popular perception that HIV is prevalent in black populations because of either the break-down of family structure or cultural norms that militate against parental discussion of sexual mores. No discussions with siblings were reported.

adaptive. However, such students were in the minority. For the most part, young people in the study operated with a notion of culture that is stereotypic, static and bounded. Take for example the following comment, which is broadly representative: 'Many cultures cannot see the danger of the disease and even if they do, they are unable to protect themselves against it due to cultural laws and practices'. Quite apart from the reification and personification of culture here, the respondent seems to suggest that 'culture' imposes rules and structural positions that cannot be challenged.[9]

Cultural practices cited in the studies as predisposing people to risk of HIV infection included: the fact that having more than one sexual partner is encouraged; polygyny; the idea that many sexual partners show off wealth; traditional medicine. (One student commented, 'When people living in a rural area become sick, their first reaction is to seek a traditional healer such as a witch doctor. It is within their culture to do this as this is what they have done their whole lives.'). One respondent considered that condom use was seen as a threat to fertility in 'some black cultures'. Many students and respondents cited repressive customary law and culturally-defined control over women as being instrumental in gender conflicts regarding sexual behaviours. Some respondents argued that traditional leaders had an important role to play in relation to HIV. Two black women suggested that such leaders should enforce stricter customary practices as a means of HIV prevention (e.g. virginity testing), and two black men confirmed that traditional leaders should play a more active and open role in relation to HIV discussion, but did not elaborate on their ideas.

Much of what respondents attributed to culture partially disguises racist assumptions about the social nature of 'the other'. Data linking promiscuity, blackness, and risk is sufficiently prevalent in the reports to mark a notable pattern of racism amongst respondents. One respondent commented that 'many blacks don't know what AIDS is'. Another said, 'Black people just do not care what they do, …and because they do not know enough about AIDS and sex, they are promiscuous'. Yet another respondent identified 'black tribal people' as being at risk, 'as sometimes their traditions can blind them from the truth, and lead to dangerous ignorance'. Another commented that 'HIV/AIDS is mainly in the black community because blacks all live on top of one another'. One white respondent reported that whites living in informal settlements would have a lower incidence of HIV infection than blacks living in informal settlements because 'in the black culture, it's acceptable to have sex with whoever you please...blacks all have sex with each other'. She concludes that even if black people were better off, their higher-class position would not stop them from having multiple sexual partners. In contrast the respondent argues that, 'Whites pair up more. With whites, sex happens in couples'.

It is evident that racism, essentialism, and ignorance are key factors in creating the illusion of safety, particularly among white youth. A few respondents linked racial oppression with the conditions of poverty that underpin poor health, inadequate access to health care, social services (including education), and the particular pressures that poor people face in relation to illness in general. Black respondents in particular tended to emphasise the relationship between poverty and HIV/AIDS and the lack of education as a primary reason for the spread of the virus. Some offered subtle analyses, working from ideas about the political-economy of illness causation. 'Conditions of poverty, i.e. education, sanitation, increased violence, [are] linked with HIV/AIDS', commented one respondent. Another, a Muslim woman, stated that, 'The lack of condom use among black people may be due to the oppression endured by them at the hands of white people', but did not elaborate on the logic that links oppression and non-use of condoms. By and large, however, respondents failed to recognise the relationship between race and class oppression in South Africa, favouring stereotypic arguments about blackness, such as, 'It is a "known fact" that black males are very forceful towards their wives and girlfriends when demanding sex or even unprotected sex'. Racist statements are offset at

[9] This stance is widespread, and is the subject of Paul Farmer's 1999 book *Infections and Inequalities.* Farmer, an anthropologist and medical doctor working in Haiti, Peru and the USA, explicitly argues that it is poverty that influences HIV infection and not cultural rules *per se*.

times by comments that 'conditions of poverty i.e. education, sanitation, increased violence is linked with HIV/AIDS', but the disturbing fact remains that many respondents hold racist attitudes that are linked with stereotypes about 'deviant' sexual practices.

Alarmingly, there is a clear indication in the reports that students and their interviewees believe that their education makes them less at risk of HIV infection. A statement made by a student evaluator, 'People think that they are protected by their knowledge' is indicative. Reported one student of his study: 'Most people see AIDS as a disease of the "other", which doesn't really affect you. We still think we are immune to it because only certain groups get it, and we just make excuses'. One respondent, an American woman, commented on 'the invincibility of upper-class kids because AIDS is perceived as a poor person's disease'. Another argued that condoms are available to and affordable for him, but he believes that this not the case in 'third world countries' where people cannot afford such 'luxuries'. Stereotypes about the sexual proclivities of poor people abound. A graphic illustration is offered in the words of one young man, in his second year of an economics major, who stated, 'Personally, I do not think poverty directly causes AIDS, but indirectly, unemployed people engage in sexual activities extraordinarily'. However, his suggestion for intervention was not centred on alleviation of poverty, as one might expect. Instead, he proposed that religion, specifically Christianity, would halt the spread of the disease. The roots of these and similar comments in nineteenth century reformism are clear.

Respondents invoked religious reasoning in relation to the cause of HIV/AIDS. Stated one, 'Society has become amoral'. Another elaborated, saying that AIDS is 'God's way of controlling population numbers'. Some seem to have great faith in the power of thought to cause and cure illness. One report states that, '…the staggering numbers of people dying from AIDS could be substantially attributed to the majority of AIDS sufferers having such a negative attitude', and that 'people almost convince themselves that they are going to die if they are diagnosed with HIV'. One respondent stated that, 'the earth chose to experience the HI virus'. Such views have resonance with the idea that people are able to exercise free choice and therefore illness is a product of carelessness. Some suggested that religious morals and rules could halt the spread of the disease. Several cited Christian ideals of abstinence before marriage and prohibitions on premarital and extra-marital sex.

Students consistently report that Muslim respondents believe themselves and other followers of Islamic law to be protected from HIV infection because of Islam's rules on sexual conduct. In some cases, respondents express this almost as though Muslims are immunised by belief. 'Muslims do not get AIDS', stated one interviewee. A young female Muslim respondent commented: 'Islamic law protects Muslims against getting HIV/AIDS. Sexual intercourse before marriage is not permitted in Islam and the abuse of narcotic drugs is not allowed since it jeopardizes the physical and mental well-being of the individual'. Another respondent is cited as having said, 'Poverty does not increase AIDS…What increases AIDS is lack of Islam'. Other Muslim students were more aware of social pressures. Said one, 'Young people like to experiment and be trendy and this influences their decision to have sex'. Another commented that Muslims need a better understanding of AIDS as a means of reducing the stigma attached to Muslims with AIDS.

These data suggest that young adults see religion as operating in similar ways to education, by providing a form of symbolic protection against HIV infection. Ideology and belief are given more weight as preventative mechanisms than are the recognition of sexual activities and the use of safer sex strategies.[10]

[10] This theme is addressed in the documentary on religious responses to HIV and AIDS, 'Body and Soul' (Emmett 2001).

Gender Roles and Stereotyping

Understandings of 'masculine' and 'feminine' gender roles indicate that respondents recognise gender inequality as a key factor in HIV transmission during heterosexual intercourse. While respondents agree that all people are equally at risk for HIV/AIDS, reports suggest that respondents appear to perceive white people, and people belonging to the upper or middle classes, as being protected from the HI virus. No explicit mention was made of white men, except in relation to homosexuality.

Interviewees assume blanket female oppression, particularly among black rural women. A theme that runs through the projects is that women are not able to negotiate condom usage. Respondents argue that men's passion determines their inability to practice safe sex, and that, due to cultural constructions of subordination, women are unable to intervene. One explained, 'Men are stubborn and women are submissive, and this affects condom usage by giving men the final say in deciding whether to use a condom'. The wives of black migrant workers are thought to be especially vulnerable to the HI virus, due to their inability to negotiate condom usage[xi]. Paradoxically, the assertion is that it is women who are primarily to blame for the spread of HIV.

Respondents identified poor women's financial dependence on men as a key reason for their greater vulnerability to the HI virus. In one extreme case a youth commented, 'Apartheid is the cause of poverty, leading ultimately to prostitution'. Respondents consistently argue that poor women have only two recourses: dependence on men or prostitution. Prostitution is represented as evidence of moral decay rather than in terms of a livelihood strategy (see White 1990). No mention was made of the possibility of alternative livelihood strategies, nor was it recognised that prostitution may support social reproduction across urban and rural areas (again, see White 1990). In short, the effects of the middle-class and reformist models of morality that are imbued in the imaginary of respondents stigmatise and stereotype poor women.

In comparison with the early US-driven discourse around the idea that gay men are the primary carriers of the HI virus, only a few students stated that men are more likely to get AIDS than women 'because they have sex with more people'. The concept of 'male promiscuity' was rarely discussed but when it was mentioned, it was used to describe men's propensity for multiple partners as innate. Male passion is perceived in this discourse as being a natural phenomenon, as opposed to the natural phenomenon of women's physiology (rather than their desire). Many respondents considered that women's physiology exposed them to greater risk of HIV infection. Said one woman, 'Women… have a biological vulnerability to HIV/AIDS due to the larger surface area of their bodies'. Biological explanations for women's vulnerability to the HI virus include the ideas that women have a 'larger surface area' that can be infected, that 'heterosexual women' are at greater risk because sperm is 'a high risk body fluid', and that 'guys secrete infected fluids, and girls end up having them'. Not a single student commented on the risks associated with anal penetration in either men or women, and the medical concerns associated with anal penetrative sex.

The data concerning sexual markers, gender stereotyping, and condom negotiation is contradictory in the sense that while many students claim that 'Masculinity in the townships prevents men from using condoms', some report that men are more likely to have sex with women if they agree to condom usage. In general, respondents appear to believe that men expect to make decisions about condom usage while women think the decisions should be shared. One respondent, a black man, stated, 'In rural Lesotho the men say what goes and the women just lie back'. He then commented on the difficulty of 'getting …women into bed, and then, once you do, you're definitely going to have to use a condom'. He complained that in 'modern places like Cape Town, women have more power', and that 'they won't be interested in you if you don't wear a condom. They know what's going on in terms of AIDS'. In all cases, interviewees report that women are more likely to ask for safe sex, and that for men it is a courtesy, rather than something they practice as a form of HIV prevention.

Empirical evidence gathered in Cape townships and among Zimbabwean women (Mapolisa, 2002 and Khumalo Sakatukwa, personal communication) support the claims made by some respondents. That is, there is extensive ethnographic evidence that supports the ideas that young black men are expected to have sexual relations with more than one woman, and that prestige is associated with sexual performance. Ethnographic research has produced similar findings among adults in Zimbabwe (Khumalo Sakatukwa, personal communication): married women say they are helpless in preventing their husbands from having unprotected extra-marital sex. The problem with studies that link female subordination, male sexual promiscuity, and blackness is that they contribute to an imagined sense that these social relations are integral to 'black culture'. While underreported, it is expected that many women, irrespective of race or class classification, are subjected to forms of subordination when it comes to condom negotiation and the ability to control the fidelity of their partners. While the ethnographic content of studies that focus on black male promiscuity and the relative powerlessness of black women are important, they may have the unintended effect of reinforcing stereotypes of black male promiscuity.

Conspiracy Theories and Youth Culture

Idiosyncratic responses suggest the contours of awareness of, and response to, HIV and the education campaigns around 'safe sex'. Several students report that respondents hold conspiracy theories about the disease, arguing that AIDS was introduced as a measure of population control by white people. The acronym has also been elaborated as AIDS = American Idea to Destroy Sex. Similar findings were made by Mapolisa (personal communication). The most extreme suggestion was made by a respondent who argued that everybody with AIDS should be killed. Several respondents felt that people infected with HIV should be quarantined, a response to the pandemic that was instituted in Cuba (see Scheper-Hughes, 1993). At the other end of the scale, the media construction that links condoms and youth style appear to have given rise to ideas about a cultural style in which 'condoms are cool'. One interviewer reports that it is 'socially acceptable… to wear a condom during sex or at least to acknowledge the fact that condoms must be used with new partners'. Another student stated that, 'It has become fashionable to say that you are having protected sex'. And another, a Muslim respondent, commented, 'Every guy I know, even if they are not active, has a condom in his wallet'. Here, condoms are transposed into fashion. One student reported to us that the distinctive shape of a condom in the back pocket of tight jeans sends a (not-so-subtle) message about sexual potency and availability.

The association of 'safe sex' and youth culture has an interesting spin-off effect: student reports suggest that young people are designated as 'at risk', while older people are considered inherently 'safe'. The ageism is explicit in responses: one student reported that four of five interviewees thought that after the ages of 25-30, people were no longer at risk of contracting HIV. This finding was replicated in other studies, where respondents believed that only people between the ages of 13 and 35 were vulnerable.

These findings suggest that the media campaign linking youth and risk has been effective, but that it may have unanticipated consequences. One of these has to do with age, another with the fact that young people are often unable to differentiate between risk and vulnerability.

Conclusions

The research data examined sketch the contours of perceptions about HIV/AIDS among young adults at a tertiary educational institution. While most respondents are able to identify modes of transmission, they associate illness with poor, black people, and most frequently with rural women. This, despite a public campaign that has attempted to de-stigmatise the disease through emphasis on risk behaviours (not groups) and through efforts to generate a positive response characterised by the slogan 'Love Life'. Many students seem to feel a sense of invulnerability to the disease: they characterise HIV/AIDS as something that happens to 'other' people. Most respondents do not know anyone with AIDS, and their perceptions lead to a particular distancing from the experiences of people in the later stages of infection and disease. In part, this seems to be spurred on both by the nature of the virus and the campaign to halt its transmission: the invisibility of the virus and the initial stages of infection appear to have the effect of distancing suffering, pain and AIDS' visible characteristics. Indeed, some students said that AIDS has no impact on their lives. Young adults hold stereotypes that appear to function as emotional and social armour. Intellectually persuaded that HIV is 'an equal opportunity disease', they seem nevertheless emotionally convinced that class and education render them immune. The lack of specific data about the different ways that young adults think about HIV/AIDS transmission along lines of race, class, and gender is something that needs serious attention, and constitutes an area for future research.

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