

BLACK FARM WORKERS' BELIEFS ON HIV AND AIDS

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God knew that no man can survive alone and therefore gave each one of us people who support and love us unconditionally. Therefore: "I am because we are".

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ABSTRACT

BLACK FARM WORKERS' BELIEFS ON HIV AND AIDS

In this dissertation, the argument is the understanding of the beliefs of Black farm workers regarding HIV and Aids and how these beliefs that protect them from being infected, will lead to the formulation of suggestions for a belief-sensitive approach, which can be incorporated by health care professionals in HIV and Aids-prevention programmes for Black farm workers.

Several authors stress the fact that if any HIV and Aids programme is to be implemented successfully, the health care profession should strive to know more about the beliefs of the community, in this case Black farm workers, so that there can be sound human relations and effective programmes.

Based on the problem statement for this study the following research questions were asked:

1. What are the beliefs of black farm workers regarding HIV and Aids?
2. How do these beliefs protect them from being infected?
3. Based on the answers to the first two questions, what suggestions can be formulated regarding a belief-sensitive approach in HIV and Aids-prevention programmes for Black farm workers?

The objectives were in line with these questions, namely to explore and describe the beliefs of Black farm workers regarding HIV and Aids; to explore and describe how these beliefs protect them from being infected; and to formulate recommendations, specifically suggestions regarding a belief-sensitive approach in HIV and Aids-prevention programmes for Black farm workers.

The study followed a qualitative, explorative and descriptive approach. A participatory rural appraisal (PRA) approach was used to collect data. '*Lekgotla*' was used as a strategy to collect data.

The results indicated that Black farm workers do have beliefs about HIV and Aids. Most of the beliefs they uphold protect them from being infected, however there are some marginal beliefs that can put them at risk of being infected.

Suggestions, which health care professionals can incorporate in HIV and Aids-prevention programmes for Black farm workers, were formulated based on the results, a literature control and ensuing conclusions. Beliefs of Black farm workers that protect them from being infected could be included in the suggestions for prevention strategies. Health care professionals involved in prevention strategies should actively listen to Black farm workers' beliefs in order for these strategies to be successful.

Keywords: Beliefs, Black farm workers, Human-immuno-deficiency virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), HIV and Aids-prevention programmes, Health Care Professionals, Belief-sensitive approach.

OPSOMMING

SWART PLAASWERKERS SE OORTUIGINGS AANGAANDE MIV EN VIGS

Die argument in hierdie verhandeling is dat insig in die oortuigings van Swart plaaswerkers met betrekking tot MIV en VIGS; en hoe hierdie oortuigings hulle beskerm teen infeksie, sal lei tot die formulering van voorstelle vir 'n oortuiging-sensitiewe benadering wat geïntegreer kan word in MIV- en VIGS-voorkomingsprogramme vir Swart plaaswerkers deur die professionele gesondheidswerkers.

Verskeie skrywers beklemtoon die feit dat die gesondheidsorgprofessie daarna moet strewe om meer te wete te kom van die oortuigings van die gemeenskap, in hierdie geval Swart plaaswerkers, ten einde effektiewe interpersoonlike verhoudings en suksesvolle MIV- en VIGS-programme te verseker.

Gebaseer op die probleemstelling van hierdie studie, is die volgende navorsingsvrae gevra:

1. Wat is die oortuigings van Swart plaaswerkers aangaande MIV en VIGS?
2. Hoe kan hierdie oortuigings hulle beskerm teen infeksie?
3. Gebasseer op die antwoorde van die eerste twee vrae, watter voorstelle kan geformuleer word vir 'n oortuiging-sensitiewe benadering in MIV- en VIGS-voorkomingsprogramme vir Swart plaaswerkers?

Die doelwitte van die studie was in lyn met die navorsingsvrae, naamlik om die oortuigings van Swart plaaswerkers aangaande MIV en VIGS te verken en beskryf; om te verken en beskryf hoe hierdie oortuigings hulle beskerm teen infeksie; en om aanbevelings te formuleer, spesifiek voorstelle vir 'n oortuiging-sensitiewe benadering in MIV- en VIGS-voorkomingsprogramme vir Swart plaaswerkers.

Die studie het 'n kwalitatiewe, verkennende en beskrywende benadering gevolg. 'n Deelnemende benadering (*'participatory rural approach'*) is gevolg tydens data-insameling. '*Lekgotla*' is as strategie gebruik om data in te samel.

Die resultate het getoon dat Swart plaaswerkers wel oortuigings aangaande MIV en VIGS handhaaf. Meeste van hierdie oortuigings beskerm hulle teen infeksie, alhoewel daar enkele grens-oortuigings is wat hulle in 'n risiko plaas om geïnfekteer te word.

Voorstelle wat die gesondheidsorgprofessie kan integreer in MIV- en VIGS-voorkomingsprogramme vir Swart plaaswerkers is geformuleer, gegrond op die resultate, 'n literatuurkontrole en gevolgtrekkings. Oortuigings van Swart plaaswerkers wat hulle beskerm teen infeksie kan ingesluit word by die voorkomingstrategieë. Professionele gesondheidswerkers betrokke by voorkomingsprogramme moet aktief luister na Swart plaaswerkers se oortuigings ten einde dat hierdie voorkomingstrategieë suksesvol kan wees.

Sleutelwoorde: Oortuigings, Swart plaaswerkers, Immuniteitsgebreksvirus (MIV), Verworwe immuniteitsindroom (VIGS), MIV- en VIGS-voorkomingsprogramme, Professionele gesondheidswerkers, Oortuiging-sensitiewe benadering.

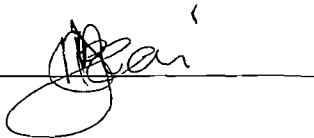
DECLARATION

I declare that *Black farm workers' beliefs on HIV and Aids* is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references

Full name: Dintletse Maria Magcai

Date: November 2008

Signed: _____

A handwritten signature in black ink, appearing to read 'Dintletse', is written over a horizontal line. The signature is stylized and somewhat cursive.

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CHAPTER 1

RESEARCH ORIENTATION

1.1. Introduction and problem statement

In South Africa, Black farm workers account for 45.8% of the population classified as rural (Phometsi, Van't Riet & Kruger, 2004:2). Black farm workers have been identified as among the poorest and most vulnerable population groups of the South African society, with a high risk to contract HIV and Aids (Leonhaeuser, 2002:5). According to a study by Phometsi *et al.* (2004:2), there is evidence that these Black farm workers have limited access to education; for example, most of them only attend school up to grade 7 in farm schools because of a lack of facilities for further education. Furthermore, a study by the International Organization for Migration (IOM) (2004:1) reveals that information regarding HIV and Aids and governmental or non-governmental HIV and Aids initiatives targeting Black farm workers is lacking and that access to mobile clinics and primary health care is low due to limited time and money.

This population group's vulnerability is furthermore due to the unavailability of prevention resources such as condoms and early detection and treatment of sexually transmitted illnesses (Phometsi *et al.*, 2004:2). An example is that mobile clinics at the farm where this study took place only visit the farm once in two months. Workers have to go to the nearest town to see a doctor and the consultation fee is deducted from their salary, which is already not enough for their monthly needs (Kruger, 2005:2). This discourages them to seek medical help in time. Natrass (2004:31) is of opinion that more attention should be paid to populations such as these, since they are extremely vulnerable to contracting HIV and Aids due to low income and lack of skills. The above-mentioned problems are exacerbated by limited access to information concerning HIV and Aids, such as health education provided by health workers, critical reading of information if they do indeed receive the information and also limited constructive discussions on the HIV and Aids with co-workers (Muturi, 2005:95).

At the same time, the spread of HIV and Aids has exceeded the worst projections by far (World Bank, 2000:5). Seventy one percent (71%) of all the people in the world who are HIV positive live in Africa (Cherian, 2005:2). South Africa is one of the worst hit countries in the world with an estimated 5,5 million people (18,8% adults) living with HIV in 2005 (UNAIDS, 2006:6). Farm workers have been classified as a community with a high disease burden and this is worsened by the HIV and Aids pandemic, as 30%-40% of farm workers in South Africa are HIV positive (IOM, 2004:1). It is clear that urgent action is needed in the battle against HIV and Aids (Cherian, 2005:2).

Such action might include prevention programmes. However, Bauman (1998:266) argues that factors contributing to the fuel of HIV and Aids in South Africa, such as poverty, migrant labour, illiteracy, social unrest, inadequate schooling, unemployment, homelessness, tuberculosis and cultural attitude make health education and prevention programmes exceptionally difficult. Additionally, cultural beliefs, values, norms and myths have played a role in the rapidly increasing epidemic in rural communities, and yet HIV and Aids programmes have not addressed these factors adequately (Muturi, 2005:77).

Additionally, beliefs on HIV and Aids might play a role in the success of prevention programmes. For example, IOM (2004:1) found that high-risk sexual behaviour is one of the factors increasing the spread of the epidemic and it is important to focus on awareness, knowledge and beliefs. Eight in every ten adult South Africans are afraid of contracting HIV and Aids, but only four in every ten believe that they can contract HIV and Aids (Anon, 2005). UNAIDS (2006:20) found that as much as 14% of the 37% adult South African population falling within the medium-risk and high-risk groups, do not really know how one contracts HIV and Aids, 15% are of opinion that HIV and Aids is not at all serious and 8% of them even say that it does not exist. These beliefs are found to be much stronger among the high-risk groups (IOM, 2004:1-2), such as Black farm workers.

In accordance with the argument that beliefs might influence health-illness behaviour, several authors (Pembrey, 2006:1; Orr & Patient, 2004:2; Anon, 2006b:6; Sithole, 2001:1) have described how religious and cultural beliefs can impede or

enhance the success of awareness programmes on HIV and Aids. Practices such as viewing HIV and Aids as being caused by evil, negative attitudes towards condom use and certain sexual practices, such as dry sex, have all been singled out as contributors to the spread of the epidemic (Sithole, 2001:1; Pembrey, 2006:13; Orr & Patient, 2004:2; Anon, 2006b:5).

Nonetheless, not all these practices and beliefs contribute to the rise of the epidemic, but can serve as protective measures. The use of initiation ceremonies for men and women, based on religious and cultural beliefs, aimed at discussing sexuality and sexual activities, can be used to communicate issues related to HIV and Aids. Sithole (2001:1) supports this by saying that certain values learned from culture and religion, such as abstinence from sex before marriage, virginity tests and encouraging boys and girls not to engage in sex at a tender age can serve to protect people from HIV infection.

The important role that beliefs might play in Black farm workers' lives implies that, although HIV and Aids awareness programmes are well-intentioned, these programmes are failing because they are not necessarily in line with the particular beliefs of the individuals who are the targets of these efforts (Pembrey, 2006:1). Beliefs have indeed played a role in the rapidly increasing epidemic in the rural communities (Muturi, 2005:95), including populations such as Black farm workers. It thus seems to be important to explore this concept further.

Beliefs are strong unverified opinions that are accepted as 'the truth', leading to personal choices (Anon, 2006a:1; Berndt, 2006:2). Beliefs do not follow the firmness or strictness of evidence and argument (Anon, 2002:2) but rather rely on personal experiences. Beliefs begin from a connection of ideas or opinions, based on knowledge, context and culture, but for it to be real and make sense a person has to have personal experience of the event or phenomenon, i.e. we come to know what will happen if we do this or if we fail to do that (Anon, 2006a:1; Van Maltzahn & Van der Riet, 2006:111). Beliefs might consist of cultural or religious beliefs.

According to Schultz and Videbeck (2005:15) cultural beliefs can be seen as multi-dimensional. They explain that although many people think of culture in terms of

race, ethnicity, ancestry or country of origin, culture also includes other aspects of a person's background and sense of self or identity, which includes values, practices and specifically cultural beliefs (Schultz & Videbeck, 2005:15). According to Sadock and Sadock (2005:598) cultural beliefs guide us to an understanding of normal and deviant behaviour patterns. Cultural beliefs have a strong influence on health and illness because beliefs embedded in culture offer an inventory of solutions (Berndt, 2006:2).

Religious beliefs on the other hand, are based on strong convictions regarding supernatural powers that control human destiny (Liddel, Barret & Bydowell, 2006:219). In times of serious illness and death religious beliefs may be a source of consolation to people (Andrews & Boyle, 2003:497). People also use religious beliefs to explain humankind's relationship with the universe (Anon, 2006b). Strong religious faith has a set of beliefs and values influencing people's perceptions and reactions and the meaning they ascribe to what happens to them. It also determines their priorities and underlies their decisions (Schott & Henley, 2002:127).

Cultural and religious beliefs are interwoven and influence people's understanding of illness and health-care practices (Andrews & Boyle, 2003:497). Patel, Bennet, Dennis, Dosanjh, Mahtani, Miller & Nadirshaw (2000:44) are of the opinion that one's cultural and religious beliefs frame one's world-view and can act as social standards by which individuals can judge, select and negotiate the respective value systems other individuals bring into interaction or relationship. They further explain that world-views are not only composed of our attitudes, values and beliefs, but also affect how we think, make decisions, behave and define events. World-view is the way a group of people (culture or subculture) see their social world, symbolic system and physical environment and their own place in each, and is revealed in people's religion, art, language, values and health care beliefs and practices; thus it promotes a group's survival and gives members a generally useful picture of the universe (Kneisl, Wilson & Trigoboff, 2004:111).

Andrews and Boyle (2003:75) examined the major health beliefs systems or world-views embraced by people from diverse cultures and explored the characteristics of the most prevalent world-views, or paradigms, related to health-illness beliefs, and

identified the following: magico-religious, scientific/biomedical and holistic health paradigms.

In the magico-religious paradigm, the world is seen as an arena in which supernatural forces are dominant, where destiny depends on the actions of God, or gods, or other supernatural forces for good or evil (Andrews & Boyle 2003:75). Included in this is a set of beliefs and ideas concerning nature and the supernatural, which offers an explanation regarding the origin of disease (Tjale & De Villiers, 2004:13). In the scientific or biomedical model, health is defined as the absence of disease or the signs and symptoms of disease, therefore being healthy is being free of all diseases (Andrews & Boyle, 2003:76). The holistic paradigm seeks to maintain a sense of balance or harmony between humans and the larger universe. This gives evidence that health and illness are based not so much on external agents as on imbalance or disharmony among the human, geophysical and metaphysical forces of the universe (Andrews & Boyle, 2003:77).

The discussion above indicates that world-view determines how members of a particular culture view health, illness and care, thus representing their overall mindset and influencing their value systems, beliefs and behaviour (Tjale & De Villiers, 2004:29). For example, in the biomedical model the cause of tuberculosis is clearly defined as the invasion by the mycobacterium. In the holistic paradigm, whereby disease is the result of multiple environment-host interactions, tuberculosis is caused by the interrelationship of poverty, malnutrition, overcrowding and the mycobacterium (Andrews & Boyle; 2003:77).

In support of this argument, the health belief model, as applied by Brieger (2006:20), highlights the importance of beliefs by saying beliefs are good predictors of motivation and behaviour; hence the importance of assessing beliefs (Brieger, 2006:20). Therefore it is argued that beliefs (cultural/religious) determine behaviour (Orr & Patient, 2004:1), influencing the way in which people describe, experience and respond to health and illness. Beliefs are powerful and relevant drivers of human behaviour as well as important in describing and understanding health and illness (Berndt, 2006:3). It is concluded that beliefs, in particular cultural and religious

beliefs, might thus influence understanding of and behaviour regarding a disease such as HIV and Aids.

It is thus expected that Black farm workers have specific beliefs regarding HIV and Aids, as influenced by their context, culture, knowledge and experience regarding this phenomenon. They might be influenced by an African world-view, which is based on a magico-religious worldview. Such a world-view entails dealing with problems from a position of values, norms, traditions and other cultural institutions as a platform to discuss and communicate issues (Sithole, 2001:1). However, because of Black farm workers context of an isolated lifestyle, lack of education and resources, they might also develop unique beliefs that influence their understanding of and behaviour regarding HIV and Aids.

In line with this argument, voices are growing for serious consideration of a cultural approach to the prevention and awareness of HIV and Aids. The world is also urged to approach the disease holistically, specifically from both cultural and medical perspectives (Sithole, 2001:1). Cherian (2005:1) raises the concern that in the midst of serious discourse on cultural and medical perspectives, it is evident that the scourges of HIV and Aids still continue to cause devastation within Southern Africa. Hence the argument that the inclusion of a belief-sensitive approach in prevention programmes should be seriously considered. Tjale and De Villiers (2004:11) argue that the concept primary health care necessitates that all health care professionals understand and embrace cultural diversity, which includes beliefs.

Tjale and De Villiers (2004:11) thus support the argument that if any HIV and Aids programme is to be implemented successfully, the health care profession will have to consider understanding the beliefs of the particular community. Health care professionals should particularly strive to know more about the beliefs of a community as strengths in health and illness behaviour in order to strengthen human relations and increase the effectiveness of programmes (Tjale & De Villiers, 2004:11). This will contribute to breaking the cultural barrier, to stepping outside the cultural constraints and care for people according to their beliefs (Schott & Henley, 2002). It is thus crucial that health care delivery be examined from cultural perspectives, in this case beliefs, to maximize appropriate quality of care by building

on already existing strengths and to ensure provision of care that is acceptable, accessible and appropriate (Andrews & Boyle, 2003:299).

However, research on the HIV and Aids-related beliefs of Black farm worker communities in the Potchefstroom district in this regard is non-existent (Kruger, 2005:3). Black farm workers have been identified as a high-risk group and are affected by the HIV and Aids epidemic and this in turn threatens their social and economic development. Therefore this research, as part of a larger research project on Farm Labour and General Health (FLAGH), focuses on understanding Black farm workers' beliefs concerning HIV and Aids. These beliefs might dictate how they perceive the risk of HIV and Aids and how they deal with it when they are infected or affected by the disease (Muturi, 2005:95). These beliefs might serve as a protective factor regarding contracting HIV and Aids, as explained earlier. The researcher paid informal visits to farms in the Potchefstroom district, and had discussions with co-researchers in the larger research project. These discussions confirmed the above discussion and arguments. The following research questions are thus arrived at:

1. What are the beliefs of Black farm workers regarding HIV and Aids?
2. How do these beliefs protect them regarding HIV and Aids infection?
3. Based on the answers to the first two questions, what suggestions can be formulated regarding a belief-sensitive approach in HIV and Aids-prevention programmes for Black farm workers?

1.2 Objectives

The objectives of this study are to:

- 1.2.1 Explore and describe the beliefs of Black farm workers regarding HIV and Aids.
- 1.2.2 Explore and describe how these beliefs protect Black farm workers regarding HIV and Aids infection.

1.2.3 Formulate suggestions for a belief-sensitive approach which health care professionals can incorporate in HIV and Aids-prevention programmes for Black farm workers.

1.3 Paradigmatic perspective

The following meta-theoretical, theoretical and methodological statements define the paradigmatic perspective within which this research is conducted.

1.3.1 Meta-theoretical assumptions

The researcher's meta-theoretical perspective, including views on man, health, environment and nursing, is in line with the Social Learning Theory of Leininger (1991:33-36). The researcher further maintains a socio-cultural world-view, namely '*ubuntu*' i.e. "I am because we are". Man, health, environment and nursing are thus defined within these frameworks.

1.3.1.1 Man

Man is viewed as a unique social being that cannot exist in isolation. Furthermore man is always a member of a group or collective "being", i.e. 'I am because we are'. It is believed that man cannot live or cope alone, he needs others to survive, i.e. fellow man and the environment. Therefore fellow men and the environment collectively play an important role in the development of man's beliefs. However it does not mean that because a group, i.e. 'collective being', share the same beliefs and thoughts, man is not unique. Individual experiences and personality enables man to have some degree of uniqueness to develop his own beliefs. Therefore man's beliefs are similar to that of the collective being he forms part of, but possibly different from other collective beings. Beliefs influence man's health/illness behaviour (Brieger, 2006:20).

In the context of this research, man includes Black men and women living and working on a farm in the Potchefstroom District, i.e. Black farm workers. These farm workers are living an isolated lifestyle and mostly influence one another in debates and discussions over issues such as HIV and Aids, using limited and unclear

information received from sources such as the media and fellow community members. Therefore, they might develop their own social group and own unique beliefs. Beliefs of Black farm workers will be explored within their environment and as a group in order to explore and describe how these beliefs protect them with regards to HIV and Aids.

1.3.1.2 Environment

Environment in this research is viewed from a socio-cultural viewpoint. The environment plays an important role in the development of man's beliefs. The environment includes the natural, physical, supernatural and human environment (Tjale & De Villiers, 2004:14). People adapt to the environment according to their culture and group phenomena. This means that a person's environment consists of others who share a common cultural orientation with him (Andrews & Boyle, 2003:247-248).

Furthermore, this environment consists of an intimate zone, personal zone and social zone, with the focus on the social zone. The social zone is mostly reserved for impersonal business or interaction with others (Giger & Davidhizar, 1995:23). In this study the environment consists of the Black farm workers' living and working environment namely the farm and fellow Black farm workers, with the focus on the social zone of these Black farm workers, namely the 'collective being'.

1.3.1.3 Health

Health is viewed as a balance between the internal (body) and the external (people, physical and social) environment. Therefore for one to be healthy there should be the existence of harmony between the internal and external environment. The imbalance thereof can lead to beliefs of illness (physical or emotional symptoms). Consequently, this can have a significant influence on health/illness behaviour (Tjale & De Villiers, 2004:14-15).

In this research the focus is on beliefs of Black farm workers as a potentially protective factor, specifically regarding the risk of contracting HIV and Aids, thereby contributing to maintaining the health balance.

1.3.1.4 Nursing

Nursing is viewed as helping a person to maintain or restore the balance between the external and internal environment (Tjale & De Villiers, 2004:28). Therefore nursing activities should focus on both these environments when planning HIV and Aids-prevention strategies. Health care professionals must recognise that one's world-view influences one's beliefs. Beliefs are developed through interaction with others who share the same culture, as well as one's personal experiences. Knowledge of beliefs will enable the health care professionals to determine how health, illness and care are viewed (Tjale & De Villiers, 2004:29). Beliefs of Black farm workers on HIV and Aids should therefore be explored and described in order to formulate suggestions for a belief-sensitive approach in prevention strategies. Furthermore the nurse might focus on '*ubuntu*' in her approach to Black farm workers, i.e. focusing not only on individuals but also on the health of group as a whole. Therefore he/she needs to know the beliefs of the group in order to adapt his/her approach to the group.

1.3.2 Theoretical statements

The discussion of the central theoretical argument and conceptual and operational definitions follow:

1.3.2.1 Central theoretical argument

An understanding of the beliefs of Black farm workers regarding HIV and Aids and of beliefs that protect them regarding HIV and Aids will lead to the formulation of suggestions for a belief-sensitive approach, which can be incorporated by health care professionals in HIV and Aids-prevention programmes for Black farm workers.

1.3.2.2 Conceptual definitions

The following concepts are defined, as they are central to this research:

- **Beliefs**

Beliefs are personal theories or facts that are accepted without proof thereof (Brendt, 2006:2). Beliefs are a result of, and can be gained through the integration of knowledge, experience and culture; and is stored in the mind, influencing decisions and behaviour regarding health and illness (Sithole, 2001:1). In this research it is expected that beliefs of Black farm workers regarding HIV and Aids will be based on both religious and cultural beliefs. Their beliefs determine how they act, and this research aims at exploring and describing their beliefs and how these beliefs protect them regarding HIV and Aids infection.

- **Black farm workers**

Black farm workers in this research are people living and/or working on a chicken farm in the Potchefstroom district. They run agricultural operations and their main job responsibilities are to grow, raise and keep chickens in order to sell them and their eggs. They also use farm machinery and equipment to perform the above activities and clean, wash, sort and grade or pack the eggs and chickens. They have been identified as a high-risk group in contracting HIV and Aids (Kruger, 2005:2). One of the factors that put them further at risk is that it is not known what their beliefs are or how these beliefs protect them with regard to the risk of being infected with HIV and Aids. They might maintain unique beliefs regarding HIV and Aids due to their isolated lifestyle. Their beliefs should be explored and described so that suggestions for a belief-sensitive approach in HIV and Aids prevention programmes can be formulated.

- **Human Immuno-deficiency Virus (HIV)**

HIV is a virus, which causes a disease called Acquired Immune Deficiency Syndrome (Aids). It compromises the immune system of a human being (Manet,

2003:8). After infection by the virus, this virus it targets T-cells. T-cells' nuclei have genetic material called DNA (deoxyribonucleic acid) which have all the information that the cells need in order to function. The T-cell has a receptor site called CD4, which is a protein on the surface of the T-cell. CD4 is therefore called the receptor site or locking port for HIV. After binding to the CD4 receptor site, the HI-viral genetic material enters the host cells and reverses the transcriptase reactions. At a later stage new viruses are formed which enter the blood stream and infect more cells. In this process, the host cell's CD4 sites are damaged and destroyed resulting in reduced immunity (Evian, 2000:5). The mode of transmission of the HI-virus is sexual intercourse, intravenous drug use, mother-to-child transmission, and the use of blood products that are contaminated (Evian, 2000:5).

- **Acquired Immune Deficiency Syndrome (Aids)**

Aids imply that the immune system of the body is severely compromised – to such an extent that it cannot fight infections. It is the last stage of HIV infection, which progresses slowly from asymptomatic infection to Aids. Therefore, for a person to have Aids, he/she must be HIV positive and have a CD4 (T-Cell) count below 200 or one or more opportunistic infections such as lung diseases, cancers and other painful debilitating conditions (Evian, 2000:5).

- **HIV and Aids-prevention programmes**

These are strategies designed by the government to prevent the spread of HIV and Aids. It includes services given by health care professionals to promote, maintain and restore health of the individual and society. HIV and Aids prevention strategies include illness prevention and health promotion (Clark, 1999:616). Services provided in illness prevention include use of universal precautions for blood and body fluids, education for safe sex, provision of prophylactic treatment for HIV positive clients. Services available for health promotion are provision of adequate nutrition, health education for self-care, risk factor elimination, stress reduction, voluntary counselling and testing, treatment of sexually transmitted illnesses, availability of anti-retroviral treatment and prevention of mother to child transmission. These services, according to government, should be accessible, affordable and available (Van den Berg &

Viljoen, 1999:20). In the context of this research, these services are mainly rendered via mobile clinics.

- **Health care professionals**

These are people employed by the health sector in order to deliver health services to individuals and communities (Tjale & De Villiers, 2004:22). The work of these individuals is centred on illness prevention and health promotion. The individuals include nurses registered or enrolled with the South African Nursing Council (SANC), and those who have received short training on basic health care. The latter are not registered or enrolled with the SANC but work as health care professionals to prevent illness and promote health. These health care professionals receive training in the bio-medical approach to the health, illness and health care (Tjale & De Villiers, 2004:22). A belief-sensitive approach is not necessarily emphasised during their training.

1.3.2.3 Operational definition

- **Belief-sensitive approach**

An approach that is belief-sensitive in HIV and Aids-prevention programmes is sensitive to the beliefs of Black farm workers. In this approach, health care professionals lend a listening ear to the Black farm workers regarding their beliefs when talking about HIV and Aids prevention strategies in order to incorporate those beliefs that protect them from being infected into the prevention programme. This will enhance care that is culturally congruent and includes their beliefs. This research aims to formulate suggestions on such a belief-sensitive approach.

1.3.3 Methodological assumptions

The Botes model is applied as a methodological base for this research (Botes, 1992:37) to increase the trustworthiness of the research. The aim of describing methodological assumptions is to improve the body of knowledge in nursing practice

(Botes, 1992:37). Research activities, as presented within Botes' model, occur at three levels (Botes, 1992:36-42) as explained below.

The first level represents the nursing practice, which forms the research domain for nursing. The nursing practice is based on activities aimed at illness prevention and health promotion of the entire being. This being is made up of both internal and external environments. Health care professionals are supposed to provide HIV and Aids-prevention programmes which are scientifically based as well as socio-culturally sensitive. The nursing practice recognises that man exists as an individual but also as part of a physical and social environment. The researcher, at this empirical level, interacts with the Black farm workers to explore and describe their beliefs in order to critically interpret the beliefs that protect them from being infected. Results can be used in formulating suggestions for a belief-sensitive approach, which can be incorporated by health care professionals in HIV and Aids-prevention programmes for Black farm workers.

The second level involves nursing research through which the body of scientific knowledge is enhanced. The researcher explores and describes the beliefs of Black farm workers on HIV and Aids and how these protect them from the risk of being infected, in order to formulate suggestions for a belief-sensitive approach which can similarly be incorporated by health care professionals in HIV and Aids-prevention programmes for Black farm workers.

The third level consists of the paradigmatic perspective of the researcher. The meta-theoretical assumptions are based on the Social Learning Theory of Leininger (Tjale & De Villiers, 2004:249) and the researcher's own socio-cultural world-view.

1.4 Research design and method

In this chapter the research design and method are summarized; while a detailed description follows in Chapter 2.

1.4.1 Research design

The research follows a qualitative, explorative and descriptive approach (Burns & Grove, 2005:52) to explore and describe the beliefs of Black farm workers regarding HIV and Aids and to explore and describe the beliefs that protect them from being infected, in order to formulate suggestions for a belief-sensitive approach which can be incorporated by health care professionals in HIV and Aids-prevention programmes for Black farm workers.

1.4.2 Research method

A participatory rural appraisal (PRA) approach (Cornwall, 1992:69) is applied to collect data, as discussed under 1.4.2.3. A brief description of population, sampling, data collection, data analysis and literature control follows (Brink, Van der Walt & Van Rensburg, 2006:53).

1.4.2.1 Population

The population is Black farm workers living and working on a chicken farm in the Potchefstroom district in North West Province, between the ages 19 and 49 and able to communicate. This is the general age group within which the Black farm workers fall. This is also the age group identified as a high-risk group and is also the productive working class which is vital to our economy, thus specifically in need of HIV and Aids-prevention programmes (UNAIDS, 2006:8).

1.4.2.2 Sampling

Sampling is conducted as follows:

- **Sampling method**

De Vos' (2002:334) discussion on sampling methods suggests that in order to obtain rich detail, in this case concerning the beliefs of Black farm workers, non-probability, voluntary, purposive sampling can be used. De Vos (2002:334) further adds that

participants – such as the Black farm workers – help in answering the research questions as they have the potential of providing a maximum range of needed information. Criteria for inclusion is male and female adults between ages 19 and 49 years, working and residing on the farm and willing to participate in the research voluntarily (Brink *et al.*, 2006:124; Burns & Grove, 2005:306).

- **Sample size**

Sample size is determined by data saturation (Burns & Grove, 2005:355). Data saturation is observed when themes repetitively emerge from the data.

1.4.2.3 Data collection

- **Method of data collection**

Data is collected using the participatory rural appraisal (PRA) approach (Cornwall, 1992:69). PRA is a research approach that can be used in exploring and describing the beliefs of Black farm workers and explores and describes beliefs that protect them from being infected. This is done within their cultural environment and their own specific context in order to empower them and allow them to control the process (Bhandari, 2003:7). As stated before, the reason for using the approach is that the Black farm workers need to be included in the issues that directly affect them, and to be afforded an opportunity to speak out about issues that impact on their lives (Chambers, 1992:2). The researcher in this process acts as participative observer whose main function is to facilitate the discussions that take place to obtain rich data and to provide guidance if the process gets out of agreed norms of behaviour (Bhandari, 2003:7).

The researcher uses 'lekgotla' method for learning about beliefs of Black farm workers (Chambers, 1992:2). Understanding is gained through action and interaction with the participants (Cornwall, 1992:69). According to Bhandari (2003:12), there are seven major techniques used in PRA of which one is semi-structured interviews, e.g. with individual farmers or households, key informants, group interviews and

community meetings. In this research, '*lekgotla*' (discussed in detail in Chapter 2) is used as data collection strategy, as a form of discussion group with the Black farm workers. A leader, selected trusted by the Black farm workers, leads the discussion as the person who is asking the research questions.

The researcher as an outsider (professional) goes to the rural area, but only to facilitate rural people in the collection of data by themselves. Data collection is done during group discussions, and the selected leader leads the discussions (*'lekgotla'*), (Bhandari, 2003:11). Participants consist of groups of men and women comprising a minimum of ten people, in line with the '*lekgotla*'. The leader facilitates a discussion to explore and describe the group's beliefs regarding HIV and Aids. Discussions are centred on the following questions:

1. What beliefs do you have concerning HIV and Aids?
2. How do these beliefs protect you from being infected?

- **Role of the researcher**

Permission is obtained from the farm owner and Black farm workers, and the importance of the research is explained to them to gain participation. On receiving permission, the leader of the Black farm workers is approached to gain consent for the research and to establish whether there is an existing '*lekgotla*' (discussed in detail in Chapter 2) in place, and if not, discuss with him how this can be established.

The researcher guarded against dominance and bias of the leader as he can misuse his power to affect the views of others. A plenary meeting is held with the leader to address the importance of non-judgmental behaviour and attitudes in conducting a participatory process, and to discuss issues regarding self-awareness, responsibility, commitment to equality and empowerment as well as emphasis on sticking to the purpose of group interactions (Añon, 2003:1), in this case exploring the beliefs of the Black farm workers.

The leader is responsible for arranging meetings and the researcher forms part of the '*lekgotla*' as a participative observer. Unstructured observations are done by the researcher during data gathering and field notes are written during that period or

immediately after these sessions (Burns & Grove, 2005:540). The researcher uses her psychiatric communication skills to observe verbal and non-verbal communication cues, and a tape recorder is used to record the '*lekgotla*' and her own reflections which she had written.

- **Role of the leader**

The leader is requested to call a first '*lekgotla*' during which the researcher discusses the research process and recruits participants. The leader is asked to arrange the second '*lekgotla*' whereby recruited participants are asked to elect two other leaders so that '*lekgotla*' can be conducted by any of the elected leaders in the case that one is not available. The researcher contacts the leader for arrangement of subsequent '*lekgotla*', which any of the elected leaders can lead.

- **Physical environment**

The group discussions ('*lekgotla*') take place at '*kgotla*', which is a place chosen by Black farm workers at their residential area. The participants are allowed to sit in a manner that is comfortable to them and where they are visible to the leader during the discussions.

1.4.2.4 Data analysis

Data obtained from participants is transcribed verbatim on completion of the '*lekgotla*' and analysed by the researcher by arranging it into categories and sub-categories. Data is coded according to both inductive and deductive categories as described by Tesch (as quoted by Creswell, 1994:152).

An independent co-coder is appointed to ensure analysis triangulation and trustworthiness. The co-coder is given a work protocol to analyse data independently. Then the researcher and the co-coder hold a consensus discussion on the categories. Field notes are included in the analysis with other data.

1.4.2.5 Literature control

Relevant literature is searched and used to compare the findings to confirm data obtained in this research and to also look into varying opinions and disagreements (Burns & Grove, 2005:73). Literature databases include peer-reviewed articles from both professional journals and the Internet.

1.5 Trustworthiness and ethical aspects

Meleis' (1996:1-16) culturally sensitive criteria are used to assess trustworthiness in a cultural approach, such as this research. These criteria incorporate Guba and Lincoln's model of trustworthiness (Krefting, 1991:215). The criteria include contextually, relevance, awareness of identity and power differentials, empowerment, flexible approach to time, disclosure, communication styles and reciprocation. This, together with the ethical issues, will be discussed in detail in Chapter 2.

1.6 Results

The results are used to formulate suggestions for a belief-sensitive approach in HIV and Aids-prevention strategies for Black farm workers. The results will be disseminated to relevant role players by means of presentations and a scientific journal publication.

1.7 Further chapter layout

CHAPTER 2: Research methodology

CHAPTER 3: Discussion of research findings and literature control

CHAPTER 4: Conclusions, shortcomings and recommendations, specifically suggestions for a belief-sensitive approach in HIV and Aids-prevention programmes for Black farm workers

CHAPTER 2 RESEARCH DESIGN AND METHOD

2.1 Introduction

Burns and Grove (2005:211) define research design and method as a detailed plan for conducting research. This detailed plan maximizes direction over factors that might interfere with the research being found sound and valid. Furthermore, it equips the researcher with guidelines for planning and implementing the research in a way that is most likely to achieve the goal intended. In this chapter, full descriptions are given of the research design, method, trustworthiness and ethical issues applicable to this research.

2.2 Research design

A qualitative, explorative and descriptive approach was followed with the aim of exploring and describing the beliefs of Black farm workers on HIV and Aids and how these beliefs may protect them from being infected. The findings were used to formulate suggestions for a belief-sensitive approach, which can be incorporated by health care professionals in HIV and Aids-prevention programmes for Black farm workers.

A qualitative design is an approach used to systematically explore Black farm workers' beliefs (Burns and Grove, 2005:211. Key (1997:1) explains that beliefs as a phenomenon consists of separate parts put together in a complex manner, such as the beliefs of Black farm workers concerning HIV and Aids. Little is known about these beliefs, while there is a need to create a deeper understanding thereof, as explained in Chapter 1. An explanation of how the holistic approach of qualitative research was relevant to explore and describe the Black farm workers' beliefs on HIV and Aids is provided:

- **Qualitative research suggests that there is no single reality (Burns & Grove 2005:52)**

Each person's reality is based on his/her own perception, meaning that it differs from person to person and it changes over time (Pyett, 2003:1173). This implies that, because beliefs differ, there can be many different meanings attached to it. Beliefs of Black farm workers were looked into, as described in detail by them, and meaning was formed depending on their views in order to create the whole, i.e. describe their beliefs and how these beliefs protect them from being infected in their own terms. Black farm workers' beliefs were formulated on the basis of collective beliefs rather than personal beliefs. This is in congruence with the socio-cultural world-view as described in Chapter 1.

- **Qualitative research suggests that what we know has meaning only within a given situation or context (Burns & Grove 2005:52)**

As stated in Chapter 1, there is an indication that the battle to prevent HIV and Aids is not won because prevention strategies generally do not follow a cultural approach. Therefore, it is essential to explore beliefs in the context of Black farm workers in order to sensitise health professionals to this aspect when designing prevention strategies (Sithole, 2001:2). In this research, the focus was Black farm workers' beliefs within a particular context, referring to the area in which they live as well as their socio-cultural world-view.

2.2.1 Context

The context focuses on the area, culture and orientation in which research takes place (Mouton & Marais, 1996:122).

2.2.1.1 Area

In this research, data was gathered in the Potchefstroom district on one of four farms which fall under the FLAGH (Farm Labour and General Health) research project.

This is a multi-disciplinary research and intervention programme aiming at improving the quality of life of farm dwellers. This research focused on one of the programme's aims, namely to outline the general situation of Black farm workers in South Africa regarding HIV and Aids and their livelihoods (Kruger, 2005:2). One specific farm was chosen, as conditions on all these farms are similar. All farms were more or less the same distance away from the nearest town, the only difference being the type of farming.

2.2.1.2 Culture

This area was predominantly Tswana. Tswana people have their own cultural practices and beliefs that might be similar to those of other Black African ethnic groups (Motelle, 2003:18). This was also verified during a feasibility visit by the researcher to gain insight into the farm workers' culture. Although some members were Xhosa speaking, the dominant culture was Tswana. It was also observed and verified with the participants that, because of cultural diffusion, culture has been influenced by other African and Western cultures. Therefore, they did not purely observe a 'westernised' or Tswana culture, but rather maintained a unique, diffused culture. This unique culture was intensified by their isolated lifestyle, as discussed in Chapter 1.

2.2.1.3 Orientation

This research was conducted departing from the fact that beliefs determine behaviour (Orr & Patient, 2004:12), particularly health and illness behaviour. Hence, how good or bad awareness programmes may be, if it is not incorporated into or co-operating with the particular beliefs, it would fail. Orr and Patient (2004:12), for example, agrees that it is important for the national health plan to recognise the importance of culturally congruent prevention programmes. This research aims at exploring Black farm workers' beliefs regarding HIV and Aids and how these protect them, so as to sensitise health professionals to the importance of the inclusion of a beliefs-sensitive approach to HIV and Aids prevention programmes.

2.3 Research method

A detailed description of the population, sampling, data collection, data analysis and literature control follows.

2.3.1 Population

The population included all Black farm workers, males and females between ages 19 and 49 years living and working on the particular farm in the Potchefstroom district, North West Province. According to the UNAIDS (2006:8) report, this particular age group can be classified as a productive age group, contributing towards the country's economy; as well as a group at high risk of contracting HIV and Aids.

2.3.2 Sampling

The method of sampling and sample size is subsequently described.

2.3.2.1 Sampling method

Non-probability, purposive and voluntary sampling was used to select participants from the identified population who met the set criteria and were willing to participate (Brink *et al.*, 2006:124). Selection criteria were based on the group most likely to answer the research questions as well as the context in which the research took place. For this research, selection criteria were thus as follows:

Black farm workers working and residing on the farms and who were:

- between the ages of 19 and 49 years;
- consenting voluntarily to participate;
- consenting to the use of tape recorders during the interview;
- able to function and co-operate in a group as team members; and
- able to communicate verbally in Tswana.

2.3.2.2 Sample size

Sample size was determined when data saturation of information was achieved. Data saturation was observed when a pattern of repetition of themes emerged, i.e. there was no new information emerging and there was redundancy of previously collected data (Burns & Grove, 2005:358). Data saturation was reached after having conducted three group discussions (*'lekgotla'*).

2.3.3 Data collection

A description follows of data collection, of the physical environment and of the roles of both the researcher and the selected leader.

2.3.3.1 Method of data collection

Participatory Rural Appraisal (PRA) was used as a data collection technique (Van Maltzahn & Van der Riet, 2006:113; Key, 1997:2), within a cultural approach (*'lekgotla'*).

A core assumption of PRA is collaboration, and PRA is therefore a collaborative research method during which research participants are actively involved in data collection and work together with the researcher (Mill & Ogilvie, 2003:3). In this research participants were actively involved by means of a traditional method for group discussions known as *'lekgotla'*, where the participants had control during the data collection.

Another core assumption of PRA is that culture and context play a key role in gaining knowledge, and that the significance of local knowledge and involvement of participants in the research process should be recognised and ensured (Van Maltzahn & Van der Riet, 2006:111). Such an approach, as applied in this research, increased the trustworthiness of the research in that the themes that emerged were important to the participants, and the researcher did not impose the process or the emerging themes. Additionally, the participants guided the data collection process in

their own natural setting, the farm. A systematic, interactive, subjective approach was used to explore the Black farm workers' beliefs as they experience them so that meaning can be attached to them (Burns & Grove, 1997:27). PRA was thus particularly beneficial in this research as it facilitated critical thinking and encouraged individuals to explore their beliefs (Mill & Ogilvie 2003:3). Through the questions asked in this research, participants were able to explore their beliefs and in the process also explore how these protect them from being infected. PRA allowed them to reflect on their beliefs individually and in a group.

A further benefit was that the researcher contributed her academic knowledge, in that she raised a problem that triggered the Black farm workers to critically reflect on as well as empower each other in a way that was otherwise never thought of (De Vos, 2002:426). On the other hand participants contributed their popular knowledge, in that all their opinions and thoughts regarding their beliefs on HIV and Aids and how these protect them regarding HIV and Aids infection were valued. Furthermore, the researcher gained deeper understanding of Black farm workers' beliefs on HIV and Aids. Therefore power balance and flexibility were adhered to as prescribed by the PRA method (Van Maltzahn & Van der Riet, 2006:113). Participants were empowered during the research process to actively participate and share their beliefs in an approach known to them, namely '*lekgotla*'.

'*Lekgotla*' is an African word and refers to a body of people assembled at a place (Schapera, 1994:19). In traditional African culture, '*lekgotla*' is a traditional public meeting at a specific place ('*kgotla*'), for example the chief's kraal. '*Lekgotla*' is traditionally headed by an ascribed village chief or leader. Community decisions are made during these discussions. Anyone is allowed to speak and share their viewpoint. This type of group discussion was adopted for this research. During visits to the farm the researcher established that the Black farm workers usually gathered together at a place specific place ('*kgotla*') to socialize and discuss issues (see 2.3.3.2). They have already democratically elected a leader to convey their needs and desires to the farmer. This leader was approached by the researcher to also act as facilitator during '*lekgotla*'.

In line with the core assumptions of PRA, '*lekgotla*' was seen as the best strategy of ensuring active participation. In this research participants guided the research process by having the leader leading the data collection process through the use of '*kgotla*'. The leader is culturally recognised to have the authority and power to control the process, as it is someone known and trusted by the participants (Schapera, 1994:19). Rich data was found as Black farm workers were more open to discuss their beliefs to someone they trust. If the researcher could have used a more 'westernised' approach, for example focus group interviews, where she was driving the process, she might have been seen as an outsider and participants might have not shared their beliefs as they did with their leader (Kelly & Van der Riet, 2001:188).

In this research, '*lekgotla*' – as a culturally congruent data collection technique within the PRA approach – followed a process similar to semi-structured group interviews. The leader started the interview with a general introductory question to trigger brief answers as well as allow participants time to feel at ease, e.g. "What are the general beliefs concerning HIV and Aids?" Thereafter, the progression of questions was from a general to a more specific question and progressing from a non-threatening to a potentially threatening question:

1. What beliefs do you have regarding HIV and Aids?
2. How do these beliefs protect you from being infected?

The origin of Black farm workers' beliefs was not necessarily questioned, as this was not the focus of the research, and it would furthermore not have been in line with a respectful, culturally congruent research approach (Tjale & De Villiers, 2004:11; Sithole, 2001:1).

After each '*lekgotla*' the researcher reflected her views through recording field notes immediately to avoid forgetting factors that might affect the researcher findings. The purpose of these field notes was to assist in data analysis as verification of information. These field notes were taken down in accordance with Creswell's (1994:152) directions (see Appendix E):

- Descriptive notes: This entailed reports on the portraits or descriptions of participants, physical setting, the researcher's account of particular events that occurred and activities that took place during the '*lekgotla*';
- Demographic notes: This included information regarding the time, place, date and weather conditions to describe the setting at '*kgotla*';
- Reflective notes: This is where the researcher records personal thoughts about feelings, problems encountered during data collection, ideas generated during the process, hunches, impressions and prejudices.

2.3.3.2 The role of the researcher

Although permission to conduct the research on the farm had already been granted through the FLAGH project, the farm owner's permission was also obtained (see Appendix A). Furthermore, permission was also obtained from the Ethics Committee of the North-West University (see Appendix B). Thereafter, the researcher visited the farm once more to inform the farm owner of the exact period when data would be collected.

At first, the researcher organised a plenary meeting through the farm owner to determine whether there were leaders among the Black farm workers and what the nature of the relationship was that existed between them and the Black farm workers. The researcher established that there was one leader and a relationship of trust existed between him and the Black farm workers. The presence of such a relationship ensured a non-threatening environment for the research process. The researcher investigated the possibility that there might be an existing '*kgotla*' (see paragraph 2.3.3.1). The finding was that there was an open space where Black farm workers usually sat together after work ('*kgotla*') and it was agreed that this place could be used for data collection. It was also arranged and found acceptable by the Black farm workers that if the weather did not allow an outside meeting, a nearby house would be used.

The researcher held a discussion meeting with the leader on the farm. The researcher explained and described the background, aims and objectives of the research to obtain his permission and co-operation as the leader. The researcher also guided him on how to ask questions for the purpose of this research, and to use listening skills and allow the Black farm workers time to discuss their beliefs openly and freely during the '*lekgotla*'. Additionally principles of respect like listening to each other and not interrupting the other participant when talking were agreed upon to ensure co-operation.

The researcher then arranged with the leader to set up the first '*lekgotla*' whereby the leader introduced the researcher and explained the objectives, method and importance of the research. Thereafter the researcher explained ethical aspects involved in this research in order to recruit participants. The researcher obtained verbal permission from participants as it is acceptable in the cultural context. Then Black farm workers were asked to elect other two leaders so that '*lekgotla*' could be conducted by any of the elected leaders in case of absence of the initial leader.

On arrival at the second '*lekgotla*' participants were asked to give their consent to the use of a tape recorder during the interviews as that was the time when the actual data collection started. This '*lekgotla*' was also seen as a trial run to explore the appropriateness of the approach and of the specific questions asked during the '*lekgotla*' (Brink *et al.*, 2006:60). Based on the spontaneous and appropriate participation of the participants, the approach and questions were accepted as appropriate and used in subsequent '*lekgotla*'. A psychiatric nurse was approached beforehand to be available for quick referral as a support system for debriefing should the need arise as a result of the '*lekgotla*' (see Appendix D). The researcher again ensured the participants of confidentiality and available psychological support.

The researcher was present during each '*lekgotla*' as a participative observer as Key (1997:1) describes, namely that the researcher should assume balanced participation by maintaining a balance between being an outsider and an insider. Before '*lekgotla*' the researcher was present to help the leader to arrange equipment such as chairs and audiotape on the organised venue. Extra batteries as well as

extra tapes were organised for audiotapes. Refreshments like water, snacks and juice were organised by the researcher.

2.3.3.3 The role of leaders

The first leader acted as a mediator and helped to recruit participants by:

- Explaining the purpose, benefits and importance of the research project to the potential participants.
- Describing the research process to potential participants:
 - 'Lekgotla' would be used as a method of data collection with no specific time frame set for this.
 - There should be at least ten or more members to ensure that everyone participates while keeping the balance to trigger a range of responses (De Vos, 2002:311).
 - No children were allowed, since sensitive issues would be discussed.

He also helped to arrange the first meeting where participants were recruited and where two other leaders were elected. The first leader and other two leaders along with the researcher then agreed on the date for the next '*lekgotla*' so that they could decide in advance who of them would conduct that '*lekgotla*'. The leaders were provided with an interview schedule before each '*lekgotla*' (see Appendix C), as well as guidance regarding asking the research questions, listening skills and facilitating the discussions, to ensure standardization of how questions were asked in each '*lekgotla*'.

2.3.3.4 Physical environment

'*Lekgotla*' was conducted at a place called '*kgotla*' (see 2.3.3.1) chosen by the participants. A conducive physical setting was arranged in such a manner that human behaviour could unfold resulting in in-depth information being captured (Polit & Hungler, 1993:306). The participants sat in a manner that was comfortable for

them with the leader sitting where he/she could see everyone. At '*lekgotla*' no cell-phones were allowed unless in an emergency and the phone was put on silence to avoid distractions and disruptions. In the case that the '*lekgotla*' was held in the house, it was ensured that the room was well-ventilated, clean, warm with participants allowed to sit in any way they felt comfortable as long as it was not impacting on other participants, i.e. in a cultural setting they are allowed to sit on the floor or on chairs. At '*kgotla*' the norm was that there were no barriers between the leader and participants. The time chosen for the '*lekgotla*' was suitable for participants.

2.3.4 Data analysis

The researcher transcribed data obtained from participants directly after completion of '*lekgotla*'. The following process was followed, as described by Tesch (as quoted by Creswell, 1994:152):

- Each transcript was divided into 3 columns.
- The middle column was used for the leader and the participants' verbal responses.
- The right hand column was used for the themes that emerged from the responses.
- The left hand column was used for the ideas that come into mind as the transcript was read by the researcher.
- Then the researcher re-read the transcripts and underlined the themes, words and phrases as stated by the participants, which were related to:
 - o What beliefs do you have on HIV and Aids?
 - o How do these beliefs protect you from being infected?
- The above-mentioned themes, words and phrases were written in the right hand column.
- The identified themes could be grouped into five main categories.

A work protocol (see Appendix F), as well as the transcripts and field notes were given to a co-coder. On completion of the analysis a consensus meeting was held between the co-coder and the researcher to discuss and reach consensus on the categories that emerged from the data.

2.4 Literature control

Relevant literature was used in Chapter 3 to compare the findings, to confirm data obtained in this research and to also look into varying opinions and disagreements between the findings and literature (Burns & Grove, 2005:73). Literature used include S.A. and international journals, relevant research reports and books.

2.5 Trustworthiness

For the research to be trustworthy, it is required that it should be conducted in an explicitly accurate manner and that results are presented accurately (Krefting, 1991:216), in this case the beliefs of participants. Measures to ensure trustworthiness help the researcher to overcome barriers or challenges that may form obstacles to accurate research results. Guba and Lincoln (as quoted by Krefting, 1991:216) suggest four criteria to ensure trustworthiness, i.e. truth -value, applicability, consistency and neutrality.

Conversely, trustworthiness has to be done in such a manner that participants' beliefs are considered and respected (Mill & Ogilvie, 2003:807). Therefore a framework that evaluate trustworthiness in this research needed a more integrated approach that balances a scientific way of ensuring rigour and that is also culturally sensitive. Meleis (1996:2) developed criteria that acknowledge culturally sensitive knowledge which can be used to assess trustworthiness in a culturally sensitive approach, while incorporating Guba and Lincon's framework. These criteria include: contextuality, relevance, awareness of identity and power differentials, empowerment, flexible approach to time, disclosure, communication styles and reciprocation.

2.5.1 Contextuality and relevance

The context and relevance of research needs to be described in detail (Meleis, 1996:2), as Black farm workers' beliefs regarding HIV and Aids can only be true

within the described context. The researcher visited the specific farm to meet the participants in their environment and this facilitated an understanding of the context of this research. It also helped to confirm the relevance of this research to this population, namely that their beliefs need to be taken into consideration in HIV-prevention programmes. The context, which is the area, culture and orientation in which research took place is described in detail in this Chapter, while the relevance of the research is described in Chapter 1.

2.5.2 Awareness of identity and power differentials

In research where culture plays an important role, such as this research, the researcher needs to demonstrate an awareness of the identity of the specific cultural group, as well as be respectful of power differentials (Meleis, 1996:3). In the traditional research field, researchers are seen as 'experts' who impose their knowledge on participants without integrating local knowledge into the research plan (Campbell, 2002:22). In this research however, the researcher visited the farms to develop an awareness of the identity of the participants. Furthermore, PRA and '*lekgotla*' were used as a data collection approach to establish a collaborative relationship and also to eliminate power differentials. This was evidenced when participants were allowed, through the leader, to guide the research process by means of '*lekgotla*'. The leader, trusted by the group, asked questions in a non-threatening way, and communicated at the same level of understanding as the group.

2.5.3 Consciousness-raising

Consciousness-raising is a process through which change is achieved (Meleis, 1996:5). In culturally congruent research, consciousness-raising facilitates empowerment of participants through change. Change can be external and internal. In this research, the researcher brought in external change by contributing academic knowledge, and internal change agents were the participants through sharing experiences and practical knowledge about their beliefs on HIV and Aids. During the research process, the questions posed helped the researcher to gain knowledge

concerning Black farm workers' beliefs. Through the discussions in '*lekgotla*', the participants could use critical thinking to evaluate for themselves whether their beliefs protect them from being infected. The research process created greater awareness of beliefs on HIV and Aids among Black farm workers.

2.5.4 Disclosure

Disclosure is one of the criteria for assessment of rigour and is determined by the ability of the participants and their willingness to tell the truth (Meleis, 1996:5). At '*kgotla*' the setting allowed participants to establish trusting relationships with the researcher and the leader, thereby increasing their willingness to disclose their beliefs as something that is personal to share.

2.5.5 Understanding communication styles

In culturally competent scholarship, the researcher's understanding of the communication styles of participants provides evidence of rigour (Meleis, 1996:6). The researcher should adequately understand normative patterns of participants' communication. Hence the interviews were conducted in Setswana, which is the common language used by the Black farm workers on this farm; and the place where communication was established was an environment that was relaxing and non-threatening by nature for them to disclose personal information. A translator, who is a Tswana of origin, translated the transcripts into English to increase the validity of the research. The reason for using a Tswana translator was that, culturally, language contains patterns, which are commonly "indirect" and obscure. Its meanings are often expressed in proverbs, communication metaphors and euphemisms (Obeng, 1994:37). The Tswana translator was able to identify and translate these patterns accurately.

2.5.6 Encouraging reciprocity

Reciprocity is the final criterion for the assessment of culturally competent scholarship (Meleis, 1996:7). This is implicit in PRA, as reciprocity defines the collaborative relationship between the researcher and the participants. In this

research, the principle of respect and understanding formed the basis of this relationship. Participants shared confidential information during data collection and the researcher respected their beliefs and avoided a judgmental attitude.

2.6 Ethical aspects

It is the moral responsibility of every researcher to conduct research ethically, since this ensures that the researcher has expertise, diligence, honesty and integrity (Brink *et al.*, 2006:30; Burns & Grove, 2005:176). Integrity was ensured through respect for the human rights of participants. According to Burns and Grove (2005:181), ethical standards are based on three main principles, i.e. **respect for human dignity**, **beneficence** and **justice**. A discussion of the relevant principles in this research follows:

2.6.1 Respect for human dignity

Respect for human dignity is based on the **right to self-determination** and **full disclosure**, meaning that the individual is able to control his or her own destiny (Brink *et al.*, 2006:30; Burns & Grove, 2005:176). When conducting research, the researcher and the leader kept in mind that these people are autonomous agents and therefore have the right to conduct their own lives as they choose and should not be controlled externally. The participants were informed about the proposed study and were allowed to voluntarily choose to participate. Participants were also given the choice to withdraw from the research at any stage without penalty. The researcher also guarded against the use of coercion, covert data collection and deception by providing thorough information about the research.

Once participants voluntarily agreed to be part of the research, the participants were also informed, before the research started, as to how it would be conducted, the data collection method used which is '*lekgotla*', that audio-taping would take place and how the information obtained from them will be used (see Appendix C). Deception was avoided by making sure that participants were indeed informed about the research and how it might have affected them physically and psychologically. The

researcher did not include persons with diminished autonomy, such as those who are mentally ill, terminally ill or children.

Informed consent was obtained through verbal permission from farm workers, as this practice is acceptable in a cultural context.

2.6.2 Beneficence

The principle of beneficence is concerned with the right to protection from discomfort and harm (Brink *et al.*, 2006:30; Burns & Grove, 2005:176). This means that when conducting research, the participants should be protected from discomfort and harm and the researcher should attempt to bring about the greatest possible balance of benefits over harm. Participants might experience temporary discomfort during '*lekgotla*', as this process is tiring. The participants' discomfort was assessed and a psychiatric nurse was on stand-by in case they needed referral for appropriate professional intervention due to emotional discomfort.

2.6.3 Justice

This is based on the right to **fair treatment** and **privacy** and it also incorporates **confidentiality** (Brink *et al.*, 2006:30; Burns & Grove, 2005:176).

Fair treatment means that the person should be treated fairly and receives what he/she is due or owed; therefore in research, selection of participants and their treatment during the course of study should be fair. All prospective participants were afforded an opportunity to be selected as long as they meet the criteria. Respecting any agreement made with them also ensured fair treatment. Data collection requires appointments with participants; therefore the researcher made effort to arrive on time. The research activities should not be changed without participants' consent, and if there are any benefits promised, they should be provided. These benefits were equally distributed, regardless of age, race and socio-economic level, i.e. refreshments and psychological help if needed. This respectful treatment of participants facilitated the data collection process and decreased withdrawal of the participants from research.

The **right to privacy** is the right an individual has to determine the time, extent and general circumstances under which private information will be shared with or withheld from others (Brink *et al.*, 2006:30; Burns & Grove, 2005:176). This information includes attitudes, beliefs, behaviours, opinions and records. This right was ensured by informing participants fully about the proposed research and they were allowed to give consent to participate in the research and to voluntarily share private information. Privacy of individuals is invaded when private information is shared without an individual's knowledge or against his/her will. This can result in loss of dignity, friendships or employment or create feelings of anxiety, guilt, embarrassment or shame. Most frequently this happens during data collection. In this research participants were asked their beliefs concerning HIV and Aids, which is private information. They were informed about this in advance and about how the questions might affect their feelings. Additionally, because this forms part of a project involving many researchers, the information collected had to be shared with other researchers. Participants were therefore informed about the aims and background of this project, as well as that analysed, **anonymous data** will be shared within the research community.

The research participants had the right to assume that the data collected was kept **confidential** (Brink *et al.*, 2006:30; Burns & Grove, 2005:176). Private information were shared, with the authorization of the participant. Confidentiality was ensured by informing participants that:

- they can share personal information to the extent they wish and that they are entitled to withhold information.
- they have the right to choose with whom they share personal information.
- the researcher has the obligation to maintain the confidentiality of the information by keeping raw data at a safe place.

Breach of confidentiality can occur when the researcher accidentally or by direct action allows an unauthorized person to gain access to raw data of a study (Brink *et al.*, 2006:30; Burns & Grove, 2005:176). This can also occur when a participant's identity is accidentally revealed, resulting in a violation of the subject's right to

anonymity. This can result in psychological and social harm, which destroys the trust participants had in the researcher. Raw data which has been collected may not be shared with anyone who is unauthorised to see it. Confidentiality was maintained by calling them participants in the transcripts. Data collected was entered in code names. Data collected was transcribed and any identifying information were removed, to ensure that the individuals could not be identified by their responses. Because this is a project, participants were informed that other researchers might have access to transcribed information from the '*lekgotla*'. Participants were informed continuously that they had the right to only share information they are comfortable with.

2.7 Summary

In this chapter a detailed description of the research design, method, data collection and analysis was given. Literature control, trustworthiness and ethical aspects were also discussed. This was done to ensure that the design chosen would meet the objectives of the research and that it was the most appropriate to answer the questions posed in this research (Burns & Grove, 2005:211). Therefore a framework was formed on how the research was conducted by the researcher. In the following chapter the findings on the Black farm workers' beliefs and the literature control are discussed.

CHAPTER 3

DISCUSSION OF RESEARCH FINDINGS AND LITERATURE CONTROL

3.1 Introduction

In the previous chapter a detailed description of the research design and method was given. In this chapter follows the findings, namely the beliefs of Black farm workers on HIV and Aids. These findings are evidenced by quotations of direct translations from the '*lekgotla*' discussions. The researcher compares these findings with existing literature pertaining to beliefs, Black farm workers and HIV and Aids. The findings that are unique to this research are also highlighted.

3.2 Realization of data collection and analysis

PRA was used as a data collection technique and '*lekgotla*' as a data collection strategy. Three '*lekgotla*' meetings (in addition to the initial '*lekgotla*' to recruit participants) were held and quality data was obtained as evidenced in the discussion of research findings in 3.3. The leader, with the researcher present as an observer, as discussed in 2.3.3.1, asked the scheduled three questions (see Appendix C). The use of '*lekgotla*' as data collection strategy contributed to obtaining rich data, and participants were comfortable to share sensitive information. Deeper nuances of specific beliefs that might be viewed by health professionals as 'general knowledge' could be explored during the '*lekgotla*'.

However, it took longer than planned to collect data as the researcher had to initially establish a relationship of trust with the participants. Participants were previously exposed to a team of researchers as part of the FLAGH project over a prolonged period of time, and they expressed that they "felt used by the team of researchers", which hampered their openness towards the researcher. Furthermore work commitments limited the participants' availability during the times negotiated for the '*lekgotla*'.

Field notes were written by the researcher after each '*lekgotla*' and were categorised as descriptive, demographic and reflective (see Appendix E). Data was analysed as described by Tesch (as quoted by Creswell, 1994:152) (see paragraph 2.3.4). Two consensus meetings were held between the researcher and the co-coder and five main categories emerged (see table 3.1).

3.3 Research findings and literature control

On reaching consensus with the co-coder, the researcher identified five main categories concerning the beliefs of black farm workers on HIV and Aids. These beliefs demonstrate a strong correlation with knowledge on HIV and Aids, as interpreted in the specific culture and experiences of Black farm workers. This confirms the argument that knowledge, culture and experience are integrated to become beliefs (Van Maltzahn & Van der Riet, 2006:111), as explained in Chapter 1.

These five main categories were:

- Beliefs concerning the existence of HIV and Aids
- Beliefs concerning causes of HIV and Aids
- Beliefs concerning protective measures against HIV and Aids
- Marginal beliefs concerning risk in relation to HIV and Aids infection
- Beliefs concerning intimate relationships

Table 3.1 portrays these categories, and provides a layout of the sub-categories.

Table 3.1: Beliefs of Black farm workers on HIV and Aids

| COLUMN A | COLUMN B | COLUMN C | COLUMN D | COLUMN E |
|--|---|--|--|--|
| Beliefs concerning the existence of HIV and Aids | Beliefs concerning causes of HIV and Aids | Beliefs concerning protective measures against HIV and Aids | Marginal beliefs concerning risks in relation to HIV and Aids infection | Beliefs concerning intimate relationships |
| <ul style="list-style-type: none"> • Black farm workers believe that HIV exists: # They believe that HIV exists # They believe that it is mostly the youth who have HIV # They believe that HIV and Aids is more prevalent among Black people • Black farm workers rely on observable evidence that HIV and Aids causes death, leading to doubt about its existence • Black farm workers believe that "there is life" after becoming HIV positive • Black farm workers differentiate between HIV and Aids: # They believe that when a person is in an Aids stage he/she can no longer lead a normal life # They believe that even if a person is on treatment while HIV positive, he/she can still develop Aids | <ul style="list-style-type: none"> • Black farms workers believe sexual intercourse is a cause of HIV and Aids, specifically in the cases of: # Unprotected sex # Multiple partners • Black farm workers ascribe the following non-sexual causes of HIV and Aids: <ul style="list-style-type: none"> • Disregarding tradition, namely: Not knowing the use of or not practicing traditional medicine # Not respecting widowhood rituals • Other causes, namely # Used needles # Exchange of bodily fluids via an open wound • Some black farm workers believe that lack of income can cause people to contract the disease on purpose | <ul style="list-style-type: none"> • Black farm workers believe they protect themselves by using sexually related protective measures, namely: # Going for blood tests # Using a condom # Abstinence from sexual intercourse • Protective measures not related to sexual intercourse that black farm workers believe in, include: # Protection during first aid # Adhering to treatment when diagnosed HIV positive | <ul style="list-style-type: none"> • Some black farm workers' beliefs might put them at risk of contracting HIV, namely: • One participant repeatedly put forward the argument that only the sperms ejaculated during the first round of sexual intercourse contains the HI-virus • Some men believe that it is acceptable to perforate condoms in specific cases | <ul style="list-style-type: none"> • Black farm workers believe that contracting the disease in a relationship is a sign of love • Black farm workers believe that trust in the relationship is based on the duration of the relationship • Black farm workers believe that sex without using a condom indicates readiness to marry someone • There is a belief that sexual intercourse is more frequent at the beginning of the relationship and it is inevitable when aroused • There is a marginal belief that contracting the disease while being faithful can cause a great deal of emotional pain |

Subsequently a detailed discussion of these beliefs, with reference to quotations and a literature control follows.

3.3.1 Beliefs concerning the existence of HIV and Aids

This main category is indicated in Column A (see Table 3.1), as well as in Table 3.1.1 below. This main category could be divided into four subcategories, as shown in Table 3.1.1.

Table 3.1.1 Beliefs concerning the existence of HIV and Aids

- Black farm workers believe that HIV exists:
 - They believe that HIV exists
 - They believe that It is mostly the youth who contract HIV
 - They believe that HIV and Aids is more prevalent among Black people
- Black farm workers rely on observable evidence that HIV and Aids causes death, leading to doubt about its existence
- Black farm workers believe that “there is life” after becoming HIV positive
- Black farm workers differentiate between HIV and Aids:
 - They believe that when a person is in an Aids stage he/she can no longer lead a normal life
 - They believe that even if a person is on treatment while being HIV positive, he/she can still develop Aids

- **Black farm workers believe that HIV exists:**

They believe that HIV exists (“*HIV e teng*”) (“HIV is there”)

Most of the participants in all the discussions agreed that HIV exists. Participants believed that HIV exists and that “it is in the blood”. They also believed that it is a

fatal disease. They maintained a strong belief that HIV is a reality, in the same way that any other disease, such as TB, is a reality.

| |
|--|
| <i>"HIV is there ..."</i> |
| <i>"My beliefs about HIV, according to me it kills, just like Sir just said."</i> |
| <i>"I believe that HIV exists."</i> |
| <i>"Yes it exists."</i> |
| <i>"Beliefs that we have...well...well ...I believe that HIV exists and you get it through human blood .."</i> |
| <i>"The question is that HIV is the blood."</i> |
| <i>"It's from the blood."</i> |

This belief might provide a positive foundation for belief-sensitive HIV-prevention programmes, as participants had knowledge of HIV and Aids and the majority held the belief that it exists. According to a study by Peltzer (2003:250) such knowledge and beliefs are important factors to foster a positive attitude towards people who have Aids and encourage willingness to offer support and care to those living with the disease.

They believe that it is mostly the youth that have HIV

There was also a belief that it is mostly the youth that is at risk of being infected by the disease. Most adults believed that the young generation is more at risk of contracting the disease because they are more prone to engaging in sexual intercourse at an early age. This results in death at an early age.

| |
|---|
| <i>"Youths are more susceptible to contract the disease."</i> |
| <i>"This youth, it's them that's dying sooner."</i> |

The belief that young people, specifically those between ages 15 and 24 years, are those with the largest proportion of HIV infections, is also confirmed by the UNAIDS (2006:5) in its report on the global Aids epidemic. This belief might motivate Black farm workers₁ to support programmes that enable young people to improve their

sexual health. Castle (2004:2) as well as Van Dyk (2001:61) confirm that a supportive community is a useful resource in the fight against HIV transmission (Castle, 2004:2, Van Dyk, 2001:61).

They believe that HIV and Aids is more prevalent among Black people

There were some participants who believed that HIV is more prevalent among Black people than White people. HIV and Aids was seen as a 'Black people's disease', and linked HIV to a disease known in the African culture as 'seshwagadi' or "mokaola" (widowhood) (refer to Table 3.1, Column B). Some participants thus distinguished between HIV as a term used in westernised cultures, and 'seshwagadi' or "mokaola" as used in African cultures.

This was a point of debate among the participants, as some strongly denied that HIV and Aids is a 'Black people's disease'. They preferred the argument that one should distinguish between 'HIV' – a disease that cannot be cured, and 'seshwagadi' (widowhood) – a disease that can be cured: *"Seshwagadi has a cure, but HIV doesn't have a cure. How come you say that they are the same?"*. They further argued that while 'seshwagadi' is caused by having a sexual relationship with someone who has lost a partner or a child, a person can contract HIV even if the person who they are involved with has not lost a loved one: *"...now I have not lost a child, I don't have anybody who died, I sleep with a girl but I have it, she also hasn't lost anyone, I get it"*.

It was clear from the 'lekgotla' that Black farm workers believe that the term 'HIV' was given only recently to an illness known to them as 'seshwagadi' (widowhood). The correlation between HIV and 'seshwagadi' is that they are both contracted through sexual intercourse. Nonetheless, it was argued that the difference between these two illnesses is that in the case of widowhood there is death of a loved one, while this is not necessarily the case with HIV.

"I stress on those words, that time of our grandfathers, it wasn't called like this, this name of HIV it's a name, it's a recent name, with our grandfathers it was not called HIV, but it, we were born with it present it has always been present."

"Listen first what I'm saying, we say 'mokaola' gets in how and when your child died or a husband, if you don't mourn, you don't mourn you have what? You get 'mokaola'. So Aids, how did it come?"

"It gets in through sex."

"Listen, Aids, isn't it we say it gets in through sex?"

"Difference of this 'mokaola', isn't it you will have Aids even if your child didn't die, you are saying 'mokaola' it's when someone died."

"I'm saying 'mokaola' comes in how."

"It's from sex which is not safe."

"'Mokaola' comes from that child who died."

These arguments are also an indication that, among Black farm workers and in relation to HIV and Aids, a distinction is made between White and Black cultures.

"Whites get HIV and Aids; 'seshwagadi' is in Black people."

"Western say it's HIV but it's 'mokaola'."

"Black people contract Aids more than Whites."

"You are lying."

In line with these findings, Castle (2004:3) found that there is a belief that HIV is a western plot to encourage condom use to halt the growth of the African population. Awareness of this myth is raised by this finding, and this awareness might sensitise health care workers to the importance of awareness raising campaigns and the significance of participatory education programmes to address scepticism concerning HIV.

- **Black farm workers rely on observable evidence that HIV and Aids cause death, leading to doubt about its existence**

In spite of the mentioned beliefs that HIV does exist, there was also some doubt about the existence of HIV or Aids as a disease causing death, as participants debated that *"there is no grave shown of someone killed by the disease"*.

Participants further mentioned that one couldn't identify a person suspected of being infected with HIV and Aids based on their appearance; therefore blood tests need to be done. Others went to the extent of arguing that a person who is HIV positive cannot be identified as being HIV positive until the Aids stage has stepped in and there are some observable signs.

Furthermore, doubt about the possibility that a person can contract HIV if that person is married and stays faithful to one partner caused some participants to question whether it really is Aids that causes death. This result links with the belief that Black farm workers see marriage as a protective factor against HIV and Aids, as discussed later (see Column C, Table 3.1).

Below are quotes regarding the argument on this result:

"Yes we haven't gone but we believe that it exist, you can't say you have Aids or you don't have without going to the doctor ... "

"You didn't really observe, you don't know this person's illness, how do you know? Sometimes you don't know his illness."

Literature related to this finding sends out a warning: a study by Castle (2004:3) confirms that in rural areas, such as where this research was conducted, there is doubt about the existence of HIV and Aids because only those who had personally seen someone with Aids believed that HIV and Aids existed. Dhliwayo, Ngoni & Ulaya (2005:18) argues that such a belief has the potential to limit the use of HIV voluntary counselling and testing (VCT) services.

- **They believe that "there is life" after becoming HIV positive**

There was a belief that even if the disease exists and someone is HIV positive, there is life after HIV. Participants believed that it is not the quality of life one leads after being diagnosed HIV positive but the quantity of that life after diagnosis that is important: *"A person who has HIV can even live for a long time, maybe ten to twelve years"*.

Participants were arguing about the value of living if a person is ill and cannot lead a normal life. Eventually participants agreed that life after being diagnosed with HIV is made possible by adhering to treatment and by living life with a positive attitude. Therefore, being HIV positive is generally not seen as a death sentence.

"Yes there is life after HIV."

"They say that, the person with HIV, can do things for himself, he can talk, live ... "

"As long as he is taking care of himself ... Even if a person has contracted HIV, he can do anything by himself. Sometimes you won't even notice that the person is infected."

Beliefs such as believing that 'there is life' after being diagnosed might thus be a motivating factor in engaging in preventative measures, such as VCT. VCT is an important part of South Africa's HIV prevention strategy (Pembry, 2006:8).

- **Black farm workers differentiate between HIV and Aids**

Two arguments emerged under this sub-category, namely that Black farm workers believe that 1) when a person is in an Aids stage he/she can no longer lead a normal life; and that 2) even if an HIV positive person is on treatment, he/she can still develop Aids. These beliefs elicited debate, as explained in the following discussion.

There was a strong belief that both HIV and Aids exist, as already discussed, but also that there is a difference between HIV and Aids "...An infected person can't do anything by himself; sometimes you won't even notice that the person is actually infected". People who are in the Aids stage can be identified through their appearance, which confirms the discussion earlier that they rely on observable evidence to believe that the disease exists. Additionally, some believed that even if a person were on treatment while being HIV positive, he/she would eventually develop Aids: "Even if you drink treatment correctly, you can get Aids".

Further quotes that support these results are:

"Aids I believe exist. I have seen people with it, when you are at the hospital you see them":

"So that is the thing that makes me to believe that Aids exist, and this person changes, the way he used to be, he has sores, the hair changes, so that thing makes me to believe that there is HIV."

Furthermore, a person who is in the Aids stage, unlike an HIV positive person, will live even though not for a long time: *"You went to the doctor on Monday, when you arrive the doctor gives you medicine to make the pain better you become better but the doctor tells you that now it's no longer HIV, it's Aids. The pain becomes better, Tuesday you go to work, Wednesday, the whole week you go to work, next week Monday sister (Name) become worse and dies, don't you have life after Aids?"*

The discussion confirms that Black farm workers have integrated some knowledge into their belief system and use this knowledge to differentiate between HIV and Aids. However, limited knowledge, as in this case, can lead to unfair judgement and stigmatisation of an individual who might be suffering from another disease than HIV and Aids. This opens up the importance of awareness raising campaigns and the significance of participatory education programmes to address stigmatisation.

3.3.2 Beliefs concerning the causes of HIV and Aids

This is the second main category, as indicated in Column B of Table 3.1. This main category could be divided into three sub-categories, as shown in Table 3.1.2.

Table 3.1.2 Beliefs concerning the causes of HIV and Aids

- Black farm workers believe sexual intercourse is a cause of HIV and Aids, specifically in the cases of:
 - Unprotected sex
 - Multiple partners
- Black farm workers ascribe the following non-sexual causes to HIV and Aids:
 - Disregarding tradition, namely:
 - Not knowing the use of or not practicing traditional medicine
 - Not respecting widowhood rituals
 - Other causes, namely:
 - Used needles
 - Exchange of bodily fluids via an open wound
- Some Black farm workers believe that lack of income can cause people to contract the disease on purpose

- **Black farm workers believe that sexual intercourse is a cause of HIV and Aids, specifically in the cases of:**

Unprotected sex

Participants believed that HIV is found in human blood and one contracts it through unsafe sex. A striking metaphor used by one of the participants, and supported by other participants, was that of driving a car (having an intimate relationship with someone), namely that if one "drive different cars" and not take care of oneself, one might "be unlucky" and contract HIV. The following quotes support this result:

"You get it through unsafe sex."

"You get it through blood and, sex is the main thing that causes this thing, if we just take a look at it ..."

"HIV? We are talking about a disease that enters through unprotected sex, so all these other sicknesses, "mokaula" and so on have nothing to do with this issue ..."

right now I'm closing. My friend it's hard. All I know is that it doesn't have a cure, it doesn't have a cure."

"You get HIV and Aids mostly when you try to have unprotected sex. This means that in most cases, these diseases enter your body when you engage in sex without a condom."

Participants: "Mm".

"Hard luck to you! (Interruption by another participant: "Take care of yourself"), if you are driving on the road, but on the road there is no experience, because you are not only driving your car, you can have ten years driving." (Exclamation: Yes) ... if you don't believe, it's your choice, you can go on, the way you want to go on if you don't care for yourself, you don't take care of yourself, it's your choice, it will affect you, if you believe it will happen to you, you will do necessary things so that you don't meet with it but if you do things to impress me or your opposite, that you know how to do something, end of the day you will be alone, I won't be there, you will be sick, the way I understand it."

The belief held by the majority of participants that the disease is spread through sexual intercourse might serve as an important protective factor. Literature indicates that if groups, such as Black farm workers, have some knowledge of causes of HIV it will be easier for them to adopt safe behaviours and to change some of their cultural beliefs and norms (Anon, 2006a:6). Furthermore this belief further confirms that Black farm workers might be more receptive of prevention messages and preventative measures such as VCT, while Dhlwayo *et al.* (2005:18) found that misconceptions about the mode of transmission can lead to unwillingness to go for VCT.

Multiple partners

In line with the previous result, Black farm workers believe that having multiple partners causes HIV and Aids, and that HIV and Aids decreases a person's lifespan. Having multiple partners is identified as being unfaithful to one partner. Black farm workers view such behaviour as 'not taking care of oneself'. Additionally, participants believed that people should think before making any decision on engaging in sexual

intercourse in multiple relationships without using a condom. The term used for such behaviour was *'fast life'*; while being faithful was referred to as the *"true way"*. The following are the discussions on their beliefs concerning multiple partners:

"Sir has seven wives he is their only man ... so what I'm saying is that I sleep with so and so then the next day I sleep with so and so and the next day I sleep with so and so. So when all these sicknesses combine they cause Aids."

"As you can hear (Name), Aids is sleeping around, Aids is sleeping around. You get it through sleeping around."

"It's caused by too many partners ... "

"They say it's because you have many partners without using a condom ... they don't explain whether in those many partners who has what, what happens in those many partners, so if you have many partners you will have HIV if you don't use a condom".

"It comes with the one that between the two of you is not following a true way".

The belief held by majority of participants that HIV is spread sexually, particularly that promiscuity puts a person more at risk, is an important protective factor (Slaymaker, Walker, Zaba & Cullumbien, 2004:6). Literature indicates that if groups, such as Black farm workers, have integrated some knowledge of the causes of HIV into their cultural beliefs and norms it will be easier for them to adopt safe behaviours (Anon:2006a:6).

- **Black farm workers ascribe the following non-sexual causes to HIV and Aids:**
- **Disregarding tradition, namely:**

*Not knowing the use of or not practising traditional medicine*

Moving away from traditional African teachings was seen as one of the causes of HIV. An example of such a cause was forgetting to help one another with traditional

medicine when one has the knowledge of traditional medicine. Another factor was disregarding traditional practices such as abstinence and postponing engaging in intimate relationships, especially by the youth *"This youth, it's them that's going"*. Older participants felt that, in the olden days, elders respected culture regarding sexual intercourse as they adhered to the principle of not engaging in intimate relationships before marriage. Additionally, when one was sick one would go to the 'bush' i.e. to dig up herbs that grow naturally in the veld, and use them as traditional medicine.

Quotes supporting these results:

"Whatever our grandfathers did, was done in an appropriate and respectable manner. Our grandfathers had a choice of marrying as many wives as they wished and raised many children. Whenever they fell sick, they would simply consult herbalists, as they were able to cure a variety of diseases and illness. The generation of 70's and downwards, cannot even go to the forest to dig up herbs in order to make traditional medicine, who of us nowadays can help with such medicine?"

"No one really, grandfathers dug up herbs and adhered faithfully to their culture unlike us. That is why we the current generation will keep on dying simply because we resent".

"We do adhere to our culture although not all of us. But not all of us know about herbs and as a result of this ignorance, we will keep on dying like flies".

"We are also leading a fast life" (to engage in unsafe sexual intercourse).

Nonetheless, there was an argument where, especially the youth, questioned the intelligence of the elders and their trustworthiness. This lack of trust seemed to stem from lack of communication between the elders and the youth about perceived 'taboo's'. Young people are, for example, not allowed to question decisions made by elders regarding sexual issues.

"The old people don't have brains (mind)."

"Those grandfathers were liars from the beginning, they said that we shouldn't eat"

eggs, if you can look, they didn't say the reason why, their things are all question marks ... "

Kananda, Van Zyl, Ngobane & Wilkens (2005:28) confirm that there is a discourse between tradition and westernised beliefs, such as portrayed in these results. Health care workers and groups upholding traditional beliefs and practices should work together to understand each other's world. Furthermore, these authors state that the bio-medical world views anything traditional and natural as of lesser significance, thereby perpetuating the stigma associated with HIV and Aids (Kananda *et al.*, 2005:28). Van Dyk (2001:64) suggests that nurses rendering health services should consider and respect cultural beliefs.

*Not respecting widowhood rituals*

Some participants believed that not respecting the mourning period as prescribed by the elders in the family when one has lost a partner or a child contributes to contracting HIV. It is believed that the bond with one's partner or child is so strong that when someone dies a blood clot forms in the person who stays behind. During the mourning period this person has to use 'cleansing' traditional medication before engaging in sexual activity with another person.

Surprisingly, it was mostly women upholding this belief. There were some men who testified about this, but in general men disagreed on this issue. Some men, especially the youth, even said that if this is true, then it means that women are causing the disease deliberately by not adhering to traditional 'cleansing' practices.

"My elders, I have passed ... my people we had lost our tradition a long time ago in our time, when a woman has lost a husband and when a husband has lost a wife, it was within the knowledge of the family."

"You have lost a husband and you sleep with someone else what happens to the blood?"

They turn into clot."

"I don't want to mislead you, I must get cleansed first."

"If I'm staying with a man for a long time, when he dies that blood of his becomes a clot."

"HIV sometimes is caused by the death of someone, neh, then you don't drink medicines like 'pitsana tsa boshwagadi' and you sleep with a male person. Sometimes when someone's husband or child dies and they don't "mourn", nor take medicines, that thing changes to Aids."

"So sister you cause it deliberately."

"Wait this person is talking here, because I'm talking about my uncle, the way, the elders told him and he agreed to do everything right, you must be cleansed and drink the medicine so that everything should be right."

"Yes, I lost a wife and I stayed for long without meeting a woman, I was drinking medicine, I listened to what they told me at home because I didn't want to experience with my two eyes."

"He must mourn, even your child, you must mourn."

Beliefs regarding widowhood are described in literature as ritual impurities (i.e. when a loved one dies, a person is seen as impure and polluted) and are associated with death (Du Plooy, 2004:17). Beuster (1997:12) and Bodibe (1992:156) also found that such beliefs are ascribed to states of pollution or ritual impurities and are expelled by cleansing methods such as enemas and emetics. Van Dyk (2001:65) further indicates that nurses rendering health services should consider the fact that beliefs do have an influence on sexual behaviour. These beliefs regarding widowhood and traditional medicine in relation to HIV and Aids are thus seen as valuable insights, and should be considered in belief-sensitive HIV and Aids-prevention programmes.

- **Other causes, namely used needles and exchanging bodily fluids via an open wound**

Participants describe other ways causing the disease: When someone is injured and the doctor injects him/her with a used needle it is seen as a cause, although some disputed this fact. They also displayed the belief that one can contract the disease with exchange of body fluids when there are open wounds "...you share blood with

another person who is injured, also by kissing a person you contract it if you are injured on the mouth and that other person is injured it's possible to come in".

However, there was a clear consensus that one cannot contract HIV by kissing another person and they both do not have open wounds or sores "*But that thing you can't get it by...by kissing a person with no wounds...*" This is an indication that they had a clear distinction of what can put a person at risk non-sexually.

Some quotes that further illustrates their understanding:

"Even if you help a person, but if you help a person yourself having a wound, but your blood gets in there, you will be infected like that, beside from that no."

"It's like the mother, if the mother gets injection she can get it even with injection, mistake can happen there ... "

"You don't inject with a dirty needle ... "

Black farm workers have thus integrated knowledge on the causes of HIV and AIDS into their beliefs system, as explained by Liddel *et al.* (2006:223-224). It is furthermore argued that, if groups, such as Black farm workers, have knowledge of the causes of HIV and Aids they are more prone to adopt safe behaviours and to change some of their cultural beliefs and norms (Anon, 2006a:6). The beliefs held by the majority of participants that the disease is spread sexually, e.g. through sexual intercourse, and non-sexually, e.g. through used needles, might thus serve as important protective factors.

- **Some black farm workers believe that lack of income can cause people to contract the disease on purpose**

Lack of income was one of the issues raised, although it was disputed by the majority of participants as a reason to contract HIV on purpose. One participant strongly argued that there are people who contract the disease for financial gain; i.e. social grants for HIV positive people. However, most of the participants disputed this point and thought it had nothing to do with the matter at hand, namely HIV and Aids.

"Cause look at people who get money who are infected, we don't get it, people who have Aids they work so that they can have money."

"What money? It's been discussed about HIV and Aids here."

"I also can get it so that I can also get money coming to me."

"We want to save our life, that where do we stand ... "

"What money?"

"We want to save our life, us."

"He wants money."

"Here we are speaking of HIV and Aids."

According to Anon (2006b:5), high levels of unemployment and an inadequate welfare system have led to widespread poverty which renders people more vulnerable to contracting HIV. It was indeed found that some people contract the disease to have access to social grants (Anon, 2006b:5). Therefore the potential of beliefs as a threat to successful prevention messages should not be undermined (Peltzer, 2003:259).

3.3.3 Beliefs concerning protective measures against HIV and Aids

The third main category, with sub-categories, is indicated in Column C of Table 3.1 and in Table 3.1.3.

Table 3.1.3 Beliefs concerning protective measures against HIV and Aids

- Black farm workers believe they protect themselves by using sexually related protective measures, namely:
 - Going for a blood test
 - Using a condom
 - Abstinence from sexual intercourse
- Non-sexual protective measures black farm workers believe in, include:
 - Protection during first aid
 - Adhering to treatment when diagnosed HIV positive

- **Black farm workers believe they protect themselves by using sexually related protective measures**

During the discussions this was one matter where there was clear consensus about the measures to be taken for protection against HIV and Aids. Sub-categories include the following:

Going for blood tests

Black farm workers believed that when, as a couple, you are ready to stop using a condom, both partners must go for blood tests. This finding relates to the belief discussed in 3.2.5, namely that in the beginning of a relationship a condom should be used, but as time goes by and they develop a trusting relationship, condom use is stopped.

"You go for a blood test both of you."

"Yes, we must test so that we understand where we stand, what must we do? So that a person can understand himself he must test, if you are able even if you can go to the doctor, wait for the results."

The belief that testing for HIV is a preventative measure can encourage the use of voluntary counselling and testing (VCT) services. Both Anon (2006a:6) and Peltzer (2003:250-260) confirm the importance of VCT in HIV prevention. VCT enhance early prevention as well as promotion of health of HIV positive persons (Castle, 2004:4).

Using a condom

Participants agreed that a condom should be used, especially before marriage. They also agreed on using a condom at the beginning of a relationship because you do not know one another or one another's past. What transpired also was the lack of trust in condoms provided by government, because they believed that these are not

safe and do not have an SABS approval. Most participants actually preferred buying SABS-approved condoms. Another fact that forced them to buy condoms was that free condoms are not always available because health services do not visit the farm on a regular basis. Condoms provided by government are used when there is an urgent need to use them and a person has run out of the ones bought.

Generally, according to them, condoms should be used at the beginning of the relationship. When the couple is ready to marry they must go for blood testing and, irrespective of the outcome of the test, the couple should stop using a condom. Furthermore, emphasis was placed on faithfulness "... *just love one person and get used to that thing of his/hers*". They believed that if a person is unfaithful, he/she must use a condom.

However, one person in only one '*lekgotla*' mentioned that he believes that condoms should not be used. It was actually not even entertained by other participants because they did not even answer him "*My belief...alone, is that condoms should be put aside*". This view was totally ignored by others.

"Yes, we must test so that we understand where we stand what must we do? So that a person can understand himself he must test, if you are able even if you can go to the doctor, wait for the results."

"My belief is to escape the fakes, I must go into shops."

"I believe that for me to be safe I must use a condom. The day that I feel that this condom is becoming a burden to me I will take (Name) for a blood test and then get married and have sex without a condom."

"So now people do you believe that as long as we carry on having sex without condomising while we still have things like "drop" (gonorrhoea) and all that we are risking ourselves ..."

"I protect myself with using a condom, if I don't use a condom I don't sleep with a woman, I leave, I will sleep with a woman when I'm married."

"Let me say the walker of the road, the person who knows road, is the person who walked it, so to me not other people, each and every person can take an option, there is no one who will make an option for you. (Mm). Point number two: I cannot be

something that you want me to be, I am the person who will be in trouble. Now my belief is one, point number one condomise, point number two so sustain from problem, it will come from the bottom of your heart ... ” (“Amen ... ”)

“This thing is the same as the condom one, you meet with a person and fall in love, you know nothing about her, so always put a condom. It’s like blood, you wouldn’t know.”

“It is that you must condomise if you have a male person.”

“But us when someone dies, you will use a condom when you first meet with the person when you get used to each other.”

“That’s true.”

Literature suggest that negative attitudes towards condom use can be a contributing factor towards the risk of HIV infection, as it poses difficulties in negotiating and following through with their use (Anon, 2002). This was not the case with the participants in this research. While Du Plooy (2004:16) indicate that condom use might be seen as a sign of mistrust, participants in this research agreed on using condoms as protection, specifically in a new relationship during which sexual encounter may be more frequent.

This finding further indicates that negotiation for condoms by both partners might not be a challenge to this group. In contrast, several researchers (Peltzer, 2003:250-260, Muturi, 2005:77-98, Van Dyk, 2001:65) found that negotiation for condom use, especially by women, can be challenging. Male authority and failed negotiation for condom use by women is one of the cultural beliefs that had been identified by these researchers to jeopardizing prevention strategies especially in rural areas.

Abstinance from sexual intercourse

As an alternative to the above beliefs, abstinence was advised as one of the measures that can be used to avoid contracting the disease. According to the discussions it did not mean that this is the belief they were practicing but it was given as an option, especially to the youth. This is one of the traditional beliefs that was maintained in the olden days, namely abstinence from sex before marriage. Some

participants even remembered that in the olden days people did not date, a partner was chosen by the elders.

"We should use that old law that sex before marriage is a sin, you see. We should use that margin, then we won't have Aids."

"In the beginning there wasn't this thing that people have to date first before they get married, there was no such thing."

"To be safe you must not have sex."

Orr and Patient (2004:1) are of the opinion that abstinence is one of the critical efforts to deal with HIV and Aids. Encouragement of this belief by health care workers can enhance prevention messages, as it is one of the factors that are congruent with cultural beliefs (Muturi, 2005:77), as in this case. Furthermore, abstinence from sex is a cultural approach that can specifically be used to prevent HIV infection among the youth (Sithole, 2001:2).

- **Non-sexual protective measures black farm workers believe in include:**

Protection during first aid

Participants believed that just like people use a condom, when helping a person who is injured, they should use protective measures. They compared this with the belief of not trusting a person at the beginning of the relationship, as there is lack of trust and the background of the person one is helping might not be known.

"I will stand up then, we once had first aid, and then they said if you help a person it can be how you must put a hand glove."

"This thing is the same as the condom one, you meet with a person and fall in love, you know nothing about her, so always put a condom, it's like blood you wouldn't know, so stay, putting on condom, like a wound you wouldn't know."

"If you have a wound put on a glove, if you touch put on a hand glove, it's not only that, because there are other things that come in that way too, that's what I say."

These findings indicate that Black farm workers display understanding regarding protective measures related to HIV and Aids. This is in contrast with the general assumption that communities such as these have limited understanding regarding HIV and Aids, for example as discussed by Muturi (2005:77).

Adhering to treatment when diagnosed HIV positive

Participants emphasized the importance of adhering to treatment and following a healthy diet when a person is HIV positive. They believe that these measures are not cures, but can prolong life when a person is HIV positive. They also believed that a woman is able to fall pregnant even if HIV positive, but that she should be given treatment to protect the child from being born with the disease.

"To increase the years you must take those pills.... You must sit down, relax, take those pills and eat the right food and go for treatment and use a condom."

"What I want to say is that it's possible for a woman to be pregnant while she has Aids but when the baby is due to be born, then she will be given a pill so that the baby is born without Aids."

One of the prevention messages is adherence to treatment once a person is HIV positive. Black farm worker's knowledge and acceptance of this message might make it easier for an infected individual to adhere to treatment, as Orr and Patient (2004:5) argue that such a person has community support and does not have to worry about stigmatisation. It is also found that this positive attitude can be of real benefit in positive living to improve quality of life for an HIV positive person, as he/she will not feel like a burden to the group (Pembrey, 2006). Additionally their knowledge of treatment benefits can encourage them to have VCT done (Orr & Patient, 2004:14).

3.3.4 Marginal beliefs concerning risks in relation to HIV and Aids infection

A minority of participants presented beliefs that were not generally upheld by the group as a whole. These are mentioned for the sake of a comprehensive discussion.

The beliefs, mentioned in Table 3.1 (Column D) and in Table 3.1.4 below, specifically relate to risks in contracting HIV.

Table 3.1.4 Marginal beliefs concerning risks in relation to HIV and Aids infection

- Some Black farm workers' beliefs might put them at risk of contracting HIV, namely:
 - One participant repeatedly put forward the argument that only the sperms ejaculated during the first round of sexual intercourse contain the HI-virus
 - Some men believe that it is acceptable to perforate condoms in specific cases

One participant repeatedly put forward the argument that only the sperms ejaculated during the first round of sexual intercourse contain the HI-virus

There was a belief by someone (who was seen by the group as having a powerful influence) that there are different sperms present in every 'round' of sexual intercourse and that these sperms do not have the same characteristics. Sperms in the first 'round' of sexual intercourse are apparently 'dirty' and during ejaculation these sperms gather blood which carries filth collected from the body. He believed that these sperms are ejaculated powerfully. He explained that, when these sperms enter the womb, the womb actually 'chooses' the sperm it wants, leading to impregnation. Children are therefore born through 'filthy' sperms.

In a discussion on this sensitive matter most men agreed that per day a man can have two only two 'rounds' of sexual intercourse. These were seen as the 'rounds that matter', and they believed that it's impossible to have more sexual intercourse than this per day. The mentioned participant added that, after the second 'round' of sexual intercourse there is no sperms in the semen, but men then ejaculate blood or air. He maintained that semen ejaculated after the first 'round' of sexual intercourse are 'clean' and do not contain the HI-virus.

"And the sperms from the first round have blood because they are strong and took everything, the filth from my veins."

"These sperms carry along blood and filth, so in your body there are filters that decide and take the ones that make babies ... that person has a womb and it will choose. It takes the sperms that make babies because they are vital."

"The law of sex is...like this, right, you are pumping and there in the waist there are veins. Now when those veins start becoming warm, you ejaculate now...you shoot, so everything comes out. In those veins there's blood that's blocked and it mixes with the sperms so that's why it's said to enter via blood, that's what I wanted to make certain. Now there are men or guys that say they do five rounds so those three rounds he is ejaculating blood, or air or blood. So what I know as normal is that a person does two rounds."

This is a unique belief on how HIV is contracted. However, the notion of the natural flow of body fluids and its influence on a person is known in traditional African culture. Van der Hoeven (1992:3) explains, for example, that the blockage of the natural flow of body fluids is seen as an inevitable cause of illness and hardship. Du Plooy (2004:14) also refer to a related belief, namely that semen is seen as containing important vitamins needed for a women's physical and mental health. Another related belief is that condoms block the "gift of self" (Van Dyk, 2001:60). Sexual encounter is believed to be an exchange of "gift of self" and this is seen as important in a relationship. Health care professionals thus need to explore and understand beliefs regarding sexual intercourse and condom use (Du Plooy, 2004:14).

Some men believe that it is acceptable to perforate condoms in specific cases

Some male participants upheld the belief that, when a person wishes to marry a woman, he will perforate a condom in order to impregnate her as a condition for marrying her.

"Let me answer him, according to me, eeh, you can marry a woman as she is, it

depends on the words that says, someone is stealing from you, isn't it, it was stolen from Adam, at times this condom will be used, there is somewhere where you will cheat, I put it but I will take off the tip, she doesn't see that I did that thing."

Although there was not much agreement on this finding, this belief might play a very important role in the prevention of HIV and Aids transmission. Van Dyk (2001:61) found that the emphasis on fertility in African communities may hinder the practice of safer sex and women especially might find themselves in a predicament to prove their fertility prior to marriage, and this put them at risk of contracting the disease. This marginal believe might put Black farm workers at the risk of contracting HIV, necessitating more participatory debate with the aim of consciousness-raising.

3.3.5 Beliefs concerning intimate relationships

This is one of the most unique themes found in this research (refer to Table 3.1, Column E, as well as Table 3.2.5 below). The focus of these themes are on intimate relationships and how people might contract HIV and Aids in these relationships.

Table 3.3.5 Beliefs concerning intimate relationships

- Black farm workers believe that contracting the disease in a relationship is a sign of love
- Black farm workers believe that trust in the relationship is based on the duration of the relationship
- Black farm workers believe that sex without using a condom indicates readiness to marry someone
- There is a belief that sexual intercourse is more frequent at the beginning of the relationship and it is inevitable when aroused
- There is a marginal belief that contracting the disease while being faithful can cause a great deal of emotional pain

- **Black farm workers believe that contracting the disease in a relationship is a sign of love**

Participants upheld the belief that contracting the disease when in a long-term relationship with a person is a sign of love. They said that even if a person knows that he/she might die because of contracting HIV and Aids in such a relationship, the person would still voluntarily choose to be in the relationship. Also, these participants held the belief that even if a blood test reveals that the couple are both HIV positive, they will choose to stay together, because they viewed such behaviour as a further proof of love.

"Those who died, they died because of love."

"Yes they died because of love."

"You are going to marry him; you will be dying for whom, you will be dying for him isn't it."

"I will use a condom until I marry her, if she has it, this virus, I will sleep with her, I will be killed by what I've eaten, but if I don't want to I will use a condom."

"Me, if I have it and the person I'm staying with also has it, we immediately stay together, it has come in isn't it at that time, at that time, at that time we don't know."

Leclerc-Madlala (2000:30) confirms that sex is generally regarded as a necessary, natural, expression of love. Additionally, Du Plooy (2004:16) confirm that being infected by one's life time partner is experienced as more acceptable than being infected due to promiscuity or unsafe sex.

- **Black farm workers believe that trust in the relationship is based on the duration of the relationship**

There was also this belief that the duration of the relationship is a determining factor in trusting the other person. When a couple has been together for some time, it is accepted that they are faithful to one another and do not have to rely on HIV testing to stop using a condom.

"Me, no, I know my status", but haven't went for a blood test, I'm HIV negative, you see ... But maybe I'm not ... I'm involved with only one person, when you take a look, I don't know whether you are sick or what, 'cause it's the first time I see you we are both in love, just the two of us. I don't know if you are already involved with someone else. I may hear that maybe he is involved with someone, but that's not a thing that I pay attention to. I know that we are only involved the two of us, I love you alone and you love me alone."

These findings seem to be unique, although a study by Peltzer (2003:250-260) confirms that condom use among non-marital partners is higher than among married partners in the rural population.

- **Black farm workers believe that sex without using a condom indicates readiness to marry someone**

Sex without using a condom indicates readiness to marry someone. Men believe that you could not marry a woman if you have not had sexual intercourse without a condom. This belief is related to trust in the relationship, proving fertility and to ensuring that the woman stays in the relationship.

"Condom won't make children for me".

"These children say, he will marry someone he hasn't heard."

"That thing doesn't happen."

"My child loves this person, he wants to marry this person, he loves her now he wants to marry her without hearing her?"

"That thing doesn't happen."

"In my mind I've told myself that I love this girl and I can't let her go, so I want to trap her with a baby so that we can stay together."

"I am saying, neh, I love the girl, I want to marry her, when you start having plans this person, you want to marry her, the first thing you think of is to have a family with her we must make children, we make a family now, if she can't have children, that thing is going to kill me as a man, because of what, my trust, because of the trust I

have, it's the intentions I have about her, I take it and I put it aside condom."

This finding confirms that for African men it is imperative to produce children in order to prove fertility. This means that for a man to marry a woman he has to ensure that this woman can have children. Thus women find themselves putting their lives in danger to prove their fertility (Du Plooy, 2004:39).

- **There is a belief that sexual intercourse is more frequent at the beginning of the relationship and that it is inevitable when aroused**

Participants believed that at the beginning of a relationship sex happens more frequently than when the relationship has been on for some time: *"If we've been sleeping with each other for a long time then we can finish the whole month without sex."*

There was a strong debate when some believed that when a person is aroused he must have sexual intercourse, while others felt that if it's in the beginning of a relationship, other alternatives can be explored besides penetrative sex: *"No wait... I'm giving you advice, I as the Nduna, I finger you instead of intercourse."* Such measures were, however, not acceptable to all participants. The discussion on this matter was as follows:

Speaker: "If it's the first time you meet, when you feel each other you feel each other"

Speaker: "You don't have sex are you going to die?" (This is put as a question.)

Speaker: "No".

Speaker: "So".

Speaker: "But you know, (Name), it's your thing if you can't control yourself".

Speaker: "Listen... unless you don't sleep in one bed".

Speaker: "Quiet!... quiet... don't runaway from the point."

(Disruptive argument)

Speaker: "One thing, one thing is that when I meet you we are still fresh we

haven't slept with each other yet..., I'm not talking about people that have been sleeping with each other for a long time, 'cause if we've been sleeping with each other for a long time then we can finish the whole month without sex."

Speaker: "Yes.., yes If it's the first time you meet, when you feel each other you feel each other".

Speaker: "No wait... I'm giving you advice, I as the Nduna, I finger you".

(Astonished remarks)

Speaker: "There's the solution, since we don't want Aids."

Speaker: "There's no such thing!"

Speaker: "It's the same thing even if I put in a finger".

(Disagreeing remarks)

Speaker: "I'll be patient...I'm a man".

Speaker: "It's the same as a condom, Aids doesn't get into you, it's the same ...".

(Disagreeing remarks)

Speaker: "It's not the same, ... a finger and that thing are not the same. You can tell if a finger has entered and you can tell if that thing has entered ...".

(Argument)

Leader: "People where we are, ok, now ..."

Speaker: "We have this belief that if I'm aroused, if aroused, you must have sex".

Leclerc-Madlala (2000:30) confirms that a new relationship might be characterised by heightened sexual activity. This finding thus might also be important in prevention programmes.

- **There is a marginal belief that contracting the disease while being faithful can cause a great deal of emotional pain**

Someone mentioned that it could cause pain to contract the disease while one has been faithful, but tests positive. This participant argued that such pain can be avoided by not engaging in a faithful relationship.

"You'll find that maybe when we go for blood tests I'm HIV positive and then I'll ask myself how come did I get it when I don't fool around. So most of the time we tell ourselves that we have Aids so HIV will get us on the way, I should rather go after it than let it get me while I'm just sitting still. So I should go after it than let it get me while I'm sitting still because if it does, then it's going to be painful for me."

This seems to be a unique finding. Such a belief might, however, be linked to using ego defence mechanisms such as avoidance of long-term relationships in order to avoid emotional pain (Kneisl *et al.*, 2004:15).

3.4 Summary

Findings of the research and a literature control regarding Black farm workers' beliefs on HIV and Aids were discussed in this chapter. Findings were discussed in accordance with different categories, sub-categories and further categories. In the chapter that follows the researcher discusses shortcomings of the research, conclusions as well as recommendations, specifically suggestions for a belief-sensitive approach which health care professionals can incorporate in HIV and Aids-prevention programmes for Black farm workers.

CHAPTER 4

CONCLUSIONS, SHORTCOMINGS AND RECOMMENDATIONS, SPECIFICALLY SUGGESTIONS FOR A BELIEF-SENSITIVE APPROACH IN HIV AND AIDS-PREVENTION PROGRAMMES FOR BLACK FARM WORKERS

4.1 Introduction

The research findings were discussed in the previous chapter. The findings were supported by direct quotations from the *'lekgotla'* discussions with the participants, and confirmation was also given through reference to relevant literature. In this chapter, the shortcomings and conclusions will be discussed and recommendations will be made, specifically suggestions for a belief-sensitive approach in HIV and Aids-prevention programmes for Black farm workers.

4.2 Conclusions

Conclusions crystallized from comparison between results and literature and from synthesizing results by identifying relationships and contrasts, which will be discussed in this chapter. Data analysis resulted in five major categories regarding beliefs of Black farm workers on HIV and Aids as discussed in Chapter 3. Conclusions regarding these categories will subsequently be discussed.

An overall conclusion is that the Black farm workers' beliefs reflect a unique belief system: a complex synthesis of experiences and knowledge gained from available information on HIV and Aids ("westernised" information) and their own unique cultural values, such as the belief that trust in intimate relationships is linked to the decision to use condoms. This conclusion confirms the principle that health care workers need to assess the unique beliefs of a group or community in order to provide appropriate services.

4.2.1 Conclusions pertaining to the beliefs of Black farms workers on HIV and Aids

Conclusions pertaining to the beliefs of black farm workers on HIV and Aids are discussed.

Conclusion 4.2.1.1

Black farm workers might be more accepting of HIV and Aids-related messages, as they acknowledge the existence of HIV and Aids

Black farm workers do believe that HIV and Aids exist. They therefore might be receptive when prevention messages were to be given by health care workers. The acceptance of HIV and Aids, especially among the rural community, has been a challenge due to several reasons as described in Chapter 1. This was not the case with these black farm workers, since they accept and know that HIV and Aids is an epidemic and a crisis which everyone has to deal with. This positive belief is what is needed if prevention messages are to be successful, both at the individual and community level, as in this particular community.

Conclusion 4.2.1.2

Black farm workers could help enhance the quality of life of an HIV positive community member

Farm workers might be more prone to support an HIV positive community member, as they believe that there is life after HIV and Aids. As a member of this community, a person might not have the fear of being ostracised if diagnosed HIV positive. Furthermore, through community support, a person might not be seen as a burden to the community, but as a very useful member of the community who can stay healthy.

Furthermore, the protective measure of encouraging adherence to treatment can be seen as a positive belief because it would mean that when one of the Black farm workers is on treatment, he/she might have the support of the community. This can

also improve the quality of life of the infected person as he/she knows that he/she can live with the virus and has a future and positive expectations if he stays healthy.

Conclusion 4.2.1.3

Older Black farm workers could instil values amongst the youth to prevent infection with HIV and Aids

Participants acknowledged that young people are the age group mostly affected by HIV and Aids while, at the same time, older members seem to uphold protective values. The older members of the community can therefore be involved to teach values to the youth, such as abstinence and emphasis on 'ubuntu' through debates and discussions with them. This can also be used as a tool to empower the youth.

Conclusion 4.2.1.4

Black farm workers could use participatory debate as an approach to awareness campaigns

Participatory debates and discussions, as used in this research, can be used as awareness campaigns to allow Black farm workers to discuss beliefs. Such debates would allow them to interactively express their views and learn from one another, instead of conveying information in a one-way direction and thereby encouraging scepticism.

Conclusion 4.2.1.5

Beliefs concerning sexual causes of HIV and Aids seem to be a protective factor due to knowledge of basic facts on how the disease can spread

A conclusion that can be drawn is that Black farm workers have a fairly good knowledge of the causes of HIV and Aids. This knowledge can therefore be a protective factor against contracting HIV and Aids. The majority of them have heard about HIV and Aids and have a fairly good level of knowledge about basic facts on how the disease spreads. Most of them believe that mainly sexual intercourse,

specifically unprotected sex and multiple partners, cause HIV and Aids. This can be seen as a positive belief towards protection from contracting the disease because if they know and believe that engaging in these risky behaviours can put them at risk, they might take precautionary measures.

Conclusion 4.2.1.6

Beliefs concerning non-sexual causes of HIV and Aids can be used as a possible means of curbing the disease

Participants also believed that there are non-sexual causes of the disease, which can equally put people at risk of contracting the disease. Non-sexual causes such as terminating the use of traditional medicine and lack of respect for widowhood rituals were seen as some of the causes of HIV and Aids. Their view that the disease is caused by loss of respect for traditional beliefs, i.e. not observing cultural norms, can be seen as a possible means of curbing unsafe sex. Elders can be encouraged to revive these traditional beliefs.

Conclusion 4.2.1.7

Fear of contracting the disease motivates Black farm workers to use protective measures against HIV and Aids

The belief that people have to use protective measures such as undergoing blood tests, using condoms, applying protective measures, being faithful, abstaining from unsafe sex and adhering to treatment might be good prevention strategies. Because there is a fear of contracting the disease, they are persuaded to resist engaging in high-risk behaviours.

Conclusion 4.2.1.8

Risk behaviours in relation to HIV and Aids can put Black farm workers at the risk of contracting the disease

Despite their knowledge of causes and prevention of HIV and Aids, which were positive beliefs, there were contradicting marginal beliefs that could put them at risk

of contracting the disease. Such beliefs include avoiding the use of condoms, and perforation of condoms. Beliefs that condom use prevents procreation, which is against their traditional beliefs, can be the reason for their negativity towards condom use and can put them at risk. A health worker at such instances must be the cultural broker, i.e. replace these risk beliefs with a belief that is culturally acceptable as well as safe. Furthermore, doubting the existence of HIV and Aids can be a barrier to voluntary HIV testing and counselling.

Conclusion 4.2.1.9

Some beliefs of Black farm workers about intimate relationships can protect or harm them

The conclusion that can be drawn from the findings regarding intimate relationships is that some beliefs protect them, but there were also beliefs that put them at risk. Use of condoms at the beginning of the relationship can be encouraged as it can be effective in HIV and Aids-prevention programmes. However, abandoning condom use after a few months in the relationship without going for VCT can put them at risk of being infected with HIV and Aids.

On the other hand, faithfulness and being involved in long lasting sexual partnerships discourages promiscuity, which can protect them from being infected. However, the belief that when in a long-lasting relationship condoms should be abandoned, as they are associated with unfaithfulness and lack of trust and love can put them at risk. Discussion on this issue should be incorporated in prevention programmes.

4.3 Recommendations for nursing education, nursing research and nursing practice

Recommendations for nursing education, nursing research and nursing practice are discussed. Reference will be made to the results and conclusions of this research (Table 4.1) as grounding for these recommendations.

4.3.1 Recommendations for nursing education

The findings of this research could add much value to nursing education if it could be included in the basic nursing programmes offered in colleges and universities. HIV and Aids-prevention programmes should not only be centred on the bio-medical model but must include the cultural and religious beliefs for them to be successful. Learners should learn the importance of respect for traditional values and beliefs when communicating prevention messages. Furthermore, they should develop attitudes of exploring Black farm workers' world-views and understanding their beliefs and related behaviour.

This aspect should also be incorporated in post-basic programmes, as well as in-service programmes so that the students who were not exposed to these in the basic programmes can be updated. They can also learn about the latest developments regarding HIV and Aids-prevention programmes.

4.3.2 Recommendations for nursing research

Based on the research findings, literature and conclusions drawn from this research it is evident that there is potential for further research in the field of prevention programmes regarding HIV and Aids. Possible areas are recommended:

There is a lack of specific research on Black farm workers' beliefs concerning HIV and Aids, since this group is classified as rural. There are no specific prevention programmes mentioned or evaluated regarding this group. Additionally, there is a possibility that some of these programmes do follow a belief-sensitive approach that recognizes the importance of beliefs and inclusion of the community in implementing prevention programmes; therefore further studies should be done in this regard. Further research is needed on communication approaches of these prevention strategies if Black farm workers are to be involved, considering the existing communication gap between them and health care professionals. Further research

needs to be conducted on how services can be accessible to all Black farm workers to enhance communication of these prevention strategies.

4.3.3 Recommendations for nursing practice

Recommendations for nursing practice are related to the objective of this research with the view of formulating suggestions for a belief-sensitive approach, which health care workers can incorporate in HIV and Aids-prevention programmes for Black farm workers.

4.3.3.1 Suggestions for a belief-sensitive approach, which health care professionals can incorporate in HIV and Aids-prevention programmes for Black farm workers

Suggestions are made based on the results and conclusions, as indicated in Table 4.1.

Table 4.1 Suggestions of a belief-sensitive approach

| Suggestions | Reference to supporting results | Reference to supporting conclusion |
|---|---------------------------------|------------------------------------|
| 1. Health care professionals should be aware that Black farm workers might have an accepting attitude regarding HIV and Aids-related messages | Results: 3.2.1. | 4.3. |
| 2. Health care professionals, when developing prevention programmes for HIV and Aids, should involve community elders to teach the community values | Result: 3.2.1. | 4.3; 4.7 |
| 3. Health care professionals should take Black farm workers' beliefs on HIV and Aids into account in their prevention programmes | Result: 3.2.1; 3.2.2 | 4.4; 4.7 & 4.8 |
| 4. Health care professionals should include Black farm workers' beliefs concerning sexual and non-sexual causes of HIV and Aids in the prevention strategies | Result: 3.2.2 | 4.5 & 4.6 |
| 5. Health care professionals should encourage and reinforce the use of Black farm workers' beliefs on sexually related and non-sexually related-protective measures against HIV and Aids in the prevention messages | Result: 3.2.2; 3.2.3 & 3.2.5 | 4.2; 4.7 & 4.9 |
| 6. Health care professionals should explore beliefs towards condom use as a potential protective factor | Result: 3.2.3; 3.2.4 & 3.2.5 | 4.9 |
| 7. Health care professionals should follow the approach of discussions and debates, rather than one-way information sessions | 3.2.1; 3.2.2; 3.2.4; 3.2.5; | 4.1; 4.4; 4.8; 4.9 |

- **Health care professionals should be aware that Black farm workers might have an accepting attitude regarding HIV and Aids-related messages**

Black farm workers believe that HIV and Aids exist, which is evidence that they might be receptive when prevention messages are discussed. They were aware that HIV and Aids is an epidemic and realized the need to be involved in dealing with it as a crisis.

- **Health care professionals, when developing prevention programmes for HIV and Aids, should involve community elders to teach values to the community**

Both the elderly and the young Black farm workers acknowledged the role that can be played by community elders in prevention programmes. The elders could be involved in teaching positive beliefs and values like respect for older people and values concerning sexual intercourse.

- **Health care professionals should take Black farm workers' beliefs on HIV and Aids into account in their prevention programmes**

Black farm workers were able to engage in participatory debates and discussions about their beliefs. This gave them a platform to express their views and learn from one another, as they would discuss an issue until they reached consensus about it, e.g. the debate on the belief that lack of income causes people to contract HIV on purpose.

- **Health care professionals should include Black farm workers' beliefs concerning sexual and non-sexual causes of HIV and Aids in the prevention strategies**

Black farm workers' knowledge about the sexual and non-sexual causes of HIV and Aids could be seen as a protective measure to prevent them from contracting the

disease. Participants had a fairly good knowledge of basic facts on how the disease spreads, which can protect them from engaging in risky behaviours and they might take precautionary measures.

- **Health care professionals should encourage and reinforce the use of Black farm workers' beliefs on sexually related and non-sexually related protective measures against HIV and Aids in the prevention messages**

Black farm workers' fear of contracting the disease, collective existence (*"ubuntu"*) and beliefs concerning intimate relationships could protect them and help in enhancing the quality of life. Group support to those affected and infected by HIV and Aids could be of great value to individuals as well as families. Health care professionals need to join hands with the community elders in HIV and Aids-prevention programmes.

Furthermore, their belief that protective measures need to be taken might already be a protective measure, which persuades them to resist engaging in high-risk behaviours. Additionally, the protective beliefs they have concerning intimate relationships such as using condoms at the beginning of the relationship can be effective in HIV and Aids-prevention programmes.

- **Health care professionals should explore beliefs towards condom use as a potential protective factor**

Health care professionals need to see beliefs towards condom use as a challenge, not a burden. Beliefs such as using a condom at the beginning of a relationship could be used in a positive manner in prevention programmes. Those beliefs that put them at risk, like abandoning condoms after a few months in the relationship should be explored. Furthermore, discussions with the black farm workers should be held to explore how these beliefs protect them or put them at risk of contracting the disease.

- **Health care professionals should follow the approach of discussions and debates, rather than one-way information sessions**

Black farm workers were able to engage in participatory debates and discussions, such as the *'lekgotla'* used in this research, where they discussed beliefs interactively to express their views. Eventually, they were able to learn from one another instead of criticising one another or being sceptical. Furthermore, community elders could be involved in the entire prevention programme to teach traditional norms and values. The successful management of HIV and Aids-prevention programmes might be possible through teamwork. This approach links to the concept of a collective being (*"ubuntu"*).

4.4 Shortcomings of the research

The following shortcomings of the research were identified:

This research formed part of the research done within a research project known as the FLAGH programme. This means that other researchers had also gone to the farm to conduct their own research. This posed a challenge, as farm workers were exhausted from being research participants and were negative towards questioning or interviewing. This meant that the researcher had to be creative in finding a suitable data collection method if she wished them to participate in this research. Furthermore, they felt that research students only used them just to pass their studies and nothing was in for them, since nobody even cared to report back to them on the results of the research. The participants did not trust the researcher initially; therefore a considerable amount of time had to be spent on rebuilding a broken relationship of trust. Eventually participants actually did co-operate through the help of the leader and, as a result, in each *"lekgotla"* there were always more than ten participants. Results were therefore not influenced negatively.

Another shortcoming was that *"lekgotla"* is a form of group discussion; therefore it requires a certain number of people to gather at a certain time. Occasionally participants would not be ready to start the discussion, even though a specific time

and date was set in advance, and the researcher had to be very patient and wait for the majority to arrive before starting the discussions or arrange an alternative date and time with them, since they would even occasionally be attending a funeral elsewhere.

Furthermore, in line with '*lekgotla*', lay community members trusted by the participants, acted as leaders during data collection. Although the researcher thoroughly oriented these leaders to the purpose and process of this research, and guided them regarding relevant communication skills, these leaders were not skilled in research interviewing. Consequently, although an 'insider's perspective' was obtained as planned, themes might have been explored on a deeper level if a person skilled in research interviewing were leading the discussions. This would have, however, been at the risk of not obtaining information deeply rooted in the belief system of this group and not shared easily with an outsider.

4.5 Summary

The objectives of this research were achieved, which were to explore and describe the Black farm workers' beliefs on HIV and Aids, explore and describe how these beliefs protect them from being infected with HIV and Aids and to formulate suggestions for a belief-sensitive approach which health care professionals can incorporate in HIV and Aids-prevention programmes for Black farm workers.

Open-ended questions were formulated which were derived from and based on the literature background of this research. The researcher conducted data collection and data analysis, which was conducted with the help of the independent co-coder. The findings of this research explicitly describe Black farm workers' beliefs on HIV and Aids. Literature was used to confirm these findings. Unique findings in this research were highlighted.

The findings of this research were that beliefs influence behaviour, especially sexual behaviour and can have a direct influence on HIV and Aids-prevention programmes. The literature control and findings of this research discussed protective beliefs. Some of these protective beliefs are positive, such as collective existence, respect

for traditional values concerning sexual intercourse and respect for widowhood, and could be utilized in prevention programmes against HIV and Aids. Community elders should be included in joining hands in prevention programmes.

On the other hand, beliefs that put them at risk of contracting the disease pose a threat to Black farm workers' health. It is therefore imperative for health care professionals to explore these issues in non-threatening ways, for instance by engaging in participatory debates and discussions in awareness campaigns. These debates allow them to interactively express their views and learn from one another.

The conclusion that can be drawn is that Black farm workers do have beliefs concerning HIV and Aids. Most of these beliefs have protected them from being infected. However, there were some marginal beliefs that can put them at risk of being infected.

Suggestions in this research were made for nursing research, nursing education and nursing practice. Specific suggestions were formulated for a belief-sensitive approach, which health care professionals can incorporate in HIV and Aids-prevention programmes for Black farm workers.

The above-mentioned suggestions could be included in the prevention strategies by incorporating those beliefs that protect them from being infected. These can also be used in the strategies of the government to win the war against HIV and Aids. This research highlighted that HIV and Aids prevention messages are not received well among Black farm workers, since these messages do not consider their beliefs on HIV and Aids. It is highly imperative for health care professionals to actively listen to these farm workers' beliefs when talking about prevention strategies.

Positive beliefs and values should form the basis to build HIV and Aids-prevention programmes. Group support (*'ubuntu'*) might be a valuable tool in the fight against HIV and Aids. It is therefore clear that a scientific world-view should embrace and understand magico-religious world-views if HIV and Aids-prevention programmes are to be successful.

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APPENDIX A

REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT THE FARM

Madam

I am currently registered as a student for M.Cur (Nursing Science) degree at the Potchefstroom campus of the North-West University and as part of the degree I plan to do research about Black farm workers' beliefs on HIV and AIDS.

The purpose of this research is to:

- Explore and describe the beliefs of Black farm workers regarding HIV and AIDS.
- Explore and describe how these beliefs protect them regarding HIV and AIDS infection.
- Formulate suggestions for a belief-sensitive approach, which health care professionals can incorporate in HIV and AIDS prevention programmes for Black farm workers.

In order to achieve these objectives, semi-structured group interviews, known as '*lekgotla*', will be conducted with the participants working and/or living at your farm.

The interviews for those who agree to participate will be conducted during June and August 2007. Interviews will be conducted at their living place and it will be outside working hours.

If more information is needed with regards to the research, please contact me at this number _____

Thanking you in anticipation

Yours sincerely

D.M. Magcai (Researcher)

Dr. Emmerentia du Plessis (Supervisor)

Dr. A.J. Pienaar (Co-Supervisor)

APPENDIX B

CONSENT FROM THE ETHICS COMMITTEE OF THE NORTH-WEST UNIVERSITY



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT

Dr E du Plessis
Bosslie 520
Potchefstroomkampus
Noordwes-Universiteit

Ethiekomitee
Tel (018) 299 1366
Faks (018) 297 5306
E-pos Ethics@pnwu.ac.za

15 May 2007

Geagte Dr du Plessis

GOEDKEURING VIR EKSPERIMENTERING MET MENSE (KWALITATIEWE NAVORSING)

Hiermee wens ek u in kennis te stel dat u projek "Black farm workers' beliefs on HIV/AIDS" goedgekeur is met nommer 07K19.

Gebruik asseblief die nommer genoem in paragraaf 1 in alle korrespondensie rakende bogenoemde projek en let daarop dat daar van projekleiers verwag word om jaarliks in Junie aan die Navorsingsetikokomitee verslag te doen insake aliese aspekte van hulle projekte asook van publikasies wat daaruit voortgespruit het.

Goedkeuring is vir 'n termyn van hoogstens 5 jaar geldig (volgens Senaatsbesluit van 4 November 1992, art 9.13.2). Vir die voortsetting van projekte na verstryking van hierdie tydperk moet opnuut goedkeuring verkry word.

Sterkte met al u werksaamhede.

Vriendelike groete

RONEL PIETERSE
SEKRETARIAAT

INSTITUSIONELE KANTOOR

• Private Sak X2001 • Potchefstroom • Suid-Afrika 2520 • Tel: (018) 299-1111 • Faks: (018) 299-2769 • <http://www.nwu.ac.za>

APPENDIX C

SEMI-STRUCTURED INTERVIEW SCHEDULE

1. What are the general beliefs about HIV and AIDS?
2. What beliefs do you have about HIV and AIDS?
3. How do these beliefs protect you from being infected?

APPENDIX D

REQUEST TO ACT AS SUPPORT SYSTEM FOR PARTICIPANTS WHO EXPERIENCE PSYCHOLOGICAL DISCOMFORT DURING DATA COLLECTION

I am a student researcher and have to conduct research as a requirement of Masters degree at North-West University, Potchefstroom Campus.

The title of my research is: Beliefs of Black farm workers on HIV and AIDS, with the following objectives:

- Explore and describe the beliefs of Black farm workers regarding HIV and AIDS
- Explore and describe how these beliefs protect them from the risk of HIV and AIDS infection
- -Formulate suggestions for a belief-sensitive approach, which health care professionals can incorporate in HIV and AIDS prevention programmes for Black farm workers.

Permission for this research project has already been obtained from the farm owner and the ethics committee of the North-West University, Potchefstroom Campus.

The research will be conducted under the supervision of Dr. E. du Plessis and Dr. A Pienaar. The research will be conducted at a farm in the Potchefstroom district.

I need assistance during data collection and data analysis of a counselling specialist, to give psychological support for participants who experience discomfort.

I hereby request your assistance as a support system. I intend to collect data between June and August 2007 on Wednesdays or Saturdays.

The research proposal is enclosed to give you an outline of the research.

Yours sincerely,

D.M. Magcai (Researcher)

Dr. Emmerentia du Plessis (Supervisor)

Dr. A.J. Pienaar (Co-Supervisor)

APPENDIX E

'Lekgotla' I

FIELD NOTES

DEMOGRAPHIC NOTES:

Date: 06 August 2007

Time was between 16h00 and 17:30.

Weather conditions: the sun wasn't too hot or cold but windy. It wasn't conducive for sitting outside

DESCRIPTIVE NOTES:

Participants: It was a group of males and females between the ages of 19 and 49. They were 12 in number. It was a mixture of new participants and older ones.

Physical setting: This interview was the first one after the trial interview. The discussion was conducted inside one the leader's house, which is a two roomed house with the kitchen and sitting/dining room combined. There is a window so ventilation was enough. He is staying alone so there was enough space for participants to sit. The house is very clean and tidy. Participants were allowed to sit in any way that was comfortable to them, so some were sitting on the chairs and others down on the ground. Participants were allowed to bring anything they wanted to eat or drink as this was an informal setting.

Leader: The leader was one of the already chosen leaders on the farm so he is generally respected and accepted as a leader. He commands a lot of respect and is someone who likes order, this can also be seen in the house. He and the researcher had a meeting before the discussion to discuss the questions to be asked and

clarified that he should facilitate not be too strict to allow free and open discussions, as he didn't facilitate the trial group discussion.

REFLECTIVE NOTES:

At the beginning of the '*lekgotla*' he explained the process so that everyone can understand. The participants warned against stigma and being judgemental on suspicion that a person might be having HIV. There was a perception that women are the ones responsible for protection in the relationship. There was a feeling that condoms are related to mistrust as once there is an element of trust then the couple can stop using the condom. There is a feeling that before being married, a woman has to pass a certain test prescribed by the man and it's a condition also that a woman must be able to have children.

'Lekgotla' II

FIELD NOTES

DEMOGRAPHIC NOTES:

Date: 25 August 2007

Time was between 15h15 and 16:10.

Weather conditions: It was a sunny Saturday afternoon.

DESCRIPTIVE NOTES:

Participants: It was a group of males and females between the ages of 19 and 49. They were 15 in number. It was a mixture of new and previous participants.

Physical setting: The discussion was conducted outside one of the participants' houses under the shade. Participants were allowed to sit in any way that was comfortable to them, so some were sitting on the chairs and others down on the ground. The setting was casual and informal.

Leader: It was the same leader as in the previous *'lekgotla'*. The researcher and the leader had a briefing beforehand to go over the questions again. Not much was discussed as he already knew the process and there weren't any problems with how he conducted the previous *'lekgotla'*.

REFLECTIVE NOTES:

The leader once again from the beginning emphasized the seriousness of the discussions by actually eliminating a participant who was out of control due to excessive intake of alcohol and he has been disturbing the discussions. This set an example for others to behave in order to remain part of the discussions and as this was interesting to them they didn't want to be excluded. Positive thinking came up about life after Aids as long as one maintains positive lifestyle. Some showed

uncertainty about the two words HIV and AIDS but some within them clarified the matter very well. One got a feeling that it was okay to talk about HIV impersonally but once it's personalized participants became defensive. The degree of high level of thinking by these participants was amazing and their ability to reason things as a result they were able to teach each other about even practical experiences. Generally the power of positive thinking dominated this discussion and the acceptance that it is a disease just any other. Generally these people are well informed, although one must admit that there are some factors which need to be corrected

'Lekgotla' III

FIELD NOTES

DEMOGRAPHIC NOTES

Date: 08 September 2007

Time was between 15h30 and 16:50.

Weather conditions: the sun wasn't too hot or cold. It was typical of Saturday afternoon, which allowed relaxation after work.

DESCRIPTIVE NOTES:

Participants: It was a group of males and females between the ages of 19 and 49. They were 15 in number. Time was between 13h30 and 15:50. It was a mixture of new participants and older ones.

Physical setting: The discussion was conducted outside one of the participants' house under the shade. Participants were allowed to sit in any way that was comfortable to them, so some were sitting on the chairs and others down on the ground. Because they just came back from work at 12:30, they were allowed to bring anything they wanted to eat or drink to also avoid delays therefore the setting was very informal.

Leader: The leader was a different one from other discussions but has been one of the participants in previous discussions. He and the researcher had a meeting before the discussion to discuss points of departure, and as this was the last *'lekgotla'*, part of his task was to summarize the points previously discussed and allow clarity on issues which were not clear.

REFLECTIVE NOTES:

With this interview there was some seriousness and intention to talk facts about what they know but allowing debate on issues eventually reaching conclusion. The leader would summarize what they debated. Advice was given and issues which were not clear were clarified. There was consensus reached in every issue and the issue they mostly agreed about was the lack of trust on safety of government condoms and participants agreed to buy condoms from the pharmacy. Another issue that was highlighted again was the lack of trust about things told by the parents as they hide things from their children. The respect that they had for each other's point of view is something that most of us can learn from, as they would allow a person to argue his/her point until the others understood what he/she was trying to say. Age difference was not an issue in discussing issues deeply, especially regarding sexual intercourse. Due to lots of intensive debates it cannot be guaranteed that speaker as numbered in the transcripts were truly like that.

APPENDIX F

WORK PROTOCOL FOR DATA ANALYSIS

Dear _____

Thank you for agreeing to be my co-coder for this research. The objectives of this research are as follows:

- Explore and describe the beliefs of Black farm workers regarding HIV and AIDS.
- Explore and describe how these beliefs protect them regarding HIV and AIDS infection.
- Formulate suggestions for a belief-sensitive approach, which health care professionals can incorporate in HIV and AIDS prevention programmes for black farm workers.

Three semi-structured group interviews in the form of '*lekgotla*' were conducted. The following questions were asked

1. What are the general beliefs about HIV and AIDS?
2. What beliefs do you have about HIV and AIDS?
3. How do these beliefs protect you from being infected?

The method of open coding as described by Tesch (as quoted by Creswell, 1994:152) is used to analyse data: The following steps are followed:

- Each transcript was divided into 3 columns
- The middle column was used for the leaders and the participants' verbal responses
- The right hand column was used for the themes that emerge from the responses

- The left hand column was used for the ideas that come into mind as the transcript is read by the researcher.
- Then the researcher re-read the transcripts and underline the themes, words and phrases as stated by the participants which are related to:
 - What beliefs do you have on HIV and AIDS?
 - How do these beliefs protect them from being infected?
- The above-mentioned themes, words and phrases were written in the right hand column.
- The identified themes are grouped into main categories and sub-categories.

The consensus meeting will take place at a convenient time for you after doing your own analysis.

Thank you,

D.M. Magcai (Researcher)

APPENDIX G

TRANSCRIPTION OF A 'LEKGOTLA'

Speaker: Last week that night, I was not here so I don't know what you were talking about.

Leader: We were talking same thing as in the weekend.

Leader: Yes so we are continuing to look for the beliefs which are full, i.e. how much do you know, you see, so I'm still going to ask questions again and then I'm asking that a person who knows something and answers, answers carefully. **Pause.** We are seriously talking about serious things we are not here for jokes. Yes so I'm going to ask the first question, you can answer individually, if you have any belief that you know something about you can explain so when you are satisfied, so we have three questions, each one we will answer after another. Hmm.....

Leader: Sorry my brother, I'm asking to make a plea, that as we are sitting here, if and only if that you want to answer just raise up your hand please yes.

Audience: Yes, mm

Leader: You are still right there.

Audience: Yes

Leader: I'm going to ask the question I will give to you and then I'm going to sit down to give you a chance. Everyone will understand what question I have asked. Which beliefs do you know about HIV and AIDS? That is the first one. **Silence.** That is the first one.

Speaker: That is according to me as an individual, this AIDS, this HIV is being ill just like any other it is anybody's sickness, because I can put it that for an example TB is

an HIV, you see it means that any sickness, according to me as I'm an individual once again. (Mm...). Yes.

Speaker: It's understandable brother in law.

Audience: Yes.

Speaker: You have spoken the words I wanted to say.

Speaker: Yes.

One speaker wants to answer

Leader: Please stand up.

Speaker: This HIV and AIDS, all of us here whatever you say, you are not right or you are not wrong, its you view, HIV and AIDS you get when, most when you try to have sex and you don't use condoms, mostly these diseases come in when you have sex without condom, so that is the way HIV comes in.

Audience: Mm.

Speaker continues: Sometimes it doesn't come in that way only, if you are injured and you go to the doctor and he injects you and you share blood with another person who is injured, also by kissing a person you contact it if you are injured on the mouth and that other person is injured it's possible to come in.

Speaker: You are telling the truth.

Leader: Any objection?

Speaker: What you should know here is that there is no right person and wrong, because there is no one who knows about HIV, so whatever you say, others should take it as is.

Speaker: We need to talk about this.

Leader: Any objection?

Speaker: At the townships doesn't it happen ...

Leader: Sorry elders, my sorry elders, I'm asking that we answer the question, right now it looks like ...

Argument

Speaker: My elders, let's answer the question, the question asked here is not what is answered, we don't want an explanation, we don't want the causes of whatever, we just ask only that when you answer your question just try only to summarize it, it's all, please.

Audience: Okay.

Leader: Do you believe, the question is, is there anyone who beliefs about HIV positive.

Speaker: That it exists?

Audience: Yes it exists.

Speaker: Because everywhere where we are going, we see it.

Speaker: I don't think that there is anyone who has gone for testing

Speaker: Yes we haven't gone but we believe that it exist, you can't say you have AIDS or you don't have without going to the doctor, but I have seen many at the township.

Speaker: It is there, because the person who is infected is a shame, when he is going there, shame, it's a shame, you can also feel sorry for him, it's a shame about a person who has HIV.

Speaker: You didn't really observe, you don't know this person's illness, how do you know? Sometimes you don't know his illness.

Argument: Like TB ...

Speaker: You don't know his illness.

Speaker: Wait first (Name).

Leader: I'm asking you to give each other a chance, I ask that there should be one person talking so that we can hear each other, so that we can understand each other please I'm asking you.

Speaker: HIV sometimes is caused by the death of someone, neh, then you don't drink medicines like '*pitsana tsa boshwagadi*', then you sleep with a male person, or you don't take medicine, isn't it sometimes when your husband dies or your children die, we don't "mourn", we don't take medicines, that thing changes to AIDS.

Audience: Yes (Women).

Speaker: That's your belief, but I'm not against it, but, HIV is a virus, it's something in the blood, I'm not against what you are saying like medicine, there is no medical doctor who has given a person those medicines, but it's your belief I'm not against it.

Speaker: And that one too.

Speaker: But it's '*mokaola*' sya it right (Name).

Speaker: That one too is '*mokaola*' say it right, (Name), when is saying it's '*boshwagadi*', because of the death of a mother.

Speaker: So sister you cause deliberately.

Speaker: It is like that, it's in the blood, you say it correctly, it is like that, it comes in through the blood, we ourselves, we must take care of ourselves, by when someone's mother dies, child or your husband, neh, you must treat yourself.

Leader: HIV and AIDS is a virus, what you are talking about is '*mokaola*'. How is it connected to HIV?

Speaker: It is like that, western say it's HIV, but it's '*mokaola*'. Yes, you must respect yourself, yes, it comes in through the blood isn't it, you must respect it.

Leader: Let's understand each other, what is the difference between '*mokaola*' and HIV and AIDS?

Speaker: '*Mokaola*' I know its '*boswagadi*'

Argument on this issue.

Speaker: Many people are dying because of '*boswagadi*'?

Speaker: Yes, it's '*boswagadi*', yes where does AIDS come from? We don't know.

Speaker: Yes according to that suggestion, I'm not saying you're wrong, it's a person's choice, but the way I myself, according to me as an individual, when you're walking on the road there is something that they call HIV, it your hard luck (**Interruption:** take care of yourself), if you are driving on the road, but on the road there is no experience, because you are not only driving your car, you can have ten years driving (Exclamation: Yes) if you have experience of the car you are driving, you are driving on the road but it's according to hard luck, you drive ten years, you have experience of the licence you have, so HIV, is your hard luck you will experience, it's something that you know it's there, if you don't believe, it's your choice, you can go on, the way you want to go on if you don't care for yourself, you

don't take care of yourself, it's your choice, it will affect you. If you believe it will happen to you, you will do necessary things so that you don't meet with it but if you do things to impress me or your opposite, that you know how to do something, end of the day you will be alone, I won't be there, you will be sick, the way I understand it.

Discussion

Speaker: But if you do it deliberately, you do it deliberately.

Speakers: Go to the second question.

Speaker: The higher it goes, the colder it becomes.

Discussion

Leader: Your beliefs about HIV/AIDS are which ones?

Speaker: Beliefs

Speaker: I didn't hear what you are saying

Leader: I am saying beliefs, we are at the beliefs?

Speaker: 'Neh', my beliefs me, about HIV and AIDS are that it exist and it kills.

Speaker: My beliefs about HIV, according to me it kills, just like sir just said, if you drive on the road, that you are supposed to drive on then you will stay safe day after day my brother.

Audience talks

Speaker: It can't be driven where the road is not drivable.

Speaker: It doesn't go together at all.

Speaker: Cousin, I am at this point, my belief is that HIV is an infection, (Audience: Yes), and then when you are sick now, being clothed and unclothed, its when you have been invaded by all these sicknesses, it means that you are now sick and your soldiers of the body. How do you get it? By doing sleeping together, that verse of that it is 'bomokaola', now we don't follow things the way they should, this thing is found in the blood by sleeping unsafely, 'mokaola' or child sickness, are things looked at traditionally.

Speaker: They are far.....

Speaker: Aao!

Speaker: Speak (Name), stop saying Ao.

Audience: Laughs

Speaker: I'm a Xhosa here, I sir and madams, I don't know well, you know, this thing they call HIV and AIDS, I don't know if it's correctly clear, because there is a lot that was said here, this thing which is said is HIV, is a lot, is a lot, but I almost don't believe it nicely because a person who has been killed, and they said this person was killed by HIV, there are many but it said, I don't see when he has died they say it's HIV, so I believe that it exists. I do see others thin as if they living, but when they are dead people say it's HIV. I haven't seen it's when he is how, but that thing I believe it, but this thing if it's me and my wife, that thing it comes with whom here at the house, if we are not 'jolling', we are sitting in the house, what does it say, it comes with whom between me and the mother in my house.

Speaker: It comes with the one that between the two of you are not following a true way.

Audience: Yes.

Speaker: Okay, stop, I haven't finished, I haven't sat down, I was saying, let me ask a little, this thing comes with whom? Let me ask a little here from our mother, this thing comes with whom, this little blood is it, it that can cause this thing truly? I sit down? Yes I will sit down but I haven't finished yet.

Speaker: Yes, you will stand up again

Speaker: Yes, but I had not yet finished

Speaker: He wants to understand that if you help a person, it's not able to infect you if you help that person?

Speaker: I know that thing, go to another one again.

Speaker: Even if you help a person, but if you help a person yourself having a wound, but your blood gets in there, you will be infected like that, beside from that no.

Speaker: I will stand up then, we once had first aid, and then they said if you help a person it can be how you must put a hand glove.

Speaker: If you have a wound put on a glove, if you touch put on a hand glove, it's not only that, because there are other things that come in that way too, that's what I say.

Speaker: This thing is the same as the condom one, you meet with a person and fall in love, you know nothing about her, so always put a condom, it's like blood you wouldn't know, so stay putting on condom like a wound you wouldn't know.

Speaker: Point number 4

Speaker: Number 3

Speaker: Number 3

Speaker: It's like the mother, if the mother gets injection she can get it even with injection, mistake can happen there.

Speaker: You don't inject with a dirty needle.

Speaker: Not deliberately, just that you are not having extra-marital affair with the mother of the house, it can happen.

Argument

Speaker: 'Cause look at people who get money who are infected, we don't get it, people who have AIDS they work so that they can have money.

Speaker: What money? It's been discussed about HIV and AIDS here.

Speaker: I also can get it so that I can also get money coming to me.

Speaker: We want to save our life, that where do we stand?

Speaker: What money?

Speaker: We want to save our life, us.

Speaker: He wants money.

Speaker: Here we are speaking of HIV and AIDS.

Speaker: And we are talking about our lives.

Speaker: Let's go to the next question.

Speaker: We want to know where we stand.

Argument

Speaker: You will agree that a child should infect you so that you can get money.

Speaker: Money doesn't come in here, we are talking about our life here.

Speaker: Lets enter into another point.

Argument

Speaker: Wait first.

Argument

Speaker: AIDS doesn't have money.

Speaker: Wait first man, you will discuss with (Name) about money there, wait first.

Speaker: We are not talking about money us.

Argument

Leader: I'm asking to go to the question that HIV/AIDS where does it come from, during the times of our grandfathers where was it?

Speaker: It's from the blood.

Speaker: My grandfather was able to go out, he makes children there, but if you look now just around the 90's, HIV where does it come from?

Speaker: Let me answer him.

Speaker: It's democracy.

Speaker: That our grandfathers were doing what, everything that they were doing, they were doing it in an appropriate manner, that grandfather had how many wives or how much it was affecting the family or he had how many children, point number one, grandfather would go to the doctor if he must or sick or how, but they were people who believed in digging medicines, with us children of the 70's downwards, who or if you are sick that I would say hey brother-in-law lets go to the forest so that I can help you, who of us can help another one with medicine?

Speaker: No one.

Speaker: No one, grandfathers are people who used to dig medicine, they were adhering to their culture, but not all that's why we will stay dying.

Speaker: We are adhering to our culture but not all of us, not all us that know medicines, that's why we will always die.

Speaker: We are also in a hurry.

Speaker: This youth, it's them that's going.

Speaker: I stress on those words, I stress on those words, that time of our grandfathers, it wasn't called like this, this name of HIV it's a name, it's a recent name, with our grandfathers it was not called HIV, but it, we were born with it present it has always been present.

Speaker: What was it?

Speaker: But it was like a sickness like a cultural thing you see like '*boshwagadi*'

Speaker: '*Mokaola*'

Speaker: It is that thing.

Speaker: I know it there, so the name HIV is only coming out now.

Speaker: Yes you are telling the truth.

Leader: I'm still repeating myself, what is the difference between '*mokaola*' and HIV?

Speaker: There is no difference there, but just the name.

Argument

Speaker: HIV ...

Speaker: Wait first let me answer, if ...

Speaker: Listen first what I'm saying, we say '*mokaola*' gets in how, and when your child died or a husband, if you don't mourn, you don't mourn you have what? You get '*mokaola*'. So AIDS how did it come?

Speaker: Listen AIDS isn't it we say it gets in through sex.

Speaker: It gets in through sex.

Speaker: I want to show you, difference of this '*mokaola*', isn't it you will have AIDS even if your child didn't die, you are saying '*mokaola*' it's when someone died.

Speaker: I'm saying where does '*mokaola*' come from, it comes in how?

Speaker: I'm saying '*mokaola*' comes in how?

Speaker: It's from sex which is not safe.

Speaker: Yes.

Speaker: '*Mokaola*' comes from there, isn't it?

Speaker: '*Mokaola*' comes from that child who died.

Speaker: '*Mokaola*' is sex.

Argument

Speaker: Let me explain, I'm saying there is a chills isn't it, that child passes away, when the child has passed away I sleep with another man, neh, I didn't mourn, I didn't cleanse, I didn't drink pots, I sleep with you, when I sleep with you, that child does what, what happens to me, I'm going to become sick, neh, what is that?

Speaker: It's own carelessness.

Speaker: It's your carelessness, so listen to what I'm saying, I say '*mokaola*' comes with having sex, so AIDS where does comes from?

Speaker: It comes from having sex, this '*mokaola*' you are talking about comes from that you didn't follow to drink cleansing medicine.

Speaker: You drink cleansing medicine, neh, where does it come from if after having sex it comes in?

Speaker: It comes from having sex.

Speaker: Listen to what I'm saying because I'm saying AIDS comes from where?

Speaker: AIDS comes from being naughty.

Argument

Speaker: This AIDS comes with me and you.

Argument

Speaker: It's being naughty, this AIDS, comes with me and you.

Speaker: You don't listen, I'm saying ...

Argument

Speaker: Wait first I explain to you ...

Argument

Speaker: You don't listen to me, that our grandfathers ...

Argument

Speaker: AIDS where does it come from, where other diseases come from, HIV has been present for a long time it has never changed a name, as we are all of us we have it, now I have not don't lost a child, I don't have anybody who died, I sleep with a girl but I have it, she also hasn't lost anyone, I get it.

Argument

Speaker: I'm asking to close it.

Speaker: You don't have it, isn't it?

Speaker: Yes,

Speaker: Right now your husband dies,

Speaker: Maybe its there,

Argument

Speaker: '*Mokaola*', '*boshwagadi*', what is it?

Audience: Yes.

Speaker: Isn't it you know that all of these things you must mourn?

Audience: Mm

Speaker: For AIDS you don't mourn.

Argument

Speaker: This AIDS where does it come from.

Argument

Leader: Let's enter into the third question

Argument

Leader: Order, order please, we enter into the third question, you think that which beliefs can protect you from HIV and AIDS, which you have, which you see that can protect you?

Speaker: It's gumboots.

Argument

Speaker: Don't laugh.

Audience: Talk, (Name).

Speaker: Don't laugh.

Audience: You are wasting time.

Speaker: It's our rights those.

Argument

Speaker: This thing, we are saying that grandfathers, are not here now, wait until you are married.

Speaker: I think that if you don't talk, that thing at least the disagreement between me and you, has something that I will know there, so let's talk.

Audience: Yes.

Argument

Speaker: You will know when you have it.

Speaker: I didn't know mine.

Speaker: Isn't it his, she knows.

Speaker: Yes, she is not talking about herself, she cannot go backwards.

Speaker: Those grandfathers were liars from the beginning, they said that we shouldn't eat eggs, if you can look, they didn't say the reason why, their things are all question marks.

Speaker: I know the reason.

Argument

Speaker: Why were we not supposed to eat eggs.

Speaker: They are nice.

Audience laughs

Speaker: Isn't it I'm stopping the news of the grandfathers of long time ago.

Speaker: We are at the verse of what do you protect yourself with.

Speaker: I protect myself with using a condom, if I don't use a condom I don't sleep with a woman, I leave, I will sleep with a woman when I'm married.

Speaker: You don't sleep with a woman you ...

Speaker: I also when I'm married.

Speaker: Let me say the walker of the road, the person who knows ... road, is the person who walked it, so to me not other people, each and every person can take an option, there is no one who will make an option for you (Mm). Point number two, I cannot be something that you want me to be, I am the person who will be in trouble. Now my belief is one, point number one: condomise, point number two: so sustain from problem, it will come from the bottom of your heart.

Audience: Amen

Speaker: It is that you must condomise if you have a male person.

Speaker: To save yourself.

Speaker: But us when someone dies, you will use a condom when you first meet with the person when you get used to each other.

Speaker: That's true.

Speaker: Me according to me, I will use a condom until I marry her, if she has it, this virus, I will sleep with her, I will be killed by what I have eaten, that if I don't want to I will use a condom.

Audience: Yes..... Mm.

Speaker: Until I make the decision that she doesn't have anything, she doesn't have it, I put her.

Speaker: It infects you.

Speaker: That's true love.

Speaker: What she is, it's what you are. Yes .

Speaker: After some months you leave it you trust her, she is yours.

Speaker: After a year or after some time you have separated, so ...

Speaker: Me, if I have it and the person I'm staying with also has it, we immediately stay together, it has come in isn't it at that time, at that time we don't know ...

Speaker: Forgive me again, they say these children, he will marry someone he hasn't heard.

Speaker: That thing doesn't happen.

Speaker: My child loves this person, he wants to marry this person, he loves her, now he wants to marry her without hearing her?

Speaker: That thing doesn't happen.

Speaker: That's what (Name) is saying.

Speaker: What is to marry (This is in Xhosa).

Speaker: To marry.

Speaker: You will be able to marry her truly without hearing her?

Speaker: That thing doesn't happen.

Speaker: Let me answer him, according to me, eeh, you can marry a woman as she is, it depends on the words that says, someone is stealing from you, isn't it, it was stolen from Adam, at times this condom will be used, there is somewhere where you will cheat, I put it but I will take off the tip, she doesn't see that I did that thing, what remains she will go with my urine, I would have urinated, isn't it.

Argument

Speaker: It means that, that point.

Argument

Speaker: Those things are for whites they don't work.

Speaker: Yes, man.

Argument

Speaker: It means when I marry her, we want children, again when I marry her will see there, because ...

Audience: Moaning.

Speaker: You don't hear Xhosa? I am saying neh, I love the girl, I want to marry her, when you start having plans this person, you want to marry her, the first thing you think of is to have a family with her.

Speaker: Yes.

Speaker: We must make children, we make a family now, if she can't have children , that thing is going to kill me as a man, because of what, my trust, because of the trust I have, it's the intentions I have about her, I take it and I put it aside condom I put ...

Speaker: Yes.

Speaker: I would rather die.

Speaker: Yes.

Argument

Speaker: Let me ask you a question then, right now I haven't had a family, I want (Name) to be my wife, I want to have children with her I just shoot.

Argument

Speaker: You want to marry her, isn't it?

Speaker: Those are my intentions. Condom won't make children for me.

Speaker: It will infect who, it will infect (Name) only if she wants.

Argument

Speaker: You will leave her only because of love.

Speaker: I think that even those who died, they died because of love.

Speaker: Yes they died because of love.

Argument

Speaker: There is no way you will just go, you go because of love.

Speaker: You are going to marry him, you will be dying for whom, you will be dying for him, isn't it?

Audience: Yes.

Speaker: Because of love.

Speaker: It's my intention.

Leader: Let's enter into other questions.

Speaker: I think that we had three questions.

Speaker: We killed them quickly.

Speaker: They haven't finished with us, they will still come.

Speaker: You see me the things I do agree with is that, you understand what has brought us here all of us, you haven't understood, completely, that is why I'm here, when everybody talks, that is why I ask questions and I sit down and keep quiet because you haven't understood. These sisters they come here to work, they are trying to help us, so it looks like we are still playing, so that is why I'm watching you, by the way we are talking about our lives.