APPROVED TITLE

Social factors responsible for the spread of HIV/AIDS in Madidi Village, Bojanala District in North West Province.

by

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Exploring social factors that contribute to the spread of HIV/AIDS in Madidi Village, Bojanala district in North West Province.

I declare that the above dissertation is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

I further declare that I submitted the dissertation to originality checking software and that it falls within the accepted requirements for originality.

I further declare that I have not previously submitted this work, or part of it, for examination at Unisa for another qualification or at any other higher education institution.

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_____ ___06/08/2024_____

SIGNATURE DATE

DEDICATION

I dedicate this dissertation to my mom and dad Maria Ntombizodwa Lekgema and Alpheus Lekgema

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ABSTRACT

The purpose of this study was to investigate social factors that are responsible for HIV/AIDS transmission in Madidi Village, Bojanala District in North West. When conducting the literature review, social factors such as poverty, unemployment, access to health services, cultural practices, stigma and discrimination were taken into account. the study focused on understanding the opinions and experiences related to HIV using data derived from interviews conducted. The study further discussed the recommendations of HIV management on how to reduce the spread of HIV/AIDS in the country.

To investigate the social factors that contribute to the spread of HIV/AIDS in Madidi Village, Bojanala District in North West Province, the study used a qualitative research approach and an exploratory paradigm. 12 participants ranging from ages 18 to 49 were interviewed using a semi-structured interview guide. The study criteria included people who originated from Madidi area and had knowledge of cultural practices that had an impact on the spread of HIV/AIDS. The study also included nurses, employed and unemployed community members, doctor and healthcare workers. Participants were chosen purposefully from the community. Face-to-face interviews were used in order to collect data which was later analysed by using a qualitative approach. Interviews were conducted on the 11 November 2023 till the 23rd November 2023. The findings of the study demonstrated that the majority of participants were aware of which social factors are responsible for the spread of HIV/AIDS, and majority mentioned unemployment and poverty as huge contributors of HIV compared to other factors since it puts a lot of women at risk by having transactional sexual intercourse; however, the researcher suggests that HIV/AIDS campaigns be implemented to educate community members about prevention methods they should use to protect themselves from contracting HIV/AIDS, such as using condoms, taking PrEP pills as well as PEP.

KEY TERMS: HIV/AIDS; Social factors; Poverty; Unemployment; Vulnerability, Circumcision; Polygamy; Tradition; Cultural norms; Beliefs; Substance abuse; Transmission; Infections; Risks; Alcohol; Sexual intercourse; Sexual partners

LIST OF ABBREVIATIONS

AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARVs	Anti-Retroviral Treatment
CDC	Centres of Disease Control and Prevention
DOH	Department of Health
HIV	Human Immunodeficiency Virus
PEP	Post Exposure Prophylaxis
PrEP	Pre Exposure Prophylaxis
PWID	People Who Inject Drugs
STATS	Statistics
STD	Sexual Transmitted Diseases
STI	Sexual Transmitted Infections
UNAIDS	Joint United Nations programme on AIDS
WHO	World Health Organization

DEFINITION OF CONCEPTS

AIDS: An acronym for Acquired Immune Deficiency Syndrome, which is an advanced stage of a disease (WHO, 2023). It is a chronic condition that can be fatal unless another cause intervenes before its progression leads to death (Scandlyn, 2000).

Culture: According to Brophy (2010:6), culture is shared, learned and transmitted values, norms and beliefs that are carried out by a group of people that governs their decisions, actions and thinking. Individuals who believe in culture are bound by the rules of the culture.

Exploring: An activity of investigating or searching in order to find the answer about a question or something. According to Machlup (2014:1080), when an individual does research on something or investigate it, it is called exploring.

HIV: An acronym for Human Immunodeficiency Virus. It is a virus that attacks the immune system and if an individual does not take treatment, it can lead to AIDS. The virus normally attacks the immune system making a person vulnerable to infections (World Health Organization, 2024).

Social factors: Social aspects of life that have an influence on an individual's life and behaviour. This may include culture, community society and family (Spacey, 2021).

Stigma: When individuals are perceived negatively due to attributes or characteristics such as cultural background, skin colour, disability etc. Negative perceptions may arise when individuals are labelled by their illness rather than being recognised for their true essence (Mayo Clinic Staff, 2017).

Unemployment: A term used to refer to individuals who are employable and looking for a job but are unable to get any work (Corporate finance Institution, 2015).

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CHAPTER 1: OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

The Human Immunodeficiency Virus (HIV) is a global health challenge that has affected millions of people worldwide since its first outbreak (UNAIDS, 2017). The virus attacks the cells of the body's immune system making it difficult to fight the disease. The virus has no cure and many lives are at risk. No other virus can spread as rapidly and widely as HIV. There is a lack of agreement on the origin of HIV/AIDS, but the majority of researchers explain that it originated as a result of the mutation of an African monkey virus (Tulane National Primate Research Center, 2006:12). The presence of related retro-viruses in monkeys and apes in Africa indicates a close relationship to the evolution of HIV, particularly in Central Africa (Peeters and Delaporte, 2012). Over the decades, HIV started spreading across Africa and then later to other parts of the world (Centers for Disease Control and Prevention, 2022:1). HIV/AIDS has played an important role in the reversal of human development in many countries such as South Africa. The epidemic has economic ramifications, contributing to a decrease in the supply of labour through increased mortality and illnesses (Martin, 2023). Additionally, it adversely affects food production, exacerbating food insecurity in many areas, as those infected often abandon or neglect agricultural work due to the challenges posed by their illness. Therefore, there is a need for prevention strategies to reduce its impact. Many strategies have been implemented, developed and put in place in order to reduce the number of people who are at risk of being infected, but the virus is continuing in an uncontrollable manner. HIV strategies such as HIV counselling and testing have been implemented in order to scale up the awareness of HIV/AIDS and mobilise individuals to seek testing and counselling (SANAC, 2010:12). Another strategy that has been implemented is male circumcision which decreases men's risk of contracting the virus (Motsoaledi, 2010:8). Also HIV campaigns such as U=U which aims at raising awareness about PLWHIV who achieve and maintain an undetectable viral load through consistent use of ART and condoms should also be promoted to end stigma, prevent new infections by promoting adherence. It is important to note that taking your medication consistently reduces the chances of infecting your child during labour, pregnancy as well as breastfeeding. According to the UNAIDS (2024), the prevalence and spread of HIV/AIDS in the North West are real, especially among young people and adults between the ages of 15-49. HIV incidences are compounded by social factors such as unemployment, poverty, illiteracy and limited human resources,

traditional practices, lack of health care services and stigma and discrimination. Recognising this pattern, the researcher identified an opportunity to conduct a study within this community. The goal was to investigate the factors responsible for the spread of HIV/AIDS impacting the community the most

In this study, the researcher investigated and identified the social factors that contribute to the spread of HIV/AIDS in Madidi Village, Bojanala District in North West Province. According to the latest UNAIDS estimates, in December 2023, the North west province has estimated 499246 PLWHIV of whom 9786 are children under the age of 15 years. The HIV prevalence among women in 2023 was estimated at 16.1% and 9.0% among males. Additionally, HIV prevalence among adults aged 15-49 years is 17.1%. The researcher saw this as an opportunity to conduct a study in this province, since there is a very large number of people infected by HIV.

The study also presents a description of the research process followed, provides data concerning the methods used when choosing participants suitable for the study and offers theoretical frameworks. The researcher employed a qualitative research approach, since it was the most appropriate design for this study. The reason for choosing this approach was that it enabled the researcher to describe and investigate social factors that contribute to the spread of HIV/AIDS in Madidi Village, Bojanala District in North West province. The researcher conducted a literature review in order to provide a summary of existing information related to the topic. The literature review is followed by a presentation of the theoretical framework relevant to the study. The researcher also described the methods that were used while collecting data. Semi-structured interviews were formulated based on the purpose and objectives of the study; this helped the researcher to focus on the issues that were under investigation, namely social factors contributing to the spread of HIV/AIDS

1.2 THE RESEARCH PROBLEM

According to Burns and Grové (2005:36-70), a research problem is an area of concern where there is a gap or insufficient knowledge. It is also the foundation of the study being conducted. Women and young girls in Madidi village in North West province are the ones who are disproportionately affected by the HIV/AIDS epidemic than men. The high prevalence in the community is due to unemployment, poverty, sexual risk behaviours, alcohol and drug abuse, as well as stigma and discrimination. Efforts have been made in order to increase awareness

among community members through HIV/AIDS programs such as Love Life in schools but the virus is still spreading. The researcher has noticed that there are limited campaigns of HIV/AIDS in the area and little information regarding the area which makes it hard for people to know about the needs of the community members.

South Africa is experiencing one of the most severe HIV/AIDS epidemics, with an estimated overall HIV prevalence rate of 13,0%. The total number of people living with HIV in 2020 was estimated 7,8 million, adults aged 15-49 who were HIV positive were estimated 18,7% (Statistics of South Africa, 2020). According to Leach-Lemens (2010:53), the majority of individuals on ART do not comply with the treatment resulting in the virus spreading in an uncontrollable manner. This may be due to side effects, a lack to follow-up as well as limited knowledge about ART, especially in rural areas. Most studies on this topic have reported risky behaviours despite HIV prevention campaigns aiming to promote HIV health. Cultural practices have been identified as barriers that contribute to the spread of HIV in the North West Province. According to Haffejee and Maksudi (2020), cultural practices include economic dependence on men for survival and imbalances in power which make women more vulnerable to HIV/AIDS and prevent them from determining their own safety, i.e. practicing safer sexual intercourse when they are with their partners. Stigma and discrimination have been reported to negatively impact the prevention of HIV/AIDS, because people living with HIV may develop a negative self-image, fearing judgment from both the society and healthcare providers. Sexually active adolescent girls and young women (AGYW) may experience stigma in healthcare facilities as well as in the society. People may label them as “bad girls” which might have a negative effect on them (Hall, Manu, Morhe, Harris, Loll, Kolenic, Dozier, Challa, Zochowski, Boakye, Adanu and Dalton 2018:60). Societal stigma among AGYW may also result in gossip from their peers, potentially causing them to resist seeking PrEP and other HIV prevention methods as well as avoiding HIV testing. Additionally, individuals living with HIV/AIDS may develop a negative self-image, fearing judgment by the society and their partners because of their status. This fear may contribute to delays in seeking medical treatment and testing for HIV, potentially leading to the transmission of the virus to their partners (CDC, 2018:4).

Another social risk factor is the lack of knowledge and certain beliefs about HIV/AIDS. The majority of people know that HIV can be spread through unprotected sexual intercourse but

they have misconceptions about other forms of transmission and how it can be prevented (Leigh & Budlender, 2002).

Condom use rates in rural areas are lower compared to urban areas due to the challenges of accessing condoms, attributed to the shortage of healthcare facilities as well as services. According to Ritshidze (2021), the North West public health system has been under strain for many years because of the shortage of medication, resulting in patients leaving without receiving any treatment. Patients often have to wait long hours in long queues, only to be told that there is no stock for medication (Ritshidze, 2021). Another challenge that is faced by the North West Province healthcare system is reaching the 95-95-95 strategy due to the poor quality of services available. Ritshidze (2021) further reports that 79 facilities experienced ARV stock outs, leading to patients defaulting on their HIV treatment. The North West Department of Health should intervene to address these issues to prevent the spread of HIV, given the shortage of medication for HIV treatment and the poor quality of services. Ritshidze (2021) also indicates that 59% of people living with HIV (PLWH) are receiving refills for one month or less. This issue needs attention to ensure that they receive three months' refills, reducing the need for frequent clinic visits, especially for those who are unemployed or lack the financial means to cover transport expenses. The most effective way to treat this virus is by taking Anti-retroviral therapy (ARVs) medication, pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) in order to prevent it, so if there are shortage or stock outs, it makes it difficult to reduce the epidemic (UNAIDS, 2018:11). ART is lifelong treatment which should be taken to help those who are already living with HIV/AIDS to suppress the viral load (Center for Disease Control and prevention, 2023)

According to UNAIDS (2011:24), the majority of women and young girls are being infected by HIV/AIDS from their unfaithful partners during unprotected sexual intercourse. UNAIDS (2011:24) also reported that the majority of cultural expectations of masculinity empower men to control their wives, particularly in financial matters. Lack of education and stigma have been identified as factors influencing the spread of HIV. Stigma and discrimination can negatively impact people's well-being and mental health (CDC, 2022). HIV/AIDS is prevalent in low- and middle-income countries and its impact is especially pronounced in rural areas of South Africa (Linganiso & Gwegweni, 2016:3).

According to South African National AIDS Council (2022), the highest HIV prevalence in Bojanala district was 13,3% in 2021. New infections continue to differ between males and

women, with a higher incidence among women. Many women fall prey in the hands of men because of poverty and unemployment. In 2020, the unemployment rate was 48,7% and it further increased to 49,3% in 2021. This shows that people are still struggling to get jobs even after they have completed tertiary education. The high rate of unemployment results in substance abuse which later leads to crime and high levels of HIV infections among young people and adults. It is evident that social factors play a significant role in driving HIV infection and influencing individuals' behaviour. According to Mahlangu (2022) there is a high unemployment rate in Madidi village with households relying on old age pensions and social grants for survival. He further adds that leaners are struggling to get jobs or go to Universities because of poverty. The researcher recommends that programs that focus on economic empowerment through job creation, skills training and social protection be implemented in order to help curb the spread of HIV as well as reduce the unemployment and poverty rate in the area. Programs such as AMcare which provides material assistance for people living with HIV/AIDS as well as Gift of the Givers which helps vulnerable families. The present study therefore sought to investigate these social factors that are affecting the community, since little is known about area.

1.3 PURPOSE OF THE STUDY, RESEARCH QUESTIONS AND OBJECTIVES

1.3.1 Purpose of the study

The purpose of this study was to investigate how social factors contribute to the spread of HIV in Madidi Village, Bojanala District in North West Province. Again, the researcher wanted to investigate and describe the knowledge and experience of the people of Madidi Village, Bojanala District in North West province regarding the spread of HIV/AIDS.

1.3.2 Study questions

Based on the discussion in the introduction section, the following questions were formulated in order to guide the study that was conducted in Madidi Village, Bojanala District in North West Province:

1.3.2.1. Which social factors are responsible for the spread of HIV/AIDS in Madidi Village, Bojanala District in North West Province?

1.3.2.2. How vulnerable are men and women to HIV/AIDS in Madidi Village, Bojanala District in North West Province?

1.3.2.3. What level of knowledge do the members of Madidi Village, Bojanala District in North West Province have about HIV/AIDS?

1.3.3 The objectives of the study

To enable the researcher to meet the purpose of the study, the objectives were:

1.3.3.1. To investigate which social factors contribute to the spread of HIV/AIDS in Madidi Village, Bojanala District in North West Province.

1.3.3.2. To determine the vulnerability of men and women to HIV/AIDS in Madidi Village, Bojanala District in North West Province.

1.3.3.3. To determine the community members' level of knowledge regarding HIV/AIDS in Madidi village, Bojanala district in North west province have.

1.4. CONCLUSION

This chapter presented an overview of the background of the study regarding the social factors that contribute to the spread of HIV/AIDS, including the prevalence rates, incidents rates as well as AIDS related mortality rates in South Africa. The study also presented the purpose of the study, the problem statement, research questions and objectives in relation to the overall focus of the study. The problem statement indicated that, although there are HIV/AIDS prevention methods in place to curb the spread of HIV/AIDS in South Africa and globally, it continues to spread in an uncontrollable way and the statistics have shown that the majority of people at risk of being infected are women and young girls who are financially dependent on men. The next chapter presents a summary of the literature review conducted in order to motivate and conceptualise the need for this study.

1.5 STUDY OUTLINE

The dissertation is organised as follows:

- **Chapter 1: Overview of the study**

The first chapter provided a brief introduction of the study and an explanation of the necessity of the area of the study. The chapter further explained the social factors that contribute to the

spread of HIV/AIDS in the North West. The chapter also illustrated the objectives and purpose of the study.

- **Chapter 2: Literature review**

This chapter provides a relevant literature review and identifies the gaps related to the title of the study. It also provides the social factors that contribute to the spread of HIV/AIDS in South Africa. A discussion of theoretical approaches is also provided in this chapter to investigate the social factors that contribute to the spread of HIV/AIDS.

- **Chapter 3: Methodology**

This chapter describes the research design and methodology employed while conducting the study. The qualitative research methods employed in this study are also described. The chapter also covers the steps that the researcher used while conducting the study and analysing data. In conclusion, the chapter discusses the research ethics that were adhered to while conducting the study.

- **Chapter 4: Findings**

This chapter presents the findings and discussions derived from the data collected. It also discusses the analysis and interpretation of these results. The results are presented in detail, highlighting the themes and sub-themes that emerged during data collection.

- **Chapter 5: Conclusion and recommendations**

This chapter constitutes the conclusion and recommendations of the study as well as the limitations emanating from the findings.

CHAPTER TWO: LITERATURE REVIEW

2.1 INTRODUCTION

The purpose of a literature review is to discuss existing studies about a certain topic (Anson, Chris and Schwegler, 2000:1). The literature review of this study covered the views of different authors on social factors that contribute to the spread of HIV/AIDS. A review was conducted of studies that had investigated issues related to poverty, stigma and discrimination, cultural practices and beliefs, illiteracy, substance abuse and a lack of knowledge about HIV/AIDS in South Africa. The researcher was guided by the research questions and objectives for literature search. In order to investigate the purpose of this study research, the researcher utilised the following three theories to guide the study: The Social Cognitive Theory, the Social Constructivist Theory and Trans-theoretical model. The researcher considered these theories as appropriate to understand the content of the study.

2.2 SOCIAL FACTORS THAT CONTRIBUTE TO THE SPREAD OF HIV/AIDS

2.2.1 Stigma and discrimination

Stigma and discrimination may refer to negative attitude, abuse and bad treatment that are directed to people living with HIV (UNAIDS, 2015:2). Stigma and discrimination significantly contribute to the spread of HIV because HIV-positive individuals often face judgment within healthcare facilities when seeking medical attention. For example, there is a fear of being stigmatised by members of the public when carrying Anti-Retroviral Therapy medication or displaying a client card as well as when utilising demarcated HIV services. Both women and men are at risk of stigma and discrimination (UNAIDS, 2017:34). Additionally, individuals may be scared to consult healthcare facilities to seek help because some healthcare professionals tend to judge them and even gossip about them making them uncomfortable and preventing them to go back to the same facilities (Stangl, Loyde, Brady, Holland, & Baral 2015:151). Some of them may even get poor treatment and are scared to disclose details about their condition to their doctor. These individuals may be at risk of contracting HIV since they do not get treatment for Sexual Transmitted Diseases (STDs) and HIV/AIDS. The majority of women face discrimination and stigma due to unequal and limited access to HIV testing, care and treatment. It is not only a positive HIV test result that can significantly impact their lives, but also the potential violent and abusive response from their partners (UNAIDS, 2019:23). The

fear of such violence often hinders women from disclosing their Serostatus to their husbands, leading them to hesitate to undergo HIV testing (UNAIDS, 2004:31). Furthermore, discrimination against women extends into communities, making it difficult for them to demand equal treatment and care (UNAIDS, 2004:32). Women may even face accusations of infidelity when their partner discover their HIV-positive status.

Stigma imposes significant hardships on people living with HIV, often leading them to isolate from society and even their own families. This isolation makes it difficult for them to seek the support and treatment they desperately need (Spire, Zoysa, Himmich, 2008:5). According to UNAIDS (2019:5), stigma and discrimination can affect the decisions of individuals living with HIV to seek for Anti-Retroviral Treatment or delay treatment altogether, thereby increasing the risk of further transmission and weakening their immune systems. Fear of judgment also acts as a barrier to HIV testing, as individuals are reluctant to face potential stigma. Stigma remains the most important barrier, discouraging many from seeking medical assistance and delaying treatment, contributing to the silent threat of AIDS. This fear of judgment extends to healthcare settings and perpetuates social disgrace.

According to Mokgatle and Madiba (2023) an increased access to ART has not changed environmental factors that contribute to low rates of disclosure and unwillingness to disclose among PLWHIV, the researcher continues to say that usually PLWH often disclose their HIV where they feel safe since they do not want to be labelled as PLWHIV. This may lead to disengagement from care as well as delaying treatment especially if they do not feel safe or there is no confidentiality. Even though disclosing your status can lead to early initiation of ART and emotional support, it may also lead to self-stigma since people may isolate themselves (Sighn and Lata, 2018).

2.2.1.1 Stigma and discrimination at workplaces

HIV/AIDS related stigma remains a problem in people's lives, affecting the lifestyles of individuals living with it. Stigma and discrimination may deny individuals living with HIV the right to participate in workplaces and communities as well as receiving access to treatment and care (Global Network of People Living with HIV/AIDS, 2018:5).

In workplaces, individuals may suffer stigma and discrimination from their colleagues and experience rejection or even isolate themselves. Some may be refused opportunities like

promotions (Jamaican Information Services, 2012:3). Individuals in the workplace may refuse to share food and utensils with people who are HIV infected because they believe they will then also get infected (Jamaican Information Services, 2012:6). This is the reason why many do not disclose their HIV status and suffer alone, leading to depression. Some people may avoid getting tested for HIV because they fear that they might lose their jobs or not get the jobs they have applied for (Mohammed, 2017:3). The persistence of stigma in workplaces can be attributed to a lack of comprehensive understanding among employers regarding the impact of HIV on individuals. Companies should create HIV/AIDS awareness programs to increase and improve wellness amongst employees in the workplace through education. This can be very helpful to employees. If companies can develop HIV workplace policies that protect the rights of people living with HIV, an environment free from stigmatisation concerning the implications of HIV/AIDS can be fostered.

In the year 2000, South Africa published a code of Good practice on key aspects of HIV/AIDS and employment in line with the employment Equity Act. The code aims to guide employers, workers and Trade Union to develop and implement HIV/AIDS workplace policies and programs. The code was intended to protect and promote mutual respect, dignity and rights of workers through eliminating unfair discrimination (Mokgale and Madiba, 2023). In order to reduce stigma in the workplaces this code should be practiced so that workers can enjoy protection of their privacy which includes confidentiality which relates to their own HIV status. Workers must not be required to undergo HIV status unless found to be justified at court. HIV results must be confidential in a way that it may not jeopardise access to jobs or other opportunities at work.

2.2.2. Poverty

According to Govender (2005:46), individuals living with HIV/AIDS are not empowered in order to deal with the situation they are facing. The majority of them live in overcrowded places with poor access to healthcare facilities and medication due to financial constraints. Individuals living in such conditions end up being at risk of contracting HIV/AIDS (Govender, 2005:48). Ganyaza-Twalo (2005:41) and Seager, (2005:76) state that South Africa has reached a stage where the morbidity and mortality rates associated with AIDS have seen a rapid increase. Adults falling ill because of AIDS are placing additional financial burdens on young people, compelling them to seek employment to support both themselves and their families (Ganyaza-Twalo, 2005:48; Seager, 2005:76). In rural areas, poverty increases the

vulnerability of women to HIV infection more so than men. The majority of women lack financial stability which leads them to engage in risky behaviours, for example having multiple sexual partners in order to take care of them (Pascoe, Langhaug, Machu, Hargreavens, Hayes and Cowan, 2015:23). Living in poverty may result in food insufficiency which contributes to HIV infection. Men who promise to take care of these women may demand unprotected sexual intercourse in turn, resulting in unwanted pregnancies and sexually transmitted diseases (UNAIDS, 2019:2). Women who depend on men are often abused sexually and physically. The capacity to use condoms and negotiate safe sexual practices is deeply embedded with power dynamics that cannot be separated from financial independence (Shisana, Zungu and Pezi, 2009). Parents in rural areas may force their children to get married at a younger age so that older men can take care of them since they are poor themselves. Some may be forced to enter into polygamous marriages for stability and protection. This has been proclaimed by pro-activists since it is the only way to sustain equity of resources (Amin, Ahmed, Saha, Hossain & Haque, 2016). Young girls may experience torture and forced sexual encounters in their marriages because their husbands expect them to demonstrate fertility to secure their status in the marriage, often compounded by the significant dowries paid by their husbands. (United Nations Population Fund and United Nations Children's Fund, 2020). These young girls may be at risk of contracting HIV and other sexually transmitted diseases since they are in polygamous marriages. Some husbands are often absent for long periods due to migration for job opportunities. This can heighten the risk of HIV transmission, particularly if he engages in sexual activities with other partners, including sex workers, during his extended stays away from home (Zeitzen, 2008:176). Women and young girls face difficulties in making decisions regarding sexual activities, including practicing safe sex. Men often hold more power over women and may take advantage of them as they typically have greater access to resources and influence.

According to Ganyaza-Twala and Seager (2005), HIV/AIDS may affect households on two levels, namely socially and economically. On a social level, members of the family may have to deal with being stigmatised by the society or community they live in and lack social support networks. On economically level, families may bear the burden of covering medical or funeral expenses, particularly if the individual who is ill or who has passed away was the primary breadwinner. This situation can lead to financial strain and a loss of income. In this context, HIV/AIDS is perceived as a contributing factor to poverty.

Poverty does not only increase the susceptibility of HIV infection; it also decreases the ability of individuals already infected to cope with the consequences of the infection. Poverty may also cause the immune system of individuals living with HIV to weaken since they do not eat healthy or lack adequate nutrition, which speeds up ill health and death (Ganyaza-Twala & Seager, 2005). Economic challenges at home can drive women to pursue some kind of stability by entering relationships with wealthier men. However, this can result in health issues such as STDs and HIV, as safer sex negotiations may be compromised due to power imbalances and economic dependency. This indicates that a significant number of women may resort to engaging in sexual activities to secure relationships with men and obtain material possessions.

2.2.3. Access to healthcare services

According to Imrie, Hoddinott, Fuller, Oliver and Newell (2013:70), access to healthcare services has always been a problem because of the attitude of the healthcare workers towards the patients. This has a negative impact on the patients. The majority of men having sex with other men (MSM) are unable to access healthcare services because of the treatment they receive. They encounter stigmatisation and discrimination as well as negative comments. Access to healthcare services is a big problem, especially in rural areas. According to Kimani-Murage (2011:1-3), HIV is associated with nutritional deficiencies because inadequate treatment can result in elevated viral loads, particularly in the context of Prevention of Mother to Child Transmission (PMTCT). Mismanagement of PMTCT programs can consequently contribute to the spread of HIV.

The availability of healthcare services plays a crucial role in mitigating the spread of HIV/AIDS. When these services are accessible, individuals are more likely to utilise them, thereby reducing transmission rates. However, people living in rural areas often face challenges in accessing healthcare due to travel long distances and limited infrastructure. As a result, the access and utilisation of healthcare services remain problematic, especially in rural areas. Public healthcare strategies have not been entirely effective in addressing this issue, highlighting the need for further attention and improvement in HIV prevention and treatment efforts in rural communities.

Stigma and discrimination persist within healthcare facilities, posing a significant problem that remains largely unaddressed despite ongoing discussions. Without effective interventions,

this trend is likely to persist in the future, leading to unchanged outcomes for individuals affected by HIV/AIDS, even with the induction of new medical interventions.

In rural areas such as Madidi Village, Bojanala District in North West province, there may be a shortage of specialists and mental healthcare professionals who can assist with diagnoses or advanced HIV care as well as extensive information. Another challenge that is faced by people in rural areas is services for MSM (Men who Have Sex with other Men). As a result of facing homophobia, these individuals often feel reluctant disclose their sexual orientations and may hesitate to undergo HIV testing and access treatment. The lack of healthcare services for MSM poses challenges for those seeking to protect themselves and their partners from HIV transmission. It is crucial to introduce targeted messages and initiatives for MSM in rural areas, such as Madidi Village, Bojanala District in North west province in order to reach individuals who may still face oppression due to cultural norms and societal attitudes. Messages and posters about the MSM/Heterosexual population should be placed in healthcare facilities to create a friendly environment for these individuals to access treatment without fear and feeling welcomed. Concerns among women and young girls about disclosing their HIV status appear to create barriers, contributing to the development of depression and anxiety. These mental health challenges can lead to increased risk behaviours and make it difficult for individuals to access HIV services. Therefore, it is crucial to ensure that services available in urban areas are also accessible in rural areas. By doing so, people can be better informed about HIV prevention, ultimately aiding in the prevention of its spread.

According to Ratshidze data, clinical and un-clinical staff including security guards continue to discriminate against people who come to consult in health facilities. Repeated violation of privacy continue to occur which destroys people’s rights and make the clinic feel unwelcoming or uncomfortable. According to the data, only 34% of staff in North West facilities were reported to be friendly. Only 14% of GBMSM (Gay bisexual Men who have sex with men), 10% drug users, 19% of sex workers and 14% of transgender individuals reported feeling safe at the facility. On the other hand, clinics may sometimes refuse to the key population access, drug users would be told that they have been denied access because they have been told that they are too dirty and need to be clean before they can enter the clinic. This is saddening because people might lose their lives or even default from their medications. According to Ratshidze (2023) people continue to suffer on a daily basis indignity of using

public health facilities, certain services remain unavailable such as lubricants, which are free on certain facilities.

2.2.4 Illiteracy

According to Ovbiebo (2011:1), knowledge is power and illiteracy is closely tied to knowledge, implying that those who are illiterate, lack knowledge and, consequently, power. HIV in rural areas spreads rapidly because the majority of people lack reading and writing skills making them powerless to access information (Ovbiebo, 2011:1). Information may be available in healthcare facilities and public spaces in the form of posters and brochures but the problem is that it is not understandable (UNAIDS, 2016:35). Medel-Anonuevo (2007:1) states that illiterate people often have no access to written information and end up unaware of issues affecting the nation. The less they know, the more vulnerable they become to HIV. For example, many people are still unaware of Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP) which can help prevent the spread. In some cases, they may receive incorrect information verbally and be unable to verify it due to illiteracy (Anonuevo, 2007:2). Although condoms may also be available, some individuals may use them incorrectly. According to Ovbiebo (2011:1), knowledge is power and illiteracy is directly linked to knowledge deficiency, suggesting that illiteracy denotes a lack of power. People in rural areas often lack reading and writing skills, rendering them powerless when it comes to accessing information and negotiating safer sexual activities (Ovbiebo, 2011:1).

Illiteracy among young people and adults may prevent them from learning about the preventive measures necessary for HIV/AIDS. Therefore, there is a critical need to provide them with basic education and training, especially considering the socio-economic challenges prevalent in rural areas. Equipping individuals with basic knowledge of HIV and necessary skills may empower them to take control of their lives and contribute to poverty alleviation efforts, particularly among women who often rely on men for financial stability.

2.2.5 The role of culture in the spread of HIV/AIDS

The word culture comes from the Latin term *Cultura* which means to cultivate. The term is used to refer to patterns of human daily activities and structures that give these activities meaning and importance (Joubert-Wallies & Fourie 2008:105). Culture may refer to knowledge that is passed on from one generation to another. Individuals often experience

limited freedom when making decisions due to various forms of control. Culture can play a significant role in the spread of HIV through its influence on practices and sexual behaviours.

2.2.5.1 Traditional male circumcision

Traditional male circumcision is still being practiced in certain cultures. Young boys who have reached puberty in Tswana, Venda, Ndebele, Southern Sotho and Xhosa cultures are expected to go to initiation schools in the mountains or forests in order to be taught how to be a man and take care of their families (Leclerc-Madlala, 2009:14). Circumcision usually forms part of these initiation practices. It takes part during winter so that they can heal fast. Unfortunately, circumcision is usually performed by traditional doctors under unhygienic conditions with no clinical setting using unsterilised instruments such as blades and knives. The same instruments may be used on all boys attending the initiation (Gray, Kigozi, Serwadda, Makumbi, Watya, Nalugoda, Kiwanuka, Moulton, 2007:658). According to Leclerc-Madlala (2009:14), the initiates are encouraged to have sexual intercourse soon after the initiation with a woman they do not intend to marry.

2.2.5.2 Polygamy

Polygamous marriages are still being practiced among Tswana people, especially by those in high authority such as kings (*Dikgosi*). According to Nkomazana (2008), the ranking of wives in these kinds of marriages creates problems, especially concerning issues of inheritance and household properties when the husband is no longer alive. They also adhere to a saying, *"Monna ke selepe wa adingwana and monna poo ga agelwe lesaka",* which means that a man cannot be confined to one part, culturally permitted and expected. The first wife is even allowed to go look for him at a concubine's house or send the kids to look for him. This behaviour puts men at risk of acquiring sexually transmitted diseases because they sleep with wives of other men, with no guarantee of their fidelity.

It is clear from the above that polygamy impacts the rights of women and also oppresses them. Women have no control over the sexual behaviours of their partners, which is why they are at risk of being infected with HIV. Men in polygamous marriages may be a potential source of HIV transmission, especially if they reunite with their families after prolonged absences. HIV risky behaviours can also affect the lives of children, particularly those who are being breastfed. They can contract HIV from their mothers. Individuals in polygamous marriages

should take measures to protect themselves, for example using PrEP if the husband refuses to use a condom. It is recommended that polygamy be practiced in a way that will not affect the health of the other individuals.

2.2.5.3 Ancestral beliefs

The majority of people in South Africa believe that ancestors form an important and intrinsic part of their lives (Van Dyk, 2001). African people believe that some sicknesses are caused by ancestors if they want to show express anger. Some people practice "*Uku phahla*" which is used to worship and communicate with the spirits. Those who believe in ancestors usually perform these rituals when there is an illness. Sometimes, illness can be the cause of a lack of protection from ancestors (Van Dyk, 2001). Individuals who adhere to these beliefs may unknowingly transmit the virus to others, particularly through sexual intercourse and traditional healers who use blades and knives during rituals. Many people believe that illnesses are a form of punishment from ancestors, especially if they delay fulfilling certain rituals or obligations (Van Dyk, 2001). It is important for individuals to undergo testing and seek medical care at clinics when they feel unwell instead of depending solely on traditional beliefs. Health education programs should be prioritised in rural areas, especially where cultural practices are prevalent. According to Van Dyk (2001), individuals with ancestral beliefs may delay seeking medical attention because they perceive their illnesses as less serious due to their cultural beliefs.

Traditional healing practices may have a negative impact on HIV management because these people believe that HIV does not exist and instead attribute symptoms to an ancestral calling. The use of 'muthi' and herbs in these practices might delay individuals with HIV from seeking proper medical treatment. Consequently, this delay could also hinder HIV testing (Ndou-Mammbona, 2022). Additionally, traditional healers themselves may be at risk of HIV infection when performing procedures such as incisions due to the lack of proper equipment when treating clients. Addressing such healthcare gaps in rural areas is crucial and collaboration between trained healthcare workers and traditional healers is necessary to ensure timely access to healthcare services (Linganiso & Gwegweni, 2016:3). This highlights the importance of enhancing traditional healers' understanding of HIV management since their belief in their ability to cure HIV/AIDS demonstrates a lack of awareness in this regard.

2.2.6 Substance abuse

Another factor that may contribute to HIV/AIDS is the consumption of alcohol and drugs (Peltzer *et al.,* 2011:30). According to Fisher, Cook, Sam and Kapiga (2008:537), when alcohol is consumed in excessive amounts, it may affect one's ability to engage in safer sexual practices, for example using condoms in a correct and consistent manner. Individuals who may be at risk of acquiring HIV are those in Shebeens. Heavy drinkers may be more prone to engaging in unprotected sexual intercourse with multiple sexual partners while under the influence of alcohol, particularly in settings such as Shebeens (Carels, Florence, Adams & Savahl, 2023). Adolescents who use drugs are also at higher risk of engaging in risky sexual activities. Injection drug use is a significant contributor to HIV transmission, especially when individuals share syringes, needles and other injection equipment contaminated with the virus. The consumption of alcohol and drugs can impair judgement, leading to behaviours that increase the likelihood of acquiring ant transmitting HIV.

2.2.7 Lack of knowledge about HIV/AIDS

The majority of people in South Africa have heard about HIV/AIDS and have knowledge of the basic facts on how the virus is spread and how condoms reduce the spread of HIV/AIDS (Rose-Innes, 2006). However, according to Rose-Innes (2006), there are still people who lack accurate information on the topic, especially those living in rural areas with a low level of formal education. The majority of people in rural areas have a strong belief in myths putting them at risk of being infected with diseases. This includes the belief that a person can contract HIV by sharing food with someone who is HIV-positive, that people who are HIV-positive can be recognised by certain symptoms and that having sexual intercourse with a virgin can cure HIV (Rose-Innes, 2006). These kinds of beliefs can cause confusion and a high level of risk among members of the community (Rose-Innes, 2006). that the absence of human rights protection can significantly increase vulnerability to HIV, especially among women, MSM and young girls who lack awareness of their rights and capabilities. These individuals may be at heightened risk of HIV transmission due to their inability to exercise their social, cultural and civil rights. For example, women may struggle to negotiate condom use within their marriages due to unequal power dynamics. The societal marginalisation of women further exacerbates their vulnerability to HIV. Moreover, the lack of human rights protection contributes to the perpetuation of stigma and discrimination, especially in healthcare settings where individuals' rights are violated based on their HIV status.

2.2.8 Religion

Aspects of religion have also been considered as factors contributing to HIV/AIDS disclosure (Zou *et al.*, 2009). The majority of church members are scared to disclose their HIV status because they fear that they will be stigmatised and judged. They believe that, when someone is HIV positive, they must be punished because it is a sin (Trevino, Pargament, Cotton, Leonard, Hann, Caprini and Tsevat, 2010:379). Many church members believe that HIV/AIDS can be cured through prayer and there is no need to seek medical help, while others believe they need to consult a doctor. According to Pugh (2010:633), Christians believe that the use of condoms promotes promiscuity, which is not allowed, especially if you are married. It is believed that it promotes marital affairs and premarital sexual intercourse. The low rate of condom use in churches may contribute to the spread of HIV since some of the members might have partners who are not Christians.

Churches often attribute the spread of HIV to lose morals among their members, which may lead to secrecy within marriages regarding HIV. Churches may have an influence on the spread of HIV, as many newly developed churches claim they can cure HIV through prayer, thereby exposing the status of those who are HIV positive. Pastors and prophets may also deceive members telling them that God can heal their illness while doctors can only treat it. Thus, the majority fall for this and end up defaulting from their treatment or infecting their partners because they do not use condoms.

2.3 THEORETICAL FRAMEWORK

According to Vinz (2023), a theoretical framework is a foundational review of theories that serves as a guide in order to develop the argument that a researcher used in their study. The theoretical framework in this study was based on three theories, namely the Liberal Feminism Theory, the Constructivist Theory and the Social Cognitive Theory, to investigate and describe the role of culture, society, gender and economy in the spread of HIV among women and men. The researcher employed these theories as a framework to investigate social factors that contribute to the spread of HIV in Madidi Village, Bojanala district in North west province. The Social Cognitive and Constructivist Theories both explain how the researcher gathers and processes the information and knowledge. They are both theories of learning. Both theories illustrate that learning incorporates an individual as well as social aspects. In

both theories, an individual is considered as an active part in the process of learning and it is not shaped by only stimuli, reinforcement or receiving information.

2.3.1 Social Cognitive Theory

The researcher employed the Social Cognitive Theory of Bandura (1977), which explains that learning occurs within a social context, where individuals learn through observing other people's behaviours and attitudes. When people observe other people's behaviours, they tend to copy and absorb them as their own, putting them at risk. According to the Social Cognitive Theory, attention, memory, motor reproduction and motivation are important elements that facilitate behaviour change through observation (Bandura, 1991:309). They show that people can choose what to observe when they are paying attention, because not all the observations can bring change in their lives (Bandura, 1986:231). The Social Cognitive Theory focusses on the behaviour of humans as a continuous interaction between environment and behaviour determinants (Flores, 2014:1). A central tenet of the Social Cognitive Theory is self-efficacy, where individuals have a belief in their ability to achieve a goal. For example, men may know they can initiate condom use with their partners, but due to cultural norms, they choose not to, as they feel pressured to prove their manhood. Flores (2014:3) states that outcome expectations are the believed consequences of one's behaviour. For example, people who use drugs know if they stop sharing needles, it may prevent them from contracting HIV/AIDS and men who have multiple sexual partners may believe that, if they use condoms every time they have sexual intercourse, it may prevent them from spreading AIDS related diseases to their wives. People who lack self-efficacy may not manage situations in an effective way, even if they know what to do, because their doubts may stand in their way, overriding knowledge and protective actions (Flores, 2014:3). People who have knowledge about how HIV/AIDS is spread may still choose not to protect themselves because some believe that having sexual intercourse without a condom bring more pleasure. According to Redding (2000:180-193), even if people may acknowledge that safer sexual practices reduce the risks of one being infected by HIV, they may still choose not to protect themselves because they believe that they cannot control their sexual relations. The majority of people are influenced by culture, surroundings as well as social context.

According to Bandura (2001), people regulate their behaviours through control and reinforcement in order to achieve their goal. There are five constructs that underpin the Social Cognitive Theory, namely determinism, observational learning, reinforcement, expectations

and self-efficacy. The variable plays an important role in people's learned behaviours, for example young women may be determined to engage in risky sexual behaviour because of their expectations of a positive outcome such as money from older men who want to sleep with them. Therefore, any reinforcement agency like money results in them repeating their behaviour. Young women who receive money from their partners have their behaviour reinforced which increases the chances of them being determined and repeating it because the outcome makes them feel good.

This theory was deemed suitable for this study as it plays an important role in HIV/AIDS education and people's engagement with information. This is more important with individuals because they are often influenced by what others do regardless of the knowledge they have about HIV/AIDS. Individuals need to be exposed to positive models or information that will influence them to produce acceptable behaviours. This theory helped to guide the behaviour change interventions, especially in the rural area of Madidi Village, Bojanala district in North West province, while examining how individuals interact with their surroundings. This also helped to investigate individuals' experiences of learning about the social factors that contribute to HIV/AIDS.

2.3.2 Social Constructivist Theory

The researcher was also guided by the Social Constructivist Theory as a framework. According to Flores (2014:1), the Social Constructivist Theory holds that individuals' reality is actually a cultural worldview and it is developed through stereotyping. Social constructivist is how society groups individuals and how it privileges particular groups over others, for example people are told who they are and not who they choose to be. Flores (2014:1) further states that the way in which individuals associate socially and their perception of their roles as men and women are determined by behaviour that is socially acceptable. The majority of individuals are influenced by their cultures, the environment they live in and the social context. Traditional societies have strong cultural norms such as imbalances in gender relationships. Gender inequalities in marital relations, especially in sexual decision making, for example negotiating safer sexual intercourse, can increase the vulnerability of HIV risk or transmission. Women are often unable to protect themselves due to the imbalances of power within the relationship. New information plays an important role in imparting new beliefs and understanding in order to bring change in cultural beliefs. Strategies that highlight the dangers of male dominance over women need to be implemented. Additionally, information about the

advantages of equal social structures can lead people to reconstruct their realities. This can also help in changing the beliefs of certain cultures in a positive way and lead to the decrease of HIV spread (Nzewi, 2009:9).

Many traditional societies influence men to have multiple partners in order to prove their manhood, especially those who just came back from initiation schools and those who want to be in polygamous marriages. This undermines safe sex messages and also increase the spread of HIV (Nzewi, 2009:11). The society should be educated on the dangers of gender imbalances so that women can be able to stand for themselves. If people can change the norm that men are supposed to have more than one sexual partner to prove their manhood, this can help decrease the spread of HIV/AIDS. Men and women in rural areas should be empowered by new knowledge, especially about HIV/AIDS in order to decrease the HIV pandemic, New information means that they will be able to protect themselves and also teach the upcoming generation about the spread of HIV. This theory was deemed suitable for this study as it shows why people are behaving the way they are and why people practice cultural customs which is another factor that contributes towards the spread of HIV/AIDS. The reasoning for choosing this theory was to help the researcher to investigate the experiences through this theory as it explains human personal development, human learning and change in the society. The theory also posits that knowledge and truth are constructed through interactions among individuals in society. People create their own understanding or knowledge when they interact with others. Thus, people in the community may be easily influenced by others and may interpret events based on their existing knowledge or beliefs. The researcher employed this theory to investigate the influences of social factors contributing to the spread of HIV/AIDS as well as participants' own experiences and perceptions of the phenomenon under investigation.

2.3.3 The Trans-theoretical model and stages of change

According to Prochaska, James, DiClemente and Carlo (2005), trans-theoretical model of behaviour change is an integrative theory of therapy that assesses a person's readiness to act on a new healthy behaviour and provides strategies to guide an individual. These theorists believe that behavioural change is a process, hence they came up with five stages for behaviour change. In order for an individual to change their unhealthy behaviour they first need to go through pre-contemplating stage whereby an individual might not be aware of their problem or risky behaviour since they do not have information about what they are going

through, for example an individual might not see anything wrong about not using a condom since he is unaware of the consequences of not using protection. If HIV/AIDS campaigns aims at encouraging individuals about protective measures to take in order to protect themselves, the epidemic would reduce. If individuals could be aware of their problems or unhealthy actions, they will begin to contemplate and start to look for pros and cons of their actions and consider changing their risky behaviours. It is at this stage where people may consider taking protective measures. When an individual has identified the necessity to change, they will now prepare themselves (preparation stage) whereby they will intend to take action by taking steps towards behaviour change. Once an individual has taken action to modify their problem, they will strive to maintain it. In this case, HIV programs should keep encouraging individuals who has already started protecting themselves to continue doing so. These should include educating individuals of the harmful consequences of unhealthy practices, this include cultural practices that are performed that put people at risk of acquiring HIV. Awareness should be raised especially on men who play a dominant role in their relationships and marriages, who usually refuse to use condoms.

The researcher employed these theories since they play a pivotal role in planning and implementing campaigns strategies. They can be used to help campaign developers understand the nature of the targeted behaviour, suitable programs for the targeted individuals, and methods that can be used to accomplish change. Social cognitive theory can be used to assist community members in learning relevant information about HIV and actions to take when making such decisions about health challenges such as adherence. Community support groups could also use these theories to empower one another or those who are already HIV positive or those who are afraid of disclosing their status due to stigma and discrimination which could lead to ART adherence. The researcher hypothesized that these theories were suitable for this study, especially for HIV prevention and sharing HIV knowledge. Healthcare workers can use them to assist or educate patients about HIV prevention, especially on which actions to take when making decisions about the disease and its associated health challenges such as adherence. Social support groups for PLWHIV and those who are vulnerable should be implemented to teach about self-Stigma, HIV disclosure, gender equality and women empowerment; these could lead to a better society.

2.4 CONCLUSION

This chapter presented a review of the social factors that contribute to the spread of HIV/AIDS. Factors such as poverty, unemployment, illiteracy, stigma and discrimination, cultural practices, substance abuse, access to healthcare services, religion, privacy and anonymity and lack of knowledge on HIV/AIDS were looked at. If people were provided with information and support, adherence would be less of a problem. The chapter also discussed the theories that were chosen for the study and the viewpoints from different scholars were explained as well as how they interact with the study. In Chapter 3, a detailed process of the research methodology is discussed as well as how the methods helped the researcher to gather data from the participants.

CHAPTER THREE: METHODOLOGY

3.1 INTRODUCTION

This chapter focusses on the research methods and design used in order to conduct the research. A qualitative exploratory design was used in this study. Semi-structured, one-on-one interviews with a schedule guide was conducted in order to assist the researcher with understanding, exploring and determining the social factors that contribute to the spread of HIV/AIDS in Madidi Village, Bojanala District in North West Province. The chapter also describes the research design, sample and sampling techniques, population, data collection, data collection instruments, data collection process, data analysis and ethical considerations adopted by the researcher while conducting the research.

3.2 STUDY PARADIGM

Research paradigm is a philosophical framework that a researcher uses based on their study. It has a pattern of beliefs and understanding from which the research project operates (Proofed, 2022:1). Paradigm is a way of viewing the world. Ideas are used in order to understand and explain something which is related to the subject that is being studied (Proofed, 2022). According to Patel (2015), the constructivist paradigm is associated with the qualitative research approach because it seeks to understand the topic that is being studied using data collection agents and techniques. The researcher used this paradigm in order to construct the meaning of the topic under investigation through the experiences of the people taking part in the study. The researcher used this paradigm in order to evaluate what the participants said to discover facts. According to Adom, Yeboah & Ankrah (2016) constructivist paradigm is used to underpin researchers who want to understand how individuals make sense of their lives where they live or work. In this study, the researcher wanted to understand which lifestyles of the participants from Madidi Village, Bojanala District in the North West Province put them at risk of acquiring HIV and which social factors affect their wellbeing.

3.3 STUDY METHODOLOGY

Methodology is an articulated theoretical approach to produce data, for example how data is collected and the process of analysing it. It is mainly concerned about how the researcher conducts the research project and demonstrates all the findings in a truthful and valid way

(Proofed, 2022). In this study, the researcher discusses the methods used when collecting and analysing data. A qualitative approach was deemed suitable for this research as the purpose was to investigate social factors responsible for the spread of HIV/AIDS in Madidi Village in Bojanala District. The researcher chose a qualitative approach because she was motivated by the nature of the objectives and the purpose of this research. According to White (2004:17), when studying people qualitatively, it allows the researcher to get to know them personally and understand their experiences. Therefore, the purpose of using this approach was to investigate and describe the experiences of people living in Madidi Village, Bojanala District in North West Province regarding the social factors that contribute to the spread of HIV. Using a qualitative approach also allowed the researcher to gain a better understanding of the participants through interviews and to build rapport. Collecting data in a natural setting is perceived as an advantage for qualitative research because it helps to provide an understanding and description of an individual's personal experiences of the chosen topic.

3.3.1 Study design

According to Burns and Grové (2011:319), a study design is a blueprint for conducting a study and includes methods for maximising control over factors that might cause interference with trustworthiness, validation and reliability of the study and how the researcher implemented the study. According to Gioia *et al.* (2013:1), a qualitative research approach provides a deeper understanding of the social phenomenon. The authors also indicated that it explores the attitudes, behaviours and experiences of participants through open–ended face-to-face interviews. The researcher employed this study design to investigate and gain a deeper understanding of the social factors that contribute to the spread of HIV/AIDS in Madidi village, Bojanala District in North West Province.

A qualitative approach also helps the researcher to collect rich descriptive information in order to develop an understanding of a particular phenomenon (Nieuwenhuis, 2007:147). In this study, qualitative research allowed the researcher to obtain the voices and commitments of the participants and to investigate in more depth their experiences and feelings. The data collection method and study design used in this study were based on the objectives that intended to investigate the social factors that contribute to the spread of HIV in Madidi Village, Bojanala District in North West Province.

3.4 DATA COLLECTION TECHNIQUES

Authorisation- Before the researcher could conduct the interviews in Madidi Village, Bojanala District in North West province, permission was obtained from the community leader, Mr Sefike, who is the ward councillor of Madidi Village, Bojanala District in North West ward number 3 (see appendix 3). The researcher also received permission to conduct the study from the Ethics Committee of the College of Human Science at UNISA (see appendix 4).

Data collection is a process of gathering information from the participants selected for the study through interview, observation, document review and visual data analysis (Polit & Beck, 2012:52). Data collection may also refer to the techniques and procedures that are used, the measuring instruments that must be utilised and the activities to be conducted in developing a study (Grinnell, 2013:276). Perez *et al.* (2015:1205) indicate that a qualitative design explores the attitudes, experiences and behaviours of participants through open-ended and face-to-face interviews. For this study, the researcher developed an interview guide that was used to collect data and open-ended interview questions were formulated in order to gain more information about the views of the participants. The guide was written in English and where the participants were unable to understand, the researcher explained in more detail. All interviews were conducted in English. The researcher used open-ended questions during the interview sessions to enable participants to speak openly and freely in order to give detailed descriptions of the social factors that contribute to the spread of HIV/AIDS in Madidi Village, Bojanala District in North West Province. Semi-structured interviews were utilised as a data gathering technique (see Appendix 1) in order to gather and gain deeper responses and additional information from the participants. The interview design was suitable for this study because it permitted a focussed investigation of the topic and also allowed the researcher to take note of non-verbal cues which were valuable for interpreting the participants' feelings towards questions and the responses they gave. According to Irvine *et al.* (2013:87), an interview schedule is a list of written questions, either open or closed-ended which are prepared by the researcher to interact with participants. The researcher used a tape recorder to record all the interviews that took place, with the permission of the participants.

In this study, the researcher used face-to-face interviews as a method of collecting data in order to give the researcher the opportunity to observe non-verbal behaviours of participants. The interviews were conversational whereby the objectives of the study were achieved. The

researcher employed semi-structured interviews in order to elicit the viewpoints of the participants for qualitative analysis. This was also used to see the world through the eyes of the participants in order to gain a rich knowledge and the opinions of the participants. Each interview session lasted an hour because the interviewer wanted to cover everything. Interviews were conducted at the Madidi community hall number 15. The setting provided a private and comfortable environment for all 12 participants. Each interview was scheduled for a particular day and time to avoid waiting long for others while being interviewed. Data collection was carried out from the 11th November 2023 till the 23rd November 2023.

3.4.1 Instrumentation

In this section, the researcher described the development of the research instruments, which is the interview schedule for the participants.

Development of the interview schedule

The researcher developed questions that focussed on the objectives and questions of the study. The first draft of the interview schedule was submitted to the supervisor for comments and the comments resulted in a final interview schedule. The researcher developed an informed consent form which was attached to the interview schedule (see Appendix 5). In the interview schedule, open-ended questions were included to allow participants' own views to be expressed freely. Open-ended questions also allow participants to provide more details on the given topic. The interview schedule consisted of three sections: demographic information of participants, questions related to the social factors that contribute to the spread of HIV/AIDS in Madidi Village, Bojanala district in North West province and questions related to their experiences.

Section A: Demographic information

In this section, the researcher wanted to obtain and establish the background information of the participants, for example race, marital status, occupation, age, number of family members, educational background, home language and ethnic group. This was to ensure that they match the criteria.

Section B: Questions of social factors contributing to HIV/AIDS

In this section, the researcher wanted to obtain participants' knowledge about social factors that contribute to the spread of HIV/AIDS. This was assessed using questions that were developed in the interview guide (see Appendix 1). The researcher asked questions about the effect of social factors on the spread of HIV/AIDS and how they affect the community.

Section C: Vulnerability of men and women on HIV/AIDS

In this section, the researcher wanted to gain a deeper understanding of the experiences of the participants. The researcher asked questions pertaining to whether there was any information available about individuals' personal experiences concerning the issue of social factors contributing to the spread of HIV/AIDS.

3.4.2 Interview phase

The interview phase is when the actual data collection takes place. Participants who had agreed to take part in the study were visited at the predetermined venue which is Madidi Hall number 15. Each participant was scheduled to attend at a particular day and time to avoid making others wait. The interviews started at 10am and each interview session lasted for an hour. Before the interview started the researcher introduced herself, then read and explained the research ethics which were written in a leaflet. The researcher explained how the interview would take place and emphasised the issues of voluntary participations and the right to withdraw at any time. The participants were also informed about the topic of the research. Potential participants must be well informed about what the study entails in order for them to make fair judgement and informed decisions about taking part (Manti & Licari, 2018). In line with this, each participant was given a detailed participant leaflet (see Appendix 7). The participant leaflet contained information about the aim of the researcher, the nature of their involvement, what was going to happen with the data they shared, risks and benefits and confidentiality measures that would be taken. The information sheet contained a statement that informed the participants that the findings would be made available to them upon request. The information sheet also included the contact details of the study supervisor and the email from the Humanities and Social Science Research Ethics Committee in case the participants had any queries and complaints. The participants were also asked to sign the consent forms (see Appendix 5) to ensure that they fully agreed taking part in the research.

Participants were given an opportunity to ask questions before the interview started and also during the interview process if they needed something to be explained. For data collection, the researcher used an in-depth interview process as stated in the data collection techniques section. Interviews were conducted in English and where the participants did not understand, the researcher explained. This was to ensure that participants understood the questions and felt free to express their views. The researcher used follow-up questions in the form of probing in order to ensure that participants gave detailed information. According to Grové (2015:509), probing is used to obtain rich information by asking questions to make the participants elaborate further on what is being discussed. This process was done until the participants were able to give enough information regarding the social factors that contribute to the spread of HIV/AIDS in Madidi Village, Bojanala District in North West province. All the information produced was recorded during the study. The researcher asked the participants permission to record them before the she could start with the questions and permission was granted. The researcher took field notes while she was busy with the interviews in order to jot down the kind of language and behaviours of the participants. This was done in order to gain a deeper understanding of how they felt about the topic that was being discussed. Field notes are written accounts of the things a researcher hears, experiences and sees while collecting data or conducting interviews (Schwandt & Thomas, 2015).

3.4.3 Probing

According to Polit and Beck (2017:407), probing is a technique used by the interviewer in order to obtain extensive information from the participants to enable them to elaborate more on the topic that has been chosen for the study. In most cases, probing is described as asking follow-up questions, especially if the researcher does not fully understand the responses or when they want to obtain more specific information. According to De Jonckheere and Vaughn (2019:6), non-verbal communication such as body language, gestures or verbal communication are also used in probing. In this study, the research prompted the participants by asking them follow-up questions about the social factors contributing to the spread of HIV in their community so that they could prove and explain their views, opinions and experiences about the topic. In order to investigate and bring out rich information during interviews, the researcher used probing questions.

3.5 THE STUDY SETTING

Research setting is the place where the study is taking place (Polit & Beck, 2012:40). This study was conducted at Madidi Village, Bojanala District in North West province. Madidi is a rural area situated in the North West Province. The area compromises 2288 households with an estimated density of 219,99per km^2 (Census, 2011). The area has one clinic providing healthcare services but it does not operate 24 hours. There is also a skill centre called the Good Shepherd which offers training and courses for those who cannot afford to go to Universities. The centre also offers counselling services for victims of abuse and drug and alcohol addiction. The place was chosen because the researcher has an interest in knowing more about the people living there, what knowledge they have about HIV/AIDS and what their opinions are of how it is spread. The researcher is also familiar with the area and the language they speak in the community. This community comprises Tswana, Pedi, Tsonga and Zimbabwean individuals, with the majority being Tswana. Many of the residents are engaged in farming activities.

3.6 POPULATION

According to Babbie (2016:16) a population is a specific, accessible subset from which a sample is actually taken, while a target population is a larger group to whom research findings are meant to be applied. The population criteria established the target population. That is, the entire set of cases about which researcher wanted to make general who met the sampling criteria (Burns & Grove 2005:342). The study population included 12 participants for reaching data saturation, both female and male (nurses, a doctor, community health worker, community members who are employed and unemployed) between the ages of 18-49 from Madidi Village, Bojanala District in North West Province, who have a general understanding and information about the social factors that contribute to the spread of HIV/AIDS since they work in healthcare facilities and are familiar with HIV/AIDS. According to the Census data of 2011, the population of Madidi is 10 680, with the majority being females. The study population consisted of Tswana people since it is the dominating language in the community and the study included participants who are black South African citizens and older than 18 years. Because of the researcher's familiarity with the site, it was a rational choice to conduct research there. In addition, the researcher is familiar with the language that is spoken in the area as well as cultural and religious beliefs in this community which made it easier for her to obtain access to conduct research.

3.7 SAMPLING METHOD

In research there are two types of sampling designs, namely probability sampling and non-probability sampling. Probability sampling refers to the selection of a sample from the population and it utilises a random selection (Fleetwood, 2018). Non-probability sampling cannot estimate the probability that each element will be included; they are selected non-randomly (Polit & Beck, 2012:215). For this study, a non-probability purposive sampling method was used in order to target the participants. Non-probability purposive sampling is used to select a specific group of individuals who may not fully represent the broader population but possess characteristics of interest to the researcher (Cohen *et al*., 2007:113). The researcher used purposive sampling techniques since it was appropriate and relevant for the study and it increased the usefulness of the data acquired from the participants.

The selected sample met the inclusion criteria specified by the researcher, ensuring that eligible participants were included in the study.

Inclusion criteria

- Participants living in Madidi village, Bojanala district in North West province
- Black African participants from the Tswana culture
- Nurses, doctor and HIV/AIDS Counsellor having knowledge about social factors that contribute to the spread of HIV/AIDS, Healthcare workers e.g. HIV/AIDS Counsellor
- Unemployed and employed community adults who have knowledge about HIV/AIDS
- Males and Females between the ages of 18-49 years' old
- Participant who give consent to participate in the study

Exclusion criteria

- Anyone who does not live in Madidi village, Bojanala district in North West province
- Anyone who is not Black African from Tswana culture
- Any male or female below 18 years' old and older than 49 years' old
- Participant who does not give consent to participate in the study

In the next paragraph, the researcher discusses how purposive sampling was used.

3.7.1 Purposive sampling

Purposive sampling, which is also known as judgemental, selective or subjective sampling is a form of non-probability sampling whereby a researcher relies on their own judgement when selecting participants who are suitable for the study and the topic (Alchemer, 2021:1). To reach the sample, the researcher wrote a letter to the Councillor of Madidi Village, Bojanala district in North West province to seek permission to conduct the study research (see Appendix 2). After the permission was granted, the researcher started making arrangements with the prospective participants to check which days will be suitable for them to be interviewed. The sample compromised of 6 men and 6 women between the ages of 18-49 years in Madidi Village, Bojanala District in North West province. The study criteria included people who originate from Madidi, had knowledge about HIV/AIDS within the area and knowledge about social factors that contribute to the spread of HIV/AIDS. The researcher chose people who were willing to take part in the study and who met the criteria of the study. The study also included both employed and unemployed participants, single and married. The reason for choosing this age group was because they had experience of social factors that contribute to the spread of HIV/AIDS since the majority work in healthcare facilities. The researcher chose them so they can share their opinions and experiences on how these social factors have influenced some of their family members and also people around them in the Madidi community as well as in their work places.

3.7.2 Sampling size

According to Lewis and Ritchie (2003:1), the sample size in qualitative research tends to be small in order to support the in-depth, case-oriented analysis that is fundamental to this mode of inquiry. In this study, a small sample size was chosen for the interviews. Participants were selected in order to avoid generating mountains of interview data. The sampling size consisted of 12 participants from Madidi Village, Bojanala District in North West Province. The researcher choose 12 participants by means of approaching some of the community members and explained the purpose of the study and asked them if they had knowledge of HIV/AIDS and social factors responsible for HIV/AIDS spread. The researcher also asked the participants if they would like to take part in the study and some volunteered especially those who met the criteria of the study. Some of the community members referred the researcher to other health workers who might meet the study criteria, until the researcher reached the desired number of participants (12 participants).

3.8 DATA ANALYSIS

According to Burns and Grové (2011:94) and Polit and Beck (2012:52), data analysis is a technique used to organise, reduce and give meaning to the data that has been collected. Data analysis includes the breaking down of collected data into smaller units by coding and naming the units accordingly (Vaismoradi, Jones, Turunen and Snelgrove, 2016:102). When analysing data, the researcher needs to keep in mind the different approaches of thematic analysis (Javadi & Zarea, 2016:34-40). The process outlined by Maguire and Delahunt (2017:3354) for thematic analysis involves six key steps, which are followed sequentially:

1. Becoming familiar with data: This involves immersing oneself in the data to gain a thorough understanding of its content and context.
2. Generating codes: The researcher identifies and labels meaningful units within the data, which will serve as the basis for further analysis.
3. Looking for themes: Patterns or recurring topics within the data are identified, forming the basis for thematic analysis.
4. Reviewing themes: The identified themes are reviewed and refined to ensure accuracy and relevance.
5. Defining themes: Each theme is clearly defined and described, providing a framework for interpretation.
6. Writing a report: Finally, the findings of the analysis are synthesised and presented in a comprehensive report, which includes extracts from the data, alignment with research objectives and questions, and integration with existing literature.

In step one, the researcher applied Tesch's analysis method to analyse the data. This involved listening to recordings, transcribing them verbatim and ensuring validity by comparing the audio with the transcripts. In this study, the researcher used manual technique to transcribe data into verbatim to ensure accuracy and deep engagement with data produced.

In step two, data organisation was conducted systematically, with manual coding using Microsoft Word to highlight important words and sentences. According to Maguire and Delahunt (2017:3355), coding serves to condense large amounts of data into more manageable units.

In the third step, the researcher checked for themes, which are essential for providing qualitative research findings. Themes capture significant data and facts relevant to addressing the research questions. In this study, the researcher established a relationship between themes, sub-themes and codes based on the research questions and objectives.

After organising codes into themes, the researcher reviewed the data, modifying themes as needed by separating, combining, refining or discarding them. It is crucial, according to Maguire and Delahunt (2017:3358), that all data are linked meaningfully to the research questions.

Subsequently, the researcher read and linked codes with themes, defining and refining them to identify their significance.

Finally, a report was written, incorporating exact extracts from transcriptions that correlated with themes, objectives, questions and existing literature.

Throughout this study, all six steps of thematic analysis were utilised, with coding and thematic analysis serving as tools for interpreting and analysing results. To ensure confidentiality, interview recordings were named using codes instead of participants' names and all data were securely stored at home with password protection, facilitating quick retrieval when needed.

3.9 ENSURING RIGOR

According to Geissbuhler, Safran and Buchan (2013:1), trustworthiness in research is crucial for demonstrating the rigor of qualitative research. In this study, establishing trust with participants, particularly those selected, was essential to gaining a deep understanding of their perspectives. Trustworthiness ensures the accuracy and reliability of data collection processes. To enhance trustworthiness in this study, various techniques were employed, including taking notes (field notes), probing for further information during interviews and using a tape recorder to capture detailed responses.

Participants were encouraged to express their views openly without fear of judgment. Before proceeding with thematic analysis, the researcher undertook the combined process of translating and transcribing the data collected from the participants. This comprehensive approach ensured that the data were accurately captured and ready for n-depth analysis.

3.9.1 Credibility

In this study, research credibility was ensured by investing more time in the field and engaging more with participants in order to develop trust. Each interview session lasted for an hour since the researcher wanted to ensure that everything was covered and the data produced were valid and corresponded. The researcher also ensured that triangulation of data collection tools was achieved during every session of the interview by taking field notes and recording all the interviews using a tape recorder. Observation notes were also taken to ensure the triangulation of data sources. Probing, listening to participants and reflective summary were used while conducting semi-structured interviews in order to obtain more information and to ensure that data gathered reflected information of those who were taking part in this study.

3.9.2 Transformability

According to Brink, Van der Walt and Van Rensburg (2018:159), transferability refers to the ability to apply findings from one context to another. In this study, the researcher ensured transferability through thick description of research methods. The researcher employed purposive sampling to recruit/select participants for semi-structured interviews.

3.9.3 Confirmability

According to Creswel and Poth (2018:256), confirmability is ensured to verify that the results presented and analysed accurately reflect the perspectives of the participants. The researcher confirmed the information and the recordings, which could be listened to more than once, assisted her. Confirmability was enhanced through recordings, follow-up questions and probing.

3.10 ETHICAL CONSIDERATION

Research ethics are a set of written or unwritten rules that governs how scientific and other research is conducted or performed. These rules set out how we expect participants to behave while taking part in the study and also how a researcher should treat participant (Resnick,2015). The purpose of research ethics is to promote the aims of the study that is being conducted and to support values such as confidentiality, mutual respect for others and fairness (Resnick, 2015). Research ethics ensures that participants can trust both the

research and the researcher involved (Resnick, 2015). It comprises of certain codes of conduct designed for gathering data, analysing, reporting and publishing information produced by participants regarding the research topic. This includes actively respecting participants' rights to privacy, confidentiality and consent (InnovateMR, 2023).

3.10.1 Confidentiality

Every researcher should respect the right to confidentiality of the participants involved in the study (Burn & Grové, 2008:38). Confidentiality, as an ethical principle, safeguards personal information and sensitive data generated during the study. According to Johnson *et al.* (2012:116), confidentiality involves not disclosing participants' identity to anyone other than the researcher and the supervisor of the module. Data that is produced should only be shared with the supervisor and kept safe and anonymous.

In this study, the researcher ensured confidentiality by informing participants that their contributions would remain confidential and their identities anonymous. The participants were instructed not to disclose their real names during recordings to protect their anonymity. The researcher assigned codes to recordings instead of using participants' names to further ensure confidentiality. Throughout the study, confidentiality and protection from invasion were prioritised.

3.10.2 Honesty

Researchers must always provide participants with a clear explanation of the aim and purpose of the study, avoiding any form of deception. It is crucial to ensure honesty without misrepresenting the nature or objectives of the research (Denzin, 2005:140). Brink (2018:36) asserts that falsification and fabrication of data should never occur during research.

In this study, the researcher upheld these principles by avoiding fabrication and misleading participants. All participants were provided with honest explanations of the study's procedures and objectives. No participant was deceived for the benefit of the researcher.

3.10.3 Protection from harm

Research should never expose participants to undue physical or emotional harm, whether during interviews or afterward. Avoiding harm is a fundamental human right that must be

upheld in research studies (McMillan & Schumacher, 2006:377). Participants should not be subjected to unnecessary risks of harm and discomfort.

In this study, participants were safeguarded from physical and psychological harm, including emotional stress, embarrassment, negative labelling or anger towards them, which could affect their dignity. If a participant experienced any harm during the interviews, the researcher committed to reporting the incident to the University CREC of UNISA for investigation and appropriate action, including referral for counselling. Participants were assured that their identities would remain confidential to preserve their dignity.

3.10.4 Right to anonymity

It is the responsibility of researchers to uphold the rights to anonymity of participants taking part in their studies. Researchers must ensure that privacy is maintained throughout the study by refraining from including participants' names or identities (Burns & Grové, 2011:114). Anonymity is particularly crucial in qualitative study, as it encourages participants to freely disclose information, including their deepest secrets (Burns & Grové, 2005:188). Descriptions of information were not linked to individual participants; instead, pseudonyms were used in this study.

Tjale and Villiers (2004:260) emphasise that confidentiality, anonymity and privacy should be carefully considered when conducting qualitative research, especially regarding publication.

3.10.5 Informed consent

When supplied with enough information, participants must be asked to provide signed consent to demonstrate their agreement to take part in the study. According to Porter (2012), informed consent is an agreement to participate in the study after being informed about its purpose, procedures, benefits, risks and the limits of confidentiality. Participation in the study should be voluntary, allowing participants to choose whether they wish to take part or not (American psychological Association, 2017). Participants should also be informed that they can withdraw at any time after receiving full information about the study's nature, risks and benefits (American psychological Association, 2017).

In this study, participants were fully informed about the rationale and nature of the research and were given the opportunity to decide whether to continue. Informed consent forms (see

Appendix 5) were provided to participants, written in English. Informed consent ensures that participants have sufficient information about the study, can understand it and have the freedom to choose whether to participate or not (Cohen, Manion and Marrison, 2007). Every participant was asked to sign the informed consent and the researcher ensured that safety and privacy of the consent forms.

3.10.6 Right to fair treatment

Participants should be selected for the study based solely on the requirements outlined by the research protocol, rather than being chosen due to vulnerability (Burns & Grové, 2007:118). Every participant should be treated equally, without any favouritism.

In this study, all participants were treated fairly and with respect, regardless of their age or background and no penalties were imposed. The researcher demonstrated sensitivity and respect for everyone's beliefs and norms.

3.11 CONCLUSION

This chapter addressed the methods used to recruit the participants and collect data from them. An explorative qualitative research design was used to investigate the social factors contributing to the spread of HIV/AIDS. The researcher also discussed gaining access to Madidi Village, Bojanala district in North West province and outlined the steps taken to obtain ethical approval from the Human Sciences Research Ethics Committee at UNISA. Trustworthiness and other ethical procedures were carefully considered during the interview process with participants. In the next chapter, the findings from the conducted interviews are presented.

CHAPTER 4: FINDINGS

4.1 INTRODUCTION

This chapter presents the findings derived from qualitative data collected during interviews. The data analysis of the collected data, along with discussions related to the study's objectives and is presented. The questionnaire had three sections, namely: demographic information of 12 participants, knowledge about social factors that contribute to HIV/AIDS and experiences and views about HIV/AIDS (please see Appendix 1 for the interview guide for the participants). The researcher used codes instead of the names of the participant and each code was assigned to a specific participant according to the sequence of the interview (please see the codes below):

Participant codes:

FCM1: Female community member 1

MCM1: Male community member 1

MCM2: Male community member 2

MCM3: Male community member 3

FN1: Female nurse 1

FC1: Female counsellor 1

FN2: Female nurse 2

MN1: Male nurse 1

FN3: Female nurse 3

FN4: Female nurse 4

MCM4: Male community member 4

MMP1: Male Medical practitioner

4.2 CHARACTERISTICS OF THE PARTICIPANTS

Table 4. 1: Demographic information of participants

Participants	Age	Gender	Marital status	Occupation	Ethnic group	Level of education	Race no of family members
FCM1	32	Female	S ingle	Unemployed	B	Matric	2
MCM1	30	Male	single	Taxi driver	B	Matric	3 own 5 home
MCM2	29	Male	Single	Unemployed Student	B	Matric	4
MCM3	31	Male	Single	Quality specialist in the automotive industry	B	Diploma	8
FN1	39	Female	Single	Nurse	B	Diploma	3
FC1	25	Female	Single	HIV Counsellor	B	HIV testing & counselling certificate and matric	5
FN2	29	Female	Single	Nurse	B	Diploma	4
MN1	34	Male	Single	Male nurse	B	B-tech in nursing science & B-tech occupational health	4
FN3	48	Female	Married	Professional nurse	B	Diploma in general nursing	6
FN4	42	Female	Married	Nurse educator	B	Degree in nursing education and admin	5
MCM4	18	Male	Single	unemployed	B	Matric	3
MMP1	36	Male	Married	Medical practitioner	B	Post graduate	5

The table above provides detailed information about the participants in the study, while the tables below present a summary of the information presented in the aforementioned table.

Table 4. 2: Age of participants (n=12)

AGE	Frequency	Percentage

18	1	8
19-25	1	8
26-30	3	25
31-35	3	25
36-40	2	17
41-49	2	17
Total	12	100%

The table above displays the ages of participants from Madidi Village, Bojanala district in North West province. A significant portion of the study participants fell within the age range of 26-30, constituting 25% of the total. Another 25% belonged to the age group of 31-35. Participants aged 18 and below accounted for 8%, while those in the 19-25 range also represented 8%. Notably, individuals between 41 and 49 years old and 36-40 comprised 17% of the participants. Therefore, the researcher successfully included individuals across the age range of 18-49, as specified in the criteria.

Table 4. 3: Gender of participants (n=12)

Gender	**Frequency**	**Percentage**
Male	6	50%
Female	6	50%
Total	**12**	**100%**

The above table indicates that 50% of the participants were males and the other 50% were females. The researcher opted for a balanced representation of both females and males in the study. This decision stemmed from the interest in exploring the equal impact of social factors contributing to the spread of HIV/AIDS on both genders. The aim was to determine which gender is more affected or vulnerable in the community. Choosing a balanced representation helped avoid any potential bias toward either gender.

Table 4. 4: Marital status of the participants (n=12)

Marital status	Frequency	Percentage
Single	9	75
Married	3	25
Divorced	0	0

Total	12	100%

The table above shows the marital status of participants in the study. Nine (75%) participants indicated that they were still single while three (25%) were married. In this study, none of the participants were divorced. The reason for asking the participants about their marital status was that the researcher wanted to determine how many were married and how many were not ready to be in a committed relationship.

Table 4. 5: Educational level of participants (n=12)

Level of education	Frequency	Percentage
Primary	0	0%
secondary	0	0%
High school	3	25%
Tertiary	8	75%
total	12	100%

The participants in the study possessed a high school matriculation (indicating completion of high school). Of these, 25% had matric only while 75% pursued further education at universities or colleges to acquire qualifications. The data indicates that participants, having attained at least a high school matric, demonstrated the ability to read, write and understand the importance of HIV/AIDS prevention. The table also reveals that those with tertiary education, particularly healthcare workers, exhibited higher knowledge levels regarding HIV/AIDS. The researcher aimed to assess participants' educational backgrounds to gauge their literacy and understanding of the topic.

Table 4. 6: Ethnic group of participants in the study (n=12)

Ethnic group	**Frequency**	**Percentage**
African	12	100%
White	0	0
Coloured	0	0
Asian	0	0
Total	12	100

The table above shows the ethnic groups of participants that took part in the study. All the participants in the study were African, because the researcher included in the criteria that only African Tswana people would be interviewed.

Table 4. 7: Occupation of participants (n=12)

Occupation	Frequency	Percentage
Unemployed	2	17%
Self employed	0	0%
Employed	10	83%
Total	12	100%

The table above shows the number of participants that were unemployed, employed and self-employed in the study. Two participants mentioned that they were unemployed, while 10 were employed. None of the participants were self-employed. This was also assessed in order to determine what the rate of unemployment in the community was as well as the economic status.

Table 4. 8: Number of family members (n=12)

Number of family members	**Frequency**	**Percentage**
1-3	4	33%
4-7	7	58%
8-11	1	8%
Total	12	100%

The table above shows the number of family members from each participant's household.

Table 4. 9: Home language (n=12)

Language	**Frequency**	**Percentage**
Setswana	12	100%
Zulu	0	0
Tsonga	0	0
Pedi	0	0
Total	12	100%

The table above shows the home language of participants in the study. All the participants (100%) were Tswana speaking people because the researcher indicated that the criteria would involve Tswana people with some knowledge about cultural practices.

4.3 DATA ANALYSIS

In this study, the researcher analysed data whereby she listened to the recordings and then transcribed everything that the participants had said. Two main themes emerged during the interviews. The findings of the study are presented under these two themes:

- Theme1: Social factors that contribute to HIV/AIDS in Madidi Village, Bojanala district in North west province.
- Theme2: The vulnerability of men and women to HIV/AIDS in Madidi Village, Bojanala district in North west province.

4.3.1 Theme1: Social factors that contribute to HIV/AIDS in Madidi Village, Bojanala District in North West province.

The participants in this study were asked about their understanding of HIV/AIDS and how it is transmitted on subtheme 1. This was to test the level knowledge of HIV individuals have in the community

4.3.1.1 Subtheme 1: Understanding of HIV/AIDS and transmission

Understanding what HIV/AIDS is, is crucial so that people can know how to prevent themselves from being infected. When a person is well-informed, it is easier for them to engage in preventive behaviours compared to those who have no knowledge at all. Consequently, the participants were asked about their understanding of HIV and how it is transmitted. The following are the responses from the participants:

FCM1 *"My understanding… HIV is a virus that causes AIDS, it is a fragile virus and it does not survive outside the the body for long... it is transmitted through unprotected sex, blood, semen, vaginal fluid, breast milk, if the mother is positive from the virus."* (Participant 1)

FCM1 explained what HIV is and how it can be transmitted from one person to the other. It is evident that the participant has knowledge about the transmission of HIV and what it is because she was able to define it and name the modes of transmission.

MCM1 *"Ok according to my understanding, HIV/AIDS it's a disease whereby so far we do not have a cure for it, and what we are using currently is measures…I would call it...uhm... how do I put it? Uhm...it has no cure but it can …uhm.reduce or …I don't know which other words I should use beside…how can I put it? It's not, we do not have a cure, but we have a way of preventing it, that is how I understand HIV... and transmission is through contact between the infected blood and uninfected blood, and also other body fluids, so mostly it is transferred sexually." (*Participant 2)

The submission from MCM1 suggests that he is aware that HIV/AIDS cannot be cured and that it is transmitted through unprotected sexual intercourse and through being in contact with a person that is already infected. This shows that MCM1 is aware of how one can acquire HIV, even though he did not explain what HIV is. His level of knowledge proves that he knows that it can only be prevented not cured.

MCM2 *"My understanding about HIV/AIDS is that is very dangerous and is that is affecting many people in our community. And how is transmitted is that is through unprotected sex and sharing certain stuff like Colgate and other stuff." (Participant 3)*

The submission from MCM2 suggests that unprotected sexual contact is the most common way of becoming infected with HIV/AIDS. He also mentioned other possible ways to become infected such as sharing Colgate. The participant brought up the issue of Colgate which has not been scientifically proven to be a transmitter of HIV. He also mentioned that the virus can spread through other things but he did not say what things. The participant seems to be unsure or unaware of other ways the virus can spread.

MCM3 *"Well what I understand is that HIV/AIDS is transmitted through blood, so it can be transmitted via cuts, if you have cuts... the most common one is through sexual activities, if you sleep with someone who is HIV positive and you are not using a condom… apparently there's pills like…I forgot their names…that can help you so you can sleep with someone who is negative and they are positive but you don't get the HIV, I forgot the name of the pill." (Participant 4)*

The submissions from MCM3 suggest that he is aware of the modes of HIV transmission because he mentioned that one can get HIV through cuts and unprotected sexual intercourse. He also indicated that there are pills that can prevent one from contracting HIV/AIDS. Thus,

this shows that the participant has knowledge about the transmission as well as prevention strategies that he can apply to protect himself. It is also shown that MCM3 is well informed about how PrEP works and who can use it, especially by mentioning that one can use it if one partner is positive and the other is negative.

FN1 *"Eer my understanding is eehh...AIDS is the actually a sickness that is caused by being Sexually engaged with multiple partners, that is how uhm...HIV can be transmitted from one person to the other, but it can also uhm... be through the drug abuse or substance abuse rather because if we..if I say drug abuse it simply says now I am excluding other factors that will be contributing to the transmission of the disease." (Participant 5)*

The submission from FN1 suggests that AIDS is a sickness and people who engage in sexual intercourse with multiple partners can be at risk of contracting it. She further explained the social factors that can contribute to HIV by saying one can acquire it through substance abuse when using drugs. FN1 did not explain her statements further.

FC1 *"HIV stands for Human Immune Virus which attacks the immune system that helps fight the infections and AIDS stands for Acquired Immune Deficiency Syndrome. Which is the late stage of HIV that damages the immune system." (Participant 6)*

FC1*" It is transmitted when someone has…uhm is having unprotected sex or has multiple, has sex with multiple partners." (Participant 6)*

The submissions from FC1 suggest that HIV attacks the immune system which helps to fight infections. She further explained the modes of transmission such as unprotected sexual intercourse and having multiple sexual partners. This indicates that FC1 has knowledge of how people can acquire HIV.

FN2 *"HIV is uhm Human Immuno-Deficiency Virus that is transferred through unprotected sexual intercourse, being in contact with blood of a person that is infected with HIV meanwhile having cuts on your hand or body." (Participant 7)*

The submission from FN2 suggests that HIV can be transmitted through unprotected sexual intercourse and being in contact with blood. FN2 stated that being in contact with a person who is already infected increases the chances of one being infected, especially if they have cuts on their body or hands. This is indicative that, not using condoms during sexual

intercourse, may increase the chances of one getting infected with HIV. Furthermore, not wearing gloves if one is in contact with the blood of an infected person might increase the risk of contracting HIV.

MN1 *"Ohk, my understanding for how we have dealt with HIV so far is that mostly is contacted through the sexual intercourse [coughs] that occurs through unprotected. So any other forms of maybe from people sharing the same razor blades, so mostly is sexual activities that leads to the spread to HIV/AIDS, Uhm people practice unsafe practices which leads to the spread of HIV in our village and it varies from all age groups." (Participant 8)*

The submission from MN1 suggests that HIV is transmitted through unprotected sexual intercourse and sharing of razor blades. The participant also added that different age groups reveal various patterns of sexual risky behaviours. This seems to suggest that participant MN1 is aware of how one can acquire HIV and he further mentioned that it affects all age groups. Individuals can get infected with HIV if they are not practicing safer sexual intercourse and are not taking precautions such as changing or replacing blades after using them.

FN3 *"Ohk... [sigh]... I will start with a HIV, the transmission is start with having unprotected sexual intercourse, uhm when you use a contaminated needle and then it pricks you, Uhm at times it might be at the workplace where a patient might be at treated with a little of negligence but often and then the other thing is transmission through from the mother to the child during pregnancy or during breastfeeding or during child birth or during breastfeeding. uhm the other factor... the other transmission can occur during when the drug users usually inject themselves with a needle, sharing a needle the very same needle to inject themselves. Uhm so it's a virus, its HI-Virus that is transmitted through those routes that I have mentioned and it starts with being an HIV, Uhm then after the person has been infected a person becomes HIV positive but the person can be HIV positive without any symptoms, no signs, you cannot see the person has HIV, that's when it starts. How it affects the body is that the HIV enters. after entering the body, it goes to the cell of the human body and then it destroys the the… the cells that are defending the human system, the immune system of the body, so it destroys those cells that are able to fight the diseases like the virus. So it changes the format inside the cell and after changing in the format to favour itself so that it can, it can spread more and multiply so then it does out of the cell into the body*

fluids and into the blood and attacks other cell in the tissue in other tissues of the body and then that's how it starts spreading in the body, meaning it attacks those that are fighting the immune system, eventually the body cannot operate healthy because they are destroyed and that's when we talk about the CD4 because those cells that are defending the body is the CD4 cells, so they so they.. when the HIV spread more in the body the CD4 cells becomes less, meaning the body cannot fight its own infection, and the virus level increases, meaning the virus of the HI multiplying in the body and become more and more in control of the body and then when it's not treated anytime it goes in to being AIDS where a person now shows the signs and the symptoms. So you ..it can even see by looking at the person you can see those signs because the person starts by having those limps that are swollen and the skin condition you can see like happy sores starts and then even the person is often more is regularly having these diarrhoea, this nauseas and then the weight you can even see severe weight loss it becomes wasted eventually if not treated the person becomes bed ridden, and the then opportunistic diseases like TB, Meningitis they become more and the person ending up in a bedridden person, if even not treated a person become, the virus is now controlling the body and become confused everything lapse in the body eventually you die because of those diseases that are in your body." (Participant 9)

The submission from FN3 suggests that HIV can be transmitted through unprotected sexual intercourse and using contaminated needles. She further explained how HIV can be transmitted by saying that one can get it from their workplace, especially in healthcare facilities where a nurse or a healthcare worker is treating a patient with negligence. FN3 also added other modes of transmission such as transmission from mother to child through breastfeeding while she is HIV positive and sharing of needles among drug users. FN3 further indicated that, before one can contract AIDS, he or she starts by having HIV and if proper treatment is not taken then, one's CD4 count becomes low and the person starts showing signs of AIDS. FN3 seems to be knowledgeable and well-informed about HIV because she was able to explain everything in detail so that the researcher could understand. According to Stewart, Wallace, Nance, Schalkoff, Uhring, Widman, Carey and Golin (2022:1696), the accurate measurement of knowledge about HIV is important so that people can put into practice what they know. This indicates that, if individuals do not take proper care of themselves, especially by taking their medication on time and not avoiding treatment, their CD4 count will drop which will cause AIDS. Taking medication can help increase CD4 levels, allowing patients to appear healthy and reducing the visible signs of the virus. Additionally,

the findings from FN3's submission suggest that HIV-positive mothers who breastfeed their children without proper medication and guidance from healthcare providers increase the risk of transmitting HIV to their infants.

FN4 *"Ohk, HIV is sexually transmitted infection like I said is sexually transmitted uhm you can get it from mainly from sexual intercourse when you have sexual intercourse with a person who is HIV positive; and other factor is when you are a nurse like in our profession you can prick yourself with a needle if you have a cut on your hands and become exposed to blood or any body fluids you can get it. The other forms it's when you…maybe in the family you are assisting or bathing someone who is HIV positive and you have cuts on you.or anywhere in your body you can still get HIV and you can still get it from injecting yourself now when people are sharing needles for giving themselves, they call it giving themselves the shots, you inject yourself and use the same needle that was used on the person and you inject yourself you can get it from there, and then it can also be transmitted from mother to child if an HIV positive mother is breastfeeding the baby..uhm that can be spread from the the mother to the baby through the breast milk. And you can also get it when the mother is pregnant and is not taking any Anti-retroviral medication, HIV can be passed from the mother to the child." (Participant 10)*

From the submission above, FN4 seems to have explained how HIV can be transmitted. This suggests that individuals, particularly healthcare professionals like nurses, are at risk in healthcare settings where they handle sharp tools like needles. Accidental needle pricks are common, posing a significant risk when exposed to body fluids or blood. She further explained that individuals can even be at risk in their own families, for example if proper care is not taken when someone who is HIV-positive are bathed. FN4 also mentioned transmission from mother to child through breastfeeding. This suggests that a mother who is HIV-positive can infect their child through breastmilk, especially if the mother is newly infected. Mothers who want to breastfeed should be advised about the importance of ART in sustaining viral suppression. Additionally, they should be informed about the challenges associated with ART.

MCM4" *My understanding about HIV is that…Uhm... HIV stands for Human Immune Virus, and it attacks the body's immune system especially when a person is not using a condom during sex. Aids stands for Acquired Immune Deficiency Syndrome, AIDS is the late stage of HIV and it cannot be cured." (Participant 11)*

The submission from MCM4 suggests that HIV stands for Human Immune Virus and it attacks the body's immune system. The participant further added that one can contract it through unprotected sexual intercourse which was also mentioned by the majority of participants in the findings above. MCM 4 also stated that AIDS is a late stage of HIV and it cannot be cured. This indicates that, not using condoms during sexual intercourse, may put an individual at risk of contracting HIV, especially if one does not know the partner's HIV status and, if treatment is not taken on time, it can lead to AIDS which cannot be cured but only treated with ART.

MMP1*" Eer HIV it's a Human Immune virus which affects eer the…the body Immune system and when the Immune system is weak enough that's it causes AIDS where we get to have or the disease that comes whereby in a natural person, they don't just come, we call them opportunistic diseases which can include eer uhm an attack in the system like TB..eer candidiasis and other infection, but they come because they are opportunistic..ya, they don't just naturally come in a person whose immune system is fine." (Participant 12)*

The submission from MMP1 reveals that HIV is a Human Immune Virus that weakens the immune system of the body and causes AIDS. He further mentioned that AIDS patients may also contract opportunistic infections such as candidiasis, tuberculosis and other infections because these conditions are acquired through opportunity rather than by accident. This demonstrates that a person's immune system may get weakened and additional opportunistic infections may arise if they take their medications poorly or not at all, because taking ART helps to suppress the viral load and helps people to live longer and healthier.

Based on the submissions by the participants above, they were able to define what HIV/AIDS is and further elaborated on their perspectives regarding the routes of transmission. The majority of participants stated that HIV can be transmitted through unprotected sexual intercourse and also explained other ways in which HIV can be spread, including from mother to child during breastfeeding, through vaginal fluids and semen, blood contact with an infected person, especially if one has cuts on one's body and needle sharing among drug addicts. Participant MCM2 mentioned that HIV can be transmitted through Colgate, which has not been scientifically proven to be one of the transmitters of HIV. Looking at the explanation and views expressed by the participants, this proves that they have knowledge about what HIV is and how it is transmitted and in certain cases, some mentioned how to prevent it. Some have

a moderate understanding about HIV/AIDS and limited information about the methods of how one can contract it.

4.3.1.2 Subtheme 2: Understanding of social factors that contribute to HIV/AIDS

The participants were questioned about their understanding of social factors that contribute to the spread of HIV/AIDS and they all reported or provided almost the same responses. The submissions from the participants suggest how these social factors may contribute to HIV and how they are affecting people. Participants (FCM1, MCM1, MCM2, FN1, FC1, MN1, FN4, MCM4) mentioned that unemployment is the main social contributor of the spread of HIV/AIDS. They further explained the risky behaviour of people who are unemployed, for example people end up engaging in sexual activities for money so they can take care of themselves since they lack financial support or because of their poor background and unemployed status. Being unemployed increases the chances of people engaging in risky sexual behaviours because they lack financial security.

***FCM1" Oh** I must say...unemployment...uhm risk sexual practices such as exchanging sex for money, drugs, housing, food, safety, alcohol, people exchange the above for sex which is..which has a much effect.. impact on HIV/AIDS, because they forget to use protection. Uhm…lack of knowledge about HIV/AIDS…or I must say for instance. Let me talk about female genders, uhm female genders get involved in sexual activities which they don't use protection, ehh..and another thing is poverty and lack of financial stability and they exchange sex for money, it end up leading them to the risk of HIV/AIDS." (Participant 1)*

Based on the submissions from FCM1, factors that contribute to HIV/AIDS include being unemployed, engaging in risky sexual practises for money, drugs, food, housing and safety as well as a lack of knowledge about HIV. The researcher further asked the participant how unemployment contributes to HIV, prompting the participant to provide detailed explanations. The participant suggested that unemployment may lead to HIV through a lack of knowledge about the virus. Additionally, she expressed the belief that women engage in transactional sex due to poverty and financial instability, which can increase the risk of contracting HIV, especially if condoms are not used or negotiated. It appears that people resort to risky behaviours to sustain themselves when unemployed. The researcher probed further to clarify and gain a deeper understanding of the participant's perspective, aiming to assess the participant's knowledge regarding HIV-contributing factors. The discussion also highlighted

the significance of HIV education, as FCM1 mentioned that individuals lacking knowledge about HIV transmission may engage in risky behaviours due to their socioeconomic backgrounds.

MCM1" *Ohk my understanding of social factors are factors that which are…uhm...they are... eeehh...impacting on the rise of HIV/AIDS spread, so meaning there are factors like unemployment, lack of social activities such as soccer...uhm lack of technology...yes and that's all I can think of right now." (Participant 2)*

The researcher asked a leading question to the MCM1 "So when you say lack of technology like how does it contribute to the spread of HIV?"

MCM1" *Ohk, so what I mean by lack of technology, I mean like if we are in an area whereby there is no technology, for instance, there Is no TV, there is no Radio, there is no internet access, ok for instance in terms of technologies is gonna be those 3, lack of social media, lack of free internet and lack of uhm TV's and stuff." (Participant 2)*

MCM1" *Ohk the way they contribute to the spread of HIV is that, remember let's say right now I do not know how HIV is spread and, but with social media, with TV's and radios they constantly talking about HIV and the spread, but me having a… me having. uhm...underprivileged those kind of information I wouldn't know how HIV is...Uhm transmitted or how will, or how it is, uhm transferred from one person to another, so meaning I will have lack of information." (Participant 2)*

Based on the submission from MCM1, social factors are factors that impact the spread or rise of HIV. The participant further stated that unemployment can be one of the factors as well as a lack of engaging in social activities such as sports. Additionally, a lack of technology can also be a major factor contributing to HIV transmission. The participant elaborated on this statement that the lack of technology encompasses limited access to the internet, television, radio and social media. This underscores how the absence of internet, crucial for obtaining health information like HIV prevention strategies and modes of transmission, can potentially contribute to the spread of HIV due to a lack of knowledge. Access to the internet could greatly enhance people's lives by providing valuable health recommendations and directing them to healthcare services available at health facilities.

MCM2*" Eh... the factors that contribute to the spread of HIV is the lifestyle of our community and the struggles that we face in the community like having enough resources to teach people about HIV/AIDS." (Participant 3)*

Researcher *"Such as?"*

MCM2" *Such as facilities whereby they make people aware about the HIV/AIDS and the spread and do maybe campaigns and NGOs to get people…unemployment and poverty and substance abuse." (Participant 3)*

The submission from MCM2 suggests that unemployment, poverty and substance abuse are the main social factors contributing to the spread of HIV. He further stated that the lifestyle of the community and the struggles that people face may also contribute to the spread of HIV. This illustrates that community members may fall victim to HIV due to the struggles they go through, for example unemployment and poverty. The participant suggested that campaigns and NGOs should be implemented to inform individuals in the community about the spread of HIV. HIV campaigns always provide public education educating individuals about the prevention methods they should follow and how HIV is transmitted. Additionally, anti-poverty campaigns can be implemented to reduce the rate of poverty in the community.

MCM3" *Well there are so many factors but the most common ones especially the most common one is just poverty, we get in to situations we don't wanna end up in, like for example someone offers let's say you are a woman, someone offers you money for sex and you find out later that eeeh they are positive or maybe factors like your father becomes positive and you didn't know about that and your mother gets tired of taking care of them and end up taking care of them, and when you take care of them sometimes you have cuts and they have blood, sometimes you have to take care of them not wearing gloves and then you contract HIV disease, or it can be…they are so many, it can be through eeh..addictions like eerr drug abuse and there's this common thing called "Bluetooth" whereby I can take myself the drug then pull out some of my blood and inject the person and then get high but they will have some of my blood and if I am positive and automatically they are infected with the disease..uhm most of the common factors...most of the factors are done by great from our..I can say the so called brothers with the GTIs, yes..yaa..they are grading. I know that I am positive and driving a GTI and there's so many kids from Ntolo (the local high school) every now and then I drive there I see eh one 'o naleng' something that I like, ass obviously,*

so when I get there, "ke tseya yena"..pick up I take her and pick her up and we go to the local guesthouse we have unprotected sex, tomorrow I feel like she was still surface because I used her because I have depression, the reason why I am saying this is because these guys do not want to admit that they have a problem and go to therapy, but yesterday they were using alcohol and drug abuse and the teenagers from high school, and these teenagers are on the period that is commonly known as adolescent, they want to do whatever their friends are doing, so they have no, they have no other choice and when you look at their background at home, they really not stable, they are always drunk, they have no food, last night they had chicken feet and pap today is gonna have chicken skin and pap, so basically these guys are offering them better like chips, fish and chips. So basically automatically she won't say no to that because that's what all friends are doing at that point and time. But it doesn't regard that their situation from the friends because the friends, the mother and the father they well they can't afford to buy so what must she do? Go to the brother with a GTI, instead of motivating, she does not want motivation but he wants to oppress and take advantage of the situation, so that's why I am saying 'great from the God brothers with GTIs". They don't want to admit their situation and take therapy instead of they take it to our younger sisters" (Participant 4)

The researcher further asked MCM3 if he would like to add more and the participant *said:*

MCM3 *"There's more, there's also the taxi drivers, our taxi driver brothers, yes..eeh recently this government just introduced the r350 situation so there's no way we can get r350 mo Madidi, so automatically tshwentse ke namele ko kreya r350 there, so if I can get a brother who can offer me a lift yao kreya di 350 every time then, If I can get a brother who can get me a transportation to 350 every time then I can offer him sex but but we know the brothers from the taxi industry they sleep with everyone anytime because they always busy they are on the streets all the time, so they don't have necessarily stable relationships they have multiple partners every time, so for someone who was preserved while growing up, and very very very disciplined might fall into that trap later when they want to go and take these r350 because I cannot spend 50bucks to move from Madidi to Hebron, it is 25rands to Hebron and is r25 back to here, so when I come back here I have 300rands but then I had plans for 350, so basically what I need is the brother, so if I can get the driver who is going now, who is "sebanebane' and come back with a brother who is coming back now which is uncle mang mang, uncle mang mang has one partner that they did not plan of from the group*

of..so it means that uncle mang mang and uncle mang mang from taxi industry got infected from this single person who was trying to survive." *(Participant 4)*

Researcher *"So are you saying having multiple sexual partners falls under social factors that contribute to HIV?"*

MCM3" *Yes, there's a major contribution or contributory to the factors."*

Based on the submission from by MCM3, social factors such as poverty, transactional sex, transmission through cuts especially if one is not wearing gloves, substance abuse and multiple sexual partners are the main contributors of the spread of HIV. The participant explained in detail how these factors may contribute to the spread of HIV, indicating that MCM3 is aware of the social factors affecting people on a daily basis and why some of the people end up being infected by STDs, STIs and HIV/AIDS. This also suggests that men tend to take advantage of young women because they are not financially stable. Transactional sex elevates the risk of HIV acquisition among young women especially if condoms are not used. These findings seem to suggest that, in order to reduce transactional sex among young girls or women, prevention strategies should be considered and job creation should be implemented, resulting in women being more independent.

FN1*" Ehh…Social factors one can name: unemployment, ehh I can name lack of studying, ehh [thinking] what else can I eh…homelessness also poverty, ya can be other contributing factor, and also polygamy, ehh..it's quite a bit actually and also the substance abuse, substance abuse it can be also one of the contributing factors, and then there's traditional practices involved in the black society*." *(Participant 5)*

The submission from FN1 suggests that there are several social factors that contribute to the spread of HIV/AIDS, including unemployment, substance abuse, lack of studying (lack of education), homelessness, poverty and traditional practices such as polygamy. This seems to suggest that social factors may have an impact on people's lives and their health, especially if one is homeless or living in poverty. It may lead individuals to seek security and financial support from multiple partners, ultimately increasing their risk of engaging in multiple relationships. On the other hand, traditional practices such as polygamy may expose women to sexually transmitted diseases, especially if they are unable to negotiate condom use in their marriages. Being uneducated or illiterate can also result in a lack knowledge or

awareness about various subjects, such as preventive measures for protecting oneself from HIV and STDs.

FC1*" Uhm... I will first start uhm mentioning the factors which is discrimination, unemployment, and like lack of information and uhm when I further explain what discrimination is, is when uhm… for example gays uhm are scared to test because they don't want to be judged...yes and then unemployment for example when a Woman mostly uhmm have sex with people for money to get money...yes...and then uhm. lack of information, when someone doesn't have information or doesn't know their status is likely for them to be infected with the virus…yes." (Participant 6)*

The submission from FC1 suggests that social factors may contribute to the spread of HIV/AIDS and further explained how they may have an impact on individuals. The participant explained that discrimination manifests as a fear of being judged, particularly evident in healthcare settings when individuals seek HIV testing services know their status. There is often a fear of judgment associated with getting an HIV test, as it may imply as being sexually active or engaging in unprotected intercourse in the eyes of others. Additionally, the participant noted that members of the LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer) community, particularly gay individuals, are apprehensive about testing due to concerns about being judges for their sexual practices, which may differ from those of heterosexual individuals. On the other hand, the participant mentioned that unemployment is one of the main contributory factors of the spread of HIV because unemployed individuals often engage in sexual activities in exchange for money. A lack of information and individuals not knowing their status were also identified as important contributory factors to the spread of HIV.

FN2 *"My understanding is that uhm uhm is poverty is one of the social factors that can lead to one to contact HIV, Uhm because when you are living in poverty you don't have uhm any means of income that can lead you and to uhm situations whereby you have to turn into prostitution in order to get money or indulge in dangerous situation that can lead you to have HIV, and also uhm when you are not educated you don't have knowledge about how these uhm virus can be transmitted and you will end up participating in activities that can lead you into having uhm this virus and also [pause] abusing substances that can also lead you into contracting virus because uhm when you are chemically off balanced as a person*

you cannot make say decision that the, that you can say no to uhm indulging in unprotected sexual intercourse." (Participant 7)

The submission from FN2 suggests that poverty, substance abuse, prostitution and not being educated are social factors that can expose individuals to end up contracting HIV/AIDS. FN2 explained that not having a source of income increases the chances one getting involved in prostitution which is also known as transactional sex. Not having knowledge about HIV poses the risk of being infected. Substance abuse was also identified as one of the contributors of the spread of HIV/AIDS because when people are chemically off balance, they struggle to make informed decisions about safer sexual practices.

MN1 *"Mostly in the villages you..what can I ..to situations that one thing uhm unemployment is at a higher rate, unemployment is at a higher rate, uhm access to educational facilities like around the community, you will find that they are mostly not there, so now you find young people who they are in an area they are unemployed, they are in an area where they cannot learn more skills to survive because now those impacts of poverty, inequality they lead to that, they lead to the spread of HIV because now people engage themselves in activities that they seek to have money, they seek to live certain lives they require that they end up in unsafe practices, so inequality, unemployment, crime, that are spread to the village they cause that…yes*."

MN1" *And mostly information in our village it's not richly like other areas, where you find where there are campaigns about HIV where you see the clinics or mobile clinics coming, the department of health here, most of the time. So there are still people who still don't understand how HIV, you will tell a person unemployment cause…can cause HIV and will be surprised, but the more you get information because the moment you are unemployed the moment you are in a society that is uhm equal, you kindly expose yourself to vulnerability of HIV..yes" (Participant 8)*

Participant MN1 suggests that unemployment, inequality, crime and access to educational facilities are the main contributory social factors of the spread of HIV/AIDS. The participant believes that a lack of skills may lead to poverty, because most companies or jobs require certain skills from employees or candidates, for example computer skills. MN1 further stated that inequality may also lead individuals to unwillingly engage in sexual activities such as unsafe sexual practices in exchange for money. Others get involved in crime so that they can

generate money quickly. MN1's concern was also the fact that there are no educational campaigns in the area so people are not well-informed or they lack information about HIV/AIDS.

FN3" *Uhm ...usually uhm I will start with lack of knowledge, so illiteracy is the main problem. People are not having any information how to prevent having HIV infections, and then the other factor is ignorance, some people are very ignorant, they just live, they just live, they are ignorant. And then poverty, some situation can put you in a position where you end up selling yourself, your body...having sex for money just to provide the basic needs, food, water, clothes. Those are the things that can lead to having unprotected sex which leads to HIV infection. Uhm alcohol abuse or substance abuse, but then mostly is alcohol, when you are drunk you are always drunk you end up not having uhm what's that?,You end up doing drugs with the very same needle that is contaminated. And then the peer pressure, what I have realised now is the peer pressure, these…especially young girls and boys, they are competing with who is the best in having sex, who is good with this sex, it's like they just take life for granted." (Participant 9)*

The submission of participant FN3 suggests that social factors contributing to the spread of HIV may include lack of knowledge and illiteracy since people do not know how to prevent themselves from contracting HIV. She further stated that people are too ignorant and they do not consider the consequences of their actions. She also made reference to poverty, transactional sex, substance abuse and peer pressure as contributing factors. This shows that FN3 has knowledge of what are social factors that affect people because she explained everything in detail. This highlights that, if people could be educated about HIV/AIDS, they might be more knowledgeable about how to prevent themselves from contracting HIV, consequently reducing the spread of HIV and decreasing the rate of HIV/AIDS.

FN4*" Ohk...in our in our African culture if the person is married, there's no way that you can as females, have have an inferior status where they cannot uhm they cannot decide to have sexual intercourse using protection, and then that is the reason for for them to get HIV/AIDS, they cannot say no to sexual intercourse without using the condom or any form of protection, and then in other cultures you find that in our case I am in Soshanguve and my husband is working in Mpumalanga having other sexual relationships can contribute mainly to the spread of HIV where you find that the person that you sleep with. The woman or man will sleep with another woman without using any form of protection that can cause*

the spread in HIV. And other issue is that urbanisation, when people move from the areas like Madidi Village you move to the city to look for employment and when you get there we know that with our African male, even females nowadays they indulge in extra-marital affairs and they end up sleeping with people that they don't even know their status. And now in our culture is not easy for males and even for females to test before they get married, because people they feel like they are not trusted, so people end up getting in to sexual activities without even testing even when they get into marriage they don't go to test pre-marital pre-sexual uhm testing, they just indulge in sexual activity without even testing, not knowing the person's status. And the other sexual issue is prostitution like in our country now uhm,it has been legalised so young women end up having sexual activities with any man that they don't even know in exchange of money. And then the other social issue is like uhm its mainly in rural areas like KZN, the incest if my husband pass away the family of the husband will say I must get married to the younger brother or older brother just to keep the family name and that can lead to high risk of HIV because you are not allowed to say anything and end up sleeping with a person who is sick and also get HIV/AIDS. Should I continue with the social factors? They are many. (Participant 10)

The participant further added that:

" The other social issues are the…like now if you you leave children with people that you don't even know like the uncles, like in our case you find that young women get pregnant and they live in the same house, so it becomes easy for them to leave their young girls with 'bo malome' uncles, trusting that unless will take care of them, but along the way they end up having sexual activities with the…without the parent knowing. Lack of supervision on young girls, we just leave them playing around when they go out they are free and then you won't even know they are sexually active. And the other sexual factors now in our schools, we don't have di separate uhm "bare keng kana' toilet facilities and they are not even supervised, our kids end up having sexual activities even at school, knowing that they are at school but they are not supervised, they get HIV at a very tender age. And the other kids in the era of HIV before we had "di" treatment we had so many orphans of HIV, you find that the child's mother was positive and they did not take the treatment or they were afraid to take treatment because of if they take it at any time the person will know that the person is HIV positive, because they have to take treatment a certain time so that they end up not disclosing that their status and not taking treatment. So this young girls and boys when they

get in to relationships you find that the child is positive without even them knowing, and when they look for antenatal care at the clinic, it is then they will know that they are positive and they will they will know at that time they are positive and they cannot ask anyone because parents died of HIV, and the grannies are at...I don't know they are fearful they don't want to tell them, to disclose that their mother passed away because of HIV. So is one of the social issues that will lead to the spread of HIV, fear of disclosing says anything to the kids and then again it is a stigma, the Stigmatisation, they will feel like it's not allowed, so they keep it as a family secret...mmm. And then the stigma again for telling people you are positive you end up now spreading the HIV because you fear of people knowing that you are HIV positive." (Participant 10)

The submission from FN4 suggests that social factors may include unprotected sexual intercourse, labour migration whereby the husband works in another city while leaving his wife at home, urbanisation whereby people move from Madid to the city to look for jobs, prostitution (people exchanging sex for money), traditional practices like incest (when a husband dies, his wife must be married to the late husband's younger or older brother in order to keep the family name), sexual abuse, unsupervised toilet facilities (children end up having sexual intercourse in such facilities, putting themselves at risk of contracting HIV). HIV status disclosure was also identified by the participant because she believes that young children who were born with HIV may not know that they are positive as their guardians did not tell them. They end up infecting one another and find out later when they start planning for antenatal care. The participant also mentioned stigma as one of the contributory factors of the spread of HIV. This indicates that the participant is knowledgeable about HIV because she identified various modes of transmissions as well as factors that have an impact on the society. This suggests that social factors as well as cultural practices may put individuals at risk of contracting HIV and STDs

MMP1 "*The social factors it can be poor education, awareness with the same community, eer poor clinics, availability and then also eerr there knowledge on sexual conduct when people don't use eerr condoms or they don't get tested when they don't...they start a new relationship for example, ya so there are people who are not able to condomise, they want the worst course of transmission. (Participant 12)*

The submission from MMP1 suggests that the social factors contributing to the spread of HIV are poor education, unawareness in the community, poor clinics and poor knowledge about

sexual conduct. He further stated that some people do not like using condoms, increasing the risk of transmitting the virus. Additionally, poor healthcare services in clinics can contribute to HIV transmission. If clinics lack sufficient medications, patients may face challenges in accessing necessary treatment, leading to missed doses and appointment. This can weaken their immune systems and increase the risk of HIV progression. Moreover, inadequate education and knowledge about prevention strategies have been shown to facilitate transmission, as individuals may lack sufficient information to protect themselves from HIV.

Based on the above submissions by the participant, they are aware of various social factors contributing to the spread of HIV. For example, they highlighted unemployment as a significant cause, leading individuals to become impoverished due to the high unemployment rate. This awareness underscores the recognition of how socioeconomic factors, such as unemployment and poverty, intersect with HIV transmission dynamics.

4.3.1.3 Subtheme 3: Social factors in Madidi village, Bojanala district in North west province.

Participants were asked which social factors affect the community of Madidi, and their responses were as follows: ***FCM1"*** *Ohk...uhm...lack of knowledge about HIV/AIDS, people forget about the virus, more especially teenagers of today, they treat, they treat the virus as if it does not exist. Unemployment and drugs play a dominant role in transmitting the the virus in Madidi e.g. exchange of needles, not knowing the status of the person you are exchanging the needles to...so drugs. And let me talk about unemployment...uhm most ladies they get involved with sugar daddies, married men for exchange of …they give them sex and those men give them money." (Participant 1)*

Based on the submission from FCM1, lack of knowledge about HIV/AIDS, unemployment, drugs/needle exchange among drug users and sex in exchange for money are the social factors that mostly affect the community of Madidi village, Bojanala district in North west province. The participant further stated that not knowing a person's status may contribute to HIV transmission. This means that people who do not disclose their HIV status may increase the chances of infecting others. The disclosure of HIV status may help protect the next person. Unemployment seems to be playing a big role in the community because there are limited job opportunities leading individuals, especially young women, to engage in relationships with older men with money in order to be taken care of.

MCM1*" Ohk, so according to my understanding and the way I see it, the factors which are impacting on HIV/AIDS transmission. Like I said number one uhm…lack of technology, number two unemployment so these two are the main drive for impacting HIV. Ohk in Madidi. Number one, the lack of uhm technology meaning people they do not have access to information and without information, yes you won't know what is right and what is wrong, number 2 with poverty, yes uhm with poverty the thing is people they are at home they have nothing to do, due to again lack of technology, they have nothing , they have free time on they have a lot of time with...ok they have a lot of time on their hands, so what I mean by that is that now these people they do not have time to research, to read, watch TV, so the only thing which is logic for them as human nature its uhm indulging in sexual intercourses and by then…now because due to lack of information they are not aware that uhm AIDS and HIV can be spread with, uhm if you are involved in sexual intercourse without protecting yourself" (Participant 2)*

The submission from MCM1 suggests that unemployment and a lack of technology are the main social factors contributing to the spread of HIV in Madidi Village, Bojanala district in North west province. The participant further stated that people lack access to the internet, depriving them of valuable information about HIV/AIDS that could benefit them. Additionally, participant MCM1 mentioned that many individuals spend their time engaging in sexual activities due to having a lot of free time. Lack of information may lead them to engage in unprotected sexual intercourse, increasing their risk of HIV transmission.

This suggests that providing access to the internet or technology could empower individuals about HIV transmission and prevention strategies if they utilise online resources. Unemployment has emerged as a significant contributing factor, as the majority of participants identified it as the key factor driving HIV transmission in the community.

MCM2 "*Mostly is unemployment" (Participant 3)*

Researcher *"How is it affecting the community whereby it has an effect on spreading HIV?"*

MCM2" *Because most of the people they don't have anything to do, so most of the time they have free time to do anything, do unnecessary things that don't add value to their lives, such as partying and not working on improving their lives and their skills."*

Researcher*" so how will one get HIV from that?"*

MCM2 *"Being unconscious, having sex, unprotected sex and drinking alcohol most of the time." (Participant 3)*

Based on the submission from MCM2 above, unemployment is a big problem in the community. This statement also supports the previous responses from other participants, mentioning that unemployment contributes to the spread of HIV in the community. MCM2 further explained that not spending one's time on improving one's life and skills may result in an individual engaging in partying, unprotected sexual intercourse and alcohol use. This suggests that, in order for individuals to enhance their skills, they should attend available skills centres in their community. Better and more skills can later help them to get jobs. Attending skills development centres can also reduce the chances of people spending their time at clubs, drinking alcohol everyday which exposes them to risky sexual behaviours.

MCM3" *Uhm...substance abuse, multiple partners, lack of knowledge which I did mention on the contributors and also uhm...poverty." (Participant 4)*

FN1 *"Eeh…one can be: unemployment rate, the high unemployment rate that can be one of the factors and then the other one can be substance abuse, and also poverty. I can say that [thinking] uhm polygamy at the other hand and also can be one of the factors. uhm did I mention unemployment? And also it can be eerr...I can also name stigma in health facilities as well". (Participant 5)*

The submissions from MCM3 and FN1 suggest that several common social factors contribute to the spread of HIV in the community, including poverty, substance abuse, traditional practices, multiple partners, notably, unemployment which was not mentioned by MCM3. It appears that many individuals in the community are finding it hard to make ends meet due to these social factors, with poverty being consistently highlighted by almost all the participants.

The prevalence of poverty seems to exacerbate sexual risk-taking behaviours, as individuals may prioritise securing financial resources over their sexual health. According to Shisana *et al*. (2009:90), poverty can expose individuals to situations that make them vulnerable to HIV infection. Without adequate financial resources, households may struggle to meet basic needs such as food, which can lead individuals to engage in risky behaviours like having multiple sexual partners or seeking support from older individuals ("sugar daddies" or "sugar

mommies"). It is evident that poverty and unemployment are closely intertwined, with both factors contributing significantly to the vulnerability of individuals to HIV infection.

MN1*" Uhm, unemployment. Unemployment is a serious concern, unemployment is a serious concern you will find, because mostly again to beat to beat unemployment you need to have the..the economic activities or add more value in the area, creating employment also if you gonna expect the people from your area to move to other areas to seek employment, because you will find the closely industrial areas that close by too close to Madidi is Rosslyn, which can give more value to hire people and then we have Rankuwa Industrial which is no longer that viable to hire people, so now again in a space where people need to travel to seek, to find jobs. So that's a problem because if the area can uhm create the economic activities around, there economy meaning if there are certain activities that are happening, people will be hired in the village then it decreases it because now people will get money around the village, they don't have to move, they don't have to…now somebody got a job somewhere and still lives in Madidi, that person will need to use a bus each and every day so half of the salary is going back to the salary again." (Participant 8)*

The submission from MN1 suggests that unemployment is a serious concern in Madidi Village, Bojanala district in North west province and is of the opinion that there should be economic activities that can add more value in the community, such as creating employment for those who are struggling to get jobs. Creation more jobs in the area will reduce the notion of people moving to other areas to find jobs. Moving from one place to another often impacts the spread of HIV, ad individuals may be more likely to engage in behaviours such as having multiple sexual partners when they relocate. For instance, a person who moves to another area to save on travelling costs may end up forming new relationships, potentially leading to multiple partnerships and increased risk of HIV transmission. This underscores the importance of addressing mobility-related factors in HIV prevention efforts.

To mitigate these risks, government intervention is crucial. Creating job opportunities in rural areas such as Madidi Village, Bojanala district in North West province as well as in industrial zones, can contribute to financial stability for individuals. this, in turn, may also help reduce the spread of HIV by addressing factors such as poverty and unemployment, which are known drivers of risky behaviours.

FN3*" Yoh! Madidi. Almost all where I live here hai. almost all people here so, most of them are illiterate, the youth here don't even get to matric, so many schools drop outs. Alcohol abuse here, uhm yes unemployment is severe and then poverty again like it's. The community here it's of such a low social life, struggling a lot, so they end up like just living just for every day, daily bread, .so they just live, so at the end of the day they just survive by these sex, these drugs, and then alcohol, ya here is too much, is too much." (Participant 9)*

The submission from FN3 suggests that poverty and unemployment may force individuals to drop out of school, especially if they do not have social support or their families are poor. Dropping out of school may lead to illiteracy and lacking knowledge about many things. It may also include a lack of skills. Both young and old individuals find themselves merely existing due to financial struggles. Some turn to drug addiction and alcohol abuse as coping mechanisms for the stress they endure.

FN4*" Ohk is the one of our culture uhm like "bo makoti" they are not allowed not to breastfeed when they they have young kids just have to follow the roots of saying you have to breastfeed, and you cannot even tell them that you are taking treatment, so you end up now spreading this HIV to the poor baby that does not even know. And polygamy is one of the factors again, polygamy because now its allowed, you marry many women thinking that the same circle. They will be in the same circle but if one of them is positive is very difficult to control the spread of HIV because it will run in the same family. And then lack of knowledge again and lack of understanding how HIV is spread. Poor education can also lead to spread because people feel gore HIV is "Makgome" is one of the social factors that people think like now. If the husband passes away, others don't follow the rules, the cultural rules of taking the muthi treatment "go ikilela ka Setswana" until a period of the year has passed, and then they will start looking for young boys or young women, that is how it is spread." (Participant 10)*

The submission from FN4 suggests that cultural norms may affect women and their ability to choose what they want or do not want to do. For example, women are not allowed to refrain from breastfeeding, especially if the mother has not disclosed her HIV status to the elders, potentially leading to mother-to-child transmission. Additionally, disclosing one's status may not be easy due to fear of judgment or being labelled as reckless. According to Mogotlane, Chauke, Matlakala, Mokoena and Young (2014:347), it is possible for a mother to horizontally transmit HIV to her child while breastfeeding if she is HIV positive. FN4 also mentioned that

polygamy is promoted in culture, allowing men to marry more than one wife, which can be risky due to the potential for infidelity. Furthermore, FN4 stated that a lack of information may contribute to confusion, as people may mistake traditional illnesses such as '*Makgome*' to HIV.

Based on the submissions by the participants above, it is clear that there are many social factors that contribute to the spread of HIV/AIDS in the community, but the most common is unemployment. Many people are struggling to secure jobs despite them having the qualifications and skills needed in companies. Due to unemployment, people are finding it hard to improve their standard of living; hence, some women resort to transactional sex in order to take care of their families. The experiences and opinions of participants shed light on how social factors impact the burden of HIV/AIDS in the community. Some stated that other factors that may contribute to the spread of HIV may be a lack of knowledge, traditional practices like polygamy, substance abuse among young people, unawareness of the status of one's partner, having multiple sexual partners and a lack of technology and access the internet. Women in the community would rather risk their lives by getting involved with multiple partners in exchange for money, a behaviour viewed as desperation. According to Magadi (2013), the majority of people remain in sexual relationships for financial support, exposing them to HIV/AIDS, particularly if they have additional partners outside of their current relationships.

4.3.1.4 Subtheme 4: The gender mostly affected

The submissions from FCM1, FN1, FC1, MN1 and FN3 suggest that females are mostly affected by social factors contributing to the spread of HIV/AIDS in the community of Madidi Village and they end up engaging in risky sexual practices in exchange for financial support. Socio-economic status sometimes influences individuals to do things they have not planned. Men tend to take advantage of females because of their financial background. Having sexual intercourse for financial security or gains may expose women to unprotected sex and having multiple partners. These findings are shown below:

FCM1*" Uhm in my community...uhm female genders are mostly affected, because like most females in our..in Madidi they don't ..they are unemployed, so the only thing they can think about is..ok I can have a sugar daddy, then I give him sex then he gives me money that's the exchange there to be." (Participant 1)*

The submission from FCM1 suggests that many women in the community are unemployed, so they end up dating older men, commonly referred to as “sugar daddies”, submitting to their sexual demands in exchange for financial support. Young women who are in relationships with such older men are less likely to consistently use condoms during sexual intercourse (Chimbindi, McGrath, Herbst, San Tint and Newell, 2010). Engaging in unprotected sexual intercourse increases the risk of these young women contracting HIV/AIDS because older men may insist on unprotected sexual intercourse.

FN1 *”Uhm I can say females, I can ..most..ya..most I can say females because now ehh you will find that eh being a female person sometimes you get in to a stage where you are homeless, actually and you get in to relationship with a person who has a maybe let’s say the accommodation or has got the power actually to house you, you know and give you the standard of living that you require, at the end of the day, ehh you will find that a you are being abused because of the situation, because now you are getting in to this relationship and then whereby you don’t have a say, actually you are being a.. what can I say? You are being with someone who has actually got power over you, because now you don’t have anything, so ya that can be one of the...of the social factors.” (Participant 5)*

The submission from FN1 also suggests that women are mostly affected by social factors contributing to the spread of HIV/AIDS. Men tend to abuse or oppress women who are dependent on them. Due to their lack of authority and homelessness, these women may find themselves subjected to the power dynamics imposed by a man simply because he provides them with accommodation. Consequently, these women often find themselves unable to advocate for their own needs or negotiate safer sexual practices, as they fear potential eviction or abuse at the hands of their caretakers.

FC1*” I think mostly its women, yes.” (Participant 6)*

The submission from FC1 also suggests that women are mostly affected by social factors contributing to the spread of HIV/AIDS but did not give reasons to explain her answer. The vulnerability of women to HIV is exacerbated by their disadvantaged backgrounds and the persistent gender inequalities present in society.

MN1*” Females, females are more exposed to HIV/AIDS than their male counterparts and you will find things that uhm in our experience that uhm young girls between the ages of 16*

to 24 or 14 to 20 for example, they are not infected by the theirs the boys from their same age group, meaning now that the boyfriend are not infected by their age group but the other age groups." (Participant 8)

The submission from MN1 suggest that females are the ones who are mostly exposed to HIV/AIDS and the majority of them are young adolescents between the ages of 14-24. These young women are mostly infected by older people.

FN3*" Young females especially in our area, Yoh uhm there's a high school here ne those kids after school they will come from the age of 14 they come for family planning most of them its girls, they bring STIs meaning that they don't use protective condoms for safety, they only [sigh] you can see is through STIs that these ones are having sex and then like I said again these young females they have children which is proof that no condoms, no protective sex is being used." (Participant 9)*

The submission from FN3 suggest that many young women are affected by social factors contributing to the spread of HIV/AIDS are girls as young as 14 years, who visit the clinic for family planning and STI treatment. It is evident that most of them do not use protection every time they have sexual intercourse. The participant further mentioned that some of these women end up having children because of the lack of condom use. A lack of information among young women also increases the risk of HIV and other STDs since they solely rely on contraceptive pills to prevent pregnancy without considering HIV prevention measures.

MCM2*" The males, I think the males, because most of the males in the community they do not work, they use substance, such as drugs." (Participant 2)*

FN4 *"Ohk I think males are the ones that get mostly infected because number one they feel that they are superior to women, they have a say in sexual practices and then most of them even if they are knowledgeable, ignorant is the one that can stay and they don't believe that they can be sick, and then the other issue is that they don't go to hospital to get treatment or more often like women, with women it's better you go to the clinic when you are pregnant and then you will be tested which is one of the protocols that needs to be followed, so women are better because they will know their status than male. And men will think if they are not physically sick then their sexual partners are not physically uhm sick they don't take*

treatment and they cannot even go to the Doctor to seek medical help, so mainly males are the ones that are mostly affected than females." (Participant 10)

Based on the submissions from participants MCM2 and FN4, males are the most affected gender in the community because the majority of them are not working and consequently engage in substance abuse. FN4 indicated that many males who are affected by HIV often harbour a sense of superiority over women, leading them to neglect their health and avoid seeking medical attention. They may be unaware of their own illness, assuming they are not sick simply because their female partners are not exhibiting symptoms. Encouraging men to undergo testing at clinics can prove to be a significant challenge in HIV prevention efforts, particularly due to their poor health-seeking behaviour (Mills *et al*. 2012). This reluctance to seek testing is evident by the fact that men are less likely to undergo HIV testing to ascertain their status and take necessary precautions despite possessing knowledge about the disease. The participant furthermore noted that women tend to be more proactive in seeking healthcare, especially during pregnancy, as it is standard protocol to monitor both the mother's and the child's health. Consequently, women are more likely to undergo HIV testing and be aware of their status.

MCM1*" I would say...uhm both the genders, males and females because sex is something which is uhm...which involves males and females and also in other circumstances whereby there's gays and and... but I would say it is 50/50." (Participant 2)*

MCM3 *"I would say it's a feminine factor…eehh the feminine gender…eh be it the gays, the males from the flatequor and the women the feminine side, be it female or the gays whereby they are most to be affected by that because their side of the hustle is that from that if you don't sell sex then they must go gamble, so they can't gamble, they can't play 'madice', they can't, so they only have pre-limited options." (Participant 4)*

FN2" *Uhm all the genders are affected, the more women because they like things, and they turn into selling their bodies to have the things that are in trend currently...uhm you will find uhm a 16 years old dating a sugar daddy or a taxi driver not knowing their status, indulging themselves in unprotected sex and end up being infected with HIV, so women are more infected than males." because unemployment in the community is high. People consult in traditional healers because there still those who believe in cultural practices. Also both*

genders practice risk behaviours that cause HIV like have unprotected sex, and that's why teenage pregnancy is very high." (Participant 7)

The submissions from MCM1, MCM3 and FN2 suggest that both genders are equally affected by social factors that contribute to the spread of HIV. MCM4 mentioned that unemployment affects both genders, people engage in cultural practices which affect both genders and people do not use protection every time they have sexual intercourse. MCM 3 mentioned that both women and gay individuals are significantly affected by HIV/AIDS. They often struggle to find alternative sources of income, leading them to rely heavily on transactional sex for financial support this limited means of income places them at a disadvantage compared to men.

FN2 acknowledged the impact of HIV/AIDS on both genders but emphasises that women are disproportionately affected. This is attributed to factors such as economic dependency, where women may enter relationships with older individuals for financial support, often engaging in unprotected sex without knowledge of their partner's HIV status. According to Luke (2006), women frequently lack agency in negotiating safer sexual practices, with older men often dictating the terms of sexual encounters. This power dynamic increases the risk of HIV transmission among young girls.

MMP1*" The ones that are affected mostly is women, because most of the time is men who wants to sleep with women, as compared to women wants to sleep with eerr men. So mostly is women who are vulnerable especially they also on those drugs and other things, alcohol over usage. (Participant 12)*

The submission from MMP1 suggests that women are mostly affected by social factors contributing to the spread of HIV/AIDS in the community. He further explained this by implying that men are always the ones who want to sleep with women, meaning they are the ones who always instigate and/or negotiate sexual intercourse. On the other hand, he stated that women may face heightened vulnerability to HIV/AIDS due to alcohol over usage. Excessive alcohol consumption can impair judgment and decision-making, increasing the likelihood of engaging in risky sexual behaviour.

The submissions from the participants above suggest that females are the ones mostly affected by social factors contributing to the spread of HIV/AIDS in the Madidi community.

The reason given for this is because there are limited opportunities for women to generate or make money compared to men; therefore, they navigate towards risky sexual behaviour, making them more vulnerable to HIV.

4.3.1.5 Subtheme 5: Understanding of cultural beliefs and norms

Participants in the study were asked about their understanding of cultural beliefs and norms that cause the spread of HIV/AIDS. Their responses are presented below:

FCM1" *Uhm...cultural beliefs and norms…or it helps to understand...uhm...it helps us to reduce the chances of making bad decisions and acceptance. Llet me say polygamy thing...uhm it reduces the fact that ladies must have or many like...many men…meaning [cough] you only have two wives so you don't have to go out and look for a girlfriends or so on, so you end up going to the clinic get tested with your two wives then it helps to reduce the spread of HIV/AIDS." (Participant 1)*

The submission from FCM1 suggests that cultural beliefs and norms help to reduce the risk of individuals making bad decisions, meaning that it shapes an individual's lifestyle and how he or she thinks they should act. Furthermore, it was suggested that practicing polygamy, where a man is limited to having only have two wives, could potentially decrease the risk of HIV/AIDS transmission within the family.

MCM1*" Ok my understanding on cultural beliefs is that eer. I would say as Africans we have culture and norms and beliefs which we are practicing and following each and every day. I think those cultures were developed the time whereby AIDS was not yet discovered, so my belief is that yes in some of the cultural..uhm..mmm...things we do they do also uhmm..transmit HIV/AIDS like let's say you know when you go to the Sangoma they cut you and and and…after cutting you I am not sure whether the same blade is gonna be used for another person or not, I am not yet sure, but what I have seen as well is that or in most of the Sangomas and traditional people, the government is what they tried to do is to make them aware that they shouldn't share blades or any cutting tools which might transmit HIV/AIDS, so yes I would say before that, before they discovered that traditional healers and Sangomas they are using those cutting blades and they might be using it on multiple people, ya I would say yes before culture was actually and also on the rise of transmission of HIV/AIDS." (Participant 2)*

The submission from MCM1 suggests a belief that certain cultural practices, which were established in times when HIV did not exist, may inadvertently contribute to the transmission of the virus. For instance, using a single blade for multiple clients during rituals could pose a risk of HIV infection. However, it is noted that government intervention has played a role in addressing these risky behaviours by informing traditional healers (Sangomas) about the potential risks associated with their practices. This awareness-raising effort has contributed to a reduction in HIV transmission among clients of traditional healers.

MCM2 *"My understanding about cultural beliefs and norms is that, as a community we have different cultures and tribal and rituals, so it will depend on which culture you are based on because we have Vendas, Tsongas and Tswanas and we all follow different cultures...yes." (Participant 3)*

The submission from MCM2 suggests that he understands the diversity of cultural beliefs, norms and rituals, acknowledging the existence of various cultures and tribes. However, he did not provide detailed explanations about the specific rituals and tribal customs within the Tswana culture, as requested by the researcher. It is evident that the participant overlooked the focus on Tswana cultural norms in the discussion initiated by the researcher. Despite the researcher's inquiry into Tswana cultural beliefs and norms, the participant did not elaborate on this aspect.

MCM3 *"I would say my understanding on cultural beliefs and norms especially in Madidi its very limited because I am an introvert so I don't spend time with people, so there's a very few people I spend time with so it's very limited, but I know that people around here they not very knowledgeable about a lot of things, and they are proud of that, they pride themselves on not knowing a lot of things, and they will argue with you, they don't…this thing of googling things is not a very familiar thing. So basically I can come and argue with you about anything." (Participant 4)*

MCM3" I *understand sometimes they, they, they contribute too much towards the distribution of HIV/AIDS especially this polygamy thing because now automatically they are positive cos these people don't, especially males in our community, if you go to the clinic you will know that out of the whole of Madidi only 3% go to the clinic, so basically we are not concerned about medical issues, our medical health, we are not concerned about it. We just concerned about if you are okay, so basically if you come back we test you ka [points his*

eyes] we test using our way or our partners, basically if she goes and comes back and says I am negative then I believe I am negative too. But I am not certain if I am negative or not. So basically these thing of cultural, cultures and norms contribute towards too much towards this thing of HIV/AIDS considering especially…eerr… really test, only 3% only test, so 93% of the males or 90% of males around the village are not certain if they are positive or not but they would consider taking more women'. (Participant 4)

The submission from MCM3 above suggests that he does not engage in extensive social interactions with a wide range of cultural norms, but he is still of the opinion that many people are generally not well-informed about various topics. The participant further indicated that cultural beliefs and norms contribute to the spread of HIV, especially polygamous practices whereby a man are allowed to have more than one wife. He also mentioned that it is rare to find men consulting a clinic about their health, noting that the percentage of men seeking medical consultation is typically around 3%. This seems to suggest that many men never consult a clinic to seek HIV testing before they start engaging in sexual activities with their partners. They believe that, if their partner is HIV negative, they would not get infected, forgetting that there are also STDs.

FC1" *Uhm cultural beliefs and norms, I think they are beliefs that people usually follow, and sometimes they oppress people or control them." (Participant 6)*

The submission from FC1 above suggests that cultural beliefs and norms oppress and control the people who usually follow or believe in them. People's behaviours are usually influenced by culture, especially concerning the decisions they make in their lives and how they should live their lives. Most of the time women are oppressed by men and they do not have any about things. Men are given more authority and more opportunities in society.

FN2" *Uhm, cultural beliefs are things that are done in culture and uhm other people are still practicing till today, like for instance uhm when let's say I am married to my husband then uhm my husband dies then they will say I will have to marry the younger brother so those are cultural beliefs that are...that are still being practiced." (Participant 7)*

The submission from FN2 suggests that cultural beliefs and practices persist in contemporary society, with examples such as the tradition of marrying the brother of a deceased husband to ensure continuity of the family name. This practice reflects the belief that widows should

be inherited to maintain familial ties. Additionally, cultural norms may restrict widows from marrying outside the deceased husband's family because they are perceived as belonging to that family due to their dowry payment. Such cultural practices may inadvertently expose widows to health risks, including infections, as they may not be aware of their new husband's sexual history of orientations.

MN1 *"One thing about...we need to remember that the one thing about our beliefs and norms, our cultural beliefs and norms is that the problem is that they are still backdated so uhm they are still backdated, in our Tswana uhm beliefs we still have that uhm a woman must be treated and behave in a certain way, so if you gonna, for example say since you are married you cannot use a condom but the woman feels that as a husband I am unfaithful and I have multiple partners outside the marriage, yes the woman still wants to stay in the marriage but feels that the more she stays in the marriage and engaging in unprotected sex she will get infected. So you get to our beliefs that they will have a pressure to women that you are in a marriage why you are using a condom, yes and our beliefs kind of promote that a husband can have other sexual partners, because we be in a session where they say a man can have a more... for example in Tswana a man 'ke selepe" meaning a man can still engage in sexual activities outside marriage impregnated because even if he impregnate other ladies they will still say he is building his family, he is increasing his children what, so that's the vulnerability because now a woman is in a risky marriage and she can't even enforce that her husband wear a condom during sex, so now if the husband is sleeping with everyone outside then again we come back to the role that that's the problem." (Participant 8)*

The submission from MN1 above suggests that cultural beliefs are outdated, implying that the society still holds onto certain beliefs about the behaviour and treatment of women. For example, in some cultures, women are not allowed to use condoms in their marriages even if the husband is unfaithful or have multiple partners outside the marriage. A man may be regarded as the head of the family and his actions may be considered beyond question. Negotiating condom use may be regarded as a sign of mistrust. Many women in cultures are unable to exercise their sexual rights because they are being oppressed. Cultural beliefs and norms may also promote the idea that a man should have multiple sexual partners or take another wife in order for the family to grow, as the second wife will also bear children. This shows that people's health is not considered and they are taken for granted.

FN3*" Mmm cultural beliefs and norms uhm I think according to my understanding it's a belief system that controls one's behaviour especially in the area that you live in how you should live or how the tribe should live in in a certain group, uhm even the religion still can be like how it determines how you should behave in an in an area mm that's how the cultural practices are done in your area. Ya." (Participant 9)*

The submission from participant FN3 supports what participant FC1 said, especially about cultures controlling one's behaviour. FN3 seems to suggest that religion can also play a part in determining how one should behave. Religion may shape an individual's decision just as culture, especially concerning condom use in the marriage. This shows that people who have been married in the church or under culture end up obeying the rules that are given to them instead of making their own decisions that will protect them against STDs.

FN4*" Ok the cultural norms, uhm norms it's a doing what is right like in our culture we know that a woman cannot have more than two males, it is social accepted that women cannot have more than one sexual partner, but with males they can have more than one sexual partner, and then the values is what we believe in. we know that what we believe in uhm you cannot have many males, you only choose one one sexual partner or one husband. And then norms and values they regulate us, they control us and they guide us on how to live, and then if the person doesn't take the norms and values positively they end up working against their life, but now our our young children the girls they think that they have the same powers as males, so in the olden days we knew that girls were reserved and they were doing the right things in the society but nowadays they do whatever they want to do, if they want to walk on the streets even if the parents are there they don't even hide themselves, and nowadays they can even have sexual activities even at the parties when they gather together they tell themselves that it's only the young couples that is not socially accepted, but nowadays it is accepted because they say it is a free country but they exercise wrong things in the name of free country democracy." (Participant 10)*

The submission from FN4 suggests that norms and beliefs play a significant role in regulating and guiding our behaviour and individuals who do not adhere to them may face consequences. Failure to take these norms seriously can lead to negative outcomes for the individual. Women are not allowed to have more than one partner while men are encouraged to take a second wife. However, nowadays young girls do as they please in a sense that they copy or practice what men are doing because they believe that they have the same rights and

live in a free country. FN4 explained that, in the past, girls were expected to be reserved, meaning that they had to follow the laws that were set for them. Today's generation do as they please and they engage in risky sexual behaviours without thinking twice. This suggests that some individuals no longer adhere to cultural norms, as they assert their right to autonomy in determining their lifestyle choices.

MCM4 *"Cultural beliefs and norms are practices that oppress people, especially women, they control people's lifestyles on how they should live." (Participant 11)*

The submissions from MCM4 seem to support those of participant FC1 and FN3 because they suggest that cultural norms and beliefs oppress people, especially women, on how they should live and conduct themselves in society and also in marriages.

MMP1*" Cultural beliefs it's a… what specific culture would consider it to be normal, ya... for them to practice, and norms are standards that certain culture practice standards ...eer I think so." (Participant 12)*

The submission from MMP1 suggests that cultural beliefs are what the cultures or groups of people may consider normal and also practice, while norms are the standards that a certain culture may consider. This implies that cultures may set their own rules that people need to follow or live according to so that they can shape their lifestyles and how they should behave. This may include traditional practices that are supposed to be practised in marriages or the society, such as polygamy, incest and circumcisions.

Based on the submissions by the participants above, the majority suggest that cultural beliefs and norms, particularly regarding polygamy, contribute to the spread of HIV/AIDS. Participants are of the opinion that norms and believes control and regulate how one should live their lives and if one does not live according to them, they end up working against them (FN4). The researcher asked this question to determine the participants' awareness of cultural beliefs since these beliefs are significant social factors contributing to the spread of HIV, especially in cultural practices. It is evident from the participants' responses that cultural factors strongly influence people's lives.

4.3.1.6 Subtheme 6: Tswana cultural beliefs and norms

Participants in the study were asked to share the Tswana cultural beliefs and norms that can contribute to the spread of HIV/AIDS in the community of Madidi. The following are the responses from the participants and the explanation of the researcher under each response.

FCM1*" Oh, some polygamies and they result in an increase of HIV/AIDS, Uhm and I can say initiation schools." (Participant 1)*

The submission from FCM1 suggests that polygamy and initiation schools are the cultural norms that contribute the most to the spread of HIV/AIDS in the community. However, FCM1 did not explicitly explain how these norms contribute to the spread of HIV. Therefore, the researcher probed the participant further to obtain more details. Below is the response from the participant:

FCM1" *There is no medical care there, so they use this lazer to do the job of circumcision and they don't disinfect those lazers, so it can play a role on infecting or transmitting the virus." (Participant 1)*

The submission from FCM1 suggests that, in initiation schools, there is a lack of medical care and they typically use razor blades to perform circumcision. She mentioned that these razors are not disinfected, which may play a role in the transmission of the virus. This implies that using contaminated razors during circumcision could potentially put initiates at risk of contracting HIV or other diseases.

MCM1*" Ohk, so I will start with number one, number one is the what we call the initiation, whereby men will go to the mountain and get circumcised there, so there might be a transmission there when they were cutting these guys or circumcising these guys, but I am not yet sure whether they are using the same blade for the whole people who are there at that time, that will also increase the rise of transmission. Number two will be again in terms of Sangomas where you go there and they cut you and cut maybe they are using the same blade for the same client as well, actually those are two main ones which are contributing or they might be contributing to the high rise of HIV/AIDS infection."(Participant 2)*

The submission from MCM1 suggests that circumcision at initiation schools as well as consulting Sangomas are cultural believes that are being practiced in the community. The

participant stated that HIV may be transmitted when circumcising individuals who attend the school, especially if the same razor blade is used for all initiates. However, MCM1 is unsure about the specific procedures, including whether one razor is used for multiple initiates. Additionally, MCM1 mentioned that, in terms of consultations with Sangomas, if the Sangoma uses the same blade on multiple clients, it might also contribute to the spread of HIV/AIDS. This implies that circumcision at initiation schools may not be safe, as precautions are not consistently taken by initiators during the procedure.

MCM2*" Eish about that, circumcision, most of the Tswanas they don't go to initiation school so that can play a role on the spread of HIV but we don't normally mean that people should have unprotected sexual and also polygamy I think." (Participant 3)*

The submission from MCM2 above suggests that circumcision is a significant cultural factor contributing to the spread of HIV/AIDS. Further, MCM2 stated that Tswana people do not typically attend initiation schools. He then emphasised the importance of avoiding unprotected sexual intercourse and identified polygamy as one of the contributors to HIV within the culture. In response to MCM2's mention of polygamy, the researcher asked him a to elaborate on how polygamy contributes to HIV transmission, seeking further clarification. Below is his response:

Researcher *"Like how is causing the spread of HIV, polygamy?"*

MCM2" *Having many partners is not good when you are not circumcised and you are not testing for HIV and not going to hospital to for medical check-ups." (Participant 3)*

The submissions from MCM2 above suggest that, having multiple partners while one has not been circumcised, might contribute to the spread of HIV, especially if individuals do not undergo HIV testing and medical check-ups at hospitals. According to CDC (2022), circumcision may reduce the risk of one contracting HIV as well as STDs. The participant is thus trying to indicate that, having multiple partners while one has not been circumcised, may increase the risks of contracting HIV.

MCM3" *Only my father is Tswana and I was raised from my father's side, so I am not familiar with their side, but I would say the tradition is not, is very ignorant to factors, most factors there is contributing to these HIV/AIDS, they are more focused on this is what*

culture is this is what we are doing, this is how we are doing, this is how we are growing and this is what we are taught, they are not open minded." (Participant 4)

The submission from MCM3 suggests that he was raised by his father's side of the family, who are Tswana people. He is, however, not familiar with their side, meaning he is not familiar with the practices of the Tswana people. The participant explained that people are primarily focussed on adhering to cultural practices without considering their potential contribution to the spread of HIV/AIDS. He believes that culture can be an ignorant factor, suggesting that certain cultural practices may inadvertently contribute to the spread of the virus. However, he did not specify which cultural practices he was referring to. This indicates that some individuals may lack awareness about their own cultural traditions since they are more focussed on current events and trends.

FN1 *"Polygamy for one, you will find that a man is married to one women and then in the process he gets into a relationship with the second person who is intending to marry, and then not knowing the health status of that particular person, you will see uhm and then a, you will find that okay you don't have any information about the person, let's say the previous relationships that this person has, you know or maybe you don't uhm actually go to the Doctor to confirm the status of this women you are getting into the relationship or marriage, you don't, normally that is the thing that is actually taking place before one gets married to the second…the second person. So you will find that in the process maybe this particular person comes in to the relationship or enters in to this marriage with some sort of diseases, which means that the husband let's say the husband. The husband which is married to these two wives me will be having a sexual intercourse with the both women you see, which means that they are uhm.let me say the first women will be at risk you know of getting the disease from this other woman because now they don't have the knowledge, the health status of this particular person so you will find that the 3 of you end up being infected, so I can say that the lack of knowledge it plays a part, ya." (Participant 5)*

"You know what let me add on to uhm the question that you just asked me'

Researcher" *The previous question?"*

FN1" *The previous question, because since I have raised the fact that we also believe in the traditional practices, traditional practices meaning that you go to consult at traditional*

healer and then even you will find that you are. The let's say maybe you go there with a particular disease ne, and then you are hoping to get uhm healed by this traditional healer [pause] where you find that uhm they use razors to cut you, you know. put in some muthi there, not knowing that that razor that is used on you was previously used or not, so that can also contribute to the spread of HIV. (Participant 5)

The submission from FN1 suggests that polygamy, a prevalent cultural practice in the community, can have negative consequences. The participant highlighted the risk associated with a man marrying someone whose health status is unknown, as this may expose both the man and his first wife to potential diseases from the new partner's previous relationships. FN1 also emphasises the role of lack of knowledge about someone's health status in the transmission of HIV. Additionally, FN1 mentioned consulting traditional healers, such as Sangomas, as another cultural norm in the community. However, this practice raises concerns as Sangomas may use razors that have been previously used on others during cultural rituals, potentially leading to the transmission of diseases.

FC1 *"Uhm I think marrying more than one wife, uhm circumcision at initiation school, uhm traditional practices such as consulting at Sangomas, yes." (Participant 6)*

The submission from FC1 suggests that circumcision, marrying more than one wife and consulting Sangomas are the cultural practices prevalent in the community. The researcher asked her how they affect the community:

Researcher" *So how are they affecting the community?"*

FC1*" For example, marrying one wife, uhm one can get infected because it is most likely uhm having multiple partners or having sex with multiple partners, and then circumcision at initiation school, uhm the people that are being circumcised…yes..and then traditional practices are uhm maybe the herbs or medicines that they use to or for example uhm the blazers that they use on the skin and then..ya I think that's all." (Participant 6)*

The submission from FC1 suggests that having more than one partner may increase the risk of contracting HIV/AIDS. FC1 also mentioned that individuals undergoing initiation at initiation schools are at risk of contracting HIV, particularly if precautions are not taken and if married couple do not undergo HIV testing before engaging in sexual intercourse. Furthermore, not

disclosing HIV statuses, especially in polygamous marriages, poses significant risks as individuals may be unaware of their new partner's past sexual relations.

FN2*" Ohk, uhm the initiation school, that can spread the because uhm when they do the procedure they don't follow the sceptic uhm um sceptic procedure they just cut all the initiates with one lazer which then can put their lives in danger they can transfer the infection from one person to the other so all the initiates will end up having HIV because of the non-sceptic procedure they followed there, ya." (Participant 7)*

The submission from FN2 suggests that circumcision at initiation schools can increase the risk of contracting the HIV due to in which certain procedures are done, such as using one blade on all the initiates. The participant further stated that this practice might endanger the lives if the initiates, as the infections could potentially be transferred from one initiate to others.

MN1" *The way women are treated; for example, they will say the woman regardless needs for example being in a situation where the family member they enforce why since you have been married to me for example why are you so far you not having kids so far such stuff. When the pressure gets there the woman can reach a stage that the husband is unfaithful then you are exposing yourself to the virus so such beliefs that uhm once you are in a marriage you must have children whether you are still planning, whether you are still figuring other certain things in your marriage, still they enforce such, so is all a problem and also the beliefs that allows a man to have more than uhm one uhm one wife because now you will find a person having sexual partners outside and they still say I'm searching for the second wife or the third wife so also becomes a problem, yah." (Participant 8)*

The submission from MN1 suggests that women in the Tswana culture are often pressured to bear children once they are married. In some cases, the husband's infidelity exposes the women to infections such as HIV. The fact that men are allowed to have more than one wife also puts them at risk of contracting HIV. In the Tswana culture, men are allowed to have more than one wife while women are not allowed to have more than one husband. This contributes to the inequality of women, as they are often oppressed and lack agency in their marriages. It is evident that some cultural practices continue to oppress women, especially within the context of marriage, where they have limited autonomy and are expected to adhere to cultural norms.

FN3 *"I have seen so many young traditional healers, I am not sure they are professional trained, they are they have the knowledge about HIV testing because it's like local, I think you become a traditional healer there's some way you should attend these courses, so here I just see them rooming around, I don't even know whether they have this knowledge about safe use of razors and these HIV. And the other thing it's the circumcision, male circumcision schools here around in Madidi eish they are so many, and then I don't even know they they know they the preventive measures when they have to do circumcisions, so they using of these razor blades, one razor blade in every child, I am not sure if they have that, so I am afraid cos it's is seem like is a local thing there's no information on like they go somewhere to be taught or is just the local thing, mmm." (Participant 9)*

The submission from FN3 suggests that there are many young traditional healers in the community, meaning that a lot of people still believe in the practice of ancestral calling. The biggest apprehension is that these individuals may not always be professionally trained or have knowledge about HIV. It appears that there is a concern that traditional healers, upon gaining knowledge about HIC, may be less inclined to take precautions during rituals aimed at protecting their clients from infection. FN3 also stated that may initiation schools still exist, where young boys are circumcised and she is concerned whether they have sufficient knowledge about preventive measures that should be taken during circumcision procedures. The participant further mentioned that the same razor blade is used on every initiate which might put them at risk of contracting diseases. She also expressed her worry about them not having information about HIV or whether the initiators are taught about the safety measures they should consider during circumcision procedures. This implies that having knowledge about HIV is crucial and necessary so that new infections may be reduced.

FN4" Ok*, I think it's the incest, other cultures they still believe that when my brother past away the family just still continue and then they end up now marrying so that they can keep the family alive." (Participant 10)*

The submission from FN4 above suggests that the Tswana cultural norms and beliefs that can increase the spread of HIV include incest, whereby a wife is expected to marry the brother of her husband when he dies. This is referred to as levirate, a practice that can pose significant risks because the two parties involved do not necessarily know each other's HIV statuses.

MCM4*" The cultural norms in Tswana culture includes practicing polygamy, which is an unsafe practice because is like having multiple partners, again going to the initiations like 'Bogwera' because they cut their foreskins with razors and knives which is risky especially in the HIV part, I am not sure of women practices in the initiations." (Participant 11)*

The submission from MCM4 suggests that cultural practices in the community include polygamy, as the majority of participants have mentioned. MCM4 believes that polygamy is unsafe because it is similar to having multiple partners. Additionally, MCM4 stated that attending Bogwera, the initiation school, is another cultural practices in the community, but it is unsafe because initiators use razors and knives to cut initiates, posing a risk of HIV contraction. The participant further explained that he is not familiar with women's initiation schools; hence, no details were provided on that.

MMP1*" Eeerr it starts from home, if there is polygamy you come from a polygamy family is more slightly that you would…between the partners, the can be unfaithfulness and of which one becomes unfaithful and contract HIV outside. Eerr it's both the fall for the rest because I don't think polygamous men use condoms with their wives, mmm." (Participant 12)*

The submission from MMP1 suggests that individuals who typically engage in polygamous marriages do so because they learned this practice from their families, especially if they were raised in polygamous households. Furthermore, MMP1 noted that, in such marriages, one partner may be unfaithful, potentially resulting in HIV infection. Additionally, polygamous men often do not use condoms during sexual intercourse with their wives. Consequently, this indicates that women in polygamous marriages may be at risk of infection due to their husbands' engagement in polygamy and lack of condom use.

Based on the submissions by the participants above, seven of them stated that Tswana people practice circumcision, which involves taking young boys to initiation schools known as 'Bogwera' in their language, where they undergo circumcision and learn how to be responsible members of society. According to Johnson *et al*. (2010), men who undergo circumcision at initiation schools are typically advised not to use condoms because the procedure is considered sufficiently protective. As a result, they may be more susceptible to infection due to a lack of knowledge regarding the transmission of HIV/AIDS. Participants also indicated that polygamy is a traditional practice whereby a man will take more than one woman to build a home with and bear him children, this practice also puts couples at risk of

contracting HIV and STDs, especially because condoms are not commonly used in such marriages.

Even though people may not believe in traditional practices, there are traditional healers that can offer treatments for illnesses that do not require medical care and people end up being healed. One should have faith that the medication given to them will work. However, it is not solely a matter of belief; some traditional medications are effective for certain sicknesses that medical doctors cannot treat.

4.3.1.7 Subtheme 7: Sexual risk factors

The participants in the study were asked about the sexual risk behaviours they engage in that make them vulnerable to HIV and their responses were as follows:

FCM1" *Unprotected sex without knowing how many sexual partners does my partner have, so I get involved with him, without using a condom." (Participant 1)*

Researcher *"So do you sometimes go with your partner maybe to go and test for HIV to know your status."*

***FCM1**" To be honest, I only go alone most of the time [laughs] ya. (Participant 1)*

The submission from FCM1 suggests that she engages in unprotected sexual intercourse with her partner only, but it could be that she is taking a risk because she does not know what her partner is doing when she is not around. The researcher also asked the participant if she sometimes goes with her partner to test for HIV and she stated that she goes alone. Evidence suggests that men are less likely to take HIV tests and use healthcare services compared to women. According to UNAIDS (2016), men in South Africa are less likely to test for HIV, for example, in 2016, it was estimated that 45% of men tested for HIV compared to 59% women. This indicates that women may be more aware of their HIV statuses within the relationships compared to men.

***MCM1**" Uhm I would say sleeping with your partner without protection, and then number two actually that's the only one hey, because remember when you get hurt, you put a plaster and no one touches your blood you know and you cannot share you're your what do you call it " Kana" what do they call these things, protection, you cannot share those things*

because of skin irritation, so I don't think that might contribute, or sharing a blade or cutting your facial hair and and…you are sharing those things, so the only thing I see is having sex or unprotected sex" (Participant 2)

Researcher" *So do you sometimes go to the clinic and test for HIV?*

MCM1*" Ya, so we have...I usually go there and I actually go and test, not to say it's a. what...a pre-determined term, but I just go there randomly, I wouldn't say maybe every 3 months or every 5 months, no…When I feel like going there I would go there." Usually I am alone." (Participant 2)*

The submissions from MCM1 suggest that sleeping with your partner without using protection might put one at risk of contracting diseases. Furthermore, taking safety precautions like using a plaster when bleeding can be beneficial and protect oneself so that another person does not come in contact with your blood. The participant was asked if he sometimes accompanies his partner when going for HIV testing and he replied that he goes alone. This is evident that some partners prefer going to the clinic alone. According to WHO (2012), it is very beneficial for couples to go together for HIV testing so that they can take informed decisions by practicing HIV safety precautions.

MN1 "*For instance the recreational sex, the one that mostly happens when you are in taverns then you will be drinking and having fun and spot a lady out of the blue you are somewhere and just have sex at the back of the toilet and stuff, it's kinda looks fun, it kinda looks as a fantasy at that time, but if you continue engaging in stuff like that all the time that whenever you go to the tavern you need to pick a girl, have sex with her, then it's starting to be something that you do every weekend, then is kinda unsafe because is not a planned sexual intercourse then for example you have a man at home that you know every night or most of the night you have sex but now this week you will be with Nthabiseng, next week with Lerato, next week with so and so, now you are exposing yourself to different ladies that you have sex with and then it's unsafe behaviour because now you are intoxicated with alcohol and you are engaging yourself in an unsafe practices." (Participant 8)*

The submission from MN1 suggests that engaging in recreational sex is a risky behaviour that might put individuals at risk. This behaviour often occurs when individuals are intoxicated and at taverns, where they may seek to explore their fantasies and end up having unprotected

sex with random individuals in secluded areas like the back of toilets. MN1 further stated that this behaviour could become habitual, with individuals regularly taking advantage of the atmosphere at taverns to engage in casual encounters every weekend.

FN3" Mmm*, the sexual risk behaviours [pause] mmm I don't know whether I can say it's a risk or what but since I am married I am not condomising and then the risk I am taking is trusting my husband, that's the only risk I'm taking, since I am not using a condom in my marriage and you will never know what he does [laughs], otherwise I only have my husband it's the only one sexual partner." (Participant 9)*

The submission from FN3 indicates that, although she is a married woman and only engages in unprotected sexual activities with her husband, she might still be at risk of contracting HIV because she does not know what her husband is doing always or if he is engaging in sexual activities with other individuals. According to Madiba and Ngwenya (2017), the use of condoms in marriages has been neglected, despite a significant portion of infections occurring among married individuals. In marital relationships, sex is often considered as a necessity for both partners and women may face barriers to condom use with their spouses. This expectation stems from societal pressure for women to bear children and the belief that condom use signifies a lack of trust between spouses. Consequently, negotiating condom use for HIV/AIDS and STD prevention becomes challenging for married individuals.

FN4*" Sexual risk behaviours that people are engaging in, ok, having sexual intercourse with the person that you don't know, and you don't even test for HIV before you engage in sexual activity, and then with our male partners they think that if a woman is negative today they take it as if she is negative for a longer period. And then you find that the time the women tested negative she was still on the window period, and then after six weeks the person is positive, and that will bring chaos in the family or in the in the couple because males believe that when the woman is negative they are both negative and they don't go for testing. Even if you encourage them to test after six weeks they don't test, and then what is ...what we always encourage is for the couple to test at the same time and go back use protection and after six weeks they must come and test together, so most males don't test, even with our females, if they are negative today they will just stay and say they are negative, and the person will only test after many many months or even years. Our people don't still know that they still need to test now and then. And other risk behaviour is that you find that people get involved in up taking of alcohol, they will go to parties and party the whole night and then*

from there, especially their young males, even the girls do that, they meet new partners there and then they will just go out and have sexual intercourse without even testing. Because when a person is drunk, their understanding and reasoning will become slower and the person cannot make any right decision because they are drunk." (Participant 10)

The submission from FN4 suggests that having sexual intercourse with a person that you do not know the HIV status of poses a serious risk of contracting HIV. Men tend to think that, if a woman is HIV negative today, it means that they are definitely not HIV positive, not realising that they might be on a window period. That is why people are advised to test after six weeks to ensure that they get valid results. Men often do not undergo testing for HIV/AIDS. They believe that, if their partners tested negative, it means they are also safe and free from the virus. This demonstrates that many males may lack knowledge about the window period and the frequency of testing required after the initial test. One participant, who is a nurse, mentioned that they always encourage couples to test together simultaneously, but men are often reluctant to do so. Additionally, she highlighted the issue of multiple partners in taverns, where intoxicated women engage in sexual intercourse with different men, making it difficult to trace the source of infection. This underscores how alcohol impairs judgment, leading individuals to engage in behaviour they may later regret.

MCM4 *"Sex risk behaviours that I engage in unprotected sex because me and my partner sometimes prefer skin to skin sex since it is more pleasurable and enjoyable than using a condom." (Participant 11)*

The submission from MCM4 suggests that he engages in unprotected sexual intercourse because he prefers skin to skin sexual intercourse with his partner. This highlights that people still believe that using a condom decreases sexual pleasure. Men may prefer "flesh-to-flesh-sex" without thinking about the consequences, especially if the other individual's HIV status is not known. This increases the risk of partners infecting each other with STDs and HIV.

MMP1*" Sexual risk behaviours…I think eerr it's is the attitude that the people show each other in parties eerr the dress codes, how they dress, how they dance, so that's something that eerr if anyone is targeting you the…they can really think that you are, you are trying to show them something off. I don't know." (Participant 12)*

The submission from MMP1 above suggests that certain sexual risk factors that people engage in may include behaviours such as their dress code and how they dance. These behaviours can potentially expose individuals to others who may target them. The participant did not answer the question based on him but in general. This suggests that dressing inappropriately exposes individuals to risky sexual behaviours, especially if they are being targeted. This can also increase the chances of being raped.

Based on the submissions by the participants above, they mentioned engaging in unprotected sexual intercourse may put one at risk since they are unaware of their partner's whereabouts. One participant mentioned that she is married and engages in unprotected sexual intercourse because she trusts her husband even though he might do things behind her back that she is not aware of. According to Nyatsvimbo (2011:1), in marriages, couples are often discouraged from using condoms in the marital bed, especially in African countries. This taboo surrounding condom use in marriages contributes to the vulnerability of HIV/AIDS among African couples. MN1 highlighted the risky behaviour of alcohol use, which may lead individuals to engage in unprotected sexual intercourse, often in taverns or secluded areas with strangers, fulfilling their fantasies. MCM3 also noted the risks associated with socialising at clubs ('grooves') and meeting new, desirable partners, which may result in unprotected intercourse, especially when intoxicated. MCM4 explained his preference for unprotected intercourse with his partner, citing increased pleasure. There is a common notion that 'unprotected sex is more enjoyable than protected sexual intercourse and people believe that condoms reduce the pleasure and it is boring'. This mind-set poses a significant risk, particularly as individuals may rely solely on PrEP and PEP, which only prevent HIV transmission and not STIs. Despite knowledge about HIV transmission. FN4 indicated that many individuals, especially males, engage in unprotected sexual intercourse without undergoing HIV testing, assuming safety if their partner has tested negative. Additionally, MMP1 pointed out that behaviours and appearance may also increase risk, as individuals may become targets for risky acts such as rape, based on their behaviours or attire.

4.3.1.8. Subtheme 8: Views on substance abuse and the spread of HIV/AIDS

Participants in this study were asked to share their views on substance abuse and the spread of HIV. Their responses are displayed below:

FCM1 *"Uhm substance abuse can harm your body, uhm example alcohol, if you took more alcohol without being careful, you end up doing things that you can…didn't want to do like having sexual intercourse with a person that you don't even know, whether she or he is positive or negative of the virus, uhm second drugs, exchanging of needles there is little blood involved and the other, in the other hand you don't know the status of a person you exchanging the needle to, so it can lead to transmitting the virus*." *(Participant 1)*

The submission from FCM1 seem to suggest that substance abuse can harm one's health especially alcohol because people end up having unprotected sexual intercourse with people you don't even know while you are intoxicated. Another form of substance that may cause the spread of HIV is exchanging needles with people you don't even know their HIV status. According to Guure,Laryea, SMO-Y, Dery, Dasilva, Asamoah-Adu,Ayisi-Addo, Loglo & Mohammed (2022), injecting drugs and reusing needles or any sharp tool they use to inject themselves may increase the risk of one getting infected with HIV or Hepatitis B and C, because the needles that they use may carry small amounts of blood from other individuals.

MCM1" *Ok the…well…there's so many substances abuse but what I have discovered is that I can say alcohol, Alcohol I think is the main contributory towards the spread of AIDS, by saying that I mean that uhm most of the time when you are drunk and you are sexually excited, that doesn't mean you gonna have unprotected sex but being sexually excited means it can contribute towards the risk towards getting infected with HIV/AIDS, by saying so I mean like if you do not use a protection, yes and then the other substances most of the substances which I saw except alcohol, I would say, if it's contributing it's not like alcohol, because if you look at people who are taking Nyaope does, the most common drug in Madidi which is nyaope, ya the Mandrax and the other drugs are there but I won't say they are high as Nyaope, so people who smoke Nyaope I have never seen people after smoking Nyaope having intercourse, and and most of the time what they do is smoke, they sleep, they wake up and look for more money buy the drug. I am not sure about the intercourse, those ones I am not sure of but one substance I would say its contributing to high rise of infection is alcohol abuse, actually its alcohol abuse." (Participant 2)*

MCM1*" Most of the time with the guys who, I am talking about the alcohol now, most of the guys who are taking alcohol, like we usually take alcohol in a social area, like I mean like places like taverns, uhm parties and, whereby you will see people which...how can I put it? Uhm people who are new to your eyes, so people being new to your eyes you gonna be*

interested or what's that word? Uhm. it's actually craving in a nice way, so ya that's how the alcohol does that." (Participant 2)

Researcher*" So those who use drugs they are not at risk?"*

MCM1" *Uhm they..there is other drugs that they take and they inject themselves and, ya but with those one I have never actually never seen people in Madidi doing those. Sharing a needle as like, sharing a sharp device like a razor or needle and."*

The submissions from MCM1 imply that using alcohol makes one sexually excited which increases the chance of people having unprotected sexual intercourse. This might contribute to the spread of HIV. According to Newswise (2023), when men abuse alcohol, they may have the courage or confidence to approach women and they are less picky when it comes to who they want to sleep with at that particular time. This can lead to individuals getting infected by STDs and HIV and it can also lead to unplanned pregnancies. The participant further stated that people who use cocaine which is known as 'Nyaope' are less likely to have sexual intercourse because it makes them sleepy, decreasing the chances of them engaging in sexual activities.

MCM2*" My views about substance abuse is that most of the time people like to drink and use drugs like Nyaope and that drug it makes them unconscious, is not good to practice sex when you are unconscious." (Participant 3)*

The submissions from MCM2 suggest that he also believes that alcohol and using cocaine can make one not be aware of the things that are happening around them, leading to them engaging in unsafe sexual practices. The respond proves that alcohol negatively impacts one's choices and facilitates participation in risky sexual behaviours.

MCM3 " *I would say substance abuse is one of the most ignored uhm..contributors towards HIV/AIDS because these guys like I said earlier that they are 'Bluetooth' now, and then these women they have what we call Alostro, so she must have a smoke get a blunt before she sleeps, but she doesn't have a plan, so she must hustle, she wouldn't mind whoever she sleeps with, she don't care about the status, she cares about satisfying her ache for the thing that she's aching for, so basically it's very like they...it's like jumping in a hole knowing this is a hole and it's 7 metres down, but I don't care, maybe I might come up, maybe I*

might not but who cares but I need this fixed. So drug abuse is a very big contributory towards the risks of getting HIV." (Participant 4)

The submission from MCM3 suggests that substance abuse is one of the contributory factors of the spread of HIV/AIDS and nowadays, drug addicts use the same needles "to Bluetooth" each other, meaning one will inject themselves with a drug, then withdraw their blood to inject the other drug addict so that they can both be intoxicated. Woman who are drug addicts end up sleeping with anyone in exchange for money to buy the drug to feed her craving, known as 'Alostro.' Individuals may be aware of what they are getting themselves into, but they still do not care about the consequences. This demonstrates that people are aware that their actions may put them at risk but they still continue with their risky behaviours.

FN1 *"Yaa, substance abuse uhm, ok I just want to give you an example of when you say substance abuse, I am gonna talk about there is this injection that uhm this Nyaope guys use, you will find that they are using one needle actually, one injection, you know I mean to inject the substance or let me say two or three people that can uhm contribute to the spread of HIV. And then also alcohol, drugs can also contribute because now you find yourself in a situation where you are not in your normal senses, you know, normal senses, ya uhm you find that you are drunk you sleep with whoever you know, you end up being in bed with someone that you don't know, so that can play a part in in the the spread of AIDS." (Participant 5)*

FC1 *" Uhm my views on substance abuse, uhm for example like when someone is drunk uhm they are likely to have sex with multiple partners or people and another thing uhm people who use drugs like Nyaope they use syringes that might infect them and maybe they might use even one syringe but on different people." (Participant 6)*

The submissions from FN1 and FC1 support the suggestions of MCM1, MCM2 and MCM3. This implies that many people are using the same needles to inject themselves with drugs, thereby increasing the risk of them transmitting HIV to one another since they are not aware of each other's statuses.

FN2 *" Uhm, it's it's…substance abuse does contribute to the spread, because uhm when you are intoxicated with the substance, whatever substance that you may have taken at that time, you cannot resonate, if a man can say let's go and will give you money, then you will*

agree to that, which will lead you to prone to contacting the infection, so substance abuse really does uhm increase the rate of HIV." (Participant 7)

MN1 *"Oh my views on substance abuse, because mostly for example I can say mostly if you engage yourself in things like dagga, drugs, alcohol mostly it kind of reduces your mental activity, so now if your mental activity is not at its capacity to think things through, there is no way that you will, you will think something to an extend that I met Lebogang today why am I, why am I uhm why am I having sex with her while I have seen her today and you can't even think for example like okay you are not sober minded, you see so such stuff the more you indulge yourself in alcohol, in dagga uhm you are exposing your mental capacity or inability*." *(Participant 8)*

The submissions from FN2 and MN1 suggest that substance abuse may reduce one's mental clarity and cognitive function. This makes individuals unable to think clearly and impairs their judgment, preventing them from making informed decisions such as using preventive measures to protect themselves from getting infected when coming into contact with others or considering sexual encounters. Additionally, when a woman is intoxicated, it becomes easier for men to take advantage of them by offering them money in exchange for sex.

FN3 *" Substance abuse and spread of HIV, you know I have experienced that these adolescents that are using drugs especially the injection, almost all of them are HIV positive, yes they will come to the clinic being sick and what they will end up not complying to the treatment, so they end up keep on spreading it and then the alcohol part, mmm like I said the area here the alcohol abuse is very high, so HIV is spreading like nobody's business in my area." (Participant 9)*

The submission from FN3 suggests that many adolescents who use drugs, especially those who inject themselves, are HIV-positive and they end up not adhering to treatment further contributing to the spread of the virus. Not adhering to medication may cause the virus to multiply and weaken the immune system. Participants indicated that individuals who use intravenous drugs are at risk of contracting HIV. Additionally, the rate of alcohol use appears to be high in the community, as reported by participants, suggesting that many individuals in the community might be at risk of contracting HIV.

FN4 *"Ok substance abuse just like uhm taking alcohol, it is a drug, when a person is taking or is abusing substance they cannot have the right …they cannot make the informed decision, the person will just get involved in many relationships and contact sexual...sexual partners, involved in sexual intercourse that might also lead to the opportunistic infections like sexual transmitted diseases. "(Participant 10)*

MCM4*" One can get HIV…when they are sharing needles during when using drugs and also when someone is drunk they might engage in unprotected sex with strangers at the taverns or even buy sex from the prostitute, which is dangerous because you are not thinking straight." (Participant 11)*

The submissions from FN4 and MCM4 imply that using alcohol increases the chance of an individual to become involved in sexual practices and acquiring the infections if they engage in unprotected sex.

MMP1" Ya, *eerr substance abuse on the spread of HIV it can be rude in many ways when they are highly intoxicated, they can have distorted mental orientation which can make them vulnerable to the spread of HIV through sleeping with other people. Number two they inject themselves, so they don't sterilise uhm injections, they use one injection and syringe to give the drug more and more and again, some they get injected on veins and when they get infected is easy to pass the infection, easy through the skin because they have lot uhm barrier protection from the skin…ya*." *(Participant 12)*

The submission from MMP1 suggests that, if an individual is intoxicated, their mental orientation may not be of good state and they can be vulnerable to the spread of HIV through having sexual intercourse with other people. Another concern is that people may share needles to inject themselves when they are using drugs which increases their risk of getting infected.

Based on the submissions by the participants above, it is clear that alcohol and drug abuse may contribute to the spread of HIV because when people are intoxicated they are unable to make informed decisions, especially regarding practicing safer sex. Participants also narrated that people may inject themselves with needles and share those needles with other drug addicts which increases their risk of getting infected by HIV since they do not know each other's statuses. According to Madlala (2009:13), an individual who is under the influence of

alcohol or drugs may be unable to practice safe sex or protect themselves from acquiring HIV. MCM3 mentioned that nowadays, when drug addicts share needles among themselves, they refer to it as 'Bluetooth,' a very risky practice. This is risky because they are withdrawing their blood and transferring it to others. According to the NIDA (National Institute on Drug Abuse, 2020), individuals may share needles when injecting drugs which is linked to the spread of HIV. Adolescents were also mentioned as part of the population using drugs. When they come to the clinic, it is often discovered that some are already HIV-positive but fail to adhere to treatment, resulting in further spread of the virus. Alcohol intake in the community was also reported as a significant problem.

4.3.1.9 Subtheme 9: Sexual activity for money

Participants were asked if they have ever engaged in sexual activities in exchange for money or any favours and their responses are as follows:

FCM1*" Uhm no." (Participant 1)*

MCM1*" No, I have not" (Participant 2)*

MCM2*" No, I haven't* "*(Participant 3)*

The submissions from Participant FCM1, MCM1 and MCM2 suggest that they have never engaged in sexual practices in exchange for money or any favours and they did not elaborate further on their answers.

MCM3*" Uhm [laughs] as a man I would say that's a very very tricky question, uh we give money, we give women money every day and we have sex, so I'd say that one is very difficult question*.' *(Participant 4)?*

MCM3" *Men, men engage in sexual activities for money every day, so that's a very difficult question for a man, every day we engage in sexual activities for money." (Participant 4)*

Researche*r" And for favours?"*

MCM3" *Some of them are good, this is my wife I must give her money to go to this wedding but later she knows, you get it ne [laughs] but some are bad because now this one I just met today but she wants six Savana, you see so I'm giving her for six Savanna but I know my*

status very well, I won't, I won't be good to her. So I am not saying some of them or not all of them are good, not all of them are bad, is just in different." (Participant 4)

Researcher *"So what are your views on that?"*

MCM3" *[sigh] heish I believe I cannot change the world, so I am saying...eish…it's a very bad situation but what can I say, I cannot change the world." (Participant 4)*

The submissions from MCM3 suggest that men do engage in sexual activities in exchange for money, but most of the time, they are the one's giving the women money. However, they are bound to give their wives money, regardless of having sex with her or not. Additionally, some women are given alcohol in exchange for sex. This clearly implies that people do engage in sexual activities in exchange for money.

FN1*" Mmm… myself ahh I have never, I have never engaged in sexual activities for money, what I can just…I can give my view on that, who are, who get in to...not actually a relationship, actually you know what on giving favours to men, sleeping with men, because now the person is stranded, she wants to buy maybe a let's say uh clothes, food you know or whatever and then now they get into the sexual intercourse with different men for the sake of getting money in return. And then there are some who are getting jobs in change for for sex, and then you don't know that this person who is saying I will give you, I will secure a job for you, you don't know how many partners this person has, so ya that is my view." (Participant 5)*

The submission from FN1 suggests that she has never engaged in sexual practices in exchange for money or any favours, but gave her views on that. She mentioned that individuals who are stranded may engage in sexual activities for favours. She further indicated that some may even be promised jobs. This may suggest that it is part of transactional sex or even prostitution indirectly, even if people do not want to label it as such. It involves a give-and-take situation.

FC1" *No, I haven't, but I think people who have sexual partners in favour of money I think they are uhm somehow hustling through those people as you can see, the unemployment is high, the unemployment rate is very high, so they are somehow making money from whatever they'll be doing." (Participant 6)*

FN2" *No I have not done that" (Participant 7)*

Researcher *"So what are your views on that?*

FN2*" Uhm it is very wrong, uhm for me, mxm it is very wrong because if you are a person and you are in need of money, there are many other ways you can use to make money, you can do laundry for someone and then they will give you money and then you can look after kids and then uhm you can get paid from doing that unlike selling your body for money, you know, there are many other things you can do to get money rather than, than involving in prostitution." (Participant 7)*

The submissions from FC1 and FN2 suggest that people may engage in sexual relations in exchange for favours and money because of the rate of unemployment. As mentioned previously, unemployment in the community is very high, so people will obviously try by all means to make money, even if it is the wrong way. Participant FN2 believes that there are a lot of ways in which people can raise money in order to take care of themselves, apart from selling your body. She mentioned various examples of how people can make money such as taking care of children and doing laundry for people in exchange of money.

MN1*" For my side I can still say no because I am working, so I am able to buy myself things and I am able to…so I am…I don't feel kinda vulnerable that I will sleep with someone for money because I have an income each and every month so ya, so for me is a no." (Participant 8)*

The submission from MN1 suggests that he does not engage in sexual activities in exchange for money because he is financially stable and does not see any need to do so. Being financially stable and having a stable job may decrease the chances of individuals getting involved in such acts.

FN3 *"[Laughs] Ok, like I said I am a married woman but then I went to school to the college far from here from home to Klerksdorp for 4 years, leaving my husband behind, my husband is unemployed, I am struggling financially from far away I have to maintain my family, I've to maintain myself, I have to buy books, I have to eat, I have other needs then I am far from home, the only idea was to have a male partner that can have money and supply me, but then you know with the male partner you can…cannot just have a male partner you will also have to sleep with a partner." (Participant 9)*

The submission from FN3 suggests that she was once involved in sexual activities in exchange for money because she was still in college and did not have enough money to look after herself and her family. This implies that college students are struggling to make ends meet while they are busy pursuing their education; therefore, they end up getting involved in non-traditional methods of obtaining money and resources in order to make ends meet. The inability of families to help by providing financial support may drive women and college students to engage in relationships with sugar daddies in order to get money. Some of the individuals may start 'no strings attached' relationships where they do not require any commitments but only sexual arrangements in exchange for money. This type of relationship is usually referred to as 'friends with benefits'.

FN4 *"No" (Participant 10)*

Researcher *"So what are your views on that?"*

FN4 *"Ok, my view is that as a married woman you cannot engage yourself with extra-marital affair, because according to our values and according to the biblical principles a woman or a man must only have one sexual partner and then if you get or exchange sex for getting money, just getting money you expose yourself to HIV infections even if the money is no longer there, HIV will stay with you for the rest of your life and you have to take the treatment for the rest of your life and some people even when they are taking treatment their viral load will always be high because of having many sexual partners even when they take treatment it won't work well because now their viral load will be very high, because of having infections." (Participant 10)*

MCM4 *"No, I have never, my view is that most guys tend to take advantage of women when they ask for favours, they help them then expect sex in return and is dangerous because they might report them for rape or might get sick rather." (Participant 11)*

The submissions from FN4 and MCM4 suggest that they have never been involved in sexual practices in exchange for favours or money, but they gave their views on that. FN4 believes that, as a married woman, you cannot engage in extra-marital affairs because of biblical principles and cultural values, she further stated that sex in exchange of money may also expose one to HIV infections. MCM4 indicated that men tend to take advantage of women

when they ask for favours or when they seek help from them, which puts them at a situation where they cannot say no because they desperately need help.

MMP1*" No, I haven't but I was drugged before [laughs], I was drugged eish is a bad…it's a sad story, I was drugged. I was given an apple juice, I hate apple juice, then the next thing I woke up around 3 am, I don't know what happened to me, but I can see that something was happening. So it's not my…that's the only thing I can say for now…ya so apple juice [laughs] I don't like it. (Participant 12)*

The submissions from MMP1 suggest that he has never engaged in drugs and alcohol, but he was drugged before through apple juice and he could not remember what happened after being drugged. This indicates that people are capable of drugging someone if they have the wrong intentions with the individual. This can be risky because they might engage in sexual activities with the individual without using any protection or they might use needles on the individual that were previously used on themselves, potentially injecting the individual with their HIV-positive blood.

Based on the submissions from the participants above, the majority mentioned that they had never engaged in sexual activities or provided any sexual favours in exchange for money. Only one female nurse indicated that she was involved in sexual activities for money because of her financial situation when she was still in college. Poor living conditions of women may expose them to the risk of contracting HIV because they engage in transactional sex, not willingly but because of the situation that they are in at that time. MCM3 stated that he had never engaged in sexual activities or provided any sexual favours in exchange for money. He believes that, if you have a wife, you should give them money to take care of her needs.

4.3.1.10 Subtheme 10: Stigma and discrimination

Participants were asked about what they think about stigma and discrimination leading to HIV and whether it has an effect on patients in healthcare facilities. The following are the responses from the participants:

FCM1"*Uhm …I have never experienced that but believing that only a certain group of people can get HIV/AIDS which lead to people being afraid to get tested to know that status, and it does have an effect on them because they feel ashamed, fear to disclose and they*

end up isolating themselves, and in Madidi people like to point people "oh that one has AIDS" to judge them, a person ends up isolating he/she." (Participant 1)

The submission from FCM1 suggests that stigma and discrimination may hinder HIV prevention, care and treatment efforts. People may be afraid to visit healthcare facilities HIV testing, fearing stigma and discrimination if they test HIV positive. This fear may lead individuals to feel ashamed and reluctant to disclose their status, isolating themselves from their community.

MCM1 *"Ohk, so I think stigma and discrimination it is caused by lack of information, what I mean like that I mean like those kind of things is because people do not know or understand the disease that's why people are stigmatised and they discriminative and and and, remember like they said with HIV/AIDS you can protect others by wearing a condom, uhm not sharing sharp devices like your razors and and and, so I believe we can still live together but because of lack of information uhm its contributing towards stigmatisation and discrimination." (Participant 2)*

Researcher" *In communities or in health facilities?"*

MCM1" *Both, actually both, actually in the country. People are lacking in the information in Madidi but as a country in a whole you might find based on my view, I would say it's people who know about HIV/AIDS, uhm to the level of understanding maybe they are 60% 70% that's my understanding and that's my view point." (Participant 2)*

The submissions from MCM1 suggest that people lack information about the transmission of HIV. If people knew that HIV cannot be transmitted by sharing of utensils and bathrooms and hugging each other, then the stigma around HIV would be much less. People in the community should be equipped with HIV information so that they can stop judging people who are living with HIV. The participant indicated that people may have 60% to 70% knowledge; hence, the many misconceptions about HIV.

MCM2" *It affects them very bad when they are not supported positively, people like judge them and not knowing their situation about sex and their health issues, and how did get HIV or spread or the spread of HIV." (Participant 3)*

The submission from the participant above suggests that individuals who are stigmatised may lack social support. They may even develop psychological distress and develop feelings of loneliness. Some may be judged or called names without knowing how they got infected by someone they do not even know, for example by being raped.

MCM3" *It does [pause] it does because, say we from the corona situation, I get the corona, Lebo gets the corona and she is a female and sister Tumi here gets corona which is gay..." No , its…that where I am headed, I am leading to. We are in the same area and sister Lebo here, its, I am positive, you are positive [pointing at the researcher] but she is negative, so the nurses discriminate against those one, they use the same injection they used from us to him, last priority, they don't even wanna use injections, so you see automatically, it means that when we leave this corona virus facility we are okay, he is worse, you get the point? So basically if they discriminate and they start to say no this one is gay, this one are okay, let us start treating this ones and then continues with the last one as them, we can even use this ' ga ana taba' that they don't matter, it means that automatically what we have they will get, so I think it's a very bad situation to discriminate against who is who or what is what, we are all humans at the end of the day.." (Participant 4)*

The submission from MCM3 suggests that people may be discriminated against in healthcare facilities because of their status or the kind of illness they have or preference may be given to ones not infected. The same injection might even be administered to the one not infected, where they might end up getting infected.

FN1" *Uhm when you talk about stigma, [pause] are we saying that people Uhm with a disease, with the HIV are being discriminated against? Uhm you know what my view on that, my view on that will be...people we are…we have different characters, there are those who are strong, there are those who are weak you know, uhm some of them ne, some of them can be judged in the in the health facilities, because now uhm you know humanity maan, they there are people who doesn't have the humanity, so ya, they often you know what, when a person let's say visit a clinic or hospital or what and then you get a negative reaction you know, from the person that you are, you are expecting to get help or, what is this kana? Or being counselled you know, so some people often, you know what they get to an extend that they just uhm exclude themselves from this facilities, they are scared to go to health centres you know, to be tested or to take medication because now the abuse, the*

verbal abuse that they get from the people who are supposed to give them help." (Participant 5)

The submission from FN1 suggest that HIV related stigma in healthcare facilities may discourage an individual from seeking care and treatment, especially if the environment is unwelcoming or if healthcare workers show negative reactions. People may end up excluding themselves from certain facilities because they are scared to go, which leads to delay in medical treatment as well as defaulting from treatment. Participant FN1 further explained that patients may be scared of undergoing tests or to collect their medication because of the verbal abuse they might receive form people who are supposed to help them in facilities. Stigma and discrimination may also discourage people to test for HIV and know their status because they are scared of being judged.

FC1" *Uhm I would say that it does have an effect on them because, when people, when someone is afraid of testing because of being judged they can uhm get affected with the infection because they don't know their status, yes." (Participant 6)*

The submission from FC1 suggests that individuals who are scared of being judged when testing for HIV may put others at risk by infecting them, especially if that particular individual is HIV positive. This implies that individuals may delay their treatment or getting tested for HIV because they are afraid of what people will say about them.

FN2*" Uhm the stigma uhm its very bad because uhm a person will fear when I am diagnosed with HIV that I will die, that's the first thing that they will think and they won't be free to go to the clinic to take uhm their ARVs, they will end up uhm being very sick because they uhm not taking their medication they default because they don't want to be seen ... they don't want to be associated with people who are HIV because in in their minds when they think about HIV all they see is death…yes*." *(Participant 7)*

The submission from FN2 suggests that individuals diagnosed with HIV may harbour a fear of mortality, leading them to avoid visiting clinics to collect medication. This reluctance to seek treatment stems from a desire to avoid social stigma and being seen collecting medication. As a result, they become sicker during to non-adherence to treatment. Stigma and discrimination are the greatest challenges for preventing HIV and delivering quality healthcare services since they result in lower uptake of HIV medication as well as testing and counselling

services for HIV. In order to reduce stigma, people should be educated about HIV and also address stigma and discrimination in the society.

MN1 *"Mmm for example I can say stigma and discrimination over the years have decreased because uhm I don't know whether I will say whether more people since they are finding out their position their HIV status and mostly people in the community who are positive are fetching their medication their ARVs, is not like back in the day when there were still backlog of having a medication and now people who are HIV are being discriminated, you have HIV you have AIDS because people back in the day, they understand that you start from having AIDS from HIV sorry and then it goes to the full blown AIDS, so now I can say the stigma the campaigns that the Department of Health has done so far I think they shared light in many people, now people are coming. I think the other thing is that it has reduced the stigma and the discrimination, is that people who are now on ARVs and who are HIV are taking their ARVs well. There have been less cases of seeing people die from it, unless people default from medication, so those who have not being defaulting they have been taking their medication as prescribed, they have been surviving and some are even having families, getting married what so not. So stigma has now reduced cos now people they know HIV. You will find in the community when people will tell you AIDS is no longer killing this days, is not like killing is just people are now familiar with it. They understand it, they are no longer that fear of people finding out that instead of taking your medication they have this fear, how people will react in my area, how my family members will react. People are now open about it, so I think the stigma and discrimination currently in 2023 is something ai, you get even surprised when somebody is stigmatising HIV people because is part of their lifestyle now. People they know there's HIV and stuff, so for me I no longer...like back in the day is was huge ya. You will be afraid to open up to disclose. Now people they disclose even the person you are entering in a relationship she can tell you that ai Johannes I am HIV positive do you still want to continue with me or what, so ya." (Participant 8)*

The submission from MN1 suggests that stigma and discrimination have decreased compared to the past. This is attributed to the fact that, upon learning of their HIV-positive status, people now tend to adhere to their medication regimen. This demonstrates an acceptance and understanding that HIV is manageable with proper care and consistent treatment, reducing the fear of mortality associated with the virus. People are now disclosing their HIV statuses, even in their relationships, says the nurse, to protect their partners from

getting infected too. MN1 believes that people are no longer being stigmatised because they have knowledge about HIV/AIDS. The cases have also decreased, unless a person decides to default from their medication. This indicates that, if people understand how HIV is transmitted, then stigma and discrimination may decrease because people will then take their medication and support those who are already positive instead of judging them.

FN3" *Mmm…Ya you know like I said here in Madidi there's too much ignorance, there's not even, there's not even a stigmatisation here ne, they are just living its normal for them to be HIV positive, is normal, the person will even talk about her status or his status like openly, they don't care like I said they are ignorant. They don't care there only problem is the foreign nations that I spoke about the illegal ones, they are spreading it in our area, the the language it's a problem and then they are especially at the facility level they are so so so... they lack so much information, it's like the they just live, they don't know anything about HIV, they just...like I said their men will come with three wives, man on treatment being HIV but then with them is normal. So you end up not understanding what's going on, but then the stigma here ahh, people are well informed they just live ignorantly so." (Participant 9)*

Researcher *"So in other words you are saying there is no stigma in health facilities because people have accepted that they are HIV?"*

FN3 *"There is no stigma at all, even in health facility the HIV positive people or clients they are treated like anybody in the clinic they go wherever everyone is collecting treatment, they also go, it's not like they have their own department or own nurse or own... they go anywhere any person is taking any chronic medication, so there's no stigma at all and there is no discrimination. They themselves they even disclose their status in the clinic…mmm...so everyone is…HIV is no longer a thing to them, they will even tell you that HIV is better than being diabetic." (Participant 9)*

From the submissions of FN3 above, it seems that there is no stigma and discrimination in healthcare facility as well as in the community because people do not care and they are too ignorant. This indicates that, when someone has accepted that they are HIV positive, they no longer see this as something that is threating to their health. They are no longer afraid to collect their medication at the clinic as the nurse stated, meaning they treat this virus as any other chronic disease.

FN4" *In health facilities? They don't have the the stigma, and then the person, even if people know that they are HIV positive, when they get to clinical facilities you will find that nurses tend to call them "that one, that person who is HIV positive" and even the services that are provided, nowadays akere uhm we have the supermarket approach when you get to the room whether you came for hypertension, you came for this, you came for this, so everything is under one roof, so it is always not possible because the HIV clients they sometimes uhm use one room and you know gore in that room is HCT where they test for HIV, is where they take blood and where they take their treatment, and then you cannot mix the high risk people like pregnant women, you can't mix them with anyone, cos uhm having to treat them takes a lot of time to treat them and they must come early and finish late. So you can't put them in a same room, so they end up now knowing gore at that room is this sister who is working with HIV positive people, that uhm causes stigmatisation and the clients intends, I feel victimised and then they end up not going even for their check up, and then sometimes like in a small uhm clinic of Madidi, at Madidi clinics and even in the location we know each other, when my father goes to the go to the clinic, we know gore others they are going for hypertension treatment, diabetics treatment and then the young ones if they are not pregnant they will obviously be going for HIV testing and then when they get there, they are taken some bloods, they take some time and then they will be returned, even when they get to pharmacy their files are not separate they just mix with everyone. And nowadays people know how to read, they will know that this one is HIV or this one has hypertension*." *(Participant 10)*

The submission from FN4 suggests that there is no stigma in healthcare facilities but sometimes people may notice that an individual is at the clinic for certain treatment just because they have seen them going to a room where they offer HIV services. Thus, people end up making assumptions of the reason for someone to visit the clinic, which causes stigmatisation. FN4 also stated that small clinics can often be a problem, especially in a community where people know each other. People may be scared that they will be seen by someone they know when collecting certain medication. For this reason, patients may end up delaying their own treatment and becoming severely sick.

MCM4*" Yes, it has an effect on patients because most people are afraid to be seen when collecting ARVs in clinics because they don't want to be judged or gossiped about, so some tends to hide when collecting ARVs or delay going to the clinics to get their HIV pills. Some*

do not want to share their status with their partners because they are scared that they might leave them." (Participant 11)

The submission from MCM4 suggests that stigma and discrimination have a contributory effect on the spread of HIV because people are scared to be seen collecting medication at healthcare facilities and they therefore rather stop taking their medication, because they do not want to be judged. Disclosing their HIV status may also be a problem because they are afraid of being divorced or dumped by their partners.

MMP1" *It has effect in terms of how they are compliant to the treatment, initiation may not be the problem but compliance may be a problem, so let's say in the health facility the the hospital is designing a way that you see that on that section is chronic only, they have separated another section for HIV, so they shouldn't make them in that way that the it already on the map it shows that when you go there is HIV only. So I think all the chronic facilities must be under one umbrella, so you shouldn't have a specific office that hey when you go there is uhm…or it makes people not to come back because of how they think the people are looking at them when they are coming for treatment mmm but the stigma is reduced now compared to before." (Participant 12)*

Researcher *"How are they reduced?"*

MMP1*" Because before there was, you would even be a stigma to yourself, some of the medication would change you physically, mmm if you have bums it will eat the bums and become flat and it will also give you something here [pointing the upper body] buffalo hump, "o kreye okare o… so ira. it used to make eerr, we used to make a lot of eerr side effects until now recently, over the years that's where the other drugs were removed and replaced with other ones and stuff like that, so now is no longer as bad as it was like before, so you won't feel any change in yourself, because you wouldn't take treatment if it makes you feel …if it changes you physically, so it will take lot of fat and distribute them at the back, or re go itse ole so and next thing you are like a carrot now because the medication side effects adverse effects. So, but now it's better in terms of medications eerr they have a better profile now, close to bo ma 30, but before it was just a hassle. (Participant 12)*

The submissions from MMP1 suggest that stigma in healthcare facilities may be caused by the layout of the facility where everyone is aware about the services that are offered in each

room. The doctor suggested that healthcare services should be under one umbrella and it should not be obvious for everyone when an individual is collecting medication. He indicated that, before they could change the ARVs medication, people used to stigmatise themselves because of the effects the ARVs had on their bodies. Self-stigmatisation may cause an individual to isolate themselves and feel ashamed of being around people because they feel guilty and ashamed of themselves. These feelings end up creating suicidal thoughts and depression.

Based on the submissions from the participants above, stigma and discrimination in the society as well as in healthcare facilities are serious concerns, especially for people living with HIV as well as those who want to undergo HIV testing in the clinics because people lack knowledge about HIV/AIDS. To some people in the community, HIV is normal. They can even discuss their HIV status or disclose it because they have accepted it. This indicates that stigma and discrimination do not exist around these people. MMP1 mentioned that, to reduce stigma, all the chronic diseases should be under one umbrella so that people cannot notice which treatment one is consulting the clinic for. In other words, healthcare providers should create user friendly environments where PLWH cannot be stigmatised and their privacy may be respected.

4.3.2 Theme 2: Vulnerability of men and women to HIV/AIDS in Madidi Village, Bojanala district in North west province.

4.3.2.1. Subtheme 1: Condom use amongst partners

Participants in the study were asked if they use condom every thee they have sexual intercourse and they responded with the answers below:

FCM1 *"No".*

MCM1*" No, I do not."*

MCM2*" Yes, most of the times, I do."*

MCM3*" Most definitely."*

FN1*" Ehh, I don't have [laughs]I don't have a partner."*

FC1*" Mmm...Yes."*

FN2" *No, not every time."*

MN1 *"Not anymore, we took a decision that we are trying for a baby, we took our our relationship to the next level, we both went for testing to check our status and we want to try for a baby, so ya currently we are not."*

FN3 *"Like I said I don't"*

FN4" *No."*

MCM4*" Not every time, because condom is not nice."*

MMP1*" No."*

The submissions from participant FCM1, MCM1, FN2, MN1, FN3, FN4, MCM4 and MMP1 suggest that they do not use condoms when they have sexual intercourse. Amongst them, only three women were married, making it understandable why they do not use condoms in their marriages. Participant MCM 2 and MCM3 indicated that they always use condoms when having sexual intercourse, which shows that they do take prevention precautions to protect themselves from contracting STDs and HIV.

4.3.2.2 Subtheme 2: The use of alcohol or drugs amongst participants

Participants were asked if they had ever used substance abuse or alcohol and to share why and where. The responses are shared below:

From the interviews that were conducted, the submissions from the participants suggest that the desire for pleasure and social enhancement are linked to alcohol use among the participants. The participants stated that they engage in alcohol use when they are feeling happy, celebrating something and when they are at parties to gain confidence while they are associating with other people. This is supported by the statements below.

MCM1" Ohk, *I would say...I would start by saying that I am using alcohol, and alcohol it's. I would put it as it is a fun drug for me, it's a drug whereby I like it because of when you are*

drunk you have more confidence and and and, and it is very addictive and I would agree that I'm addicted to it as well." (Participant 2)

The submission from MCM1 suggests that he is addicted to alcohol and it helps him to gain confidence. He considers it as a fun drug. This indicates that alcohol increases self-confidence and self-assurance. It helps them to do things that they are otherwise not brave enough to do. This may have a negative impact, especially if one drinks alcohol with the wrong intentions, such as desiring to engage in sexual activities with multiple women or have unprotected sexual intercourse just because they feel more confident to approach women.

MCM3" *Yes, I have, I have used them, I smoke weed every day, I drink alcohol sometimes" (Participant 4)*

Researcher *"Where and why?"*

MCM3" *Alcohol it's the most definitely, it's just to be happy, so I drink it out there with other people at the grooves, at the places, clubs and staff. Weed I smoke it just to keep my mind in order in in control, so basically I would say sometimes I overthink things, so I get agitated easily, so that's why I smoke weed. It calms me down and I can reason with myself even though sometimes 90% of the times, I am wrong, this person is just disrespectful but it will leave eventually." (Participant 4)*

The submissions from MCM3 suggest that he smokes marijuana every day, but drinks alcohol only occasionally, especially when he goes out to clubs with other people. He further explained that marijuana helps him to keep his mind under control, especially when he overthinks things. This implies that the participant uses this drug as a coping strategy of what he might be going through at that particular time, especially because he mentioned that it keeps him calm and helps him to think and make decisions.

FN1" *Yes, I did. I am going to be honest on that, I did but then now, uhm I was, I was using a, actually let me say I was drinking a lot, but then now uhm the good part about that I was not a social person, I used to drink but then now indoors, actually I am an extrovert, so I was just a person who preferred to stay at home and drink you know peacefully without you know what a going out you know, I could just play my music, have my drinks afterwards go to bed and drink, uhm sleep." (Participant 5)*

Research "*Was there any reason for drinking alcohol or you were just doing it for fun?"*

FN1 *"For fun actually, for fun, no reason at all*." *(Participant 5)*

The submissions from FN1 suggest that he used to drink alcohol a lot but indoors since she is an extrovert. He would play music and then after drinking, go to bed. The participant stated that the reason for drinking is mainly for fun not for any other reason. This indicates that people end up drinking alcohol because they have nothing to do and then resort to alcohol to have fun or to avoid being bored.

FC1" *Mmm I would say that well I have had alcohol at home though and maybe it's when I am trying to celebrate an event or something." (Participant 6)*

The submission from FC1 suggests that she only drinks while she is celebrating something. This implies that the desire for pleasure and celebrating events are linked to alcohol use.

FN2'*'Ok, uhm I have never abused any substance but I do drink alcohol, occasionally and I do not abuse it, I drink normally during uhm leisure time or at attending parties, ya. But I don't. I don't abuse it." (Participant 7)*

The submission from FN2 suggests that she does drink alcohol but has never used any substance. She further explained that she drinks alcohol during her spare time and when she is attending parties; however, she has it under control. This seems to suggest that individuals may drink just for social enhancement while they are at parties or for enjoyment. However, alcohol usage may increase the risk of one engaging in risky behaviour, especially if they cannot control their actions while they are drunk.

The submission of MN1 above suggests that he does not engage in drug abuse because it has a negative impact on him, especially in the workplace and he might lose his job. He explained that he only drinks alcohol for fun and to enjoy himself.

MCM4" *I smoke weed and drink alcohol just to relieve stress and sometimes for fun." (Participant 11)*

The submission from MCM4 above suggests that he drinks alcohol and smokes weed as a stress reliever. This seems to indicate that people may drink alcohol and smoke dagga as a coping mechanism - it helps them to forget and not deal with their problems. According to

Roberts (2021), alcohol may reduce stress or any emotional discomfort but it can lead to adaptions in the brain, wherein individuals require more alcohol to achieve the same effect. This may result in alcohol abuse and increase the likelihood of addiction.

Based on the submissions by the participants above, they reported their reasons on why they indulge in alcohol use and most of their responses showed similar patterns. Alcohol use was common among the participants. The majority admitted that they do drink alcohol for fun, especially when they are out with friends and family or when they want to relax. The participants expressed that alcohol use also helps them to gain confidence. The majority of the participants indicated that they do not engage in drug abuse. Only two participants mentioned that they smoke weed which is well known as marijuana. MCM3 mentioned that smoking marijuana it helps him to be calm and think properly. MCM4 mentioned that smoking marijuana also helps in relieving stress. This is indicative that some people may smoke in order to forget about and deal with the challenges they are going through, meaning they use this as their coping strategy.

4.3.2.3 Subtheme 3: Circumcision at initiation school

The participants were asked about their views on circumcision at initiation schools and their responses were:

FCM1*" I don't think it is safe because there is no medical care at the initiations schools, so I don't it is safe." (Participant 1)*

The submission from FCM1 suggests that circumcision at initiation schools is not safe because there is no medical care.

MCM1*" I think circumcision in initiation school is good, it's good when it is performed in an environment whereby it is safe and where you wouldn't get infections including HIV or AIDS or any other diseases. You're your privacy it's uhm it's accommodated in to it as well and then you are treated with respect, I would say if if all the circumcision schools are like that, I wouldn't say ya, they would be equal to the same as hospitals if their hygiene is good. I won't see any difference because they are what they all do is use a blade to cut your foreskin." (Participant 2)*

The submission from MCM1 suggests that circumcision in initiation schools is good, especially if the right procedures are followed or it is performed in a safe environment where everyone were not put at risk of contracting HIV/AIDS and other diseases. The participant further stated that, if the hygiene is good, then he does not see any difference between getting circumcised at the hospital or at the initiation school. This indicates that the participant believes that, if everything is done correctly at the initiation schools, then no one will get infected and privacy should also be practiced in order to respect each other.

MCM2*" I feel like is not safe because mostly like they are not using the right resources to... such as knives and new injections and other stuff." (Participant 2)*

MCM2's submission expresses concern about the resources used at the initiation schools, such as knives and injections. However, the participant did not elaborate explain further on how these resources may impact the initiates attending.

MCM3*" I am not certain about the methods they use there, and I've never really been interested in the initiation schools, so I have never asked anyone about them. All I know is that they get bread from Sasko in the morning [laughs] but about…I've never been interested, it just being guys who being dum to me and my eyes, this guys are dum maan, these guys wanna go to the forest for three months [laughs] I can't afford to do that, my time is precious[laughs]. So basically in my views I have never been interested in those stuff." (Participant 4)*

The submission from MCM3 suggests that he has no interest in what is happening at initiation schools; hence, he has no knowledge about circumcision per se. He mentioned that he sees the people who goes there as 'dum' meaning that he does not take them serious. This implies that some of the people in the area do not approve of or are not interested in initiation schools; hence, they do not have any knowledge about what is happening.

FN1 *"I think is very risky hey, I think it's very risky because now they are people who are taking chances this days, you know previously people were…were going to this circumcision schools and then coming back without being affected, infected you know, but this days it's very very very risky because now even the inexperienced people you know they take chances, open the schools you know, whereby you will find that uhm…people die,*

ya in such schools, because now people don't have proper knowledge of actually what should they apply to these initiates." (Participant 5)

The submission from FN1 suggests that attending initiation schools is no longer safe. Nowadays, inexperienced individuals take risks with people's lives, leading to deaths at the initiation schools. Some initiates may return infected. This highlights the danger of opening an initiation school without proper experience in treating initiates, which may expose them to infections such as HIV, especially if the individual lacks knowledge about HIV transmission.

FC1*" For…from my perspective I don't think it's safe for kids to be circumcised at the initiation schools because the risks might be uhm the things, the material that they use to circumcise them…yes." (Participant 6)*

The submission from FC1 suggests that she supports the statement of previous participants that circumcision at initiation schools is not a safe practise. She further indicates that the equipment used during these procedures may not be safe or sterilised.

FN2*" Ok, uhm I think if the initiation, the initiates ne involve the healthcare sector that can be done correctly. The healthcare sector can make sure that when they circumcise ehh the boys there, they make sure that they use one lazer for one male, so that they can prevent uhm ethical transmission ya, so I think when it can be done like that then it can be...you know, accepted. Yes." (Participant 7)*

The submission from FN2 suggests that, if healthcare providers can be involved in initiation schools to ensure that proper medical procedures are taken, then initiates would be safe. Healthcare providers might help by ensuring that one single razer is not used on all the initiates in order to prevent the spread of HIV infection.

MN1*" Mmm I still think is the policy we can still continue with is in our culture, uhm I think is a pattern that young boy to manhood can go through too. It can be improved in our initiation schools because due to the spread of HIV is now at its prevalence because in my time when we go there I think most of us were still virgins, but now you will find boys that are still going there are still exposed to the woman body, they have had sex before. So kinda like that now, we need to brief people who circumcise this boys, now we need to get professionals who can do it uhm perfectly and then…ya, is something that I feel I can still support it. Whoever still wants to go to initiation school can still go. It's a culture that has*

been practised, yes there are those that practice back doors and there are those who still do it officially legally, so we need just to erase these ones that are doing back door initiations and do the official ones that there are association of 'Dikoma', they are registered they know and they follow the laws and other stuff." (Participant 8)

The submission from MN1 suggests that he supports the tradition of circumcision because it still exists in his culture. He continued by mentioning that initiation schools are open to everyone who wants to attend and that these schools can be improved by involving professionals, meaning people who are well trained to perform proper circumcision without putting anyone at danger. He further states that it is a path whereby young boys are transitioned into manhood or go through a process of manhood. In the past, initiation schools were mostly attended by those who had not been exposed to a woman's body, meaning boys who had not had sexual intercourse before, which was safer for them. He finally highlighted the importance of initiators registering in their association. This ensures compliance with laws and regulations and helps eliminate illegal practices.

FN3" *Ahh initiation schools, I really don't acknowledge it, we do medical circumcision, so at the initiation schools ah I really don't know what they really do, but then the very very high risk of spread of HIV. Since I said they are so many here, anyone here can just start and say I am a Sangoma, starting an initiation school without any information, without being taught how to prevent HIV and stuff, without the suppliers of doing that circumstance. Circumcision may be even the razor blade there dressing the…so it might end up with the very very very rapid spread of HIV." (Participant 9)*

The submission from FN3 suggests that she does not approve the notion of initiation schools because circumcision at initiation schools for one, is very risky and people may be exposed to HIV. Nowadays, doctors perform circumcision at healthcare facilities. She further raised concerns about Sangomas who open initiation schools without obtaining knowledge or information about prevention methods of HIV. This shows that individuals may be at risk of being infected by HIV because, as stated by the participant, any Sangoma can decide that they want to open an initiation school without having the proper equipment/tools that are required for circumcision.

FN4" *Mmm…[laughs] it's very bad, the circumcision that is done at the initiation schools yoh is bad because that's where people get the spread of the infection of HIV, because you find*

that uhm it's young boys they are just taken there, they are not tested and then we know gore the Inyangas some of them they...most of them they don't have any information about health related issues. They use one blade for cutting the foreskin of all the boys of all cultural backgrounds not knowing where they come from, not knowing their sexual uhm practices, and then they end up now spreading this HIV in the whole community that is there and then they go in large numbers especially in winter, others even go ka December when the schools are closed and everyone is there. Most a lot of people must be tested and then even the experiences that they get from the people that have been there, they don't wash hands, they eat with dirty hands, they share everything, they don't bath and they go to the bathrooms gona koo strateng just on the forest [laughs]. They don't wash their hands, they will just eat in one bowl, spreading HIV and other infectious that are not dispute, there's no hygiene, poor hygiene." (Participant 10)

The submission from FN4 suggests that circumcision at initiation schools is very bad because the boys who attend these schools have not been tested for HIV. This may put others at risk because all these initiates might not know their statuses. FN4 further stated that most of the initiators have no knowledge about health-related issues. Participants mentioned that traditional circumcision involves the use of a single blade to cut the foreskin of the boys. Additionally, hygiene practices are lacking, as one participant expressed concern about the initiates not washing their hands before eating, which increases the risk of contracting opportunistic diseases. This highlights that traditional circumcision performed under poor or harsh conditions may pose risks on the initiates, particularly the risk of HIV infection.

MCM4*" I think circumcision at initiation school is both good and bad, because it might put you at risk. The good part is that you learn about becoming a man and how to handle your family." (Participant 11)*

The submission from MCM4 suggests that circumcision at initiation schools may be good or bad. What is positive about initiation schools is that initiates are taught essential skills for caring for their families and transitioning into manhood. However, he also acknowledged potential risks associated with the process but did not elaborate on his concerns.

MMP1 *"Eer circumcision at initiation school in the olden days it was a way to show that you are a man, you have grown up eerr but nowadays eerr…it it..is not useful ya because a lot of youth are no longer going to school, they don't want to listen to their parents and some*

they take that initiation school as a way to say that they are older and they become disruptive in their own lives so in terms of today's days the circumcisions eerr traditional way they used to do it at the mountains, the Department of health had to intervene and then we go at the bushes to cut to cut them." (Participant 12)

***Researcher**" So now the Doctors can go to the initiation schools?"*

***MMP1**" Yes, with our tents, mmm that's what I heard." (Participant 12)*

***Researcher** "Oh so you have never done it"*

***MMP1**" Nna I can't go there, because I haven't been there." (Participant 12)*

***Researcher**" Oh so only people who come from the initiation schools are allowed to go?"*

***MMP1**" They can go, so that it remains eerr less painful, less infections and no transmission of other ones of diseases to the other. And also on circumcision, on circumcision is good cos it helps to reduce the HIV infections and STIs. (Participant 12)*

The submissions from MMP1 suggest that attending initiation schools was once a rite of passage to manhood. However, in modern times, individuals may disrespect their parents simply because they feel that they have reached adulthood. MMP1 further stated that modern initiation is much safer because there are doctors present with tents and appropriate equipment to circumcise the boys, to reduce the spread of infections and to make it less painful.

Based on the submissions by the participants above, the majority believe that circumcision at initiation schools is bad because people who usually attend these schools are not even tested for HIV/AIDS, putting others at risk. In modern times, individuals attending initiation schools may already be sexually active, while others are still virgins. This poses risks, because those who are sexually active may be HIV positive and could transmit the virus to the virgins. Participants highlighted poor hygiene practices at the schools, such as eating from a communal bowl and unwashed hands, which increases the risk of illnesses. FN3 expressed scepticism about circumcision at initiation schools, noting that medical circumcision services are available at clinics. However, MMP1 argues that, attending initiation schools nowadays is

much safer because there are doctors performing circumcisions. By involving doctors at initiation schools, the Department of Health is trying by all means to reduce the spread of HIV.

4.3.2.4 Subtheme 4: Polygamy

Participants were asked if they believe in polygamy and the following responses emerged:

FCM1*" Uh no I don't believe in it, is the same as having multiple partners which can give risk of being infected by the virus, so you never know if you agree to polygamy for your man to take a second wife. Uhm there is STIs and you don't know the love life of that person cos you already find her already she is a woman, you don't know the lifestyle she was living back then, so I don't believe in it." (Participant 1)*

The submission from FCM1 suggests that she does not believe in polygamy because it is the same as having multiple partners and can put one at risk of being infected by HIV. The participant also indicated that unawareness of the love life or lifestyle of the second women who is brought into the marriage or family may put them at risk because.

MCM1*" Yes, I do believe in polygamy." (Participant 2)*

Researcher*" Why?"*

MCM1*" I don't think uhm, it is relevant to the topic or its general?" (Participant 2)*

Researcher *"No, it's relevant."*

MCM1*" I don't see it as a threat or something that might increase HIV/AIDS because it's like same as having your own partner but you have multiple partners who know that they are your partner, and polygamy means you are married to too many people, not like you have many girlfriends." (Participant 2)*

The submission from MCM1 suggests that he believes in polygamy because it does not pose any threats or risks for people to contract HIV. He further explains that having a second wife is the same as having one partner but with multiple partners, rather than having many girlfriends.

MCM3" Eish *because I believe that one man can love more than one women, then I believe in polygamy automatically, and I know from my experience that is possible, so I would say polygamy I believe in it but it needs to be well well well uhm constrained polygamy or well ehh constructed. I don't know how to put the wondering but it's need to be well observed and very very eehh taken ...well taken care off. Everyone must be happy, so basically I believe if you want to be polygamous as a man and believe in it you must get the money my brother to avoid this risk of HIV, just get the money you will be okay*." *(Participant 4)*

The submission from MCM3 supports the response of MCM2 about approving polygamy or believing in it. He further states that, in order to initiate polygamy, a man must have enough money to take care of his family. It is crucial to ensure that everyone is happy and to minimise the risks of HIV. This illustrates that, if a man decides to marry another woman, he must be financially stable enough to ensure the happiness of both women. This reduces the likelihood of them seeking financial stability from other men outside the marriage.

FN1*" I don't believe in polygamy, I don't believe in polygamy, why should a man have more than one wife, and my believe is God created man to only love one woman, you cannot extend your love to the next person, one man one woman man." (Participant 5)*

The submission from FN1 suggests that she disapproves of polygamy because she believes that God created a man to love only one woman and a man cannot extend his love to more than one woman. This indicates that some participant still believe that a man should only have one wife and follow biblical principles.

MN1 *"Yes, I do believe in it because it depends on the structure of the family and stuff, but it also needs to be a concern from the first wife to the family to such and then and another thing we must not use it as men as allowing of having sexual...many sexual partners, yes if at home is something that has been practiced that polygamy does exist, yes we have to still continue and say okay let's do it ehh let's uhm it can be done, so if there's a communication entlik communication that way a second wife needs to be taken and other reasons then we can still do it . Yes, I still believe that other families can do it, ya through proper communication." (Participant 8)*

The submission from MN1 suggests that he still believes in polygamy and that people should still practice it, but only if both partners agree to it. It should not be the man who only allows

it; both partners should have an agreement and reasons should be given as to why another wife is needed in the family. This implies that the participant has no problem with polygamy, as long as it is practices in a correct manner and if both parties agree to it. This also proves that the participant is still rooted in cultural beliefs, believing that polygamy should continue to be practiced.

FN3*" Haa I don't, yooh [laughs] yoh hai no." (Participant 9)*

Researche*r" Why?"*

FN3" *Polygamy? I don't see the reason for for polygamy really, especially in this nowadays where there's HIV, there's STIs, there's everything, no and you know once the man is married regardless of how many wives he wants to sleep with them without a condom, especially our traditional man, they always want to have sex without the condom, regardless of how many wives his sleeping with, so that's when you get HIV from that wife to that wife, no I don't believe in polygamy.*" *(Participant 9)*

The submission from FN3 suggests that she does not believe in polygamy, especially because of HIV and STDs. She further stated that traditional men will have unprotected sexual intercourse regardless of how many women they expose to HIV.

FN4" *Mmm I don't believe in polygamy*." *(Participant 10)*

The submission from FN4 suggests that she does not believe in polygamy although she never explained why.

MCM4*" Yes, I believe in polygamy, because if the other partner is not satisfying you or treats you right, you should get another one*." *(Participant 11)*

The submission from MCM4 suggests that he believes in polygamy because he believes that, if a man is unsatisfied by a woman, he should seek another wife who will satisfy him. This implies that men may only think about their sexual desires without taking into consideration the feelings of their partner.

MPP1*" Uhm I don't believe in polygamy, eerr I don't believe in it, but people who believe in it they got their own reasons, some is because is like that in their cultural beliefs and norms, is*

because of what happened along the process etc., moving on… one one partner is enough [laughs] the stresses of one partner is enough." (Participant 12)

The submission from MMP1 suggests that he does not believe in polygamy, although he is aware that there are people who believe in the practice for their own reasons. He said that individuals sometimes believe in it because of their cultural norms and beliefs.

Based on the submissions by the participants above, the majority of participants do not believe in polygamy because they feel that it is the same as having multiple partners and they believe that a person should only have one partner at a time. Two participants mentioned that they believe in polygamy, with one stating that, if a partner is not satisfying them, they should seek another, while another participant mentioned that a man can love more than one women as long as he can support them financially. Based on these responses, it appears that many people do not believe in polygamy since it can lead to marital issues and infections. It may be safer for those practising polygamy to undergo testing for HIV/AIDS, such as monthly or every three months and consider using PrEP pills for protection.

4.3.2.5 Subtheme 5: Traditional practices

Participants were asked to share, in their opinion, the traditional practices that have an effect on the spread of HIV. Their responses are presented below:

***FCM1**" Sexual violence by men against women, Uhm dry sex practices, it increases the spread and the tattooing you don't know whether the instrument is properly disinfected. Initiation schools and blood exchange, that's all."(Participant 1)*

The submission from FCM1 suggests that sexual violence by men, dry sexual intercourse, getting tattoos, initiation schools and blood exchange all contribute to the spread of HIV. According to FCM1, using an instrument that has not been disinfected to get tattoos, put individuals at risk of contracting HIV. Dry sex may also increase or facilitate the transmission of HIV, as the lack of lubrication during intercourse can cause abrasions or small cuts in the vagina, thereby increasing the risk of HIV transmission. In African culture, some men may perceive dry intercourse as more pleasurable compared to wet intercourse, believing that a wet vagina indicates previous sexual activity with multiple partners. Additionally, traditional practices such as blood exchange and circumcision were mentioned as factors contributing to HIV transmission, as previously explained.

MN1 *"Uh the mostly in our village we are experiencing the practices of people who have ancestral calling which is a…some is a misconception, misinterpretation and stuff, so ya so far because now people they are hiding that disease through that disease, that should be taken through the clinic and health facilities that are vulnerable, is not a problem when someone is hiding and stuff but now you are delaying your progress in combating the virus because at the time you are supposed to be taking your ARVs you are hiding between uhm 'wa thwasa and stuff' and you end up after that period when now finally say ok maybe this virus is irading my body let me take medication is too late for you, so we don't want that. Take medication, if you have ancestral calling go for 'go thwasa' and is fine and continue healing people in that session." (Participant 8)*

The submission from MN1 suggests that people should stop hiding behind ancestral callings and start consulting clinics to seek medical help if they are sick in order to avoid delaying treatment and being in denial. Individuals can still take their medication, even if they are in a process of becoming a Sangoma.

MMP1*" The one that they cut people, mmm because we don't know how they sterilise their equipment, what they use to sterilise their equipment, and this again of drinking bloods, you don't know whether those animals are sick or its human blood, you don't know. So if they do those things passes the fluids, human fluids from one to another human fluid from one another they can transmit the diseases of animals to themselves."(Participant 12)*

The submission from MMP1 suggests that unsterilized equipment can put one at risk of contracting HIV. He further mentioned that the drinking of animal or human blood may transmit diseases. According to Clark (2022), drinking animal or human blood may have serious health risks, including contracting blood borne illnesses.

Based on the submissions by the participants above, it was indicated that consulting traditional healers who perform cuttings on their skin and circumcision are the main traditional practises that can contribute to the spread of HIV/AIDS. The Social Constructivism Theory states that the cultural environment and traditional beliefs control the lives and sexual practices of people resulting in so many people ending up being infected.

4.4 DISCUSSION OF THE FINDINGS

The following discussions were derived from the findings, and some corresponds to the literature review section 2.2.

The participants in this study were aware of HIV/AIDS and its modes of transmission. Having sexual intercourse without using a condom was the most common mode of transmission that was mentioned by the participants as well as through blood. This indicated that participants are well informed about HIV/AIDS. The participants cited that social factors are indeed causing the spread of HIV/AIDS in the community of Madidi, more especially unemployment. Based on the above findings, participants indicated that females are the gender mostly affected in the community, rendering them vulnerable to HIV. This vulnerability, in turn, makes it challenging for women to secure jobs; hence, they resort in being in relationships with older men to take care of them, putting them at risk of contracting HIV since they cannot negotiate safe sexual intercourse in their relationships. The majority of women who are financially unstable depend on men for money. Young women end up trading sex for material goods which put them at risk of being infected since they do not know the status of the people they sleep with. According to Lopman, Lewis, Nyamukapa, Mushati, Chandiwana and Gregson (2007:57), the more the lack of employment, the more people are at risk of contracting HIV, especially women. Erinosho, Isiugo, Joseph and Dike (2012:123) added that, in difficult situations where people are unemployed and their family is experiencing poverty, women may end up trying to look for ways to make money which contributes to transactional sex.

The participants also mentioned that poverty is another factor contributing to the spread of HIV/AIDS in the community, similar to unemployment. MCM3 mentioned that poverty often leads people, particularly women, into undesirable situations, as men may take advantage of their financial vulnerability to engage in sexual relations. The statement may correspond to that of Pascoe, Langhaug, Machu, Hayes and Cowan (2015:23) (see section 2.2.2 literature review poverty), where they stated that majority of women lack financial stability hence they engage in risky behaviors with multiple partners to take care of them. Power dynamics between individuals of different socioeconomic backgrounds often translate into gender-based power imbalances, as men, who are more likely to be employed and have better paying job opportunities, assert power by engaging in multiple sexual relationships, often targeting financially unstable individuals.

Gender imbalances, such as unequal access to social resources like education and employment opportunities, stem from societal structures that restrict women's rights (Giddens, 2001). This is perpetuated by a patriarchal mind-set that upholds male dominance over females. Women should have the same rights and access to opportunities as men, thereby reducing the power gap between genders. The studies from our literature review have proven that gender imbalances impact the rights of women in the society, and even oppresses them especially women who are in polygamous marriages (see section 2.2.5.2 of the literature review).

Another participant mentioned that, if an individual is in need of money, there are various ways they can raise funds, such as providing childcare services or offering laundry assistance for payment, rather than resorting to selling their body.

The other issue that was raised by the participants was that traditional practices or cultural practices have contributed to the spread of HIV/AIDS because traditional healers may use the same razor during incisions on different clients putting them at risk of infecting one another.

Circumcision was mentioned as one of the cultural practices that contribute to the spread of HIV/AIDS in the community. Matters of male circumcision were not discussed openly or in details According to Mathebula (2013:10), initiation schools conduct certain rituals that are highly very sacred for young people, serving as a significant step in their transition to adulthood. In the Tswana culture, the initiation of young boys on the mountain, known as *"go rupa'* in *bogwera*, is considered an essential rite of passage to manhood (Morton, 2011:1). Participants stated that, during initiation, boys are circumcised by traditional doctors or initiators using sharp tools such as razor blades, without proper sterilisation. This risky practice increases the potential for HIV/AIDS transmission as initiates are not tested for HIV during initiation, as stated by Van Dyk (2012:368). Such practices endanger the lives of innocent young boys, especially those who may be virgins or not yet sexually active. This also corresponds with our literature review, whereby it was mentioned that circumcision is conducted by traditional healers who uses certain tools to circumcise all the initiates, and this may be under unhygienic conditions (See section 2.2.5.1)

Despite the risks, some participants expressed acceptance of initiation schools, equating the circumcision process there to hospital procedures, provided that good hygiene and proper

precautions are maintained. This suggests continued belief in circumcision at initiation schools within the community.

However, medical practitioners indicated that the Department of Health has intervened by sending doctors to the initiations schools to perform circumcision, aiming to reduce the number of HIV infections minimise pain. Only medical practitioners who have undergone initiation themselves are permitted to assist. Circumcision is also believed to reduce the risk of STIs and HIV transmission. Nonetheless, initiation schools may have negative consequences, including discouraging youths from returning to school and obeying their parents, as they are now considered men. According to Baliso, Manyonda, Mpateni, Ndyokolo and Siqoko (2015), customs in these schools may also impart negative teachings, leading to behaviours like excessive alcohol consumption, violence, disrespect and criminality among the initiates.

The Social Cognitive Theory posits that learning occurs in a social context, with individuals influenced by and influencing their environment. Initiates may be influenced by negative behaviours during initiation, as suggested by the Social Cognitive Theory, deeply rooted in African cultural norms. Traditional male circumcision holds different social meanings, shaping individual's worldviews, beliefs, values and perceptions of morality, whether conducted at initiation schools or healthcare facilities, as explained by Aggleton (2007:21).

Participants expressed a strong belief in and reliance on traditional healers within the community. Many noted the abundance of traditional healers available and confirmed that consulting them is a common practice among community members when facing illness or personal challenges. This highlights the significant role that tradition plays in the lives of people within the community and underscores the widespread trust placed in traditional healing methods to address various health and personal issues.

Traditional healers typically employ methods such as using bones to communicate with ancestors. People often seek their guidance with the belief that they possess the ability to heal, diagnose and even prevent illnesses from recurring (Van Dyk, 2012:218).

In the theory of Constructivist, as outlined by Merriam, Cafferella and Baumgartner (2007), there are five orientations to learning, each emphasising the role of learning. Of particular interest in this study is the distinction between how individuals learn within their social

environment, as understood by the Social Cognitive and Social Constructivist theories. In the Social Cognitive Theory, learning is viewed as a product of both behavioural and cognitive factors, which focus on how individuals acquire knowledge from others, particularly in social settings where learning occurs through interaction. On the other hand, the Constructivism Theory posits that individuals construct knowledge through their experiences, implying that consulting with Sangomas allows them to learn from the information conveyed during their interactions. This highlights the process and knowledge construction through dialogue and social engagement with traditional healers, aligning with the principles of the Constructivist Theory.

One participant noted that nowadays, some individuals in the community may use the notion of being “called” by their ancestors as a way to justify becoming traditional healers, especially after being diagnosed with HIV. However, it is emphasised that people should also consider seeking medical attention from hospitals and clinics to ensure clarity about their health conditions and to avoid delaying necessary treatment that could lead to severe illness. Additionally, Van Dyk (2012:217) mentioned that some people may believe that their sickness is usually caused by their ancestors to express their anger (see section 2.2.5.3). Such individuals may end up delaying their treatment for since they are being told about ancestral calling.

Additionally, traditional healers are sometimes called upon by family members to perform certain rituals involving all the family members. These rituals may include the use of incisions made with a single blade or razor. According to Nxumalo (2014:33) this practice is similar to the one that is being practiced by Zulu people where traditional healers perform rituals in the household in order to protect themselves from diseases and witchcraft. The majority of traditional healers do not wear gloves when performing these kinds of rituals, which puts them at risk of contracting HIV, especially if they cut themselves by ’is take. One participant highlighted concerns about potential negative effects arising from the simultaneous use of antiretroviral drugs (ARVs) and traditional herbs, known as muthi. They suggested that combining these treatments could lead to complications or interfere with each other's effectiveness in bolstering the immune system. This sentiment was echoed by a medical practitioner who warned that traditional medications might interact with ARVs, either by altering their dosage or causing toxicity, particularly in the liver. Traditional healers need to be educated about HIV prevention so that they can be able to protect their clients and give

them correct information if they suspect that their clients are HIV positive, instead of misleading them. Families should also be educated about HIV so that they can encourage traditional healers about taking safety measures. Furthermore, the Traditional Healers Organization should promote HIV prevention and educate traditional healers.

The findings suggest that, within the culture, elders typically advise new mothers to breastfeed their infants due to the significant health benefits it offers to the child. However, a potential risk arises if the mother, unaware of her HIV status, breastfeeds her child, potentially transmitting the virus. Breastfeeding is culturally valued as it fosters a strong bond between mother and child, thus mothers are expected to breastfeed for a specific period (Oyelana, Kamanzi, and Richter, 2021).

In African societies, men are traditionally prohibited from engaging in sexual activity with women who have recently given birth or are breastfeeding. This custom aims to discourage extramarital affairs and promote monogamous relationships. (Van Dyk, 2001:120).

However, polygamy is still practiced, particularly among the Tswana people, where men may take additional wives while working away from home. This practice has been linked to the spread of HIV due to increased sexual activity and potential infidelity. According to Van Dyk (2001:120), polygamy held value in ancient times, where African men sought additional partners to cohabit with while they were away from their village wives. However, this practice, which predates the discovery of HIV, now poses significant risks, as modern men engaging in polygamous marriages may unknowingly contract HIV from additional partners, particularly in cases of infidelity.

Furthermore, societal norms often grant men greater control over sexual decisions within marriages (Chimbiri, 2007:1115), perpetuating gender imbalances and leaving women vulnerably to HIV/AIDS and other STIs. The payment of dowries by men can reinforce this imbalance, leading to the assumption of ownership over a woman's life and limiting her agency (Osuafor & Mturi, 2014:550).

While there are governmental efforts to promote gender equality, progress remains slow, particularly in rural areas where cultural practices continue to oppress women. Despite liberal theories advocating for equal treatment and opportunities for men and women, disparities persist, with women often being denied the same freedoms as men, such as the ability to

have multiple sexual partners. To address these issues, continuous HIV testing among couples in polygamous marriages could help reduce the risk of transmission. Additionally, efforts to challenge and reform cultural practices that perpetuate gender inequalities are essential for achieving meaningful progress towards women's equality and reducing vulnerability to HIV/AIDS.

The findings also reveal that married women often hesitate to negotiate condom use within their marriages due to fears of damaging trust or honesty in their relationships. Additionally, pre-marital counselling and testing are not commonly practiced in many cultures, leaving individuals at risk of contracting STDs, which can lead to infertility and potentially prompt men to seek additional wives who can bear children.

Since women and young girls are the most vulnerable, the researcher suggest that they should start taking control of their own lives. Women and young girls should resist conforming to cultural expectations that prioritise men over their own well-being and autonomy. However, one participant disclosed that she does not use condoms with her husband, despite harbouring doubts about his fidelity. This lack of condom use in relationships is often observed to begin with condom use but diminish as trust develops between partners, leaving women vulnerable to HIV and other sexually transmitted infections.

Hattori, Richter and Greene (2010) further emphasise this vulnerability, noting that trusting one's partner not to transmit infections can lead to a false sense of security and increase the risk of HIV transmission. Therefore, it is crucial to promote open communication and empower women to assert their sexual health needs within their relationships, including advocating for condom use and prioritising their own well-being. Another cultural practice discussed in the study is the tradition of a brother marrying his late brother’s wife. According to Masenya (2010:7), “Lebitla la mosadi ke bogadi” (a women’s grave is at the place of her husband’s”) this applies to the cultural expectation that when a husband passes away his wife must still remain with his family and re-marry one of the brothers of family members. This practice poses a risk of infection transmission if the individuals involved to not undergo testing. The reluctance to use condoms in African marriages further compounds this risk.

According to the Social Constructivism Theory, proposed by Hoffman (1990:1), knowledge is constructed through social interpretation influenced by culture, language and family dynamics. Cultural practices like this one may hinder individuals from protecting themselves

against HIV and STDs. The expectation for women to marry their late husband's brother highlights the significant role of social norms and expectations in shaping behaviour and attitudes towards women.

Findings from the study also revealed that drug addicts in the community often inject themselves with needles when using drugs, putting them at risk of being infected with HIV/AIDS. One of the participants mentioned a practice called ‘’Bluetooth", where drug users share blood by injecting drugs from one person to another. Alcohol consumption was also identified as a social factor contributing to the spread of HIV/AIDS, as intoxicated individuals may struggle to make informed decisions, such as using protection when engaging in sexual encounters meeting strangers at a tavern. Some participants attributed alcohol or substance abuse to seeking fun and gaining social confidence.

Another issue raised in the study was migrant labour, where individuals seek employment in other cities and end up staying there to avoid transportation costs. This situation often leads to forming new partnerships, which can be risky, particularly if individuals have left partners behind in their home villages. Based on the findings above, one participant disclosed that they engage in unprotected sexual intercourse for pleasure, while also maintaining two girlfriends, with one of them not residing in the area. This behaviour carries significant risks, particularly if the individual is unaware of their partners' potential infidelities or sexual orientation.

Lack of parental supervision and peer pressure were also mentioned to be social factors contributing to the spread of HIV/AIDS in the community. Participants noted a lack of supervision in school toilets, raising concerns about the safety of young girls who might be vulnerable to sexual activity there. Furthermore, one participant pointed out the risk of uncles exploiting unsupervised girls at home, potentially exposing them to HIV despite their lack of sexual activity.

Partners who fail to disclose their HIV status to one another run the risk of transmitting the virus if there is a lack of honesty within the relationship. According to Van Dyk and Van Dyk (2003:4-9), individuals may refrain from disclosing their HIV status to their partners due to fears of potential negative reactions, including violence, or concerns that the relationship or marriage terminate upon disclosure. Additionally, Evian (2003:115) states that keeping one's

HIV status a secret from a partner can lead to fear, resulting in anxiety and depression, which can subsequently affect personal relationships.

Disclosing one's HIV status within a relationship is crucial as it enables the other partner to provide both physical and emotional support. Furthermore, this disclosure may encourage the other partner to consider utilising preventive measures such as PrEP and condoms to reduce the risk of HIV transmission (Antelman, Smith, Kaava, Mbwambo, Msamanga, Hunter and Fawzi, 2001:1865-1874).

The participants indicated that illiteracy within the community poses a significant problem due to its correlation with the risk of HIV spread. Limited knowledge about HIV/AIDS prevention strategies, especially regarding PrEP and PEP pills, heightens this risk. Some community members may lack awareness of' PrEP and PEP, increasing their vulnerability to HIV transmission. Individuals who are unaware of these prevention methods may be at risk following instances of rape or engaging in unprotected sexual encounters with strangers, unaware of their partners' HIV status. Therefore, it is imperative for HIV campaigns to prioritise educating the community about the usage of PrEP and PEP to mitigate the spread of HIV.

In the Social Cognitive Theory, Bandura stated that self-efficacy plays a crucial role as a proximal determinant of human motivation, affect and action. Self-efficacy consists of two components: one relating to the skill required for successful performance and the other concerning an individual's competence. Therefore, self-efficacy refers to a person's perception of their capabilities to successfully execute actions or engage in specific behaviours as well as their sense of control over events that affect their lives (Bandura, 1977). This suggests that individuals must first acquire the necessary HIV related skills or knowledge to effectively utilise PrEP/ PEP pills and implement prevention measures.

Stigma and discrimination in healthcare facilities were also identified as social factors contributing to the spread of HIV/AIDS in the community. Based on the findings from the interviews, participants indicated that individuals may experience stigma in healthcare facilities where they are being labelled or called by their HIV status. This usually causes them to end up not going to the healthcare facility and consequently defaulting from their treatment. According to the Social Cognitive Theory, individuals tend to adopt and imitate the behaviours of others through observation if their observation is positive. The theory states that individuals' past experiences usually shape their future. Those who usually undergo HIV testing are more

likely to continue testing; however, those who saw an individual being stigmatised and discriminated because they had been tested HIV-positive, may avoid going to the healthcare facility or getting tested because they do not want to be stigmatised as well. The statement was supported by Ncitakalo, Mabaso, Joska and Simbayi (2021) where they indicated that stigma may pose obstacles for treatment and prevention of HIV/AIDS. Participants also stated that using a room where other patients are aware of the health services offered therein may also lead to stigma because individuals may be judged or presumed to be HIV-positive or seeking HIV testing. Others stated that stigma and discrimination may deter individuals from HIV testing, fearing exposure to others due to their sexual activity. This suggests that individuals may continue to spread HIV or refrain from disclosing their status due to lack of awareness. According to Ncitakalo, Mabaso, Joska and Simbayi (2021), HIV related stigmatizing attitudes are usually higher among older people, especially those who lack knowledge about HIV/AIDS, those from rural informal areas since majority of them do not have correct information. This seem to suggest that, HIV education campaigns should also target such areas to avoid misinforming one another and stigmatizing people.

According to Van Dyk (2012:259), disclosing one's HIV status can have various benefits, including improved access to healthcare services, reduced stigma, and facilitating condom use negotiation in relationships where one partner is HIV positive. However, some participants claimed that stigma and discrimination are not prevalent, as individuals in the community appeared to openly share their HIV status without shame. This indicates acceptance or ignorance regarding potential negative reactions, with some even viewing HIV as less concerning than conditions like diabetes.

The Social Cognitive Theory, developed by Bandura in the 1960s, posits that people learn behaviours by observing others. However, merely acquiring knowledge of a behaviour does not guarantee its adaption; individuals must first be motivated to model or perform the observed behaviour. In essence, individuals engage in a cognitive process where they weigh the pros and cons of using condoms or other preventive strategies to protect themselves against HIV transmission, which in turn affects their self-efficacy and likelihood of practicing safer sex.

In this study, some participants reported not using condoms with their partner's despite being aware of the consequences. Additionally, some individuals acknowledged the risk associated with certain sexual behaviours, yet continued to engage in them or maintain multiple partners.

CHAPTER 5: CONCLUSION

5.1 INTRODUCTION

The aim of the study was to investigate the social factors responsible for the spread of HIV/AIDS in Madidi Village, Bojanala district in North west province. The findings were analysed and presented in the previous chapter. In this chapter, the researcher discusses the limitations of the study, the weaknesses, strengths summary of study and recommendations that can assist the community in implementing HIV/AIDS campaigns and programs.

5.2 WEAKNESSES, LIMITATIONS AND STRENGTHS

5.2.1 Weaknesses and strengths of the study

Weaknesses

- The results of this study cannot be generalised to a broader population due to the use of a small sample. Had a larger and more diverse sample been employed, encompassing a broader population, the researcher would likely have obtained a wealth of information regarding the social factors contributing to the spread of HIV in the community of Madidi Village, Bojanala District in North West province. Additionally, including individuals living with HIV/AIDS would have provided insight into how stigma and discrimination affect them within the community and healthcare facilities. Furthermore, incorporating Sangomas could have allowed for the sharing of their experiences and perspectives on cultural influences.
- Using one-on-one interviews in qualitative research limits the participants' opinions and experiences because they might be afraid to give honest answers about their experiences; instead, they might try to impress the researcher by sharing information that suits them.
- The researcher included only participants between the ages of 18-49 in the study.

5.2.2 Strengths

1. The objectives of the study were to determine the vulnerability of men and women between the ages of 18-49, to HIV/AIDS in Madidi Village, Bojanala District in North West province and all the benefits were covered in the study.
2. The other objective of the study was to investigate which social factors contribute to HIV/AIDS, which was also covered in the study.
3. And to determine the community members' level of knowledge regarding HIV/AIDS in Madidi village, Bojanala district in North west province have, which was also covered in the study.

5.2.3 Limitations

Healthcare professionals' reluctance to share information about HIV/AIDS, despite the researcher's probing, may stem from their commitment to protecting patient confidentiality or from their own personal experiences in dealing with the condition. The sensitive nature of HIV/AIDS and the potential stigma associated with it could also contribute to their hesitancy in divulging information.

Similarly, some community members may not have shared sufficient information due to a lack of knowledge or understanding about HIV/AIDS. This could be a result of limited access to accurate information or cultural taboos surrounding the topic, which may discourage open discussion. The inclusion of only one cultural group in Madidi Village, Bojanala District in North West Province limited the breadth of information gathered regarding the social factors contributing to HIV/AIDS. By incorporating multiple cultural groups, a more comprehensive understanding of the various cultural dynamics at play could have been achieved.

Furthermore, targeting a wider range of age groups could have provided additional perspectives on the topic. Different age groups must have unique experiences and insights regarding HIV/AIDS, which could have enriched the study's findings.

Additionally, allowing participants to use their own language could have facilitated more detailed and nuanced expressions of their experiences and perspectives. Using participants' preferred languages can enhance communication and ensure that their voices are accurately represented in the research findings.

5.3. Summary of the study according to the study questions

Question 1: Which social factors contribute to the spread of HIV/AIDS in Madidi village, Bojanala District in North west province.

The researcher found the following based on theme 2 (see section 4.3.1.2 and 4.3.1.2) where participants demonstrated that unemployment and poverty is the main contributor of HIV spread in the community. Eight out of twelve participants mentioned that unemployment promotes sexual risk behaviour, since people end up being involved in transactional sex in order to take care of their families. However, poverty was also linked to unemployment since participants behave the same when they are in these situations. The study has also demonstrated that other individuals may resort to alcohol and drugs which end up putting their lives at risk.

Individuals who are unemployed should receive cash transfers that is enough to buy their basic needs, this would help reduce the chances of them sleeping with multiple men for money or in exchange of food and shelter. More RDP houses should be built for those who are homeless or need shelter, the government should assist those who are unemployed to take care of their families. Women and girls should be empowered so it can increase their social status and strengthen their ability to seek employment. There is a need for sex education and training programs which will prepare young people about self-control whereby they will learn to say no to everything that put their health at risk, this include casual sexual practices in taverns with strangers. Again there should be campaigns that talk against alcohol and drug abuse in the community since it affects majority of individual's decision making.

The study findings and discussions indicated that cultural customs and beliefs also have an impact in HIV spread since they promote or encourage unsafe practices that expose individuals to HIV see section (4.3.1.5) participant MN1 and (4.3.1.6) where issues of cultural beliefs and norms are discussed.

The researcher found that there are barriers that may inhibit behavior change such as social factors, because individuals might be stuck on the contemplating stage, deciding whether it is worth it to leave the behavior or not. This is according to the theory of Trans-theoretical model. On the other hand, some participants may have complete volitional control over their intended HIV prevention behavior but these factors may hinder them from realising their

intended behavior. For example, living in a family where cultural norms and beliefs are a thing, it may be hard to convince them that you do not want to be part of them anymore or advising them that they need to be precautious when performing rituals, this may come as disrespect to them or like you are undermining them.

Recommendation

The study indicated that the need for HIV education programmes that address cultural practice and religious beliefs for community members in order to enhance their understanding about the spread of HIV, on how the cultural practices may have an impact on the spread of HIV. Also cultural acceptable interventions should be developed in order to address gender imbalances in the society. These programmes should teach women and men about their sexual rights and decision to enhance sexual health of women and to educate men to understand and respect decisions of women.

Question 2: How vulnerable are men and women to HIV/AIDS in Madidi village which is in Madidi village Bojanala district?

The study revealed that women are most vulnerable group in the community to HIV/AIDS compared to men, see theme 4 (section 4.3.1.4). Women who are not financially independent tend to date older guys or sugar daddies to take care of them, as expressed in the study by one of the participants in theme 4. This may also be linked to variables including gender inequality, restricted access to education, poverty, unemployment and societal standards.

Recommendation

Since women are more vulnerable to HIV/AIDS, the researcher recommends that campaigns that empower women to do better be implemented also address gender inequality that oppress rights of women, also social norms should be addressed and dealt with. Investing in women's education and providing opportunities for economic empowerment since they are mostly affected.

Question 3: what knowledge of HIV/AIDS does members of Madidi village have

Majority of participants gave different views regarding what HIV/AIDS is and how it is transmitted. Participants were able to distinguish between HIV and AIDS which indicated that

they do have knowledge about of HIV/AIDS, except for the participant that mentioned that, HIV can be transmitted through Colgate, which has not been scientifically proven. Other participants were able to mention different modes of transmission. The high level of basic information could be due to the large number of healthcare workers who formed part of the study since they work in health facilities and some have completed high level of education depicted in table 4.5 on the biographical details. This also shows that they have benefited from educational programmes done at school. The researcher used the Social cognitive theory to describe the participant's knowledge of. An individual usually learn through observing, copying and absorbing the behavior as their own. In this case, learners in school who are taught about HIV/AIDS are able to observe and copy what is being taught, then put it into practice by changing their behavior. If they are being taught about HIV, they might learn and start taking prevention measures and also be knowledgeable about the spread of HIV. If individuals are being empowered with HIV information, they might change their behavior.

Recommendation

It is therefore recommended that there is a need for community members to be informed about HIV so that they can provide correct information instead of misleading others. Educational campaigns should provide frequent updates for community members who do not have adequate information on HIV/AIDS, this must include changes in incidence relating to HIV/AIDS and change in mutation of the virus. Some of the recommendations are discussed below to help reduce the spread of HIV/AIDS in the community and to reduce the social factors that are responsible for HIV spread.

5.4. Recommendations of the study

It is evident that the majority of people in the community are at risk of contracting HIV due to the beliefs and cultural practices in their cultures or society. The participants mentioned that some people still go to initiation schools instead of going to clinics or hospitals for circumcision and polygamy is also still being practiced in the community. The findings need to be looked at and HIV/AIDS strategies need to be taken into consideration. Men should be taught about male circumcision in clinics where it is performed for free.

The researcher is proposing the following recommendations stemming from the findings and discussions of the study:

- The researcher recommends conducting further research targeting individuals between the ages of 12 and 60 years. This age range is crucial because many teenagers become sexually active at a young age since they are exposed to sexual activities by people around them, and often due to exposure to social networks and media, which can sometimes include harmful influences like pornography. It is important to educate these teenagers about the spread of HIV/AIDS and how to protect themselves from infection. Community involvement is essential in implementing strategies to reduce the spread of HIV/AIDS. It is crucial to engage both community members and leaders in this process to ensure the effectiveness and sustainability of the interventions. Strategies should be introduced in a manner that is accessible to everyone in the community, particularly targeting young people and those who are illiterate or marginalised. Community leaders play a pivotal role in addressing traditional practices, beliefs, and rituals that may contribute to the spread of HIV/AIDS. The researcher recommends leveraging the existing Skills Centre in Madidi Village, Bojanala district in North West province to provide training for both young and older community members in various skills. Specifically, there should be a focus on providing computer skills training, as many companies now require computer literacy for employment opportunities. This will empower individuals, particularly the unemployed, to enhance their employability in today's digital age job market. Furthermore, the Skills Centre should offer services aimed at empowering both young and older individuals to develop entrepreneurial skills. This could include training and support for starting businesses, particularly in sectors such as agriculture where the community has access to land. The Department of Agriculture should be engaged to provide assistance, such as equipment and resources, to individuals interested in starting agricultural ventures. The researcher recommends that law enforcement authorities take a proactive role in controlling and enforcing regulations pertaining to taverns, particularly those that sell alcohol and drugs to young people. It is imperative to strengthen existing rules and regulations governing these establishments to prevent underage drinking and drug abuse. One key measure is to restrict tavern operating hours, particularly to avoid opening in the early hours of the morning and closing no later than 3 am. By enforcing these limitations, law enforcement can mitigate the risks associated with excessive alcohol consumption and drug use, especially among vulnerable populations such as young people. The researcher recommends that the Department of Sport and Recreation visit the community to implement programs aimed

at developing and showcasing the sports skills of young children. These programs can provide valuable opportunities for children to engage in sports activities, helping to keep them occupied and away from potentially harmful activities on the streets. The researcher recommends the implementation of comprehensive sex education programs aimed at educating young people on various aspects of sexual health. These programs should provide information on the use of condoms, as well as the availability and importance of Pre-exposure prophylaxis (PrEP) and Post-exposure prophylaxis (PEP) in reducing the risk of HIV infection. It is suggested that these programs be held regularly, with participants encouraged to attend at least once a month. During these sessions, individuals should be provided with informational materials such as pamphlets and IEC (Information, Education, and Communication) materials that cover topics related to HIV/AIDS, ARVs, PrEP, PEP, and the correct use of condoms. Additionally, to promote safe sexual practices, participants should be given "goodie bags" containing essential items such as condoms, lubricant, and educational materials. These materials serve to reinforce the information provided during the sessions and empower individuals to take proactive steps towards protecting their sexual health. The researcher suggests that community leaders and health providers collaborate to implement and enforce rules aimed at combating stigma and discrimination, particularly against individuals who are HIV positive or those who are hesitant to get tested for HIV. It is essential to develop policies that explicitly address and challenge stigma and discrimination within the community, with the overarching goal of reducing the spread of HIV/AIDS. The researcher recommends that community leaders and health providers collaborate to establish community-based support groups aimed at providing encouragement, support, and counselling to individuals affected by HIV/AIDS. These support groups offer a safe and non-judgmental space where individuals can share their experiences, seek guidance, and receive emotional support from others facing similar challenges. Community leaders should seek help from NGOs and NPOs which offer care and treatment as well as HIV/AIDS services for people who are HIV positive. The National Department of Health should also work with Madidi community leaders in assisting with the implementation of outreach programs which will educate young and old about the prevention strategies they can use in protecting themselves.

- The NDOH should provide training about HIV/AIDS in order to inform the community about the spread of HIV/AIDS.

- HIV/AIDS prevention strategies should be part of the school curriculum to educate young people about HIV/AIDS, PrEP and PEP because some of the parents are not comfortable speaking with their children about such topics and some have no knowledge about the use of PrEP and PEP.
- Couple counselling should be promoted in healthcare facilities, so that both partners can know their HIV status.
- Traditional healers should collaborate with healthcare providers to ensure the safety of traditional practices like circumcision, particularly in initiation schools. This partnership would allow for the integration of modern medical knowledge to minimise the risk of disease transmission and complications during these ceremonies. Additionally, healthcare providers can offer training, guidance, and resources to traditional healers to enhance sterilisation techniques and infection prevention measures. This collaboration would promote communication and coordination between traditional healers and healthcare providers, ultimately prioritising the health and well-being of initiates. Efforts to prevent HIV/AIDS should prioritise strategies tailored to the cultural and social context, particularly those that empower women. Implementing interventions that empower women is crucial, as certain cultural practices perpetuate oppression and gender inequality, often promoting male dominance. By addressing these cultural norms and providing support and opportunities for women, such interventions can help shift power dynamics and promote gender equality, ultimately contributing to more effective HIV/AIDS prevention efforts. Women in the community should receive education on self-respect and their inherent value, as some may compromise their health and well-being by engaging in risky behaviour, such as unprotected sex for financial gain. Implementing laws that empower women to make their own decisions is crucial in protecting them from being controlled or oppressed by cultural norms that prioritise male dominance. These measures can help ensure that women are able to assert their rights and protect themselves from harm, ultimately promoting their health and autonomy. ART adherence programs are already in place in South Africa. These programs should explore methods to effectively reach patients and remind them about their ART medication intake schedules and clinic visit dates to prevent lapses and delays in treatment. One strategy could involve regular phone calls to patients to ensure they are adhering to their treatment regimen and to provide timely reminders for clinic appointments and medication collection. By implementing proactive measures to

support ART adherence, healthcare providers can help improve health outcomes and reduce the risk of treatment defaulting among patients living with HIV/AIDS. The researcher suggests utilising the radio station available in Madidi Village, Bojanala District in North West province as a platform for disseminating HIV/AIDS information by health professionals. This approach can effectively educate community members, as both elders and young people frequently listen to the radio. By leveraging this medium, health professionals can reach a broad audience and promote awareness of HIV/AIDS, including information about available health services at the clinic. Furthermore, the radio can be used as a tool to remind individuals living with HIV/AIDS to collect their medication from the clinic. Regular announcements and programming dedicated to health topics can help reinforce the importance of medication adherence and regular clinic visits for managing HIV/AIDS. Economic empowerment initiatives are essential for rural areas like Madidi Village, Bojanala District in North West province aiding individuals in finding employment or starting businesses. By reducing unemployment, these programs lower the risk of HIV/AIDS transmission. Stable income discourages behaviours leading to HIV transmission and improves access to healthcare services, including HIV testing and treatment. Hence, investing in such initiatives is critical for both community prosperity and HIV/AIDS prevention in rural settings. NACOSA has implemented economic strengthening and livelihoods interventions targeting various vulnerable groups such as young women, sex workers, people living with HIV, and individuals who inject drugs. These programs, which include components like financial literacy skills, work readiness, job opportunities, training, and entrepreneurship, have proven effective in addressing the impact of HIV/AIDS. Introducing similar programs in rural areas like Madidi Village, Bojanala district in North West province could significantly reduce the impact of HIV/AIDS by providing opportunities for economic empowerment and skill development. By equipping individuals with the necessary tools to secure employment, start businesses, and improve their financial stability, these interventions can address public health challenges and foster sustainable solutions within the community. The implementation of the People Who Use Drugs Programme in Madidi Village, Bojanala District in North West province is recommended to educate youth about the negative effects of drug use, prevent new HIV infections, and enhance access to drug treatment services. This initiative aims to raise awareness about the risks associated with substance abuse and improve treatment options for drug users. Providing rehabilitation and new injection

equipment can help mitigate the spread of HIV among drug users in the community. Programs such as Health4 MEN should be introduced in communities and should cover other areas that are in need. This can help to educate men about their sexuality.

- The other program that should target young girls and women in the Madidi community is the DREAMS (Determined, Resilient, Empowered, Aids-free, Mentored and Safe) program which can help reduce the risk of HIV among adolescents. These kinds of programs shouldn't limit their services to certain areas; they should also help underdeveloped areas like Madidi Village, Bojana District in North West province where people are struggling.
- Free WI-FI services should be provided in the community to accommodate those who lack internet services as one of the participant (see section 4.3.1.2. participant 2) mentioned that another problem is the issue of technology whereby people are not exposed to the internet to an extent that they can google somethings online. This will help individuals in the community to apply online for jobs since the unemployment rate is very high.

5.5 CONCLUSION

The aim of this study was to investigate social factors responsible for the spread of HIV/AIDS in Madidi Village, Bojanala district in North west province and to determine which gender is mostly affected by these factors. The study included participants between the ages of 18-49 years which are community members as well as healthcare workers. The information that was gathered in this study can help in making recommendations about how Government and other programs can assist the community in preventing these social factors that are affecting the community members, thereby reducing the negative impact of HI/AIDS.

The study can also aid government organisations in identifying and addressing the issues raised, allowing for more targeted interventions to reduce factors such as stigma and discrimination related to HIV/AIDS. Non-governmental organisations (NGOs) that focus on HIV/AIDS and related issues can also use the findings to tailor their programs and services to better meet the needs of the community.

Educational campaigns play a crucial role in HIV/AIDS prevention, especially considering the lack of information among many community members. By disseminating the findings of the

study, educational efforts can be better informed and more effectively reach those who lack knowledge about HIV/AIDS.

Furthermore, the study can contribute to increasing the level of knowledge about HIV/AIDS among individuals who are currently uninformed. This increased awareness can lead to better prevention practices and ultimately reduce the prevalence of HIV/AIDS within the community.

LIST OF REFERENCES

Adejoh, I. & Uchenna, O.M. 2011. Condom use in Nigeria: an evaluation. *Current Research Journal Economic Theory*, 3(1):10-13.

Adom, D, Yeboah, A & Ankrah, K. 2016. Constructivism Philosophical Paradigm: Implication for research, Teaching and Learning. *Global Journal of Arts Humanities and Social Sciences*. Vol 4(20526350). Available at: https://www.eajournals.org/wp content/uploads/Constructivism-Philosophical-Paradigm-Implication-for-Research-Teaching-and-Learning.pdf (Accessed on 11/08/2022).

Aggleton, P. 2007. "Just a snip"?: a social history of male circumcision. *Reproductive health matters*, *15*(29):15–21. https://doi.org/10.1016/S0968-8080(07)29303-6

Ajrouch, K.J. 2015. Towards a vigorous incorporation of culture in the study of human development. *Research in Human Development* 12(3):202-208**.**

Alchemer. 2021. *Purposive sampling 101*. Available at:https://www.alchemer.com/resources/blog/purposive-sampling-101/ (Accessed on 11/12/2023).

American Psychological Association. 2017. Ethical principles of psychologists and code of conduct. Available at: http://www.apa.org/ethics/code/index.html (Accessed on 02/03/2024).

Amin, S, Ahmed, J, Saha, J, Hossain, M & Haque, E. 2016. Delaying child marriage through community-based skills-development programs for girls: Results from a randomized controlled study in rural Bangladesh. *Poverty, Gender, and Youth*. doi.org/10.31899/pgy9.1009.

Anglewickz, P. & Clark, S. 2013. The effect of marriage and HIV risks on condom use and acceptability in rural Malawi. *Social Science and Medicine,* 97(1):29-40.

Anson, CM & Schwegler, RA. 2000. *The Longman Handbook for Writers and Readers*. Longman.

Antelman, G, Smith Fawzi, MC, Kaaya, S, Mbwambo, J, Msamanga, GI, Hunter, DJ & Fawzi, WW. 2001. Predictors of HIV-1 serostatus disclosure: a prospective study among HIV-

infected pregnant women in Dar es Salaam, Tanzania: *AIDS*. 15(14):1865–1874. doi.org/10.1097/00002030-200109280-00017.

Audet, C. M., Blevins, M., Rosenberg, C., Farnsworth, S., Salato, J., Fernandez, J., & Vermund, S. H. 2014. Symptomatic HIV-Positive Persons in Rural Mozambique Who First Consult a Traditional Healer Have Delays in HIV Testing. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, *66*(4), e80–e86. https://doi.org/10.1097/qai.0000000000000194

Audet, C.M. 2017.Traditional healer treatment of HIV persists in the era of ART: a mixed methods study from rural South Africa. *Complementary and Alternative Medicine,* 17(4):1-6.

Audet, C.M., McGowan, C.C., Wellstson, K.A. & A.M. 2013. Relationship between HIV stigma and Self-isolation among People Living with HIV in Tennessee. *PLos one*, 8:e69564.

Avert. 2019. *HIV prevention programs overview*. Available at: https://www.avert.org/professionals/hivsocial-issues (Accessed on 19/05/2022).

Baliso, K., Manyonda, A., Mpateni, A., Ndyokolo, A. & Siqoko, A. 2015. '*The behavioural changes of male adolescents post traditional circumcision: The case of Alice, Eastern Cape'*, Unpublished Honors dissertation in Social Work, University of Fort Hare, South Africa.

Bauni, E.K. & Jarabi, B.O. 2003. The low acceptability and use of condoms within marriage: Evidence from Nakuru District, Kenya. *African Population Studies*, 18(1):51-65.

Bandura, A. 1977. Self-efficacy: toward a unifying theory of behavioral change. *Psychology Review*, 84:191-215.

Bandura, A. 1977. *Social learning theory*. Englewood Cliffs, NJ: Prentice Hall.

Bandura, A. 1986. *Social foundations of thought and action: A social cognitive theory.* Englewood Cliffs, N.J.: Prentice-Hall.

Bandura, A. 1991. Social cognitive theory of self-regulation. *Organizational behavior and human decision processes*, 50:248-287.

Bandura, A. 2001. Social cognitive theory of mass communication. *Media Psychology*, 3:265-299.

Betz, N.E. 2004. An expert's perspective: self-efficacy. Contributions of Self-Efficacy Theory to career counselling: a personal perspective. *The Career Development Quarterly*, 52:340-353.

Beyeza-Kashesya, J., Kaharuza, F., Mirembe, F., Neema, S., Ekstrom, A.M. & Kulane, A. 2009. The dilemma of safe sex and having children: challenges facing HIV sero-discordant couples in Uganda. *African Health Science Journal*, 9 (1):2-12.

Bogoch, I., Scully, E.P. & Zachary, K.C. 2012. Antiretroviral medication for preventing HIV infection in non-occupational settings. *Canadian Medical Association Journal*, 184(10):1153-1157.

Brink, H., Van der Walt C. & Van Rensburg, G. 2018. *Fundamentals of Research Methodology for Health Care Professionals.* 3rd edition. Cape Town: Juta Ltd.

Brophy, F.C. 2010. *The perceptions and experience of male farm workers of the effects of a transpersonal social work intervention in addressing domestic violence.* Unpublished Draft. Paarl: University of Stellenbosch.

Burman, C.J., Aphane, M. & Delobelle, P. 2015. Reducing the overall HIV-burden in South Africa: is 'reviving ABC' an appropriate fit for a complex, adaptive epidemiological HIV landscape*? African Journal of AIDS Research*, 14(1):13-28.

Burns, N. & Grové, S.K. 2005. *Qualitative research methods*. 2nd edition. Philadelphia: Elsevier Saunders.

Burns, N. & Grové, S.K. 2005. *The practice of nursing research conduct, critique and utilization*. 5th edition. St Louis: Saunders.

Burns, N. & Grové, S.K. 2011. *Understanding nursing research, building evidence based practice*. 5th edition. Philadelphia: E'sevie" Saunders.

Calabrese, S.K., Magnus, M., Mayer, K.H., Krakower, D.S., Eldahan, A.I., Hawkins, L.A.G. ... & Dovidio, J.F. 2017. "Support your client at the space that they're in": HIV pre-exposure prophylaxis (PrEP) prescribers' perspectives on PrEP-related risk compensation. *AIDS Patient Care and STDs*, 31(4):196-204.

Career development. 2004. *What is Research methodology, why it's important and types?* https://://www.indeed.com/career-advice/career-development/research-methodology (Accessed on 26/07/2022).

Carels, C, Florence, M, Adams, S & Savahl, S. 2023. Alcohol Use as a Predictor of Risky Sexual Behaviour among Young Adults in the Western Cape Province of South Africa. *International Journal of Environmental Research and Public Health*. 20(22):7053. doi.org/10.3390/ijerph20227053.

Census. 2011. Main place: Madidi n.d. Available at: https://census2011.adrianfrith.com/place/661027 (Accessed on 12/02/2022)

Centers for Disease Control and Prevention. 2013. *Condoms and STDs: Fact sheet for public health personnel*. https://www.cdc.gov/condomeffect'veness/l'tex (Accessed on 12/09/2022).

Centers for Disease Control and Prevention. 2019. *HIV basics*. Available at: https://www.cdc.gov/HIV/basics/prevention.html (Accessed on 13/09/2021).

Centers for Disease Control and Prevention. 2022. About HIV/AIDS/HIV Basics/HIV/AIDS. Available at: https://www.cdc.gov/hiv/basics/whatishiv.html#:~:text=It%20was%20probably%20passed%20to,the%20mid%20to%20late%201970s (Accessed on 10/02/2023).

Centers for Disease Control and Prevention. 2023. Treatment/Living with HIV/HIV Basics/HIV/AIDS. Available at: https://www.cdc.gov/hiv/basics/livingwithhiv/treatment.html (Accessed on 03/04/2024).

Chimbiri, A.M. 2007. The condom is an 'intruder' in marriage: evidence from rural Malawi. *Social Science & Medicine*, 64:1102-1115.

Chimbindi, NZ, McGrath, N, Herbst, K, San Tint, K & Newell, M-L. 2010. Socio-Demographic Determinants of Condom Use Among Sexually Active Young Adults in Rural KwaZulu-Natal, South Africa. *The Open AIDS Journal*. 4:88–95. doi.org/10.2174/1874613601004010088.

Chirwa, E., Malata, A. & Norr, K. 2011. HIV prevention awareness and practices among married couples in Malawi. *Malawi Medical Journal*, 23(2):32-37.

Clark, C. 2022. Drinking blood: is it safe? Healthline. https://www.healthline.com/health/drinking-blood(Accessed on 12/05/23).

Clow, K.E. & James, K.E. 2014. The marketing research process. *Essentials of marketing research: putting research into Practice*, 25-61.

Cohen, L., Manion, L. & Morrison, K. 2007. Research methods in education. London: Routledge.

Corporate Finance Institute Team. 2015. What is Unemployment. Available at: https://corporatefinanceinstitute.com/resources/economics/unemployment/ (Accessed on 03/03/2024).

Creswell, J.W. 2018. *Qualitative inquiry & research method: choosing among five approaches*. Thousand Oakes: Sage Publications.

Creswell, JW & Poth, CN. 2018. *Qualitative inquiry & research design: choosing among five approaches*. Fourth edition ed. Los Angeles: SAGE.

De Jonckheere, M. & Vaughn, L.M. 2019. Semistructured interviewing in primary care research: a balance of relationship and rigour. *Family Medicine and Community Health*, *7*(2), e000057. https://doi.org/10.1136/fmch-2018-000057

De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.L.S. 2011. *Research at grass roots: for the social sciences and human service professions*. 4th edition. Cape Town: Creda Communications.

Denzin, N.K. 2005. Introduction: the discipline and practice of qualitative research. *In* N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 140). Thousand Oaks: Sage.

District Health estimates. 2018. *Bokone Bophirima (North West) Implementation plan on HIV, TB and STI.* https://sanac.org.za/wp-content/uploads/2019/02/PIP_NorthWest_Final-1.pdf (Accessed on 22/04/2023)

Erinosho, O., Isiugo-Abanihe, U., Joseph, R. & Dike, N. 2012. Persistence of risky sexual behaviours and HIV/AIDS: Evidence from qualitative data in three Nigerian communities. *African Journal of Reproductive Health*, 16(1):113-123.

Evian, C. 2003. *Primary HIVAids Care. A practical guide for primary health care personne*l. 4th edition. Houghton, South Africa: Jacana Media.

Ferguson. S. 2022. Why Self-Esteem Matters and Tips to Build Yours Up. Available at: https://www.healthline.com/health/mental-health/high-self-esteem (Accessed on 03/03/2024).

France, NF, Macdonald, SH -f., Conroy, RR, Chiroro, P, Cheallaigh, DN, Nyamucheta, M, … Byrne, E 2019, '"We are the change" - An innovative community-based response to address self-stigma: A pilot study focusing on people living with HIV in Zimbabwe', *PLoS ONE*, vol. 14, no. 2, p. e0210152.

Fisher, J. C, Cook, PA, Sam, NE & Kapiga, SH. 2008. Patterns of Alcohol Use, Problem Drinking, and HIV Infection Among High-Risk African Women. *Sexually Transmitted Diseases*. 35(6):537–544. Available at: https://www.jstor.org/stable/44971008 (Accessed 2/03/2024).

Fleetwood, D. 2018. Sampling Methods: Guide To All Types with Examples. Available at: https://www.questionpro.com/blog/types-of-sampling-for-social-research/ (Accessed 04/04/ 2024).

Flores, S. 2014. *Indian female perceptions of HIV and AIDS in the community*. MEd thesis. University of Kwazulu, Durban.

Flores, L. 2014. *What is social construction*? University of California Oakes College: USA. Available at: http://oakes.ucsc.edu/academics/Core%20Course/oakes-core-awards2012/laura-flores.html (Accessed on 06/02/2022).

Frost, L, Jenkins, LS & Emmink, B. 2017. Improving access to health care in a rural regional hospital in South Africa: Why do patients miss their appointments? *African Journal of Primary Health Care & Family Medicine*. 9(1). doi.org/10.4102/phcfm.v9i1.1255.

Geissbuhler, A., Safran, C. & Buchan, I. 2013. Trustworthy reuse of health data: a transnational perspective. *International Journal of Medical Informatics*, 82(1):1-9.

Giddens, A. 2001. *Sociology*. Oxford: Polity Press.

Gioia, D.A., Corley, K.G. & Hamilton, A.L. 2013. Seeking qualitative rigor in inductive research notes on the Gioia methodology. *Organisational Research Methods*, 16(1):15-31.

UNAIDS. 2024. Global HIV statistics. Available at: https://www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf (Accessed on 28/01/2024)

Global Network of People living with HIV/AIDS. 2018. HIV Stigma and Discrimination in the World of Work: Findings from the People Living with HIV Stigma Index. Available at: https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/documents/publication/wcms_635293.pdf (Accessed on 04/04/2024).

Govender, G.B. & Abdool, K. 2005. Understanding women and men's acceptability of current and new HIV prevention technologies in KwaZulu-Natal, South Africa. *Journal of AIDS Care,* 30(10):1311-1314.

Gray, RH, Kigozi, G, Serwadda, D, Makumbi, F, Watya, S, Nalugoda, F, Kiwanuka, N, Moulton, LH, et al. 2007. Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trial. *The Lancet*. 369(9562):657–666. doi.org/10.1016/s0140-6736(07)60313-4.

Grinnelle, L. & Maskie, S. 2013. *Understanding HIV/AIDS, building evidence-based practice*. 5th edition. Philadelphia: Elsevier Saunders.

Guure, C, Laryea, SMO-Y, Dery, S, Da Silva, CB, Asamoah-Adu, C, Ayisi-Addo, S, Loglo, M-G, Mohammed, A, et al. 2022. Behavioural Risk for HIV, Hepatitis B, and Hepatitis C Infections among a Population of Drug Users and Injectors across Four Regions in Ghana. *Interdisciplinary Perspectives on Infectious Diseases*. 2022:1–12. doi.org/10.1155/2022/2544481.

Haffejee, F. & Maksudi, K. 2020. Understanding the risk factors for HIV acquisition among refugee women in South Africa. *AIDS Care*, 32(1):37-42. https://doi.org/10.1080/09540121.2019.1687833

Hall, KS, Manu, A, Morhe, E, Harris, LH, Loll, D, Ela, E, Kolenic, G, Dozier, JL, et al. 2017. Development and Validation of a Scale to Measure Adolescent Sexual and Reproductive Health Stigma: Results From Young Women in Ghana. *The Journal of Sex Research*. 55(1):60–72. doi.org/10.1080/00224499.2017.1292493.

Hattori, MK, Richter, K & Greene, J. 2010. Trust, Caution, and Condom Use with Regular Partners: An Evaluation of the Trusted Partner Campaign Targeting Youth in Four Countries. *Social Marketing Quarterly*. 16(2):18–48. doi.org/10.1080/15245001003746774.

Hingson, F. 2001. Understanding the Scourge of HIV/AIDS in South Africa. *Journal of the International AIDS Society,* 8(30):1-8.

HIV.gov. 2025. *Viral suppression and an undetectable viral load*. n.d. Available at: https://www.hiv.gov/hiv-basics/staying-in-hiv-care/hiv-treatment/viral-suppression#:~:text=People%20with%20HIV%20who%20take,for%20people%20who%20inject%20drugs. (Accessed on 16/03/2025).

Hoffman, L. 1990. Constructing Realities: An Art of Lenses. *Family Process*. 29(1):1–12. doi.org/10.1111/j.1545-5300.1990.00001.x.

InnovateMR. 2023. *The Top 5 Ethical Considerations in Qualitative Research*. Available at: https://www.innovatemr.com/insights/the-top-5-ethical-considerations-in-qualitative-research/ (Accessed on 2/04/2024)

Imrie, J, Hoddinott, G, Fuller, S, Oliver, S & Newell, M-L. 2013. Why MSM in Rural South African Communities Should be an HIV Prevention Research Priority. *AIDS and Behavior*. 17(1):70–76. doi.org/10.1007/s10461-012-0356-1.

Irvine, S., Drew, M. & Sainsbury, A. 2013. Combination of social protection for reducing HIV-risk behavior among adolescents in South Africa. *JAIDS Journal of Acquired Immune Deficiency Syndrome,* 72(1):87-104.

Jamaican Information Services. 2012. Fight against HIV/AIDS Stigma and Discrimination continues. Available at: https://jis.gov.jm/fight-against-hivaids-stigma-and-discrimination-continues/ (Accessed on 03/03/2024).

Johnson, S., Kincaid, D.L., Figueroa, M.E., Delate, R., Mahlasela, L. & Magni, S. 2010. *The Third National HIV Communication Survey*, 2012, Pretoria: JHHESA.

Javadi, M. & Zarea, K. 2016. Understanding thematic analysis and its pitfall. *Journal of Client Care*, 1(1):34–40.

Johnson, B. & Christensen, L. 2012. Educational research: quantitative, qualitative and mixed approaches. 4th edtion. California: Sage.

Joint United Nations Programme on HIV/AIDS (UNAIDS). 2017. *How AIDS changed everything. MGD 6. 15 years, 15 lessons of hope from the AIDS response. Fact sheet: 2014 Global Statistics.* https://www.unaids.org (Accessed on 23/10/2022).

Joubert-Wallis, M. & Fourie, E. 2008. *Culture and the spread of HIV*. Unpublished Draft. Paarl: University of South Africa.

Joubert, R., Morell, R.E. & Christofides, N. 2009. Empowering teenagers to prevent pregnancy: lessons from South Africa. *Journal of Culture, Health and Sexuality,* 11(7):675-88.

Kalichman, S.C., Simbayi, L.C., Vermaak, R., Jooste, S. & Cain, D. 2008. HIV/AIDS risks among men and women who drink at informal alcohol serving establishments (Shebeens) in Cape Town, South Africa. *Society for Prevention Research,* 55-62.

Karim, K. 2005. Managing fear in public health campaigns: A theory-based formative evaluation process. *Health promotion,* 6(4):31.

Karim, S.S.A. & Karim, Q.A. 2005. HIV/AIDS in South Africa. Cape Town: Creda Communications.

Karim, Q.A. & Karim, S.S.A. (eds). 2010. *HIV/AIDS in South Africa*. 2nd edition. Cape Town: Cambridge University Press.

Kimani-Murage, E.W. 2011. Nutritional status and HIV in rural South African children. *BMC Pediatrics*, 25:11:23. https://doi.org/10.1186/1471-2431-11-23

Krishna, A. 2023. *The psychology behind dating multiple partners at the same time*. Available at: https://drkrishnaathal.com/2023/06/26/the-psychology-behind-dating-multiple-partners-at-the-same-time/ (Accessed on 17/11/2023).

Kuczynski, J. 2012. *Evaluation of the implementation of an HIV/AIDS workplace policy for farm workers: a case study of Country Mushrooms*. Unpublished Draft: University of South Africa: Pretoria.

Leach-Lemens, S. 2010. Managing fear in public health campaigns: a theory-based formative evaluation process. *Health promotion,* 4(3):32.

Leclerc-Madlala, S. 2003. Transactional Sex and the Pursuit of Modernity. *Social Dynamics*. 29(2):213–233. doi.org/10.1080/02533950308628681.

Leclerc-Madlala, S, Simbayi, L, & Cloete, A. 2009. The sociocultural aspect of HIV/AIDS in South Africa 25 years on. Spring Science + Business Media, 13-25.

Linganiso, W.S. & Gwegweni, J.M.T. 2016. What perpetuates the spread of HIV/AIDS in rural South African communities? A closer look at social factors. *Austin Journal of Public Health Epidemiology*, 3(1):1031.

Lopman, B., Lewis, J., Nyamukapa, C., Mushati, P., Chandiwana, S. and Gregson, S., 2007. HIV incidence and poverty in Manicaland, Zimbabwe: is HIV becoming a disease of the poor? *AIDS (London, England)*, *21*(Suppl 7), p. S57.

Luke, N. 2006. Exchange and condom use in informal sexual relationships in urban Kenya*. Economic Development and Cultural Change*, 54(2):319-348.

Machlup, F. 2014. *Knowledge: its creation, distribution and economic significance, Volume I: Knowledge and knowledge production.* Princeton University Press.

Madiba, S. & Ngwenya, N. 2017. Cultural practices, gender inequality, and inconsistent condom use increase vulnerability to HIV: narratives from married and cohabiting women in rural communities in Mpumalanga Province: *South Africa. Global Health Action*, 10(13):23-45.

Magadi, S. 2013. Factors influencing the health of men in polygynous relationship. *African Journal for Physical, Health Education, Recreation and Dance (AJPHERD*) (Supplement 1):12-21.

Maguire, M. & Delahunt, B. 2017. Doing a thematic analysis: a practical, step-by-step guide for learning and 'teachin' scholars. *The All Irela'd Journal of Teaching and Learning in Higher Education*, 8(3):3351–33514.

Makhubele, M.Z.B. 2007. *Risk and sex in an HIV epidemic: challenges for HIV prevention*. Gauteng AIDS Conference. Boksburg, CADRE.

Manti, S & Licari, A. 2018. How to obtain informed consent for research. *Breathe*. 14(2):145–152. doi.org/10.1183/20734735.001918.

Martin. (2023, October 19). *Economic Growth - United Nations Sustainable Development*. United Nations Sustainable Development. Available at: https://www.un.org/sustainabledevelopment/economic-growth/ (Accessed on 24/09/2022).

Masenya, M. 2010. Is Ruth the 'ēšet hayil for real? An exploration of womanhood from African proverbs to the threshing floor (Ruth 3:1-13). *Studia Historiae Ecclesiasticae*. 36:1–21. Available at: http://www.scielo.org.za/scielo.php?script=sci_abstract&pid=S1017-04992010000300004&lng=en&nrm=iso&tlng=en (Accessed 02/03/2024).

Mash, R., Mash, B. & De Villiers, P. 2010. 'Why don't you just use a condom?': Understanding the motivational tensions in the minds of South African women: review article. *African Primary Health Care and Family Medicine*, 2(1):1-4.

Mathebula, M. 2013. *800 Years of Tsonga History (Year 1200-Year 2000)*. Burgersfort: Sasavona Publishers and Booksellers.

Maundeni, T. 2004. The boy child and HIV/AIDS in Botswana: A neglected issue in research and practice. Available at: https://ubrisa.ub.bw/handle/10311/879 (Accessed 04/04/ 2024).

Mayo clinic staff. 2017. *Mental health: Overcoming the stigma of mental illness*. Available at: https://www.mayoclinic.org/diseases-conditions/mental-illness/in-depth/mental-health/art-20046477 (Accessed on 18/12/2023).

McClethe, M. 2012. *Primary health care fresh perspective*. Cape Town: Pearson Education.

McMillan, E. 2006. Exploring gender perceptions of risk of HIV infection and related behavior among elderly men and women in South Africa Province South Africa. *Journal of social aspects of HIV/AIDS,* 13(1):6-8.

McMillan, J.H. & Schumacher, S. 2006. Research in education: evidence-based inquiry. 6th ed. Cape Town: Pearson.

Medel-Añonuevo, C & Diarra, MC. 2007. *Literacy matters: making the connections – why literacy matters for HIV prevention.* (Literacy initiative for empowerment). Hamburg: UIL.

Merriam, S. B, Caffarella, RS & Baumgartner, L. 2007. *Learning in adulthood: a comprehensive guide*. 3rd ed. (The Jossey-bass higher and adult education series). San Francisco: Jossey-Bass.

Mogotlane, S., Chauke, M., Matlakala, M., Mokoena, J. & Young, A. 2014. Juta's complete textbook of medical-surgical nursing. Cape Town: Juta and Company Ltd.

Mohammed. A. S. 2017. These workers face discrimination from inside, and out. Available at: https://www.bbc.com/worklife/article/20170302-these-workers-face-discrimination-despite-protective-laws (Accessed on 03/03/2014).

Mokgatle, M & Madiba, S. 2023. Community perceptions of HIV stigma, discriminatory attitudes, and disclosure concerns: A Health Facility-Based study in selected health districts of South Africa. *International Journal of Environmental Research and Public Health*. 20(14):6389. doi.org/10.3390/ijerph20146389.

Mill. J.S. 1879. *On liberty and the subjection of women*. New York: Henry Holt and Company.

Mills, E.J., Beyrer, C., Birungi, J. & Dybul, M.R. 2012. Engaging men in prevention and care for HIV/AIDS in Africa. *PLoS medicine*, 9(2):e1001167. https://doi.org/10.1371/journal.pmed.1001167

Morton, F. 2011. Bogwera and Mephato. *Botswana Notes and Records*, 43:38–51. Available at: http://www.jstor.org/stable/23237955 (Accessed on 04/02/2024)

Motsoaledi, A. 2010. *Outline of the national HIV Counselling and Testing (HCT) campaign. Special address by the Minister of Health, South Africa*. Available at: http://www.info.gov.za/speeches/2010/10032611051001.htm (Accessed on 12/09/2022).

Mutton, N. & Grové, S.K. 2003. *Understanding HIV/AIDS re, building evidence-based practice*. 5th edition. Philadelphia: Elsevier Saunders.

Ncitakalo, N, Mabaso, M, Joska, J & Simbayi, L. 2021. Factors associated with external HIV-related stigma and psychological distress among people living with HIV in South Africa. *SSM - Population Health*. 14:100809. doi.org/10.1016/j.ssmph.2021.100809.

Ndou-Mammbona, AA. 2022. The effects of traditional healing on HIV and AIDS management: An ethnographic study. *South African Family Practice*. 64(1). doi.org/10.4102/safp.v64i1.5559.

Newswise. 2023. Alcohol makes you more likely to approach attractive people but doesn't make others seem better looking: Studies on Alcohol and Drugs. Available at: https://d.newswise.com/articles/study-finds-that-alcohol-increases-the-likelihood-of-approaching-attractive-individuals-but-does-not-alter-perceptions-of-others-attractiveness#:~:text=Alcohol%20may%20not%20be%20altering,less%20likely%20to%20do%20otherwise. (Accessed on 17/09/2022)

NIDA. 2022. *Addiction and Health*. Available at: https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/addiction-health Accessed on 2024, January 12.

Nieuwenhuis, J. 2007. Qualitative research designs and data gathering techniques. *In*: Maree, K. (Ed.). *First steps in Research* (pp. 147). Pretoria: Van Schaik.

Nkomazana, F. 2018. POLYGAMY AND WOMEN WITHIN THE CULTURAL CONTEXT IN BOTSWANA. *Scriptura*. 92(0). doi.org/10.7833/92-0-1366.

Nxumalo, J. 2014. The long battle against HIV/AIDS in Swaziland. Nursing Update. *The Magazine for the Caring Profession*, 39(2):32-33.

Nyatsvimbo, M. 2011. “The Silent Cry of Married Women”. *Journal of AIDS Care Zimbabwe.* Vol. 37. pp. 1.

Nzewi, O. 2009. *Exploring gender issues and men’s vulnerability to HIV/AIDS in Sub-Saharan Africa*. Johannesburg: Centre for the Studies.

Osuafor, G.N, & Mturi, A.J. 2014. Attitude towards sexual control among women in conjugal union in the era of the HIV/AIDS epidemic in Mahikeng, South Africa. *African Population Studies*, 28(1):538-550.

Ovbiebo, M.O. 2011. Illiteracy and vulnerability to HIV/AIDS: THE CASE OF IGUEBEN WOMEN IN NIGERIA. *Problems of education,* 97(30):105-106.

Oyelana, O, Kamanzi, J & Richter, S. 2021. A critical look at exclusive breastfeeding in Africa: Through the lens of diffusion of innovation theory. *International Journal of Africa Nursing Sciences*. 14:100267. doi.org/10.1016/j.ijans.2020.100267.

Parker, W., Makhubele B, Ntlabati, P & Connolly, C. 2007. Available at: https://://www.comminit.com/en/node/269915 (Accessed on 21/12/2023).

Parker, W., Zungu, N.P., Pezi, S. & the SABSSM III Implementation Team. 2009. *South African national HIV prevalence, incidence, behaviour and communication survey 2008*: *A turning tide among teenagers*. Cape Town: HSRC Press.

Pascoe, S. J.S, Langhaug, L. F, Mavhu, W, Hargreavens, J. S, Hayes, R & Cowan, F.M. 2015. Poverty, Food Insufficiency, HIV Infection and Sexual Behaviour among young rural Zimbabweans women. *PLOS ONE.*10(1): e0115290. doi:10.1371/journal.pone.0115290.

Patel, S. 2015. *The research paradigm-methodology, epistemology and Ontology-explained in simple language*. Available at: https://salmapatel.co.uk/academia/the-research-paradigm-methodology-epistemology-and-ontology-explained-in-simple-language/ (Accessed on 13/12/2023).

Peacock, D. 2013. South Africa's Sonke gender justice network. Educating men for gender equality. Agenda: Empowering women for gender equality. Available at: https://www.genderjustice.org.za (Accessed on 23/06/2022).

Peeters, M & Delaporte, E. 2012. Simian retroviruses in African apes. *Clinical Microbiology and Infection*. 18(6):514–520. doi.org/10.1111/j.1469-0691.2012.03843. x.

Peltzer, K., Simbayi, H.L., Banyini, M. & Kekana, Q. 2011. HIV risk reductio' intervention among traditionally circumcised young men in South Africa: a c'uster randomised control trial. *Journal of the association of nurses in the AIDS care,* 1-10.

Perez, A., Holt, N., Gokiert, R., Chanoine, J.P., Legault, L., Morrison, K., Sharma, A. & Ball, G. 2015. Why don't families initiate treatment? A qualitative multicenter study investigating parents' reasons for declining pediatric weight management. *Pediatrics & Child Health*, 20(4):79-84.

Polit, F.D.L. & Beck, C.T. 2004. *Nursing research: generating and assessing evidence for women*. 10th edition. Philadelphia: Lippincott Williams & Wilkins.

Polit, D.F., Beck, C.T. & Hungler, B.P. 2004. *Research principles and methods*. Philadelphia: JB. Lippincott.

Polit, D.F. & Beck, C.T. 2010. *Essentials of Nursing: Appraising Evidence for Nursing Practice.* Wolters Kluwer, Lippincott, Williams & Wilkins.

Polit, D. F. & Beck, C.T. 2012. *Nursing research: generating and assessing evidence for nursing practice*. 10th edition. Philadelphia: Lippincott Williams & Wilkins.

Polit, D.F. & Beck, C.T. 2017. Nursing research: generating and assessing evidence for nursing practice. 10th edition. Philadelphia, PA: Wolters Kluwer.

Porter, J. 2012. Informed consent in Leprosy Studies. *Leprosy review*. 84(4):326–330. Available at: https://researchonline.lshtm.ac.uk/id/eprint/856717/ (Accessed 2 March 2024).

Proofed. 2022. Research Paradigms. Explanation and Examples. https://proofed.com/writing-tips/research-paradigms-explanation-and-examples/ (Accessed 18/11/2022).

Pugh, S.A. 2010. Examining the Interface Between HIV/AIDS: religion and gender in Sub-Sub-Saharan Africa. *Canadian Journal of African Studies*, 44(3):624-643.

Redding, C.A. 2000. Testing a model of situational self-efficacy for safer sex among college students: stage and gender-based differences. *The International Electronic Journal of Health Education*, 3(3):180-193.

Resnick, D.B.2015. What is ethics in Research & why is it important? National Institute of Environmental Health Science. Available at: https://www.niehs.nih.gov/research/resources/bioethics/whatis/index.cfm (Accessed on 02/03/2024).

Ritchie, J. & Lewis, J. 2003. *Qualitative research practice*. London: Sage.

Ritshidze. 2021. North West State of Health. Available at: https://ritshidze.org.za/wp-content/uploads/2021/06/Ritshidze-North-West-State-of-Health-2021.pdf (Accessed on 27/04/2023).

Roberts. F.N. 2021. Alcohol as a coping response: Hyperkatifeia and how it influences our drinking. Available at: https://www.forbes.com/sites/nicoleroberts/2021/02/07/alcohol-as-a-coping-response-hyperkatifeia--how-it-influences-our-drinking/?sh=4026935c12d2 (Accessed on 12/01/2024).

Rose-Innes. 2006. Social-cultural aspects of HIV/AIDS: News24. Available at: https://www.news24.com/life/wellness/body/condition-centres/hiv-aids/the-south-african-culture/sociocultural-aspects-of-hivaids-20120721 (Accessed on 17/12/2023).

Rural Health Information Hub. 2022. Healthcare Access in Rural Communities Overview. Available at: https://www.ruralhealthinfo.org/topics/healthcare-access (Accessed on 03/03/2024).

Scandlyn, J. 2000. When AIDS became a chronic disease. *Western Journal of Medicine*. 172(2):130–133. doi.org/10.1136/ewjm.172.2.130.

Schwandt, Thomas, A. 2015. The Sage Dictionary of Qualitative Inquiry. 4th edition. Thousand Oaks, CA: Sage.

South African National AIDS Council. 2022. The Bokone Bophirima (North West) Provincial Implementation Plan on HIV, TB and STIs (2017-2022). Available at: https://sanac.org.za/wp-content/uploads/2019/02/PIP_NorthWest_Final-1.pdf Accessed on 03/03/2024).

Spacey. J. 2021. 57 Examples of Social Factors. Available at: https://simplicable.com/society/social-factors (Accessed on 03/03/2024).

Schunk, D. 2008. Learning theories. An educational perspective. 5th ed. Harlow: Prentice Hall.

Schreuder, A.M. & Coetzee, M. 2008. *Careers and organizational perspective*. Lansdowne: Juta Academic.

Seager, J., Ganyaza-Twalo, T. & Tamasane, T. 2005. Development of a conceptual framework to help understand the interactions between poverty and HIV/AIDS at the household level. (Paper presented at the International Union for the Scientific Study of Population Seminar, Cape Town, 12-14 December).Available at: https://hdl.handle.net/20.500.11910/6890 (Accessed on 16/02/2023).

Shisana, O. Rehle, T. Simbayi, LC., Zuma, K., Jooste, S., Pillay-van-Wyk, V., Mbelle, N., Van Zyl, J, Parker, W., Zungu, NP., Pezi, S. & the SABSSM III Implementation Team. 2009. *South African national HIV prevalence, incidence, behaviour and communication survey 2008*: *A turning tide among teenagers* Cape Town: HSRC Press.

Shisana, O., Zungu, N. & Pezi, S. 2009. Poverty and HIV and AIDS. *HIV/AIDS in South Africa 25 years on: psychosocial perspectives*. New York: Springer. 89-104. Available at: http://hdl.handle.net/20.500.11910/4438 (Accessed on 23/04/2023).

South African National AIDS Council (SANAC). 2010. *Meeting the challenges of HIV treatment and Prevention through independent Mobilization and work through the SA National AIDS Council*. Available at: https://section27.org.za/2010/10/meeting-challenges-of-hiv/ Accessed on (13/06/2022).

South African National AIDS Council (SANAC). Department of Health. 2018. *National Strategic Plan on HIV, STIs and TB* (NSP): 2012–2016. Pretoria.

South African National AIDS Council. 2019. The Bokone Bophirima North West Province Implementation Plan on HIV, TB and STIs (2017-2022). Available at: https://sanac.org.za/wp-content/uploads/2019/02/PIP_NorthWest_Final-1.pdf (Accessed on 03/04/2024).

Stangl, L, A, Loyde, J, Brady, M, Holland, C & Baral, S. 2015. A systematic review of interventions to reduce HIV related Stigma and discrimination from 2002-2015. *Journal of the international AIDS Society.* 13(2): 2-7.

Statistics of South Africa. 2020. 2020 Mid-year population estimates. Available at: https://www.statssa.gov.za/ (Accessed on 03/03/2024).

Stewart, JL, Wallace, DD, Nance, A, Schalkoff, CA, Uhrig Castonguay, BJ, Widman, L, Carey, MP & Golin, CE. 2022. Validated HIV Knowledge Scales for Use with Adults and Adolescents: A Systematic Review. *AIDS and Behavior*. 26(5):1695–1715. doi.org/10.1007/s10461-021-03521-4.

Spire, B, De Zoysa, I & Himmich, H. 2008. HIV prevention: What have we learned from community experiences in concentrated epidemics? *Journal of the International AIDS Society*. 11(1):5–5. doi.org/10.1186/1758-2652-11-5.

SunlightRecorvery. 2022. *Why People Drink to Have Fun-sober answer*. Available at: https://sunlightrecovery.com/drink-to-have-fun/ (Accessed on 16/12/2023).

Tegan, G. 2022. Promoting behaviour change in Botswana. An assessment of the peer education HIV and AIDS prevention programme at the workplace. *Journal of Health Communication*, 8: 1-2.

Tjale, A & de Villiers, L (eds). 2004: *Cultural issues in Health and Health Care*. Cape Town: Juta.

Tong, R. 2009. *Feminist thought*: a more comprehensive introduction. USA: University of North Carolina, Charlotte, Westview Press.

Trevino, KM, Pargament, KI, Cotton, S, Leonard, AC, Hahn, J, Caprini-Faigin, CA & Tsevat, J. 2010. Religious Coping and Physiological, Psychological, Social, and Spiritual Outcomes

in Patients with HIV/AIDS: Cross-sectional and Longitudinal Findings. *AIDS and Behavior*. 14(2):379–389. doi.org/10.1007/s10461-007-9332-6.

Tulane National Primate Research Center. 2006. AIDS/HIV. Available at: https://tnprc.tulane.edu/aids (Accessed on 03/03/2024).

Twalo, TG & Seager, J. 2005. Literature review on poverty and HIV/AIDS: measuring the social and economic impacts on households. Pretoria: HSRC.

UNAIDS. 2014. 90-90-90 An ambitious treatment target to help end the AIDS epidemic. Available at: https://www.unaids.org/sites/default/files/media_asset/90-90-90_en.pdf (Accessed on 14/07/2022).

UNAIDS. 2017. *Women and girls living with HIV/AIDS*. https://www.unaids.org/en/keywords/women-and-girls (Accessed on 18/06/2022).

UNAIDS. 2018. The Global AIDS epidemic-key facts. Available at: https://www.unaids.org (Accessed on 17/09/2021).

UNAIDS. 2018. Global HIV/AIS statistics. https://www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf (Accessed on 26/07/2022).

UNAIDS. 2018. Global update response. https://www.samumsf.org/en/resources/hiv/hiv/-response/unaids-global-aids-update (Accessed on 11/03/2022).

UNAIDS.2021. HIV AND STIGMA AND DISCRIMINATION: *Human Rights Fact Sheet Series.* Available at: https://www.unaids.org/sites/default/files/media_asset/07-hiv-human-rights-factsheet-stigma-discrmination_en.pdf Accessed on 04/04/2024).

UNAIDS. 2023. *HIV sub-national estimates viewer*. n.d. Available at: https://naomi-spectrum.unaids.org/. (Accessed on 16/03/2025).

UNAIDS. 2025. *South Africa | UNAIDS*. Available at: https://www.unaids.org/en/regionscountries/countries/southafrica. (Accessed on 16/03/2025).

United Nations Population Fund and United Nations Children's Fund. 2020. Child Marriage and Other Harmful Practices: *A desk Review of Evidence from South Asia*. Available at: https://asiapacific.unfpa.org/sites/default/files/pub-pdf/child_marriage_and_other_harmful_practices_unfpa_apro_and_unicef_rosa_2020.pdf (Accessed on 05/03/2024).

Vaismoradi, M., Jones, J., Turunen, H. & Snelgrove, S. 2016. Theme development in qualitative content analysis and thematic analysis. *Journal of Nursing Education and Practice,* 6(5):100-110.

Van Dyk. 2001. *HIV/AIDS Care and counselling: A Multidisciplinary Approach*. 2nd edition. Cape Town: Pearson Education South Africa.

Van Dyk, A. C. 2001. Traditional African1 Beliefs and Customs: Implications for AIDS Education and Prevention in Africa. *South African Journal of Psychology*, *31*(2), 60–66. https://doi.org/10.1177/008124630103100208

Van Dyk, AC & Van Dyk, PJ. 2003. "To know or not to know": service related barriers to voluntary HIV counselling and testing (VCT) in South Africa. Curations, 26(1):4-9.

Van Dyk, A. 2012. *HIV AND AIDS Education, Care and Counselling: A multidisciplinary approach*.5th edition. Cape Town: Pearson Education.

Vinz, S. 2023. *What Is a Theoretical Framework?* | *Guide to Organizing.* Scribbr. https://www.scribbr.com/dissertation/theoretical-framework/ Accessed on 21/12/2023)

White, C.J. 2004. *An introduction to research Methodology*. Pretoria: Inthuthuko Investment.

World Health Organization. 2009. Antiretroviral therapy for HIV infection in adults and adolescents, Recommendations for Public health approach 2019 revision. www.whqlibdoc.who.int/publications/2010/978924159964 (Accessed on 25/05/2022).

World Health Organization. 2024. HIV and AIDS. Available at: https://www.who.int/news-room/fact-sheets/detail/hiv-aids#:~:text=Overview,cells%2C%20weakening%20the%20immune%20system (Accessed on 23/03/2024)

Zeitzen, M.K. 2008. *Polygamy: a cross-cultural analysis.* Oxford: Berg Publishers.

Zou, J, Yamanaka, Y, John, M, Watt, M, Ostermann, J & Thielman, N. 2009. Religion and HIV in Tanzania: influence of religious beliefs on HIV stigma, disclosure, and treatment attitudes. *BMC Public Health*. 9(1):75. doi.org/10.1186/1471-2458-9-75.

APPENDIX 1: INTERVIEW GUIDE

Appendix 1: Interview guide

Section A (Questionnaire)

Age:	Race:	Ethnic group:
Sex:	Occupation:	Educational level:
No. of family members:	Parental occupation:	marital status:

Section B (Questions regarding social factors that contribute to HIV/AIDS

1.What is your understanding about HIV/AIDS and how is it transmitted?

2.What is your understanding about social factors that contribute to the spread of HIV/AIDS?

3. Which social factors affect the community of Madidi on the ones that you have mentioned?

4.Which gender is mostly affected by this social factors that contribute to the spread of HIV/AIDS in the community?

5.What is your understanding about cultural beliefs and norms?

6. Can you kindly share with me the Tswana cultural norms and beliefs that can cause the spread of HIV/AIDS in Madidi community?

7.How is the unemployment rate in the community of Madidi and which gender is mostly affected?

8. What are the sexual risk behaviours that you engage yourself in that makes you vulnerable to HIV?

9.Describe your views or experiences of having multiple sexual partners?

10.what are your views on substance abuse and spread of HIV?

11. Have you ever engaged in sexual activities for money or any favour? If yes, why and if not what are your views on that?

12. What do you think about stigma and discrimination that leads on HIV? Does it have any effect on patients in health facilities?

Section C Vulnerability of men and women HIV/AIDS in Madidi village

1. Are u in a relationship?
2. How many sexual partners do you have?
3. Do you use condom every time you have sexual intercourse?
4. Have you ever had a sugar daddy/sugar mommy and what was the reason for dating him?
5. Have you ever used any substance abuse/drugs including alcohol? if yes, where and why?
6. Do you believe in traditional norms/healing? If yes do you think they have any effect on the HIV pandemic?
7. Are you circumcised? If yes, did you get circumcised at the hospital/clinic or initiation school?
8. How do you feel about circumcision at the initiation schools?
9. Do you believe in polygamy and if yes, then why?
10. Which traditional practices do you think can have an effect on HIV spread?

THANKS FOR YOUR PARTICIPATION…

APPENDIX 2: PERMISSION LETTER

Title: Exploring social factors that contribute to the spread of HIV/AIDS in Madidi Village, Bojanala District in North West Province.

Date: 12 June 2023

To: Ward Councillor Mr K Sefike

2092 Block E

0190

Cell no. 0712711713

Email address: boikagoentle89@gmail.com

Dear Councilor Mr K Sefike

My name is Lebogang Esther Lekgema, I am doing research towards a Master's degree in Social Behavioural Studies in HIV/AIDS in the Department of Sociology at the University of South Africa. I would like to invite you in the study entitled: Exploring the social factors that contribute to the spread of HIV/AIDS in Madidi Village, Bojanala District in North West Province.

The purpose of this study is to investigate and describe the social factors that contribute to the spread of HIV/AIDS in Madidi Village, Bojanala District in North West Province. The main objective of the study is to determine the vulnerability of men and women on HIV/AIDS in the community.

The place was chosen because the researcher has an interest in knowing more about the people who live there and what knowledge do they have about social factors that contribute to the spread of HIV HIV/AIDS, also to share their experiences about the topic that is being studied.

The study will involve face-to-face interview which will be conducted in English with 12 participants between the ages of 18-49 years, which will be tape recorded. The reason for recording the interviews is that the researcher wants to be able to transcribe and analyse the information collected, this will also help to produce more detailed information without leaving anything.

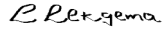
The researcher will use open- ended questions during the interview session to enable the participants to produce more information and raise their opinions and experiences about the given topic. Each interview session will last for an hour so that all the information can be covered. Every participant will be interviewed for an hour depending how they will be sharing their opinions or rather experiences.

Please note that taking part in this study is entirely voluntary and there won't be any reimbursement, however, the results can assist you in understanding social factors that contribute to HIV/AIDS and strengthening prevention programs that are available in the community in order to fight against the spread.

In this study, participants will not be exposed to any physical and psychological harm such as: emotional stress, embarrassment and negative labelling, anger towards them, and dignity which might affect them.

During the course of interviews, if the participant suffers any harm or become exposed to any harm, the researcher will report the matter to the University CREC so they can investigate the matter and act on it, then refer the participant for counselling. Your identity will not be revealed to anyone and the information you produce will be protected and no one will have access to it except for the CREC and the supervisor.

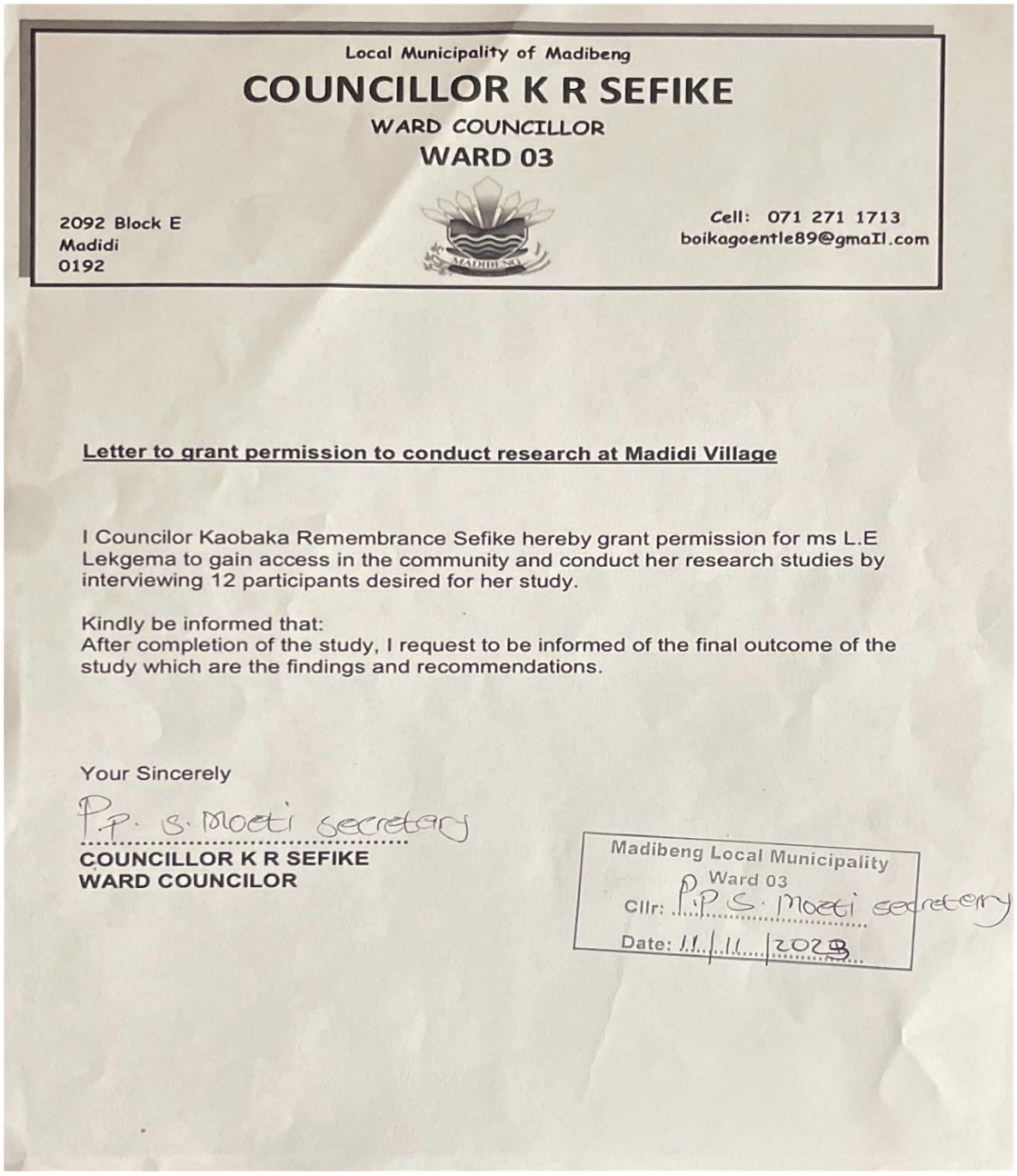
Yours faithfully



Lebogang Esther Lekgema

UNISA STUDENT

APPENDIX 3: APPROVAL LETTER FROM MADIDI VILLAGE



Local Municipality of Madibeng

COUNCILLOR K R SEFIKE

WARD COUNCILLOR

WARD 03

2092 Block E
Madidi
0192

Cell: 071 271 1713
boikagoentle89@gmail.com

Letter to grant permission to conduct research at Madidi Village

I Councilor Kaobaka Remembrance Sefike hereby grant permission for ms L.E Lekgema to gain access in the community and conduct her research studies by interviewing 12 participants desired for her study.

Kindly be informed that:
After completion of the study, I request to be informed of the final outcome of the study which are the findings and recommendations.

Your Sincerely

P.P. S. Moeti secretary

COUNCILLOR K R SEFIKE
WARD COUNCILOR

Madibeng Local Municipality
Ward 03
Cllr: P.P.S. Moeti secretary
Date: 11/11/2023

APPENDIX 4: ETHICS APPROVAL

UNISA university of south africa

COLLEGE OF HUMAN SCIENCES RESEARCH ETHICS REVIEW COMMITTEE

25 October 2023

NHREC Registration # :
Rec-240816-052
CREC Reference # :
47561599_CREC_CHS_2023

Dear Ms Lebogang Lekgema

Decision:
Ethics Approval from 25 October 2023 to 25 October 2024

Researcher(s): Name: Ms. L. Lekgema
Contact details: 47561599@mylife.unisa.ac.za
Supervisor(s): Name: Dr. P. Nhlanhla
Contact details: nhlanpp@unisa.ac.za

Title: EXPLORING SOCIAL FACTORS THAT CONTRIBUTE TO THE SPREAD OF HIV/AIDS IN MADID VILLAGE WHICH IS IN BOJANALA DISTRICT (NORTH WEST PROVINCE).

Degree Purpose: Masters

Thank you for the application for research ethics clearance by the Unisa College of Human Science Ethics Committee. Ethics approval is granted for one year.

The ***medium-risk application*** *was reviewed by* College of Human Sciences Research Ethics Committee, in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the College Ethics Review Committee.
3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the confidentiality of the data, should be reported to the Committee in writing, accompanied by a progress report.
5. The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study. Adherence to the following South African legislation is important, if applicable: Protection of Personal Information Act, no 4 of 2013; Children's act no 38 of 2005 and the National Health Act, no 61 of 2003.
6. Only de-identified research data may be used for secondary research purposes in future on condition that the research objectives are similar to those of the original research. Secondary use of identifiable human research data require additional ethics clearance.
7. No fieldwork activities may continue after the expiry date **(25 October 2024).** Submission of a completed research ethics progress report will constitute an application for renewal of Ethics Research Committee approval.

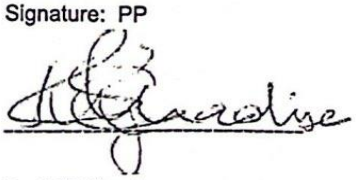
Note:

*The reference number **47561599_CREC_CHS_2023** should be clearly indicated on all forms of communication with the intended research participants, as well as with the Committee.*

Yours sincerely,

Signature: 

Prof. KB Khan
CHS Research Ethics Committee Chairperson
Email: khankb@unisa.ac.za
Tel: (012) 429 8210

Signature: PP 

Prof ZZ Nkosi
Exécutive Dean: CHS
E-mail: nkosizz@unisa.ac.za
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APPENDIX 5: CONSENT FORM

Appendix 5: Consent form

CONSENT TO PARTICIPATE IN THIS STUDY

Research title: Exploring Social factors that contribute to the spread of HIV/AIDS in Madidi village which is in Bojanala District (North west province).

I, Salphina Mohwase (participant name), confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty (if applicable).

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I agree to be tape recorded during the interview session

I have received a signed copy of the informed consent agreement.

Participant Name & Surname..Salphina Mohwase..... (please print)

Participant Signature.....Date..19/11/23

Researcher's name & surname ....Mebogang Lekgema.....Date.19 Nov 2023

Researcher's signature..Lekgema..... Date..19 Nov 2023

APPENDIX 6: RESEARCHER ACKNOWLEDGEMENT FORM

RESEARCHER ACKNOWLEDEGMENT

Research title: Exploring social factors that contribute to the spread of HIV/AIDS in Madidi Village, Bojanala District in North West Province.

Researcher: Lebogang Esther Lekgema

I LEBOGANG ESTHER LEKGEMA ID number 9108040292980 in my personal capacity as a researcher, acknowledge that I am aware of and familiar with the stipulations and contents of the

- Unisa Research Policy
- Unisa Ethics Policy
- Unisa IP Policy

and that I shall conform to and abide by these policy requirements.

Signature: L Lekgema

Date: 111/11/ 2023

APPENDIX 7: PARTICIPANT LEAFLET

Ethics clearance reference number: 47561599_CREC_2023

Research permission reference number (N/A)

Date 12 June 2023

Title: Exploring Social factors that contribute to the spread of HIV/AIDS in Madidi Village, Bojanala District in North West Province.

Dear Prospective Participant

My name is Lebogang Lekgema and I am doing research in the Department of Sociology towards a Master's degree at the University of South Africa. I am inviting you to participate in a study entitled Exploring social factors that contribute to the spread of HIV/AIDS in Madidi Village, Bojanala District in North West Province.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to investigate and describe the social factors that contribute to the spread of HIV/AIDS in Madidi Village, Bojanala District in North West Province. The main objective of the study is to determine the vulnerability of men and women on HIV/AIDS in the community. The findings of the research will bring more insight and understating that will assist healthcare policies, government and other non-governmental organisations to assist the community in decreasing HIV/AIDS by implementing and devising educational programs and awareness.

WHY AM I BEING INVITED TO PARTICIPATE?

You have been selected to participate in this study to form part of the study sample size of 12 people from Madidi Village, Bojanala District in North West Province. Before you take part in this study you will be provided with a consent form which you have to sign to show that you agree to take part in the study.

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?

The study will involve face-to-face interview, which will be tape recorded. The reason for recording the interviews is that the researcher wants to be able to transcribe and analyse the information collected, this will also help to produce more detailed information without leaving anything. The researcher will use open-ended questions during the interview session to enable the participants to produce more information and raise their opinions and experiences about the given topic. Each interview session with each participant will last for an hour so that all the information can be covered.

CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?

Statement that participation is voluntary and that there is no penalty or loss of benefit for non-participation. Participating in this study is voluntary and you are under no obligation to consent to participation. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form. You are free to withdraw at any time and without giving a reason. Participants will not be put in any situation where they might be at risk of harm (physically, emotionally, economically, politically and psychologically.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

Your participation in this study is entirely voluntarily and there won't be any reimbursement offered. However, the researcher hopes that you will gain more knowledge and better understanding about the social factors that contribute to HIV/AIDS.

ARE THEIR ANY NEGATIVE CONSEQUENCES FOR ME IF I PARTICIPATE IN THE RESEARCH PROJECT?

The researcher will ensure that no participant will be exposed to any risks that will harm them. If you feel any discomfort when answering the questions, you are allowed to withdraw from the study but I will ensure that your identity remains anonymous. The information that you provide will be kept anonymous and confidential.

WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER AND MY IDENTITY BE KEPT CONFIDENTIAL?

All the information that will be produced during the interview session will be kept safe in a lockable cabinet at the researcher's home. All the recordings will be secured by the use of created password by the researcher and will be known by me and the supervisor/ the Research Ethics Review Committee. Anonymity will be ensured at all means. The participants were informed that they should not mention their names anywhere in the recording to protect their identity. Instead of using the names of the participants on the recording, the researcher will use codes to ensure confidentiality. The report might be submitted for publication but your name will not be identified.

HOW WILL THE RESEARCHER(S) PROTECT THE SECURITY OF DATA?

The researcher will store hard copies of your answers (field notes) for a period of five years in a locked cabinet at the researcher's home in case the researcher might be interested in conducting similar research. The electronic information will be stored in a password protected computer. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable. When the five-year period expires, all the electronic information will be destroyed as well as field notes will be destroyed and permanently deleted from the hard drive of the computer.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?

There will be no compensation given to the participants.

HAS THE STUDY RECEIVED ETHICS APPROVAL?

This study has received written approval from the Research Ethics Review Committee of the college of Human science at UNISA. A copy of the approval letter can be obtained from the researcher if you wish to see it.

HOW WILL I BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?

If you would like to be informed of the final research findings, please contact Lebogang Lekgema on 0714893500 or email on Lekgemael@gmail.com. The findings can be accessible December 2023 or January 2024.

Should you have concerns about the way in which the research has been conducted, you may contact Dr Phillip Nhlanhla on 0124293275/ 0826794028 or email Nhlanpp@unisa.ac.za. Should you have any query about any ethical concerns please contact the research ethics chairperson of the college of Human Science at UNISA Prof MA Antwi, email: antwima@unisa.ac.za Thank you for taking time to read this information sheet and for participating in this study.

L Lekgema

Lebogang Lekgema

APPENDIX 8: TURNITIN REPORT

Submission status

Attempt number	This is attempt 1 (1 attempts all
Submission status	Submitted for grading
Grading status	Not marked
Last modified	Tuesday, 18 March 2025, 10:46 F
File submissions	LEBOGANG LEKGEMA.dc 11%
Reference ID	Q0hTIE0mRCBUdXJuaXRpbiAyM
Submission comments	Comments (0)