11. Using a sociolinguistic approach to safe sex promotion in Cape Town: the challenges of multiculturalism

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Introduction

The relationship between language and culture is a complex one. Cross-linguistic and intercultural communication are intertwined in a complex manner. In Africa, where medical institutions embody the contradictions between colonial paradigms and indigenous paradigms, and where prevention work emanates from global discourses on sex and behaviour, issues of culture and language cannot be ignored.

This paper sets out to explore some of the practical and theoretical issues of intercultural communication as they impact on AIDS prevention and educational work in multilingual and multicultural settings. The first section describes practical experiences of cross-linguistic and cross-cultural in AIDS prevention work conducted in Cape Town, South Africa. The second section explores some of the theoretical issues and looks at research by Luyanda Mapekula that explores intercultural conflict between the Western biomedical paradigm, and popular culture in Cape Town townships.

This leads to a discussion of the question of cross-cultural perceptions of agency, autonomy and action as regards safer sexual behaviour. The author argues that there is not necessarily a cross-cultural equivalence of power to take unilateral decisions, and that this context needs to be understood by prevention workers. From another angle, however, culture can be held up as a defence of disempowerment and failure to take personal responsibility.

The author argues for further research to test the assumptions about culture and behaviour motivation that currently underlie prevention work in Africa. A synthesis of Mapekula's findings and the author's own experience supports an approach that allows the client's (or workshop participant's) paradigm to be acknowledged and regarded as the foundation of learning relationship. However, this boundary may be subject to a mutually agreeable change as the prevention worker helps the client or participant understand the transmission route of HIV and the implications for his or her sexual activity.

ASET's workshop experience

To meet prevention objectives of promoting safer sexual behaviour and informing people of the particulars of HIV transmission during sex, AIDS educators must be able to use language that is explicit, precise and accurate. Whereas Western societies have adequate discourses available and sociolinguistic norms that permit this communication, southern African societies currently have restrictions on language use which may obscure the central themes of safe sex / AIDS prevention education.

This section examines one workshop developed in Cape Town, South Africa, by the AIDS Support and Education Trust (ASET)[1] that attempted to address this problem. The workshop was informed by principles of adult education and sociolinguistics. The design and strengths of the workshop are described and a critique is provided. The critique looks at the cross-cultural problems inherent in AIDS education that cannot be addressed at the level of linguistic strategies.

Much of the early safe sex promotional / AIDS awareness material was developed in Western European and North American countries where norms about language use and cultural appropriateness were different from much of the rest of the planet. Generally speaking, Western cultures developed scientific or technical registers[2] for sexual and anatomical matters prior to AIDS. In English, for example, this meant there were at least three registers to draw on when speaking of sexual matters: vulgar or profane language, polite social language, and scientific or technical language.

These levels of discourse emerged out of the particular relationship Western societies had with science and industrialisation. These discourses were further expanded by the massive social changes that took place in the 1960s and 1970s where sexual and anatomical matters became common place in the mass media. Pornography, erotica and nudity were available to the general public and discourses arose to accommodate these changes.

The introduction of sex education into North American secondary schools and in some cases primary schools by the mid-1970s is an example of the extension of language norms. Topics which previously would have only been discussed in youthful peer groups, or between adult family members and youths, was shifted into a new formal institutional setting with its own language norms.

When the AIDS epidemic began, Western societies had readily available linguistic resources for publicly discussing the details of transmission and prevention. For safe sex education there was an established precedence for explicitness, so long as an appropriate register was used. Appropriate terminology for mentioning genitals and

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1 In 1996, ASET changed its name to Triangle Project and shifted its focus towards sexual minorities in the African and coloured townships of Cape Town.

2 Register is a sociolinguistic term referring to the level of formality or social distance in speech.

coitus even in formal, mixed gender settings was provided by the quasi-medical register that had established itself.

This ability to be explicit was amplified by the large gay male cultural presence in North America and Europe. The gay media in North America and Europe was less constrained by mainstream norms and was able to provide uncensored, sexual education in vernacular language (i.e. it was not constrained to use scientific language). This in turn influenced the form safe sex education was to take for the heterosexual majority.

In southern Africa, most cultures have prohibitions or restrictions on the use of sexually explicit language in public. In Nguni cultures, there were traditionally strict rules about language and gender that carried over into sexual matters. The importance of maintaining respect, *ukuhlonipha*[1], when speaking to one's elders or people of the opposite sex placed social constraints on detailed discussion of sexual practices and anatomical terms. Early AIDS educators found themselves having to censor their work, or risk offending people by using Western models.

South African AIDS educators working in African language constituencies were faced with the challenge of how to be sexually explicit and precise without losing their audiences by giving offence.

Background of the workshop

The AIDS Support and Education Trust started providing safe sex and other AIDS related information to the Cape Town public in 1986, soon after the first cases of AIDS occurred in South Africa. The target audience was primarily English- and Afrikaans-speaking (white) gay men. At that time South Africa was under a state of emergency and contact with the mainly African-language townships was minimal to non-existent. The question of serving an African clientele did not emerge until the 1990s.

In March 1992, ASET sponsored the visit of one of Holland's leading safe sex educators, Robert Hubers of the Stichting Aanvullende Diensverlening (SAD). Hubers provided training in safe sex education to a number of AIDS Service Organisations (ASOs), including those working in the townships. For the first time the issue of cultural differences in discussing safe sex came to the surface for ASET.

The Dutch gay approach to safe sex was blunt and disturbing to all the participants, including English South Africans. It involved facilitator-led discussion of sexual desires, practices, body parts and body fluids using vernacular language. Xhosa-speaking AIDS educators were concerned that they could not relay these effective, yet inappropriate, education techniques to their constituencies.

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[1] *Hlonipha* refers to a deferential language of avoidance used by Xhosa married women. In its original form it involved noun substitution to avoid the use of words similar to male in-law's names or even syllables within the husband's name.

Following Hubers' visit, the ASET safe sex team redesigned its general introductory workshop to include a number of elements from the training. The workshop was run monthly between 1992 and 1995 [1]. Over three years approximately 60 workshops were run and between 1 500 and 2 000 people attended. Of these workshops the majority were in English, with a few bilingual workshops. Township AIDS Project in Soweto adopted elements of the workshop and used in a number of languages in Gauteng and other provinces (Crawhall 1994: 13-15).

During this time, the workshops were evaluated by participants and facilitators, and adjustments were made accordingly. Particularly helpful to evaluation were the training sessions with other ASOs where ASET volunteers had to communicate their workshop skills to other AIDS workers. It was during these occasions that discussion focused on cross-cultural applicability and the didactic strength of different units.

The target group for the workshops, according to ASET's mandate, was meant to be gay men, lesbians, and bisexuals. In practice, at least half of the people who eventually attended workshops were heterosexual. Most of the ASOs being trained in the workshop methodology had heterosexual target groups with diverse cultural and linguistic profiles. The workshop therefore had to accommodate a wide range of constituencies including: sexual minorities, men, women, all ages, at least two major religions (Islam and Christianity), different social classes, at least three languages (English, Afrikaans and Xhosa), and different occupational interests ranging from psychologists to sex workers.

Effectiveness of the workshop

In the last five years, AIDS educators and psychologists have observed once successful prevention initiatives in gay male communities in Western countries cease to be effective (Odets 1993; Gold 1995). At the Vancouver AIDS Conference (1996), we have been reminded how little research is being presented on the effectiveness of prevention work. This lack of research should warn us to beware of untested assumptions and prejudices that may be held up as truths.

Indicators for the success of the ASET workshop included: the public demand for the workshop (though not necessarily from the target group), the high degree of satisfaction registered in the participant evaluation forms, and the requests for training by other ASOs.

Between 1992 and 1995, ASET, on request, trained a number of leading ASOs in the methodology of the workshop. These included Planned Parenthood Association, SHAWCO AIDS Resistance Programme (SHARP) at the University of Cape Town, Township AIDS Project (TAP), Belville Community Health Project, and community

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[1] From 1996 on the demand from the public decreased but the training demand increased from other ASOs and schools.

organisation such as Association of Bisexuals, Gays and Lesbians (ABIGALE), and Gays and Lesbians of the Witwatersrand (GLOW).

However, owing to capacity constraints (both resources and skills) the real effectiveness of the workshops, in promoting sustainable safer sex was never measured. Like most prevention efforts, the impact could only be assumed.

Aims of the workshop

The primary goal of the workshop was to provide participants with an understanding of HIV transmission that was credible and would help inform their future sexual behaviour. Within this understanding a hierarchy of risk was established to help the participant focus on modifying the most serious risk taking. A number of other goals were incorporated into the workshop.

In order of presentation the following outcome aims were identified:

— participant is aware of the importance of talking about HIV and safe sex;
— participant acknowledges that the decision to have safe sex or not is complicated by the emotional and other issues (e.g., power relations) that are associate with sex, i.e., it is not a simple rational choice issue;
— participant understands and is able to explain how HIV is transmitted sexually and is able to judge his / her own sexual behaviour according to the transmission model;
— participant understands that ejaculation of semen into the vagina or anus, without a barrier, is the most likely form of HIV transmission;
— participant understands the basics of effective condom use;
— participant acknowledges his/ her rational and irrational fears of infection and the unfair discrimination that may arise from that;
— participant is aware of the need for compassion for HIV positive people;
— participant has the empathetic experience of what it is to receive a sero-positive diagnosis and therefore revitalise acute awareness of the risks he or she may be taking.

The order of the workshop content was structured to promote group dynamics, a sense of security, risk taking (i.e., sharing personal experience and asking questions), and closure.

All of this was carefully arranged into a two-hours workshop. One of the assumptions behind the workshop was that most participants would only attend a single workshop and might not access other ASET services (the clinic, counselling, other workshops). Therefore, the emphasis was on providing the target audience members with enough information that they could make decisions, without overloading them with information. Too much information could confuse people and blur the essentials, too little would not allow them to move to a further awareness and the development of personal strategies.

Adult education tools

South Africa has a dynamic non-governmental sector that provided Freirean style adult basic education to the majority population under the apartheid years. ASET was able to access tested principles of effective adult education from the NGOs experience.

Because the primary goal was to inform people of something which they did not know previously, i.e., a model of HIV transmission through body fluids, the workshop was necessarily didactic and teacher-driven rather than an open, learner-initiated event. However, bearing this constraint in mind the Team worked toward the most interactive approach possible within the time constraints.

The most complex part of the workshop, and its most important unit, is the presentation of the transmission model referred to as *the Risk Triangle*. The Risk Triangle is a diagram presented in the workshop to help participants understand the different dosages of HIV carried in different body fluids, and the impact this has on chances of infection during sex. There were a number of motivating assumptions behind this approach, which was notably different from other ASOs and government education.

Firstly, it was assumed that an individual is more empowered when he or she is given information and encouraged to make his or her own choices. The emphasis was placed on right and wrong information. We repeatedly noted in evaluations that this workshop was the first time people understood why some sexual activity could lead to transmission and others not.

Secondly, messages given out by mainstream ASOs that sex transmits HIV and fidelity protects the individual is inaccurate and confusing, not to mention unrealistic in its assumptions about human behaviour. In the ASET approach questions of sexual fidelity were secondary to understanding viral transmission. The approach, rooted in the Dutch original, was devoid of moral judgement. This allowed the adult learner to apply the information to his or her own moral system and personal situation.

Thirdly, it was felt that setting rules for people was counter-productive. In a society where rules and laws had been used to abuse people and commit crimes against humanity, it was not a sound basis to promote a rule-based model. Promoting '*good*' behaviour and '*bad*' behaviour was likely to encourage alienated youths to choose the '*bad*' option as a matter of principle. If bad people had unsafe sex then rebellious youth would wear unsafe sex as a badge of bravery and honour.

The Risk Triangle involves communicating a daunting amount of information. Participants receive an explanation of different concentrations of HIV in infected fluids, the requirement of direct transmission into blood and the vulnerable points of contact during sex. The facilitator then works with participants to analyse all likely sexual behaviour in comparison with the transmission model.

The Team developed a visual prompt, the Risk Triangle. The Risk Triangle put body fluids in one of three categories depending on

possible concentration of HIV. The effect of infected fluid transmission to blood of each category (corresponding to a level of the Triangle) was explained, starting at the level of blood and semen.

Techniques such as repetition, referring to the visual aid, using gestures were all included in facilitator training. Once transmission is explained, the facilitator takes the participants through the list of sexual activities they have brainstormed to get them to apply the model. In this way the learner has stated his or her particular concern, the facilitator has presented a model, and the learner brings his or her concern together with the model to learn its application. The information was usually reviewed again at the end of the workshop.

This technique proved reasonably successful, though training evaluation revealed that most people did not fully grasp all the details of the Risk Triangle the first time and some prompts like hand gestures sometimes confused rather than clarified. Client evaluations usually listed the Risk Triangle as the most significant element of learning in the workshop.

Sociolinguistic tools

In his 1993 address to the First Bellville Community Conference on AIDS, Cape Town, then Health Secretary of the African National Congress, Dr Ralph Mgijima, noted that: "All cultures have ways of talking about sex... Sex (in African culture) is a private thing; something that people would speak about to a mother or father. The challenge is to take that talk into public" (Crawhall 1993: 23).

Community AIDS workers in both governmental and non-governmental organisations complained about the difficulty of explicitness in AIDS education. The usual approach was either too vague, and therefore failed to inform people, or too vulgar and ended up alienating people. A new approach was required.

During training with ASET, the then Director of Township AIDS Project (TAP) in Soweto, Ennea Motaung, reported: "I say to people that I am going to be very open and that this is not accepted in our culture. I ask people to leave if they want" (Crawhall 1993: 25). Her approach signifies a key concept of *leave taking*, of seeking special permission.

The ASET Team solution was to negotiate sociolinguistic norms with the participants. As Mgijima indicated, every culture has a time, a place and, frequently, a register in which individuals can talk about sex. The trick would be to gain consent to use the sexual register in a different, more public context.

Workshop facilitators were trained not to use any sexual terminology until they had successfully negotiated this change of rules with the workshop participants. The participants themselves would introduce a register that matched their level of comfort.

During the initial word association around the word '*sex*' the participants could decide for themselves how much sociolinguistic risk they were willing to take in that social setting. Sometimes groups were

explicit and frank from that moment on, in which case the facilitator could do likewise. More often the word association signalled that participants were feeling restrained in their choice of terms. This restraint would cue the facilitator for further negotiation in the following technique.

After the word association, participants were asked to name specific sexual acts. It was often at this point that the facilitator would have to actively negotiate a loosening of the sociolinguistic norms. The difference between this approach and previous strategies, such as Motaung's cited above, is that the facilitator would not proceed without consent. The participants would have to own the decision to change the rules.

The brainstorming of sex acts often started off with an embarrassing silence, which would eventually be broken by a participant. Once broken, a new sociolinguistic norm would be established. The participants, though they had abandoned one norm, would set another register norm that would vary from group to group. Again the facilitator would only use terms generated by the group.[1]

The process was still not complete. Participants who chose a register so remote from explicitness that it was obscure were required to be more precise and accurate. For example, a participant would refer to penetration as *ukwabelana isondo* (literally: *to share a small piece of cloth*). This *hlonipha* term is widely understood in Xhosa and has come into increasing public usage through AIDS education. It is in contrast with more vulgar (e.g., less respectful) terms such as *ukulalana* (to sleep together).

The facilitator, preparing for the explanation of the Risk Triangle model, is required to take the participant to a new level of explicitness that makes clear which fluids go where during any particular sexual act. Whether starting with *isondo* in Xhosa or *intercourse* in English, the participant would be asked to be more precise. The facilitator would ask: w*hat happens?* Having established a commitment to openness and a relatively comfortable register, the participant would go down one more level in precision. This could be: *indoda ifaka ubhuti kusisi* (literally: *the man puts his brother in the sister*) or in English, *the man puts his penis in the vagina.*

There is another register in Xhosa where a person might say: *indoda ifaka incanca enyweni* (literally: *the man puts his penis in the vagina*). The terms are generally considered disrespectful and would not be used in front of anyone to whom respect is due. Use of such terms in a workshop would likely give extreme offence to participants.

In English, the use of terms like '*brother*' and '*sister*', instead of '*penis*' and '*vagina*' would appear overly coy and unco-operative. In the European and North American approach to AIDS education, the participant might be challenged to use '*the real words*'. However,

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[1] It should be noted that not all facilitators liked the approach initially. Some felt it their responsibility to show being comfortable with explicit language. The Team generally stuck to the rule because the technique was perceived to be more effective, empowering and respectful than the alternative.

from a linguistic and semantic point of view there is no need to force the participants to abandon euphemisms when they are adequately precise. The cultural implications of violating sociolinguistic norms of English and Xhosa should not be taken as equivalent. There is a substantial difference between the Anglo-Saxon distinctions between medical register, vulgar register, and coy euphemisms on the one hand and Xhosa distinctions between respectful language and disrespectful language.

For the purposes of education, the *brother* / *sister* terminology is adequate, keeping in mind that the objective is to be able to identify and trace fluid transmission. That these are noun substitutes is not important so long as the participants are sure of their semantic meaning in this particular context.

Once the first silence has been broken and the consent of the participants reached the narrowing down to precise and accurate descriptions is a fairly fast procedure. Throughout this part of the workshop the facilitator has not used any terms that the group has not consented to. No one in the group can accuse the facilitator of being disrespectful.

The evaluation forms checked for responses to the facilitator's clarity and politeness. Overwhelmingly participants of all ages, of different religions, of different sexual orientations and languages, approved of the most sensitive unit of the workshop.

It is interesting to note that the negotiation in the workshops was primarily about language and sociolinguistic rules. The facilitators used latex dildoes (imitation penises) to demonstrate and encourage description of sexual activities. In South African society, objects like dildoes were very rare in the early 1990s and few participants would have seen one. Initially, some white facilitators expressed a concern that black participants would find the dildoes offensive. Over time it was evident that, in general, black participants were much more at ease with dildoes and condoms than white participants, even though white (English and Afrikaans) participants were more rapidly accepting of changed sociolinguistic norms.

The sociolinguistic concerns of Xhosa speaking participants should not be confused with unease about sex or sexuality; the problem is one of the rules of speech and how to modify these without losing the target group.

Questions of culture and autonomy

South Africa is an unusual country. It has founding cultures from three continents. Despite its natural resources and strong industrial base, it has one of the greatest disparities in wealth in the world. There are eleven official languages; large immigrant and migrant populations; an aboriginal population; and Africa's most active gay and lesbian population. Most of the world's major religions are observed ranging from Calvinist Christianity to Zionism, Islam to

Hinduism. It is, in short, a land of diversity and sometimes of contradictions.

Though its diversity is enthusiastically embraced as a resource by the new dispensation, the economic and political inequalities, culturally linked as they are, have remained a source of conflict and suffering for the last three centuries, and acutely so after forty years of under apartheid. It would be unwise to assume that those inequalities and the psychological and sociological effects do not dramatically influence the types of AIDS prevention interventions that are required.

To be effective AIDS workers have to understand the needs of a range of constituencies with very different circumstances. There is no single strategy or approach that is going to work for everyone, and more so what is effective in one context may be inappropriate and even counter-productive in another.

The idea of '*translating*' one type of prevention or education instrument from one language (the dominant one) into another language (a subjugated one) without considering other cultural and power issues is likely to be ineffective at best. At worst, it is contributing to the sense of powerlessness that feeds the epidemic.

This is also not to imply that identifying appropriate cultural parameters is easy in a complex society. Referring to the challenge faced by AIDS counsellors in South Africa, Nhlanhla Mkhize has noted that:

> "Cross-cultural counselling is therefore even more crucial in societies whose meaning systems are being challenged or modified. In some South African communities (especially Indian and black) this usually manifests itself in disagreements between parents and offspring in relationship matters such as choice of spouse. The worst situation is where the meaning systems of a marginal culture are negated without an opportunity being afforded to participate fully and meaningfully in the dominant culture of the time" (Mkhize 1995: 9).

When we think of cross-cultural, as in the quote from Mkhize, we may be tempted to think solely in terms of white and black South Africans negotiating power relations. However, there is evidence that within communities that share cultural origins and meaning systems, there can be cultural conflict that contributes to silencing the marginal culture.

In a thought-provoking research project, University of Cape Town (UCT) graduate student Luyanda Mapekula compared the views of five Xhosa-speaking HIV positive patients and five Xhosa-speaking counsellors in the public health care system who handled their cases.[1]

Mapekula's hypothesis is that "HIV counselling and training enculturates people within a particular view of illness which may not be shared by their clients" (Mapekula 1996: 1). The research and literature review looks at the inflexibility of the Western biomedical

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[1] At the time of writing this paper Mapekula's thesis was still under consideration and may go through changes before it is finalised. The paper is part of a Masters of Arts programme in Clinical Psychology.

paradigm and the problems this creates between health care workers and patients who are otherwise ostensibly of the same cultural origin. She points out that the relation between doctor and patient takes place within a predetermined power relationship, which under apartheid is particularly severe. Nurses and counsellors are forced into this unequal power relation and usually end up having to "assimilate certain beliefs about diseases, their aetiology and modes of treatment in a similar way to doctors... it can be assumed that they [nurses] identify largely with doctors rather than clients on aspects of health care that are more similar to doctors than to their clients" (Mapekula 1996: 18).

There were a number of themes where the cultural and epistemological frameworks of clients and counsellors were at odds. Some of these, such as blaming foreigners for spreading AIDS, are likely found in many societies. However, one of the troublesome observations included that two clients attributed supernatural causes to their condition which the counsellors did not encourage them to discuss or even accept as legitimate.

Mapekula notes that four of the five counsellors found clients to be irrational and difficult to contemplate. She cites the following comments:

> "they sometimes *tuja* - like I have given up on one of them. I have said when he is ill, he should come back. They tell you that '*lidliso*' or '*libekelo*' or they will way '*weqile*' or '*weqe umkhondo*'. Those are really the difficult ones more especially if you want to make them understand.
>
> It is important when you are going to counsel a person to note that we are at various levels, with a person like you I would not talk about soldiers, we would talk anatomy. Let me make an example, a person with TB [tuberculosis], they will say 'it's not TB it's *lidliso*'. When you tell them about HIV/AIDS, they can hear you, at the back of their minds, the person has a witchdoctor, that cures incurable things so he half believes you when you say that it is incurable. There is also a notion that whites tend to have incurable diseases. Now, you have to start from there, it is useless to oppose and explain it in the Western way..." (Mapekula 1996: 54).[1]

Though the counsellors recognise the culture of the patient they tend not to be able to effectively mediate the cultural and psychological conflict which ensues. Mapekula makes a number of significant comments in her conclusion including that counsellors in their predominant use of the medical model seemed aware but unaccepting of the "different approaches more particularly the traditional approaches used by clients to explain the condition..." (Mapekula 1996: 55).

The health care system, such as it is in South Africa, has an *apartheid* foundation that continues to plague it and its users. The Western biomedical model of health is unequivocally the only valid

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[1] Glossary of terms: *tuja* = pretend not to understand something; *lidliso* = it is a poison; *libekelo* = it is a curse involving soil from the victims footprint; *weqile* / *weqe ukhondo* = symptoms acquired when a person unknowingly walks on the trail of evil and witchcraft creatures.

paradigm for official health care. Traditional and alternative views of health care are banished from hospitals and training. This silencing of the subordinate position is detrimental both to the quality of democracy in a country and the good mental health of the individual.

Mkhize has called for health counselling in South Africa to take better account of its aims and the needs of clients:

> "assumptions underlying counselling ought to be revisited and formu-lated within the client's value system. Counselling is informed by appropriate client needs and values, and exploits strengths that are already in place in the client system. For example, we need to learn more about respect, and affirm the manner in which traditional communities deal with issues such as bereavement, recognising the psychological and therapeutic value of such practices" (Mkhize 1995: 9).

At this point it is worth considering the experience of the ASET workshop and the lessons which are worthy of reflection. Initially, the workshop was designed in Europe for gay, Dutch-speaking men. Through its adaptations, it came to be used in amongst: heterosexual, Northern Sotho-speaking, rural women in the Northern Province; amongst Afrikaans-speaking Moslem youth groups in Cape Town; amongst hostel dwellers in Soweto; amongst male, female and transgender sex workers in Cape Town; and business people of all background. Basically the full spectrum of South African society was exposed to the workshop.

The strength of the workshop, as described in the preceding section, rests in its negotiation of sociolinguistic norms without jeopardising clarity of message and standard content. This flexibility was necessary to adjust to other languages, sociolinguistic norms and cultural values.

Using Mapekula's research, I took the opportunity to interview three ASET workshop facilitators to get their reaction to Mapekula's research and to find out if they felt the existing workshop had a similar bias.

Neither of the two Xhosa-speaking facilitators was aware that people were ascribing AIDS to poisoning or witchcraft. However, on reflection they could see the parallels and were aware that there was a conflict between Western and African views of AIDS and HIV. They both felt that if someone raised the issue at a workshop that it should be discussed, but with the aim of reinforcing the view that HIV is transmissible and the cause of AIDS.

One of the interviewees, Bongani Peter, a trainee counsellor with Triangle Project, raised his concern that blaming AIDS on *idliso* or witchcraft could be a form of avoidance.

> "People blame others: AIDS is from white people, AIDS is from gay people. They also believe in *idliso*... Mostly it's the people who are ignorant of AIDS. They will say it's *idliso* and things. And they won't listen to what the second person will be saying about HIV and AIDS" (Interview, 1996).

I believe that herein lies a difficult problem: that of determining agency, autonomy and responsibility in a cross-cultural setting.

One of the original premises of the safe sex workshops, as developed in Holland, was that the individual is responsible for his or her sexual choices. The assumption is that the individual acts independently and rationally. This view is fairly typical of Western psychology and philosophy.

Not all cultures share this view of individual autonomy. A contradictory belief within a number of Southern African cultures, at least traditionally, is that evil, including disease, is the result of someone else's ill-will and intent. If a person believes that he or she will become infected due to external influences, such as God's will, fate, or witchcraft it calls into question the effectiveness of prevention work.

If one compares the arguments between health care workers and clients in Mapekula's research, we have one side working with a cultural paradigm that says *AIDS is caused by HIV, a virus without intent or morals* and on the other there is the view that *one only gets sick in such a manner if one is the victim of malintent of a supernatural nature*. Is one true and the other false? If so, what becomes of multiculturalism and client-centred counselling?

The European and North American aim in AIDS prevention, at least initially, was to concentrate on building the individual's commitment to behaviour change and survival. There is limited evidence of this strategy being successful over an extended period of time (Odets 1993; Gold 1995).

African strategies have been similar, with greater emphasis on monogamy, sexual fidelity and social responsibility. There is little evidence that this approach has been more successful.

Who is responsible for decisions and agency around HIV transmission? We know that there are conditions within which it is unreasonable to expect an individual to take decisions in her best interest. We know that in a number of societies married women may not be in a situation where they can even mention safer sex, let alone introduce condoms into their sex lives. Similarly in situations of war or destabilisation individuals may lose their sense of control.

Referring to the deep scarring within South African psychosocial experience, Mkhize suggests that loss of control is a matter for consideration in counselling:

> "Being critical [about the relevance of counselling] is important especially if one is working with populations that have been adversely affected by outside forces. For example, an external locus of control is an appropriate and realistic response for a client whose well being is affected largely by external factors" (Mkhize 1995: 10).

Pao Saykao provides an interesting Asian example of agency and responsibility in an address to a Conference on Cross Cultural Communication in the Health Professions in Australia:

> "It is important to add that the people from Indo-China are members of their own close-knit network, and very often some decisions may need to be referred to the 'group leaders' in the family or the network, so that they can have the final say. This means that if there is, for example, a consent form

for surgery to be signed, the patient may not be the decision maker" (Saykao 1989: 76).

In this example, decision making is known to take place beyond the level of the individual. It is not that the individual is powerless, it is just that she is only part of the decision making process.

Returning to Bongani Peter's question with regard blaming *idliso* for AIDS, we are left with the question of how to respond to this lack of autonomy and / or absence of individual responsibility. Mkhize, Saykao and others stress the importance of knowing the client base, listening to the issues and working with people from their starting point. Intuitively, there should be a dividing line between situations wherein disempowerment or non-autonomy occur as a result of external cultural forces, and those that are still within the realm of the individual. Within this understanding, the supporting agent, be it the nurse or the prevention worker, needs to decide where support may be required for behaviour changes or learning. Finding that dividing line may not be easy but is likely an important and worthwhile exercise.

Conclusion

The ASET / Triangle Project General Safe Sex Workshop was not designed to deal with complex issues of culture and empowerment raised in this paper. I have described the workshop's reasonably successful approach to negotiating sociolinguistic boundaries with participants from diverse socio-cultural backgrounds.

Within that approach are some of the answers for working cross-culturally in a relevant and authentic manner without either imposing a Western paradigm or jettisoning what we know about viral transmission in favour of cultural relativism.

These observations are echoed in Mapekula's research. The contradictions between the biomedical model and popular culture do not pose an insurmountable challenge to communication. The implication of Mapekula's research is that the health care professional needs to start with the populist norms and assumptions and actively mediate an introduction to a bio-medical model of HIV and AIDS. The approach should emphasise opportunities for the client to play an active role in understanding the information, the gap in paradigms, and make choices within that space.

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[1] Note: this is a draft thesis submission and may be changed before acceptance by the University of Cape Town.

Nigel Crawhall, *Using a sociolinguistic approach to safe sex promotion in Cape Town: the challenges of multiculturalism*

Summary — The author looks at cross-linguistic and intercultural issues impacting on AIDS prevention and education work. He provides a case study of a safe sex workshop developed in Cape Town, South Africa, and highlights the effectiveness of negotiating changes in sociolinguistic norms in a workshop environment. The paper looks at more complex intercultural issues, including individual autonomy and agency in responding to the need for behaviour modification to cope with the risk HIV infection from sex. Drawing on the work of Luyanda Mapekula, the author suggests that there is a complex interaction between the top-down biomedical paradigm that dominates institutionalised health care, and the mobilisation of popular culture that may be used to obscure and avoid personal responsibility.

Keywords: AIDS prevention • sociolinguistics • multiculturalism • safe sex education • South Africa.

Nigel CRAWHALL, *Essai d'une approche sociolinguistique pour la promotion de la sexualité à moindre risque à Cape Town : les défis du multiculturalisme*

Résumé — L'auteur examine les problèmes translinguistiques et interculturels qui ont un impact sur la prévention du sida et le travail d'éducation. Il propose une étude de cas à partir d'un atelier — sur la sexualité à moindre risque — qui s'est déroulé à Cape Town en Afrique du Sud. Il met en relief l'efficacité de la négociation des changements de normes sociolinguistiques dans l'environnement spécifique d'un atelier. L'étude porte, au-delà, sur des problèmes interculturels plus complexes, comme l'autonomie individuelle et l'organisation de la réponse aux besoins de changement de comportement pour faire face au risque d'être infecté sexuellement par le VIH. S'appuyant sur le travail de Luyanda Mapekula, l'auteur suggère qu'il existe une interaction complexe entre le paradigme biomédical qui domine le système de santé institutionnalisé et la mobilisation de la culture populaire qui peut être invoquée pour cacher et dénier la responsabilité personnelle.

Mots-clés : prévention du sida • sociolinguistique • multiculturalisme • éducation pour une sexualité à moindre risque • Afrique du Sud.